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Congressional Record

United States of America PROCEEDINGS AND DEBATES OF THE 103d CONGRESS, SECOND SESSION

SENATE—*Wednesday, August 10, 1994*

(Legislative day of Monday, August 8, 1994)

The Senate met at 9:15 a.m., on the expiration of the recess, and was called to order by the President pro tempore [Mr. BYRD].

The PRESIDENT pro tempore. The prayer will be led by the Senate Chaplain, the Reverend Dr. Richard Halverson. Dr. Halverson.

PRAYER

The Chaplain, the Reverend Richard C. Halverson, D.D., offered the following prayer:

Let us pray:

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights * * * to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed * * *."—Declaration of Independence.

Almighty God, our Founding Fathers established this Nation upon the belief in a Creator-God. Thomas Jefferson asked, "Can the liberties of a nation be secure if we have removed from the hearts of the people the belief that those liberties are the gift of God?"

The prophet Jeremiah declared, "Thus speaks the Lord: What injustice did your fathers find in Me that they abandoned Me, habitually followed after futility, and became useless?"—Jeremiah 2:5, Berkeley Version.

Forty-five years ago the editors of Life magazine wrote: "The greatest threat to our civilization comes from within that civilization itself—our $64 euphemism for it is secularism. A much blunter word is godlessness. Our civilization, for all its churches and all its churchgoers, is predominantly a secular, godless civilization."

Holy God, awaken us to our national peril and help us to return to the God of our fathers.

In Jesus' name and for the sake of our national welfare. Amen.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT

The PRESIDENT pro tempore. Under the previous order, the Senate will now proceed to the consideration of H.R. 4606, the Labor-HHS Appropriations Act, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 4606) making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies, for the fiscal year ending September 30, 1995, and for other purposes.

The Senate resumed consideration of the bill.

Pending:

(1) Helms amendment No. 2466 (to committee amendment on page 63, beginning on line 5), to express the sense of the Senate regarding the congressional timetable for considering health care reform.

(2) Graham amendment No. 2478, to provide funds to carry out the Emergency Immigrant Education Act of 1984 or its successor authority.

AMENDMENT NO. 2478

The PRESIDENT pro tempore. Under the previous order, the Senator from Florida [Mr. GRAHAM] is recognized to speak for up to 15 minutes on amendment No. 2478.

The Senator from Florida.

Mr. GRAHAM. Mr. President, the amendment which has been filed by myself and others would provide for full funding of the Emergency Immigrant Education Act. This act was recently the subject of an amendment during our consideration of the Elementary and Secondary Education Act, at which time the authorization level for this program was set at $150 million. The purpose of this amendment is to provide appropriations to match that authorization.

Mr. President, immigrant education is, unfortunately, yet another example of the failed Federal-State partnership. In the case of Plyler versus Doe, the U.S. Supreme Court held that States have a legal responsibility to educate all children, regardless of immigration status. That is, the States have the legal responsibility to provide a free public education for children who are the children of citizens, permanent residents, and all other forms of legal residents as well as undocumented aliens.

Since that ruling more than a decade ago, the Federal Government has not provided adequate funds to reimburse States for these mandated services, particularly to the children of undocumented aliens. Individual States, of course, have no capacity, either under law or with their resources, to control access of illegal entrants to this Nation. Under the U.S. Constitution, that responsibility has been vested in the Federal Government.

Unfortunately, when the Federal Government does not adequately address its responsibility for illegal immigration, State and local governments are left with the burden of that failure.

The Emergency Immigrant Education Act program is the only Federal education program dedicated exclusively to assisting communities impacted by such immigration. The EIEA reimburses local school districts for the additional costs of educating immigrant children whom States are constitutionally bound to serve. Unfortunately, the program has been grossly underfunded since its inception in 1984, and the trend line has been down. Today, there are almost 810,000 immigrant children in the United States who qualify for funding under the EIEA. In 1984, the appropriation level for EIEA equaled $86 per pupil. The current appropriation for fiscal year 1994 of $39 million provides only $48 per pupil.

So, in 10 years, with increasing education costs, we have gone from a paltry $86 per pupil to today's $48 per pupil. Because Federal funding has not

● This "bullet" symbol identifies statements or insertions which are not spoken by a member of the Senate on the floor.

kept pace with increased immigration, thousands of school districts must devote more of their own scarce resources to educating immigrant children. Meanwhile, overcrowded classrooms have caused an explosion in construction costs, and the quality of education for both immigrant and American-born children, children of American citizens, is in jeopardy.

If I could use some examples, Mr. President, from my own State. In April 1994, Florida Governor, Lawton Chiles, and the Dade County School Board, a school board that serves the metropolitan Miami area, sued the Federal Government for the unreimbursed cost of serving the State's immigrant children, primarily for the 345,000 who are living there illegally, that is, the total number of immigrant children.

Education is the third largest of the costs which the State and local government are carrying as a result of that immigrant population. In 1993 alone, the Florida Department of Education and local school districts spent an estimated $517 million to provide education to immigrants. However, Florida received only $1.5 million under the Emergency Immigrant Education Act.

Compare those figures. The State and local school district spent $517 million to educate immigrant children, the Federal Government provided $1.5 million.

In Dade County, for each foreign-born student, the district incurs additional costs of approximately $1,152 from local funds which are not reimbursed from either Federal or State funds.

Mr. President, if I could personalize this, my daughter, Suzanne, taught for several years in the Dade County school system. In her last year of teaching in the Dade County school system, she taught in a kindergarten in a public school that served a community with large numbers of immigrant children, children who spoke a diversity of languages, with great educational needs, great differences in terms of their family circumstances. Her classroom, Mr. President, had 38 students—38 students—with only a part-time aide to assist her with 5-year-old kindergarten students. My daughter has subsequently married, has moved to northern Virginia, and taught last year at a public school in northern Virginia. She had fewer students in her north Virginia school system, only 24 or 25, with much less diversity in terms of the background of the students.

One of the consequences of this is that we are causing, very distinctly, unequal education to be made available not only to immigrant children but also to children of native-born American parents as a result of this disparity in terms of where immigrant children are being educated, a constitutional requirement that they be educated at State and local expense and the failure of the Federal Government to provide adequate supplemental resources.

More than 75,000 students, almost 25 percent of the student body in Dade County, are foreign born, thus costing the district over $86 million in unreimbursed costs. In addition, based on the net increase of 23,661 foreign-born students since 1980, it would cost Dade County a total of $285 million to build and renovate schools to accommodate these new students, the additional cost of such construction being an average of $12,000 per student.

A 1993 report entitled "Immigration Impact on Broward County Schools" stated that while,

> * * * the intent of the Federal law is that students should be funded at $500 per student, this never happens.
>
> Those levels have never risen above 2 percent of our total cost any year since 1989. For the past 3 years, we have received a minuscule portion of that money.

For the 1992–93 school year, Broward County received only $17.25 per student for its 8,240 students, resulting in $3.9 million in unreimbursed costs.

During consideration of Improving America's Schools Act, we increased the authorization level for the Emergency Immigrant Education Act to $150 million. This was an important step. However, it will be a hollow victory unless we provide full funding for this critical program.

The bill we are considering today provides $50 million. This is an increase of $11 million from the 1994 level. But it still equals only $62 per eligible student, far less than the over $1,000 per student which local and State funds are required to be spent in terms of incremental costs.

The amendment that Senator HUTCHISON and I are offering would transfer $100 million from salary expenses and program management to the Emergency Immigrant Education Act. This has been endorsed by the National School Boards Association, the National Conference of Mayors, and the National Council of State Legislatures.

I recognize that many administrative accounts in this bill have already been frozen or reduced. However, our States are facing an emergency situation, one which requires us to make tough choices about how we will spend our Federal funds. For the past 10 years, the Federal Government has avoided these tough choices because it has had little incentive to provide adequate assistance to the States for immigrant education services. Whether or not we provide adequate funds to reimburse States for the costs of educating immigrant students, States will continue to provide these services and will continue to have to pay the tab and will continue to have to dilute the quality of education to all of the children in their school districts.

The Senator from Iowa has argued that the EIEA Program primarily benefits only five States. That is because there are currently five States facing emergency immigration situations. We have had other examples of emergencies: in my State with the hurricanes, in the State of the Senator from Iowa with floods, and the State of the Senator from California with earthquakes and otherwise.

This Congress has not refused to recognize an emergency just because it was highly concentrated in its impact. I believe, Mr. President, that similarly we should answer the question: Should we abandon those communities of America which are heavily impacted by immigration? The answer is clearly no. But in this situation, when our States are overwhelmed by the impact of Federal immigration policy, a policy which has failed to protect our borders, failed to enforce our immigration laws, and has allowed hundreds of thousands of undocumented aliens into our country, and our States have repeatedly asked the Federal Government for assistance to deal with this problem, we have the responsibility to provide that assistance.

The Senator from Iowa has also argued that the number of immigrant students has decreased over the past year. However, that has not changed the fact that the EIEA Program has never been adequately funded, and currently reimburses States for only a minuscule percentage of their cost of educating immigrant children.

The Federal Government has the complete constitutional responsibility for our Nation's immigration policies as enumerated in article I, section 8 of the U.S. Constitution. The power and singular responsibility was conferred from the States to the Federal Government to "establish a uniform rule of naturalization." When there is an egregious failure of the Federal Government to carry out their responsibility, the community in which this failure is projected should not have to pay the cost.

Until the Federal Government is required to meet its responsibility for its dereliction in its duty to protect the borders and enforce immigration, then the Federal Government has no basis upon which to refuse to provide assistance to those States which have been heavily impacted. States and localities do not have the luxury of avoiding this responsibility.

I urge my colleagues to join with the cosponsors of this amendment in support of the proposition that the Federal Government should meet its obligations and should assure that the goal of providing equal educational opportunities for all children in all communities of America is realized.

Thank you, Mr. President.

The PRESIDENT pro tempore. The pending question is amendment No.

2466, offered by the Senator from North Carolina [Mr. HELMS], to the committee amendment on page 63, line 5 of the bill.

The debate on the amendment is limited to 30 minutes, with 10 minutes under the control of the Senator from North Carolina [Mr. HELMS]; the Senator from Iowa [Mr. HARKIN]; and the Senator from Pennsylvania [Mr. SPECTER].

Who seeks recognition?

Mr. SPECTER addressed the Chair.

The PRESIDENT pro tempore. The Senator from Pennsylvania [Mr. SPECTER].

ORDER OF PROCEDURE

Mr. SPECTER. Mr. President, the bill was originally set for 9:30. It is now 9:33. The proponent of the amendment has not yet arrived on the floor. I just learned at about 9:10 this morning that the Senator from Florida had 15 additional minutes on his amendment. I have been advised by staff of the chairman, Senator HARKIN, that they were only advised this morning, as well. So it may be that we will need some additional time to respond to the amendment by the Senator from Florida.

Mr. President, in the absence of the pending amendment's sponsor, I ask unanimous consent to take 5 minutes in replying to the Senator from Florida, so that we can save that time after the other Members arrive.

The PRESIDENT pro tempore. Does the Senator not wish that that time come out of the time allotted to the Senator from Pennsylvania under the order?

Mr. SPECTER. Mr. President, that is correct. The time that this Senator has, 10 minutes, relates to the Helms amendment. I had not anticipated using any time on the amendment of the Senator from Florida.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. SPECTER. Perhaps I might propound a unanimous-consent request, if it is satisfactory to the chairman, for 10 additional minutes to reply to the Senator from Florida, 5 minutes being used by this Senator, and 5 minutes being used by the chairman.

Mr. President, after consulting with the chairman of the subcommittee, our request for unanimous consent is that we be allotted 10 extra minutes, 5 minutes which I will take and 5 minutes which Senator HARKIN will take, and then we will begin the Helms amendment at the conclusion of that 10 minutes. Thirty minutes will start to run at the conclusion of the 10 minutes which I have just requested.

The PRESIDENT pro tempore. Is there objection? The Chair hears no objection. The request is granted.

The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, I have sought the 5 minutes to reply briefly to the arguments made by the Senator from Florida [Mr. GRAHAM], on his amendment for a transfer of $100 million additionally to the program for immigrant education. I am very sympathetic to what Senator GRAHAM has requested. It is my wish that we fund an additional $100 million. However, the funds which the amendment proposes would be taken from salaries and expenses of the Departments of Labor, Health and Human Services, and Education. This would have a very, very severe impact.

When this bill was crafted, we were slightly under $70 billion, which seems like a great deal of money at first blush, but really is not when we have to accommodate all of the needs of Education, Health and Human Services, and Labor at the Federal level. There has already been an increase this year of some $11 million for immigrant education, which is an increase of some 28 percent, which is an enormous increase for this program compared to what has happened to other programs within this bill.

If the funds were taken, illustratively, from the Department of Labor, some $33 million and a third of a million dollars, it would block OSHA's initiative to target inspections of the worse offenders of the health and safety laws. It would leave the Bureau of Labor Statistics unable to revise the Consumer Price Index, which is enormously important for measuring inflation in America. It would reduce the number of mine inspections, and it would reduce the Department's ability to apprehend and prosecute violators.

On the education bill, there would be a very significant impact, eliminating the student aid guide and student aid enforcement center, which is instrumental in helping over 7 million college students to obtain Federal student aid dollars. It would require about 30 days' furlough for the Department's 5,000 employees.

And on Health and Human Services, the reduction would impact on the intermural research program and clinical center at the National Institutes of Health, and on the epidemiological and disease surveillance staff capacity of the Centers for Disease Control. There would have to be significant reduction in the Social Security Administration's disability determination programs.

We have very carefully considered these expenses, Senator HARKIN and I, as chairman and ranking member of the subcommittee, as has the full committee, which the Presiding Officer chairs, and we have done the best we can.

In view of the limited time, Mr. President, I ask unanimous consent that a letter of August 8 to Senator HARKIN from Acting Director of OMB, Alice Rivlin, be printed in the RECORD, as well as the impact statements from the three Departments, which more fully set forth the very significant cuts which will have to be imposed if this amendment were to be adopted.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT AND BUDGET,
Washington, DC, August 8, 1994.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, HHS, Education, and Related Agencies Appropriations, Committee on Appropriations, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The purpose of this letter is to express the Administration's opposition to the "Hutchison-Graham" amendment to H.R. 4606, the Labor, Health and Human Services, Education, and Related Agencies appropriations bill, FY 1995. This amendment would substantially cut the agencies' administrative budgets in order to increase funding for the Immigrant Education Program.

The Administration is sympathetic to the Senators' desire to support State efforts to educate immigrants. However, this amendment would have a devastating impact on administration of programs in each agency. Examples include significantly delaying student financial aid grants and loans, preventing the Department of Labor from implementing its initiative to improve the targeting of OSHA inspections, reducing Health and Human Services' capacity to administer priority AIDS grants and childhood immunizations and to ensure the accuracy of Medicare and other entitlement payments, and delaying the Social Security Administration's ability to reduce the disability claims backlog.

The Administration strongly objects to the Hutchison-Graham amendment, and I urge the Senate to reject it.

Sincerely,

ALICE M. RIVLIN,
Acting Director.

IMPACT OF THE SALARIES AND EXPENSES CUT ON THE DEPARTMENT OF LABOR

The amendment to cut approximately $34 million from the Department of Labor's Salaries and Expenses (S&E) account would have a devastating impact. This is primarily a cut in DOL enforcement programs—not cuts in administrative overhead.

Adoption of this amendment would gut the Department's worker safety enforcement initiative aimed at improving the lives and workplaces of American workers. DOL enforcement activities have declined by 19 percent in the last 14 years, even as the Department's responsibilities have increased with the passage of new legislation, such as the Family Medical Leave Act, and with the growth of the workforce. The bill before the Senate has already decreased DOL S&E funding by $80 million, or 5%, below the Administration's request.

The action will have the following impacts:

It will block OSHA's long overdue initiative to target inspections on the worst violators of our health and safety laws. It will cut the number of inspections OSHA can undertake and increase the likelihood of another disaster like the Hamlet, N.C., chicken plant fire.

It will render the Bureau of Labor Statistics unable to undertake the proposed revision of the Consumer Price Index (CPI). The revision of the CPI is vitally needed. It is estimated that a 1% error in the CPI costs the

American people $600 million annually. It is truly pennywise and pound foolish not to make this small investment.

It will reduce the number of mine inspections, which will put miners at greater risk and could result in more accidents, injuries and deaths.

It will reduce the Department's ability to catch and prosecute those who embezzle from or defraud pension plans and health benefit plans, leaving retirees and workers less protected.

DEPARTMENT OF EDUCATION

SALARIES AND EXPENSES AMENDMENT

The Senate Committee bill has already reduced S&E by $19 million, or 5 percent below the President's request—and by $13 million, or almost 4 percent, below the House approved level.

A further reduction of $33 million would:

Eliminate the Student Aid Guide and Student Aid Information Center that help over 7 million college students obtain Federal student aid dollars.

Significantly delay the award of grants, loans, and work-study opportunities to these 7 million students.

Eliminate management improvements to prevent fraud and abuse in all Federal student aid programs—something for which this Body has severely criticized the Department.

Significantly delay the award of Federal dollars to States, local school districts and institutions under all the Department's 240 programs.

Eliminate providing assistance and information on Federal programs and successful education practices to States, school districts, teachers, and parents—at a time when the Nation needs to make dramatic reforms in education and to become more competitive.

Require about 30 furlough days for the Department's 5,000 employees.

EFFECT OF ADMINISTRATIVE COST REDUCTION—HHS

A $33 million reduction in Salaries and Expenses for DHHS would impact on all aspects of the Department's operations including:

Payment of Medicare claims through the Medicare contractors.

The entire intermural research program and clinical center at the National Institutes of Health.

Epidemiological and disease surveillance staff capacity at the Centers for Disease Control.

Capacity to manage and implement expansion of Head Start and reform of the welfare system.

Social Security Administration's disability determinations operations.

Such an amendment ($33 million) is equivalent to nearly ¼ of the funds needed to pay the statutory Federal pay raise during FY 1995.

The Senate level, by either "freezing" administrative cost or cutting below FY 1994 levels, will force agencies to absorb the mandated pay raise in other budgeted items. An additional $33 million reduction will exacerbate this situation.

Removal of $33 million could jeopardize the Department's ability to meet its streamlining objectives through the use of buy-outs. Buy-outs cost $25,000 plus an average of $2,000-3,000 in lump-sum payments for annual leave.

Actions already taken:

Staff reductions—In 1994, 900 FTE will be eliminated and an additional 425 in 1995.

Procurement reduction—The procurement budget amendment reduced all procurement funding by $37 million. This will require agencies to purchase less services (consultants, data processing, Medicare insurance claims processing) and equipment.

Rent reduction—The rent payment budget amendment reduced funds available for space rental by $8 million, in order to downsize the current office space usage by HHS.

Administrative offsets for IHS Budget Amendment—Offsets of $27 million were taken against salaries and expenses to finance an April Indian Health Service budget amendment. This reduction represented an approximately 1.5 percent across-the-board cut.

Mr. SPECTER. I yield the floor.

The PRESIDENT pro tempore. The Senator from Iowa [Mr. HARKIN] is recognized.

Mr. HARKIN. Mr. President, I want to join my colleague, Senator SPECTER, in opposing the Graham amendment.

I had spoken about it the other day. I think Senators ought to be fully aware of what this amendment does. It may be couched in terms that you are cutting salaries of bureaucrats in some of these Departments by $100 million, and then we can use this for immigrant education.

First of all, a close reading of the amendment will show it is not just salaries. If you read the amendment, it says salaries, expenses, and program management, not just in the broad context, but in each program, project, or activity. That means that every entity in the Departments of Labor, Health, and Education, will all have to take a proportional share of the cut.

What that means is that it is not just some sort of a mushy taking out of some salary someplace. It means that the actual running of the offices, the management of the offices, the phone calls, the equipment, and everything else, is affected by this. So what it means is that the reduction could result in the closing of Social Security offices and delays in processing Social Security checks.

Mr. President, every Senator has on his or her desk a "Dear Colleague," signed by a bipartisan group of Senators, including the occupant of the chair, our President pro tempore, Senator BYRD; Senator HATFIELD; myself; Senator SPECTER; Senator INOUYE; Senator STEVENS; Senator COCHRAN; Senator PELL; Senator KASSEBAUM; and Senator DODD. This "Dear Colleague" lays it out very clearly as to the impact of the Graham amendment.

The backlog in Social Security disability claims is expected to be over a million in fiscal 1995 and will grow even larger because we will not be able to process Social Security disability claims. The reduction would cut funding appropriated for the process of Medicare claims, making millions of senior citizens wait longer for reimbursement. Audit activities to control fraud and abuse would also suffer and result in the loss of more than $100 million in Social Security and Medicare funds. Efforts to control SSI payments to drug addicts, alcoholics, and illegal aliens would be affected. The $100 million reduction will cut funding and delay the implementation of programs to immunize the Nation's children.

This amendment will cut funding for Public Health Service programs for AIDS, breast and prostate cancer, and necessary funds to respond to outbreaks of diseases such as tuberculosis. The reduction would delay services to 7 million college students who apply for Pell grants and other campus-based aids.

So, Mr. President, this amendment is one that would just be devastating. I must also add that in the past couple of years we have increased funding for immigrant education by almost 70 percent in the last 2 years, at the same time that the number of school districts reporting immigrant students has actually declined by 2 percent.

So I ask Senators to resist this amendment. It sounds good. It would have a devastating impact on other programs, plus the fact that we have increased immigrant education, increased it substantially, even while the reports are that the number of immigrant students is declining.

I yield the floor.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent to speak in favor of the Graham amendment for 5 minutes.

The PRESIDING OFFICER (Mr. CAMPBELL). Is there objection?

Without objection, the Senator is recognized for not to exceed 5 minutes.

Mrs. HUTCHISON. Thank you, Mr. President.

I thank Senator HARKIN and Senator SPECTER for allowing me to speak in favor of the Graham amendment.

I do understand what the Senators are facing trying to get this bill through, and I know there have been some cuts, and I realize that it is very difficult to take money on the floor for another purpose. But the border States have been paying for a Federal mandate—this time it is a Supreme Court mandate—year after year after year. We are educating illegal immigrants in our school systems, and it is a very great burden that really should not be borne by the States. It is a Federal issue.

There are 810,000 illegal immigrant children in the school systems in America, and 70,000 of those are in my State. The school districts are not rich. These are local school districts. They get matching funds from the State, but it is mostly local. These are generally poor school districts that have a hard time providing the education at the level that we would like for them to be anyway.

But to have the burden of illegal immigrants coming into our education system is really more than those local school districts are able to bear. The States do help, but it is still not a fair issue for the States to have to pick up the cost. There are probably 10 States in this country that are picking up the cost for the other 40. And that is just not right.

So what we are asking for today is equity. We are asking for the help from the Federal Government because we are not controlling our borders as we should be. The Federal Government is responsible for keeping illegal immigrants out of our country, as we welcome legal immigrants and as we try to serve the citizens and taxpayers of our country. It is very important that we recognize that this is a Federal issue, that the States and the local governments and the borders have been burying this infrastructure problem year upon year upon year.

I ask that the Senate pass this amendment. It is $100 million that will be taken from the administrative costs of three agencies. That is just a belt-tightening. Most businesses and most homes in this country have done belt-tightening. I think we ought to be doing it throughout the Federal Government anyway. In fact, I have introduced a separate bill that would provide a $50 billion cut, $10 billion a year, most of which is administrative costs of Government across the board.

I think everybody can belt-tighten 5 or 10 percent, as our businesses and our families have in this country. I think this would be a good exercise. Let us put it where we really need it, and that is to help the States and local school districts that are bearing this Federal burden to educate illegal immigrant children under a Federal mandate by the Supreme Court that we must do it.

I thank the Chair and I thank the managers of the bill.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BYRD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The pending question is amendment No. 2466 offered by the Senator from North Carolina [Mr. HELMS], to the committee amendment on page 63, line 5 of the bill.

Debate on the amendment is limited to 30 minutes, with 10 minutes each under the control of the Senator from North Carolina [Mr. HELMS], and the Senator from Iowa [Mr. HARKIN], and the Senator from Pennsylvania [Mr. SPECTER].

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

PRIVILEGE OF THE FLOOR

Mr. SPECTER. Mr. President, I ask unanimous consent that John McCann, an intern on my staff who helped me prepare the chart on the Mitchell health care bill, be admitted to the floor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SPECTER. Mr. President, I suggest the absence of a quorum, and I ask unanimous consent that the time be divided equally among the Senator from North Carolina, the Senator from Iowa, and myself.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. HELMS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HELMS. Mr. President, may I inquire what is the status of the unanimous consent regarding the order in which amendments will be voted on this morning? I understand that there is some alteration.

The PRESIDING OFFICER. The Chair will tell the Senator the first vote will be on his amendment No. 2466 to the committee amendment, followed by the committee amendment, and then followed by amendment of the Senator from Florida [Mr. GRAHAM].

Mr. HELMS. I have been informed that a unanimous consent is in the process of—I think I will yield to the Senator from Pennsylvania.

Mr. SPECTER. Mr. President, will the Senator from North Carolina yield to me?

Mr. HELMS. I yield.

Mr. SPECTER. Mr. President, I am advised by the majority staff that this amendment is cleared and the amendment is acceptable to this Senator for unanimous consent to vote on or in relation to the Helms amendment No. 2488 occur immediately following the disposition of the Helms amendment No. 2466 with the remaining votes occurring as previously scheduled.

I believe that that would call for the time sequence of the 30 minutes to begin now on the Helms amendment No. 2488.

Mr. HELMS. Which of my amendments is amendment No. 2488?

The PRESIDING OFFICER. The Senator will withhold a moment.

Mr. HELMS. I certainly will.

The PRESIDING OFFICER. To identify the amendment the Senator is requesting it is amendment No. 2488 on the Department of Defense appropriations bill dealing with health care reform.

Mr. HELMS. That answers my question then, I am sure. In other words, amendment No. 2488 is the modification of the first health reform amendment, is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. SPECTER. Mr. President, will my colleague yield one more moment?

Mr. HELMS. I yield.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, since this amendment has been substituted, I ask unanimous consent that the 30 minutes previously allotted to the prior amendment be allotted to this amendment with 10 minutes going to the Senator from North Carolina, 10 minutes to the Senator from Iowa, and 10 minutes to this Senator.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from North Carolina.

Mr. HELMS. Mr. President, let me save the Senate a bit of time. The immediately ensuing rollcall vote on the first Helms amendment to Labor-HHS will be a waste of the Senate's time because I am going to move to table my own amendment and ask for the yeas and nays on the motion to table unless the Senate proceeds and grants my unanimous consent to vitiate the yeas and nays on that first amendment. I ask unanimous consent in that regard. There is no point in having a rollcall vote on it.

The PRESIDING OFFICER. The Chair as the Senator from Colorado will object, in the absence of the majority leader being here.

Mr. HELMS. All right.

I understand what is going on, I say to the distinguished Senator occupying the Chair.

So, before I do move to table my amendment, then, I think I should make clear that following the vote on the motion to table my original amendment, another vote will immediately follow, on virtually the same amendment, this one having been offered to the Defense bill. That is what the Chair just confirmed to me. Is that not correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. HELMS. I thank the Chair.

So the two amendments, the one that I shall move to table and the one on the Defense appropriations bill, are identical except for my addition of the following language to the original sense-of-the-Senate declaration. It is a portion that is in both amendments that I read now.

> It is the sense of the Senate that major health care reform is too important to enact in a rushed fashion and Congress should take whatever time is necessary to do it right by deferring action until next year to give Congress and the American people ample time to obtain, read and consider all alternatives and make wise choices.

That is where the first amendment ends. The second amendment, which is the one to the Defense appropriations bill merely adds the following:

> Unless the Senate has had the full opportunity to debate and amend the proposal after Congressional Budget Office estimates have been made available.

Now, as I say, this next vote is totally unnecessary. But let me explain why we are forced to proceed with such an unnecessary vote. Yesterday, Senator STEVENS on my behalf suggested that since I intended to modify my original amendment, the original amendment be withdrawn inasmuch as the yeas and nays had been obtained on the original amendment. When the unanimous consent to have my first amendment was proposed, an objection was heard on the Democratic side, as it was just moments ago.

I do not know what kind of games they are trying to play. That suits me fine. I can play them, too. Normally, in a situation like this courtesy prevails in the Senate, but in this case courtesy did not and does not prevail.

Now, let me point out that every publication, every observer that I know of has said wait to reform our health care system until January; do not do this thing in a rushed order. A recent NBC-Wall Street Journal poll found that 61 percent of those polled said to wait on health care reform. Only 34 percent said pass the bill now.

Here is the telephone number if you want to call Senators at the last minute and say, lay this thing aside until January and do not be foolish and pass something that is going to be bad for the American people. The Senate telephone switchboard number is 1-202-224-3121. You might want to call right now and get hold of your Senators.

Other polls also say that we should wait. The Hart-Teeter poll for the Wall Street Journal and NBC was conducted on April 30. It said "pass the bill this year, 34 percent"; "continue to debate the issue and act next year, 58 percent."

So, by a wide margin, Americans are of the opinion that it is a mistake for the Senate to rush through health care reform this year. It has become strictly a political issue. It is not a health issue anymore. It is a political issue. And we ought not to operate in that atmosphere in passing a piece of legislation this important.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. SPECTER. Mr. President, I am advised that technically the unanimous-consent agreement was not entered. So I would renew the unanimous-consent request that the vote on or in relation to the Helms amendment No. 2480 occur immediately after the disposition of the Helms amendment No. 2466, with the remaining votes occurring as previously scheduled; with 10 minutes being allotted to the Senator from North Carolina, as in the previous unanimous-consent request; 10 minutes to the Senator from Iowa, Senator HARKIN; and 10 minutes to this Senator, as in the previous unanimous consent request; with the time used by Senator HELMS having been deducted from his 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. INOUYE. Mr. President, parliamentary inquiry. Does Senator HARKIN have 10 minutes assigned?

The PRESIDING OFFICER. The Senator is correct; the Senator has 10 minutes.

Mr. INOUYE. Mr. President, in his behalf, I yield back the remainder of my time.

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Parliamentary inquiry.

Under the unanimous-consent request, is it true that I now have 10 minutes to speak on the Helms amendment?

The PRESIDING OFFICER (Mr. LIEBERMAN). The Senator is correct.

Mr. SPECTER. I thank the Chair.

Mr. President, I have asked for 10 minutes to speak on the amendment by the Senator from North Carolina, which had as its original purpose to delay the consideration of health care legislation until next year, and it has been modified, as I understand, to delay consideration until there is adequate time. We will be voting on the Helms amendments in due course.

I had reserved these 10 minutes to speak on the subject because for many weeks I have said that I would not join any filibuster against health care legislation. However, over the last weekend I have reconsidered that position because of the complexities of the Mitchell bill and what may be a rush to judgment.

My current thinking is that we should take up this bill and take the time to do it right and not on anyone's political timetable. The bill is a very complicated bill, as is evident from the fact that it has not yet been filed, as I understand it.

This morning's Washington Post contains a report which questions whether the Mitchell bill can be scored and be presented to the Senate at this time. The report notes that "Since MITCHELL unveiled his plan last week, the legislation has been rewritten hundreds of times, sources said, because the original plan would have created a huge deficit." And there are many, many questions outstanding as to what the Mitchell plan would actually do.

When the original Clinton health care plan was proposed, I asked my staff to make a list of all the agencies, boards, and commissions, because I was so surprised by the complexity of the plan. Instead, my staff made a chart of the new agencies, boards, and commissions in the Clinton plan, and the chart showed that the plan had some 105 new agencies, boards, and commissions in a bill that was 1,342 pages long.

If the Chair will indulge me, I will go to the back of the Chamber to show the chart.

Mr. President, this is the chart of the Clinton health care program, with the boxes in red signifying 105 new agencies, boards, and commissions and the boxes in green signifying the existing agencies which have new administrative responsibilities.

Since my staff and I obtained the draft of the Mitchell proposal, with the work of John McCann, who is an intern in my office from the University of Pennsylvania's Fells Institute, working literally night and day, this chart has been prepared which shows at a glance the enormous bureaucracy of the Mitchell health bill. This was prepared from the preliminary draft of the Mitchell bill, and as yet we do not have the final version of the bill. The initial draft was 1,410 pages long and the red boxes here show 170 new boards, agencies, councils, commissions, programs, and functions, and 44 existing agencies with new and expanded functions.

Mr. President, this chart shows the enormously complicated bureaucracy which would come into play with Senator MITCHELL's bill. My suggestion has been consistently that what the Senate should do is not to scrap the current health care system but to build on it. Toward that end, I introduced, some 18 months ago, Senate bill 18, which would be directed at covering the 37 to 40 million Americans now not covered, provide for coverage for preexisting conditions, coverage for change of jobs and the reduction of spiraling health care costs. I intend to speak about that later today when my time will come to address the overall Mitchell proposal.

I believe that the Congress has not faced a challenge as serious as the one now confronting it, perhaps, in the history of the Congress; certainly since Social Security was enacted in the 1930's. I believe that we have to take whatever time is necessary to do it right. I do not think we ought to be motivated by any political timetable, where it is said that it is necessary to get this bill out before the November elections so the President's purpose can be accomplished. I do not think there ought to be any Democratic timetable to help Democrats. I do not think there ought to be any Republican timetable on a filibuster for political purposes, either.

During the course of the last week, as I have been in my home State, Pennsylvania, I have heard many, many questions raised about this plan. People approach me on the train traveling to and from Washington, DC, in the shopping malls, and again in restaurants.

I believe I struck a chord, apparently, 2 days ago when, discussing this matter, I commented about what my Aunt Rose in Wichita, KS, had to say about the Clinton health care plan and what she has read about the Mitchell proposal. From time to time, I find more wisdom in talking to my Aunt Rose than I find in the committees and on the floor of the U.S. Senate.

Aunt Rose had a very basic approach. Her approach was, "I like the health care coverage I have now. I have Medicare and I pay $91 a month. What will happen to me under Senator MITCHELL's bill?" And I could not answer that question.

And then she said, "I'd like to see the poor people covered. I'd like to know what is going to happen there." She said, "What is it going to cost if we have the Mitchell health care plan adopted?" And I could not answer that question for her.

I was talking to my wife over the weekend. Joan used to have a small business which was a bakery which made candy, walnut pies, and double chocolate mousse pies. She said, "Arlen, what would these health care plans cost me if I were still running that small business?" She said, "I certainly could not afford to pay several thousand dollars a year for each additional employee."

And I said, "Joan, I do not know. I do not know the answer to that question."

We have just seen a report come out from the Entitlement Commission, again drawing the dangers of the cost of entitlements in America. And on the Senate floor no subject has been debated more in my 14 years here than the deficit, which is around $250 billion a year, and the national debt, which is $400 trillion. What these entitlements will cost is unanswered. Today's story in the Washington Post again reiterates that.

So, Mr. President, it is my view that we ought to take up health care reform and we ought to seek answers to these questions. I do not think it is indispensable——

Mr. BUMPERS. May I borrow your chart?

Mr. SPECTER. You may borrow my charts, Mr. BUMPERS.

Mr. BUMPERS. I want to borrow the maker of the chart.

Mr. SPECTER. You want to borrow the maker of the chart? I will be glad to make the maker of the chart available to Senator BUMPERS as well.

Mr. President, the Senate is not in order.

The PRESIDING OFFICER. The Senator is correct. The Senate will come to order. The Senator from Pennsylvania has the floor.

Mr. SPECTER. Mr. President, the concern which I have is that in this rush to pass health care reform we will not have a chance to receive input from the American people. Hearings would be useful, but I am not saying the hearings on the Mitchell bill are absolutely indispensable.

But there is a quality that, when time passes and there are newspaper analyses, editorials, op-ed articles, and radio talk shows, the American people will discover what the bill is all about. We should have input from organizations representing senior citizens, consumers, doctors—if I may have 1 additional minute, Mr. President?

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SPECTER. Mr. President, that is what I think is necessary in order to have an evaluation of the program.

When the Clinton health care proposal was introduced in October of last year, the initial response was terrific. But as the American people began to understand it, the favorable rating for the Clinton health care plan went way down.

We have not yet even had the final version of the Mitchell health care plan. But I submit that when you take a look at this chart with the 170 new agencies, boards, commissions, programs, and functions, and 44 new agencies existing with new responsibilities, that we ought to pause. We have to take our time on this vital subject to do it right if we are to do it at all.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina has 4 minutes 58 seconds remaining.

Mr. HELMS. Mr. President, momentarily I shall move to table my own amendment, and I am going to urge all Senators to join me and vote to table. Before I do that, I ask unanimous consent that several things be printed in the RECORD at the conclusion of my remarks. First is a poll by the Times Mirror and the Harvard School of Public Health which asks:

> "Will health care reform give you the freedom to choose a doctor?" Thirty-three percent said they would have as much freedom. But 58 percent said they would have less freedom to choose their doctor.

Second, a poll conducted by the CNN/USA Today/Gallup Poll, in mid-July asked:

> "Do you think you have enough information to judge the health care plans which have been proposed?" Twenty-nine percent said they have enough information. A resounding 70 percent said they need more information.

Third, a Hart/Teeter poll from the Wall Street Journal/NBC asked:

> "Should Congress pass the health bill this year?" Thirty-four percent said yes. But 58 percent said continue to debate the issue and act next year.

I ask unanimous consent that these three polls be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. HELMS. Now just a sample of commentaries. One is from this morning's Washington Post. It says the same thing I have said in my amendment—let us wait until next year. Written by Robert J. Samuelson, who has a similar piece in the latest issue of Newsweek, the article is headed, "Health Care: Start Over Next Year. They don't know what they are doing up there." I would say that is an understatement. So I ask unanimous consent that this article be published in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 2.)

Mr. HELMS. One of the most sensible publishers in the country is the publisher of the Charlotte Observer in my own State, Rolfe Neill. This past Sunday, Rolfe devoted his op-ed piece to a Viewpoint headed, "What's The Rush? Don't hurry to provide lifetime, irrevocable benefits that we can't afford."

I ask unanimous consent that Rolfe Neill's column be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 3.)

Mr. HELMS. Let me make one more attempt to save the Senate 15 minutes—it will be 25 minutes. There is no point in having two votes on this. It suits me fine, but I am going to ask unanimous consent, once more, that the yeas and nays be vitiated on my first amendment, the one to Labor/HHS, so that I can withdraw it. Then we can proceed to the vote on my second amendment, the one to the defense bill, which is almost identical.

The PRESIDING OFFICER. Is there objection to the motion to vitiate the yeas and nays?

Mr. INOUYE. Objection.

The PRESIDING OFFICER. Objection is heard.

Mr. HELMS. Let the RECORD show this side is not trying to delay anything.

EXHIBIT 1

[From a Times Mirror-Harvard School of Public Health poll, June 23-26, 1994]

WILL HEALTH CARE REFORM GIVE YOU THE FREEDOM TO CHOOSE A DOCTOR?

As much freedom: 33%.
Less freedom: 58%.

DO YOU THINK YOU HAVE ENOUGH INFORMATION TO JUDGE THE HEALTH CARE PLANS WHICH HAVE BEEN PROPOSED?

Have enough information: 29%.
Need more information: 70%.
No opinion: 1%.

CONGRESS SHOULD . . .

Pass the Health Bill this year: 34%.
Continue to debate the issue and act next year: 58%.

EXHIBIT 2

[From the Washington Post, Aug. 10, 1994]

HEALTH CARE: START OVER NEXT YEAR

(By Robert J. Samuelson)

They don't know what they're doing up there.

Among other things, the Democratic health care plan contains a large—and unjustified—multi-billion-dollar tax on younger workers. You wonder whether most members of Congress know this or even care. The whole health care debate is now completely out of control. The desperate effort to craft something that can be advertised as "universal coverage" means that Congress literally no longer knows what it's doing. Anything resembling the Democrats' bills, if enacted, would produce massive unintended side effects.

Apparently, most Americans grasp this. In a Newsweek poll last week, respondents were asked whether Congress ought to "pass reform this year" or "start over next year." By a two-to-one margin (65–31 percent), they said "start over." They sense that the versions of health reform crafted by House and Senate leaders are hodgepodges of conflicting provisions whose only purpose is to win passage. But what is clear to ordinary Americans is denied in Washington. In the capital, the fiction is that legislators know what they're doing and are debating rational alternatives.

"I think you're going to see a very good, erudite back-and-forth," says House majority leader Richard Gephardt, sponsor of the House bill. Well, it won't be "erudite" if members of Congress don't understand the consequences of their actions.

Gephardt's plan, for instance, would create a new Medicare Part C program for the unemployed, workers in small companies and many existing Medicaid recipients. The Congressional Budget Office estimates that the program might enroll 90 million people. But the projection could easily err by millions in either direction. More important, Medicare Part C emphasizes "fee for service" medicine (patients selecting individual doctors), while the rest of the bill emphasizes "managed competition" (reliance on health maintenance organizations and similar plans).

In a single stroke, the bill would separate the under-65 population into two groups, mainly based on income and size of employer. Each group would be crudely steered toward a different type of medicine. In practice, this division may not be politically acceptable or economically workable. Many Americans may find one type of medicine more appealing than the other and resent being excluded. Or the artificial segmenting of the medical market may raise costs for both "managed competition" and "fee for service." Gephardt doesn't know; no one does.

Now, consider the tax on young workers. It arises from "community rating." As people age, their health costs and insurance premiums rise. But "community rating" requires that everyone pay the same rate. This provision is included in the House bill and, in a modified version, in the Senate bill. The effect would be to raise insurance for younger workers (say those below 45); the amounts are hard to estimate, but a good guess is at least $300 to $500 a worker. If employers have to pay higher insurance, they will pay lower salaries. The invisible tax on young workers might total $15 billion to $25 billion annually.

Is this fair? No. If enacted, it would compound the existing bias against the young. Already, one-third of the federal budget goes to the elderly; the young are taxed to support the old. How much farther is this to go? Or is it a cynical reaction to voting patterns (the young vote less than the middle-aged or old)?

Questions like these swirl around both Gephardt's plan and Senate majority leader George Mitchell's. It is hard even to describe Mitchell's plan. He says it's voluntary and lacks a "mandate." Wrong. It's true that it doesn't mandate companies to buy insurance for workers. But it does mandate a standard benefit package for firms—the vast majority—that offer insurance. Because the mandated benefits are, above average, this would probably raise health spending. Companies below the new standard would increase benefits; those above would have trouble lowering them.

Next, Mitchell hopes to achieve 95 percent insurance coverage by offering subsidies for low-income workers to buy it. But there's a "fail-safe" mechanism to limit subsidies if the budget costs exceed projected costs. However, if 95 percent coverage doesn't occur by 2000, Congress could require employers to pay 50 percent of their workers' insurance. But this would apply only to firms with more than 25 workers. Got it? Neither Mitchell nor anyone else knows whether this would reach 95 percent coverage.

These plans are confusing because the health debate evaded the basic tension between expanding health services ("universal coverage" etc.) and controlling health spending. It's hard to do both at the same time. The plans' complexities—as with the original Clinton plan's—aim to disguise this conflict. Republicans haven't been especially constructive in this debate because they haven't faced up to it either. But they are now correct that a bad bill would be worse than none.

Chaos is now the most important (and largely unreported) reality about the health care debate. Dozens of provisions in these bills would have huge unappreciated consequences. John Sheils of Lewin-VHI, a health consulting firm, says premiums for small businesses in the Mitchell bill could be 25 percent higher than for big companies. The CBO agrees a gap exists but puts it lower. Who's right? Do most members of Congress understand the gap? Probably not. Still, the pretense in Washington is that Congress is making conscious choices.

The pretense is sustained because in Washington politics is sport, especially at the climax of a legislative battle. All attention fixes on who wins and loses—and the deals that enliven the game. Rhetorical blasts are taken for reality; political reporters know little of how legislation would work and care less. This often leads to bad laws, and in health care, the potential for blunders is huge because Congress is tinkering with one-seventh of the economy and most aspects of medicine.

In May, Robert Reischauer, head of the CBO, warned that trying to find a compromise by combining provisions from different bills might make the health system worse. He compared it to building an auto engine with incompatible parts: "You can't say I want a piston from Ford, a fuel pump from Toyota . . . and expect the engine to run." Well, that's precisely what's happened. The contraption is no longer even a car made with incompatible parts. It's now part car, part tractor and part rollerblades. It's a clunker. Most Americans seem to understand this. Will Congress?

EXHIBIT 3

[From the Charlotte Observer, Aug. 7, 1994]

WHAT'S THE RUSH?

(By Rolfe Neill)

Don't hurry to provide lifetime, irrevocable health-care benefits that we can't afford.

Amid the insanity of congressional health-care debate comes an idea so compelling you yearn for its acceptance but know better. Americans for Tax Reform is circulating a 30-word covenant and asking each member of Congress to sign. It says:

LEGISLATIVE PRIORITY PLEDGE

I pledge to the taxpayers of my state that I will not vote to enact any health-care reform plan that I have not first personally read in its entirety.

The Wall Street Journal editorial page, boosting ATR's efforts, reports Republicans are signing but no Democrats. Hillary Clinton's original plan was some 1,300 pages of rules and definitions. You believe this will not increase health-care costs? When Medicare began in 1965, estimated annual expense for the hospital trust fund by 1990 was $10.1 billion. The reality: $68 billion. Name a single government scheme that costs less than predicted. I don't trust my government to design a national health system.

Two health issues are entangled, fueling a volatile discussion. One is to retard or reduce expense for the 85% of us insured; the other is to provide universal health coverage, taking in the 15% of people without insurance. The Clintons say the debate is between the caring and the uncaring. More accurately, it's between the questioning and the unquestioning.

The 15% is a fungible figure which proponents don't break down. Included are:

1. A charm group who are between jobs.

2. People who refuse to buy insurance because they feel they don't need it, estimated as high as 8.5 million of the 38 million uninsured.

3. Those who work but are too poor to pay insurance premiums, even though their Medicare and Medicaid payroll tax deductions pay for health coverage for retired people and nonworking poor.

None of these 38 million people is without emergency care. Any person showing up at a hospital emergency room is treated irrespective of ability to pay. We are about to radically redesign 14% of the gross national product. Everything we know about large systems suggests that we proceed very carefully. Instead, the president is horse trading with reluctant senators and representatives, promising pork for their districts and states if they will vote in a national health scheme that Americans are increasingly dubious about.

CANADIANS MUST WAIT

A doctor friend just back from Toronto tells of months of waiting by Canadians for free surgery because of insufficient government funds. There's a quota, and when those dollars are exhausted the list of waiting patients is carried over to the next year. He saw seven of 12 operating rooms empty in a major hospital despite the clamor for operations. An estimated 40% of Canadians in severe pain must wait more than a year for surgery, according to Fraser Institute, a public policy group in Vancouver. It may take a half year to see a neurologist and equally as long to obtain neurosurgery after it is prescribed, says the institute.

The London Times recently carried this headline about England's National Health Service: Indigestion Patient Gets Date to See Doctor: April, '96.

American hospitals have seen the future, and it is cost containment. They are diligently wringing out expenses. President Clinton has done the nation a service to focus on health care. But the rush to provide lifetime, irrevocable benefits for which there is not sufficient money is unwise advocacy. Bankruptcy or government health rationing loom.

The 6.2% taken from your paycheck for Social Security stops after you earn $60,600 in a year. For Medicare, the payroll tax is 1.45%, and you pay the tax on every dollar earned. Your employer pays a like amount of 6.2% for Social Security and 1.45% for Medicare. Even so, the hospital trust fund will be exhausted as early as 1998 and no later than 2000.

Medicare's actuaries say payroll taxes (employee + employer = 2.9%) will have to rise to 4.3% of payroll by 2000 and to 10% by 2035 to pay estimated costs.

MOVE CAUTIOUSLY

Scary? There's worse news. Today, four workers support each retiree. By 2050, when today's 10-year-olds retire, only two workers will be available to pay the Social Security and medical costs of each retiree.

Move cautiously. Make change gradually and see if it works. Pull back from the rush-to-adjournment stampede for a health bill. We could attempt to fix it for 15% while butchering it for the 85% now covered. Hippocrates was right: First, do no harm.

Mr. HELMS. Mr. President, I move to table my amendment. I do hope every Senator will join me in voting to table my amendment.

Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

VOTE ON THE MOTION TO TABLE AMENDMENT NO. 2466

The PRESIDING OFFICER. The question is on agreeing to the motion to lay on the table the amendment No. 2466.

The clerk will call the roll.

The legislative clerk called the roll.

The result was announced, yeas 100, nays 0, as follows:

[Rollcall Vote No. 267 Leg.]

YEAS—100

Akaka
Baucus
Bennett
Biden
Bingaman
Bond
Boren
Boxer
Bradley
Breaux
Brown
Bryan
Bumpers
Burns
Byrd
Campbell
Chafee
Coats
Cochran
Cohen
Conrad
Coverdell
Craig
D'Amato
Danforth
Daschle
DeConcini
Dodd
Dole
Domenici
Dorgan
Durenberger
Exon
Faircloth
Feingold
Feinstein
Ford
Glenn
Gorton
Graham
Gramm
Grassley
Gregg
Harkin
Hatch
Hatfield
Heflin
Helms
Hollings
Hutchison
Inouye
Jeffords
Johnston
Kassebaum
Kempthorne
Kennedy
Kerrey
Kerry
Kohl
Lautenberg
Leahy
Levin
Lieberman
Lott
Lugar
Mack
Mathews
McCain
McConnell
Metzenbaum
Mikulski
Mitchell
Moseley-Braun
Moynihan
Murkowski
Murray
Nickles
Nunn
Packwood
Pell
Pressler
Pryor
Reid
Riegle
Robb
Rockefeller
Roth
Sarbanes
Sasser
Shelby
Simon
Simpson
Smith
Specter
Stevens
Thurmond
Wallop
Warner
Wellstone
Wofford

So the motion to lay on the table the amendment (No. 2466) was agreed to.

Mr. HELMS. Mr. President, I move to reconsider the vote.

Mr. ROBB. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The question now occurs on agreeing to the underlying committee amendment on page 63, line 5 of the bill.

The amendment was agreed to.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

The Senate resumed consideration of the bill.

Pending:

(1) Dole Amendment No. 2479, to provide for the termination of the United States arms embargo of the Government of Bosnia and Herzegovina no later than November 15, 1994

(2) Helms Amendment No. 2480, to limit military assistance and military sales financing to the Government of Colombia until the President certifies that it is fully cooperating in counternarcotics efforts.

(3) Bumpers Amendment No. 2481 (to committee amendment on page 37, line 7), to reduce the amount for the acquisition of Milstar satellites.

(4) Helms Amendment No. 2488 (to committee amendment on page 2), to express the sense of the Senate regarding the congressional timetable for considering health care reform.

(5) Bumpers Amendment No. 2489, to reduce the amount for the procurement of the Trident II Missile Program.

VOTE ON AMENDMENT NO. 2488

The PRESIDING OFFICER. The question now occurs on agreeing to amendment No. 2488 offered by the Senator from North Carolina.

Mr. LEVIN. Mr. President, I support tabling this amendment. As it is drafted it is self-defeating and counter to the United States' efforts to combat international drug cartels.

The amendment would prohibit us from appropriating some of the funds we spend to curtail the production and transport of illegal Colombian drugs unless the Colombian Government takes detailed, specific actions to change Colombian law. Whether or not these changes would be good or appropriate is not the question. Rather, the question is, is it wise to condition what we think is best in our own interests on changes the Colombian Government may or may not make? We do not give Colombia assistance to fight illegal drug cartels out of charity. We give that assistance because it is in our interest to do so. This amendment would be self-defeating. If we determine that such assistance is best for our antidrugs effort, then the funds should be appropriated. If, however, we determine that such assistance is not best for our antidrug effort, then they should not be appropriated. But if we tie our own hands by conditioning our antidrug efforts on whether or not Colombia makes the changes we tell them to make, that just doesn't make sense.

Should many, many countries in the world make changes in their laws and conduct? You bet. Should countries that receive U.S. assistance make changes? You bet. But the nonhumanitarian assistance we give other nations is not given for their benefit, but for ours. Therefore I am not willing to allow another nation to determine whether we can appropriate funds that we think is in our best interest to do so. Therefore I urge the tabling of this amendment.

Mr. INOUYE. I move to table.

The PRESIDING OFFICER. The Senator from Hawaii is recognized to make a motion to table.

Mr. INOUYE. I move to table.

Mr. HELMS. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk called the roll.

The result was announced—yeas 54, nays 46, as follows:

[Rollcall Vote No. 268 Leg.]

YEAS—54

Akaka
Baucus
Biden
Bingaman
Boren
Boxer
Bradley
Breaux
Bryan
Bumpers
Byrd
Conrad
Daschle
DeConcini
Dodd
Dorgan
Exon
Feingold
Feinstein
Ford
Glenn
Graham
Harkin
Heflin
Hollings
Inouye
Johnston
Kennedy
Kerrey
Kerry
Kohl
Lautenberg
Leahy
Levin
Lieberman
Mathews
Metzenbaum
Mikulski
Mitchell
Moseley-Braun
Moynihan
Murray
Nunn
Pell
Pryor
Reid
Riegle
Robb
Rockefeller
Sarbanes
Sasser
Simon
Wellstone
Wofford

NAYS—46

Bennett
Bond
Brown
Burns
Campbell
Chafee
Coats
Cochran
Cohen
Coverdell
Craig
D'Amato
Danforth
Dole
Domenici
Durenberger
Faircloth
Gorton
Gramm
Grassley
Gregg
Hatch
Hatfield
Helms
Hutchison
Jeffords
Kassebaum
Kempthorne
Lott
Lugar
Mack
McCain
McConnell
Murkowski
Nickles
Packwood
Pressler
Roth
Shelby
Simpson
Smith
Specter
Stevens
Thurmond
Wallop
Warner

So the motion to table the amendment (No. 2488) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. LEVIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

(Later the following occurred.)

CHANGE OF VOTE

Mr. SHELBY. Mr. President, on rollcall vote 268, I voted aye. It was my intention to vote no. Therefore, I ask unanimous consent that I be permitted to change my vote. This will in no way change the outcome of the vote.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The foregoing tally has been changed to reflect the above order.)

DEPARTMENT OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT

The Senate continued with the consideration of the bill.

VOTE ON AMENDMENT NO. 2478

The PRESIDING OFFICER. The question occurs, under the previous order, on a motion to table amendment No. 2478 offered by the Senator from Florida [Mr. GRAHAM].

Mr. GRAHAM. Mr. President, I request the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays are ordered, and the clerk will call the roll.

The legislative clerk called the roll.

The PRESIDING OFFICER (Mr. DORGAN). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 66, nays 34, as follows:

[Rollcall Vote No. 269 Leg.]

YEAS—66

Akaka
Baucus
Biden
Bingaman
Bond
Breaux
Bryan
Bumpers
Byrd
Campbell
Chafee
Coats
Cochran
Cohen
Conrad
Danforth
Daschle
Dodd
Dorgan
Exon
Feingold
Ford
Glenn
Gorton
Gregg
Harkin
Hatfield
Heflin
Helms
Hollings
Inouye
Jeffords
Johnston
Kassebaum
Kerrey
Kerry
Kohl
Leahy
Levin
Lieberman
Lugar
Mathews
Metzenbaum
Mikulski
Moseley-Braun
Murray
Nunn
Packwood
Pell
Pryor
Reid
Riegle
Rockefeller
Roth
Sarbanes
Sasser
Shelby
Simon
Simpson
Smith
Specter
Stevens
Thurmond
Warner
Wellstone
Wofford

NAYS—34

Bennett
Boren
Boxer
Bradley
Brown
Burns
Coverdell
Craig
D'Amato
DeConcini
Dole
Domenici
Durenberger
Faircloth
Feinstein
Graham
Gramm
Grassley
Hatch
Hutchison
Kempthorne
Kennedy
Lautenberg
Lott
Mack
McCain
McConnell
Mitchell
Moynihan
Murkowski
Nickles
Pressler
Robb
Wallop

So the motion to lay on the table the amendment (No. 2478) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. METZENBAUM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

DISASTER ASSISTANCE

Mr. NUNN. Mr. President, I rise to address two amendments offered by Senator COVERDELL and myself that provide additional disaster assistance to areas of Georgia, Florida, and Alabama that were hit by Tropical Storm Alberto in July.

The first of these amendments adds $35 million in fiscal year 1995 to the appropriation for the public health and social services emergency fund. The existence of this fund reflects the broad range of human resources needs created by natural disasters, especially floods. Community life is disrupted—local health and human resource services are disrupted—and families are disrupted. The money provided under this amendment can help to meet these needs.

The floods associated with Alberto struck hardest at some of the lowest income areas of Georgia's lowest income region. Not surprisingly, these same areas have the highest rate of public assistance and the greatest dependence on public health and social services. The bulk of the appropriation made in this amendment to go into four categories—substance abuse and mental health services, services for children and families, disease control and prevention, and services for the elderly.

The Alberto disaster has created a particular threat to public health. The sanitation problems accompanying any flood are serious and in Georgia this has been compounded by widespread breakdown in water and sewer systems. The Centers for Disease Control needs additional money to help monitor disease outbreaks related to the disruption. Public health services need funds to help treat individuals with flood related injuries and illnesses. This appropriation will provide money for the CDCP to identify public health threats and to community and migrant health centers to treat a surge of patients seeking medical treatment.

All spending made possible by this amendment will be strictly contingent on a future request by the administration for an emergency appropriation. From the experience of the midwestern States last year, it is clear that the administration will require extremely detailed documentation before making a request, and that the actual figure requested may well be less than the amount provided through this amendment.

The second amendment sets aside $10 million in the Department of Education's impact aid account to assist school districts affected by the floods. Several school districts in Georgia saw their property tax bases reduced or eliminated by flood damage. These impact aid funds will assist these districts in replacing the lost revenues. This amendment is not a new appropriation. I am informed by officials at the Department of Education that there is over $20 million in unobligated funds in the impact aid account. This amendment sets aside up to $10 million of the existing account for damage associated with Tropical Storm Alberto.

Mr. President, I thank Senator HARKIN and Senator SPECTER and their staffs for their assistance in getting these amendments cleared and adopted.

RE TARKIO, MO

Mr. BOND. For some time now I have been working with officials from the Heartland Educational Institute in Tarkio, MO, on a project to utilize the former Tarkio College campus, create new jobs and stimulate a depressed economy in Atchison County, near our border with Iowa.

Officials from the city of Tarkio have requested a Department of Education write-down on their debt and release of the liens against the Tarkio college property. The Department of Education opposes this, believing that it can recoup some of the funds owed on the facilities' loans by a sale.

I would like to ask the distinguished chairman of the subcommittee if he would be willing to work with me, and with officials from Tarkio and from the Department of Education on finding a solution to this problem that will satisfy all the parties involved and permit the local community to move forward on generating economic development through a new youth rehabilitation facility.

Mr. HARKIN. I too am concerned about the situation in Tarkio, and believe that economic development there would help my own State of Iowa. I plan to work with my friend from Missouri and the Department to develop a plan that will work for the local community as well as for U.S. taxpayers.

TRIBALLY CONTROLLED COMMUNITY COLLEGES

Mr. CONRAD. Will the Senator from Iowa, the chairman of the Labor, Health and Human Services and Education Appropriations Subcommittee, yield for a question?

Mr. HARKIN. I would be pleased to yield for a question.

Mr. CONRAD. First, I want to thank the chairman, Senator HARKIN, and the ranking member, Senator SPECTER, for including language in the committee report to expand the telecommunications-telemedicine infrastructure to provide education and training to medical, psychology and nursing students in the four-State area of North Dakota, South Dakota, Montana, and Minnesota. This project will link the four community-based campuses of the University of North Dakota's School of Medicine, 67 rural community-based hospitals in North Dakota, Minnesota, and Montana, and 16 tribally controlled community colleges in North Dakota, South Dakota, Montana, and Minnesota.

I would like to speak in more detail about one particular component of this project: the linkage to the 16 tribally controlled community colleges. The primary and initial purpose of this linkage is to allow Indian students to receive their first 2 years of education toward a degree in psychology in a reservation setting—an approach proven successful through other Indian educational programs such as the Indians into medicine program. The University of North Dakota's Department of Psychology is nationally recognized by the American Psychological Association for its education and training of native Americans. This telecommunication linkage will facilitate the recruitment and training of native Americans in the field of psychology.

Of the estimated total projected cost of $1,560,000, $160,000 will be available to purchase equipment for 16 downlink sites at the tribal colleges, and up to $50,000 of the administrative funds for this project could be used for tuition, fees, and stipends for the native Americans enrolled in the field of psychology.

Does the chairman concur that this level of funding is consistent with the language included in the Senate report on telecommunications-telemedicine infrastructure?

Mr. HARKIN. Yes, I do, and I thank the Senators from North Dakota for bringing this important issue to my attention.

Mr. CONRAD. Just for further clarification, I would like to ask the chairman if he concurs with the spending totals for the other elements of this package. It is my hope that the total for the project could be allocated as follows: equipment for the digital video system—$500,000; equipment for 25 downlink sites in Montana—$250,000; equipment for 10 downlink sites in Minnesota—$100,000; transmission costs for both fiber and satellite—$370,000; and administrative costs—$200,000.

Mr. HARKIN. The Senator has presented what seems to be a very realistic package. I am certainly hopeful that the Health Care Financing Administration will respond favorably.

Mr. DORGAN. I also want to thank Senator HARKIN and Senator SPECTER for their assistance in this very important project.

Mr. INOUYE. I want to compliment my colleagues on developing this creative approach to addressing the critical health and mental health needs of American Indians in the Northern Plains region. The American Indian population served by this program will total more than 120,000 in a part of the country that experiences some of the highest levels of morbidity and mortality in accidents, suicide, and infant mortality, amongst any population group in the United States.

I am particularly pleased that the tribally controlled community colleges, at least half of which are located in this region, are an integral part of this effort. Section 115 of the Indian Health Care Improvement Act (P.L. 94-437, as amended by P.L. 100-713) was enacted to assist these institutions in providing opportunities for Indian students to enter the health professions. The appropriation which we are discussing today will certainly provide the infrastructure necessary to carry out the purposes of the act.

In closing, I have visited the Northern Plains and understand the profound health care needs of the tribes in this region. I am, therefore, very encouraged by the efforts of my colleagues in the development of health care education by use of telecommunications.

Mr. BYRD. Mr. President, the Senate has just completed action on the fiscal year 1995 Labor/HHS appropriations bill, the 12th of the 13 regular appropriation bills, leaving only the Defense appropriations bill remaining. I commend the chairman of the subcommittee, Senator HARKIN, as well as the ranking member, Senator SPECTER, for their outstanding efforts on this very important appropriations bill.

As members are aware, the Labor/HHS appropriations bill contains funding for numerous critical programs designed to address many of the social problems facing our Nation. This bill seeks to provide educational opportunity for our Nation's young people. In addition, this bill seeks to make further progress in the area of biomedical research through appropriations to the National Institutes of Health, as well as appropriations to the Department of Labor to ensure a safe workplace for all Americans.

The managers of the bill deserve particular recognition for their efforts to balance these many competing demands and to do so while remaining within the subcommittee's very tight 602(b) allocation.

Senators HARKIN and SPECTER have served on the Labor/HHS Subcommittee for a number of years and have worked together in their capacities as chairman and ranking member. The Senate and the Nation owe them a debt of gratitude for their dedication and their commitment to excellence in carrying out their responsibilities on their subcommittee.

Mr. SIMPSON. Mr. President, I rise to speak concerning this amendment which would appropriate $100 million to reimburse states for the cost of educating immigrants. The money would be distributed under the Emergency Immigration Education Act of 1984.

This amendment and the underlying Emergency Immigration Education Act do not differentiate between legal and illegal immigrants, which very much concerns me. The Commission on Immigration Reform recently issued an excellent interim report making recommendations to the administration and the Congress on a variety of immigration issues, including that of providing Federal financial aids to the States for the costs of immigration.

The Commission recommended a "short-term authorization of financial aid to offset at least a portion of certain identifiable costs to states and localities resulting from unlawful immigration."

I have seen no solid evidence that it is even possible to accurately identify either the number or cost of illegal immigrants. One reason for this is that—believe it or not—many State and local government agencies are prohibited by law, ordinance or rule from even "communicating" with the Immigration and Naturalization Service.

The Commission on Immigration Reform recommended that if there is to be such Federal reimbursement to State and local governments that there also be "a requirement that the state and local governments cooperate with Federal authorities to enforce the immigration laws of the United States."

If this appropriation were to reimburse impacted States for the cost of educating illegal alien children, then taking $100 million from other programs to fund this amendment might well be justified—if those costs can be identified.

However, since many State and local governments prohibit their officials from communicating with the Immigration Service, I do not know how they can identify those costs attributable to illegal immigration. Cooperation with the INS should be a condition of any such amendment.

If this appropriation is to reimburse States for the costs of educating legal immigrant children, then this amendment is not the proper approach to reduce those costs.

If legal immigration is so high it is placing an unreasonable financial burden on the States, the answer is to reduce immigration, rather than provide Federal reimbursement. Also, States could rethink some of their very expensive bilingual education programs.

It has been the policy of the United States for more than 100 years that newcomers should "pay their way" after immigrating to the United States.

Personally, I believe that legal immigrants do pay their way, and that the impacted States probably benefit from legal immigrants, if they are coming in reasonable numbers. Some studies have found that legal immigrants more than pay their way, although there have also been contradictory studies.

If the numbers are unreasonable, and if immigrants are causing a burden the states cannot bear, then we should be discussing reducing admissions until the economies of the impacted states have had an opportunity to recover.

Mr. COVERDELL. Mr. President, I rise in support of H.R. 4606, the fiscal year 1995 Labor, Health, and Human Services, and Education appropriations bill. I want to congratulate my colleagues, Senator HARKIN and Senator SPECTOR, for their diligent work on this bill.

I rise to lend my support to language included in the report that accompanies this legislation. This language deals with the extramural construction funds provided under the National Center for Research Resources. The mission of the Center is to support the research technologies and shared resources that are critical to maintaining the health of all Americans. As such, the National Center supports construction programs which directly assist the Center in achieving its goals and mission.

One such project mentioned in the report is the National Center for Primary Health at the Morehouse School of Medicine in Atlanta. Since its founding, the Morehouse School of Medicine has dedicated itself to the primary health care needs of the American people, with a particular emphasis on minorities. As a result of this dedication, the Morehouse School of Medicine leads the Nation in the percentage of graduates who enter the primary care specialities. And, despite the fact that the school is less than 20 years old, its faculty has successfully competed for more research funding than one-third of all of the medical schools in the country. The National Center for Primary Care will build upon this foundation.

The National Center for Primary Care will be a national resource that will conduct, sponsor and participate in academic, clinical, and health services research. To achieve this mission, the center will accomplish the following goals:

To increase significantly the number of primary care physicians.

To create a national health and social policy center focused on identifying and analyzing the complex social, education, psychological, behavioral, economic and historical factors which contribute to current problems of diminished health status, access and quality in the provisions of both preventive and acute health care.

To augment both outreach and community-based clinical networks with new communications technologies to form a solid base for its expanded research and health policy efforts.

To create a new set of collaborative linkages focused on medical education, health and social policy and the dissemination of basic and applied research supported by expanded on-site teleconferencing capabilities and computer support.

I cannot think of an institution better suited to undertake this challenge than the Morehouse School of Medicine. The school, under the stewardship of its president, Dr. Louis Sullivan, already possesses the elements that are necessary to ensure that the National Center for Primary Care will be a national model for basic biomedical and applied research.

For example, the school has established an outstanding program of medical education. The Morehouse School of Medicine also possesses a fundamental understanding of the complexities and challenges involved in the provision of primary care services to individuals and families in low-income urban neighborhoods and rural communities. As a result, the school has built a long-standing and solid base of trust within many underserved communities. Finally, the Morehouse School of Medicine has developed an excellent program of basic applied research with an increasing emphasis on community-based research related to the environmental, economic, and social factors affecting health status.

I want to thank the chairman for recognizing the contribution the Morehouse School of Medicine has made in the area of primary health care. The inclusion of report language is testimony to the success and respect the school has achieved. I want to urge the Assistant Secretary for Health and the director of the National Center for Research Resources to carefully review and consider the Morehouse School of Medicine's application for extramural construction funds for the National Center for Primary Care.

FUNDING FOR SCHOLAR-ATHLETE COMPETITIONS IN 1995

Mr. CHAFEE. Mr. President, I would like to thank the managers of the appropriations bill for the Departments of Labor, Health and Human Services, and Education for their help in providing funding for a program that was authorized earlier this week in the Improving America's Schools Act which reauthorizes the Elementary and Secondary Education Act. The provision included in the ESEA authorizes the Secretary of Education to provide $1 million for scholar-athlete games to be conducted in 1995. I am delighted that the appropriators were able to provide $500,000 for this program. Of course, we will be back next year with the hope of securing the rest of the authorized amount.

In 1993, the Institute for International Sport at the University of Rhode Island conducted the World Scholar Athlete Games; 2,000 students from 125 countries and all 50 States participated in the games. Through these games, friendships were formed and understanding was developed between boys and girls who would otherwise never have crossed paths. I believe that through this form of interaction bridges between diverse populations are built.

The Institute for International Sport plans to conduct similar games in Rhode Island in 1995. The Rhode Island Scholar-Athlete Games will bring together boys and girls from the 5th through 12th grades. These students will have a record of academic excellence or have demonstrated marked improvement in their school work. The institute is dedicated to making a special effort to include low income and minority students. Rhode Island is a small State with a lot of diversity. These games will reflect that diversity and help to develop greater understanding between these students.

The sports activities that are planned include: baseball, softball, sailing, basketball, volleyball, soccer, tennis, swimming, and track. The cultural activities will include: art, band, debate, choir, theater, poetry, and creative writing. The Institute for International Sport also plans to hold theme days on the subjects of ethics and fair play, the environment and substance abuse.

Educators and civic leaders from every State will be invited to attend and observe the games. The institute will offer training sessions to these individuals to enable them to emulate the Rhode Island Scholar-Athlete Games in their home States.

I greatly appreciate the cooperation of Senator SPECTER and HARKIN in providing the funds for this program, and I am delighted that Senator PELL has joined me in ensuring funding for scholar-athlete competitions in 1995.

The PRESIDING OFFICER. The question is on the engrossment of the amendments and third reading of the bill.

The amendments were ordered to be engrossed and the bill to be read a third time.

The bill was read a third time.

Mr. INOUYE addressed the Chair.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. INOUYE. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The bill having been read the third time, the question is, Shall it pass? On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The bill clerk called the roll.

The PRESIDING OFFICER. Are there Senators in the Chamber wishing to change their votes?

The result was announced—yeas 87, nays 13, as follows:

[Rollcall Vote No. 270 Leg.]

YEAS—87

Akaka
Baucus
Bennett
Biden
Bingaman
Bond
Boren
Boxer
Bradley
Breaux
Bryan
Bumpers
Burns
Byrd
Campbell
Chafee
Coats
Cochran
Cohen
Coverdell
D'Amato
Danforth
Daschle
DeConcini
Dodd
Dole
Domenici
Dorgan
Durenberger
Exon
Feingold
Feinstein
Ford
Glenn
Gorton
Graham
Grassley
Harkin
Hatch
Hatfield
Heflin
Hollings
Inouye
Jeffords
Johnston
Kassebaum
Kennedy
Kerrey
Kerry
Kohl
Lautenberg
Leahy
Levin
Lieberman
Lott
Lugar
Mack
Mathews
McCain
McConnell
Metzenbaum
Mikulski
Mitchell
Moseley-Braun
Moynihan
Murkowski

Murray
Nickles
Nunn
Packwood
Pell
Pryor
Reid
Riegle
Robb
Rockefeller
Sarbanes
Sasser
Shelby
Simon
Simpson
Specter
Stevens
Thurmond
Warner
Wellstone
Wofford

NAYS—13

Brown
Conrad
Craig
Faircloth
Gramm
Gregg
Helms
Hutchison
Kempthorne
Pressler
Roth
Smith
Wallop

So the bill (H.R. 4606), as amended, was passed.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. FORD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. HARKIN. Mr. President, with that vote, the Senate has overwhelmingly approved H.R. 4606, the Labor, Health and Human Services, Education, and related agencies appropriations bill for fiscal 1995. I want to thank all Senators for their indulgence, for bringing their amendments to the floor, and for their support for passing this important bill.

I specially want to thank the staff who have worked so long and so hard on this bill. As Senator SPECTER and I have stated earlier, with the tight budget caps, this has been a particularly tough year on this subcommittee. In spite of these pressures, we have crafted a good bill, with strong bipartisan support. Much of the credit should go to the staff.

On the majority side, I want to recognize our staff director, Ed Long, along with Jim Sourwine, Carol Mitchell, Susan McGovern, Bill Cordes, Ellen Murray, Ron Yucas, Gladys Clearwaters, and Antonio Clinkscales. For the minority, I want to thank Craig Higgins, Bettilou Taylor, and Margaret Snyder.

To all of them, my heartfelt thanks and gratitude for the many hours they put into this effort.

We are now looking forward to conference with the House. Last year, conference on the fiscal 1994 bill lasted less than 3 hours. I'd like to complete conference on next year's bill in record time.

Again, I thank all my colleagues for their support.

The PRESIDING OFFICER. Under the previous order, the Senate insists on its amendments, requests a conference with the House, and the Chair appoints the following conferees.

The PRESIDING OFFICER (Mr. DORGAN) appointed Mr. HARKIN, Mr. BYRD, Mr. HOLLINGS, Mr. INOUYE, Mr. BUMPERS, Mr. REID, Mr. KOHL, Mrs. MURRAY, Mr. SPECTER, Mr. HATFIELD, Mr. STEVENS, Mr. COCHRAN, Mr. GORTON, Mr. MACK, and Mr. BOND conferees on the part of the Senate.

FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS APPROPRIATIONS ACT, 1995—CONFERENCE REPORT

The PRESIDING OFFICER. Under the previous order the Senate will now proceed to the conference report on H.R. 4426, the Foreign Operations appropriations bill, which the clerk will report.

The bill clerk read as follows:

Conference report to accompany H.R. 4426, making appropriations for foreign operations, export finance and related programs for fiscal year ending September 30, 1995.

The Senate resumed consideration of the conference report.

The PRESIDING OFFICER. The question is on agreeing to the conference report to H.R. 4426.

The yeas and nays have been ordered.

The clerk will call the roll.

The assistant legislative clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 88, nays 12, as follows:

[Rollcall Vote No. 271 Leg.]

YEAS—88

Akaka
Baucus
Bennett
Biden
Bingaman
Bond
Boren
Boxer
Bradley
Breaux
Brown
Bryan
Bumpers
Burns
Campbell
Chafee
Coats
Cochran
Cohen
Conrad
Coverdell
D'Amato
Danforth
Daschle
DeConcini
Dodd
Dole
Dorgan
Durenberger
Exon
Feingold
Feinstein
Ford
Glenn
Gorton
Graham
Gramm
Grassley
Gregg
Harkin
Hatch
Hatfield
Heflin
Hutchison
Inouye
Jeffords
Johnston
Kassebaum
Kennedy
Kerrey
Kerry
Kohl
Lautenberg
Leahy
Levin
Lieberman
Lugar
Mack
Mathews
McCain
McConnell
Metzenbaum
Mikulski
Mitchell
Moseley-Braun
Moynihan
Murray
Nickles
Nunn
Packwood
Pell
Pressler
Pryor
Reid
Riegle
Robb
Rockefeller
Sarbanes
Sasser
Shelby
Simon
Simpson
Specter
Stevens
Thurmond
Warner
Wellstone
Wofford

NAYS—12

Byrd
Craig
Domenici
Faircloth
Helms
Hollings
Kempthorne
Lott
Murkowski
Roth
Smith
Wallop

So the conference report to H.R. 4426 was agreed to.

Mr. LEAHY. Mr. President, I move to reconsider the vote by which the conference report was agreed to.

Mr. EXON. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

MILITARY CONSTRUCTION APPROPRIATIONS ACT, 1995—CONFERENCE REPORT

The PRESIDING OFFICER. Under the previous order, the Senate will now proceed to the conference report on H.R. 4453, the military construction appropriations bill, which the clerk will report.

The assistant legislative clerk read as follows:

The committee on conference on the disagreeing votes of the two Houses on the amendment to the bill (H.R. 4453) a bill making appropriations for military construction for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses this report, signed by all of the conferees.

(The conference report is printed in the House proceedings of the RECORD of July 27, 1994.)

Mr. BYRD. Mr. President, the Senate version of the fiscal year 1995 military construction appropriations bill included an amendment, which I authored, which would have appropriated $25.1 million to the Department of Defense, to be transferred to the Coast Guard, to defray the expenses for a consolidation of activities at the Coast Guard's operations systems center at Martinsburg, West Virginia. These funds would have been completely offset by the rescission of $25.1 million previously appropriated for a Navy military construction project, which was canceled. The bill, as so amended, passed the Senate on July 15. The conferees agreed to the amendment. However, the managers on the part of the House decided to delete, without prejudice, the appropriation proposed by the Senate for the Coast Guard, inasmuch as the matter comes under the jurisdiction of the Transportation Appropriations Subcommittee. Therefore, the conference agreement at issue does not include any funds for the Martinsburg Coast Guard project, and I do not plan to offer an amendment at this time to restore the funds.

By way of explanation, Mr. President, the purpose of the Senate amendment was to provide funds for construction of facilities in connection with a consolidation at the Coast Guard Operations System Center at Martinsburg sought by Coast Guard officials in their quest to streamline operations.

The Coast Guard Commandant has indicated that that agency has undertaken a number of cost-benefit studies that could result in the centralization of certain information functions at the Coast Guard's Operations Systems Center. The Commandant indicated his belief that such consolidations will prove to be cost effective to the taxpayer.

Mr. President, the Coast Guard has developed a program to streamline its vessel documentation function at an eventual savings of approximately 20 personnel and $1 million per year. The Coast Guard advises that this initiative would consolidate 14 regional documentation offices in one location. A centralized vessel documentation processing facility will produce significant efficiencies. Currently, with 14 regional documentation offices, the representatives of industry, law enforcement, and other users must often make several inquiries to more than one office to gather information on a vessel. Additionally, service delays are inherent whenever a vessel's records are required to be forwarded to a new office as a result of the vessel's changing its port of documentation. Under the consolidated office concept, only one inquiry will be necessary and customer service delays will be significantly reduced.

In summary, the Coast Guard has embarked upon a program to consolidate and streamline its operations, and it has expressed its desire to expand upon its successful experience in Martinsburg.

The location of the Coast Guard Operations Systems Center at Martinsburg is not unique. Other examples of Coast Guard support facilities which are not located at coastal sites include the Coast Guard Pay and Personnel Center located in Topeka, Kansas, and the Coast Guard Institute, located in Oklahoma City, Oklahoma.

The Navy also has support facilities which are not located at coastal sites, including the Naval Weapons Support Center in Crane, Indiana, the Naval Ships Parts Control Center in Mechanicsburg, Pennsylvania, and the Navy Finance Center in Cleveland, Ohio.

Mr. President, the Coast Guard provides a valuable service, nationally and internationally. This funding would have helped the Coast Guard to consolidate, to operate more efficiently, and to save the taxpayer money in the long run. I support those efforts.

VOTE

The PRESIDING OFFICER. The question now occurs on agreeing to the conference report to H.R. 4453.

The yeas and nays have been ordered. The clerk will call the roll.

The bill clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 95, nays 5, as follows:

[Rollcall Vote No. 272 Leg.]

YEAS—95

Akaka
Baucus
Bennett
Biden
Bingaman
Bond
Boren
Boxer
Bradley
Breaux
Bryan
Bumpers
Burns
Byrd
Campbell
Chafee
Coats
Cochran
Cohen
Conrad
Coverdell
Craig
D'Amato
Danforth
Daschle
DeConcini
Dodd
Dole
Domenici
Dorgan
Durenberger
Exon
Faircloth
Feingold
Feinstein
Ford
Glenn
Gorton
Graham
Gramm
Grassley
Harkin
Hatch
Hatfield
Heflin
Helms
Hollings
Hutchison
Inouye
Jeffords
Johnston
Kassebaum
Kempthorne
Kennedy
Kerrey
Kerry
Kohl
Lautenberg
Leahy
Levin
Lieberman
Lott
Lugar
Mack
Mathews
McConnell
Metzenbaum
Mikulski
Mitchell
Moseley-Braun
Moynihan
Murkowski
Murray
Nickles
Nunn
Packwood
Pell
Pressler
Pryor
Reid
Riegle
Robb
Rockefeller
Sarbanes
Sasser
Shelby
Simon
Simpson
Specter
Stevens
Thurmond
Wallop
Warner
Wellstone
Wofford

NAYS—5

Brown
Gregg
McCain
Roth
Smith

So the conference report was agreed to.

Mr. FORD. Mr. President, I move to reconsider the vote by which the conference report was agreed to.

Mr. INOUYE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENTS CONCURRED WITH EN BLOC

The PRESIDING OFFICER. Under the previous order, the Senate concurs en bloc with the House amendments to Senate amendments number 6, 10, 13, 15, 16, 19, 20, 23, 24, 27, 31, and 32, and the Senate recedes from its amendment numbered 29; as follows:

In the House of Representatives,

Resolved, That the House agreed to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 4453) entitled "An Act making appropriations for military construction for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.".

Resolved, That the House recede from its disagreement to the amendments of the Senate numbered 8 and 14 to the aforesaid bill, and concur therein.

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 6 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$49,386,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 10 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$188,062,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 13 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$57,370,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 15 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$22,748,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 16 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$57,066,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 19 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$1,013,708,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 20 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$1,183,710,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 23 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$1,205,064,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 24 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$277,444,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 27 to the aforesaid bill and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: "$1,102,289,000".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 31 to the aforesaid bill, and concur therein with the following amendments:

Restore the matter stricken by the Senate, with a amendment as follows:

In lieu of the section designation "SEC. 126.", insert: "SEC. 127."; and

Retain the matter proposed by the Senate with an amendment as follows:

In lieu of the section designation "SEC. 126." insert: "SEC. 128.".

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 32 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the section designation "SEC. 127.", insert: "SEC. 129.".

Resolved, That the House insist on its disagreement to the amendment of the Senate numbered 29 to the aforesaid bill.

The PRESIDING OFFICER. The motions to reconsider these votes are laid upon the table.

DEPARTMENT OF DEFENSE APPROPRIATIONS

The PRESIDING OFFICER. Under the previous order, the Senate will now resume consideration of H.R. 4650, the Department of Defense appropriations bill, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 4650) making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

Pending:

(1) Dole Amendment No. 2479, to provide for the termination of the United States arms embargo of the Governments of Bosnia and Herzegovina no later than November 15, 1994.

(2) Helms Amendment No. 2480, to limit military assistance and military sales financing to the Government of Colombia until the President certifies that it is fully cooperating in counternarcotics efforts.

(3) Bumpers Amendment No. 2481 (to committee amendment on page 37, line 7), to reduce the amount for the acquisition of Milstar satellites.

(5) Bumpers Amendment No. 2489, to reduce the amount for the procurement of the Trident II Missile Program.

VOTE ON AMENDMENT NO. 2481

The PRESIDING OFFICER. Under the previous order, the question occurs on amendment numbered 2481 offered by the Senator from Arkansas to the committee amendment on page 37, line 7. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The assistant legislative clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 38, nays 62, as follows:

[Rollcall Vote No. 273 Leg.]

YEAS—38

Biden
Bradley
Breaux
Bumpers
Byrd
Conrad
Dorgan
Feingold
Graham
Harkin
Hatfield
Hollings
Jeffords
Kassebaum
Kerrey
Kohl
Lautenberg
Leahy
Levin
Lugar
Mathews
Metzenbaum
Mitchell
Moseley-Braun
Moynihan
Murray
Pell
Pryor
Riegle
Robb
Rockefeller
Roth
Sarbanes
Sasser
Simon
Simpson
Wellstone
Wofford

NAYS—62

Akaka
Baucus
Bennett
Bingaman
Bond
Boren
Boxer
Brown
Bryan
Burns
Campbell
Chafee
Coats
Cochran
Cohen
Coverdell
Craig
D'Amato
Danforth
Daschle
DeConcini
Dodd
Dole
Domenici
Durenberger
Exon
Faircloth
Feinstein
Ford
Glenn
Gorton
Gramm
Grassley
Gregg
Hatch
Heflin
Helms
Hutchison
Inouye
Johnston
Kempthorne
Kennedy
Kerry
Lieberman
Lott
Mack
McCain
McConnell
Mikulski
Murkowski
Nickles
Nunn
Packwood
Pressler
Reid
Shelby
Smith
Specter
Stevens
Thurmond
Wallop
Warner

So the amendment (No. 2481) was rejected.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. NUNN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. MITCHELL addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the majority leader.

VISIT TO THE SENATE BY PRESIDENT TER-PETROSSIAN OF ARMENIA

Mr. MITCHELL. Mr. President, we are being visited today by a distinguished guest, and I will, following this brief introduction, ask unanimous consent that there be a recess for approximately 10 minutes to permit Senators to greet our guest, who is in the rear of the Chamber.

It is my privilege to introduce to the Senate the President of the Republic of Armenia, Levon Ter-Petrossian.

President Ter-Petrossian has the distinction of being the first democratically elected President of that country. He also played a critical role in the efforts which led to Armenia's independence in 1991, paying for his efforts with a period of imprisonment from 1988 to 1989. Three months after his release from prison, he was elected to the Supreme Council, Armenia's legislature, and became Chairman of that body from 1990 until 1991, when he was elected President.

In addition to securing such a prominent role for himself in the recent history of his country, President Ter-Petrossian is a noted scholar of ancient Armenian history, with a Ph.D. in philology from Leningrad University.

On behalf of all of the Senate, we welcome President Ter-Petrossian and wish him well in the quest for peace for his troubled region. In that context, I would like to salute the efforts which have led to a cease-fire in the Nagorno-Karabakh crisis and to express the Senate's hope for a lasting peace plan to which all parties can agree.

Mr. President, I ask all Senators now to join me in welcoming President Ter-Petrossian.

[Applause.]

RECESS

Mr. MITCHELL. Mr. President, I ask unanimous consent that there now be a recess for a period of approximately 10 minutes to permit Senators to greet the President of Armenia.

There being no objection, the Senate, at 12:11 p.m. recessed until 12:20 p.m.; whereupon, the Senate reassembled when called to order by the Presiding Officer [Mr. DORGAN].

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

The Senate continued with the consideration of the bill.

VOTE ON AMENDMENT NO. 2489

The PRESIDING OFFICER. Under the previous order, the question occurs on amendment No. 2489, offered by the Senator from Arkansas [Mr. BUMPERS] to the committee amendment on page 25, line 8 of the bill.

The yeas and nays have been ordered and the clerk will call the roll.

The legislative clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 40, nays 60, as follows:

[Rollcall Vote No. 274 Leg.]

YEAS—40

Baucus
Biden
Boren
Boxer
Bradley
Brown
Bryan
Bumpers
Byrd
Conrad
DeConcini
Dorgan
Feingold
Grassley
Harkin
Hatfield
Jeffords
Kassebaum
Kerrey
Kerry
Kohl
Lautenberg
Leahy
Levin
Mathews
Metzenbaum
Moseley-Braun
Moynihan
Murray
Pell
Pryor
Reid
Riegle
Rockefeller
Roth
Sarbanes
Sasser
Simon
Wellstone
Wofford

NAYS—60

Akaka
Bennett
Bingaman
Bond
Breaux
Burns
Campbell
Chafee
Coats
Cochran
Cohen
Coverdell
Craig
D'Amato
Danforth
Daschle
Dodd
Dole
Domenici
Durenberger
Exon
Faircloth
Feinstein
Ford
Glenn
Gorton
Graham
Gramm
Gregg
Hatch
Heflin
Helms
Hollings
Hutchison
Inouye
Johnston
Kempthorne
Kennedy
Lieberman
Lott
Lugar
Mack
McCain
McConnell
Mikulski
Mitchell
Murkowski
Nickles
Nunn
Packwood
Pressler
Robb
Shelby
Simpson
Smith
Specter
Stevens
Thurmond
Wallop
Warner

So the amendment (No. 2489) was rejected.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. BUMPERS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Under the previous order, the question occurs on amendment No. 2480 offered by the Senator from North Carolina [Mr. HELMS] to the committee amendment on page 2, line 15.

The yeas and nays have been ordered.

Mr. INOUYE. Mr. President, I move to table, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

VOTE ON THE MOTION TO TABLE AMENDMENT NO. 2480

The PRESIDING OFFICER. The question is on agreeing to the motion to table amendment No. 2480.

The clerk will call the roll.

The assistant legislative clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 53, nays 47, as follows:

[Rollcall Vote No. 275 Leg.]

YEAS—53

Akaka
Baucus
Bennett
Biden
Bingaman
Boren
Breaux
Bryan
Bumpers
Byrd
Chafee
Cohen
Conrad
Coverdell
Craig
Danforth
Daschle
DeConcini
Dodd
Dorgan
Durenberger
Exon
Feinstein
Ford

Glenn
Gorton
Graham
Harkin
Inouye
Jeffords
Johnston
Kennedy
Kerrey
Leahy
Levin
Lugar
Mathews
Metzenbaum
Mikulski
Mitchell
Moseley-Braun
Moynihan
Murray
Nunn
Pell
Pryor
Reid
Riegle
Robb
Rockefeller
Sarbanes
Simon
Wofford

NAYS—47

Bond
Boxer
Bradley
Brown
Burns
Campbell
Coats
Cochran
D'Amato
Dole
Domenici
Faircloth
Feingold
Gramm
Grassley
Gregg
Hatch
Hatfield
Heflin
Helms
Hollings
Hutchison
Kassebaum
Kempthorne
Kerry
Kohl
Lautenberg
Lieberman
Lott
Mack
McCain
McConnell
Murkowski
Nickles
Packwood
Pressler
Roth
Sasser
Shelby
Simpson
Smith
Specter
Stevens
Thurmond
Wallop
Warner
Wellstone

So the motion to lay on the table the amendment (No. 2480) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote by which the motion was agreed to.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

HEALTH SECURITY ACT

The PRESIDING OFFICER. Under the previous order, the Senate will now resume consideration of S. 2351, calendar No. 539, which the clerk will report.

The legislative clerk read as follows:

> A bill (S. 2351) to achieve universal health insurance coverage, and for other purposes.

The Senate resumed consideration of the bill.

Mr. DOLE addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. DOLE. Mr. President, I wonder if I might claim my leader time before we start on the health care. Has leader time been reserved?

The PRESIDING OFFICER. The Senator is correct.

Mr. DOLE. Mr. President, I yield 5 minutes of my leader time to the Senator from New York, [Mr. D'AMATO]. I will take about 2 or 3 minutes. I do not want to delay my colleagues.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. DOLE. Mr. President, I would like to call the attention of my colleagues to four articles in today's Washington Post.

First, I recommend the story on page 1 entitled, "CBO Is Lukewarm on Senate Health Plan." This story summarizes some of the problems the nonpartisan Congressional Budget Office has with Senator MITCHELL's proposal. Let me share a few quotes from that story.

> The CBO also found the [Mitchell plan] would be difficult if not impossible for individual States to implement, and that a proposed tax on health care plans whose benefits costs exceed certain levels could increase the cost of insurance for many people and cause some to drop coverage.
>
> Furthermore, the bill's proposal that there be an employer mandate only in States that do not reach 95 percent coverage by 2000 would cause businesses to move across State borders to avoid the payment.
>
> The Agency also found an aspect of the Mitchell bill—establishing three additional medical subsidy programs—would be difficult to accomplish in a sensible and administrable fashion.

It is obvious from this story, Mr. President, that the CBO preliminary analysis of the Mitchell bill should be read by every Member of this Chamber before we begin the amendment process.

The second article worth reading is on the front page and it is entitled "A Second Opinion as Debate Begins." And this article reports that Mrs. Clinton believes the Mitchell bill is an "untested approach," and she expresses her skepticism that "it would work as advertised." Mrs. Clinton also expressed her preference for the legislation sponsored by Congressman GEPHARDT.

Mrs. Clinton's influence on this issue is well known. And no doubt about it, she has been a very eloquent voice in this debate. But if she believes the Gephardt bill is better, it should lead us to wonder what will happen in a House-Senate conference committee. Will the White House be exerting its influence to set aside whatever bill the Senate passes, and to adopt the Gephardt approach? If that is to be the case, why do we not just bring the radical Gephardt bill up for a vote right now.

Also on the front page is a headline that reads "Businesses Desert Key Health Bills."

And the article reports that:

> A wide range of small and very large businesses have come to the same conclusion that the bad news [in the Mitchell and Gephardt bills] far outweighs the good.

The article also contains a very compelling quote from James Klein, the executive director of the Association of Private Pension and Welfare Plans.

Mr. Klein points out correctly that the folks who are saying that the Mitchell bill is not as bad as the Clinton or Gephardt bill are asking the wrong question. And he says the right question about the Mitchell bill is, "Is it better or worse than the current system with all its flaws?"

And Mr. Klein concludes:

> Business, both large and small, is increasingly of the view that it is worse than the current system and shouldn't be allowed to go through.

That is also the conclusion shared by the highly respected economist Robert J. Samuelson, in the fourth article in today's Post that I recommend to my colleagues.

Let me just share a few quotes from Mr. Samuelson's op-ed which can be found on page A-19.

> Among other things, the Democratic health care plans contain a large—and unjustified—multi-billion dollar tax on younger workers. You wonder whether most Members of Congress know this or even care. The whole health care debate is now completely out of control. The desperate effort to craft something that can be advertised as "universal coverage" means that Congress literally no longer knows what it's doing. Anything resembling the Democrats' bills, if enacted, would produce massive unintended side effects.
>
> Chaos is now the most important (and largely unreported) reality about the health care debate. Dozens of provisions in [the Democrats' bills] would have huge unappreciated consequences. John Sheils of Lewin-VHI, a health consulting firm, says premiums for small businesses in the Mitchell bill could be 25% higher than for big companies. The CBO agrees a gap exists but puts it lower. Who's right? Do most Members of Congress understand the gap? Probably not.

And Mr. Samuelson—who, to be fair, also criticizes Republicans in his article—concludes by writing:

> In May, Robert Reischauer, head of the CBO, warned that trying to find a compromise by combining provisions from different bills might make the health system worse. He compared it to building an auto engine with incompatible parts. "You can't say I want a piston from Ford, a fuel pump from Toyota—and expect the engine to run."

Well, that's precisely what's happened. The contraption is no longer even a car made from incompatible parts. It's now part car, part tractor, and part rollerblades. It's a clunker. Most Americans seem to understand this. Will Congress?

Mr. President, Will Rogers once said that "All I know is what I read in the paper."

And no doubt about it, after reading the Washington Post this morning, one thing I know is that it would be foolhardy for Americans to trade in the best health care system in the world for a plan that raises as many questions and as many concerns as the plans by Senator MITCHELL and Congressman GEPHARDT.

I ask unanimous consent that the two Washington Post articles be printed in the RECORD.

There being no objection, the articles were ordered to be printed in the RECORD, as follows:

HEALTH CARE: START OVER NEXT YEAR—THEY DON'T KNOW WHAT THEY'RE DOING UP THERE

(By Robert J. Samuelson)

Among other things, the Democratic health care plans contain a large—and unjustified—multi-billion-dollar tax on younger workers. You wonder whether most members of Congress know this or even care. The whole health care debate is now completely out of control. The desperate effort to craft something that can be advertised as "universal coverage" means that Congress literally no longer knows what it's doing. Anything resembling the Democrats' bills, if enacted, would produce massive unintended side effects.

Apparently, most Americans grasp this. In a Newsweek poll last week, respondents were asked whether Congress ought to "pass reform this year" or "start over next year." By a two-to-one margin (65–31 percent), they said "start over." They sense that the versions of health reform crafted by House and Senate leaders are hodgepodges of conflicting provisions whose only purpose is to win passage. But what is clear to ordinary Americans is denied in Washington. In the capital, the fiction is that legislators know what they're doing and are debating rational alternatives.

"I think you're going to see a very good, erudite back-and-forth," says House majority leader Richard Gephardt, sponsor of the House bill. Well, it won't be "erudite" if members of Congress don't understand the consequences of their actions.

Gephardt's plan, for instance, would create a new Medicare Part C program for the unemployed, workers in small companies and many existing Medicaid recipients. The Congressional Budget Office estimates that the program might enroll 90 million people. But the project could easily err by millions in either direction. More important, Medicare Part C emphasizes "fee for service" medicine (patients selecting individual doctors), while the rest of the bill emphasizes "managed competition" (reliance on health maintenance organizations and similar plans).

In a single stroke, the bill would separate the under-65 population into two groups, mainly based on income and size of employer. Each group would be crudely steered toward a different type of medicine. In practice, this division may not be politically acceptable or economically workable. Many Americans may find one type of medicine more appealing than the other and resent being excluded. Or the artificial segmenting of the medical market may raise costs for both "managed competition" and "fee for service." Gephardt doesn't know; no one does.

Now, consider the tax on young workers. It arises from "community rating." As people age, their health costs and insurance premiums rise. But "community rating" requires that everyone pay the same rate. This provision is included in the House bill and, in a modified version, in the Senate bill. The effect would be to raise insurance for younger workers (say those below 45); the amounts are hard to estimate, but a good guess is at least $300 to $500 a worker. If employers have to pay higher insurance, they will pay lower salaries. The invisible tax on young workers might total $15 billion to $25 billion annually.

Is this fair? No. If enacted, it would compound the existing bias against the young. Already, one-third of the federal budget goes to the elderly; the young are taxed to support the old. How much farther is this to go? Or is it a cynical reaction to voting patterns (the young vote less than the middle-aged or old)?

Questions like these swirl around both Gephardt's plan and Senate majority leader George Mitchell's. It is hard even to describe Mitchell's plan. He says it's voluntary and lacks a "mandate." Wrong. It's true that it doesn't mandate companies to buy insurance for workers. But it does mandate a standard benefit package for firms—the vast majority—that offer insurance. Because the mandated benefits are above average, this would probably raise health spending. Companies below the new standard would increase benefits; those above would have trouble lowering them.

Next, Mitchell hopes to achieve 95 percent insurance coverage by offering subsidies for low-income workers to buy it. But there's a "fail-safe" mechanism to limit subsidies if the budget costs exceed projected costs. However, if 95 percent coverage doesn't occur by 2000, Congress could require employers to pay 50 percent of their workers' insurance. But this would apply only to firms with more than 25 workers. Got it? Neither Mitchell nor anyone else knows whether this would reach 95 percent coverage.

These plans are confusing because the health debate evaded the basic tension between expanding health services ("universal coverage" etc.) and controlling health spending. It's hard to do both at the same time. The plans' complexities—as with the original Clinton plan's—aim to disguise this conflict. Republicans haven't been especially constructive in this debate because they haven't faced up to it either. But they are now correct that a bad bill would be worse than none.

Chaos is now the most important (and largely unreported) reality about the health care debate. Dozens of provisions in these bills would have huge unappreciated consequences. John Sheils of Lewin-VHI, a health consulting firm, says premiums for small businesses in the Mitchell bill could be 25 percent higher than for big companies. The CBO agrees a gap exists but puts it lower. Who's right? Do most Members of Congress understand the gap? Probably not. Still, the pretense in Washington is that Congress is making conscious choices.

The pretense is sustained because in Washington politics is sport, especially at the climax of a legislative battle. All attention fixes on who wins and loses—and the deals that enliven the game. Rhetorical blasts are taken for reality; political reporters know little of how legislation would work and care less. This often leads to bad laws, and in health care, the potential for blunders is huge because Congress is tinkering with one-seventh of the economy and most aspects of medicine.

In May, Robert Reischauer, head of the CBO, warned that trying to find a compromise by combining provisions from different bills might make the health system worse. He compared it to building an auto engine with incompatible parts: "You can't say I want a piston from Ford, a fuel pump from Toyota * * * and expect the engine to run." Well, that's precisely what's happened. The contraption is no longer even a car made with incompatible parts. It's now part car, part tractor and part rollerblades. It's a clunker. Most Americans seem to understand this. Will Congress?

CBO IS LUKEWARM ON SENATE HEALTH PLAN

(By Dana Priest and Helen Dewar)

The Congressional Budget Office yesterday gave a decidedly mixed review to the Senate leadership's health care reform bill.

The agency, in a preliminary analysis, said the bill would achieve its goal of covering 95 percent of the population in 1997, almost immediately after enactment, but would increase the deficit by $9 billion by 2000. The CBO said it would also be necessary to require employers to cover the 14 million people who would remain uninsured after 2000. The requirement is called the employer mandate.

Because of the way the Congress's budget rules are structured, the deficit would not prevent Congress from adopting the bill. The agency, which Congress created to give it independent economic analysis and forecasting, predicted the bill's adverse impact on the deficit would eventually disappear.

The CBO also found the plan by Sen. George J. Mitchell (D-Maine) would be difficult if not impossible for individual states to implement and that a proposed tax on health care plans whose benefits costs exceed certain levels could increase the cost of insurance for many people and cause some to drop coverage.

Furthermore, the bill's proposal that there be an employer mandate only in states that do not reach 95 percent coverage by 2000 would cause businesses to move across state borders to avoid the payment.

"Because of the disruptions, complications, and inequities that would result, CBO does not believe that it would be feasible to implement the mandated system in some states but not others; the system would have to include either all states or none."

The agency, which is charged with estimating the cost of legislation on the federal budget, also found an aspect of the Mitchell bill—establishing three additional medical subsidy programs—would be difficult to accomplish in a "sensible and administrable fashion."

The subsidies would cost the federal government $115 billion over four years in addition to what it would spend on Medicaid, the current federal-state Medicaid medical program for the poor.

Since Mitchell unveiled his plan last week, the legislation has been rewritten "hundreds of times," sources said, because the original plan would have created a "a huge deficit." The bill now includes few subsidies for small, low-wage firms. It also would not limit, as the Clinton bill did, out-of-pocket costs for individuals. The changes could pose serious political problems for Mitchell because the business subsidies had been a sweetener to attract lawmakers worried about burdening firms with new costs.

The bill includes a novel approach to cost containment—a 25 percent tax on health plans whose annual price increases exceed a government-set limit. The tax is projected to raise about $6 billion in 2000.

Mitchell adopted the provision as a way to raise money and to force health plans to lower their costs. To avoid criticism by labor unions, which oppose it, he inserted a rule prohibiting health plans from passing the tax on to consumers. But the CBO said such a restriction would be difficult to enforce, the tax would be passed on and, if insurance were voluntary, the increase would force some people to drop coverage.

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. D'AMATO. Mr. President, I thank the leader for yielding me this time.

REMOVING TREASURY OFFICIALS

Mr. D'AMATO. Mr. President, today eight of my colleagues on the Senate Banking Committee joined me in sending a letter to Secretary Bentsen. It is a short letter. I am going to take the time to read it because it is important.

DEAR MR. SECRETARY:

As you are no doubt aware, the Senate Whitewater hearings revealed that Roger Altman and Jean Hanson were not fully truthful or forthcoming with the Senate Banking Committee on February 24. Thereafter, they continued to be less than truthful in a series of letters to the committee dated March 2, 3, and 11.

> Indeed, undisputed testimony by White House witnesses at the Whitewater hearings concluded last week established that White House officials specifically warned Mr. Altman on March 1 that his February 24 testimony "could be misleading." In addition, Josh Steiner, your chief of staff, gave testimony during the Senate hearings on Whitewater that the New York Times has described as "comical," referring to his efforts to repudiate his own writings.
>
> By their actions, these officials have brought dishonor on your office, and we believe their continued service at Treasury cannot be productive. They have irretrievably lost the confidence of this committee. We hope that you will act swiftly to remove these officials and restore the Department's standards.

As I say, eight of my colleagues joined with me.

Secretary Bentsen has an obligation. It is not good enough to wait to see what the signal from the White House is. It is the Secretary's stewardship that is in question, and in terms of the actions of these three people who serve at his pleasure, I believe that their swift removal is the only thing that will restore the honor and credibility of the Department.

Mr. President, I have noticed something of late, and it has to do with Whitewater, but it goes beyond. Every time someone appears to be at odds with the President, the White House immediately has their minions running out there, whether it is DNC, whether it is Members of the Congress, whether they take to the floor of this Chamber or the other, and they look to attack the character and undermine the credibility of the person who may be at odds or have a difference of opinion. It has been going on and it continues to go on. This is their modus operandi. They try to be disingenuous after the President's lawyer, Mr. Bennett, who is the attack dog, starts. Oh, we disavow. And then one Member of the Congress after another.

It is pretty partisan. You cannot suggest to me that some of those Members up there attacking the people have not been part and parcel of this operation. They attacked Jay Stephens, the former U.S. attorney in Washington. They attacked the new independent prosecutor, Judge Kenneth Starr, and now they are even attacking the three-judge court that appointed independent prosecutor Starr. This game has gotten tired and old. It is their little tricks.

The President's lawyer, Robert Bennett, and the White House operatives should know better. I think it is about time we call them the way we see them, and that is the way this Senator sees them. I for one believe we have an obligation to stand up and not submit to this new kind of attempt to still the voices of people who have a difference of opinion.

I thank the Chair. I yield the floor.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

The PRESIDING OFFICER. Under the previous order, there will now be 4 hours of debate on the bill, S. 2351, equally divided and controlled between the majority and the minority leaders or their designees.

Who yields time?

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Oregon.

Mr. PACKWOOD. Mr. President, in a moment, I am going to yield to the Senator from Minnesota such time as he wants.

But I am telling you, I have reached the limit of my patience. Last night, the majority leader introduced a new bill. It has no number. He has not introduced it. He had it printed by the Government Printing Office. It is not a star print, which requires unanimous consent. It is a new bill. And apparently what he has done—I have it all on the one page, and I have not had a chance to look at it yet.

The following sections have been modified since the initial printing of S. 2351, which was his bill only last week. Title I, 101, 102, and so forth; title II, title III, IV, V, right on through title IX.

We have no idea what he has done. We are now soon going to be on this bill. This is exactly the problem I have been talking about for the last month. Are we going to go day by day with brandnew bills, brandnew amendments, with no chance to see them? Do these have to be costed? Do they have any cost? Does anybody know? Has anybody seen them? No.

Is the majority party so determined to pass a bill, any bill, that they do not care whether anyone sees it or not? We have already turned down Senator HELMS' sense-of-the-Senate amendment this morning that we should not proceed unless we have Congressional Budget Office estimates. We turned that down. That is the budget procedure we have voted to follow for years. We should have estimates before we go. We defeated that.

Now we have a bill we have never seen. We have modifications to the previous bill that we only saw last week that was 1,400 pages, 14 pounds.

It is an absolutely insane, inane, unfair process to ask us to now know what is in this bill that has not been introduced, but was printed last night at the request of the majority leader.

Mr. President, I yield to the Senator from Minnesota such time as he may deem necessary.

Mr. KENNEDY. Will the Senator just yield for purposes of clarification? What exactly is the point that the Senator was making?

The PRESIDING OFFICER (Mr. AKAKA). Does the Senator from Oregon yield?

Mr. PACKWOOD. No, not on my time.

Mr. MOYNIHAN. Mr. President, now, comity, comity; and no breaking of furniture.

Mr. PACKWOOD. I just did not want it on our time. That is fine.

Mr. MOYNIHAN. Sure. I yield to the majority leader such time as he requires.

Mr. MITCHELL addressed the Chair.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. MITCHELL. Mr. President, I simply want to make one point, and then I will be glad to yield to our colleagues.

I introduced my bill 1 day after announcing my plan.

It was based upon the Finance Committee bill. That committee had completed its work a month before, and the Labor Committee bill which completed its work 2 months before. In June, Senators DOLE and PACKWOOD announced that they had a plan, and it was introduced as a bill last night, 6 weeks later. No one has yet had a chance to read it. It was for many weeks a phantom bill.

We welcome the opportunity to read the bill now finally after a 6-week delay. But I hope now that we can concentrate on debating the issues, not on when which bill was printed for whom. We moved as promptly as possible.

There will be ample opportunity to debate this bill. I have said many times no one will be rushed. We will stay here as long as it takes, as many days and weeks, months, if necessary, for every Senator to be able to consider the bill amply.

But let us be clear with respect to proceedings on the bill. My bill was introduced 1 day after I announced my plan for everyone to see. And it took more than 6 weeks to get our colleagues' bill from the time they announced the plan. We welcome the debate. We welcome the discussion. Perhaps we can get to the issues before this debate is through.

I thank my colleagues.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. PACKWOOD. Mr. President, just so the record is complete, in late June, Senator DOLE and I asked the legislative counsel's office—that is, the professional staff that drafts bills—to draft our bill. They only have so many people. They indicated they had to draft the finance bill first—and I am not complaining about that. Then they again set aside our bill to draft the majority leader's bill. We would have loved to have had our bill last June, the first week in July, or the second week in July. We just did not get it. We could not get it. I am not blaming anybody. It is no one's fault.

But for the majority leader to blame us because the professional staff that drafts the bills put his bill ahead of ours, seems to me, borders on a bit of hypocrisy.

I am glad we are going to have plenty of time. Senator DOLE and I are not suggesting that we rush our bill. We would be perfectly happy to take a recess for a month, and let everybody study our bill.

I hope that this is the last bill he is going to introduce because we spent a lot of time going through last week's bill.

I do not know. But I might say to my good friend from New York that I have heard—I do not know if this is true—that the provision he and I especially do not like about percentages of residents and number of residents may not be in this bill now. I do not know if it is or not. But I would hope it is out.

I hope the day after tomorrow we do not get another list like this. This is effective August 9, another list of titles and changes when we have spent hours and hours studying the last bill we have. You cannot quite go through this in a night.

So I would implore the majority leader to discuss with himself what it is he wants and make up his mind. I will not ask him—make up his mind and give us one last bill that we can work on.

I yield such time as my good friend from Minnesota wants.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. ROCKEFELLER. Will the Senator from Oregon yield?

Mr. PACKWOOD. On Senator MOYNIHAN's time. Yes.

Mr. ROCKEFELLER. Just as a point of clarification, the objection that the Senator raised on work force and residency caps has been removed. It is not in the bill printed on the podium before the Senator.

Mr. PACKWOOD. Let me thank my good friend from West Virginia. I am delighted it is out of the bill. Does he happen to know what else is out of the bill? I do not know what else is out of the bill. Does he know what is in the bill? I do not know what is in the bill either. That is all I am asking.

Mr. MOYNIHAN. May I say we will have those specifics for the Senator presently.

Mr. PACKWOOD. I thank my good friend from New York.

I now yield as much time as the Senator from Minnesota needs.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. DURENBERGER. Mr. President, I thank my colleague from Oregon for yielding, and for my other colleagues for this brief debate.

I must also begin my comments by thanking 4-plus million constituents in the State of Minnesota for making this opportunity available to me. It has been a tremendous thrill, and it has been a real challenge as the last few minutes—perhaps the last few weeks have indicated—to serve in the U.S. Senate, particularly to serve them on an issue like this. I have enjoyed it a great deal.

I also want to thank my colleagues on the Finance Committee and on the Labor and Human Resources Committee for the most valuable education anybody could ever get both on the health policy and into the process by which legislation is made.

As I was listening to the debate which preceded my colleague from Oregon yielding to me, I was reminded of an incident that some wonderful staff person pulled out of a little history book on how Medicare came to be. He has been reading a series of L.B.J. books, and people who have written about L.B.J.

But he has this wonderful little story about Lyndon Johnson who is in the middle of negotiating with Medicare with the Ways and Means Committee and, in Johnson's book called "The Vantage Point," on page 216, he talks about this story. The story is about a man in Texas who was being tested for a job as a railroad switchman. They asked him the following:

> What would you do if a train from the east was going 60 miles an hour, and a train from the west was coming 60 miles an hour, and they were both on the same track, they were a mile apart, and they were headed for each other?

The guy responded:

> I would run and get my brother.

And they asked him why. He said:

> Because my brother has never seen a train wreck.

L.B.J. wrote that he at that time turned to Wilbur Cohen, who was his health staff, and said:

> I thought I would run and get my brother because if the Ways and Means Committee Medicare bill got reported out, there would be a train wreck.

I am sort of getting the sense here as I follow the opening on health care reform that we may well have a 60-mile-an-hour train from one direction and a 60-mile-an-hour train from another direction. But I do not think I am going to run and get my brother. I am going to, if my colleagues do not mind, make a couple of comments about the process, and then particularly about the bill which the majority leader has put in front of us.

I only reluctantly supported this resolution by the Senator from North Carolina this morning because I do not think we are rushing to health care reform. We have been doing health care reform ever since I got here. I do not agree with the notion that we are rushing to do health care reform. I remember writing a speech for George Bush in January 1992, while he was President of the United States. And we were trying to persuade him to take leadership on health care reform. A lot of people have been doing health care reform.

It is a reality that in the last few months we have had a variety of plans added to the wide variety of plans which we have been debating over the last year, and viewed from a public standpoint, there is a certain amount of rushing to a conclusion and a lot of confusion about exactly what this is all about.

But if I may begin my comments by reminding my colleagues and perhaps others that I stand at a desk that was occupied by health care reformist. There was nobody in this body when I arrived here as committed to health care reform as the late John Heinz from Pennsylvania. I sat next to John Heinz on the Finance Committee for at least 8 or 10 years before his untimely death. And there was a person who was totally committed to reforming the health care system, the way we pay for it, the way we insure it in this country. I stand now next to the Senator from Oregon who, when I got here in 1978, was a leader in health care reform. At various times we will hear from the Senator from Kansas, our Republican leader, who was doing health care reform when I got here. I remember our first act in 1979 on the Finance Committee was to beat, by one vote as I recall, the hospital cost containment approach to health reform of President Carter. While I do not know where my colleague from New York was at on that particular vote, I do know where the majority leader, the Democratic leader of the House was; he, too, voted against it.

In those days, we were doing bipartisan health care reform. The decision was that a national budget for hospitals and price control of hospitals in this country—by at least one vote in the Finance Committee and by a narrow vote in the Ways and Means Committee—was not the way to reform or change the system.

Congressman GEPHARDT was wise then, and Senator PACKWOOD was wise then, as was Senator DOLE, and anyone else who voted against that particular approach to health care reform.

In the 1980's the Republicans led in reform, using the Government program—the little-known Government program—called Medicare as the vehicle for health care reform. One of our colleagues said this morning on the floor of the Senate—Senator SPECTER from Pennsylvania—that his Aunt Rosie does not want anybody messing with her $91 payment on her Medicare plan. She thinks it is the Blue Cross plan she buys at home. Another one of my colleagues at breakfast said that a relative of his called and said, "I do not want any Government in my Medicare plan." I have a poll taken by AARP back in 1984 which tells us that even in 1984, 4 out of 5 Americans who are on Medicare do not realize that it is a Government-run program. I suspect that the number may be greater today.

Anyway, we have been using, through the 1980's, that Government program—Medicare—as a way to try to change the approach to health care in this country. Mr. President, I remind the occupant of the chair, the Senator from Hawaii, because he was not here, that in the first 6 years of this period when we had a Republican Senate and President, I happened to chair the Health Subcommittee of the Senate Finance Committee. Senator BAUCUS from Montana was the ranking member and then GEORGE MITCHELL, the majority leader, was the ranking member, and many people I see on the floor today were part of that committee. Every single thing we did, from prospectively pricing hospital payments to the so-called DRG payments to prospectively pricing the part B payments in 1989, was bipartisan. Everything we did to try to bring catastrophic insurance and drug benefits and long-term care to the elderly were cooperative efforts—in that case, between Senator MITCHELL and myself and others on the Finance Committee. Bipartisan. It was not a Republican bill; it was a bipartisan approach. The same thing is true of the outcomes of the work we did on AHCPR. The same thing is true of every effort that we made at changing the system—which everyone says is the greatest system in the world. It is not. It delivers the best health care in the world. That is why people come from all over to use it. But, as a system, it has been found wanting by many of us. We have tried to change it using Medicare as a vehicle. Every single time we have done it, it has been bipartisan.

Mr. President, I went back and looked at a book I wrote in the early 1980's. I wrote two books on health policy, but only one of them ever got printed. The other one is buried in about seven chapters that are edited and not published. I looked at the one that got printed back in 1979. I laid out the first health care reform bill that I authored, and its principles are the same as the principles that are incorporated into bills like Kerrey-Chafee, Breaux-Durenberger, Cooper-Grandy, and the current bipartisan Finance Committee bill.

I was reminded of this because in a conversation with my number two son, who is now working at a hospital in Minneapolis, he started telling me, "Dad, you know, in your book you said" this and that. I said, oh, my God, what a compliment that a kid will read and remember something his dad said or wrote. But in 1981, I laid out eight principles for reform. I am not the only one. I am sort of identifying those of us who have been involved in health care reform before Bill Clinton got to be a Governor, to say nothing of being a President. Health care reform did not start with the election of 1992. It did not start with the election in Pennsylvania. It started before I got to the U.S. Senate and has been ongoing, and the bottom line is that it has been bipartisan.

Mr. President, if for no other reason than history, I ask unanimous consent that the speech I referred from September 1981 be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

A FRAMEWORK FOR HEALTH SYSTEM REFORM

(Remarks by Senator Dave Durenberger to the National Health Council, Washington, DC, September 18, 1981)

It was over two years ago that I first introduced the Health Incentives Reform Act. Since that time I've learned a lot about health care in this country. I've learned which government programs work and which ones don't. I've learned about fraud and abuse. I've learned about getting the best health care in the world to the people who need it. And I've learned how much it all costs. But through it all, my faith in the principles underlying the Health Incentives Reform Act has not wavered. I started out with a strong belief in the value of choice and the strength of the private sector. Somewhere along the way the ideas were translated as "pro-competitive" and that's true—but the underlying theme remains consumer choice.

Choice gives individual consumers the opportunity to select a product or service that best meets their needs. The most successful provider of that goods or service will be the one that best responds to consumer desires—whether those desires include cost, quality, appearance, or other factors. As I'm sure you know, these very basic elements of a competitive market do not exist in health care. The ultimate consumer of health services, the patient, is usually insulated from the cost of care by a private or government insurance plan. Furthermore, when patients do share in the cost of their health care, they find there's nothing to shop around for—in other words, no choices. How many employees have a choice of health plans? How many Medicare beneficiaries do? Not many. And without consumer choice to stimulate providers to be responsive and efficient, we really can't expect doctors and hospitals to change their behavior. More regulation won't cure the ills of our health system. But neither will the status quo. We must introduce the basic elements of choice and competition into health care.

In the course of thinking about these issues I've come to realize that achieving a better health system entails much more than simply enacting a so-called pro-competitive bill. No single bill can include all the elements needed to make our health system more competitive. The reason we have market failure in health care cannot be attributed to any single piece of legislation in the past. The course to our present state of affairs has been incremental, and likewise our movement toward greater competition will have to be incremental. That doesn't mean that our action will be limited or slow in coming. It only means that we will act broadly and persistently.

An incremental approach requires that a competitive framework be established which can be used to formulate positions on the entire range of health issues. It's very easy for health policymakers to view issues in isolation and forget the contribution each one makes to the whole. You can't expect a business to produce a good product if each division sets its own agenda. There has to be coordination and an overall corporate strategy. Improving the health system is no different. It needs an overall framework and gameplan.

EIGHT GUIDING PRINCIPLES FOR CHANGE

I've thought a lot about a framework for health, and I'd like to share with you today the guiding principles I've been developing. Most of these principles apply to other issue areas in addition to health, and are representative of my general philosophy on the role of government in society.

1. Choices are good. Government policy should expand choices to the individual, not limit them.

Monopolies in service provision, whether public or private in nature, should be avoided. Citizens benefit from choice, whether it's in the form of competition with Ma Bell for long distance rates or in the alternatives to the U.S. Postal Service for package delivery. Government has done a reasonably good job of extending health care choices to its employees through the Federal Employees Health Benefits Plan. Similar choices should be extended to Medicare beneficiaries and veterans.

2. The government is generally a better purchaser of services than provider of them.

Government does not allocate resources as well as private markets and should directly provide services only when a private alternative is unavailable. In cities like New York, private bus lines are able to make a profit on runs the transit commission consistently loses money on, despite charging the same fare. Another example is in the area of municipal garbage collection. Those communities like Newark, Kansas City, and Minneapolis, that contract out for refuse collection, are able to save millions of dollars compared to communities that directly provide the service.

A further extension of this principle is that, if possible, government payments should go through the beneficiary rather than directly to the provider.

As an example, consider the G.I. Bill. Veterans were given the choice of going to whichever institution they wanted to receive their education, certainly a preferable alternative to building exclusive Veterans Colleges to handle all veteran education. In the area of subsidized housing, special projects conducted by HUD in Green Bay and South Bend have demonstrated that housing allowances—a form of voucher—give beneficiaries a range of choices that made them happier and the market more responsive. The same approach should be used with Medicare and Medicaid.

3. Consumer choice is enhanced as information increases. Government policy should facilitate the flow of information.

Individuals cannot be expected to make sound choices if they are provided with insufficient or inaccurate information. Furthermore, information must be presented in a straightforward and comparable manner. Individuals should not have to compare apples with oranges. Consider the value and popularity of a publication like Consumer Reports. It helps us compare products on the basis of cost and quality. On the other hand, look at the information the government provides federal employees under the FEHBP—there seems to be plenty of information there, but at least for me it's very difficult to make heads or tails out of. Information must be provided in a usable form.

4. The price of goods or service should be a true measure of its cost. Government policy should not facilitate hidden costs or cross-subsidizations.

A good example is the subsidy our government provides for tobacco. It's bad enough that the government gets in there and mucks up all the price signals that would otherwise be shaping the market—but then to have the stuff so unhealthy on top of that. It just doesn't make sense. In the health area, Medicare cost allocation formulas often force hospitals to shift legitimate expenses to private paying patients. Such cost-shifting doesn't save the system any money, but it does distort the price signals buyers perceive. Consumers should get what they pay for and pay for what they get.

5. The government should guarantee access to necessary care. However, standards of access cannot be open-ended and must be realistic.

Not every town has a Bloomingdale's or a hospital or an orthopedic surgeon, but access to these facilities and services is usually reasonable. In the medical area, geographical access is only one issue; there's also economic access. We provide medical services to those who can't afford them. But consider the difficult issue we face as medical technology offers us expensive new treatments for disease. True, the treatment may be better, but is it worth 10 times the cost? We simply cannot afford a health system which sets standards solely on the basis of available technology with no regard for price. Setting standards for access is a thorny but unavoidable government responsibility.

6. A responsive market will have fluctuations in capacity. Temporary shifts and increases in capacity are to be expected as the market adjusts.

Shifting buyer preference causes some producers to increase output while others decrease theirs. Consumer preference for fuel-efficient cars left our American auto manufacturers with too many large cars and too much capacity to produce them. Even though they are rapidly downsizing their models, they still have more capacity than they need for producing large automobiles. But that's not bad; it's just part of the process, and government shouldn't be tempted to meddle with it. In the health area, that means getting away from certificate-of-need.

7. The government should establish guidelines for quality, but recognize that quality will ultimately be judged by the individual.

Consumer protection often takes the form of government regulating the producer and setting standards for quality. For years the government has tried to regulate standards for mileage and crash restraints in automobiles. The government has also tried to control the use of artificial sweeteners, even though diabetics might choose to accept the risk of cancer to decrease their sugar intake. A more appropriate role for government is to establish guidelines and, as mentioned earlier, provide adequate information to the individual making the choice.

8. The government's role in stimulating competition should be to assure fair market conditions, not regulate its particular brand of competition.

We each have a slightly different definition of competition. What's important is not that we install one particular model, but that we create the conditions that will allow the market to diversify and shape its own future.

That's it. If I get up to ten, maybe we can call them the Commandments. For now, I guess they're just the Beatitudes.

As an example of how they might be used, take health planning. The concept is a good one. When it comes to a community's health system, citizens should have some input. But the regulatory authority we've given planning agencies is dangerous and uncalled for. To a planner, excess capacity is the bane of our health system. To a believer in the market and my sixth principle, excess capacity is a part of change and innovation. As I see it, the elimination of all excess hospitals beds in a community would significantly reduce the pressures for change within the hospital industry. Franchising may be okay for McDonalds or Wendy's, but it's not okay for the government. We should neither franchise peanut growing nor health care, and HSAs should not have the certificate-of-need authority they now enjoy.

I know you are interested in the more talked about pro-competitive provisions. I tend to think in terms of public buyers and private buyers. As the major purchaser of health care, government certainly has a responsibility to shape up its own act. Consequently, I have been very interested in proposals which would extend voucher-type options to Medicare and Medicaid beneficiaries. The proposals range from fairly limited ones, like Senator Heinz' bill to capitate HMOs under Medicare, to broader voucher schemes in the mold of Alain Enthoven's ideas.

I recognize both the technical difficulties and unknowns associated with a shift to capitated payments, but I believe we must pursue it now. From the standpoint of the budget process, capitated government contributions would make Medicare spending predictable and precise. From the standpoint of the beneficiary, there would be choices; choices which would allow the individual to best match his or her health needs with a qualified health plan. It all fits with my guiding principles, especially the first two. I expect the scope and details of a capitation plan for Medicare and Medicaid to be developed by my staff and the administration over the next several months. The Senate Finance Committee should be in a position to hold hearings and mark up a bill by early next year.

I'd be less than candid if I said I expected smooth sailing for these provisions. There is tremendous inertia in current federal policy. Government is accustomed to what we have, and so is the private sector. As a public buyer, government must change its position by directing its dollars through the beneficiary, offering choices, and returning coverage to the private sector. As private buyers, businesses must assure that fair market conditions exist for their employees. The market place can work if we all work to make it happen.

Mr. DURENBERGER. Mr. President, one of the things that our chairman of the Finance Committee has taught us this year, in literally hours and hours and hours of hearings on health care reform, is to define our terms. And we are all grateful to him for having done that. I hope that in the course of the debate, in the next week or two, however long it takes, that those definitions will come in handy. I must say, listening to the debate and discussion last night, the opening statements last night, starting with the majority leader's statement, I heard a lot of examples of Americans denied access to health insurance because of medical conditions.

As someone who has been trying to change the system for a long time, and who stood on the floor in 1992 with Lloyd Bentsen when he was chairman of the Finance Committee, and passed the national legislation that would have eliminated all of those problems, I do not like the idea that today's health care reform is premised on a set of real problems that could have been resolved in 1992, except the Democratic Congress would not permit us to take up that bill on the House side. But every one of those stories is a real story. My colleague from West Virginia told these stories about the medically uninsurable in Minnesota. They are real people who are really suffering. We have been trying for years to resolve that through insurance reform. It has been held up, for whatever reason, until now when it becomes a part of the overall health care reform. But it is only part of the health care reform debate.

One of the Sergeants at Arms was kind enough to come up to me and say, "Senator, I just learned you were not going to be here next year." In a way, that, too, is a compliment, that the word has not gotten out, even though I announced it a year ago. I went back to Minnesota in September and announced that I was not going to run for a fourth term, and Mrs. Clinton came to town the next day and sort of wiped me out. That is probably why he did not hear about it. She did a wonderful job all day long, as she did in many communities, alerting people to the need for health care reform.

At the end of the day, there was a 1-hour television program, one-third of it came from Rochester, MN, at the Mayo Clinic where Mrs. Clinton was, and PAUL WELLSTONE was up in a small town in northeastern Minnesota, and I was sitting in my hometown of St. Cloud, MN, which, to you Garrison Keillor fans, is Lake Woebegon. In Rochester, there was a 5-year-old youngster who had a serious disability with which she had been dealing since birth, a very expensive, medically uninsurable person. We talked for 15 minutes about how health care could help her and billions of people like her.

Then we went up to northern Minnesota to the little town of Moose Lake, and Senator WELLSTONE was there with Dr. Ray Christianson, who that year had been the Family Practitioner of the Year, and talked for 15 minutes on how health care reform put a family practitioner in every rural community in America.

We came to Lake Woebegon where I was sitting with the owners of the Ace Hardware Store, Cathy and Denny Timm, who were 35 years old—I remember that—from Clearwater, outside Saint Cloud, and have the Ace Hardware Store.

They had the television camera there, and Hillary Clinton was on the other end of it. It is hard to know what the Timms were going to ask.

Well, Denny Timm looks right in the camera and says:

> Mrs. Clinton, we so appreciate your coming to Minnesota. This is my question: I am glad we are going to do health care reform. I need to know how much is it going to cost, who is

going to pay for it, and how is it going to affect my 16 employees, half of whom are part time, and most of them are college students.

That was a much more difficult question to answer in 2 or 3 minutes by the First Lady of the United States, and it has become a more difficult question to answer as time goes on: How much is it going to cost? Who is going to pay for it? And how is it going to affect me?

Mr. President, I am going to deal with that subject in the context of the majority leader's bill. I wish I were here dealing with the context of the Finance Committee bill because it is the one bipartisan, or nonpartisan, bill that passed out of any committee of the House or the Senate. But I do not have that opportunity right now. I would like to talk about it in that context. But we will talk about it in the context of the Mitchell bill.

Before I do that, I want to say to the majority leader how much I have enjoyed working with him. I already referenced the fact that he and I worked on Medicare catastrophic. We worked our way through all the difficult efforts to pass it and stood on the floor of the Senate here trying to defend it as it was being defeated by a 65 to 35 vote. His heart is in the right place. There is no question about it.

(Mr. KERREY assumed the chair.)

Mr. DURENBERGER. But it is critical, Mr. President, as we try to find a solution to the challenge of what is health care reform, how much is it going to cost, who is going to pay for it, and how are we, the people of America, going to benefit from it, and what changes are we going to have to engage in in order to enjoy these benefits, that I talk about the Mitchell bill.

After July 2, when the Finance Committee bill was reported out, it was common knowledge that the Finance Committee bill, which was basically a market-based bill, and the Labor Committee bill, which is very much like the Clinton bill, were going to be melded. The word also went out that the drafters were going to reach out to those of us on the market side of the ledger.

We had one meeting, no ongoing discussions, no negotiations, no involvement in the drafting of the bill. When the draft emerged, we were told this was a market bill.

The majority leader says today that he tried to write it on the Finance Committee bill. Mr. President, I have read the Finance Committee bill. I wrote a lot of the Finance Committee bill. My staff did and other staff did. This is not the Finance Committee bill. It is not a market bill.

Today I want to tell you why. I have come to the conclusion that it is not health reform. It is 95 percent universal enrollment. It does insurance reform, but it does not do market reform.

Most people have never seen a medical market, at least not that they would recognize when they see it, but Americans live in a market economy and we operate in markets all the time. We are accustomed to choosing from a variety of products that we need on the basis of value, quality, price, service, satisfaction. We all know that. We have markets for food, for homes, for cars, for furniture, for dancing lessons, for restaurants, just to name a few. But we do not for health and medical services.

There are some, and I know some of my colleagues on this floor, who will say medical services cannot be bought and sold, you cannot put a value on them, you cannot put a price on them, you cannot judge consumer satisfaction; they are a social good; the heck with the price; the heck with the service.

Mr. President, we have medical markets now. Most of them do not work as well as they could. Some work better than others, and for most of our lives, the fact is that we have taken the quality of medicine and access to medical services for granted. Everyone who is here today knows that. Cost was no object. We pay doctors' fees for their services on a piecework basis.

I imagine, when I was a kid there were probably 100 different services doctors could do for you. Today there are apparently 9,000 different services, if you look just at the Medicare codes, a piecework service. And cost was no object. We sent the bills to insurance companies, and they paid them for us.

Doctors and lawyers and insurance companies then got State governments into the business of protecting fee for service. They passed laws preventing competition and choice. They taxed insurance premiums. They mandated long lists of benefits. They imposed other requirements. Every time in the licensure proceeding there was a new kind of doctor or medical professional, someone passed a law saying that new kind has to be in the benefit package.

The result is we have lots of services available. We have very high quality, but you really would not know it. We have the best care, as has been said often, but it costs so much. We are approaching a crisis in access and affordability, as the majority leader said last night.

The only thing that has demonstrated that we can actually do reform and actually get cost under control in this system is one national rule. It is called ERISA, and there is an ERISA rule, written in 1974 as a way to protect pensions at the national level, which has now been expanded to include all employee benefits, including health insurance. One little law has made it possible for employers and employed people all over America to say the system does not work; it costs too much and produces too little. And all over America, from Multnomah County, OR, to Mahnomen County, MN, you name it, employers and employees have come together in coalitions to self-insure. Self-insure. What does that mean? It means that at work our group will take on the risk of providing for the medical services of our employees.

What does it really mean? What it really means is you are not going to use health insurance because, if you use health insurance, you have to buy a whole bunch of services you do not need. You have to buy a whole bunch of providers you do not need, and you have to pay twice as much as you ought. Lately, it means you also have to take on taxes at the State level, surcharges at the State level, whatever the case may be.

What do you get in return for it? You think you get malpractice reform from the States? No. You think you get insurance reform from the States? No. Not until the last year or so did they start insurance reform.

You get a lot of costs on a fee-for-service system, and it is only because of this one little national law, the ERISA law, that people have said we are going to take responsibility for changing this system. And in community after community and company after company and CALPERS in California and the Minnesota public employees in Minnesota and Rochester, NY, and places all over America, people have gotten together and said the system is broken. Yes, the care is the best in the world, but the cost has no relationship to what we are buying. And so they have used this to take charge of their own access to the system. They are demanding value for their money.

And in this whole series of relationships that are being built up—the latest in my home community is called a health care action group, and it is a marvel the way intelligent employers and intelligent employees, banding together with people like the Mayo Clinic, the Park-Nicollett Clinic, all these doctors who in other places we accuse of being greedy—but not here. If you tell the doctors that they are going to be rewarded for being the best that they can be, they will be the best that they can be, not the most expensive they can be.

Because they understand, like in any other market in the world, that the measure of success in being best at what you are is that you get all the business, not that you get to charge the highest prices. That only works in professional baseball and football; but not in the grocery stores, not in any other competitive markets. If you are the best that you can be, you get the business.

That is why in the health care action group, you have all these people coming together to negotiate better ways to define what is health; what is a good medical service; what is a good outcome; how do we better share the risk; how do we get our employees more involved in making these decisions; how do we reward people for staying healthy?

This is ordinary Minnesotans at work. No Government told them what to do. No Government or alliance or HIPC, or anything else. Only them. They made it up themselves.

All over America, this sort of thing has been going on in just the last few years. Efficient networks of care have expanded enrollment today. Up to 51 percent of private sector employees are in some kind of new network. I think my colleague from Oregon talked about this last night. The goal of market-based health care reform is to capture the gains of this trend toward competitive markets, to recreate national rules so that all these local markets can work, to give the hospitals of this country some sense of direction.

If we are going to cut them in half, the number of beds, they ought to know how it is going to be done. If you are going to get rewarded as an insurance company for being accountable rather than just being a bill-paying service, we ought to know what the rule is. And if you buy your health insurance in Minnesota but you use it in Florida, you ought to know the rule is the same in Florida as it is in Minnesota. National rules for local markets.

And no two markets are the same, Mr. President. The Omaha market is different. It is a different culture. Medicine is a series of relationships. Health care is a series of relationships at the local community level. But everyone in those relationships needs to deal by the same rules.

So, taking this little national rule, this so-called ERISA rule, we have tried to adopt a set of principles that said if we can just have national rules by which these markets can operate, then we do not have to tell the markets how to operate.

If they can do it in Minnesota without the Government telling them how to do it, if the Mayo Clinic, which is 1,100-plus doctors—you know, now they are in the primary care business and the rural business and the specialty business.

If the Mayo Clinic, from 1986 to 1992, can be averaging a growth of only 3.4 percent a year and in the last 2 years less than 1 percent growth in cost, they must be doing something right.

We have talked before in the Finance Committee about liver transplants at the Mayo Clinic—which is one of the best in the world, according to the U.S. News and World Report—are something less than $150,000—for a liver transplant.

Now that is a lot of money, but nothing compared to Tampa General Hospital in Tampa, FL, where my folks live, where it is over $300,000.

Now, who is better, Mayo or Tampa General? I do not know. Ask King Hussein. He goes to Mayo. But ask the average American, they do not know, because nobody tells them; because we pretend this is a social good and we cannot tell them this sort of stuff. Why not? Why not? No good reason.

Now, I am going to use that chart in just a second for another purpose, but the reality is—to get to the heart of what I want to talk about—the reality is that all of the Democratic bills that I have seen, and that includes the majority leader's bill, start out the same way. They all say we are for managed competition. They all say we have buyer co-ops, we have insurance reforms, we have rules for accountable health plans. They all start out the same way. They preempt some States' actions, in many cases, so we can have national rules and preempt the States from their anticompetition work.

But what they give with one hand, they take away with the other. They are so anxious just to get to universal coverage without having Government pay its fair share of its promises, that they compromise the market in order to get there.

President Clinton paid for universal coverage with something he called savings—savings.

Senator MOYNIHAN—and I know he does not like it when any of us say this—called that financing scheme "fantasy financing."

But, Mr. President, practically every committee in the House and the Senate has turned down explicit financing. There is no broad-based income tax to cover the 15 percent of Americans that are uninsured. There is no broad-based income tax or excise tax or anything like that to cover the cost of bringing all low-income people into this system.

There was a large tobacco tax but, thanks to a lot of Democrats, in particular from tobacco-growing States, that tax is practically gone.

So, we cannot raise real taxes. Fortunately, we cannot raise debt anymore, because we have a resolution that says we have to stop at $5.3 trillion.

We have only two choices.

Congressman GEPHARDT says, and the President has said in his original bill, we have to mandate somebody else to pay the bill. Let us have an employer mandate so all the employers pay 78 percent of these premiums, and then we in the Government will not have to raise the money to pay for universal coverage. It is called regulatory federalism, for those who are students of the way intergovernmental systems work.

There are three things the Federal Government can get people to do. First is taxes; the second is debt borrowing; and the third is tell someone to do it—mandate it.

Now, the employer mandate does not seem to be going anywhere, and there is a very soft employer mandate in this particular bill.

The universal coverage sponsors need a mandate. Without it, they have to resort to hidden financing. They have to shift funds from one place to another—cost shifts. They say we need to have universal coverage in order to end cost shifts. But what they do is force everybody into community-rated pools of payers in order to do cost shifts.

Let me say that again. What they do is force everybody into community-rated pools. The President had these things called mandatory alliances. In the labor bill, they had alliances which they said were voluntary, but the coverage pools served as the cost-shifting vehicle. Now, in the Mitchell version of this, we are going to have 78 percent of American workers in large community rated pools, and the other 22 percent in experience-rated pools, composed of employers of 500 or more. The objective is to get everyone into a community-rated pool of payers in order to do cost shifts, not to stop them.

What does raising this requirement of a firm from 100 to 500, for example, have to do with anything? You cannot self-insure if you are less than 500 employees. You have to go into some kind of community-rated pool. And I think they begin with adjusted community ratings, then they go community rated, or something like that.

What does that accomplish? Well, for one thing it stopped all these employers from getting together and negotiating what I was talking about earlier.

In the State of Vermont, there is only one company that employs more than 1,000 people. So in all of the State of Vermont, you have all these negotiators who are trying to change the system probably down to one or two or three people.

There are 50,000 employers between 100 employees or less and 500 employees or less—50,000 people all over this country who could be negotiating to get the quality of health care up and the prices down, but they are all wiped out. They are all wiped out. Half of the employees in this country are in groups of 100 or less and half in groups of 100 or more, which is why we chose 100 as the breaking point. In smaller firms, they need to group up to get market power.

The second reason we chose it, those of us who believe in the market, is that we wanted people, a lot of employers and a lot of employees, working to change this market. But, no, that is not what the Mitchell bill does.

All the firms in the Mitchell proposal are required to sign up for a cooperative within these pools. Remember, there are 78 percent that are in one of these mandatory pools. If there is no co-op available, believe it or not, what do you do? You go to Washington, DC, where the Federal Employee Health Benefit Plan will put a co-op together for you; a Government buyer from Washington, DC, given a competitive advantage over all other co-ops.

Senator MITCHELL takes away the incentive for many employers and many groups and associations to negotiate. We have carefully tried to bring trade associations, MEWA's, a lot of other employer organizations into this process. And now they are gone. What happens? Once all of these buyers are into one pool, what happens? Now the cost shifting begins in earnest. Last night, I heard our colleague, the chairman of the Labor and Human Resources Committee, Senator KENNEDY, say the majority of the funding in the Mitchell bill comes from savings in the Government programs. He is right. This bill increases cost shifting from Government to private employers in several ways. Today, two-thirds of the current cost shifting is embraced under payment by Federal programs, Medicare and Medicaid—something in the neighborhood of $24 billion to $25 billion a year.

Not only will this cost shift continue, but the Mitchell bill plans to increase it. What are Medicare savings? They are budgeted reductions in fees for Medicare expenditures. Medicare currently pays 59 cents on $1 of medical charges of part B, and 71 cents on a $1 of hospital charges in part A. Who pays the rest? That is a cost shift. There is no question about it. The cost shift works easily in the suburbs, where you have a lot of third-party payers to shift it on, but it does not work so easy in rural areas where two-thirds of the people are in Medicare or Medicaid.

So the difference is consistently shifted onto employers. And the rationale in the Mitchell bill for getting 78 percent of the working people into these large co-ops is so that you have this much larger pool, guaranteed to pick up the costs that are shifted from the Government programs. Senator MITCHELL said he is changing Medicaid so these people can join private plans as well—again, through these pools. Senator MOYNIHAN and I had a proposal for how to do this, how to phase it in over a period of time. But that is not the proposal in this bill. The proposal in this bill is to have all of the low-income people come right into the pool with working people or small businesses. The problem is that insurers do not know how to estimate the risk of previously uninsured individuals, so they will inflate the potential risk, thus raising the cost to everyone in the pool. So workers' rates go up. This makes risk adjustment, which we barely understand, very difficult. And health plans will go back to risk avoidance rather than seeking risks to insure.

Low-income individuals who qualify for subsidies would not have to pay for deductibles and copayments. The Government does not pick up the cost of the copayments or deductibles—you will. These will be shifted onto working people in that pool, as well. Subsidized people do not have to follow open enrollment rules, according to the Mitchell bill. They can sign up when they are sick without penalty. Think of that. When you know you are sick, you can go buy an insurance plan in part of this pool. So prices will reflect this personal risk selection, as well.

If that is not bad enough, plans cannot cancel people who fail to pay their premiums. Those losses are passed on to people who pay their bills. In effect, free riders shift costs onto riders. And we are not done yet. Not satisfied with cost shifts onto employers in the community-rated pool, the Mitchell bill allows new cost shifts from the community-rated pools to larger employers who are buying in experience-rated markets. Using "risk adjustment" programs governed by Federal and State rules, the funds will be transferred from huge community-rated pools to large employers. And this is simply a hidden payroll tax. Because it is hidden it is unlimited and open-ended.

The focus of criticism so far on the Mitchell bill has been on the triggered mandate on employers. But you do not need a mandate to force employers to pay the Government's obligations. You do not need a mandate to force employers to pay the Government's obligations. This bill, the Mitchell bill, does it for you. This 2001 trigger is not the problem with the Mitchell bill. The majority leader said in his opening statement today the only way cost shifting can be stopped is to cover everybody. The way his bill does it, the cost shift does not stop, it is institutionalized —from politicians who make promises and then break them and force working people to pay the bills.

Any kind of coverage extension that is premised on savings in this place has to be looked at very closely. And whether it is the drug benefit for the elderly, the $90 billion drug entitlement which is paid for from savings, or any of the other additional benefits, somebody has to answer the question that Denny Timm asked up in the Ace Hardware Store: Who is going to pay for it? How much is it going to cost? And how much is it going to affect me?

Shared responsibility, I cannot find it in this bill. People who have gold-plated plans continue to have unlimited tax deductions. Some of the law firms in this town pay $1,000 a month for plans, with a tax subsidy of 39 percent. That is $4,680 a year of your taxes going to buy their health plan. They put nothing at risk to maintain that system. The self-insured in the Mitchell bill—over 5 years, self-insured people will only get a 50 percent deduction for their premiums. Working people who pay their own premiums get nothing—nothing—while the lawyer gets a $4,680 tax subsidy.

I appreciate very much the efforts of the majority leader. Let me conclude by saying to the majority leader and to my colleagues who are on the floor, particularly those who are the leaders of the committees who brought us to this day, what I said earlier. First is that I do not think we are rushing to judgment on health care reform. We have been at this for a long time, and it is about time we take action. So I am on your side on that.

But I also say, we have to start looking at the forest, not at the trees. Universal coverage is a tree. We cannot even define it. Medically uninsured is a tree. Employer mandate triggers, there is a tree. FEHBP, that is a tree. Risk adjustment, that is a tree. Mandated benefits, that is a tree.

We need a vision of what the forest could be. We cannot get to a bipartisan—which I think it needs to be—health care reform bill one amendment at a time on this bill. We cannot get there one vote at a time.

I just need to conclude by reading from the quotation from Bob Reischauer, that was included in the Robert Samuelson article in today's Washington Post. For whatever else you may think of Reischauer's estimating prowess, I think he has been in health policy for as long a time as many of the rest of us. He warned trying to find a compromise by combining provisions from different bills might make the health system worse. He compared it to building an auto engine with incompatible parts.

"You cannot say," he says, "I want a piston from a Ford and a fuel pump from a Toyota, and expect the engine to run."

Mr. President, the majority leader, I am afraid that is what we are trying to do with these melded approaches to health care reform. We need a vision for what we could be as a nation; the role of medical invention, of information technology and, yes, the role of Government in getting us there.

I also think that it needs to be—and I have pledged to all of my colleagues—it needs to be bipartisan. By that, I do not mean one or two or three Republicans. I think there are a substantial number of Republicans in this Chamber and there are a substantial number of Democrats who do not want to put this off, who want to deal with this issue. And we need to be given the opportunity to do that.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Who yields time? The Senator from New York is recognized.

Mr. MOYNIHAN. Mr. President, may I first thank the Senator from Minnesota for his words. That he has not dropped out of this effort is hugely important to us.

He has been on this issue from the day he arrived in the Senate. I, for one, hope he will leave a large achievement behind him. I think it is still possible. I think what he has said this afternoon makes it even more so. I want to thank him, and tell him of the gratitude I have had for his work in the Finance

Committee all these years and, in point of fact, the only slight change I would make to his erudite factual statement is that the bill before us is, in fact, at this moment still the Finance Committee bill.

Mr. DURENBERGER. Will the chairman yield?

Mr. MOYNIHAN. Of course.

Mr. DURENBERGER. I leave you with one story. This is gleaned from the Tragedy of Lyndon Johnson by Eric Goldman. This is a story, again, that involves the passage of Medicare in 1965. As the story goes, one of the ways in which this Medicare bill was ensured of success is that Lyndon Johnson, being given a variety of ideas that came from Republicans, said laughingly to his staff, and I will quote:

> Just tell them to snip off the name Republican and slip those little old changes into the bill.

I thought of that story in the context of my advice to the majority leader and to my colleagues on the Democratic side of the aisle. That sort of sums up the essence of bipartisanship in this place, and it is a long tradition. It goes back to LBJ. You can, as far as I am concerned, snip off any contribution I make to the effort if, in fact, you can make sure it is bipartisan and you can make it happen this year in a way that—as the Finance Committee chairman said earlier, at least 60-plus Members of this body to get it passed.

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. Mr. President, I yield the learned and indefatigable Senator from West Virginia as much time as he desires, 20 minutes.

The PRESIDING OFFICER. The Senator from West Virginia is recognized.

Mr. ROCKEFELLER. Mr. President, I thank my dear friend from the State of New York.

Mr. President, as we prepare to finally work the Senate's will on health care, a story comes back to me. Back about 50 years ago, a Russian visitor to Washington sat and observed a session of the Congress and said: "Congress is so strange. A man gets up to speak and says nothing. Nobody listens and then everybody disagrees."

I think everybody in this body can remember debates on this floor where we have had the same kind of thought. But I hope and I pray that all of us will approach the next days and weeks as we debate and resolve a bill to deal with our Nation's health care crisis, that we will approach it very differently than what the Russian observer saw.

When each of us sought election by the people of our States to this Senate, we never thought or agreed that it would be easy. I truly doubt that any of us tell our constituencies that we serve in the U.S. Senate just to talk or to make speeches or to argue amongst ourselves until we can go home for the night. We are all here to confront problems, not to pretend they do not exist. We are all here to represent the people of our States as part of the same union bound together as a nation. And now we have reached this moment when we confront a problem called health care in America.

In our wake are years and years of speeches about the crisis of rising health care costs and diminishing health care coverage.

I noted my friend from Minnesota, as he spoke, said many true things. And I think that the majority leader, Senator MITCHELL, has reached out in his bill by making many compromises. I interrupted the Senator from Oregon to point out that the cap on residency at academic health centers have been eliminated. That was in order to reach out, not only to the Finance chairman but also to the Senator from Oregon, and others, who felt that way.

We have reached out in terms of making alliances not mandatory but voluntary. We have stretched out the time line. If there is ever to be a mandate, it will never happen until the next century and only then under certain circumstances, only if the Congress does not follow the orders of the commission. We have reached out.

But I have to say that in the search for the 60 votes that the Senator from Minnesota so dearly wants, that this does have to be a two-way process. We cannot constantly be reaching out and out and more and more and then nothing comes back. It is very hard to reach agreement that way.

So here we are with our years of speeches about this crisis. This debate begins after, as you go over the years, I would say virtually thousands of hearings in Congress. Certainly tens of thousands of hearings and public meetings in our homes and visits that all of us have had with people in our States. Hundreds of reports, hundreds of studies and commissions, mountains. They fill cabinets in everyone's offices and in distant chambers somewhere in this complex, telling us some of the grim facts about health care in America.

We have to be realistic. The Senator from Minnesota spoke about the fact that we let the market work. That is one of the compromises Senator MITCHELL has made in this bill, is to give more time for the market to work. But I have to point out to my friends on the other side that the Department of Labor has recently indicated that workers who are insured, who have insurance through their jobs, that their numbers dropped from 66 to 61 percent over the last 10 years and that the trend is downward under the voluntary system. That means, Mr. President, that 5.5 million more working Americans are now uninsured.

The market system works in different sectors in different ways. Does it work perfectly in health care? I am afraid not. At some point, we have to draw on everything that we have learned, from the experts, from our own constituents and from our own souls, and decide on the actual steps that will solve as much of the problem as we possibly can this year.

With the health care plan submitted by the majority leader, we now have that opportunity. This is a bill that tries to achieve the major goals of health care reform in ways that will work and that we can afford and that are fair. The majority leader can only offer the rest of us the opportunity to act. He has no powers further than that. Then it is up to us. In order to complete this process and pass a good bill, enough of us have to commit to the hard work, commit to the honesty, looking at ourselves squarely in the mirror that comes along with solving problems that are as difficult and complex as health care. We have to do the listening and ultimately the decisionmaking that must occur if action is to be taken on behalf of the American people.

That, Mr. President, is what a legislative body is supposed to do. That is why we are here. That is why we are hired on. If too many Senators treat this debate upcoming as only a chance to score points, one against the other, one party against the other, their win is the American people's loss.

If too many Senators also stay stuck on the idea that we should hold off one more time until next month or next year or the next election, their delay dashes the hopes of millions of Americans—many in my State—who are now thinking maybe—just maybe—something will soon happen here to help them with their health care nightmare. If too many Senators refuse to admit that solving problems takes compromise and risk, their evasion means leaving the health care problem exactly where it is, and there is that possibility, Mr. President. There is that possibility, that from all of this effort, nothing will happen; that we will talk about bipartisanship but in the end there will be only one Republican and a number of Democrats and everybody else will be "no" and the votes will not be there. There is that possibility that we have to confront.

If we do that, leave the problem where it is, sadly, millions of Americans will have the terror of getting sick or of getting a pink slip, and yet everywhere I look someone is calling for more delay. We hear battle cries of filibusters against Senator MITCHELL's health care reform bill, itself a compromise bill based upon a compromise bill. Most astonishing is the talk that it is too late. Too late for whom? For us? Mr. President, it is not too late for the people that I represent. As West Virginians have told me now for many years, over the many years that I have worked on this issue, they simply need the politics and the posturing in Washington to stop. That is the only way—there is no other way—to actually solve the health care problems that are hurting our people, choking our businesses, and robbing our future.

For what are the champions of delay waiting? Is it not obvious enough that if Americans could get health care that they need on their own, through the current system by simply working hard and playing by the rules, they would have it, that they would be insured, that we would have universal coverage? The system has been in existence for quite a long time.

Unfortunately, this is a problem where they need Congress to act and to not make excuses. The rules that affect their lives, that are ruining lives, have to be changed, and only we can do that. That is what the bill from the majority leader is about. We have the time we need to pass a good bill. We have the time to keep faith with what matters most to the American people. We are building from years of work by Senator after Senator, many of them on this floor now—Senator MOYNIHAN, Senator DURENBERGER, Senator DOMENICI, Senator DOLE was here, many others—Senator PRYOR, Senator SIMON—many years of work by many Senators, 40 alone among the Finance Committee and the Committee on Labor and Human Services, Senators who have been steeped in this for years, who devoted untold hours to this issue, and we have 8 weeks left in this session to produce something that meets the basic test.

For West Virginia, there is only one outcome that deserves to be called too late. That is if Congress fails to pass a good health care bill this year. Then it will be too late for thousands of families in my home State—11,000 of whom will continue to lose their health insurance each month through no fault of their own. If trying to enact reform is pushed off once again, it will be too late for thousands and thousands of our senior citizens, veterans, children, young people, small business owners, and, Mr. President, for the 210,000 people in working families in my State who work each day, pay taxes and play by the rules but do not have health insurance. In a country called America, that should not exist.

These West Virginians cannot put their health care problems on hold or send them on recess, and they sure cannot turn to the Federal Employees Health Benefits program like we can. They have their own life savings, their homes, their peace of mind, their financial future, and, in some cases, their lives on the line. So for West Virginians, too late comes only if the Senate does not work through this bill, through our disagreements, and through our way to real results for very real people.

Mr. President, I think about Gary Smith and his family in Salem, WV. Their situation to me says it all. One of Gary Smith's three sons suffers from neuro-fibro mitosis, which is an unusual disease commonly called elephant man's disease. The son needs surgery to correct part of his face that is growing out of proportion with the rest of his body.

Gary, the father, works, painting high tension towers for a Pennsylvania company, but that very high stress job does not come with health benefits. The last time his son had surgery, the surgery cost $50,000. They were lucky that time; the hospital absorbed some of the costs and saved the family from bankruptcy. But this time they have to come up with the money; this time no more relief; the extra surgery cannot be put off; and yet the Smiths have too much to qualify for Medicaid—he is working—and too little to buy insurance on their own. He does not make that much. They have nowhere else to go.

I have no idea whether Gary Smith is a Democrat or a Republican. I have no idea if his political thinking is mainstream, midstream, to the left, or upside down, and I could care less. I just know that America cannot go on being a country that leaves hard-working people like Gary Smith out in the cold. It does not make sense, morally or economically, to be a people that are divided between those who can get health care and those who cannot, or between the people in businesses who shoulder the costs of rising health care and those who cannot or will not.

That is why Democrats and Republicans, the left, the middle, the right, whoever you are, have to do this together or we will fail. The majority leader deliberately and carefully crafted a bill that draws on the work of Senators from both sides of the aisle, from many committees—particularly two—and from other bills, a compromise on a compromise on a compromise, to try to get the votes, earnestly to try to get the votes.

The bill passes the most important test. It lays out the steps to universal coverage. We will get there, step by step—more slowly than I had hoped but with the important beginning of focusing on children. The bill responds to the fears about more bureaucracy which is so often discussed on this floor. It cuts most of it out. That will be an interesting subject for debate.

There are now protections and benefits for America's small businesses. Senator MITCHELL's bill includes prescription drugs and long-term care, the very proposal in fact that DAVID PRYOR and I made in the Finance Committee to guarantee home- and community-based care to millions of people, not just older but people of all ages, since 40 percent of the people who need long-term care are, indeed, younger than 65.

The bill has essential provisions to address the chronic shortage of primary care physicians all over our country, in both rural America and in our inner cities. We spend billions and billions of hard-earned taxpayers' dollars, Mr. President, to train physicians. Most taxpayers do not know that—billions of dollars to train physicians. Tax dollars through the Federal Treasury pay for over half the cost of what is spent in the totality of training a physician in America today.

Now, does that not suggest the Federal Government on behalf of taxpayers should also have something to say in suggesting that the money be used to train the kinds of providers that Americans need and where they need them, and in the right numbers? Taxpayers' money, public policy should follow behind that.

That simply is what the work force section in this bill is about, to make sure that we have the kinds of doctors to meet the needs of all Americans in West Virginia, in New York, in California, and in every other State.

The bill before us aims at keeping faith with America's veterans. There happen to be 27 million veterans in America. Comprehensive health care reform makes it finally possible to improve the quality and availability of medical care for all veterans, not just the 2.67 million who use the veterans hospitals now, but for all 27 million. It has extraordinary possibilities. It is in the bill. The leader's bill is our chance to meet that goal.

So, Mr. President, in conclusion, when all this is taken together, there is no arguing with the notion that Americans will have better, more affordable, more dependable, more secure health care with the Mitchell bill.

Mr. President, I urge all of my colleagues to think long and hard about the consequences of how we spend these next several weeks. It is in our power to produce a bill that eases the burdens of families and businesses and children in every State and town of this country. It is in our reach to work out our differences and put our energies into achieving positive results. It is now up to us, each of us, of both parties, to prove that we can turn our years of words about health care into deeds that extend to Americans the basic health security that can never, ever be taken from them.

I thank the Chair. I thank my distinguished finance chairman.

I yield the floor.

Mr. MOYNIHAN. Mr. President, could I just congratulate my learned and, as I said, indefatigable friend, the Senator from West Virginia, on his statement. He is entirely right. There is no reason whatever to go out of this Congress without legislation. He has said, in somewhat different tones but with the same level of comity, exactly what the Senator from Minnesota said, Senator DURENBERGER, who opened the debate today.

I think it is going very well. I hope people are listening to this.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER (Mr. MATHEWS). The Senator from Oregon.

Mr. PACKWOOD. Mr. President, the Senator from West Virginia is one of the decent and kind people in the Senate. I have a quarrel with a number of things he said. But I will take only one.

He said the majority leader very carefully crafted this bill, taking bits and pieces from other bills and coming forth with almost nirvana. I did not think the last bill was nirvana.

But if this bill was so carefully crafted taking bits and pieces from all of the bills from all of the hearings, why last night do we have this? It does not have a number on it yet. This is the majority leader's new bill with every section, every subsection practically, changed. We do not know what is in it. If the last bill that he introduced was so carefully crafted, why do we need this? And if we need this, is this the last carefully crafted bill? Or are we going to have another carefully crafted bill tomorrow, or next week, or next month?

I think what crafting is attempting to do is to pick up a vote here and there, and he will craft it and craft it and craft it until he thinks he has the votes. It has nothing to do with the substance of the subject. It has a lot to do with the votes for the subject.

I yield as much time to my good friend from New Mexico as he may want.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, might I say to the junior Senator from West Virginia, while I have not had the opportunity to work with him as much as some Senators on the Finance Committee, we disagree on some things. But I, too, want to compliment the Senator from West Virginia on the way he conducts himself both on a personal basis and on a senatorial basis. I hope I am considered his friend because I take that view with his family. I am very pleased to be working on this bill. I hope we can come up with something together, bipartisan. I am not sure we can. But I want to express that right up front.

Mr. President, when I first came to the Senate a long time ago, I brought to Washington my children, all eight. And my last born were twins. They were 5½ when I was elected. We brought them and we bought a big enough house for all of them. So we live pretty far out, because, obviously, we do not have a lot of money. The further out you go, the more you buy. So we actually bought a house from the Israeli Embassy, which had a staff house out there. I did not know that. But it turned out to have a nice basketball pole and everything.

So I worked hard and did not spend much time with the children. But one morning I said, I am just going to go in late. I am going to be with them. It is teachers' holiday, so they were home. By then they were about 7. They were sitting in two chairs, as you might suspect, in front of the television set. Things have not changed much. And they were attentive as can be.

I put on my trusted robe. I sat behind them, and I was going to kind of be part of them, I thought, for a little while. So I put in a few words this way, a few words that way to see if they would focus on me instead of that television. Finally, one of them looked over her shoulder and said, "Daddy, you is no king. You're just a Senator."

Well, you know, this problem is big enough for a king. It is big enough for somebody who just sits down and says we are going to fix it. We do not have that luxury. So the second best luxury, as I see it, is to be a Senator, to be in this body at this historic time and to do just one very simple thing; that is, to try to get health care reform without doing a lot of harm to other things. And that is what worries me.

I am going to talk about the bill today that I thought was the premise for Senator MITCHELL's and President Clinton's proposals to reform health care. And many in this Senate know—and I take a great deal of pride in this—I did not come here today unprepared. I mean, there will be some things I will tell the people of this country and the Senate that nobody knows yet about this bill. I thought the good thing about being here right now and the way we are structuring it was maybe we would educate the American public and maybe we would educate ourselves, and maybe we would do the right thing. You cannot do the right thing in this kind of reform without knowing what you are talking about.

I just want to suggest that nobody is to blame. It is just sort of an admission on my part that I feel a bit let down today because I am going to spend about 35 or 40 minutes talking about what I think is very important about the deficit of the future, the debt on our children in the future, the fiscal policy of our Nation, new taxes and what they are going to do to our future, and how this great health care system might be adversely affected by what we are trying to do in the name of doing things better.

So I feel a bit let down after that work because I have just got this piece of paper that lists sections effective August 9 of yet a new bill. Frankly, I am not sure I am explaining to the American people the health care reform bill that is pending before the Senate for their consideration because I now find that this very well could be a whole new bill. First of all, it has grown. I did not catch that until just a couple of minutes ago. But this is 38 pages longer than the first bill—whatever that means. However big it was, it is 38 pages longer. I now find that in this bill, believe it or not—this new one, which I assume is out there to see whether 51 Senators can join it—there are a total of 139 sections that have been modified, amended, or deleted. That means that every single one of the 11 titles in the previous bill have been changed.

I assume that these changes are not one-word changes or grammatical changes. I assume there are some big substance changes. So I apologize right up front to those in our country and those who listen in the Senate; I apologize if my analysis is wrong. I do not believe I made a mistake. I choose to quote outsiders as much as I can in this statement. But we may be totally off the mark, because we may be talking about one proposal, and the majority leader may have a completely different proposal. I believe that is the case and, frankly, I want to make this last point only one more time: There is nothing more important to our future than that we do health care reform right. If we do it wrong, the repercussions, the legacy is an enormous thing for us to bear and for others to be burdened with.

I believe that the first Mitchell-Clinton bill that preceded this modification—I have looked at it enough and analyzed it, that I cannot believe it was seriously intended to become law. Had the U.S. House—after 51 Senators got signed up to that bill—agreed to accept that bill, I tell you, I cannot believe that it would really become law. Let me say, if that were the case, it is such a piecemeal project that I believe we would be back in 6 months with major surgery—to borrow something from the medical profession. I believe when the people of this country found out what was in it, and what they were going to have to do, for those who think this would be a good election ploy—if in 2 months they can find out things wrong with it, it will be a terrible thing for those who vote for it, because by the time people analyze what it does to the future of the American economy, to health care, to new costs, new taxes, to lack of ability to choose, and what it might do in the future to our health delivery system and professionalism, let me tell you, there would be a big price to pay.

I want to put this problem somewhat in perspective. Let me state at the outset that I believe we should enact health care reform. I think there are things in the system we ought to correct, and some of those are very serious. I give the President of the United States, Senator MITCHELL, Senator DOLE, and a myriad of others, credit for putting this issue at the top of our agenda. But as we move toward reforming our health care system, we in this Congress, like doctors who deliver health care, should take the Hippocratic oath to do no harm. We should take that oath to do no harm. We must remain conscious of the strengths of the health care system and careful that in our rush to reform it, we recognize these simple truths:

First, our health care system is huge and it is complex, consisting of almost $1 trillion in expenditures, private and public. It is one-seventh of the American economy now, and if not controlled, by shortly after the turn of the century it will be one-fifth of the entire gross domestic product. That is astonishing. I do not even know how to put that into common words for people to understand.

Since the gross domestic product is the sum total of everything of value that we do in a year, I think I might put it this way: This health care system will be so big that one of every five Americans will be taking care of you. So we might say, is that not wonderful? I say you can walk down the street and you can almost be assured that if five people have passed you, one of them is taking care of you.

I do not believe we will make it with that kind of system. I do not believe we can have a standard of living that is befitting of our people if one-fifth of everything of value we do, from producing cars to making desks, to buying food, to the myriad of things we live with—paying for electricity—if one-fifth of it is to stay healthy. That is what scares me, because my first point is that if you look at the leader's plan—the so-called Mitchell-Clinton plan—you do not reduce the costs of health care, you increase them. So that if you did nothing, we would be at 20 percent of the gross domestic product—and my good friend from Oregon said yesterday slightly less than that—after we do all this cost containment and all this other rigmarole that is in the bill.

Mr. PACKWOOD. If it all works right.

Mr. DOMENICI. And "if it all works right," says my good friend from Oregon.

The second point: Most Americans—85 percent—have health insurance that gives them access to the finest quality health care system in the world. That does not happen to be the case in my State. There are more uninsureds. But taking the Nation, 85 percent have health insurance, and most people think it is pretty good.

So the first point to be made is that we are talking about 15 percent of Americans that are uninsured, and a system that is trying to take care of those 15 percent in a rather willy-nilly way. But built into the system we are paying a lot of money already to take care of them, but not in an ordinary, primary care way, rather through emergency care and the like.

As I see it, I do not believe that we should pass anything that we are not as certain as we can be that it does no harm to the system that is delivering first-class health care services to tens of millions of Americans. As we move to improve the physical health of Americans, I believe it is imperative that we protect our Nation's fiscal health, our budgets, our obligations and our taxes, all of which are our fiscal health, and in our rush to reform, that we do not underestimate the costs and bankrupt this Nation.

The best way for us to ensure that we are moving in the right direction is to build our reform on principles that have wide bipartisan support already. Unfortunately, there is a lot of rhetoric—and much of it is partisan—surrounding this debate. I believe it does not add very much to the actual performance of our ultimate job. But it makes achieving bipartisanship, and an agreement based on that, much more difficult.

I would almost conclude for the people of this country that if a totally partisan bill is produced, what the majority leader will have to piece together to get the segments of the party and philosophies on his side of the aisle, will end up being a plan that does great harm.

I do not see it otherwise. I do not think there should be a rush to pass a bill that is partisan, because I think anybody who understands what that means would conclude that it will not be balanced.

Health care is too important because it affects every American in one way or another. Therefore, I believe sooner or later, hopefully sooner, we will put some of this rancor aside and focus on reforming health care without driving American families and American business or our Government into huge debt and, in some instances, into the inability to pay those debts.

This great country of ours has a huge private sector. Frequently we speak of that private sector, and many do not understand what it really means. But, first, the private sector in this country is principally made up of businesses large and small. They survive, if they are competitive, for the most part. If they are not, they do not make money. They cannot pay people. They do not pay good wages.

So let us recognize that we are taking up in this legislation at a time of tremendous reform and change in this health care system that is already occurring, and most of that change is in the private sector where they are driving health care costs down.

Let me repeat. Led by large employers, our health care system is already making enormous strides in controlling costs by enhancing quality. That is happening. We can see market forces at work in my home city of Albuquerque, where competition is strong. Hospital costs in that city are 40 percent lower than 200 miles away, in the city of Lubbock, TX, for such things as heart procedures and that kind of very sophisticated hospitalization and surgery.

Recently, the Wall Street Journal carried a report that a large coalition of employers in northern California used a competitive bidding process to successfully negotiate reductions in health insurance premiums of between 5 percent and 18 percent from 18 different suppliers of health services called HMO's.

This is beginning to happen all over America, especially in areas where large employers have aggressively begun managing their costs. The days of paying anything, not challenging it—just send the bill—are gone. They do not need the Federal Government to tell them how to make those kinds of changes. They are occurring dynamically and dramatically in the marketplace.

In my view, health care reform should encourage the favorable trends now taking place in the private sector, not turn over control to the Government.

Now, despite the strengths of this system, there are some facts to be faced. For too many Americans, the health care system is not working. If you work for small business, as so many New Mexicans do, you face some very serious problems because small business faces some very serious problems in terms of insurance premiums for health care. Insurers are likely to charge you much higher premiums for administrative costs than they charge larger businesses. You have less market power to negotiate good rates with insurers, and workers may be charged higher premiums. When a coworker has a medical problem like diabetes, insurers can deny you renewal of insurance if you had any major medical expenses, and insurers can exclude preexisting conditions if you switch jobs, creating job lock, one of the words that health care has brought into focus.

Moreover, if you are poor or of low income, but not on Medicaid, the high cost of health insurance makes it nearly impossible to get coverage, which is the primary reason there are so many uninsured Americans today. Americans with incomes below 200 percent of poverty, roughly $15,000 for an individual, are three times more likely to be uninsured than Americans with incomes above that level.

And, finally, we cannot assume that costs are under control even though I have stated what is going on in the marketplace, and there is a great anecdotal evidence regarding even those emerging signs of better cost controls, principally by big businesses and big purchasers. It is clear that some regions of our country are still experiencing very high cost increases. So any health care reform must attempt to address those problems.

I want to depart—since people here frequently think of me as one who deals with the budget and they ask me questions about the budget, want to talk a little bit about health care reform and the Federal budget. Why would I do that? Because essentially, whether we like it or not, we are going to be voting on legislation that has a big effect on our children and grandchildren in terms of the budget of the United States, whether we are still in an enormous deficit position, whether we are still unable to pay our bills as a nation. And thus, in a very real sense, the effect on the Federal budget of this plan and any major plan is of extreme importance, and we ought to try our best up front to understand it.

That is not so easy, because we are sending new things to those who make the estimates all the time. Evidence of that is today, when every section in this bill has been changed, and yet we had some estimated costs in here the day before yesterday and yesterday.

So we must be careful not to saddle our young people and to burden future generations with today's health care costs. After all, the administration in its 1995 budget document revealed that future generations of taxpayers are already projected to face taxes amounting to 82 percent of their income without health care reform. That is in the President's budget document.

To quote Harvard law professor Laurence Tribe, and this quote was made in a public hearing regarding a balanced budget. Listen to it as it resonates with reference to the issues at hand, and I quote:

> Given the centrality in our revolutionary origins of the precept that there should be no taxation without representation, it seems especially fitting in principle that we seek somehow to tie our hands so that we cannot spend our children's legacy.

That is a pretty good statement by a constitutional scholar who understands the significance of indenturing future generations. He calls that taxation without representation.

There is no more compelling case for controlling health care costs than their current and projected impact on the Federal budget. Indeed, one of the most critical issues facing the country is continued growth of open-ended, mandatory spending in the Federal budget. That is, you create the situation where a citizen is entitled, as a matter of law, to benefits, and if you do not pay them, they can enforce it in a court of law. That is the definition of an entitlement. And this is led today by Medicare and Medicaid and the resulting growth in budget deficits.

It is amazing—I cannot pass judgment on the majority leader's bill or this serious modification—but it is amazing, since the major cost of future deficits is the open-endedness of Medicare, that that program was not found in the President's health care reform package; rather amazing, the very program causing the deficit problem and the cost containment problem for future generations, that program was left out of the reform, presumably to run much as it is today.

These costs of Government health entitlements which are not subject to competitive pressure have escalated at a remarkable pace since they were enacted in 1965 and will continue to do so in the future.

Between 1970 and 1993, Medicare spending has grown on average more than 14 percent a year, and Medicaid has grown more than 15 percent a year. It is no coincidence that the explosion of these programs coincides with the beginning of our long struggle to control the Federal debt. If, in the end, we do not control these programs, it will not matter that we have health security because our jobs, our prosperity, and our future will be in jeopardy.

I want to speak a moment about what I perceive to be a significant broken promise. I thought that the President agreed with me and many others in the production of his budget and the projections for the future. In fact, the President has said on many previous occasions that we will never get the budget under control if we do not control Medicare and Medicaid. You may remember, as I do, that the President sold his tax and budget plan to the American people on national television in July of 1993. During that TV news conference, the President said:

> We need to bring the deficit down to zero. To do that, we have to pass health care reform.

In fact, his promise of spending cuts in the context of health care reform was one of the arguments he used to get Congress to approve the tax increase, which I believe the distinguished chairman of the Finance Committee said was the largest tax increase in the world in history; anyhow, somewhere close to being the highest ever for Americans.

Now, might I explain to you what was found in the President's budget and vision statement with reference to health care?

Found on pages 116 to 120 of A Vision of Change for America, the President's tax and budget plan, issued in February of 1993, the President promised massive deficit reduction from his yet-to-be unveiled health care plan. In fact, Mr. President, he promised a $300 billion deficit reduction between 1995 and 2000.

On this chart, the President's promise is reflected in the red or orange area. Here we were. Here is where we were going to go on the green line if we left everything alone. This entire orange or red area was going to be applied to the deficit of the United States and get the deficit under control.

The President was right in one sense. We cannot balance the budget with Federal health care costs growing as they are. Despite the slowdown in private health spending, let me repeat, CBO, the Congressional Budget Office, continues to project that Medicare and Medicaid will grow at around 11 percent a year even if inflation is 3 or 2 percent. In 1980, those programs cost $48 billion. In 2004, they will cost $650 billion.

Now, here is what has happened to the promise and the reality.

This orange is what everybody is telling the American people is the savings that are going to accrue in the two major health care programs of the United States when and if we get the costs under control. So the President projected we are going to get health care costs under control, and here is the new line.

Here is what was projected.

And the yellow is what we are adding in new costs.

And, believe it or not, none of this goes to the deficit, for all of it is spent on the new programs. And, I might add, with the exception of one bill, every single bill on health care reform assumes $300 billion worth of savings. We do not know whether it will work, but we assume it. Because if we are going to get health care costs down, everyone assumes that every penny of it will be spent.

And I said, let us put $100 billion of it on the deficit by mandate and spend only what is leftover. But that was done because I understand it this way and understand that you will never get the deficit under control after you have adopted a health care program that uses all these savings unless you decide to tax the American people hugely, cut defense a huge amount—I do not think you will do that—or dramatically change the pension programs of this country.

So this debate and this program has a huge, huge footprint on what else has to happen in this country with reference to our fiscal policy for generations yet to come.

So, in other words, even after the $260 billion tax increase, the deficit is not under control. Despite some efforts to make it appear that it has gone away, it will begin to skyrocket again. And, I must say, it will be over $350 billion again shortly after the turn of the century.

So, looking back to the chart, we can see that the health care reform plan would actually push this deficit line to the top line from this line. A total difference between the promise and reality is close to $400 billion. And that is $400 billion less in deficit reduction; or, to put it the other way, $400 billion more in deficit spending.

Now I think it is vital that we understand this. I am not sure that anybody wants to do anything about it, but I believe we ought to minimize it at the very least.

While that promise clearly was broken and cannot be met, so that nobody will misunderstand, we did offer budget proposals that reduced the deficit by cutting things. And the cuts were not in Medicare or Medicare exclusively, but many others, so we would have had a much different approach to where the deficits would end up.

Now, I want to take a look in terms of Senator MITCHELL's proposal of yesterday—clearly, I do not know about today—and tell you what it does. It creates 6, I say to Senator DURENBERGER, 6 new open-ended Government spending programs and creates or expands 15 others.

Let me repeat. We are all worried about entitlements and mandatory spending; that is, creating a program where a citizen is entitled to resources of the Government under order of the court. We have 6 major new ones, open-ended, and 15 other ones are changed, as well. None of the changes is downward, from what I can tell.

These new entitlements will cost—and this has pretty much been agreed upon by the Congressional Budget Office and our experts. Let me give you this one. The new entitlements will cost $501 billion between 1995 and 2000, and $1.4 trillion between 1995 and 2004. These new entitlements will bring millions of Americans on to the Federal Government's subsidy program.

And let me give you the best estimates I can there. An estimated 100 million Americans will be eligible for Senator MITCHELL's premium subsidies alone, not counting the long-term care, which is a new program with new beneficiaries, and other entitlements in this bill. I am not counting them. I am only counting the recipients of subsidies in whole or in part for insurance premiums.

And what is most alarming to me is the growth rate of these new entitlement programs. According to the Congressional Budget Office, the new premium subsidy program will grow over 10 percent a year, even after it is phased in. So if we thought we had things under control and were getting them there with new health care reform, admittedly, right up front, the Congressional Budget Office warns us that these subsidy programs will grow at a rate of 10 percent a year even after they are phased in.

The Medicare drug benefit, a brand new one, grows at 10.5 percent a year even after phased in. The long-term care program grows 44 percent a year according to the Congressional Budget Office once it is in full effect.

So I do not think there can be any mistake about it. The Mitchell-Clinton bill, under the guise of health care reform, will create several new open-ended, runaway entitlement programs.

Now, why do we have to do that when we are having difficulty understanding the reform programs and their effect? Why would we have new programs costing huge numbers of billions of dollars?

I guess I might say—and I hope this is not the case—that maybe it is because some of those programs bring some votes and bring some support out in the country that might not otherwise be there.

It should not be surprising, then, that the proposal of yesterday does nothing to slow the rate of growth of overall health care costs in this country. Everybody is wondering—we have said that. I think Senator DURENBERGER said that. But, after all, we are just Senators. In fact, according to the Congressional Budget Office, the Mitchell proposal will actually increase national health expenditures by between $240 and $285 billion over the next decade. Instead of controlling it, it goes up.

I have heard a lot—at least I did 2 weeks ago, it seems like it is not so loud and often now—that we ought to pass this reform package because it is good for the middle class. Right? Let me talk about the new taxes in this bill. If the middle class feels put upon by previous taxes they better hold on to their wallets. This new proposal has massive new taxes. Between 1995 and 2000, $110 billion; between 1995 and 2004, nearly $300 billion. Let us add them together, in the next 10 years it is $410 billion in new taxes. I find it very hard to believe that these new taxes will help middle-class Americans as the President has indicated.

First let me tell you about some of these taxes. There is a 1.75-percent tax on all health insurance for $74 billion, between 1995 and 2004; a 25-percent excise tax on health insurance premiums that grow faster than a premium cap—whenever those premiums do that, that 25-percent excise is on. And yesterday Senator PACKWOOD explained in some detail how the starting point for that 25-percent tax—how that would go. It is very complex and I believe very unfair. But that is $75 billion between 1995 and 2004.

Another 1 percent tax on health insurance premiums is levied by the States to fund administrative expenses, another $50 billion. That tax revenue goes to the States. These are big tax increases, billions and billions of dollars in new revenue.

According to the Congressional Budget Office, these taxes do little or nothing to contain health care costs and may actually pose, "an impediment to coverage." That is taken from the Congressional Budget Office.

To quote from that report, on this 25 percent new excise tax on high-cost premiums—and let me before I quote say it does not matter to me what is written in any bill that says that is going to only be a tax on the insurance companies and the providers. In the end, the cost of the delivery system will assimilate that and the insurance premiums will be higher on everybody. There is no way to get around it. You cannot write supply, demand, costs and expenditures, and some profit out of the private sector and claim you want them to do this, you want them to cover everybody. It will be there.

Now let me quote:

> The tax on premiums of high-cost health plans in Senator MITCHELL's proposal would be difficult to implement. In addition, its contribution to containing health care costs would be limited and it might be considered inequitable and an impediment to extending coverage.

Not PETE DOMENICI, not DAVID DURENBERGER—the Congressional Budget Office. Frankly, I believe they are being generous. I cannot imagine that they would write it in the toughest language, being a neutral body and with the director being subject to confirmation by the Senate and the House.

I continue quoting the Congressional Budget Office:

> Unlike taxes as contained in the Managed Competition Act and bill reported by the Committee on Finance, which would not affect the lowest-cost plans, virtually all plans would be subject to the assessment called for in Senator MITCHELL's proposal.

That is a vindication of my notion that all premiums would go up.

For middle-class Americans these taxes add up. I am not sure what it is. We are trying to find out. But I will say that for most middle-class Americans, their taxes will go up to at least an additional $500 a year in very short order. I think it is more but I feel comfortable in saying that.

Perhaps that is why the respected president of the Kaiser Family Foundation, Drew Altman—very reputable and very professional—gave this assessment of this health care reform just last week.

> The group that is most likely to be helped least, at least as the discussion stands now, is the working middle class. Which is a little surprising [he says] since it was the rise of the middle-class concern that put these issues on the front burner in the first place.

I repeat, this is not my evaluation. It is Drew Altman. I have inquired. Everybody I can ask says this is a man of high repute, and he indicates that at least as the discussion stands now, the group that will be hurt the most is working middle class.

Again, everybody is asking, if these are entitlement programs, can we not make sure they do not go through the roof? Can we not make sure they are contained? Can we not put a cap on them?

I want to offer my own observation first. If you put benefit programs in place where the citizens of America are entitled to something, and that something is health care, you are probably going to pay for it whatever the cost is, because it is very hard to take things like that away, change them, modify them, make them less of a package than you originally promised and gave.

Nonetheless, we have tried. In fact, I believe this Senator, with some very able staff, came up with a first attempt to do that. It now has a nickname. It is called a fail-safe provision. Right?

Mr. MOYNIHAN. Yes. Right.

Mr. DOMENICI. "Fail-safe" meaning we are only going to spend as much as we want to spend and we have a failsafe way to do that.

I am telling my colleagues, that fail-safe was first found in the Chafee bill. We helped draft that. But I am very concerned that if we have a significant underestimate in the cost of these new entitlements—and I repeat what I said a while ago, we have had that in every entitlement that deals with health care; so big, in fact, that it was estimated Medicare hospital insurance was going to cost us only $9 billion in 1990. I assume the Senator is aware of that. Instead its cost was $67 billion.

That is why I believe any legislation that we ultimately pass, in order to protect our children and children yet unborn from huge deficits, has to have a fail-safe mechanism to control costs. Unfortunately, the proposal of yesterday—perhaps it has changed today. I note that section on fail-safe is changed. I cannot tell what it does. But, unfortunately, the Mitchell-Clinton proposal on fail-safe is so watered down in terms of its rigidness, in terms of real control, it is worthless—worthless. It is based on inexact, estimated baselines, not on real dollar limits. It has a $10 billion cushion. It leaves incredible discretion to the Office of Management and Budget. And it exempts increases attributed to economic and technical changes from the rigors of discipline.

Mr. DURENBERGER. Will my colleague yield for a question?

Mr. DOMENICI. Of course.

Mr. DURENBERGER. I know my colleague from Rhode Island is getting sensitive to the amount of time that is being allotted Republicans. But let us assume you have all of these promises made to extend all of this coverage. But the cost of the coverage exceeds what you estimate. This is your point.

Mr. DOMENICI. Yes.

Mr. DURENBERGER. At that point you have to either borrow the money, increase the deficit——

Mr. DOMENICI. Yes.

Mr. DURENBERGER. Or just using the Medicare Program as an example, you can, at the budget level here, reduce the amount that is going to be paid for doctor services or hospital services, thus you do not increase the deficit; right?

Mr. DOMENICI. The amount that the insured has to pay can be increased. That is another way.

Mr. DURENBERGER. It seems to me that if, in fact, the demands on the entire system exceed the fail-safe amount, what we normally do here is reduce the Medicare payments in the coming year for doctor services or hospital services. That is how we get to the place where a party is paying 71 cents on a dollar of charges for hospitals and 59 cents on a dollar of doctor fees. Is that not the process?

Mr. DOMENICI. Absolutely.

Mr. DURENBERGER. So the problem then presented to the working class in America is the degree to which they end up, when they go to the doctor's office or when they go to the hospital, how much of that difference between 59 cents and $1 do they end up paying?

Mr. DOMENICI. Right.

Mr. DURENBERGER. It seems to me—my colleague can correct me if I am wrong—no matter which way you cut it, these overpromises are either going to be paid out of debt or they become an additional tax on working people's premium.

Mr. DOMENICI. That is right.

Mr. DURENBERGER. So one of the problems we talked about earlier in the day with the Clinton-Mitchell proposal to get all working people into these large pools, and so forth, is to facilitate the additional tax from the cost shift from the promises that are made but not paid for onto the working people's premiums.

So, in addition to the specific tax—a tobacco tax, or premium tax or State surcharge—there is this hidden tax of the cost shift which occurs in the doctor's office, which is difficult to measure. I thank my colleague.

Mr. DOMENICI. You are absolutely right. The point is that to try to say to those who are worried about the next generation and how much we will have gone into debt, do not worry, even though we do not have any idea what our promises are going to cost—we have this measure out there that says it is only going to cost $300 billion and if it is more than that, something will be done about it. I believe you have to know much better up front the cost of what you are promising. So fail-safe is a tool that is not going to be used because, if you need it, you probably will not implement it. That is the point I am trying to make.

Might I ask the Chair, how much time do the Republicans have left?

The PRESIDING OFFICER (Mr. FEINGOLD). Twenty and a half minutes.

Mr. KENNEDY. How much time on our side?

The PRESIDING OFFICER. Ninety-four minutes.

Mr. DOMENICI. Mr. President, I have some other remarks, but I note my friend Senator CHAFEE is waiting.

OTHER CONCERNS WITH THE CLINTON-MITCHELL APPROACH

But my concerns with the Clinton-Mitchell approach to health reform are not confined to just economic and budgetary questions.

GOVERNMENT-RUN HEALTH CARE

The Clinton-Mitchell plans—and all of its variation in Congress, such as the Kennedy and Gephardt plans—are characterized by massive new Government controls, regulation, and bureaucracy.

The American people simply do not trust the Government to run the health care system. They know a Government system will be less responsive to them and will slowly undermine the quality of our health care delivery system; a system unsurpassed in the world.

Let me cite just a few examples of the massive Government role in the Clinton-Mitchell plan:

MANDATED STANDARD BENEFIT PACKAGES

Under Clinton-Mitchell, every American who wants to get health insurance will be required to buy a Government-set benefit package.

They will not be able to buy anything less.

You can be sure that if the Government is setting benefits, no treatment will be uncovered, no provider left out, and it will only get worse with time.

There is some value in standardized benefits in certain contexts, particularly for determining subsidies for low-income families.

But I am against the Clinton-Mitchell bill's limitations on choice and "one size fits all" approach.

PRICE CONTROLS

The Clinton-Mitchell bill also requires Government-set price controls, based on data that does not currently exist.

Under the proposal, the Secretary of the Treasury would set reference premium amounts for every geographic area in the country.

These reference premiums would be established based on 1994 national health expenditure data that the Secretary would somehow try to distribute by region.

According to CBO:

> These determinations would be extremely complex and difficult to make, requiring adjustments for demographic characteristics (age, sex, socioeconomic status), health status, current levels of health care expenditures, uninsurance and underinsurance, the presence of academic health centers, and other factors. Little reliable information of this sort is available, and the Secretary would have to collect a mass of new information. With the reference premiums affecting not only tax liability but also premium levels, the process could prove to be quite controversial.

But, nonetheless, the Secretary would set these reference premiums, and then allow them to grow by inflation plus: 3 percent in 1997, 2.5 percent in 1998, and 2 percent thereafter.

Health insurance premiums growing faster than this rate would face the 25-percent excise tax.

Clearly, this proposal is a back door attempt to adopt the Clinton premium caps.

It is an especially bad idea because it does not distinguish between efficient and inefficient plans.

All health plans would be held to the same growth rates, regardless of whether they have been low cost and efficient to start off with.

Moreover, the Clinton-Mitchell proposal exempts large employers' plans from the tax until after 1999.

Clearly, the tax is designed to protect, to the extent possible, the very expensive, high-cost, union-negotiated health plan.

Similar attempts at price controls have never worked in this country, and never will.

Shortcuts will be implemented and instead of reducing costs, they will lead to more inefficiency.

OTHER EXAMPLES OF GOVERNMENT INVOLVEMENT

The Government is going to determine the number of specialists and primary care physicians that can be trained in each medical residency program in the country.

The Government is going to run a new, voluntary long-term care insurance program.

The Government is going to determine which doctors, hospitals, and other health care providers are essential and therefore protected under managed care.

The Government is going to provide new opportunities for lawyers to bring suits against insurance companies for disputes over insurance claims.

The Government is going to provide new entitlement spending for health research, occupational safety and health, school-related service programs, dental schools, and countless other Government programs.

The Government is going to establish a risk adjustment program to measure the relative health status of enrollees in every health plan in the country, and then require States to transfer billions of dollars among plans based on that methodology, which today does not exist.

Do you detect a pattern of excessive Government interference here?

JOB-DESTROYING MANDATES

And now let us turn to the job-destroying employer mandates in the Clinton-Mitchell bill.

I am opposed to including any kind of employer mandate in the reform proposal.

It does not matter if it is delayed until after the next election, or triggered, or cut in half.

Because, clearly, this President and the Democratic Congress want an employer mandate—and the majority leader's proposal is just a foot in the door. It is the camel's nose under the tent. And if this bill passes and goes to conference, as sure as I am standing here, it will come back with an even more devastating, job-destroying employer mandate.

Let me quote from a senior administration health official from the August 4 Washington Post explaining their support for the Mitchell proposal:

> . . . we hope the bill we get out of conference will have mechanisms [mandates] that will get us to universal coverage by a more direct route.

I am particularly worried that Senator MITCHELL'S proposal would single out States like New Mexico—where nearly 97 percent of all businesses are small business; and 86 percent are businesses with fewer than 20 employees.

As I read it, the mandate will be triggered only in those States that fall below 95-percent coverage.

Well, obviously, States with lots of small businesses, low income families, and high uninsured rates today are the most likely States to fall below the target.

And so the Clinton-Mitchell bill would penalize small businesses in low income States with a mandate, which will only make matters worse.

Such a mandate would destroy hundreds of thousands of jobs and severely curtail economic growth.

And, according to CBO, this state by state kind of mandate will not work, would drive business out of small States like New Mexico, and is not workable.

To quote CBO:

> [a state by state mandate] would produce inefficient reallocations of business activity. Some firms that did not wish to provide insurance would migrate to states that were not included in the mandate.
>
> Because of the disruptions, complications, and inequities that would result, CBO does not believe that it would be feasible to implement the mandated system in some states but not in others; the system would have to include either the states or none. Accordingly, CBO's cost estimates of the mandated system assume that a nationwide mandate would be in effect.

OTHER ISSUES

There are other problems with the Clinton-Mitchell bill as well: massive shifting of resources from the young to the old through strict community rating; weak medical liability reforms; State single payer options; and HMO-killing regulation and litigation.

At the appropriate time, I will have much more to say about each of these controversial issues.

THE SEEDS OF A BIPARTISAN SOLUTION

I believe we should only pass a health care reform bill that has strong bipartisan support.

I believe we can see the beginnings of that kind of an agreement in some of the major proposals put forward in the Senate, such as: the mainstream group's proposal, which is largely incorporated into the Finance Committee bill; the bill I introduced in May, the Health Care Reform Act of 1994; and the Dole-Packwood proposal, which has been endorsed by 40 Republicans.

All of these proposals differ in their details—some of which are significant—but they share some very critical core features:

EXPANDING COVERAGE IN A VOLUNTARY SYSTEM

Most Americans want health coverage to ensure good care when they need it and to avoid the financial risk of going uninsured.

The primary obstacle for the uninsured is cost.

Nearly two-thirds of the uninsured have incomes below 200 percent of poverty.

These proposals would expand subsidies for poor and low income Americans to make private health insurance affordable.

And they reject the notion that we should begin reform by imposing new Government mandates on businesses or individuals.

CONTROLLING COSTS IN A REFORMED MARKETPLACE

Only market incentives can improve the productivity of the health care delivery system. And that is the most effective and efficient route to holding down costs while maintaining or improving quality.

To make the market work better, consumers must be permitted to compare the price and quality of competing health insurance plans.

Our proposals would give consumers the standardized information needed to evaluate the cost and quality of their health insurance and their providers.

Moreover, we should encourage consumers to be cost conscious by putting a limit on how much employers an employees can deduct from taxes for health premiums.

SMALL BUSINESS INSURANCE REFORMS

These proposals all recognize the need to establish fair insurance rules for small businesses and individuals.

They would: ban preexisting condition clauses; establish some modified form of community rating for small businesses, with age adjustments; and give small businesses the ability to pool their purchasing power and get lower premiums.

REFORMING FEDERAL PROGRAMS

Moreover, these proposals would change the Medicaid program to allow those beneficiaries to enroll in private health insurance plans like other Americans.

The proposals would protect Medicare but expand the opportunities and incentives for beneficiaries to enroll in competing health insurance plans.

Today, some 50 percent of private group health insurance is in managed care, but only 5 percent of Medicare beneficiaries are in managed care.

ACCESS IN RURAL AREAS

Our proposals would dramatically expand funding for access to care in rural areas.

In particular, they would increase funding for community health centers and the National Health Service Corps.

FISCAL RESPONSIBILITY

Finally, these proposals all recognize that we cannot afford another new runaway entitlement program.

To ensure fiscal responsibility, they incorporate a "pay as you save" or fail safe process.

That means we can only expand coverage as we achieve savings in current programs.

I believe a bill with these elements could pass with overwhelming support if we can get beyond the partisanship and focus on what we can do to help the lives of millions of Americans.

SEVERE MENTAL ILLNESSES

During this debate, Senators will disagree on many issues, and the debate will be vigorous.

However, there are a few issues which I believe cross party lines and transcend politics.

Three years ago, I introduced a bill that stated when the Senate passes health care reform, it must provide equitable health insurance coverage for persons with severe mental illness.

That bill had 21 cosponsors evenly divided between Democrats and Republicans.

In September 1993, the National Alliance for the Mentally Ill [NAMI] held a rally across the street from the Capitol where they presented me with nearly 500,000 signatures supporting my bill.

Among those persons signing the petition were President Clinton, Vice-President GORE, and Mrs. Tipper Gore.

In the time since I introduced that bill, I have spoken on the Senate floor and at numerous assemblies with both Democrats and Republicans.

Nearly every time, one of my colleagues would take me aside and agree that we must help the severely mentally ill.

People with severe mental illnesses have been subjected to discrimination because of ignorance and fear resulting in public and private health insurance plans setting arbitrary limits on the amount of coverage a person can receive for these illnesses.

As a result, individuals and families often can't gain access to care because of this very limited coverage.

It is now estimated that one out of every three homeless persons suffers from severe mental illness.

Severe mental illnesses such as schizophrenia, major depression, bipolar disorder, obsessive compulsive disorder and panic disorder, are crippling and disabling illnesses that can strike any person from any background.

We have made a lot of progress as health care reform has moved through the Congress, but I must say to my colleagues that the bill introduced by the majority leader does not go far enough.

Unfortunately, the Mitchell proposal leaves the door wide open for the continued discrimination of the severely mentally ill.

In fact, this bill explicitly authorizes cutbacks in benefits for the mentally ill to finance other types of coverage if the National Board finds the benefit package is too costly.

So, the standard benefit package could provide coverage for eyeglasses, but may not provide coverage to someone suffering from major depression to keep them from committing suicide.

Frankly, I believe we need to rethink that kind of prioritization in the benefit package.

I can assure my colleagues that before this debate is over we will have the opportunity of a lifetime to provide equitable coverage for the severely mentally ill and end at least one form of discrimination.

I want to close by simply stating that the bill before us—again I repeat, before we got the new bill—that this bill has severe problems and, frankly, I do not think it can be fixed. This Clinton-Mitchell bill, as I see it, is a roll of the dice and the stakes—the bet, that is—is enormously high: one-seventh of the American economy. But it is also high for every person in this country that we are trying to help: those who currently have little or no health care, those who have good health care. They are all at risk.

And if we are going to take these risks, let us do it together in a much more coherent and bipartisan approach that has broad support of all Americans. I yield the floor.

Mr. MOYNIHAN. Mr. President, I yield 4 minutes to the Senator from Massachusetts, followed by 10 minutes to the Senator from Nebraska.

Mr. KENNEDY. Mr. President, I have in front of me the Gramm-Latta amendment that was offered in the House of Representatives in behalf of the Republican administration on June 26, 1981. It is an inch and a half thick. It was offered at 11:15 in the morning and debated until 7:45—8½ hours. I did not hear a lot of criticism from a lot of our Republican friends at that time that it was going to be so difficult for people to understand. I hope they can put that argument aside.

I heard our colleagues talk about their positions with regard to the health care measures. One of the oldest techniques in this body is to describe your opponent's position. In many instances, you do not accurately describe your opponent's position.

That is what has been done this afternoon. I listened with great interest to this whole debate and discussion from my colleagues, and I could not understand the Mitchell bill as described by my good friends or what, in many instances, their complaints were really about, including my friend from Minnesota, talking about national standards and State rules. If he has amendments—that is a concept in the Mitchell bill—if he has amendments on that, if he has proposals, I hope they will be forthcoming.

When I saw my good friend from New Mexico get on his feet and talk about this legislation, I thought he would talk about one of the most important provisions, and that deals with a cause that he has been identified with in the U.S. Senate, and that is on mental health.

One of the critical issues was whether we were going to have parity in treating mental health with the physical ailments of the people of this country. That has been debated in hearing after hearing. He was good enough to testify on that issue before our committee, and we have included it. It was included in the earlier bills, and it has been included in the Mitchell bill.

So for all those Americans who have been listening to that debate, they ought to understand that we are committed in the Mitchell bill, in this legislation on page 114, to the kind of mental health benefits that the mental health needs of this country ought to have.

Mr. President, I was hopeful to hear this afternoon that some proposals by our Republican friends were going to be forthcoming. In our committee, we have had a series of different amendments and suggestions, which we worked out without having to have votes on these measures.

We eliminated a lot of the mandatory requirements on the alliances in the legislation; we were able to come together, Republican and Democrats alike; we made adjustments in terms of the malpractice provisions; we simplified the benefits package; we made some changes in cost control—all suggestions that were made by Republicans and Democrats, not waiting until the amendment process and the part of the debate and discussion earlier in the day.

Bipartisanship requires coming at least halfway. And here we have the majority leader, who has been trying to move that whole process forward. I hope that at least in the remaining time—although there is not a great deal more time on that side—this afternoon, we will at least have some areas, some suggestions, some recommendations prior to the time that we are going to come to the point of voting on these matters where we can hear about where they are going to agree. Let us hear where they want to try to make some progress.

Maybe we have to delay the point for some days and finally come to grips and have the votes on some measures. But let us at least hope that the next time we speak and Members address that that we can at least find some suggestions and recommendations on where we can begin to build the bipartisan legislation which many people have talked about but which so far has at least escaped.

I want to thank my colleagues for indulging me at this time. I see the Senator from Arkansas as well as the Senator from Nebraska on the floor.

Mr. DOMENICI. Mr. President, I wonder, since Senator KENNEDY alluded to mental illness, if I might take 3 minutes on our side to respond.

Let me do that. I ask unanimous consent that the 3 minutes I use not be counted to either side.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DOMENICI. Mr. President, I really hope the distinguished Senator from Massachusetts was not implying that the Senator from New Mexico, because I proposed something in the Mitchell bill, is not going to be shoulder to shoulder with him on whatever bill passes to get parity for the severely mentally ill. But I might tell my good friend, his bill that he reported moved more toward covering the mentally ill than this bill.

In fact, this bill, Mr. President, to be honest with you, does not take care of the parity that is required. And I know the question is how are we going to pay for it.

But let me tell Senators, I think we ought to treat severe mental illness in this country exactly like other major ailments. We should not have to fund it separately. If we do not have enough money for other things, we cut everything back, but we do not have to continually treat the severely mentally ill as if they do not have parity.

This bill does not do that, so I am not worried about it.

Mr. KENNEDY. Mr. President, just on our side, 30 seconds.

I welcome the opportunity, with the Senator from New Mexico, and I am sure Senator WELLSTONE, who has been a leader here, to offer an amendment on this legislation as one of the first amendments that we can consider about how we can strengthen this proposal, and work with the CBO and find ways that we can do it. This is just the kind of bipartisan effort that we should have.

I acknowledge the leadership of the Senator from New Mexico. And Senator WELLSTONE has been a leader. This would, I think, make an enormous difference and indicate that in this area of public policy we do have bipartisan support.

Mr. MOYNIHAN addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, if I may yield myself 1 minute simply to once again remind you that the bill before us is the bipartisan bill reported from the Committee on Finance, and in that, if the Senator from New Mexico could hear me, and the Senator from Minnesota will attest, mental health has full parity with all other medical needs. It is a matter of principle, and bipartisan, and was never contested.

Ten minutes to the Senator from Nebraska.

Mr. KERREY. I thank the Chair and I thank the Senator from New York.

Mr. President, I rise to discuss the matter before us, the health care reform bill introduced by Majority Leader MITCHELL.

Something needs to be done to change the laws that govern the financing and delivery of health care in America. The status quo is unacceptable.

For those of us with personal wealth who are well insured life looks pretty good. However, for the majority, whose insured status and financial capacity to pay is in doubt, life looks very uncertain.

Too many hard-working young Nebraskan families do not have insurance and cannot afford to go to the doctor until the medical situation has become an emergency. Routine health care is not affordable for many whose take-home pay must cover rent, food, clothing, and other necessities.

Just one example of the cost of a familiar health care service should help focus our minds on the need to lay aside partisan differences and pass a bill which helps make health care more affordable.

The health care service is the delivery of a baby. It costs $12,000 to have a baby in Washington, DC, it costs $5,000 to $6,000 for the same services in Nebraska.

Bringing a baby into this world at either of these prices—which 20 years ago was considered to be within the household budget and thus was treated as an out-of-pocket expenditure—can be a financial catastrophe. Today, it is a procedure that is most often paid by an insurance company, the government, or by a now financially strapped family. Twenty years ago I paid cash to the doctor and hospital when my children were born. I did not have to be insured. Today, uninsured Americans who approach the birth of their first child do so with more economic anxiety and insecurity than their parents did a generation earlier.

Americans who have themselves or friends that have entered the world of high cost health care understand: The thin ice of medical indigence could break at any moment. In America the physical trauma of getting sick is an event which can also be accompanied by great financial trauma.

Therefore, we know that an urgency exists to change our laws. We also know that an urgency acted upon without careful consideration given to the question where we are going could result in our making the problem worse.

In particular we must take care not to allow the urgent need to subsidize those who cannot pay health care bills to dominate the need to contain costs. Every significant Federal intervention to expand coverage in this century—tax deductibility, Hill-Burton, Medicare, Medicaid—has increased the demand for expensive health care. This demand has increased the availability of expensive health care. Not surprisingly this has made health care more unaffordable and—we are back where we began—increased the demand for subsidies.

As I have said on earlier occasions, without a fundamental change in the way we become eligible for care—namely merely by being an American under color of law—we risk accelerating this cycle of subsidies driving demand, driving subsidies. This fundamental change, however, has been rejected by many as politically impractical.

Therefore, Americans smell politics all over this debate. They do not have to look too far to discover that political insecurity has become a greater concern than the insecurity Americans feel about health care. Mr. President, it should be this insecurity which motivates the need for change. It is this insecurity which gives such resonance to the call to provide health care that is always there.

However, Mr. President, Americans feel insecure about more than just health care. They feel insecure because they are becoming both afraid for and of their children. They feel insecure because of the pace of technological change. While technology has made us more productive and created new jobs, wealth and opportunity, it can make us feel we are skating at the wrong end of the pond. Downsizing is the bogie man of the 1990's. The stress of wondering if tomorrow is the day when they are given the news their job has been eliminated by the latest edition of the company's computer software program is very real.

American workers are also on alert to cheap worldwide labor and conscious free investment capital whose flow knows only the dictates of estimated rates of return. The recent revival of U.S. productivity demonstrates that America's work place team is willing to face international competition with the same courageous performance that has lifted our standard of living to the highest in the world. Still, in spite of this success, in the back of their minds, as they fight traffic to and from work, blue- and white-collar workers alike wonder: Is this the day my job goes to Mexico or Indonesia or China.

Insecurity in the midst of an economic recovery is the reason Americans still do not feel like their country or their political leaders are heading in the right direction. They feel misled and let down as we fail time and again to inspire and help them believe in the uncharted course of our future.

Wealthy, economically secure Americans can only guess at the terrible change which has accompanied the technological and economic advances of the past 30 years. They can only guess why the cry for health care that is always there hits home even for Americans who are currently protected with affordable insurance.

Some of them are still smarting from last year's deficit reduction legislation. That legislation and that attitude continue to influence the debate on health care. Where this influence subjects us to the need to make certain that health care reform contains costs and contributes to deficit reduction, it is a force for good. Where this influence is an angry, petulant one note interference, it obstructs the path of progress.

Made angry by last year's increase in their rates of taxation some wealthy Americans cannot see or do not care that tens of millions of low income working Americans were given more security by an increase in the earned income tax credit. Some of them cannot see or do not care about families who refinanced their homes making it easier to keep their budgets in balance. They cannot see or do not care about self-employed Americans who are finding that health care is more affordable now that they are able to deduct 25 percent of the cost of their insurance.

They cannot see or do not care that the economic recovery—which was in place when this legislation was enacted—has strengthened Americans' job security. The demand for skills is on the rise and with it the confidence of consumers who are buying cars, building houses, and adding to the security of those who build both.

In part, wealthy Americans whose taxes were raised have a right to complain. They were made to be the fall guy rather than being told they were participating in something which needed to be done. Instead of thanks they felt the abuse captured in the phrase we are only taxing those who profited from the excesses of the 1980's.

The taxes we raised in 1993 on upper income Americans and the spending restraint we enacted reduced the amount of borrowing required by the Federal Government to pay its bills. Those who paid those taxes and those whose programs have been curbed should be allowed to feel they have done something good. There can be no doubt we have borrowed hundreds of billions of dollars less than we would have otherwise. And there can be no doubt this effort has on balance been good for the American economy.

The best test of this truth cannot be found in liberal or conservative think tanks predisposed to be for or against tax increases. Reliable truth also cannot be found in the campaign material of those who voted for or against the act.

Instead, the best guide to find the truth is to witness the response of the stock and bond markets. These markets—which may have as many individual liars as a collection of politicians—does not lie in its aggregate decisions. It looks at this kind of legislation with the cold eye of the investor. There is no mercy given on account of ideological orientation.

The market hit the bid. They bought the spending caps. They believe they will work. It even liked the tax increases although that the attitude of the individual traders was less benevolent. Measured by the positive movement of interest rats, inflation, job growth, business starts, business confidence, and investment spending on equipment, the economy not only survived the blow of higher taxes, it has thrived.

The market, however, wants us to do more to reduce Federal borrowing needs. It does not want us to pass a health care bill which expands entitlements taking deficits higher. The Federal Reserve is already poised to raise interest rates on account of economic good news and fears of inflation. Action taken by us which pushes deficits higher in the name of health care security could reduce security by taking the steam out of economic growth and expansion.

America's collective capacity to subsidize those who cannot pay their health care bills is dependent on the strength of our economy. Our national capacity to buy is directly proportional to our national income. We should not make commitments to spend money unless we have the money to spend.

America needs to travel down a road of further deficit reduction. Our goal should be to arrive at a point where we are making annual payments to reduce our debt instead of annual additions. If we continue—and if we reduce the savings and investment barriers in our Income Tax Code—America's income will rise along with our capacity to pay health care bills.

The Mitchell bill contains language which provides a fail safe mechanism to make certain that does not happen. This portion of the law is designed to prevent the Federal Government from providing subsidies unless savings are obtained. In addition the law would require the Federal Government to disclose the amount of taxes that would be needed to pay for Federal health spending.

Unfortunately, this bill—in addition to bringing tens of millions of low income Americans into a subsidized system—would also give new benefits to those Americans who are already beneficiaries of Federal subsidies. This expansion causes me to doubt the promise of deficit neutrality.

This is my first category of concern: The Mitchell bill does not have sufficient safeguards against a further expansion of nonmeans tested Federal entitlement programs. Without expansion of eligibility or benefits, the year to year increase in Federal spending just for health care is almost equal to the entire amount spent on Medicare and Medicaid the year Senator MITCHELL began his distinguished career in this body. These two programs cost $50 billion that year; this year they will cost $280 billion.

My firm conclusion is this: Do not promise anything you will not pay for up front. Given a chance we would all prefer to have someone else pay our bills. This is particularly true with expensive health care. These bills carry a hefty weight.

My second category of concern is the increased centralization of decision-making required by this law. This new law would shift more power over health care to Congress and Federal agencies than is desirable. If we candidly assess our abilities, most of us would admit we make decisions today which are little more than educated guesses.

Let me provide a recent example offered to make this point: We should be making fewer health care decisions in Washington, DC, not more. Last week, I received a letter written to me by Dr. Paul Collicott, chairman of the Nebraska Medical Association ADHOC Committee on Medicare. The purpose of the letter was to ask me to offer a technical amendment authorizing the Secretary of the Department of Health and Human Services to do something Dr. Collicott believes would be good for Nebraska Medicare patients and the providers who care for them.

I am inclined to agree with Dr. Collicott. He is a man with well known integrity and credentials that give his suggestions an air of correctness. How could it be wrong to help? Particularly when it sounds so fair and so likely to bring a little benefit to Nebraska's Medicare beneficiaries.

The problem is that I am not making an informed decision. The decision is based more on an assessment of what makes good political sense than on what makes good medical sense. From the point of view of a policymaker concerned about cost and quality listen to the letter and answer honestly if you feel qualified to make this decision:

> This issue has to do with the impact of budget neutrality calculations on relative values under the Medicare Fee Schedule (MFS) due to coding changes for physician services and the arbitrary reduction of Relative Work Units (RWU's) that have been assigned to these codes by the Health Care Financing Administration (HCFA).
>
> Presently, the RWU's are assigned to a certain CPT code by a peer review process through the AMA's Relative Value Update Committee (RUC). These values then are forwarded on to HCFA, and either accepted at face value or reassigned a different value. In the past, in order to achieve budget neutrality, all RWU's have been arbitrarily reduced 2–3% in order to achieve budget neutrality. These RWU's have been reduced either within a family of codes or at the individual code level. This practice has led to distortions and underlying relative base work estimates developed through the AMA/RUC process a refinement process.

Current law gives the Federal Government—and we as representatives of the people—the power and the obligation to answer this question. Allow me to summarize it. In order to achieve budget neutrality, should we stop assigning RWU's to CPT's through the AMA's RUC particularly if HCFA is going to arbitrarily reduce the RWU's within a family of codes or at the individual level? No cheating now. Do not ask your staff to explain all the terms. You make the decision.

Just a little ridiculous, do you think? Well, the Mitchell bill would have us making even more of these kinds of decisions. Last week, I pointed out five examples where power and control were both being shifted to us and the bureaucracies which I would like to summarize again:

FEDERAL OVERSIGHT OF STATES

The Federal Government would set requirements which States must follow in the new system. States would submit an application to the Federal Government specifying how they will meet the requirements. If the State does not submit an application, or if the Federal Government does not approve the application, the Federal Government can step in and take over health care reform in the State, and charge a 15-percent tax on all insurance. After a State's application is approved, it is subject to Uncle Sam's variation of the random drug test: It can audit a State's program at any time.

FEDERAL OVERSIGHT OF MEDICINE

The Federal Government would decide how many doctors will be trained each year and how many go into primary care and how many will be permitted to train in each specialty and where they will train. The National Health Board will set standards for what is medically necessary and appropriate treatment instead of doctors. Furthermore, the National Health Benefits Board and the National Health Care Cost and Coverage Commission are exempted from the Federal Advisory Committee Act. Translation: They do not have to allow the public into their meetings.

FEDERAL REGULATION OF HEALTH SPENDING

The Federal Government would set the baseline for total health spending excluding Medicare and SSI based on 1994 spending for the standard benefit package. That number is trended forward in 1995 and 1996 based on CBO estimates for health care growth in their 1993 report. The Government then sets what the rate of growth will be beginning in 1997 and forward. Any plan that exceeds that will be taxed at 25 percent of the difference beginning in 1997. Big business and big unions are exempt from the tax until 1999.

FEDERAL REGULATION OF HEALTH INSURANCE

These regulations have the net effect of eliminating the existence of hospital indemnity policies, cancer policies, and other types of supplemental policies.

FEDERAL REGULATION OF SMALL BUSINESS

No business with less than 500 employees would be permitted to self-insure. All businesses of less than 500 would be required to join purchasing alliances.

This week, I would like to point out five additional parts of this proposed new law which would shift power inappropriately to the Congress or to Federal agencies.

FEDERAL REGULATION OF EMPLOYERS

The Federal government is authorized to audit, regulate, and investigate employers who contribute to their workers insurance. In addition, employers will be prohibited from offering an alternative-standard benefits package. The Federal Government also will develop certification criteria for all workplace wellness programs.

FEDERAL ROLE IN ADMINISTERING PRIVATE HEALTH PLANS

Where self-insured, employer-sponsored health plans are found insolvent, the Federal Government will assume temporary responsibility for operating the plan.

FEDERAL REGULATION AND ADMINISTRATION OF PURCHASING COOPERATIVES

The Federal Government will establish procedures for operating all purchasing cooperatives. In addition, the Office of Personnel Management [OPM] must "make every effort to enter into an agreement with a purchasing cooperative in each community rating area in the United States * * *" to ensure that standard health plans offered by the Federal Employee Health Benefits Program [FEHPB] are available to all community-rated individuals. If no purchasing cooperative exists in an area or if OPM is unsuccessful in contracting with an existing cooperative, OPM must establish and administer a purchasing cooperative in that area.

FEDERAL ROLE IN COLLECTIONS

The Federal Government shall provide States with such technical and other assistance as may promote the collection of amounts owed by families. In addition, the Federal Government is responsible for assuring that employers make payments of any employer premiums. The Federal Government may also provide for collection activities to collect amounts owed to States by purchasing cooperatives.

FEDERAL OVER-REGULATION OF BENEFITS

The amount of detail in this bill significantly increases the power of the Board so that it becomes a regulatory agency with few limits on its authority to interfere in plan decisions on coverage, similar to the Medicare model. The National Health Care Board is given broad powers to promulgate guidelines, establish and update periodically tables for all categories, and to specify and define specific items and services as clinical preventive services. In addition, the Board will develop standards for appropriate management of mental illness services, establish criteria for determinations of medical appropriateness, and regulations and guidelines for determining whether an item or service is medically necessary and appropriate.

Mr. President, these are my top 10 objections. Of importance is the omission from my list of the triggered 50-50 business mandate. While that may appear on a later list, its regulatory impact is much less than meets the political eye.

Mr. President, perhaps all of these can be changed in the Mitchell bill. Certainly the majority leader has clearly and fairly indicated a willingness to make changes. My problem is that the more I read the bill the more of these things I find. And the more I find, the more work I think needs to be done to construct a bill that will make health care more affordable to all Nebraskans.

Mr. President, I am willing to work to accomplish this goal.

Mr. President, the question really before us is whether or not we have the capacity to bridge the differences between Republicans and Democrats and pass a bill that is urgently needed by the people—urgently needed.

The distinguished Senator from Massachusetts is probably the best legislator, authorizer, in this body. The distinguished Senator from New York as well has a considerable amount of experience in writing legislation, enacting legislation, and working on behalf of the people not just of the State of New York but the people of this entire country.

I see the distinguished Senator from Oregon down here, who has been a part of extremely controversial legislation in the past and has managed to get over the partisan differences and bridge the gap between the left and the right, the up and the down, the back and the forward, and all that sort of thing, and get a piece of legislation. We passed tax reform in the past. There were great differences.

Mr. President, today lives are at stake. There truly are people in America who are watching now, hoping this debate gets interesting and hoping the debate, as a consequence of getting interesting, leads to a finished product, the enactment of legislation.

The question before us is, can we bridge the differences? I say with great respect to every single Member of the Labor Committee, I wish the vehicle today was going to continue to be the Finance Committee bill, because it is a bipartisan bill. There we have Republicans and Democrats that may not have liked the getting together that occurred, may not have liked just exactly the way it was done, but because it is bipartisan, it is much less likely that you are going to get the kind of, I think, frankly, dishonest representations back and forth that lead nowhere, that make for good press releases and make for very interesting sound bites on the television stations, but do not in fact inform us so that we can make a reasonable decision.

It is true we are dealing with one-seventh of the U.S. economy. It is true we are dealing with something that is life and death for the American people, so we need to give it our full and serious consideration. We are prepared to do that. Many of us—indeed, I would say most of us—have spent a great deal of time studying this issue, a great deal of time at home in looking at the problems that are there. It is, as the President said, bankrupting this country. There will be a $38 billion increase from last year to this year just in Federal spending for health care—$38 billion, Mr. President.

Now, this year alone, we will spend $320 billion directly and $70 billion with an income tax deduction and an offset against FICA —nearly $400 billion in Federal tax dollars being allocated.

Now, I argue we do not disclose it, and we need to balance it. We are honest in the way we do it, but it is a tremendous amount of money. The President of the United States, when he started this thing, said it is bankrupting America, and it is. It is bankrupting businesses, and increasingly it is bankrupting families.

Why? Well, in part, we are demanding expensive health care. Not very many of us walk in and say, "Could you give me the cheapest thing you have?" Most of us walk in and say not only do we want expensive health care but, like Richard Dreyfuss in "The Tin Man," we say we want the Cadillac for nothing. And so over the past 50 years, we have come to Congress, and we have said we want expanded coverage. We want to have our purchase be income tax deductible. We want Medicare, Medicaid. We want Hill-Burton.

Every single time, indeed, we have helped people pay the bills, we have increased the coverage. We have done lots of good things. But in addition to that, we have gone from the point, in 1950, where 80 percent of the bills were paid with cash, to today, where 80 percent is either socialized through the Government or it is socialized through insurance—80 percent of us have our health care bills paid by someone else. As a consequence, most of us do not even know what the price is, and most of us in this body need to be reminded that for tens of millions of Americans, even having a baby can be a financial catastrophe.

Mr. President, it costs $12,000 to have a baby in this city—imagine that, $12,000. That is 2 days, a normal vaginal delivery. Now, the insurance companies only pay for 1 day. Two days, normal delivery, $12,000.

Mr. President, my babies were born 19 and 17 years ago. I paid cash. I did not have to be insured 20 years ago. Why? Because having a baby was not a financial catastrophe if you were not insured. We have driven increased demand into the system in order to provide coverage for individuals. In order to reach out and help individuals pay the bills, we have driven increased demand into the system. The price goes up. The requirement for increased subsidies occurs as a consequence, if you follow what I am saying. Every single time we come and drive demand into the system with Government action, it increases the price and then, not surprisingly, more Americans finding themselves needing subsidies, come to us and ask for the subsidies.

Mr. President, it is crucial for us to be honest with the American people in this debate. We are bankrupting America. We have to decide what Americans as individuals have to be responsible for in making a payment and in what areas are we going to pass the collective hat.

Every single one of us knows, and very few of us will mention, that we are subsidizing people in America today who have the capacity to pay. They just do not want to pay the bills.

Now, we subsidize lots of people with part B Medicare. We are subsidizing lots of people, as the distinguished Senator from Minnesota said earlier, who are getting high-cost health insurance plans through their employer. We have lots of subsidies in place for people today who do not deserve it.

Mr. President, we cannot pay all the bills. We cannot promise American people we are going to pay every single one of their health bills because the definition of health continues to expand.

There is no researcher in America that has instructions to find a cure or treatment for some terrible disease that is being told "Find a cure that is cheap; find a cure or treatment that is not going to cost very much money." And rarely do they find a cure or treatment that is not expensive, that is not again outside the reach of the American people's capacity to pay.

Mr. President, at some point we have to be honest and say that this stuff gets expensive. We have to be honest as well and say that there is substantial agreement in this body and feel an urgency to help those who genuinely need it. There are tens of millions of Americans out there who do not have the capacity to pay the bills, who are forced to ingratiate themselves to remain on welfare before they are told that they are eligible.

All of us know there is a problem in America. We can see the gaps and differentials that separate Republicans and Democrats. My sincere hope and prayer is that the momentum that seems to have stopped, seems to have caused lots of us to say, well, I am not sure we are going to get a bill; I hope that we are able, in a quiet moment, to acquire the humility necessary to see that the American people are counting on us to set aside our differences and enact legislation this year. It is urgently needed.

We ought to do the best we can to get a bill to the President of the United States so he can sign it on behalf of millions of Americans who are hoping and praying that we are able to get the job done.

As I have said before, I have offered some additional suggestions for changing, in particular, the Mitchell bill. I do it with great respect for the majority leader. I trust his capacity to be deficit neutral.

We began this whole thing by saying we want to reduce the deficit with health care reform. That is the reason our deficits are going up. That was the great line that began this whole debate. We have to make sure that on final passage we are able to go home and say that we did what we said we were going to do, that we passed health care reform that reduced and not increased the deficit in spite of our desire to say, yes, it expands benefits, expands and gives people all sorts of new things. It has to reduce the deficit.

I pointed out, as well, the things where I think we shifted the power of the Government in this legislation to the Federal bureaucracies and Members of Congress.

I reiterate a request made to me by a doctor in Lincoln, NE, who frankly is asking me a question that I pretend I know what I am talking about when I answer. But the truth of the matter is I do not have the capacity to answer the question. I am shooting at a target that is behind a wall, and a spotter comes out every now and then to tell me to adjust left and right. I really, as a Member of Congress, do not have the ability to make detailed decisions that very often are not economic decisions. They are moral decisions. They are ethical decisions, decisions about life and death.

Mr. President, all of us know that typically what goes on out there in the medical community is we have a desire to keep people alive, keep someone alive, to stay alive. These are very difficult moral decisions. I must tell you I do not feel comfortable as one individual in Congress making those decisions. I certainly do not trust signing it off to some bureaucracy in Washington, DC, which will, in my judgment, do very little other than perhaps to make it difficult to get a plane into Washington National Airport.

Mr. President, I hope that our strategy here is to recognize that Americans need it. Our economic security depends upon it, and our capacity to go to bed at night and say that Americans are going to be able to afford health care depends upon our taking action.

I will continue to work with the mainstream coalition. I will continue to focus and to work with the mainstream group, a group of Republicans and Democrats, who want a piece of legislation enacted. We are tormented by the problems that we see in the country, and the status quo is unacceptable.

I will pay a great deal of respect and attention to the Senator from New

York, the chairman of the Finance Committee, and the senior Senator from Massachusetts who is probably this body's best legislator, probably the best able to see the gaps and the differences that separate one from another.

I pay a great deal attention as well to the Senator from Rhode Island who is waiting patiently to speak next, and last, and certainly not least, the majority leader.

Mr. President, we have to take action. There is agreement here in this body. I hope in the process of debating that we do not do as the Senator from Massachusetts cautioned us against doing, and that is simply coming down with a laundry list of complaints, simply coming down and saying, here is what is wrong, here is what is bad, here is what it is, but come down, and say, here is what we want changed. And, if it is changed, we will vote on it. That is what we need to be doing; not coming down here and offering a reason to vote no. Lord knows, there are a thousand reasons to vote no. But there are tens of millions of Americans out there that are good reasons for us to vote yes.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. PACKWOOD. I yield such time as the Senator from Rhode Island may consume.

Mr. CHAFEE. Mr. President, first, I want to thank our ranking member, Senator PACKWOOD, and the distinguished chairman of the Finance Committee. Also, I would like to congratulate my good friend from Nebraska who gave such a fine statement. What he said are the feelings that I have. I think they reflect the feelings of everyone in the mainstream coalition. We want a bill. We want a bill this year. We believe we can get a bill.

Yes, there are problems we find in the legislation before us, but I think we can arrive at a strong bipartisan measure that will get enthusiastic support in this Chamber.

So for my part, I want to say I am delighted we are moving into this health reform legislation this week. It is very complicated. I think it is time for us to do the best we can to struggle for constructive changes that are going to help our citizens lead healthier lives.

A great deal of emphasis is placed on the limited amount of time we have. Yes, we were to go out on recess at the end of this week. Can we stay another week and another week? Sure. I recognize the need to move quickly, but I do think we have to proceed with some care because the legislation we enact will have widespread and not necessarily predictable consequences. No American is going to remain untouched. It is going to affect how we are born, how we live, how we die. This is far-reaching.

I just saw in the paper a note of a little child born in Pawtucket, Diana Rebello, born on Sunday night, August 7, at Women and Infants' Hospital in Providence. Think of her life and what it means. Then I think of Theresa Nigrelli of Westerly. She is 100 years old and still stringing pearls every day at Nigrelli Jewelers. She does not need glasses. So we think of her, too.

The financial aspects of this are mind-boggling. They have been touched on before. But I would like to repeat that one-seventh of our economy in the United States of America is devoted to health care, one-fifth of the Federal budget. Of the five biggest items in the Federal budget, Social Security, defense, interest on the debt, Medicare and Medicaid, it is the last two that are going right off the chart, Medicare and Medicaid. Defense is banging along, going down; Social Security, fairly stable; interest on the debt going up, not such a substantial amount. But it is the last two that are causing us our principal problems.

The 1,410-page bill before us was only released a couple of days ago. As I understand—I am not sure it is accurate—changes are still being made to it. So it is up to us during this debate to air thoroughly for the American people what is in this proposed legislation and to ensure that our actions do not make the situation any worse. Clearly, we do not want to go backward.

I would like to quote to my colleagues a warning from Reischauer of the Congressional Budget Office in February before the Finance Committee. This is what he said:

> Estimates of the interactive effects of so many complex changes to an industry that encompasses one-seventh of the economy are highly uncertain.

Underline that "highly uncertain." The estimates are "highly uncertain."

> Assumptions, used by the Congressional Budget Office and other analysts, about people's behavioral responses to new incentives are frequently based on research evidence from small changes in the existing marketplace.

They are very small samplings.

> In the case of the Administration's proposal—

This applies to any proposal—

> however, the entire marketplace and the configurations of the actors within it would be changing, and there is no precedent for estimating the effects on health spending or the economy.

That is the end of the quote. That is what the Director says.

The same caveat applies to each of the estimates that are given in the various bills that have come before us. We all know from study and vast experience and in listening to witnesses much that is right and much that is wrong with our health care system. And we acknowledge that in many respects it is exemplary in technology and innovation, the skill of our professionals, and the range of choices. We also know there are several things that demand reform. It seems to me very important to keep in mind what we are trying to do? What is the end game here? I think our objectives are three.

First, we must give Americans health security. We want to ensure to hard-working people like Christopher North of North Smithfield, RI, that he does not live in fear of losing his coverage. He, his wife, and two sons were covered by his wife's policy through her employer. She lost her job. They applied for a new policy. They were turned down. Why? Because their son had a preexisting condition. Minor though it might have been, it was enough for the insurance company to turn him down and thus turn down their family's insurance.

Insurance companies do not like to insure poor risks. They are very skillful at finding healthy people. And that is why many small businesses with employees who are older or have preexisting conditions are finding their health insurance—they can get it, but they cannot afford it. It is unaffordable. If one employee develops a debilitating condition, all or most of his employees are going to be dropped, frequently. This is a tricky problem in our States where 86 percent of the firms employ less than 20 people.

What about "job lock?" In other words, staying in a job, and you want to leave, but you cannot because, if you go to the new place, you will not be able to get insurance.

Donald Bolster, Bristol, RI, 13 years with Blue Cross—his wife suffers now with Parkinson's. No other insurance plan will take them on because of a preexisting condition. They cannot shop for insurance coverage. They cannot get an alternative plan. They do not have portability. They cannot move to another job. That is what is known as job lock.

The second objective: We must extend health insurance to those—as many as we can—who are not now covered. We want to make sure that the first group can keep their insurance. The second group, we want to extend it to them. We know the statistics: 15 percent of Americans, 37 million Americans at any one time, are without health insurance. In my State, it is 92,000 of our citizens, and 15,000 of them are, regrettably, children. They cannot get or do not have health insurance.

Who are these uninsured? Many people have the impression that the uninsured are the poor or elderly. That is not so. The very poor have Medicaid, and the elderly have Medicare. Ironically, in our system, single-parent families are better off in terms of health insurance than two-parent families. Single-parent families are frequently on Medicaid. Two-parent families are not. One may be working and the wife is at home, or she may be working in a firm where they do not provide insurance. Therefore, they earn too much to qualify for Medicaid.

The vast majority of people without health insurance live in families in which the head of household is employed for at least some portion of the year. These are not people who are the unemployed, never getting a job; they are employed at least some portion of the year. In my State, 76 percent of the uninsured are in families in which the head of household works full time. Eighty-five percent have incomes above the poverty level. We all know that it is very costly for society when individuals like these do not have health insurance. They are the ones that go into the emergency rooms of hospitals for treatments or for procedures, and the hospital emergency room is not the right place. It is far too expensive for these individuals. Or else they do not go anywhere, and then the child, or the individual, or parent, comes down with a devastating illness that, in the end, costs our society far more.

The third objective is to do something about controlling costs. "Cost containment" is the buzzword used. The cost of health care in our society is getting tremendously expensive for the individual, for companies, for States—particularly through Medicaid—and for our Federal Government. In the United States as a whole, we spend 14 percent of our gross domestic product on health care—more than any other industrial nation. The Federal Government spends 19 percent of its budget—nearly 20 percent, one-fifth of all our expenditures, on health care. That is projected to go up to 25 percent by the end of the century.

Local and State governments, particularly through the costs of Medicaid for State governments, spend about 15 percent. The country just cannot sustain these costs. When you talk about what it is doing to businesses, the statistic is well known that there is a greater cost for health care than for the automobiles built by Chrysler, Ford, and General Motors. It costs more for health care than for the steel in the automobile. We spend twice as much for health care in the United States per automobile worker per car than is spent in Japan.

We have a wonderful opportunity to do something about all of this. This does not come along very often. It came along in the 1930's in the New Deal, in the 1940's under President Truman, and it came along in the 1970's under President Nixon. Yet, in each of those instances, the extremists, those demanding perfection and those who said do not do anything, got together and thwarted the chances of the group that wanted to do something. Obviously, it was not a majority.

So our challenge in 1994 is to make some history. I think we have the wisdom to put partisanship aside and to enact broad health care reform. I was honored 4 years ago when Senator DOLE asked me to be chairman of the Republican task force, and we worked on this and came up with legislation in 1991, and then a better bill in 1993, the Health Equity and Access Reform Today Act of 1993. We had 20 Republicans on that and, subsequently, we had two Democratic Senators join us, making it one of the only two bipartisan health care reforms.

In November of last year we formed a bipartisan group called the mainstream coalition to see if we could not work together. We are drawn by the common belief that reform is too important to be destroyed by party politics. We wanted to formulate a proposal that would put us on a responsible path toward universal and affordable coverage with effective cost controls.

We had some principles to guide us. The first was caution. Nobody knows how this thing is going to work out. Will we get better health care? How much will it cost? We have to implement the reforms slowly and build on the ongoing assessment of how it is affecting individuals and businesses and the Government.

Second, do not add to the deficit. We believe financing should have a realistic conservative time line for phasing in health insurance and for granting vouchers to the low-income individuals, which is part of our plan. And thus we came up with a so-called failsafe mechanism, which is a big word for slow it down, when you phase in the coverage, the costs, or accelerate it, depending on the success of the reforms. We want to ensure that the reforms do not add to the already dire Federal deficit.

Third, there should be a minimal level of Government intervention. Let us not replicate Medicare, which has been fine for the beneficiaries, but a disaster in terms of cost containment. That is the ultimate of the micromangement program. It is cumbersome and top heavy with regulation and produces a 12 percent annual growth in cost, which is more than double what the private sector is going up in. And only in Government-run programs do you have the bizarre situation during a House-Senate conference, where Congressmen PETE STARK and Senator JOHN CHAFEE are huddled at 2 a.m. in a corner of the Capitol deciding who is going to be reimbursed for reading an EKG, or whether nurse practitioners should be reimbursed directly or not. I do not know whether I can speak for Congressman STARK, but I can say I am incompetent to make those decisions. I suspect that he might be, too, but I have to be careful.

These service delivery issues should not be decided by politicians at 2 o'clock in the morning, but by health care professionals working in competitive, efficient markets.

Mr. President, this Government intervention is kind of interesting. I got a letter from Jim Wilson, owner of Wilson's clothing store in Wickford, Rhode Island. He indicates he is not too sure of what the Government is doing. He asks two simple questions: First, what is the Government's track record in projecting the costs of entitlements? How good is the Government in predicting what something is going to cost when it is entitlement? And how well have these programs been managed and controlled?

I think, reluctantly, the answer has to be "horrendous" to the first one and "poorly" to the other.

In the reforms we develop, I believe there should be the least possible Government intervention and the greatest possible reliance on market forces.

Fourth, the solution we must enact must have the broadest possible bipartisan support. That does not mean Democrats or Republicans caving in to the other side, it means all of us giving up a little bit to meet in the Senate. When we are enacting reform, we will be asking the public to accept a great deal on faith. How can we earn our trust if we pass a bill by one vote? The public will be suspicious, and rightfully so. We can see what happened with catastrophic a few years ago. We can debate in earnest taking up the bill by the majority leader. He has worked hard to fuse the two bills in the Finance Committee and Labor and Human Resources Committee, which was a herculean effort. I think we are indebted to Senator MITCHELL for his effort.

There are a number of provisions in this that cause me great concern.

The Senator from Massachusetts says: "Well, list them, but just do not attack the measure. Tell us specifically what you are talking about."

I personally feel that these points that I will make should be corrected. Maybe I am misunderstanding. Maybe I do not read the legislation right. Maybe it has changed in a subsequent rewrite. I do not know.

But the President and Senator MITCHELL, and others, have indicated they are willing to give voluntary market solutions a try before imposing Government controls. In this bill and in many areas, in my judgment, that voluntary market solution effort has not been given the chance it deserves.

Some of us have been chided in the Senate for not recognizing how far Senator MITCHELL has moved. I take such criticism seriously and have spent some time looking through this proposal. What I found is surprising. It is absolutely true the approach does not have the immediate mandate on the employers which was in the original bills that were discussed, such as the President's bill.

But the leader, it seems to me, has in that instance attempted to accommodate those in his own party as well as Republicans. But let us look at some of the other issues that have been less debated and less publicly discussed since the Clinton bill was first presented, vestiges of which we still find in the Mitchell bill.

First, mandatory alliances. A single alliance set by the Federal Government through which all employers and all individuals must purchase insurance appears no longer to be part of this proposal. It is out. It appears to be. However, in its stead is a requirement that all employers with fewer than 500 employees must join a purchasing cooperative and pay any required fees, all employers, with 500 or less employees. In my State that is practically everybody. Yes, we have a few employers with over 500, but they are relatively few.

The proposal of Senator MITCHELL appears to accept the idea that there would be competing cooperatives, and would allow employees to purchase coverage outside any cooperative. This sounds good.

Let us look a little further. There also is a requirement that the Federal Government, through the Office of Personnel Management, choose what one might call a favored cooperative. That is the responsibility of the Office of Personnel Management. All employers of 500 or fewer are required to join that cooperative, although they can join others likewise, but you have to join that one and pay your dues. PPM is mandated to establish a cooperative if there is none in the area. Follow this, the end result would easily be what we sought to avoid, single alliances in an area set up by OPM, thus run by the Federal Government with all businesses under 500 required to belong.

This is one of the things that we objected to and many objected to right in the beginning.

Second, price controls. Under the original proposal, Clinton proposed a premium cap above which insurance plans could not charge. That was in the original plan. Many of us objected and argued that competitive forces should be used instead to bring the price of insurance down.

The proposal before us by the majority leader contains a provision that purports to be a market-based, cost-containment mechanism, but on closer examination, it looks like the premium cap enforced by a tax. The Government sets what it believes is a reasonable premium in each area. The Government sets this. And it is indexed to increase at a fixed amount. And if it exceeds that, then the Government imposes a tax on the difference between what the plan charges and this other amount. This is clearly not letting the market forces work.

Third, the proposal creates new regulations for all health care insurance plans sold in the United States, not just those that are involved in the so-called uniform benefit package. In other words, it says that a whole new set of Federal regulations will apply to a whole series of plans that exist out there. It might be the cancer policy, for example. That would not be involved either. That would not be involved in the uniform benefit package.

Clearly, we can see why these new regulations apply to the uniform benefit package. There cannot be any denial for preexisting conditions, and all the things that we previously discussed in insurance market reform, but this proposal extends all of those rules to the policies that currently exist that someone might want to buy even though those policies receive no Federal subsidies.

We do not understand why you get the Government involved in this whole set of new regulations for an area that is working perfectly well now.

Next, the fail-safe mechanism that has been touched on already by prior speakers is something that we believe deeply in to make sure that what you are doing does not cost more than the expenditures that would have taken place in the plan before us. We do not believe that it accomplishes that objective.

Malpractice reform. One objective of health care reform has been to reduce the costs through medical liability reform. The bill before us proposes only modest Federal reforms. The proposal requires alternative dispute resolution but still allows the parties to go to court. There are no caps on noneconomic damages, no changes in the statute of limitations. Most important of all, the bill appears to preempt tougher State malpractice laws currently on the books in favor of the weaker Federal rules.

For example, in California, they have enacted substantial medical tort reform, medical liability reform, after hard-fought statewide debate. Those California rules would all be preempted now by these Federal rules by the Federal Government. In other words, there will be total Federal preemption.

Next is medical education that has been discussed. It was discussed last night by Senator PACKWOOD and in some detail. I would like to echo my concerns that he voiced. I cannot understand—obviously, there should be inducements for those to go into primary care but for someone to sit here and say x percentage of practitioners be in primary care and y percentage in the specialties, if one wants to study to be a ophthalmologist, three cheers. It may well turn out that the market forces will work out that he does not have a job, but that is his business. Maybe he is going to be the greatest ophthalmologist. But to restrict who can and cannot take up the various specialties does not seem to me to be a constructive way to proceed.

Again, we would hope that the market forces would work that way, and as we go more and more into managed care, the market forces in that particular area are going to be stronger and stronger.

Next, ERISA. ERISA are the rules that pertain to companies that operate in many States and those that have self-insurance. Many provisions in this proposal before us will have the effect of gutting the ERISA preemptions that currently exist and that have worked successfully for the health plans of multi-State companies and self-insured companies.

The effect of these changes will be to substantially increase the cost of these plans to employers and to employees. An example is a requirement that these companies be subject to State laws involving so-called risk adjustments, in other words, to paying from one set of plans into another set of plans, so-called community-rated plans. That is an open-ended ability of States to impose a new tax on the premiums of these companies. They do not know what it is going to cost.

Association plans. There currently exists the capacity for businesses, such as a group of automobile dealers or the local chamber of commerce which may put together a whole series of small businesses in groups. They are formed to purchase insurance. Now, many of us would like to see these plans grandfathered with slightly modified rules so they can continue to exist.

To enact a health care reform bill this year, is it really necessary, as is done in this proposal, to completely revamp even those parts of our existing health system that are currently working? I do not think so.

Next is the costly new litigation proposal that exists in this plan. It establishes broad new rules that will open State and Federal courts to a huge influx of claim disputes. In fact, under this proposal attorney's fees are subsidized for certain individuals bringing suit against the claims decisions made by a health plan. There is no question that the plans will simply pay off nonvalid claims, get rid of them solely to avoid the litigation costs.

This is hardly cost containment. It is a bonanza for cost, and it is a bonanza for lawyers. General Electric has told us that it is their estimate this will add $1 million a year to their health care costs.

Perhaps some of these ideas have merit. But I do not think any of them are essential to the enactment of health care reform.

Another point. After the employer mandate triggers into effect, this legislation prohibits insurance plans from ending an individual's health insurance coverage even if the individual or the group does not pay their premiums.

In other words, you cannot drop them for failing to pay their premiums. That is an unusual provision. So I guess the proposal, the rationale behind it, is they want everybody insured. So you can be insured even though you do not pay your premium. I think it would be a great incentive for people not to pay their premium.

But then there is set up a shortfall add-on assessment on all insurance payers. That amount is to be used to pay for those deadbeats who do not pay for their insurance. In other words, every insurer or rate payer will pay an additional amount for those who do not pay their premiums.

Finally, next to last, is community rating. That was discussed last evening by Senator PACKWOOD. Pure community rating, as you know, eliminates any difference between the amount paid by older Americans and those paid by younger Americans. This comes in the year, I think it is, 2002. It will inevitably lead to price increases for younger workers who are not the most wealthy of groups and will force them to drop their coverage.

And then, finally, for some reason, a new occupational safety and health program is established under this legislation. I do not quite know why we have to get into that in the name of health care reform.

These are some of the reasons I have concern over the proposal set forth by the majority leader. The Mitchell bill, but for the employer mandate, appears to reflect few of the principles that those of us in the mainstream have, those of us who err on the side of less Government intervention, more marketplace competition, and effective-cost containment.

What does that mean? Does that mean that we Democrats and Republicans cannot unite on a bipartisan plan that will enjoy broad support? I do not think so. By that I mean, I do not think the negative.

I will start that over again. Does it mean that we cannot unite? I believe we can unite. Does it make sense for us to try for a bipartisan measure that keeps in mind the two objectives we all say we are for?

I think if you ask people out here what are they for, they will all say two things: We want to increase the number of Americans who have health insurance, with our goal of eventually covering everyone. Everybody would agree with that, I think. Very few would not. Second, our objective is to get costs lower for individuals, for companies, for State governments, and for the Federal Government. Cost containment.

Nearly all of us pay tribute to the effectiveness of the marketplace. We all seem to subscribe to the notion of competition. There would be very few people who would get up on the floor of this Senate and say, "I don't believe in competition. I don't believe in the effectiveness of the marketplace."

We subscribe to the notion of competition, those of us in the mainstream. We are, for the most part, extremely skeptical of Government intervention.

So why can we not unite behind a bill that incorporates those beliefs? We do not have to achieve everything this year that we would like to. There will be other opportunities to deal with this subject, to ascertain whether we should do more or less.

I and all the other members of the mainstream group want to see good health care reform enacted this year. We will do all we can to be helpful. We believe it is extremely important to have a bill with broad support.

What am I talking about? Seventy-five or eighty votes in favor—that is not an impossibility—rather than a measure that sneaks through with 51 or 52 votes.

Time is getting short, but there still remains time to produce a product that will be of great benefit to millions of Americans. What an opportunity. What a wonderful opportunity. So let us not let it slip through our grasp.

I thank the distinguished chairman of the committee.

Mr. MOYNIHAN. Mr. President, I thank the Senator from Rhode Island for a remarkable statement and a hugely positive and encouraging one, to this Senator.

We can do this. We can do it. And if it is done, he will be one of the principal reasons it was done.

I thank the Senator.

Mr. CHAFEE. I thank the Senator very much.

Mr. MOYNIHAN. Mr. President, I ask unanimous consent that the time yielded to Senator CHAFEE not be deducted from the Democratic time, and that the time for the Democratic side be adjusted to equal that used by the Republican side.

The PRESIDING OFFICER. Is there objection?

Mr. PACKWOOD. I have no objection. I would just like to know how much time, therefore, that leaves the Democrat side. We have used ours all up.

The PRESIDING OFFICER. The Democrats will be restored to 77 minutes.

Without objection, it is so ordered.

Mr. MOYNIHAN. Mr. President, the able and learned Senator from Arkansas has been patiently waiting his opportunity, and I yield him 15 minutes.

Mr. PRYOR. Mr. President, I thank the distinguished chairman of the Finance Committee.

I would just like to say that I am very, very proud that this debate is finally here, that we are joining our forces here on the floor of the Senate, that we are doing our duty. Hopefully, this is going to be a constructive endeavor, ending up in meaningful health care reform legislation that can be sent to our President.

Mr. President, in late July, the very distinguished majority leader was faced with the daunting task of integrating the two major health initiatives that were offered by the Senate Labor and Senate Finance Committees. Senator MITCHELL was challenged to develop a bill that would effectively serve as the starting point of debate for one of the greatest legislative undertakings in recent history—reform of our health care system. I applaud the majority leader for meeting this challenge and bringing to the table a bill of considerable merit. I am certain all of my colleagues would agree that he has shown impressive leadership by acting both expediently and in a very, very bipartisan manner.

The majority leader's bill is the culmination of almost 2 years of intense congressional examination, and today we are presented with a real opportunity to use our hard work to effect positive changes in our health care system. Some of my colleagues are claiming that no bill is better than a bad bill. Yet, to imply that the majority leader's proposal is a "bad bill" misrepresents the work we have done the past several months. As a team, we have built upon the groundwork laid by President Clinton with his Health Security Act. And at least up until now, we have overcome many of the barriers presented by partisan politics.

I recognize that we still have plenty of work to do. But I firmly believe that instead of throwing up our arms in frustration, we have an obligation to the American public to meet the challenge put before us today.

Mr. President, I have stated before that the cost of doing nothing far outweighs the cost of reform—both in financial and human terms. My statement today is an effort to urge this Congress to take action and to seize this very unique opportunity to offer Americans the health care they deserve. With that said, I would like to comment on a few aspects of the majority leader's bill, which I find of particular importance.

As chairman of the Special Committee on Aging, I am very pleased that the majority leader included in his plan programs aimed to alleviate the two biggest concerns of older Americans—long-term care and prescription drugs. Understanding that the financing of any health care plan must include significant savings in the Medicare Program, we simply must provide senior citizens with something in return. The inclusion of a new long-term care program as well as prescription drug coverage is a major start, I truly believe, toward guaranteeing the health security of our Nation's most vulnerable populaton—the elderly.

Our Nation's elderly and disabled will rest easier knowing that the majority leader's plan includes a new home- and community-based care program. This new program is a major step in the effort to reform our long-term care system. By providing services for persons of all ages, this thrust will help give American families peace of mind regarding long-term care.

This new concept will also help end the institutional bias of our long-term care system. Currently, for many elderly and disabled Americans, the only public help available is offered in a nursing home setting. The lack of options will change, should Senator MITCHELL's plan go forward. The wedge of available services will widen, and more people with disabilities will be able to remain living at home with their families.

Another important benefit is that families will no longer have to impoverish themselves in order to get help paying the high cost of long-term care. Instead of forcing the elderly and the disabled to spend down to a low eligibility level, this opportunity is going to be made available to all Americans with disabilities. Many recipients will be required to pay some of the cost of their services. However, these copayments will be equitably set on a sliding scale, according to income. In this way, the welfare-based Medicaid methodology will be replaced by a fairer system of personal responsibility that removes incentives to squander income or to hide assets.

Our long-term care addition is going to offer a broad array of services, providing all disabled Americans with the option to remain in their homes and communities. Homemaker/chore assistance, respite services, adult day care, rehabilitation and home health care services will be among the services made available.

In our home State of Arkansas, nearly 40,000 people will benefit from this new concept. Let me tell you about a few of these people. There is a 90-year-old woman living in a small frame house—and I have been there—in rural Arkansas. She needs assistance in completing activities of daily living. She copes with seizures, heart problems, arthritis, and has a hip replacement. Her only family caregiver is a 68-year-old daughter. If it were not for the services provided by a personal care assistant, this 90-year-old woman would be living in a nursing home today and her stay there would be financed by the taxpayers.

This woman, however, is fortunate, relatively speaking, because she does have access to personal care assistance. Countless others living in our State and our country as a whole lack access to these types of services.

For example, another woman living in rural Arkansas suffers from numerous physical and emotional health problems. Despite these disabling conditions, she was turned down for community-based services because she somehow failed to meet the medical criteria. Now, as she continues to deteriorate on a daily basis, she has become increasingly concerned about her ability to continue living in her own home. She could apply again for help but is justifiably disillusioned by the health care system. Most likely, she will end up in a nursing home, and the taxpayers, again, will foot the bill.

There are many, many other stories that I could tell to illustrate the need for the new home- and community-based program. One of those people came before the Senate Special Committee on Aging back in April. Tom Chapman is 53 and is suffering from Alzheimer's. Hazel, his wife, has done everything that she can do, including leave the work force to become a full-time caregiver to keep her husband at home.

Their daughter, 13-year-old Angela, has all but given up her childhood as a result of her father's disease. Mrs. Chapman told our committee how her husband was diagnosed with Alzheimer's 3 years ago, how the disease has progressed to the point where he can no longer dress or go to the bathroom by himself. He shadows her all day long because he is afraid to be alone. When he eats, he often does not know the food is supposed to go into his mouth.

One of Mr. Chapman's major problems is that because of his age, 53, he is shut out of many of the community-based programs that are available to those who are over 60. The Mitchell bill would change that. It would set up a new home- and community-based care program open to disabled people of all ages. Because they have no options, and Tom's care needs have become so overwhelming, Hazel, his wife, has decided to look for a nursing home for Tom. The costs of nursing home care are so prohibitive that the Chapmans have recently had to give up their home because they can no longer afford it.

These are case studies that only barely scratch the surface of the problem at hand. It is imperative we take action this year, take action now to help the millions of people in this country who are struggling to gain access to long-term care.

Mr. President, I also point out the majority leader's proposal, thankfully, includes prescription drug coverage for older Americans. Prescription drugs provide us with some of the most cost-effective medical care at our disposal. Yet under the present system, too many people have been forced to make the desperate choice between buying food and utilities or buying the medications they need to stay healthy. Over the past decade, skyrocketing prescription drug prices have made medications unaffordable to many Americans, especially our Nation's elderly. In spite of the many studies which show the harmful effects of this relentless inflation on our Nation's poor and elderly, the country's drug manufacturers today say that Congress should not take any action to contain drug prices. They say we should, instead, rely upon market forces to hold down the prices of medications.

Because pharmaceutical companies retain a high degree of control over the prices of drugs they manufacture, the market fails to produce adequate cost containment for the American consumer. Competition in drug pricing is almost nonexistent because today the companies are buying the generic drug manufacturers that serve as their competition. The drug companies are also now buying the businesses which distribute these drugs throughout the American marketplace.

Through the course of my years in office, I have received thousands of letters, as I know the entirety of this Senate has, from older Americans, pleading for help in paying the cost of prescription drugs. Unfortunately, the elderly spend over two and a half times as much as the younger generation on medications, and they pay for a higher percentage of their drugs directly out of pocket. In fact, for over 75 percent of the elderly, prescription drug bills represent their highest out-of-pocket medical costs.

The Mitchell bill addresses this dilemma. It provides seniors with greater parity by including a Medicare drug benefit as part of the provisions. As I have already stated, with significant proposed cuts in the Medicare Program, we must now offer seniors some degree of help in return. This drug benefit, although many will say it is moderate, will have the added effect of reaping considerable Medicare savings due to reduced hospitalizations, generic substitutions, and improved health conditions.

The Center for Policy Studies recently found that these savings could total as much as $37.2 billion saved over 5 years. The seniors who stand to benefit from this program are not the wealthy elderly. They, instead, represent seniors who fall within 100 to 200 percent of the poverty range.

In my home State of Arkansas, the Medicare drug benefit will result in more comprehensive prescription drug coverage for over 250,000 people age 65 and older. These seniors will be a part of the older, poorer minority elderly population who are going to benefit greatly from the so-called Mitchell proposal that is now before the Senate.

Because of these two forward thinking concepts—long-term care and prescription drug coverage—we received this morning for Senator MITCHELL's proposal the endorsement of the American Association of Retired Persons.

I would like at the proper time to place this endorsement of the Mitchell plan into the RECORD. But I would like, Mr. President, before I do that, to quote from this endorsement. It is in about the fifth paragraph.

The PRESIDING OFFICER. The Senator has utilized the 15 minutes yielded to him.

Mr. PRYOR. It has expired?

The PRESIDING OFFICER. It has expired.

Mr. PRYOR. Mr. President, may I seek 3 or 4 additional minutes?

Mr. MOYNIHAN. Can we make it 3 minutes?

Mr. PRYOR. Yes.

The PRESIDING OFFICER. The Senator is recognized for an additional 3 minutes.

Mr. PRYOR. Mr. President, it states:

> The Mitchell and Gephardt bills are about protecting American families. They offer an historic opportunity to provide each of us with affordable, high-quality health and long-term care. If either bill is defeated, health care reform will be dead for years to come.

In closing, let me state that this morning in the Washington Post, I read a very, very disturbing news article about a group of business people who are now meeting at the very exclusive City Club in downtown Washington. They have decided to oppose all health care reform bills, especially, it appears, the ones offered by the Democratic Senators.

The most disturbing statement was given and attributed to Mr. John Motley. I know Mr. Motley. He is a friend. He runs the NFIB, the National Federation of Independent Businesses. By the way, this is not a small organization. They have an enormous PAC fund, they have an enormous number of employees. This is something that Mr. Motley stated yesterday: "We are all very good at putting together votes against something," said Mr. Motley.

Mr. President, if Mr. Motley said that, this is the most cynical statement that I have seen yet in this long debate about health care. Here are a group of business people and their spokesman is saying, quoting again: "We are all very good at putting together votes against something."

I do not know exactly what our country is coming to. But unless we can really get to the bottom of some of these issues and tackle the many special interests that for years have profited from this health care crisis in America, I hate to say that we are going to be admitting that we do not have the fortitude nor the ability to carry forward with our commitment to provide health care for all Americans.

Mr. President, I ask unanimous consent to print in the RECORD the statement by the AARP president.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

STATEMENT BY AARP PRESIDENT EUGENE LEHRMANN

AARP recommend to our members that they support the health care reform bills introduced in the Congress by House Majority Leader Richard Gephardt and Senate Majority Leader George Mitchell. Although neither bill is perfect, after careful review, we conclude that they provide the foundation for comprehensive health care for all Americans.

AARP has been a constant voice calling for comprehensive reform of the nation's health care system. Throughout this long and often confusing debate over how to accomplish health care reform, AARP has not endorsed any proposal, but has held steadfastly to our basic reform goals that would provide: universal coverage; long-term care coverage; prescription drug benefits; provisions to protect and strengthen Medicare; controls that reign in skyrocketing health care costs; and a fully-funded health care system that is affordable to every American.

In the almost three decades since Medicare was enacted, two other Presidents—Nixon and Carter—proposed major reforms, but Congress did not act. The time for proposals without action has passed. We are now dealing with specific legislation that demands difficult choices but offers the hope of real reform.

Trade-offs will be required of each of us, regardless of age or income. For AARP members, cuts in Medicare must be balanced by new home and community-based long-term care and prescription drug benefits. AARP will continue to fight to protect Medicare and to make sure that older Americans are always able to get the doctor and hospital care they need.

Ultimately, the choice must be between health care reform and the current health care system. We all know the problems with the current system. The Mitchell and Gephardt bills are about protecting American families. They offer an historic opportunity to provide each of us with affordable, high-quality health and long-term care. If either bill is defeated, health care reform will be dead for years to come.

This is why we are asking our members to support the Mitchell and Gephardt bills. AARP pledges to our members that we will continue to fight for our goals until they are fully achieved. By supporting these bills, we can all make health care reform a reality, not only for ourselves, but for our children, our grandchildren, and the generations to follow.

Mr. PRYOR. Mr. President, I yield the floor, and I thank the distinguished chairman for providing me the opportunity to speak.

Mr. MOYNIHAN. And we thank the tenacious Senator from Arkansas for particularly drawing attention to the pharmaceutical benefit, which is of great importance.

Now I have the pleasure to turn to a natural authority on this subject, the junior Senator from Hawaii where we have had universal health care for many years and with great and felicitous results. I yield 10 minutes to Senator AKAKA.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, I thank the chairman for giving me this time.

I have joined today's debate on health care because I represent Hawaii and Hawaii leads the Nation in ensuring that basic health care is available to all. Our system delivers high-quality care without high costs, despite Hawaii's high cost of living.

When the majority leader and the Republican leader opened the debate on health care on Tuesday, they described in very eloquent terms the problems with our health care system and their differences over how to correct these problems.

The one thing both leaders agreed was that affordability and access were the core problems with health care today. In both their speeches, the leaders used the identical words—affordability and access—to describe what is wrong with the current system.

Mr. President, for 20 years, since 1974, Hawaii has had a prepaid health care system whose keystone is shared responsibility, or employer-employee mandates. I want you and my colleagues to know, and the Nation to know, that it works for Hawaii and it will work for our Nation.

In Hawaii, we have solved the problems of affordability and access. Hawaii has achieved the American health care dream, near universal health care for its citizens and at a cost that is 25 to 30 percent below the national average. We achieved this because of shared responsibility—employers and their employees joining together to share the costs of health care coverage.

In Hawaii in 1974, we had opposition. We had opposition from the American Medical Association. We had opposition from the business community. We had opposition from small business associations. We had opposition from the Chamber of Commerce. And despite this opposition, because of the strong, solid Democratic majorities and a strong Democratic legislature and because the bill was a Democratic priority, it was passed in 1974, and we have had it now for 20 years.

So for 20 years, Hawaii has maintained a model health care system. The cornerstone of health care in Hawaii is shared responsibilities. For 20 years, Hawaii's employers have shared the cost of health insurance with their employees. As a result, Hawaii has one of the healthiest populations in the Nation.

I quote from the Journal of the American Medical Association:

> Considering that health outcomes ought to be the key objective of a health care system, Hawaii fares very well, if not the best of all States, in terms of longevity, low infant mortality, and very low premature morbidity and mortality rates for cardiovascular and pulmonary disease and cancer. Two recent national analyses of the comparative health status of all 50 States, one by Northwest Insurance Company, Milwaukee, WI, and another by the Public Health Association, Washington, DC, have rated Hawaii first among all States. We believe a considerable amount of this success is attributable to direct and indirect effects of Hawaii's employer mandate over the past two decades.
>
> * * * the State's continued emphasis on ensuring access to primary care for nearly all its citizens has been a major factor in better

health outcomes and improved health status for Hawaii's people.

Death from chronic health problems, such as cancer, heart disease and lung disease, are also among the lowest. Our cancer rate is one-quarter less than the national average, our heart disease rate is one-third less than the national average, and the incidence of lung disease is half the national average.

Opponents of health care reform and shared responsibility——

Mr. KENNEDY. Will the Senator answer a question on that?

Mr. AKAKA. Yes.

Mr. KENNEDY. Does the Senator draw a conclusion that because there is early intervention—as I understand it, Hawaii has twice the visits to the doctors as we do in other States and it has half the hospitalizations. A good deal of the analysis in Hawaii, as I understand, is for preventive aspects which you included in your program which are very similar to the programs in the Mitchell program; and that that has resulted in a reduction in both the utilization of hospitals and more extensive types of treatment. Is that part of the experience?

Mr. AKAKA. The Senator from Massachusetts is absolutely correct.

Mr. KENNEDY. I thank the Senator.

Mr. AKAKA. Hawaii has enjoyed this over many, many years.

The opponents of health care contend that requiring employers to provide health insurance will lead to widespread business failures, yet our experience is just the opposite. The dire predictions about economic decline, lost jobs, and small business failures have not materialized. Requiring businesses and employees to share the cost of health insurance has not undermined Hawaii's small business climate.

Critics respond by saying, "Hawaii is different. Your State is not representative," or that, for one reason or another, Hawaii is not a good test case on the effect of shared responsibility on small businesses.

In fact, Hawaii is a very good test case because Hawaii is a small business State. Small business is the engine that drives our economy. Ninety-eight percent of the businesses in Hawaii have fewer than 100 workers. Firms with 50 or fewer employees constitute 95 percent of our businesses. Hawaii is a haven for small businesses, not the Fortune 500 companies.

Since Hawaii implemented shared responsibility, we have enjoyed steady and nearly uninterrupted small business growth. With the exception of 1 year out of the past 20, small business employment has increased each year.

The Hawaii experience defies the predictions that shared responsibility will lead to higher insurance premiums or an increase in small business failures. Beginning in 1977, Mr. President, when an index for business failures was first created, Hawaii's small business failure rate has been half the national average. Hawaii has also been heralded as the number one "entrepreneurial hot spot" for start-up companies.

Critics also insist that employees will respond to health reform by eliminating low-wage employees. Yet, they contend that small businesses will be forced to cut jobs or shift to using part-time employees because they cannot afford the cost of contributing to health insurance.

Neither of these problems have surfaced in Hawaii.

These critics also fail to take into account the positive effect of lower insurance costs on business. What they do not appreciate is that as they get closer to universal coverage, insurance becomes less expensive, not more expensive. In most cases, businesses that currently provide insurance will see their premiums drop under the Health Security Act.

Because of Hawaii's near-universal coverage, health insurance premiums for small businesses are competitive with the low rates that large employers are able to negotiate. Despite our high cost of living, insurance rates for Hawaii's small businesses are 11 percent lower than the rest of the country. In 1993, a Kaiser Family Foundation study found that small business premiums averaged $251 less in Hawaii than the national average. Shared responsibility and universal coverage means that small businesses obtain rates that are usually reserved for large corporations.

Shared responsibility is the best way to reduce health care costs and make insurance affordable.

Requiring employees to share the responsibility for providing health care coverage has not hurt Hawaii's economy. Hawaii has impressive economic evidence to show that our small business sector has not suffered harm from 20 years of shared responsibility. Some might even say Hawaii's economy is strong because it has a work force that enjoys quality health care.

Our employers understand that a healthy and motivated work force is the key to business success. Our businesses receive an economic payoff that is well worth the cost of providing coverage for employees. And because of this and because it has worked in Hawaii for 20 years, I know it will work in our country when we pass this bill. I urge my colleagues to keep Hawaii's experience in mind as we act on health care reform.

I thank the chairman for giving me this time.

Mr. MOYNIHAN. Mr. President, we are coming to the close of 2 days of general debate on the health care proposals, and I for one have not heard a more forceful and relevant and revelatory statement than the Senator from Hawaii—the point that as you approach universal coverage there is not the cost shifting that brings premium rates up for small business, the fact that you have seen small businesses in 20 years in just 1 year decline in numbers through many recessions, a powerful statement for which I one for and the Senate in general are deeply grateful.

Mr. KENNEDY. Could I inquire of the Senator?

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Is it true that Hawaii now has the most favorable business climate for small business in the country?

Mr. AKAKA. That is the prediction and also that is the feeling there now; Hawaii businesses have grown over the years.

Mr. KENNEDY. Just finally, does the Senator not agree with me—we have heard a great deal from those who oppose the Mitchell program—that in many respects the program that was actually adopted in Hawaii and has been in effect 20 years in terms of universal coverage, the preventive aspects of health care, many of those features have been tried and tested in Hawaii and have been effective? As I understand, Hawaii also has the burden of looking after the health needs of many of the American possessions in the Pacific basin as well; many of those people come in from the Marianas and from the other islands, and they also utilize the Hawaiian facilities, and still with all of those kinds of burdens they are able to have the kind of excellent system with all of the health benefits and economic benefits that the Senator has identified.

Mr. AKAKA. The Senator from Massachusetts is correct. We do service the Pacific region. They do use our facilities and our program, and it has worked very well for the Pacific.

Mr. KENNEDY. I thank the Senator.

Mr. MOYNIHAN. We thank the Senator for a remarkable statement. But is the Senator sure it is not somewhat connected with the climate?

Mr. President, the Senator from Montana is here, and I am happy to yield 10 minutes to him.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. I thank the chairman. I wonder if he could yield more than 10 minutes because my statement will take more than 10 minutes.

Mr. MOYNIHAN. Fifteen.

Mr. BAUCUS. I appreciate that.

Mr. President, first, I commend the chairman of the Senate Finance Committee and also the chairman of the Committee of Education and Labor. Many, many Members of this body have explained to their colleagues and to the public at large how much we all owe our gratitude to these very fine men, and I want to join in that praise and those compliments. Without their efforts, it is clear we would not now be here attempting to work out a solution to the health care crisis that our country faces.

Mr. President, I wish to take a few minutes here to discuss the health reform proposal now before us. I begin by saying that this is a monumental effort. It is a historic effort. It is an effort that has been well framed in this debate, particularly by the measure offered by Senator George Mitchell, our majority leader.

I commend him for his work and the extraordinary, almost herculean, efforts he has undertaken to get us here.

Montanans have discussed health care in many ways and discussed it in depth. I, for example, held town meetings and conferences and have had more talks with Montana businesses, union members, health professionals, and ordinary citizens than I have had on practically any other issue. Virtually all agree that we have to act now.

Too many middle-class Montanans are in danger, for example, of losing their coverage. Too many Montana businesses are facing the choice of whether to offer health benefits at all. That is because costs for them are rising too fast.

Listen to Gary Beley, a self-employed, self-ensured rancher from Big Timber, MT.

> My wife and I are 59 years of age, and ranch for a living. We have a * * * $1,500 deductible policy on which we have filed one accident claim in over a 10-year period. They rate us in good health. From 1991 to 1993, our premium has gone up from $3,970 to $7,352 per year. This is an 85 percent increase in over a two year period. The increases over the last two years have been about 20 percent per every 6 months.

Mr. President, people like the Beleys are hard-working. They are middle-class Americans. They need some relief. And it is time for us to step in and do what we can to provide it.

I believe the proposal before us now will help. It will not solve all of the problems we face in health care, but it is a big step forward. Today, as we begin the debate, I want to discuss its major features. I begin with some of the reforms that will be most critical for America, rural America, particularly my State of Montana.

The first proposal before us has strong insurance reforms. These will make it easier for consumers and small businesses to buy insurance. Many have a hard time today. The proposal will limit the ability of insurance companies to deny health insurance to middle-class Americans with preexisting conditions—very important—and it limits the ability of insurance companies to cut benefits, arbitrarily drop coverage, or charge sick people dramatically higher rates, a lot of which is going on today.

Second, the measure before us offers assistance to businesses that want to offer health insurance but are unable to afford it.

Third, it will increase the number of primary care doctors, an area in which Montana in particular has serious shortages.

Fourth, it will improve the quality of rural health care because it includes a rural health condition that I proposed earlier this year. Its main features are: First, it makes Montana medical assistance facility demonstration projects permanent. This project is known as MAF's, and now operates in the towns of Jordan, Circle, Terry, and Ekalaka. And according to Walter Busch, the administrator at Roosevelt Medical Center in Culbertson, MT, a small town with a population of about 796 people by the North Dakota border—this is what he says:

> The Medical Assistance Facility has improved access to quality health care services in a cost-effective manner. It has restored health care services to four remote rural communities and prevented loss of services in two others. The program has cost relatively little to implement, and has been well received by both residents and rural communities. It is a very flexible program, and yet one that has provided consistently high quality care.

The rural provisions also offer grants for what is called "telemedicine," letting rural doctors and nurses use modern technology to confer with specialists in other areas. This is very high technology and is very important to remote rural areas. It creates a program of branching to create networking among providers, allowing them to share information on equipment and techniques and to cooperate much more effectively than they can today.

It also offers tax credits to doctors and nurses who practice in underserved rural areas. That includes two-thirds of Montanans.

Finally, it creates a new, permanent position of Assistant Secretary for Rural Health at HHS. This will help make sure Federal officials do not forget about places like Culbertson, MT.

On the whole, the proposal before us is a very good effort. However, it contains two troubling provisions. These discriminate against Montana and other rural States, place a burden on middle-class taxpayers, and endanger any support for the proposal as a whole. What are these two provisions?

The first creates a fund for teaching hospitals. These are large profit-making institutions, and about half of this fund will go to hospitals on the east coast. The fund is financed with a 1.5 percent premium, or a tax on health plans, all health plans, designed to raise about $65 billion over the next 10 years for these hospitals.

These hospitals also receive about $80 billion in transfers from the Medicare trust fund. The mere existence of this fund is a problem for me. There is no hard evidence that teaching hospitals require this kind of a new fund. I am not convinced that creating it is good policy. And my preference would be to eliminate it and return to the subject when and if a critical need is proven in the next several years.

However, the fund has a lot of support, and I do not insist upon striking it. But I do insist that it be fair. If we create a fund, it must support all hospitals with critical needs wherever they are because I will offer an amendment to set aside 30 percent of the fund for rural hospitals. That will deal with a real, grave, and worsening crisis, because 10 percent of rural hospitals closed in the last decade. They are gone. They provide no care. Rural areas where 3 in 10 Americans live have fewer than half as many physicians for providing patient care as urban areas. Where cities on the average have 225 doctors per 100,000 residents, rural areas have only 97 doctors per 100,000 residents.

Two of every three Montana counties are underserved, and rural areas have higher levels of chronic or serious illness—that is documented—and have higher percentages of senior citizens than any part of the country as a whole.

My amendment will give hospitals in these regions some critically needed aid. It will make sure that the fund is shared evenly among hospitals that need support. And it will preserve 70 percent of the money to deal with any problems that teaching hospitals might encounter.

The second problem is the proposed tax on high-cost insurance plans. This is an idea which sounds good. After all, we do need to control costs. We want people to choose the most sensible plan for themselves. So why not give them a push toward less ambitious, lower cost plans by taxing the higher cost plans? But when you look closer at this proposal, you find it is much more complicated. You find in fact that the tax will hit again rural heartland States harder than other parts of the country.

Many of the health plans this text covers are not luxuries. They are not gold-plated plans. They are the only option for people in high-risk jobs like logging, millworking, mining, and agriculture. Farming is now the most dangerous occupation in the United States with annual death rates at 52 per 100,000 workers, almost five times the national average. These people are responsible, they are hardworking middle-class citizens, and these jobs are the backbone of Montana's economy. This tax, then, has a large and unfair impact on middle-class Montana workers and industries.

This version, I must say, is less onerous than the version which led me to vote against the Finance Committee package that Senator MITCHELL has attempted to improve upon. But in its current version, it is still unfair to Montana, and it is hard to see how I can support any bill containing it. We should not raise the cost of premiums for honest, hardworking, middle-class families. Health reform should do just the opposite. It should make premiums cost less; not more, but less.

This proposal also would require large businesses to share the cost of health insurance for their employees. But it is a requirement unlikely ever to take effect. It provides that only if market forces fail to push us to 95 percent coverage by the year 2000, and if Congress does not bring us to that level by 2002, then all businesses with more than 25 full-time employees will be required to pay 50 percent of the cost of health insurance for their employees.

Most Montanans now, as a matter of course, get their health insurance through their employers. But some large businesses nationwide do not help provide insurance. They contribute to cost shifting, and thus to waste in our health care system. That makes everyone's premiums higher. In essence, they impose a private tax on middle-class Americans. And people like the Beleys in Big Timber, MT, are paying it.

These businesses should cover their employees. They have no excuse.

Small businesses, however, should not be subject to a mandate. They operate on small financial margins, and mandating health coverage would cost jobs, that is clear. Thus, the proposal exempts all businesses with 25 or fewer full-time employees from any mandate, ever. That is more than 80 percent of Montana firms. I believe it is fair to small business and does give the market a chance to work.

The Congressional Budget Office believes the proposal will cover 95 percent of Americans. Even if CBO is wrong, Congress has 2 years to address the issue. Only if this fails will large businesses be required to help provide insurance. It is a responsible approach, and I will vote to keep it.

I think we will not do enough to control costs. In many ways, this is the fundamental issue. Rising health costs put Federal and State budgets under tremendous pressure. Within the next 5 years, higher health costs will reverse the progress we have made in the deficit reduction bills of 1990 and 1993. They hold down wage increases for Montana and American workers, lowering the standard of living. And they make American business less competitive relative to foreign firms.

Sooner or later, we will have to deal with this problem. Budget pressures will give us no choice. I hoped we would do it this year, but it seems to be a political reality that we have no consensus to do it. Neither this proposal nor any Republican alternative will control costs effectively. But whether we pass a Democratic reform, a bipartisan proposal, a Republican bill, or nothing at all, we will have to do it soon.

This proposal's creation of a Commission on Health Care Costs is at least a step in the right direction. This Commission will report on health costs, gather information on the reasons health care costs are rising, and suggest possible ways to address the problem. That means pressure will come on Congress to take on health costs, and that we will have the most current information available to us on how to deal with it.

The fact that we will not control costs this year is regrettable. I think the American people want us to focus more on costs, and we are not doing so. But the Commission on Health Care Costs is an acceptable—barely—second best. And the failure to do more is no reason to oppose the reforms we have before us—support for small business, insurance reforms to guarantee coverage, and improved rural health care.

In conclusion, I again commend the majority leader, in particular, for his work. As he said, this proposal will change before it passes. But its introduction helps us along the way toward our goal of national health care reform. With this bill, Gary Beley and his wife will no longer have to insure on their own. They will be able to join a group and get lower rates. That may not be everything the Beleys need, but it is a start.

Finally, I want to take a minute to commend my legislative assistant, Maureen Testoni, for her tremendous work on health care over the past 2 years. She has worked long hours and provided me with consistently good, sound advice, cogent advice. I want to thank Maureen for her work and congratulate her on her wedding later this month.

Thank you, Mr. President. I look forward to the debate.

Mr. MOYNIHAN. Mr. President, I thank the Senator from Montana for his very cogent remarks.

I yield 15 minutes to the chairman of the Committee on Agriculture, the able, learned Senator from Vermont, Senator LEAHY.

Mr. LEAHY. Mr. President, I thank my good friend and neighbor across the beautiful Lake Champlain. I know that he, like I, wish we could be almost in parallel areas—he in his lovely farm in upstate New York, and me on my lovely farm in upstate central Vermont, where we could then protect both shores of Lake Champlain. But, Mr. President, we are here to do something that I hope will protect all of us, all Americans, and that is to bring health care to all Americans.

I was reading the sports page the other day, and I came across a quote from Shaquille O'Neal, the famous basketball star who plays for the Orlando Magic. "The Shaq" hurt his back, but he said he was not worried. He said, "I am not too concerned—I have good health insurance."

That quote hit me because it summed up what we are all debating about—whether we give America's families the same kind of peace of mind about their health care. We should not have to be a famous basketball star and somebody who makes millions of dollars a year to have good health insurance.

In Vermont, my home State—and this is a State of only 560,000 people—5,000 people in Vermont lose their health insurance each month. There are 56,000 Vermonters without health coverage; 49,000 of them are in working families. Almost 6,000 of those Vermonters are children.

Mr. President, I know many, many of these Vermonters. Many of them are my neighbors, my friends. Some of these Vermonters without health insurance went to school with me. Some grew up on the same street I did in Montpelier, VT. Some are people I have known all their lives. They are hardworking, good, honest, decent people. The fact of the matter is that they have worked as hard as anybody in this Chamber and do not begin to have the kind of health coverage we have.

Too many Vermont families do not share "The Shaq's" sense of security because they know that if they have an illness or if they lose a job, it might mean the very end of their health insurance. They are asking everybody in this Chamber to do something to end their fears.

Let me give a personal example. A Vermonter, a mother of three children, one of whom is developmentally disabled and another of whom has a chronic disease, said it this way:

> I am asking the congressional delegation from Vermont to make sure that this work is done in a timely fashion. Our children cannot wait while party lines are haggled over. This issue is so important to many of us. Please remember that there are real families out here, struggling to provide meals and a roof over their heads and their families'. They should not have to worry about who is going to pay the doctor bill, too.

That is why we need health care reform, to give this mother, and so many parents like her across this country, some peace of mind.

There are those who do not agree. They say, "We want health care for Americans, and we understand that Americans who lose their jobs may lose their health care. We want to do something, but not quite yet, and really not in this form. We have to do something a little different, so let us make changes. Of course, we want everybody to have health care—believe us when we say that—but maybe not quite yet because we are not quite ready."

The people who say they are all in favor of health care but not yet and not quite in this form or that form and maybe we should wait a year to study it, the people who say this are invariably people who do have health care. They can wait until next year or the year after or the year after that because they have health care, and they know they and their spouses and brothers and sisters and parents and children are all covered.

But what do you say to those people who are hard working Americans who do not? What do you say to people who have a child with a chronic illness and could not get insurance for that child no matter what? What do you say to the people who have a preexisting condition and they know no matter how hard they work or how good they are they are not going to get health insurance?

Those people who do not have health insurance are also very real. They are just as real as those who have health insurance who say we can wait. They are trying to raise families, like this Vermont mother of three. They want us to remember them while we are having this debate.

I think of the debate on programs of Social Security and Medicare. During the debate on Social Security, we were told about how little good it would do for older Americans. We heard about the end of the American tradition. We heard about socialization of America. We heard when people were talking back in the thirties whether we would have Social Security, we were told by many who opposed it, that it would do more harm than good, that it would hurt older Americans, that it would turn us into some kind of socialistic nation.

During the debate on Medicare, one Senator said:

> It would achieve little for those who need it, while subjecting the very fabric of American life to the strain of severe and unnecessary sacrifices.

We are going to hear these arguments again. We will hear all of the reasons why we cannot cover people, why we cannot have guaranteed coverage through the workplace.

The special interests have hired the best lawyers in Washington to make sure they lose no ground in this bill. Some groups have gone so far as actually placing calls for people who they then supply with a script so they can say "We oppose this" or "We oppose that." That is shameless.

Let real Americans talk. Let us let the real people with a personal stake in this come forward, not someone who is a hired gun for or against any plan.

I congratulate Senator MITCHELL for getting us to this historic moment. He introduced a bill that will let us do what is right for the people of this country. His bill is a moderate and reasonable approach. It can move this country toward universal coverage.

The majority leader listened to the concerns people have with the President's plan and put together a bill that is less bureaucratic, emphasizes primary and preventive care, provides extra protection for businesses, and pays for itself.

Some say it does not go far enough. Others say it goes too far. We have seen the debate. I watched many of the debates the distinguished Senator from New York had in his Finance Committee. I wish to commend him. I think there was probably not a single issue that he did not bring out and explore in the best possible way. The distinguished senior Senator from Massachusetts [Mr. KENNEDY] did the same in his committee.

We have heard these debates. I think it is safe to say in listening to them we know there is never going to be a perfect solution. We are not in a perfect world. And if we wait for the perfect, if we let the perfect be the enemy of the good, we would never get off the ground, and millions of Americans would be without health insurance.

Is the bill before us the one I would have drafted? Is it the one the Senator from New York would have drafted or the one the Senator from Massachusetts would have drafted if they could write it all by themselves? I doubt if it is. But there are 100 Senators who have to vote on it here and 435 Representatives in the other body who have to vote on health care. And every one of us could look at whatever piece of legislation is before us and say it is not precisely what I would have wanted but it is a start.

The debate goes forward. I want to look at each part as we vote on it, but I would like to see us get to the bill, debate each part, and then decide up or down. I will look at how it will affect Vermont and how it will affect the country.

I want to make sure my own State's efforts to make our own health care system more efficient and more accessible are not diminished in any way.

There are a lot of things I like about Senator MITCHELL's plan. It has full funding of WIC. That is a goal my colleague, Senator JEFFORDS, and I shared and fought for for many, many years. It is something that we can say to poor pregnant women in this country that they can get the same kind of nutrition as someone who has more money. Their children can have at least a chance at birth. Having gone through the pregnancy, the gestation with decent nutrition, they should then have decent nutrition when they start their young life.

It has strong privacy protections. We want to know that people will not have their medical histories the subject of curiosity or harmful disclosure for commercial advantages, that someone cannot go into computers and find out everything about a person's life and sell it.

It has State flexibility, allowing States to implement national reforms on a fast track.

Coming from one of the most rural States in the Nation, I am glad to see it has strong rural provisions so that when you talk about health care reform that is not an empty promise to those who live in small cities and towns.

Many Senators last night mentioned the 59th anniversary of Social Security is coming this Sunday. I want to quote one Representative whose words from that debate are just as wise today. Here is what he said:

> I have looked forward to the initiation of such a program for many years. I must not let temporary disappointment over one feature of the program blind me to the great benefits of the program as a whole.

I urge Senators to remember these words and remember the hard-working people we are fighting for.

Let us debate the Mitchell plan. Let us improve it where we can. Let us, when we disagree with something, vote it up or down. Let us debate every amendment Senators have to offer. And let us vote.

Let us not give the American people the spectacle of a Senate unwilling to come to grips with this, unwilling to vote on each issue.

We have worked hard on this. The distinguished Senator from New York, the distinguished Senator from Massachusetts, the distinguished majority leader and many, many of our Republican colleagues have worked very, very hard on this.

Now let us bring it to fruition. I think on the thousands of hours by hundreds of professional staff members who worked on this. I am proud to be joined on the floor of the Senate by the senior staff member of my office who worked on this, Theresa Alberghini. She started off as a member of Mrs. Clinton's Health Care Task Force early on last year. She has worked with the President, with the First Lady, with Members of this body and their staffs, and with the Governor of our own State, trying to bring to me at least the best information possible but also to bring her own other talents. There are hundreds of other men and women associated with the Senate who have been doing the same.

Let us not let all that work go in vain. Let us face up to this, and let us hope in the coming days and weeks we can reach a conclusion for the American people.

Mr. President, I thank the distinguished chairman and my good friend from New York for yielding me this time.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, may I especially thank the chairman for the wisdom and for the experience behind his counsel, that no bill is going to satisfy all of us about all of the things, but this is the moment for a bill.

Again, I thank the Senator.

Mr. President, may I ask how much time is remaining?

The PRESIDING OFFICER. The Senator from New York controls 14 minutes and 16 seconds.

Mr. MOYNIHAN. Mr. President, in an act of abandon but enthusiasm, I yield it all to my friend from Ohio, and may I say that with this the distinguished Republican manager and I will have used all of our time, and so this will be the last address of the day in this debate.

Senator METZENBAUM.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. METZENBAUM. Mr. President, I thank my colleague from New York and rise to take the position of the abandoned Senator, having been given this position by reason of an act of abandonment by my friend and colleague.

I rise to express my strong support for comprehensive national health care reform.

Let us not kid ourselves. This is a defining moment.

At many points in this century, the Congress has been on the verge of enacting a universal health care system and each time we have shied away from it.

Once again, we have a chance to rise to the challenge.

I implore my colleagues, please do not let this moment slip away again.

To the naysayers who say no bill, filibuster, or next year, I say, you are letting the American people down; you are playing politics with the health needs of the American people.

We must put the long-term needs of the American people first.

I believe that each one of us elected to this Chamber knows that this country should have a universal health care system.

Every American should have the right to go to a doctor or a hospital when they are sick. That is the heart of what we need to do: Assure every American access to affordable high quality health care.

We are elected Senators in order to lead. We are elected to do what is right for the country.

There will always be a certain amount of politics being played between Democrats and Republicans. The Republicans have made a political calculation that they can become the majority party if the American people believe that the Democrats failed to enact health care reform.

And, regrettably, too many Democrats also are fearful of reform. They want Republican cover to hide behind with some of their constituents.

But bipartisanship solely for its own sake would only mean a lowest common denominator reform bill.

Democrats need not fear health care reform. As long as we do what is right for the American people, we will be heroes, not failures.

Health care reform can be relatively simple. If we only have the courage of our convictions, we can do it.

The American people are fed up with politicians because of our willingness to put politics before policy.

So, as we begin this debate, I implore my colleagues, let us cast each vote in the name of a better health care system, let us live up to the aspirations of the American people, let us put the need for comprehensive health care reform first.

Every one of us is going to get sick at some point in our lives. And everyone must be able to go to a doctor or the hospital when he or she is sick. Every one of us; young and old; rich and poor; husbands and wives; children and grandchildren.

Let me tell you some of the cases that we are talking about. These are individual cases from Ohio.

Patrick Joyce, 3 years old, has cystic fibrosis. He needs access to specialized care to live a normal life. But without the money to get the medical care, he cannot live a normal life.

And then there is Shawn Durham, a 1-year-old child, rare heart defect, who has already had three heart surgeries—three heart surgeries on a 1-year-old child. The parents are in college. They have no insurance, and no insurance company will cover them. Can we in good conscience turn our backs on such cases?

John Corcoran, whose wife has Alzheimer's; his daughter has seizures. Neither can get insurance. And poor John is a farmer who would lose his business if either were to be hospitalized.

Then there is Donna McNamee, born with a bone disease, considered a preexisting condition. She cannot get insurance. She has to stay as a dependent of her parents in order to get Government help.

Fred Griffith, his wife has diabetes. That was considered a preexisting condition. He lost his job. He searched for a job which would insure his wife's preexisting condition. The only job he found was in Indiana. So he must travel and be away from his wife for extended periods of time to keep insurance.

Health care is not just a broad term. Health care relates to real people. Health care means people who today do not have insurance—37 million of them, maybe 39 million by this time, out there in the countryside. It is not a particularly important figure to you, unless one of your loved ones is one of those 39 million.

Donna Osmond is 59 years old. In 1989, she was stricken with breast cancer. She was insured through her husband's company. Her husband now wants to retire. He is 62. But if the husband retires before he turns 65, he loses coverage for his wife. And he cannot find insurance coverage elsewhere because of Donna's preexisting condition.

Eugene Schumacher, 70 years old. His mother is in a nursing home. In the last 6 months, he spent over $10,000 for room and board and $1,200 for medication. He is afraid he will run out of money because of the medical expenses. David Kuehl is a hemophiliac, his medication costs up to $100,000/year. He is no longer employed, but has extended health insurance coverage for 2 years through COBRA. When the 2 years is over, it is unlikely he will find insurance coverage elsewhere.

Under a national health care plan, we can cover everyone. That is what they do in other countries. That is what we ought to do in the United States of America. This is the richest, most powerful country in the world.

There is absolutely no reason why we cannot provide adequate health care to all of our citizens.

No one can claim that we are not already paying enough for health care in this country. We are spending $1 trillion dollars a year—I did not say million, I did not say billion, I said trillion—14 percent of our GDP each year on health care and still we have 39 million Americans without health insurance.

This is an absurdity. We must start by creating a national framework for the financing and delivery of health care. We must have the courage to step in at the Federal level.

The Mitchell bill takes an important first step. I am frank to say the Mitchell bill does not go as far as I would like, but it represents a sound attempt by the majority leader to craft a middle-ground health care reform package.

Under the Mitchell bill, workers and their families would continue to get their insurance through the workplace. Nonworkers and those workers whose employers do not provide benefits, would be covered through publicly sponsored programs.

Everyone would receive a standard set of health care benefits with an emphasis on preventive care to reduce long-term costs.

Employers may voluntarily contribute to their workers' health coverage, but if a voluntary system does not work, in the year 2000, a national commission, with Congress' acquiescence, would impose a mandatory employer contribution.

The Government will provide subsidies to low-income individuals and businesses.

This bill, as I said, is not all that I would like it to be, but represents a good start. I would like to see it strengthened in a number of areas, and will fight to change it.

I believe employers should be required to contribute to their workers' health insurance now, not in the year 2002.

I believe we need better subsidies for low-income and working families.

I also believe we need to do more to control health care costs.

Currently, there are a lot of people making money—important money—off our health care system.

The hardest challenge we face is standing up to the special interests—

the AMA, the AHA, the insurance companies, the pharmaceutical companies. But we must make our decisions based on what is the right policy, not on what the lobbyists want.

The special interests will adapt to whatever system we deem right. But we in the U.S. Senate must bite the bullet.

Quite frankly, we have too many doctors and hospitals who are ripping off the system. And we have too many doctors and hospitals spending too much time figuring out how to make money and not enough time providing health care.

We need to turn things around. We need to control the spiraling rate of increase in health care spending.

We need to recognize that we have many doctors who provide to the economy and to the health care of this country, not ripping off the system to protect their interests.

We need to get control of provider fraud and abuse, which is estimated to exceed $100 billion a year.

We need to reduce the administrative wastes of the insurance industry, which is ripping us off for almost 25 percent of every health care dollar, about $200 billion a year.

Frankly, I think we ought to eliminate the insurance industry entirely from the health care business.

But even if there is not support to eliminate unnecessary insurance, we must require insurance companies to bring their costs under control. Some companies are spending as much as 40 percent of insurance premiums on administrative costs.

Mr. KENNEDY. Will the Senator yield for a question?

Mr. METZENBAUM. I will, indeed.

Mr. KENNEDY. Does not the Senator agree with me that the kinds of inclusions in the Mitchell bill to deal with fraud and abuse could mean the savings of billions of dollars that are escaping at the present time?

Mr. METZENBAUM. I certainly agree with the Senator from Massachusetts. There is not much doubt about that. There are abuses. There are excesses. And the Mitchell bill deals, in my opinion, very effectively with trying to eliminate those.

Mr. KENNEDY. Without that bill, we do not have in place today those kinds of provisions that have been included in the measure. I must say, as I think the Members of this body know, to a great extent they were the result of the activities and the suggestions or recommendations by the Senator from Ohio.

Finally, I would just like to know whether the Senator feels the kinds of protections for consumers in this legislation are important as well?

Mr. METZENBAUM. I think the Mitchell bill moves very far in the effort to protect the interests and concerns of the consumer. The Senator from Massachusetts and I have worked many hours—many years—trying to protect consumers, whether it had to do with consumer fraud generally or whether it had to do with consumer abuses in the health care field. I think the Mitchell bill will do much to protect the average American consumer. That is the reason I think it is so important we move forward.

Mr. KENNEDY. I was interested in working with the Senator because we included in there sort of a report card on different health care systems, hospitals, and also on doctors, so the consumers would be able to find out whether there was consumer satisfaction, whether there were delays, whether there was service, whether there is good service, so consumers would be able to have additional kinds of information which does not now exist, generally speaking.

Some States, for example Pennsylvania, have moved on it. But does the Senator not agree with me that those features which have been included in the Mitchell program would be of great help and assistance? They may even be strengthened. I know the Senator would like to strengthen them.

Mr. METZENBAUM. The features in the bill move a long way in providing that protection. The Senator is correct. I hope we can do more. I hope to be able to achieve some of those changes on the floor of the Senate. But let us face it, half a loaf of bread—in this case maybe three-quarters of a loaf of bread—is better than no bread at all. And I think this bill goes a long way in providing consumer protection.

Mr. KENNEDY. I just wanted to commend the Senator because I have been here for the last part of the debate yesterday and this afternoon, and this is really one of the first comments made about the advantages of this bill in terms of dealing with the problem of fraud and abuse and, second, in identifying one of the additional features of the Mitchell bill, besides moving us towards universal coverage and helping get a handle on cost containment and the preventive programs and the downpayment for our seniors. But there are important kinds of consumer protections and information, as well as dealing with fraud and abuse. These seem to me to be factors the American public would welcome.

Mr. METZENBAUM. I have no doubt about that. I think passing the Mitchell bill would do much to help the American people as far as consumer fraud and consumer abuses in the health care field.

Mr. KENNEDY. I thank the Senator.

Mr. METZENBAUM. I thank the Senator for his questions. Frankly, I would like to see a collaborative program in which all the major parties participate.

The PRESIDING OFFICER (Mr. CONRAD). The time of the Senator has expired.

Mr. METZENBAUM. Let me inquire if anyone else is seeking the floor. If not, I ask for an additional 5 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. METZENBAUM. I prefer to see a collaborative system in which all the major parties—consumers, doctors, hospitals and Government—sit down and negotiate what we will spend and how we will spend it. That is what every other country does. It is not a perfect or painless system, but it works. Everyone sits down together and decides what they are willing to spend on health care.

Some people say we can control costs through competition. I have my doubts about that. Individuals are not in a position to shop around for the cheapest surgeon or forego surgery if they think the price is too high. Individuals should not be shopping around for the cheapest doctor. And doctors should not be competing against each other on price—but rather on the quality of the care they provide.

Employers and managed care companies claim they can assure quality care at a lower cost, but neither data nor logic is on their side. Almost all of the studies show managed care companies are not saving much more money than traditional insurance companies. And to the extent that managed care companies are saving money, they are doing it by pressuring doctors and hospitals to discount their fees and not by improving the quality of health care they provide.

All that managed care does is substitute a level of managed care bureaucracy for insurance company bureaucracy. One need look no further than the financial pages to see what is going on in the health care market. Managed care companies are merging like wildfire in order to take over and control the health care market. Just this year Metropolitan Life and Travelers agreed to merge to create the second largest HMO, controlling one out of every four doctors in this country.

Columbia Health Care merged with Medical Care of America, a deal worth over $1 billion.

New York Life purchased Ethix Co. to create a 2 million enrollee HMO.

The list goes on and on and on. Insurance companies are at the forefront of this movement now, owning 45 percent of all the HMO's in this country. Two-thirds of all HMO's are for-profit entities. These companies are not in this business solely to deliver health care. They are in the business to make money—a respectable effort on their part. But when that money comes out of those dollars needed to provide adequate health care for the people of this country, or comes out of the pockets of doctors and hospitals who are squeezed up against the wall, then there is something wrong.

HMO profits increased 20 percent in 1993: Cigna, Aetna, Humana, U.S.

Health Care, and Prudential had combined annual profits of almost $500 million last year. And who is paying for these profits? The American taxpayer, that is who, the average American.

Let us not kid ourselves. Managed care is big business and big money, and that is not good for the American people. Putting all this power, all of this economic strength in the hands of these HMO's, which are buying each other up at an unbelievable pace, means they think no matter what system we here in Congress bring about, they are going to be able to squeeze more and more dollars out for themselves, for their executives, and for their shareholders.

I am willing to give the managed care industry a chance to prove that it can hold down costs. But I have very little—very little—confidence they will. I think Senators will be speaking on this floor 10 years from now and they will see the HMO's have really been a detriment to bringing about a better national health care system. I think we could do it better on our own, without turning it over to the HMO's. But I believe we have to start now, one way or the other, with or without the HMO's, to take control of this monster that has been created and that is depriving average Americans of the health care that is so much needed.

In conclusion, let me say I believe we have an incredible opportunity before us. We have the opportunity to make a real difference in people's lives and improve our country for future generations. We can do it, but only if we put politics aside and put the American people first. I would say, anyone in this Senate who delays this matter from moving forward on the appropriate pace is providing a disservice to his constituents and is not the kind of American of which I or any other American could be proud.

I yield the floor.

Mr. KENNEDY. Will the Senator just yield? How much time does the Senator have?

The PRESIDING OFFICER. The Senator has 15 seconds.

Mr. KENNEDY. I will engage my colleague at another time. I see the Senator from Hawaii here and I know the Senator is about to begin.

The PRESIDING OFFICER. All time on the bill has expired at this time.

The Senator from Oregon.

Mr. PACKWOOD. I ask unanimous consent for 30 seconds to respond to the Senator from Ohio.

Mr. KENNEDY. If I get 30 seconds as well.

Mr. PACKWOOD. Mr. President, my colleague speaks about managed care as being almost corrupt. I will cite him just one statistic. In the Portland metropolitan area, 53 percent of the Medicare beneficiaries are now in managed care programs and they joined it voluntarily. You cannot compel a Medicare beneficiary to join. These people are not joining something they think is corrupt, evil and profit-minded that is going to do in their health care. They are joining because they think they get better service and quality than they do from the regular Medicare Program.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, just to address a similar issue. Would the Senator not agree with me that in some areas it has been successful; in other areas there has been a squeezing of the services to the patients and the patients have not been able to take advantage and be adequately protected?

One of the features of the Mitchell bill is it does provide for remedies for individuals if they are going to be squeezed out by the budget crunches in the development of the HMO's. If it is not necessary, it does not need to be utilized. But where it is necessary, there are additional kinds of protections which otherwise do not exist under current law.

Mr. METZENBAUM. Without the Mitchell bill there would be no protection. As a matter of fact, in response to my friend from Oregon, the fact is right at the present time many doctors are being squeezed by being told to bring in 12,000 at $2 a head. And the doctors then have to provide a different kind of medicine than they are providing now.

I think it is important that we not kid ourselves. The HMO's, in some instances, have provided useful services, but, in the long run, I think we need some of the protection provided in the Mitchell bill. Without it, I think the patients will suffer.

The PRESIDING OFFICER. All time has expired.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

The PRESIDING OFFICER. Under the previous order, the Senate will now resume consideration of H.R. 4650, which the clerk will report.

The bill clerk read as follows:

A bill (H.R. 4650) making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

The Senate continued with the consideration of the bill.

The PRESIDING OFFICER. The pending question is the committee amendment on page 2, line 15.

Mr. BROWN addressed the Chair.

The PRESIDING OFFICER. The Senator from Colorado.

AMENDMENT NO. 2491 TO THE COMMITTEE AMENDMENT ON PAGE 2, LINE 15

(Purpose: To ensure that the President of the Republic of China on Taiwan can enter the United States on certain occasions)

Mr. BROWN. Mr. President, I rise to offer an amendment to the committee amendment. I send the amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Colorado [Mr. BROWN], for himself, Mr. SIMON, Mr. LIEBERMAN, Mr. MURKOWSKI, Mr. STEVENS, and Mr. INOUYE proposes an amendment numbered 2491 to the committee amendment on page 2.

Mr. BROWN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the pending amendment, add the following new section:

"SEC . VISAS FOR OFFICIALS OF TAIWAN.

Section 4(b)(6) of the Taiwan Relations Act (22 U.S.C. 3302(b)(6)) is amended—

(1) by inserting "(A)" immediately after "(6)"; and

(2) by adding at the end the following:

"(B) Whenever the president of Taiwan or any other high-level official of Taiwan shall apply for a temporary visa to visit the United States for the purposes of:

(i) Discussions with United States federal or state government officials concerning trade or business with Taiwan or the reduction of the U.S.-Taiwan trade deficit;

(ii) Discussions with United States federal or state government officials concerning nuclear proliferation;

(iii) Discussions with United States federal government officials concerning U.S. national security or the national security of Taiwan; or

(iv) Discussions with United States federal or state government officials concerning the provision of humanitarian relief and assistance for regional disasters;

The official shall be admitted to the United States, unless the official is otherwise excludable under the immigration laws of the United States.".

Mr. BROWN. Mr. President, this amendment is not new to the Members. It is one we have considered on other bills. It is known as the visas-for-Taiwanese-officials amendment. It is proposed by myself and Senator SIMON and has been strongly opposed by a few Members of the other body and has not been retained in conference. Thus, it is offered here again.

This amendment, passed by the Senate with 94 senators voting in favor of it and none voting in opposition, is one which expresses the Senate's intent in no uncertain terms. In addition to Senator SIMON and myself, Senators LIEBERMAN and MURKOWSKI join us, as well as the distinguished senior Senator from Hawaii who has been kind enough to lend his cosponsorship and support to this particular amendment.

The amendment attempts to correct a problem that has arisen in our relations with Taiwan: Specifically, the failure of this administration to allow the leadership of Taiwan to enter our Nation and to conduct official business with our government.

To correct this problem, the amendment outlines some very distinct areas in which it is clearly in the United States interest to have a dialog with the Taiwanese leadership. It requires that the president of Taiwan and other high-level officials be admitted to the United States for discussions to reduce the trade deficit between the United States and Taiwan; for discussions concerning efforts to reduce nuclear proliferation; for discussions involving United States national security; for discussions with regard to humanitarian relief and assistance with regional disasters.

These are all areas where I think most Members or all Members would feel it is appropriate and vital for us to work with the Taiwanese. Thus, we felt it essential to make the Congress intention clear.

Generally, decisions concerning entry into the United States for high-level visitors belongs with the administration. But Taiwan has been completely prohibited by this administration from any entry into the United States for its top officials. This administration's policy led to the rather humiliating experience of when the Taiwanese president visited Hawaii this past May and was denied the right to stay overnight in Hawaii while his airplane was being refueled. Humiliations of this nature should not be repeated. Our amendment sets forth minimal reasons for which Taiwan's leadership would be welcome to enter the United States, all of which are very much in our Nation's interest.

Mr. President, since the Senate has already expressed its opinion by voting 94 to 0 in favor of this provision, I see no reason to ask for a record vote, unless the distinguished senior Senator from Hawaii feels it would be appropriate.

Mr. INOUYE. Mr. President, if my colleague from Colorado will yield.

Mr. BROWN. I yield to the Senator.

Mr. INOUYE. Mr. President, this measure has been debated at quite some length. It has been accepted by the Senate by a vote and, as noted by the author, I am one of the cosponsors and I would be very pleased to accept it as a manager on the part of the Democrats.

Mr. STEVENS addressed the Chair.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. STEVENS. Mr. President, I join in accepting the amendment of the Senator from Colorado. I am also a cosponsor, as I recall.

The PRESIDING OFFICER. Is there further debate?

Mr. INOUYE. I would like to assure the Senator from Colorado that we will do our best to see that it stays in the conference.

Mr. BROWN. I thank the chairman.

VISAS FOR HIGH-LEVEL TAIWANESE OFFICIALS

Mr. MURKOWSKI. Mr. President, I am pleased to join my good friend from Colorado, Senator BROWN, in offering this amendment to ensure that high-level officials from the Taiwanese Government will be issued visas to visit the United States to discuss issues of mutual interest to our two governments.

I find it shocking that this amendment is even necessary. The Taiwan Relations Act was passed "to promote the foreign policy of the United States by authorizing the continuation of commercial, cultural, and other relations between the people of the United States and the people on Taiwan." 22 U.S.C. 3301. This policy has been impeded because of the U.S. Government's restrictive policies on high-level visits.

I remind my colleagues that Taiwan is the world's 13th largest trading partner and the United States 5th largest trading partner. With $16.2 billion in United States exports to Taiwan in 1993, it was the United States second largest export market in the Asia-Pacific region, after Japan. It holds the world's largest foreign reserves. Taiwan is friendly, democratic, stable and prosperous. Its human rights record has steadily improved.

And how do we treat this democratic country that plays such an important part in our economic and security interests in East Asia? I believe we wrongly treat them like an international pariah. In May of this year, I was embarrassed to learn that the Department of State refused the request of the Honorable Lee Ten-hui, the freely elected leader of the democratic Republic of China on Taiwan, to overnight in Hawaii en route to Costa Rica. I believe this decision was extremely ill-advised. Similar snubs have met other high-ranking Taiwanese officials. For instance, Taiwanese officials are forced to meet with United States Government officials in hotels, rather than Government buildings, even though they are discussing issues that are of mutual interest to the people of both countries.

The U.S. Government has the opportunity to make long overdue changes to its policy. For well over a year, the United States Government has been engaged in an interagency review of its policy toward Taiwan. President Clinton could take important steps to show clear United States support for Taiwan as part of this policy review. He could begin by welcoming President Lee Ten-hui on U.S. soil for a visit. There is ample precedent for such a visit by the leader of a country with which we don't maintain formal diplomatic ties. Senator BROWN and I also would like the State Department to allow President Lee to visit our home States of Alaska and Colorado as part of our efforts to expand and strengthen ties between the people of the United States and the people of Taiwan.

President Clinton could also incorporate high-level exchanges into its new policy. I encourage President Clinton to send one of his Cabinet officers to Taiwan this fall. Fifty-three of my colleagues joined me in a letter to the President inviting him to do just that. Such visits will promote American interests in Taiwan and ensure the continued success of American business projects.

Even small, but symbolic changes, such as allowing the Coordination Council on North American Affairs to change its name to the Taipei Representative Office will show that the United States is prepared to treat the people of Taiwan with the respect they deserve.

Mr. President, I know my colleagues have supported many amendments over the past year that have had the intent of sending a signal both to the United States Government and to the people of Taiwan that the United States Senate supports positive changes in United States policy toward Taiwan. I am confident that this amendment will be added to that list. I hope the administration is listening.

The PRESIDING OFFICER. Is there further debate? If not, the question is on agreeing to the amendment.

The amendment (No. 2491) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote by which the amendment was agreed to.

Mr. BROWN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BROWN addressed the Chair.

The PRESIDING OFFICER. The Senator from Colorado.

AMENDMENT NO. 2492 TO THE COMMITTEE AMENDMENT ON PAGE 2, LINE 15

(Purpose: To make Poland, Hungary, the Czech Republic, and Slovakia eligible for allied defense cooperation with NATO countries, and for other purposes)

Mr. BROWN. Mr. President, I rise to offer an amendment, which I send to the desk.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Colorado [Mr. BROWN], for himself, Mr. SIMON, Ms. MIKULSKI, Mr. ROTH, Mr. DOLE, Mr. WARNER, Mr. DOMENICI, Mr. LIEBERMAN, Mr. HELMS, Mr. COHEN, and Mr. KOHL, proposes an amendment numbered 2492.

Mr. BROWN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

Without objection, it is so ordered.

The amendment is as follows:

At the end of the Pending amendment, insert the following new section:

SEC. . ADDITIONAL COUNTRIES ELIGIBLE FOR PARTICIPATION IN ALLIED DEFENSE COOPERATION.

(a) SHORT TITLE.—This section may be cited as the "NATO Participation Act".

(b) TRANSFER OF EXCESS DEFENSE ARTICLES.—The President may transfer excess defense articles under section 516 of the Foreign Assistance Act of 1961 or under the

Arms Export Control Act to Poland, Hungary, the Czech Republic, and Slovakia.

(c) LEASES AND LOANS OF MAJOR DEFENSE EQUIPMENT AND OTHER DEFENSE ARTICLES.—Section 63(a)(2) of the Arms Export Control Act (22 U.S.C. 2796b) is amended by striking "or New Zealand" and inserting "New Zealand, Poland, Hungary, the Czech Republic, or Slovakia".

(d) LOAN MATERIALS, SUPPLIES, AND EQUIPMENT FOR RESEARCH AND DEVELOPMENT PURPOSES.—Section 65(d) of the Arms Export Control Act (22 U.S.C. 2796(d)) is amended—

(1) by striking "or" after "United States)" and inserting a comma; and

(2) by inserting before the period at the end the following: ", Poland, Hungary, the Czech Republic, or Slovakia".

(e) COOPERATIVE MILITARY AIRLIFT AGREEMENTS.—Section 2350c(e)(1)(B) of title 10, United States Code, is amended by striking "and the Republic of Korea" and inserting "the Republic of Korea, Poland, Hungary, the Czech Republic, and Slovakia".

(f) PROCUREMENT OF COMMUNICATIONS SUPPORT AND RELATED SUPPLIES AND SERVICES.—Section 2350f(d)(1)(B) is amended by striking "or the Republic of Korea" and inserting "the Republic of Korea, Poland, Hungary, the Czech Republic, or Slovakia".

(g) STANDARDIZATION OF EQUIPMENT WITH NORTH ATLANTIC TREATY ORGANIZATION MEMBERS.—Section 2457 of title 10, United States Code, is amended by adding at the end the following new subsection:

"(g) It is the sense of the Congress that, in the interest of maintaining stability and promoting democracy in Eastern Europe, Poland, Hungary, the Czech Republic, and Slovakia, those countries should, on and after the date of enactment of this subsection, be included in all activities under this section related to the increased standardization and enhanced interoperability of equipment and weapons systems, through coordinated training and procurement activities, as well as other means, undertaken by the North Atlantic Treaty Organization members and other allied countries.".

(h) INCLUSION OF OTHER EUROPEAN COUNTRIES EMERGING FROM COMMUNIST DOMINATION.—The President should recommend legislation to the Congress making eligible under the provisions of law amended by this section such other European countries emerging from communist domination as the President may determine if such countries—

(1) have made significant progress toward establishing democratic institutions, free market economies, civilian control of their armed forces, and the rule of law; and

(2) are likely, within 5 years of such determination, to be in a position to further the principles of the North Atlantic Treaty and to contribute to the security of the North Atlantic area.

(i) CERTIFICATION REQUIRED.—Before exercising the authority in subsection (a), or in section 63(a)(2) of the Arms Export Control Act, with respect to Poland, Hungary, the Czech Republic, or Slovakia, the President shall determine and certify to the appropriate congressional committee that no such country is selling or transferring defense articles to a state that has repeatedly provided support for acts of international terrorism, as determined by the Secretary of State under section 6(j) of the Export Administration Act of 1979.

The PRESIDING OFFICER. The Senator should know that the pending question is the committee amendment. The Senator has drafted the amendment that he has sent to the desk as an amendment to the bill.

Mr. BROWN. Mr. President, I ask unanimous consent that the amendment be considered as an amendment to the pending committee amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. Mr. President, the cosponsors of this amendment include Senators SIMON, MIKULSKI, ROTH, DOLE, WARNER, DOMENICI, LIEBERMAN, HELMS, COHEN, and KOHL, in addition to myself. The amendment has also been considered previously by this body. It relates to Eastern Europe and specifically the countries of Poland, Hungary, the Czech Republic, and Slovakia, making these countries eligible for allied defense cooperation with NATO countries.

When the Brown-Simon-Mikulski-Roth amendment was considered previously, Slovakia was not included. The version before the body includes Slovakia as well as Poland, Hungary and the Czech Republic. In addition, this version differs from previous amendments in one other respect. At the end of the amendment has been added a section involving certification. I might simply read it to the body because I think it is different from what we have proposed before:

> Before exercising the authority in subsection (a),—

And here I might insert this is discretionary power for the President, it is not mandatory, but discretionary for him to use—

> or in section 63(a)(2) of the Arms Export Control Act with respect to Poland, Hungary the Czech Republic or Slovakia, the President shall determine and certify to the appropriate congressional committees that no such country is selling or transferring defense articles to a state that has repeatedly provided support for acts of international terrorism, as determined by the Secretary of State under section 6(j) of the Export Administration Act of 1979.

This modification came as a result of discussions with Members in the past conference committee who expressed concern that it would be inappropriate to include any country under this authority who has exported defense articles to terrorist countries. In addition, Members felt that excess U.S. defense articles should be restricted from countries that have made other infractions of international discipline that we would reasonably expect NATO members and potential members of NATO to have complied with. It seemed a reasonable request and appropriate to include in this amendment.

Let me simply emphasize, because we have debated this before, what I think is so important. Right now the countries of Eastern Europe are making decisions about their future. The history of Poland, as well as these other Eastern European republics, is replete with stories of domination and subjugation by other countries in the region, whether it is as in the case of Poland which was once divided between the Soviet Union and Germany in the initial stages of World War II, or whether it is the other countries that have struggled under years of foreign domination.

The local politics of these countries are pushing them to deciding whether or not they become associated with NATO.

The democratic governments of these countries want to be associated with NATO. They want to be part of NATO. They want to stand side by side with the free men and women of this world and stand up for freedom and independence and opportunity.

Actions led by our Government and joined by other NATO members have cast a cloud over the hopes for security of these fledgling democracies. The question has been raised as to whether or not membership is appropriate and whether or not we wish them to be part of NATO.

Mr. President, it is my own feeling that our reluctance to allow them to immediately move into NATO is not a manifestation of the opposition of the American people.

Consequently, this amendment carries with it an important message, a message that goes far beyond simply qualifying them for a small but significant step on the road to NATO membership.

The message is that the United States is interested in the security concerns of these nations; we are interested in establishing thriving democracies in Eastern Europe. We are interested in standing side by side with the men and women of these countries to promote a free and democratic world.

The amendment merely grants discretionary authorization. It gives the President the option to work with these countries in making them eligible for aspects of allied defense cooperation. It does not mandate any action by the executive.

Nonetheless, the Brown-Simon-Mikulski-Roth amendment is a sign: a symbol that the United States wants to move towards their NATO membership and evidence of our interest in their fate.

I hoped very much that this would have been unanimous. When it was voted on earlier, it received a 76 to 22 vote. But I hope in time it will be unanimous because these brave people of Eastern Europe want to stand with America and with NATO for freedom.

My own sense is that if we turn our back on them, if we do not encourage their movement towards NATO, we will send a signal that it is all right for other countries to once again exert their influence over the heartland of Europe. It will indicate that we may be willing to stand aside if others attempt to dominate these nations.

Mr. President, I hope that day never comes. I hope we never ever, ever again turn our back on Eastern Europe. I hope we never again send a message that it is all right for powers to try to control them, and dominate them, and subject them to their will.

What is more, I believe by making our intentions clear, by moving ahead with NATO membership, we will take the issue off the table. Instead of being an open question where countries can suggest that a course of policy for their country would be to once again exert control over Eastern Europe, if Poland, Hungary, the Czech Republic and Slovakia become members of NATO or at least move toward membership, that eventuality would not even be a subject of debate.

That, I think, is our purpose here. It is to extend a hand of friendship, extend a hand of interest, extend a hand of commitment to the people who so eagerly want to be a part of the free world. These countries, all four of them, have expressed an interest in joining NATO. All four of them have a democratic system of government. All four of them have established civilian control over the military. And all four of them I believe are on the path toward becoming contributing, substantial, and important members of NATO.

So while this is merely permission, while this is merely authority that gives the President the opportunity to include them in allied defense cooperation efforts, the symbolism of this measure is terribly important. That is why I have asked the chairman to include this amendment in the bill.

The NATO Participation Act has been considered before, but it was not held in the conference. This issue is too important to let pass. The moment is too critical. I for one will continue to stay the course, working to ensure its final enactment into law. I think the bipartisan nature of the support for this amendment is one that will result in its passage if it receives full consideration by Members of the other body.

Mr. President, I believe the amendment has been cleared on both sides. I ask the chairman if he feels it would be helpful in conference to have a record vote, or if the body has already expressed its will on this matter.

Mr. INOUYE. Mr. President, under the able leadership of the distinguished Senator from Colorado, this measure was fully debated and accepted by the Senate by a vote of 76 to 22. The Senate has spoken, and accordingly I will be most pleased to accept the amendment. I am certain my colleague, the vice chairman of the committee, will be pleased to do likewise.

However, may I suggest to the Senator that the amendment as presented will amend a section on military personnel, and it would make it a bit more difficult for the managers of this bill to serve as advocates in the conference. May I suggest that it be made part of the amendment on page 142, between lines 5 and 6?

Mr. BROWN. Mr. President, I ask unanimous consent that the amendment be placed to the bill on page 142, between lines 5 and 6.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. I thank the Senator.

Mr. INOUYE. With that, I will be most pleased to accept the amendment.

The PRESIDING OFFICER. Is there further debate? If not, the question is on agreeing to the amendment.

The amendment (No. 2492) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2493 TO COMMITTEE AMENDMENT ON PAGE 141, LINE 22

(Purpose: To express the sense of the Congress concerning the progress of reform in Bulgaria)

Mr. BROWN. Mr. President, I rise to offer an amendment to the committee amendment and ask for its immediate consideration.

The PRESIDING OFFICER. The pending question is the first committee amendment, the Chair reminds the Senator from Colorado.

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Colorado [Mr. BROWN] proposes an amendment numbered 2493 to the committee amendment beginning on page 141.

Mr. BROWN. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the committee amendment, add the following new section—

SEC. . SENSE OF THE CONGRESS CONCERNING THE REPUBLIC OF BULGARIA.

(a) FINDINGS.—The Congress finds that:

(1) In the spring of 1990, Bulgaria held its first round-table discussions and held its first free, democratic elections in June, 1990;

(2) In August 1990, the Bulgarian Grand National Assembly elected Dr. Zhelyu Zhelev as President of the Republic;

(3) On July 12, 1991 the Parliament of Bulgaria adopted the new Constitution of the Republic of Bulgaria, which proclaims that Bulgaria is governed by the rule of law;

(4) In addition, the Bulgarian Constitution establishes the principles of a market economy in Bulgaria, including Article 17 which guarantees and protects the right to property and inheritance and proclaims the inviolability of private property, and Article 19 which states that the economy of Bulgaria is based on free economic enterprise;

(5) In October 1991, Bulgaria held its second parliamentary elections;

(6) Since 1990, the Bulgarian parliament has passed more than 200 laws establishing legal protections for a free market economy including the Law and Land Ownership, the Law on the Protection of Competition, the Law on Commerce, the Law on Privatization, the Law on Accounting and the Law on Banking;

(7) The Bulgarian private sector has grown from 5% of GNP in 1990 to 22% of GNP in 1993, and by the end of 1993, 47% of Bulgarian farm land had been returned to its owners prior to 1948;

(8) In June 1990, Bulgaria established diplomatic relations with NATO and on February 14, 1994, joined the Partnership for Peace;

(9) Since October 1991, the Bulgarian minister of defense has been a civilian and this practice is scheduled to be institutionalized when the Bulgarian Law on Armed Forces is adopted in September 1994.

(b) SENSE OF CONGRESS.—Therefore, it is the sense of the Congress that:

(1) The Republic of Bulgaria is making swift and important progress to join the West and should be strongly commended for its efforts;

(2) The Republic of Bulgaria is making significant progress toward establishing democratic institutions, a free market economy, civilian control of the armed forces and the rule of law;

(3) As the President evaluates increased defense cooperation with central and eastern Europe, Bulgaria's extensive reform efforts should be given every possible consideration.

Mr. BROWN. Mr. President, I ask unanimous consent that the amendment be considered as an amendment to the pending committee amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Colorado.

Mr. BROWN. Mr. President, this is a sense-of-the-Senate amendment, and is designed to express the sense of Congress concerning the progress of reform in Bulgaria.

Mr. President, this amendment's purpose is similar to that of the previous amendment concerning the countries of Poland, the Czech Republic, Hungary, and Slovakia.

Bulgaria has made progress of a dramatic sort in developing democracy, a market economy, and civilian control of its military. Although not included in the previous amendment, nevertheless we felt a sense of the Congress amendment was appropriate and important to send a signal to the Bulgarians that we have noted their progress toward democracy, that we have noted their commitment to civilian control of the military, and that we have noted, most importantly, their strong and sincere interest in becoming part of NATO.

As a sense of Congress, it does not commit us to legislative action, but it does make it clear that we applaud their progress, that we recognize their interest in becoming part of NATO, and we express our support for continued progress.

Mr. President, I personally feel it is most important that the Bulgarians understand how much we appreciate their commitment and their interest in promoting democracy. I also believe it is important that Bulgaria not take our failure as a nation to move rapidly with regard to NATO membership as any sign that we lack an interest or concern in their future or their commitment to democracy.

Thus, this sense of Congress is a first step in conveying that message. I am certain it will not be the last as Bulgaria moves toward full NATO membership.

Mr. President, I also ask unanimous consent that the pending amendment be considered as an amendment to the committee amendment on page 142, between lines 5 and 6.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. INOUYE. Mr. President, as manager of the bill, I would be very pleased to accept this amendment, and we will do our best to see that it hangs on in conference.

Mr. BROWN. I thank the Senator.

The PRESIDING OFFICER. Is there further debate on the amendment? If not, the question is on agreeing to the amendment.

The amendment (No. 2493) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2494

(Purpose: To require a study by the JCS and the Secretary of Defense for a master plan for basing of Reserve 130's)

Mr. BROWN. Mr. President, I ask unanimous consent to lay aside the pending committee amendment. I rise to offer an amendment.

The PRESIDING OFFICER. Without objection, the pending amendment will be laid aside.

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Colorado [Mr. BROWN], for himself and Mr. CAMPBELL, proposes an amendment numbered 2494.

Mr. BROWN. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, add the following new section:

SEC. . STUDY OF C-130S.

(a) REPORT.—Within six months of enactment of this Act, the Chairman of the Joint Chiefs of Staff (JCS) shall recommend to the Secretary of Defense a master stationing plan for C-130 aircraft for the active and reserve components based on the National Military Strategy and current contingency plans of the Joint Chiefs of Staff. The report shall include:

(i) a review of existing Air Reserve Component C-130s; and

(ii) a master plan for basing future Air Reserve Component C-130s over the next twenty years.

(b) INTERIM REDUCTIONS.—No reductions of primary authorized C-130 aircraft (PAA) shall be permitted until after completion of the report.

(c) APPROVAL.—Within 2 months of receipt of the report from the Chairman of the JCS, the Secretary of Defense shall approve the final master stationing plan for C-130 aircraft and shall provide it to the congressional defense committees. The Secretary shall also provide the final report to the Air Force and to the National Guard Bureau for implementation.

Mr. BROWN. Mr. President, in recent years, it has become a practice by Members of the other body and others to deal with the location of C-130 transportation aircraft through specific legislation; that is, to have Members stand up and seek to gain, for bases within their State or region, additional aircraft.

We can all understand and appreciate this interest and this vigilance in promoting one's district or one's State. On the other hand, it strikes this Member that the decision as to where to deploy aircraft should be made by our military leaders after sufficient study and objective review, not from legislation added without either.

There is a need, of course, for military flexibility. There is also a need, I think, for objective analysis. It would be a tragedy if the location of these aircraft becomes a question of simply amending the appropriations bill when it is brought before the body.

Thus, we have proposed an appropriate study and report as to where these aircraft as they are purchased should be located. We have asked that within 6 months of the enactment of this amendment that the Chairman of the Joint Chiefs of Staff shall recommend to the Secretary of Defense a master stationing plan for C-130 aircraft for the active and reserve components based on our national military strategy and on current contingency plans for the Joint Chiefs of Staff.

Mr. President, Colorado would love to have additional C-130 aircraft. But that is not the purpose of this amendment. The purpose of the amendment is to ensure that aircraft are located where they are most needed. Colorado, just as every other State, must take its chances. We must be willing to compete for these aircraft and to ensure that they are located where they are most needed, where they will be most effective.

The purpose of this amendment is simply that; to ensure that there is an objective analysis and review that the aircraft are located where they will do the most to defend our Nation, not simply to satisfy one Member's or the other's desire to increase the aircraft located within his or her district. It will be helpful in maximizing the cost-effectiveness of U.S. defense capabilities.

The PRESIDING OFFICER. Is there further debate on the amendment?

Mr. INOUYE. Mr. President, the managers will be most pleased to accept this amendment with one modification for clarification purposes. In section B, Reductions, "No reductions of primary authorized aircraft", if the author of the measure would modify this to place between the words "of" and "primary" the term "C-130", otherwise, someone could interpret this to mean that it would cover all sorts of aircraft.

Mr. BROWN. I thank the distinguished chairman for his suggestion.

I ask unanimous consent that the amendment be so amended.

The PRESIDING OFFICER. Without objection, it is so ordered.

Would the Senator please send the altered language to the desk?

Mr. INOUYE. Mr. President, I have just been advised that the modified version of the amendment is at the desk at the moment.

With that understanding, the managers are pleased to accept the amendment.

The PRESIDING OFFICER. Does the Senator from Colorado wish to vitiate his request to modify?

Mr. BROWN. Thank you, Mr. President.

I ask unanimous consent to vitiate.

I thank the chairman.

The PRESIDING OFFICER. Without objection, it is so ordered.

Is there further debate on the amendment? If not, the question is on agreeing to the amendment of the Senator from Colorado.

The amendment (No. 2494) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote by which the amendment was agreed to.

Mr. BROWN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BROWN. Mr. President, I ask unanimous consent to lay aside the pending committee amendment in order to offer an amendment to the bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2495

(Purpose: To express the sense of the Senate concerning Lowry AFB)

Mr. BROWN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Colorado [Mr. BROWN], for himself and Mr. CAMPBELL, proposes an amendment numbered 2495.

Mr. BROWN. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, add the following new section:

"SEC. . SENSE OF THE SENATE CONCERNING LOWRY AFB.

It is the sense of the Senate that—

(a) in issuing any lease, permit or deed of conveyance for use to assist the homeless under the Stewart B. McKinney Assistance Act concerning Lowry Air Force Base, Colorado, the Secretary of Health and Human Services, representatives of the City of Denver, Colorado, representatives of the City of Aurora, Colorado and representatives of homeless providers whose applications have been approved by the Secretary of Health and Human Services should jointly determine that such use is reasonable under the redevelopment plan for Lowry Air Force Base, Colorado; and

(b) the Department of Defense and the Department of Health and Human Services, in coordination with the appropriate committees of Congress and appropriate state and local authorities, should develop a reform proposal to address the many difficulties created for local communities by existing laws relating to the loan, lease or conveyance for use of government property during the base closure process.

Mr. BROWN. Mr. President, this is a sense of the Senate and it concerns Lowry Air Force Base. The amendment attempts to address the question of the administration of the McKinney Act as it applies to Lowry Air Force Base. Included in the bill is a provision that allows exemptions from the provisions of the McKinney Act for a base other than Lowry. This amendment does not attempt to duplicate that exemption, but it expresses the sense of the Senate that there be consultation and cooperation between the Secretary of Health and Human Services and representatives of the cities of Denver, Aurora, and representatives of the homeless providers.

Mr. President, the land transfer that is underway with Lowry Air Force Base is one of the largest transfers of Federal military property to the local communities in the history of Colorado. It has enormous impact. I think, as all Members will appreciate, the process of losing a base is difficult and troublesome at best.

What we have found as Denver and Aurora have undergone the difficult process of base closure at Lowry is enormous consternation and people who feel their hands are tied as they attempt to find the best and most effective use for the base. The McKinney Act obviously has significant impact in terms of the future use of this base as well. Provisions of the McKinney Act may require significant changes from current land use patterns in that part of the community.

Lowry Air Force Base was originally located on the outskirts of Denver, some distance away from housing. Over the years, it has been encompassed, engulfed and surrounded by an attractive neighborhood as well as a variety of other uses that differ significantly from its original surroundings. Our amendment simply makes it clear that the Senate wishes for full communication and coordination to occur between Denver and Aurora, the homeless providers and the Secretary of Health and Human Services. All determinations concerning the future use of Lowry AFB should be made jointly. We believe that by working together, they can improve the transition and make the adjustments to Lowry ultimately a benefit for the community. In addition, their coordination will provide a great opportunity not only for housing the homeless, but ensure uses for the base compliment the existing land use patterns of the community.

I believe this amendment has been cleared on both sides.

The PRESIDING OFFICER. Is there further debate?

Mr. INOUYE. Mr. President, I suggest the absence of a quorum.

The assistant legislative clerk proceeded to call the roll.

Mr. BROWN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. I ask unanimous consent to set aside the pending amendment.

Mr. INOUYE. Mr. President, may I ask my friend from Colorado to temporarily withhold his request. I have a very important request to make.

UNANIMOUS-CONSENT AGREEMENT

Mr. INOUYE. Mr. President, I ask unanimous consent that all floor amendments in order to H.R. 4650, the defense appropriations bill, must be offered by 7 p.m. this evening; that at the hour of 6:50 p.m., Senator STEVENS will be recognized to offer amendments for Republican Senators who have not had a chance to offer, and at 6:55 p.m., Senator INOUYE be recognized to offer amendments for Democratic Senators who have not had a chance to offer; that no votes occur prior to 9 p.m. this evening; that the two leaders or their designees have until 9 p.m. to offer amendments that are in response to possible nonrelevant amendments that may be offered; that when the Senate considers the Nunn-Mitchell Bosnia amendment and the Dole Bosnia amendment No. 2479, there be 2 hours for debate on both amendments under the control of Senators DOLE and NUNN, or their designees, with an additional 30 minutes under Senator MCCAIN's control; that when all time is used or yielded back, the Senate vote on the Nunn-Mitchell amendment, followed by a vote on Senator DOLE's amendment No. 2479; that no amendments be in order to either of these two Bosnia amendments; that when the bill has been read a third time the Senate vote on passage of the bill; that the Senate insist on its amendments, request a conference with the House on the disagreeing votes of the two Houses, and the Chair be authorized to appoint conferees, with the preceding all occurring without any intervening action or debate; that the Senate resume consideration of S. 2351, the health care reform bill, at 9 a.m. on Thursday, August 11, for 4 hours of debate only, with the time equally divided between the two leaders, or their designees, and that at the conclusion of that time, the Senate resume consideration of H.R. 4650, the defense appropriations bill.

The PRESIDING OFFICER. Is there objection?

Mr. STEVENS. Mr. President, I am informed that there is no objection on this side at this time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. Mr. President, I had intended at this time to offer an amendment that dealt with a study of the transportation of chemical weapons. More specifically, included in the bill as it came over from the House is a provision that prohibits a study on the feasibility of transportation of unitary chemical weapons.

I thought that it was appropriate to study a slightly different item related but dissimilar—that is, the transportation and destruction of neutralized portions of unitary chemical weapons. The difference, quite clearly, is that one is neutralized and not as able to do damage. The other, a unitary chemical weapon being transported, has a much greater potential for damage. The problem is basically this: The Defense Department has been unsure that the prohibition on the study of transportation of unitary chemical weapons which was included in appropriations legislation prevents them from studying the feasibility of transportation and destruction of neutralized portions of those unitary chemical weapons. Defense Department lawyers, quite naturally, want to follow the law, want to follow the guidelines, and are cautious in this regard.

My intention simply had been to clarify the existing provision in the bill by offering an amendment to ensure that studying transportation and destruction of parts of those weapons that have been neutralized already is permitted.

In discussions of this matter with the distinguished chairman and his staff, I have been assured that their intention is to allow the study of the transport of neutralized portions of unitary chemical weapons. My intention would be to include within the RECORD a colloquy with the chairman that deals with this clarification, rather than offering the amendment.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. INOUYE. Mr. President, I would like to express my gratitude and appreciation for the accommodation of the Senator from Colorado. I think we can work this out.

Mr. BROWN. I thank the chairman for his help.

I yield the floor, Mr. President.

The PRESIDING OFFICER. The Senator from Hawaii.

If the Senator will withhold one moment, if I might inquire of the Senator from Colorado his intentions with respect to his amendment No. 2495.

Mr. BROWN. Mr. President, the amendment, we believe, will be cleared on both sides. There is one Member from whom we have not been able to get a final word on that clearance. My hope is that the body will proceed with other matters while we attempt to get that cleared.

Mr. INOUYE. I ask unanimous consent that that amendment be temporarily set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

MODULAR AIRBORNE FIREFIGHTING SYSTEMS [MAFFS]

Mrs. FEINSTEIN. I would like to engage the distinguished chairman of the Defense Appropriations Subcommittee in a brief colloquy regarding an important National Guard equipment issue: replacement of the Modular Airborne Firefighting System [MAFFS].

As a Senator representing a state which has been especially hard-hit by the damage and destruction of wild fires, I am particularly aware of the importance MAFFS play in National Guard and U.S. Forest Service fire fighting efforts. In 1992 for example, MAFFS were used on 163 occasions to successfully combat some of the 65 major forest fires that burned more than 623,420 acres of land and caused $285 million in damage.

As the Chairman knows, MAFFS are self-contained, reusable fire fighting systems carried on National Guard C–130 aircraft that supplement commercial firefighting aircraft. There are currently eight MAFFS located in various locations throughout the county, each capable of delivering 30,000 pounds of retardant in just 7 seconds.

Through the use of MAFFS, the National Guard has been able to prevent immeasurable damage to lives, property, forest lands, and scenic areas. Between 1973 and 1993, National Guard units completed more than 2,600 missions with MAFFS that delivered nearly 8 million gallons of retardant. In fact, all eight MAFFS are currently being used in the west to combat wild fires in California, Oregon, Washington and several other States. Every region of the country is protected by the critical mission that MAFFS perform.

Unfortunately, the MAFFS in operation today are more than 20 years old; the technology dates to 1971 and there are consistent problems with maintenance and repair of the systems. The estimated cost to replace the eight MAFFS is $15 million—each unit costs $1.5 million, with an additional $3 million needed to re-engineer the outdated technology.

I know that the distinguished Chairman understands the importance of MAFFS in firefighting efforts, and hope that the Chairman will consider the need to replace the National Guard's MAFFS during conference on this bill.

Mr. INOUYE. I agree with the distinguished senior Senator from California that Modular Airborne Firefighting Systems are an important resource that the National Guard and the U.S. Forest Service use to combat wild fires throughout the country. I also understand that the MAFFS currently in operation today are more than 20 years old and are in need of replacement.

The Senator from California is aware that this bill provides $180,000,000 of undesignated funds for the National Guard to procure any equipment it needs to meet both its federal and state missions. I can assure the Senator from California that I will do everything I can to ensure the National Guard funding for miscellaneous equipment will not go below the Senate level. I am also hopeful that when fiscal year 1995 equipment funds are made available to the National Guard they will see the urgent need to replace the eight MAFFS you have identified.

Mrs. FEINSTEIN. I thank the distinguished Chairman very much for his consideration of this very important issue.

FUNDING FOR THE CONVERSION OF FORT ORD

Mrs. FEINSTEIN. I would like to engage the distinguished Chairman of the Defense Appropriations Subcommittee in a brief colloquy regarding defense conversion funding for Fort Ord.

Fort Ord has a long and illustrious history as one of the nation's largest military facilities. Named in honor of Maj. Gen. Edward Ord, who commanded Union troops during the Civil War, Fort Ord encompasses 28,000 acres on the Monterey Peninsula, where it has served as an important Army staging area for 77 years.

At the peak of World War II, when it served as a staging area for troops fighting in the Pacific theater, more than 50,000 troops were stationed there. It played an important role in the Korean and Vietnam wars as well. From 1972 through 1993 it was the home of the 7th Infantry Division, and as recently as last year, over 15,000 troops were stationed there.

As my colleagues can well realize, the closure of this facility has had a devastating impact on the surrounding communities of Monterey, Seaside, Marina, as well as other cities up and down the Monterey Peninsula. In response to the closure, the California State University system has put together an ambitious plan to utilize the existing facilities to develop a new university campus, an initiative that I strongly support.

Last year, Congress expressed its support and provided $15 million to begin the conversion, and I thank Chairman Inouye for everything that he did to make that possible. I am hopeful that $18 million can be provided in 1995 to continue the work. These funds are critical to the successful conversion of Fort Ord from a military base to a world-class university, that when completed will serve 25,000 students from all over the nation.

This project is moving full steam ahead. On July 8 of this year, Secretary of Defense William Perry personally attended the ceremony transferring the title of the first of three land parcels to the University. The other two parcels will be transferred once they are deemed safe for use.

The defense conversion funds will be used primarily for converting buildings into classrooms, laboratories and administrative offices, and bringing the existing buildings up to both seismic, and health safety (i.e. asbestos abatement) codes. Funds will also be used to provide for accessibility according to Americans with Disabilities Act guidelines. No funds will be spent on overhead, which are being funded by the State in a cost-sharing arrangement. I strongly believe that we must keep this project on track, and a continued Federal commitment is vital to that end.

I am hopeful that the Chairman will be able to review this matter in conference and address the continued need of defense conversion funding for Fort Ord.

Mr. INOUYE. The distinguished Senator from California can be assured that I will indeed review this matter in conference with the House, and will address Fort Ord's need for continued defense conversion funding.

Mrs. FEINSTEIN. I thank the distinguished Chairman very much for his consideration.

Mr. INOUYE. Mr. President, I have an amendment proposed by Mr. GORTON, Mrs. MURRAY, and Mr. INOUYE.

The PRESIDING OFFICER. Does the Senator intend to offer this as an amendment to the committee amendment or would he want the committee amendment set aside?

Mr. INOUYE. Mr. President, I ask unanimous consent that we set aside the committee amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2496

(Purpose: To impose an additional condition regarding the requirement to reimburse the Mucklesoot Indian Tribe of Auburn, Washington)

Mr. INOUYE. Mr. President, I send to the desk an amendment proposed by Mr. GORTON, Mrs. MURRAY, and Mr. INOUYE, and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for himself, Mr. GORTON, Mrs. MURRAY, and Mr. INOUYE, proposes an amendment numbered 2496.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 19, line 19, after the period, insert the following: "The Secretary may not pay the Muckleshoot Indian Tribe the reimbursement otherwise required by the preceding sentence unless the Tribe waives in writing all claims that the Tribe may have against the United States or any agency or official of the United States (in the official capacity of that official), against the State of Washington or any agency or official of the State of Washington (in the official capacity of that official), and against the City of Seattle, Washington, or any agency or official of the City of Seattle, Washington (in the official capacity of that official), regarding the disposal of the Puget Sound Naval Air Station.".

AMENDMENT NO. 2496

Mr. GORTON. Mr. President, I am offering an amendment that would place an additional condition on the reimbursement of funds to the Muckleshoot Indian Tribe for its expenses in developing and submitting a reuse base for Naval Station Puget Sound. Specifically, my amendment would require that the tribe forfeit its ability to file suit against local, State or Federal Government in writing before receiving this reimbursement. I understand that the amendment has been agreed to on both sides.

This issue began with the 1991 Base Closure Commission's recommendation to close Naval Station Puget Sound. Because the base sits on Lake Washington near downtown Seattle, a number of groups have expressed interest in acquiring portions of its real property. Beginning shortly after the Commission's recommendation, the city of Seattle, in conjunction with the local Navy office, began work on a community reuse plan that sought to accommodate as many groups as possible. After numerous hearings and revisions, the city arrived at a plan that accommodates two Federal agencies, the McKinney Act, and the various concerns of the surrounding community. At the same time, the Muckleshoot Indian Tribe was developing a separate reuse proposal.

While the Department of the Navy will ultimately decide which plan is implemented, the Department's decisions are guided by a Federal screening process that prioritizes requests. That process asks that Federal entities be considered before the McKinney Act and State and local governments.

Various Federal agencies have disputed the standing of Indian tribes in this process. Some agencies, such as the Bureau of Indian Affairs, have suggested that an Indian tribe proposal represented by a Federal agency be considered with other Federal requests. Others, such as the Department of Navy, have determined in accordance with their interpretation of U.S. law that Indian tribes should be considered as State and local governments.

The administration has yet to decide which of these interpretations the Department of the Navy is to follow. As a result, the Department of the Navy has delayed choosing between the proposals for Sand Point. Regardless of its decision, however, I understand that the Muckleshoot Indian Tribe developed its proposal while under the impression—from Federal agencies—that Indian tribes would be considered as Federal agencies. In the event that the Navy does not give tribes that status, this bill will compensate the Muckleshoots by as much as $600,000 for the cost of developing and submitting a proposal. In the end, this language will help the city of Seattle, the Navy and the Muckleshoot Indian Tribe reach an agreement acceptable to all sides.

The amendment I am offering would simply clarify this language to prevent the Muckleshoot Indian Tribe from receiving this compensation if it also chooses to file suit against a Federal or State Government or the city of Seattle. Law suits have tied up the reuse of other military bases while imposing significant legal expenses on all parties. A lawsuit on the final reuse of Sand Point would, in my opinion, be one of the worst possible outcomes of this long process. It would cost the taxpayers, it would cost the tribe, and it would leave the base closed, but not surplussed.

Mr. President, I wish to thank the distinguished Senator from Hawaii for including the reimbursement provisions in this bill and agreeing to this amendment. If the White House chooses to emphasize the importance of community reuse proposals, as this body has directed it to on some occasions, I believe that it is probable that the Muckleshoot Indian Tribe will not have a Federal claim to Sand Point. In that event, this reimbursement will discourage the tribe from filing suit, while compensating the tribe for its real expenses in developing and submitting a proposal. This is in the very real interest of the city of Seattle.

Mr. INOUYE. Mr. President, this amendment has been cleared by both sides and approved and accepted.

The purpose is to impose an additional condition regarding the requirement to reimburse the Muckleshoot Indian Tribe of Auburn, WA.

The PRESIDING OFFICER. Is there further debate on the amendment?

If not, the question is on agreeing to the amendment.

So the amendment (No. 2496) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. INOUYE. I ask unanimous consent that the prior vote be also reconsidered and tabled.

AMENDMENT NO. 2497

(Purpose: To limit the use of funds for deactivating or reducing Army ROTC units)

Mr. INOUYE. Mr. President, I send to the desk another amendment proposed by Senator DANFORTH and Senator BOND.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for himself, Mr. DANFORTH, and Mr. BOND, proposes an amendment numbered 2497.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . Funds appropriated for the Army by this Act may not be expended to deactivate or to take any action necessary to deactivate any Army Reserve Officers' Training corps unit, or to reduce any such unit for the purpose of eventually deactivating that unit, unless the Secretary of the Army has determined that the unit has been placed in, and has been evaluated for a full evaluation period under, the Effective Management Program of the Army Cadet Command.

Mr. DANFORTH. Mr. President, I rise today to offer an amendment to rectify what I believe is a very unfair and arbitrary decision made by the Department of the Army last week. On August 2, the Army announced that it would deactivate 18 Army Reserve Officers' Training Corps units at colleges and universities throughout the country. Seventeen of the units that the Army will deactivate had been placed in the Army Cadet Command's Effective Management Program [EMP] and were the subject of long reviews. The Army Cadet Command uses the EMP program to evaluate and assist units which suffer from declining enrollment. After an evaluation period of between 2 and 4 years, units not achieving full viability are recommended for closure. According to the Army, "using the EMP process for closure purposes provides a definable, defensible DOD supported logic for these actions." Mr. President, I recognize that military budgets are shrinking and that each of the services must take extraordinary steps to cut spending. The Cadet Command's EMP program appears to be a reasonable way to cut back ROTC units which have outlived their usefulness.

For one of the 18 schools, however, the Army did not utilize the EMP. The Army announced that Washington University in St. Louis, MO, would lose its ROTC unit "under the provision of the contract agreement between the University and the Secretary of the Army." For Washington University, the Army did not undertake a thorough review. It did not put its unit on evaluation status or provide assistance to correct any deficiencies in the program. It did not give Washington University 2 to 4 years to rebut allegations against its program or to demonstrate its commitment to the ROTC program. Instead, the Army avoided a thorough review and, to the great surprise of Washington University, elected to deactivate the ROTC because of alleged contract violations. Mr. President, this is the first time the Department of the Army has ever attempted to close an ROTC unit based on contract violations. If a drop in numbers of participants—an easily measured occurrence—deserves a thorough, 2 to 4 year review, then certainly alleged contract violations should be given a comparable review and an equal opportunity for rebuttal and for rectification. In the case of the Army's actions towards Washington University, the lack of a formal review process has permitted the Army to begin the process of deactivating a unit based on erroneous and very poor arguments which would not—and will not—survive a serious review.

The Army alleges three contract violations. The first alleged contract violation, according to the Army, is that the ROTC facilities at Washington University are not on the Washington University campus. There is no section of the contract which specifically requires that an ROTC facility be on campus. This alleged violation must relate to section 2(b) of the contract between the Army and Washington University, signed April 8, 1965. That clause requires Washington University "to make available to the Departments of Military Science the necessary classrooms, administrative offices, office equipment, storage space, and other required facilities in a fair and equitable manner in comparison with other departments of the institutions."

Mr. President, the Washington University ROTC facility is on campus and has been in the same location on campus for the last 16 years. The University owns the Academy building in which Army ROTC is housed. The ROTC building is directly across the street from the classrooms and offices of the School of Engineering and it is located in a neighborhood where many Washington University students live. To provide ROTC and other students with easy access to the north side of campus, the university built a walkway over Milbrook Boulevard, which provides a direct link between the Academy building and the School of Engineering. This walkway is similar to the underpass constructed by the university to connect the south side of the university to student dormitories, recreational fields, and the Department of Music facilities. This allegation by the Army is simply incorrect. if the Army truly had a problem with the location of the ROTC building, one would think it would have taken considerably less time that 16 years to voice objections.

The second allegation is that Washington University does not provide academic credit for ROTC courses. This requirement is found in section 2(d) of the contract: "The governing authorities of this institution agree * * * to grant appropriate academic credit applicable toward graduation for successful completion of courses offered by the Department of Military Science."

Once again, this allegation is not accurate. The university leaves it up to individual schools within the university to determine whether or not ROTC courses should be provided academic credit. The School of Engineering provides up to three course credits for ROTC programs, and is considering expanding that to six. Those courses count as electives and are not factored into students' grade point averages [GPAs]. The School of Arts and Sciences does not provide course credit. That is Washington University's interpretation of appropriate credit.

Washington University's policy regarding course credit is better for its ROTC students than the policies of several other schools and is similar to many others. Some universities offer no course credit at all for ROTC courses. Bucknell University, Princeton University, Syracuse University, the Clairmont Colleges, the Massachusetts Institute of Technology, Georgetown University, and George Mason University are among those institutions which fit into this category. Several place restrictions on course credit. Neither Rutgers University nor the University of Pennsylvania include ROTC courses in a cadet's GPA. Davidson gives credit for only one ROTC course. The University of Washington does not award credit towards graduation for ROTC courses taken in the first two years of college. The University of Indiana offers activity credit but not regular course credit. Some universities give discretion to the university's colleges in a similar manner as Washington University. The University of Cincinatti, Temple University, the University of Pittsburgh, and the University of Michigan all follow that approach.

The third allegation is that Washington University does not support the ROTC program. The Army alleges that because Washington University includes a disclaimer in certain university publications pointing out the difference between university policy and DOD policy regarding sexual orientation, Washington University is somehow not supporting the ROTC program. First, I can find nothing in the contract which requires that the university provide general support for the ROTC program. It is required only to meet the specific terms of the contract. Second, to read this disclaimer as a serious lack of support of ROTC is misguided at best, and at worst can be viewed as an attempt to scapegoat Washington University for having a policy on sexual orientation which is different from the military's.

Washington University's nondiscrimination statement reads: "Washington University encourages and gives full consideration to all applicants for admission, financial aid, and employment. The University does not discriminate in access to, or treatment or employment in, its programs and activities on the basis of race, color, age, religion, sex, sexual orientation, mational origin, veteran status, or disability. Present Department of Defense policy governing ROTC and AFROTC programs discriminates on the basis of sexual orientation; such discrimination is inconsistent with Washington University policy."

Mr. President, this is a statement of fact. This does not demonstrate a lack of support for the ROTC program. Lack of support would be kicking ROTC off campus. This is what Pitzer College, California State University-Chico, and California State University at Sacramento did. It simply represents an attempt to deal with a contradiction between university and Pentagon policy in a responsible, respectful manner. And Washington University is not alone in utilizing disclaimers. Rutgers, Bucknell, Princeton Claremont, Cincinatti, and Pittsburgh all have disclaimers.

Washington University has supported the ROTC program since 1919. It is the only Army ROTC program in the St. Louis area, which is home to several universities. In February of 1970, protesting students fire-bombed the ROTC building and burned it down. Despite strong student sentiment to the contrary, the University committed itself to keeping ROTC on campus. And over the past several years, as student and faculty sentiment has clashed with DOD policy on the issue of sexual orientation, Washington University has issued a disclaimer rather than taking more severe action. Washington University has supported the Army. And now, instead of giving Washington University ample opportunity and due process to rebut and respond to the allegations, it has made a quick decision to destroy the 75 year relationship.

Mr. President, in summary, these three allegations offer no good reason to deactivate the ROTC program at Washington University. Washington University behaves no differently than many other schools which continue to have ROTC programs. For the Army to suggest otherwise is simply inaccurate and unfair.

Mr. President, my amendment would not permit the Army to use these very shoddy allegations to deactivate ROTC at Washington University, or at any other university. It would require the Army to utilize a fair process to deactivate all ROTC units. Cadet Command already has such a procedure. In the Army's words, "using the EMP process for closure purposes provides a definable, defensible DoD supported logic for these actions." This amendment would require the Army, if it does see fit to review the ROTC program at Washington University, to place the unit in the EMP and give it the same degree of consideration and support that it has given other units. If, at the end of the EMP 2- to 4-year evaluation period (the full evaluation period), it feels ROTC should be discontinued at Washington University, then at least it will have given the University a fair chance to rebut allegations it views as unfair and to demonstrate its intense interest in continuing the program. Anything short of that would be grossly unfair to an institution which takes its 75-year relationship with the Army very seriously and expects the same in return.

Mr. President, I ask unanimous consent to print in the RECORD a memorandum dated August 2, 1994.

There being no objection, the memorandum was ordered to be printed in the RECORD as follows:

INFORMATION FOR MEMBERS OF CONGRESS

SENIOR RESERVE OFFICERS' TRAINING CORPS CLOSURES

The Department of the Army announced today that 18 Army Reserve Officers' Training Corps units at colleges and universities throughout the country will be deactivated. Each year, the U.S. Army Cadet Command does an Annual Program Review and assessment of schools on the Effective Management Program [EMP]. The EMP is a program Cadet Command uses to assist units which are marginally effective. Each year, all programs are reviewed. As a result of that review, some units are put on evaluation status and provided positive assistance. After an evaluation period (usually 2-4 years), those units not achieving full viability are recommended for closure. The program also identifies potentially strong markets for possible ROTC unit establishments.

As a result of this year's review, 18 ROTC programs will be deactivated. Based upon the EMP review, 17 of these units have exhibited a downward trend in many of the performance categories, including officer production, cadet enrollment, and academic disciplines of officers commissioned. One of the 18 units will close under the provision of the contract agreement between the University and the Secretary of the Army. Of the 18 units to be deactivated, seven are host schools and 11 are extension centers (smaller units that work under the direction of a nearby "host" unit). These extension centers have an average of three ROTC instructors assigned, and commissioned an average of four officers per school during the past years (versus a target of ten).

This year's review also identified 10 host units for downgrade to extension centers. Consequently these units will be missioned and resourced at a lower level commensurate with their performance and market size. Additionally, the Annual Program Review identified one extension center for upgrade to host status, moving a host position to another location, and an opening of an extension center.

Recognizing that some hardships to both schools and cadets will result from these closures, the Army will provide options for completing ROTC and obtaining a commission to all cadets in their junior and senior years and all scholarship cadets. Cadet Command will notify and assist each affected cadet during the School Year 1994-1995. Senior officers from Cadet Command will deliver notification letters to the presidents of the affected schools on August 3, 1994.

When these reductions are completed, the Army will still have 316 units with representation in all 50 states, the District of Columbia, Puerto Rico, and Guam. Once closures are completed at the end of School Year 1994-1995 (there is normally a 1 year lag between notification and actual closure), the opportunity to participate in ROTC will remain in each State.

Last year, the Army leadership approved the closure of 17 schools at the end of School Year 1993-1994. Using the EMP process for closure purposes provides a definable, defensible DoD supported logic for these actions. Cadet Command works diligently to support these "at risk" programs and the closure decision will not be unexpected. The closures are an integral part of the overall re-engineering of Cadet Command. It is efficient to close our least productive units and redirect resources to move viable programs.

This action will have no effect on the Army's Junior Reserve Officers' Training Corps (JROTC) program which is conducted at the high school level.

Furnished by Office, Chief of Legislative Liaison.

Mr. INOUYE. Mr. President, this amendment has been cleared by both sides and is acceptable.

The PRESIDING OFFICER. Is there further debate? If not, the question is on agreeing to the amendment.

The amendment (No. 2497) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. INOUYE. I ask unanimous consent that the prior vote be also reconsidered and tabled.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2498

(Purpose: To require a preference for the use of local and small businesses for environmental restoration and remediation of Kaho'olawe Island, Hawaii)

Mr. INOUYE. Madam President, I send to the desk an amendment proposed by Senator AKAKA.

The PRESIDING OFFICER (Mrs. BOXER). The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. AKAKA, proposes an amendment numbered 2498.

Mr. INOUYE. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. 8121. PREFERENCE FOR LOCAL AND SMALL BUSINESSES TO CARRY OUT ENVIRONMENTAL RESTORATION AND REMEDIATION OF KAHO'OLAWE ISLAND, HAWAII.

(a) PREFERENCE REQUIRED.—In entering into contracts with private entities to carry out environmental restoration and remediation of Kaho'olawe Island, Hawaii, and the waters surrounding that island, the Secretary of the Navy shall, to the maximum extent practicable, give a preference to small business concerns and small disadvantaged business concerns located in the State of Hawaii. In giving the preference, the Secretary shall give especial preference to businesses owned by Native Hawaiians.

(b) DEFINITIONS.—In this section:

(1) The term "small business concern" means a business concern meeting the requirements of section 3 of the Small Business Act (15 U.S.C. 632).

(2) The term "small disadvantaged business concern" means the business concerns referred to in section 7(d)(1) of such Act (15 U.S.C. 637(d)(1)).

(3) The term "Native Hawaiian" means any individual who is a descendent of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now comprises the State of Hawaii.

Mr. AKAKA. Madam President, I offer an amendment to H.R. 4650, the Department of Defense appropriations bill for fiscal year 1995. The amendment I am offering would provide preference to small and minority-owned businesses in Hawaii for the restoration and remediation of Kaho'olawe, Hawaii.

Kaho'olawe holds a special place in the hearts of Hawaii's people. This island, devastated by years of bombings, still contains many culturally and historically significant resources. Ancient burial places, fishing shrines, religious monuments of old Hawaii can still be found on Kaho'olawe. Fortunately, the island was placed on the National Register of Historic Places.

The restoration and remediation of Kaho'olawe is important to the people of Hawaii, particularly to the Native Hawaiian community. In fact, the State of Hawaii recently designated the island as a cultural preserve. Thus, it is only fitting that preference be given to native Hawaiian-owned business and other small businesses in Hawaii, who have the cultural sensitivity in restoring and preserving Kaho'olawe.

Such preference is not new or unique. Native American groups have also been given preference for similar projects, and preference to local firms has also been given to communities affected by base closure or realignment. Given the cultural significance of Kaho'olawe to the people of Hawaii, it is only fair and fitting that we also extend a preference to the island's cleanup to its people.

Mr. INOUYE. Madam President, the purpose of this amendment is to provide preferential treatment to small businesses in the cleanup of the island of Kaho'olawe.

This amendment has been studied and approved by the managers.

The PRESIDING OFFICER. Is there further debate?

If not, the question is on agreeing to the amendment.

So the amendment (No. 2498) was agreed to.

Mr. INOUYE. Madam President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Alaska.

AMENDMENT NO. 2499

(Purpose: Limitation on Compensation)

Mr. STEVENS. Madam President, I send an amendment to the desk on behalf of Senator NICKLES.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Alaska [Mr. STEVENS], for Mr. NICKLES, proposes an amendment numbered 2499.

Mr. STEVENS. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 11, line 19, before the period, insert the following: ": *Provided further*, that the Undersecretary of Defense for Policy, shall, not later than October 15, 1994, transmit, in unclassified and classified forms, the Rand Corporation Study, published on or about December 1993, on The U.S. Role in Possible Middle East Peace Settlements to the congressional defense, intelligence and foreign affairs committees."

Mr. STEVENS. Madam President, I ask consideration of the amendment. It has been cleared on both sides in amendment form.

The PRESIDING OFFICER. Is there further debate?

Hearing none, the question is on agreeing to the amendment.

The amendment (No. 2499) was agreed to.

Mr. STEVENS. Madam President, I move to reconsider the vote.

Mr. INOUYE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. STEVENS. Madam President, if I may speak to Members on my side, I have now until the hour of 6:50 p.m. to offer amendments on behalf of Republican Senators. We have no more ready to be offered at this time. I am hopeful that the Members and their staffs will be aware of the deadlines that have been set for offering of amendments and will bring them to the staff and to me as soon as possible.

Mr. INOUYE. Madam President, I would like to also advise Members on this side of the aisle that we have until 6:55 p.m. to offer amendments. Furthermore, I would like to point out that we hope to finish this measure tomorrow. If that is the case, I hope amendments will be brought up as soon as possible.

Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MCCAIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. MCCAIN. Mr. President, in the next few weeks, Congress—at the President's behest—may determine for all time not only the availability, but the quality of health care in America. The magnitude of this undertaking is so immense, the risks so consequential, and the potential for doing harm to a system that, with all its imperfections, remains the envy of the world is so evident that it should humble us all.

I have no doubt that every Member—in both Houses and on all sides of the debate—is motivated to act by the very best of intentions. But neither the nobility of the cause nor the sincerity of its advocates necessitates our careless disregard for the axiom of governance that our past experiences have shown to be the most sound principle for organizing the affairs of a great nation: the least government involvement practical is preferable.

Alexis de Tocqueville, to whose wise observances we often turn for insights about our national character, illuminated the pivotal importance of a minimally intrusive government to the success of democracy in America by envisioning the relationship between government and the governed in the event that democracy failed in America. He wrote:

> [Government] will be an immense and tutelary power, which takes upon itself to secure [the people's] gratifications, and to watch over their fate. That power is absolute, minute, regular, provident and mild. It would be like the authority of a parent, if, like that authority, its object was to prepare men for manhood; but it seeks, on the contrary, to keep them in perpetual childhood. For their happiness such a government willingly labors, but it chooses to be the sole agent and the only arbiter of that happiness; it provides for their security, foresees and supplies their necessities, facilitates their pleasures, manages their principal concerns, directs their industry, regulates the descent of their property, and subdivides their inheritances. What remains, but to spare them all the care of thinking and all the trouble of living?

From the outset of the health care debate, I have adhered to a set of principles that I believe are essential to constructive reform of our health care system. Reform should maintain the high quality of American health care; expand access for those who are currently excluded from the system; allow those who have insurance to keep it if they become ill or lose their job; preserve choice and strengthen security for all Americans. The distinguished Majority Leader's bill, which we are now considering, does not meet these criteria for a number of reasons which I will detail in subsequent debate.

But it is that first principle of governance, that the least government involvement practical is preferable, and which I believe the Majority Leader's bill seriously violates, that forms the basis of my opposition to Senator MITCHELL and the President's approach to health care reform.

Let me briefly explain why. The new taxes and employer mandates proposed by Senator MITCHELL and the President will be used to finance an enormous Government takeover of the health care system. They will pay for a huge new entitlement program that will subsidize at least 100 million people—almost half of the country. Subsidies would be available to some families with incomes up to 300 percent of the poverty line. Families of four with income of $44,000 would be entitled to a subsidy.

Additionally, the bill creates three other new entitlement programs at an estimated cost of $172 billion, including Medicare prescription drugs, a new long-term care program, and a new government-run medical education program funded by a tax on all health insurance plans.

Under Senator MITCHELL's plan, at least 20 new bureaucracies will be created. They include: the National Health Care Cost and Coverage Commission; the National Health Benefits Board; State health insurance purchasing cooperatives; Federal health insurance purchasing cooperatives established by OPM; a National Quality Council; a Worker's Compensation Commission; a National Council on Graduate Medical Education; State Consumer Information and Advocacy Centers; Quality Improvement Foundations; a National Guarantee Fund for Multi-State Self-Insured Plans; State guaranteed funds; a Biomedical and Health Services Research Fund; and mandatory State alternative dispute resolution.

The President and Senator MITCHELL's plan imposes substantial new Government regulation. In addition to the employer mandate, it would impose a complicated new tax on health plans whose premiums increase faster than the Government allows. It will operate in a manner similar to price controls. The plan also bans self-insurance for firms with fewer than 500 employees, and imposes a standard benefits package which limits consumer choice.

In short, Mr. President, for those of us who worry about excessive Government interference in one of the most personal decisions any American will ever make—choosing health care for his or her family—there is a great deal for us to be concerned about in the President's and Senator MITCHELL's health care plan.

I do not question the motives of the proponents of this plan. I am confident that theirs is a principled advocacy motivated by a belief that a huge Government role is necessary to reform those aspects of our health care system which we all agree need to be reformed. Again, I do not question anyone's motives. I only question their solution.

Likewise, ours is a principled opposition based, as I have said, in our profound skepticism about new and expansive Government activism in regulating America's health care system. As the debate on health care reform proceeds, much discussion will be focused by necessity on many arcane and complex aspects of various reform proposals. But we should not lose sight, Mr. President, that at the core of this debate is a fundamental disagreement about the extent of Government involvement that is necessary to make a good system better.

That is, in the end, most of what this debate is all about. And I deeply resent attempts by proponents of the President's approach to ascribe all manner of devious and nefarious motives to opponents of the President's plan. Again, this is a principled disagreement. We opponents believe just as sincerely in our plan to reform America's health care system, as the President, First Lady and their allies in the Congress believe in their plan.

Last week, the distinguished majority leader appealed to all Senators to avoid casting aspersions on the intentions of any one involved in this historic debate, on either side, and to keep partisan bickering to a bare minimum; that the issue was too important and the moment too consequential to be settled through personal attacks and political posturing. I could not agree more.

Yet, I would have hoped that the majority leader's plea would have been heard on both sides of the aisle, at both ends of Pennsylvania Avenue. Apparently, that was not the case.

Today, our Democratic colleagues denied Senator HELMS' request to vitiate the yeas and nays on an amendment which he proposed. If there was anything other than a political motive for opposing his unanimous-consent request it was not apparent to me.

Yesterday, the First Lady, Mrs. Clinton, was reported to have described opponents of the President's plan as a "small core of people" who want to prevent America from being a "compassionate and caring nation." She went on to apparently link those with different views on health care reform from hers to efforts to inject "hatred * * * into our political system." Lastly, she questioned the motives of one of our colleagues by name.

I would point out to the First Lady, that in every poll I have seen, the American people also oppose the President's health care plan. Does this mean that the majority of Americans lack compassion or are morally bankrupt?

I find the First Lady's unfair and unfounded characterization of our intentions to be entirely inappropriate, deeply offensive, and certain to undermine the majority leader's attempt to conduct the debate on health care in a respectful and informative manner.

No one in this town has cornered the market on compassion—no one. We are all moved by the many compelling personal stories that are often recounted to argue for one view or another in this debate. Americans share a great many concerns. We all have families. We all suffer anxieties about their welfare. We are all sympathetic to the anxieties of others. The ability to appreciate the pain of human suffering is not a virtue unique to the President's character.

Just like the President, the First Lady, and our Democrat colleagues, Republicans elected to Federal office came to this town with the intention of doing right by their constituents and their country. We are just as sincere in wanting to leave this good and blessed Nation better than we found it. We all believe in progress. We disagree over means, but not ends.

I find it most unfortunate to be obliged to remind the White House that what occurred in January, 1993 was that Bill Clinton was inaugurated the 42d President of the United States. What did not occur was the arrival of a morally superior force of public servants determined to save the country from a small core of cold-hearted evildoers bent on frustrating the President's attempts to make America a more compassionate Nation.

I hope the First Lady's attack yesterday will be the last time this debate is marred by White House efforts to turn a principled debate about the proper role of Government in one-seventh of our Nation's economy into some cosmic struggle between good and evil. Such tactics do a grave disservice to the President, to Congress and to the American people who, quite rightly, want this debate to be enlightening and conducted with the respect and fair-mindedness appropriate to a decision of such profound consequences for their well-being.

Madam President, I suggest the absence of a quorum.

Mr. BRYAN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

I ask unanimous consent the pending committee amendment be set aside for the purpose of offering an amendment.

The PRESIDING OFFICER. Does the Senator from Arizona withdraw his request for the call of the roll?

Mr. MCCAIN. I withdraw my request for the quorum call and maintain my right to the floor.

The PRESIDING OFFICER. The Senator does continue to have the floor. The Senator from Arizona.

AMENDMENT NO. 2500

(Purpose: To provide for a temporary waiver of the prohibition on concurrent payment of disability compensation and uniformed services retired and retainer pay for certain totally disabled career members and former career members of the uniformed services)

Mr. MCCAIN. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Arizona [Mr. MCCAIN], for himself and Mr. GRAHAM, proposes an amendment numbered 2500.

Mr. MCCAIN. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a) The prohibition on concurrent award of compensation and retirement pay (including naval pension) set forth in section 5304(a)(1) of title 38, United States Code, does not apply to a person who has a service-connected disability if—

(1) the person has completed at least 20 years of service in the uniformed services that is creditable for purposes of computing the amount of retirement pay to which the member is entitled;

(2) the disability was incurred or aggravated in the performance of duty as a member of a uniformed service, as determined by the Secretary concerned; and

(3) the disability is a disability rated as total—

(A) by the Secretary concerned as of the date on which the person is retired from the uniformed services; or

(B) by the Secretary of Veterans Affairs within four years following the date on which the person is retired from the uniformed services.

(b) Notwithstanding section 1463(a) of title 10, United States Code, the amount of retirement pay paid in accordance with subsection (a) concurrently with the payment of disability compensation to the recipients of such retirement pay shall be paid out of funds appropriated by this Act.

(c) Subsection (a) is not applicable to a person for any period for which the disability of such person is not a disability rated as total as described in paragraph (3) of such subsection.

(d) In this section:

(1) The terms "compensation", "service-connected", and "Secretary concerned" have the meanings given such terms in section 101 of title 38, United States Code.

(2) The term "disability rated as total"—

(A) means a disability that is rated as total under the standard schedule of rating disabilities in use by the Department of Veterans Affairs; and

(B) does not include a disability for which the schedular rating is less than total but for which a rating of total is assigned by reason of inability of the disabled person concerned to secure or follow a substantially gainful occupation as a result of service-connected disabilities or by reason of any other factor.

(3) The term "uniformed services" has the meaning given such term in section 101(a)(5) of title 10, United States Code.

(e) This section shall take effect on October 1, 1994, and shall apply to months that begin on or after that date and before October 1, 1995.

Mr. MCCAIN. Madam President, I ask unanimous consent to add Senator GRAHAM of Florida as a cosponsor of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MCCAIN. Madam President, for over 3 years now I have been engaged in fighting for a cause which I feel strongly about—the discrimination of disabled veterans who must forgo retirement benefits. Current law prohibits concurrent receipt, requiring a career military servicemember who retires with 20 years of service and is disabled, to offset his or her retirement pay with any VA disability compensation the member receives. Because the career Military servicemember receives no separate payment for his service-connected disability, our Government is effectively requiring career military retirees to fund their own disability benefits. Therefore, I rise today to offer an amendment to correct this gross inequity.

Madam President, the amendment I have offered would waive the prohibition of concurrent receipt for a year and provide for concurrent payment of disability pay and retired pay if the following criteria is met:

First, a veteran has completed 20 years of military service; and

Second, the disability was incurred or aggravated in the performance of duty in military service; and

Third, disability is rated as 100 percent at the time of retirement or within 4 years of the veteran's retirement date.

According to recent figures from the Department of Defense, there are about 7,000 former servicemembers who are rated 100 percent disabled and have completed 20 years of service. The cost of paying concurrent receipt in this legislative provision is about $55 to $60 million and will affect about 3,500 veterans.

Because the Office of Management and Budget has scored this change in concurrent receipt policy as a PAYGO cost, offsets elsewhere in the Department of Defense account must be found. However, although this task has become increasingly difficult, I believe that there are still some areas in the Department of Defense budget that can be cut and not have a detrimental effect on readiness in our Armed Forces.

For example, the travel pay of senior-level officer and civilian executive travel of the Pentagon staff. This travel is primarily for Department of Defense civilians, Generals and Admirals and Members of Congress. Additionally, funds that are available for support to travel such as the operation and maintenance funds of the Air Force 89th Airlift Wing, the Marine Corps HMX-1 Squadron, and the Joint Chiefs and Service Secretaries executive transport aircraft should be considered. According to the Department of Defense's own figures, it seems outrageous that these costs for executive travel approach nearly $370 million.

Equally as astonishing is the exorbitant administrative costs that the Department of Defense spends each year processing travel orders. In fact the Department of Defense spends more each year to process travel orders than it does on travel itself. According to figures compiled by Vice President AL GORE and the National Performance Review [NPR], the Pentagon spends $2.3 billion each year processing $2 billion worth of travel vouchers.

I do not believe it is necessary for me to list for the Appropriations Committee all the areas in the Defense budget which could be reapportioned to find funding to pay for concurrent receipt. Suffice it to say this should be done, not at the expense of readiness in our Armed Forces, but rather from defense accounts such as executive travel, university research, research, development, test, and evaluation, and military construction, for example.

Concurrent receipt is a fairness issue. The present law simply discriminates against career military people. Career military retired veterans are the only group of Federal retirees who are required to waive their retirement pay in order to receive VA disability. This inequity needs to be corrected. Over the past several years the Congress and the Department of Defense have sought to deal with this issue in a variety of ways.

I know personally the character of Americans who take up arms to defend our Nation's interests and to advance our democratic values. I know of all the battles, all the grim tests of courage and character, that have made a legend of the Army, Navy, Marine Corps, and Air Forces' devotion to duty.

Let me remind this body of the grave sacrifice that our men and women who risk their lives for their country must endure. The United States has exerted military force more than 240 times since the end of World War II. That number will almost certainly increase in the future.

We have seen the efficacy of U.S. military power in this new era displayed in Panama and the Persian Gulf. But we have also seen conflicts that reveal the limits of that efficacy, and for which we have few, if any, viable military answers. Such is the case in the horrible tragedy of Somalia and Bosnia.

But be assured, we will continue to place our servicemen and women in harms way. When our vital interests are so threatened that such a grave step becomes necessary.

It is also appropriate to note, Mr. President, that we know how important our Armed Forces have been to advancing the just influence of our values. The Iron Curtain did not collapse by accident. The triumph of freedom in the world today is a direct consequence of the blood shed by those in battles too numerous to mention. Their sacrifices protected more than a narrow definition of our national interest. They served, in Lincoln's words, as "a beacon light of liberty" to the most oppressive societies on Earth.

We now have an opportunity to show a measure of our gratitude to these brave men and women. It is time for Congress to reverse the law that prohibits career military who are wounded during their service to our country from receiving earned retirement benefits.

I have learned, through personal experiences, that our human resources are our most valuable asset. You cannot win a war on firepower alone. Our Armed Forces have the most technically advanced weapons in the world, but if you don't have skilled, experience to operate and the best trained soldiers, sailors, marines, and airmen to operate them, then we are not adequately prepared to fight to defend our national interests.

I believe we have prepared ourselves properly. Never has this Nation seen a better trained and better educated Armed Forces.

However, we are moving to a smaller force structure, from 1.8 million to 1.2 million personnel by the turn of the century. Our service men and women are losing faith in the careers they have chosen. Draconian cuts in the defense budget negatively impact our active and retired military service members each day. In my nearly 25 years of military service and my continued close observation of the military since I retired, I have seen an erosion of benefits for active and retired service men and women each and every day. To opponents of concurrent receipt who make the argument that the military receives an abundance of benefits which should exclude them from any additional benefit, I can only remark that they are dead wrong.

I cannot think of a more fitting way for Congress to appropriate some of the reduced defense expenditure, than to correct the policy of requiring American veterans, injured in service, to waive their earned retirement benefits in order to receive disability benefits. It is entirely inequitable that military retired pay is offset dollar-for-dollar by veterans' disability compensation pay.

I firmly believe that nondisability military retired pay is post-service compensation for service rendered in the U.S. military. Veterans' disability compensation pay is not.

In my view, the two pays are for very different purposes; one for loyal and selfless service to our country and the other for physical or mental pain and suffering; occurred in that service.

Previously, I have cosponsored concurrent receipt legislation, like that sponsored by my friend and colleague from Florida, Senator BOB GRAHAM, which required a sliding scale of offsets that would reduce compensation as disability ratings increase. Other proposals call for a phase-in over a number of years, a proposal only to individuals who have a 30 percent or less rated disability, and other variations on these themes.

Because of the complexity of some of these proposals and the costs associated with them, I believe that most of the proposals compromise the basic philosophy behind the purpose for this legislation. Again, that philosophy holds that VA disability pay is for physical or mental pain or suffering and it should remain independent of career military service pay.

Last year, it was involved in a very sad case where a career Arizona sailor lost his leg from injuries sustained while serving aboard a Navy guided missile destroyer. This young man lost his leg above the knee, yet only received 60 percent disability. So, with a veteran with 100 percent disability, how can you say no? No, to his earned retirement pay for his 20 years of service to his country. No, to the disability compensation for mental or physical pain or suffering caused from service to his country. How can anyone deny a military retiree with 100 percent disability from receiving his retirement pay and veterans' disability pay?

I am very hopeful that, once the administration and the Pentagon finally understands that Congress will not allow it to ignore disabled military retirees, that the Department of Defense will provide the Congress with a fair and equitable plan to permanently and property compensate military retirees with disabilities.

I hope my colleagues understand the grave injustice that we have subjected our most seriously injured veterans to. I hope that they will vote for this amendment as a first step to correct this inequitable policy and restore to our disabled service men and women the proper measure of our Nation's gratitude for their great sacrifices on our behalf.

Madam President, I ask unanimous consent that letters of support for this legislation from the Military Coalition, a consortium of 25 nationally prominent military associations, the Veterans of Foreign Wars, the American Legion, the Disabled American Veterans, the Paralyzed Veterans of America, and the Uniformed Services Disabled Retirees be printed in the RECORD.

There being no objection, the letters were ordered to be printed in the RECORD as follows:

THE MILITARY COALITION,
Alexandria, VA, August 6, 1994.
Senator JOHN MCCAIN,
U.S. Senate, Washington, DC.

DEAR SENATOR MCCAIN: The Military Coalition, a consortium of 25 nationally prominent military associations (signatures enclosed) representing 3.75 million active, retired, and reserve members of the seven uniformed services and their families and survivors, strongly supports your proposed amendment to the FY 1995 Defense Appropriations bill that would provide concurrent receipt of military retired pay and VA disability compensation for retired members with 20 or more years of service, who are determined to be 100 percent disabled, and whose disability was incurred as a direct result of their military duties.

The Military Coalition has long supported the concept of concurrent receipt, but recognizes that funding constraints may necessitate limiting eligibility to those whose disability is most severe. This approach is consistent with the recommendations made by the Coalition during testimony before the Senate Armed Services Subcommittee on Force Requirements and Personnel on April 14, 1994. The Coalition concurs that the required funding should not come from readiness-related areas of the defense budget.

We deeply appreciate your continuing advocacy of the need to redress the compensation inequity imposed upon disabled military retirees, and will continue to work with you toward achieving this worthy goal.

Sincerely,

PAUL W. ARCARI,
Colonel, USAF (Ret),
The Retired Officers
Assn., Co-chairman.
MICHAEL OUELLETTE,
Sergeant Major, USA
(Ret), Non Commissioned Officers
Assn., Co-Chairman.

The letter was also signed by representatives of the following organizations:

Air Force Sergeants Assn.
National Association for Uniformed Services.
The Retired Enlisted Assn.
Enlisted Assn. of the National Guard Assn. of the US.
Marine Corps Reserve Officers Assn.
National Military Family Assn.
Commissioned Officers Assn.
Marine Corps League.
CWO & WO Assn., USCG.
Jewish War Veterans of the USA.
United States Armed Forces Assn.
Naval Enlisted Reserve Assn.
Navy League of the US.
The Military Chaplains Assn.
US Army Warrant Officers Assn.
US Coast Guard CPO Assn.
National Guard Assn. of the US.
Naval Reserve Assn.
Reserve Officers Assn.
Air Force Assn.
Assn. of Military Surgeons.
Fleet Reserve Assn.
Assn. of US Army.

VETERANS OF FOREIGN WARS
OF THE UNITED STATES,
August 10, 1994.
Hon. JOHN MCCAIN,
U.S. Senate, Washington, DC.

DEAR SENATOR MCCAIN: The Veterans of Foreign Wars of the United States (VFW) strongly and unconditionally supports your proposed amendment to the FY 1995 Defense Appropriations Bill that would provide concurrent receipt of military retired pay and VA disability compensation for retired members who have served on active duty for 20 or more years and who were subsequently determined to be 100 percent disabled as a result of illness and/or injury incurred in the line of duty.

The VFW has had a nationally approved resolution reflecting the collective judgment of our 2.2 million member organization for each of the past eight years asking Congress to grant concurrent receipt of military retirement pay and veterans disability compensation to all disabled retirees. Given the present budgetary constraints this Congress is working under, we believe your amendment is absolutely the right course of action to take today. We wholeheartedly agree that the required funding should not be taken from the readiness related areas of the defense budget.

In closing, we again thank you for all your efforts on behalf of disabled veterans in general and disabled military retirees in particular. The VFW will continue to work closely with you and your professional staff to achieve our common goals.

Sincerely,

BOB MANHAN,
ASSISTANT DIRECTOR,
National Legislative Service.

THE AMERICAN LEGION,
Washington, DC, August 9, 1994.
Hon. JOHN MCCAIN,
U.S. Senate, Washington, DC.

DEAR SENATOR MCCAIN: For many years The American Legion has believed that the professional members of the Armed Forces of the United States throughout their careers, have made repeated sacrifices for their country in ways neither found nor expected in a civilian profession. They live under circumstances of adverse environmental conditions, suffer through long periods of family separation while deployed in military operations, work in foreign lands under hostile weapons fire with insufficient personnel to meet mission requirements and receive little recognition for a job well done. It is that unquestioned loyalty, commitment to ideals and reaction to danger throughout a career that can result in permanent physical impairment and a requirement to fund their own disability compensation from their retired pay.

The American Legion supports your proposed legislation to award concurrent receipt of both retired and disability pay to those professional career veterans who are adjudged to be 100 percent disabled after their 20 year retirement, or within four years afterwards, and are disabled because of service-connected or line-of-duty service. The numbers of retirees who meet these criteria are estimated at less than 3,500, but are the most deserving because of their sacrifices and the reduction or negation of their earning potential for follow-on employment.

It is recognized there are other circumstances and criteria that cause military retirees to become 100 percent disabled. Under your proposed criteria some of them may be exempt from this bill. However, even though they are no less deserving, and even though The American Legion continues to support concurrent receipt for all disabled military retirees, the fiscal realities of today's budget may for now, prohibit coverage of all retirees who are 100% disabled. But, as a grateful nation this small initial step should be taken for the most seriously disabled who have unselfishly served their country.

Sincerely,

BRUCE THIESEN,
National Commander.

DISABLED AMERICAN VETERANS,
Washington, DC, August 10, 1994.
Hon. JOHN MCCAIN,
U.S. Senate, Washington, DC.

DEAR SENATOR MCCAIN: On behalf of the more than 1.4 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I take this opportunity to express our support for your proposed amendment to the Fiscal Year 1995 Defense Appropriations Bill. Your amendment would provide concurrent receipt of military longevity retirement pay and Department of Veterans Affairs (VA) disability compensation for totally disabled veterans.

As you are aware, the DAV has long supported the principle of concurrent receipt for military longevity retirement pay and VA disability compensation. While your amendment does not grant concurrent receipt to all service-connected disabled military longevity retired veterans, it would provide meaningful assistance to our nation's most seriously disabled service-connected military retirees.

Your efforts on behalf of America's disabled veterans are greatly appreciated. If there is anything my staff can do to assist you in achieving this worthy goal, please do not hesitate to contact them.

Sincerely,

RICHARD E. MARBES,
National Commander.

PARALYZED VETERANS OF AMERICA,
Washington, DC, August 10, 1994.
Hon. JOHN MCCAIN,
U.S. Senate, Washington, DC.

DEAR SENATOR MCCAIN: The Paralyzed Veterans of America (PVA) wholeheartedly supports your proposed amendment to the FY 1995 Defense Appropriations Bill which would enable service-connected disabled veterans to receive both retirement and disability pay. This concurrent payment would only be applicable to those veterans whose disability is rated 100 percent, and is granted upon their 20 year retirement, or within four years afterwards. Although PVA would like to see this benefit extended to all 100 percent service-connected retired members, the need to limit the number of beneficiaries due to budgetary constraints is appreciated.

PVA appreciates the support you have extended to the disabled veterans in the past and again thank you for your efforts in this proposed amendment.

Sincerely,

RICHARD F. JOHNSON,
National President.

UNIFORMED SERVICES
DISABLED RETIREES,
Albuquerque, NM, August 10, 1994.
Hon. JOHN MCCAIN,
U.S. Senate, Washington, DC.

DEAR SENATOR MCCAIN: The Uniformed Services Disabled Retirees (USDR) represents all service-connected disabled military retirees who served in not only one (1), nor two (2); but in three (3) of our Nation's wars. It also includes the Cold War.

We strongly support your proposed amendment to the FY 1995 Defense Appropriations Bill. We realize that the Bill would provide concurrent receipt for those retired members with 20 or more years of military service and determined to be 100 percent disabled by the Department of Veterans' Affairs as being incurred in the line of duty. I would hope that under the determination of the Department of Veterans' Affairs, that they would include those who are rated as 100 percent disabled for unemployability.

The issue of concurrent receipt denial is a century old law. In its original state, the law was written to make it unfair and unjust besides discriminatory towards the service-connected disabled military retirees. Today, it places a financial hardship upon this group of America's disabled veterans, especially those rated as 100 percent disabled for total disability and or unemployability.

USDR encourages the United States Congress to accept your amendment and finally partially end the unfairness and injustice.

We of USDR greatly appreciate your continued advocacy to address the unfairness and place an end to the injustice pertaining to concurrent receipt.

Sincerely,

STEPHEN WOLONSKY,
President.

It is my understanding that this amendment may be accepted by the managers. If not, I will request the yeas and nays.

I ask unanimous consent to add as cosponsors Senator DOLE, Senator GRAMM, Senator FORD, Senator PRESSLER, Senator BINGAMAN, Senator MACK, Senator AKAKA, Senator DASCHLE, Senator SARBANES, and Senator LAUTENBERG.

The PRESIDING OFFICER. Without objection, it is so ordered.

Without objection, the pending committee amendments are set aside.

Mr. MCCAIN. Madam President, I yield the floor.

The PRESIDING OFFICER. Is there further debate?

Mr. BINGAMAN addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. BINGAMAN. Madam President, I rise in support of the McCain amendment which addresses a fundamental matter of fairness and equity for a group of 100 percent disabled military retirees who incurred their disability in the performance of duty. In my view there is no one more deserving of the full benefits they earned than these individuals who each served our Nation at least 20 years and now are generally unemployable as a result of disability.

The amendment would, for this carefully selected group, allow concurrent receipt of their military retired pay and their VA disability benefit without the currently mandated dollar for dollar reduction in their retired pay. As the Senator from Arizona has pointed out, career military retired veterans are the only group of Federal retirees who are required to waive a portion of their retirement pay in order to receive VA disability compensation.

I commend the Senator from Arizona for his perseverance in trying to find a way to address this inequity within the budget constraints we face. He has designed a narrow exception to the current statute that will begin to deal with this inequity by focussing on those most needing these benefits. The cost, estimated at $55 million, is paid for through nonreadiness reductions, particularly in the travel area where recent reports have indicated the Pentagon is spending an inordinate amount of money on administrative expenses.

I am delighted to be part of this effort to ensure those military retirees with 100 percent disability as a result of the performance of their duty for the Nation over a 20-year career can receive the full benefits they earned through their service. I hope the amendment will be broadly supported by our colleagues.

Mr. GRAHAM. Madam President, I also rise in strong support of the amendment offered by the Senator from Arizona. There is a perversity here in that two military veterans, both of whom have suffered an injury in the course of service to their Nation, both of whom are receiving disability payments, one of whom elects to continue in military service until retirement. That individual, upon retirement, will see his or her retirement benefits reduced proportionate to the receipt of disability payments.

The second serviceman or woman who elects to leave the service and go into other employment, including employment with another Federal agency and serves until retirement, continues to get their full disability payment and the retirement that they have earned.

So the practical effect of this is to penalize those persons who, after having suffered a disability in the service to the Nation, then continue that service until retirement. It is a very perverse set of incentives in terms of maintaining the loyalty and service of outstanding people for our Nation's military.

It is, I think, an inexplicable example of unfairness to a group of citizens who, if anything, deserve our special commendation, both for having suffered an injury in service of the Nation and then having continued to serve until retirement.

I hope this Senate will end that unfairness this year with the adoption of the amendment offered by the Senator from Arizona. I am very pleased to join him in this effort.

The PRESIDING OFFICER. Is there further debate on the amendment?

Mr. MCCAIN. Madam President, it is not clear to me yet whether the managers of the bill will choose to accept the amendment or at the appropriate time I will seek the yeas and nays. At this time, I yield to the distinguished manager of the bill, the Senator from Hawaii.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. INOUYE. Mr. President, if the Senators will indulge us, may I suggest the absence of a quorum?

Mr. MCCAIN. Could I ask the Senator to withhold that? I ask for recognition.

The PRESIDING OFFICER. Does the Senator from Hawaii withhold his request for a quorum call?

Mr. INOUYE. I just suggested the absence of a quorum to discuss this matter.

The PRESIDING OFFICER. The Senator from Arizona has asked that the Senator from Hawaii withhold that.

The Senator from Arizona.

AMENDMENT NO. 2501

(Purpose: To require reimbursement of the Department of Defense for funds made available by the Department for civilian sporting events)

Mr. McCAIN. Madam President, I ask unanimous consent that the pending amendment be set aside so that I may send an amendment to the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. McCAIN. I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Arizona [Mr. McCAIN] proposes an amendment numbered 2501.

Mr. McCAIN. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. 8121. REIMBURSEMENT FOR FUNDS PROVIDED IN SUPPORT OF CIVILIAN SPORTING EVENTS.

(a) AGREEMENT FOR REIMBURSEMENT.—Notwithstanding any other provision of law, funds made available to the Department of Defense under title II of this Act may not be expended either directly or indirectly to support the World Cup Soccer Games, the Goodwill Games, an Olympiad, or any other civilian sporting event until the Secretary of Defense—

(1) enters into an agreement with the entity or entities that are to receive the funds to provide for such funds to be reimbursed to the Department under terms and conditions established by the Secretary; and

(2) certifies to Congress that the agreement ensures that such reimbursement will be made.

(b) TERMS OF AGREEMENT.—An agreement entered into under subsection (a)—

(1) may not require any reimbursement until after the sporting event is complete and all event-related contractual obligations have been met by the entity or entities with which the agreement was made;

(2) shall provide that the amount reimbursed may not exceed 25 percent of surplus funds; and

(3) shall provide that no reimbursement is required if the entity or entities with which the agreement was made has no surplus funds after all other contractual obligations have been met.

(c) DEFINITION.—In this section, the term "surplus funds" means the amount equal to the excess of the total amount of revenues (other than tax revenues) and contributions received by the entity or entities referred to in subsection (b) over the total amount of the expenditures made by the entity or entities.

Mr. McCAIN. Madam President, the amendment is a rather simple, straightforward amendment. It requires that the Department of Defense be reimbursed for expenditures entailing the use of Department of Defense personnel and equipment to provide security for any civilian sporting event, but that the Department of Defense only has to be reimbursed if there is a profit and if there is a profit, only on 25 percent basis of that profit.

What I am saying is that if the taxpayers' dollars are spent in the World Cup, the Olympics, the Goodwill Games, or any other, and a profit is made, as happened in the Los Angeles Olympic games which made a staggering $222 million profit, if there is a profit, then this amendment says that on a 25-percent basis of that profit, that the Department of Defense would be reimbursed.

I want to make it clear that I strongly believe that security needs to be provided for any of these games. The memory of the 1972 Olympics tragedy in Munich haunts all of us, and I would not want to reduce that security in any way. But I do believe that since we are spending taxpayers' dollars and sending Department of Defense personnel and equipment to be used, that if that Olympic game or that civilian sporting event makes a profit, then some of the money of the profits should be returned to the Department of Defense.

It is pretty straightforward, and I think it is logical and I think it is reasonable. I know that the Senators, especially from the State of Georgia, and other places, object to this amendment.

Let me also point out, Madam President, that most of these games do not make profits. The Senior Olympics, the Special Olympics—all of those—and the Olympics in Atlanta, I am told, do not expect to make a profit. So I do not expect the Department of Defense to be reimbursed if they do not make a profit.

I am only saying if they do make a profit, at least on a 25-percent basis that the Department of Defense should be reimbursed.

Madam President, on this amendment, I ask for the yeas and nays.

Mr. HEFLIN. Madam President, the announcement that the city of Birmingham had been selected to host the preliminary competition in the 1996 Olympic soccer tournament was an occasion for all the citizens of Alabama to rejoice. We were even more delighted to learn that Birmingham was one of two host cities for the quarterfinal games.

Thousands of people turned out in August 1993 when members of the Atlanta Committee for the Olympic Games, the U.S. Soccer Federation, and the Federation of International Football Association visited Birmingham. I think the spirit and enthusiasm which were so evident that day had a great deal to do with the decision to award these games to Birmingham.

I assure you this spirit is even stronger today. The citizens of Alabama will put forth every effort and dedicate every resource to guarantee that the athletes and spectators to these games receive an Olympic welcome that is second to none. I am told that as much as 60 percent of the world's population will watch these games on television. We know well the opportunity this presents to put our State on display around the world, and State leaders have assured me it will be taken full advantage of.

Hosting these prestigious games means much more than games run efficiently and people being welcomed. Those attending the games must be kept safe. The bitter memories of Munich in 1972, when terrorists scarred this celebration of the human spirit, remain with us still. We simply cannot afford to take a chance on anything like that happening on American soil.

The resources of the Department of Defense and other agencies involved in this security—the FBI, State Department, and Department of Treasury—are vital to the success of this mission. We cannot do it without them, and providing this assistance is clearly within one of Government's basic responsibilities—that of protecting its citizens and visitors to our shores.

Mr. President, my distinguished colleague from Arizona maintains that adoption of this amendment will not compromise security. However, I know that Senator NUNN, chairman of the Armed Services Committee, is opposed to this amendment. He clearly does not believe it to be in the best interests of the Olympic games being held in Atlanta. I also understand that the Defense Department itself does not support the amendment. Existing DOD policy allows for reimbursement in appropriate cases.

Therefore, I urge my colleagues to oppose this amendment. Planning is simply too far along, and the success of that planning is too critical for the process to be changed now. It is a risk we cannot afford to take.

Mr. SHELBY. Madam President, I rise in opposition to the amendment offered by my distinguished colleague from Arizona. My colleagues know that I am a strong supporter of national defense, and have always supported efforts to make sure that our men and women in uniform have the resources needed to perform their mission. I think this amendment could have disastrous results, and I must therefore oppose it.

I share the pride felt by all Alabamians at the decision to designate Birmingham, AL, as the host city for preliminary Olympic soccer games. Alabama, as well as the rest of the South, will be on display in July 1996 for the entire world to see. These games will build on the momentum generated by the recently held World Cup Games in this country, and the added prestige afforded by the Olympic rings will assure that thousands of people will assemble in Birmingham to watch the preliminary Olympic soccer games.

Security is unfortunately a vital part of the modern Olympics. We all remember the tragedy of the Munich Olympics, and no one wants to see any repeat of that in our own country. Local and State officials are going to need significant help in preparing for the complex threat posed to these games by the increasingly sophisticated and numerous groups of terrorists springing up around the world. The majority of the entire world will be watching these events, and this affords tempting opportunity for these evil and dangerous groups to elbow their way into the spotlight of world attention.

Madam President, I too want to help DOD husband its resources, but this amendment is wrong. In fact, I am told that DOD does not support this amendment. As I understand it, existing DOD policies allow for reimbursement for security expenses whenever it is appropriate, and DOD does not feel the need for any added protection.

The distinguished chairman of the Senate Armed Services Committee opposes this amendment because he fears that it may adversely impact the complicated process that is necessary to develop and implement a plan with the flexibility and sophistication to meet the serious threat of international terrorism. I concur in that judgment.

Madam President, those who have planned for the Atlanta Olympic Games have relied for more than 4 years on the continued ready availability of certain limited DOD resources. Introducing a new and complicated reimbursement process at this late date gains us little, and could cost our Nation much.

I urge my colleagues to defeat this amendment.

Mr. LIEBERMAN. Madam President, on previous occasions I have come to the floor of the Senate to speak about a program which helps people across the country and the world demonstrate courage, build self-respect, and feel the pride which comes from doing one's best even in the face of adversity. As you well know, the program I am speaking about is the Special Olympics which is the result of the vision, energy, and efforts of a very special woman, Eunice Kennedy Shriver, some 25 years ago.

This coming year, July 1 to 9, 1995 to be exact, the Ninth Special Olympics World Summer Games will bring over 6,700 special athletes from over 135 countries along with 2,000 coaches, 15,000 family and friends, 45,000 volunteers, 1,500 media representatives, and over half a million spectators to Albert Magnus College, Quinnipiac College, Southern Connecticut State University, the University of New Haven, and Yale University. For 9 exciting days, these Special Olympic games give men and women with mental retardation the opportunity to compete in Olympic athletic events and to feel the reward of their hard work, training, perseverance, and courage. These games will, in fact, be the largest sports event in the world in 1995.

I know that no one in this body wants to deny these Special Olympians their days of competition and celebration and that the amendment which we are currently debating is not aimed exclusively at the Special Olympics. But I am compelled by my strong feelings for these games to point out the difficulties which would befall the Special Olympics if this amendment passes.

The Special Olympics is being organized through a network of volunteers throughout the country. As a 501(c)(3) charitable organization, it relies on corporate sponsorships, philanthropic donations, and individual contributions to fund the events. The organizing committee has sought assistance from governments at the local, State, and Federal levels. It has no alternative. Response to its calls for help have been resoundingly positive. The White House welcomed the participation of the organizing committee in the activities of the Federal task force organized to support the 1966 Olympic Games and the 1994 World Cup Games. The Department of Defense has guidelines in place for determining the degree to which the Department can assist such activities. We should note that DOD has provided "in-kind" services with the consent of the Congress for such past events as the Los Angeles and Lake Placid Olympic Games, and the World Cup USA.

The Department of Defense has worked with the Special Olympics Organizing Committee to identify specific needs which it cannot fulfill by other means—such things as security, traffic support, medical support, emergency ordinance disposal, water resupply, and some limited transportation. The Department is prepared to provide these services and estimates that the in-kind costs will not exceed $3 million. Many of these tasks will be performed by the men and women of the Connecticut National Guard in conjunction with training; the leadership of the Connecticut Guard is proud and eager to have the opportunity to provide these services. The cooperative efforts of the Department of Defense and the organizing committee have produced a plan to provide those services which the military does best and would do if called on in a military action. It is the view of those responsible officials in the DOD that providing these services will not attrit the readiness of our military forces or deplete DOD funds for a cause totally unrelated to national security.

The pending amendment would establish reimbursement requirements and procedures which supplement, or perhaps replace, existing DOD policies which already allow the Department to request reimbursement for any service or mission that resides with another public or private entity. The proposals would result in detailed reimbursement negotiations and a process which will make it very difficult for the organizing committee of this event to concentrate their efforts on making these important games a reality in less than a year from now. This process is unnecessary and will, in reality, complicate the efforts of thousands of volunteers trying to do a noble task. Further, it could result in the negation of agreements already reached on particularly vital services such as security. I believe this amendment is not necessary and would be counterproductive to these Special Olympics.

Madam President, I fully agree with the desire of the amendment's sponsor to seek ways to protect the readiness of our vital military forces. If I thought that the $3 million of in-kind services which we have already authorized and now seek to appropriate would denigrate the ability of our forces to respond to a call to arms, I would not support it. I do not believe this is the case. Support of these games is consistent with past practices of the Department of Defense as approved by the Congress. Moreover, it is consistent with the best traditions and values of the people we represent. I will vote against this amendment and urge my colleagues to do the same.

Mr. BENNETT. Madam President, I would like to raise a few concerns about the McCain amendment. I understand his concern about shrinking defense budget. His concerns are valid. However, I am not convinced this amendment will result in a boost to DOD coffers.

On its face, this amendment appears reasonable. It requires that DOD be reimbursed for providing security at international sporting events, provided they make a profit. However, I believe, this amendment will do more damage than good. In fact, the McCain amendment may have the unintended effect of reducing the level of reimbursement that DOD currently receives.

Since winning an Olympic bid is of great interest to many in my State, I took the time to look into exactly what providing security at the Olympic games entails. I was astounded. My colleague from Atlanta, Senator COVERDELL, has already outlined the onerous process, so I will not recount it now. However, I think it is important to reiterate that their is a reimbursement mechanism currently in place. Where it is appropriate, DOD can negotiate reimbursement agreements to individual entities, on an ongoing basis. Under the McCain amendment, contracting would be required up front. When 34 different agencies are involved, contracting with every entity can only add time and expense to an already complex process that is based on good faith negotiations.

This amendment would also provide DOD reimbursement in the event a profit is made. However, this may never occur in some instances. It would seem to me that ongoing reimbursement is likely to benefit the military far more than the alternative.

The Department of Defense, the supposed beneficiary of this change in procedure, opposes this amendment. I think that is a good indication that the promise of improved or increased reimbursement under this amendment is suspect.

If the McCain amendment held the promise of dramatically improving current practice, I would assuredly vote for it. However, this is not the case, so I will oppose the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. Is there further debate on the amendment?

Mr. COVERDELL addressed the Chair.

The PRESIDING OFFICER. The Senator from Georgia.

Mr. COVERDELL. Madam President, I reluctantly oppose the amendment as offered by my good friend and colleague from Arizona.

First let me say to the Senator from Arizona that I share, as I am sure every American does, the deep commitment that he has made and does make to the men and women of our military and the sacrifice that they make on a day-to-day basis for the welfare of our Nation.

But I have believed in the context of Government and its relationship with business, and Americans as citizens, and taxes that we should never get in the business of changing the rules in the middle of the road.

This is an American Olympiad, not a Georgia Olympiad. Georgia is the house, so to speak, of a great accomplishment that America would entertain the centennial Olympiad. We are well over, well over half of the way through the planning process for the Olympics that occur in the summer of 1996 in Atlanta, in America. Over half the planning has been exhausted. We are deep into the process. We have only 700 days until the torch is lighted in America and in Atlanta.

This is not the right time to upset or interrupt or convolute the process of the arrangements in terms of the financials nor in terms of the security.

I personally think that the international community has begun to have questions about this Nation's commitment to the international Olympiad. We are one of the only nations that does not fund it. This is privately funded in the United States, and that has always raised questions. So to begin at this point, halfway through the planning process, on the Olympics to occur in this country in 1996, not only do we destabilize the planning and preparation for this massive event, this massive world event, but we also send signals about the planning process in other cities that are negotiating for the Winter Olympics, like Salt Lake City, UT.

Disruption of a multibillion dollar event halfway through the process is a very serious issue for this country and for those planning the Olympics.

Now, Madam President, there are 34 different governments involved with the planning of the 1996 Olympics. They are not all in Georgia—34 different Olympic venue sites and governments affected.

Now, I wish to read from the amendment. It states, Madam President, that no funds made available to the Department of Defense under title II of this act may not be expended, either directly or indirectly, to support the World Cup soccer games, the Goodwill Games and Olympiad—that is the 1996 Olympics—or any other sporting event until—and this is the pertinent language, Madam President—"until the Secretary of Defense enters into an agreement with the entity or entities that are to receive the funds, to provide for such funds to be reimbursed to the Department under terms and conditions established by the Secretary and certifies to the Congress that the agreement ensures that such reimbursement will be made."

So with 700 days to go, the Secretary of Defense—and we know the pace with which the Federal Government moves—700 days away from the torch being lit—would begin discussions on terms of the financing for security of the world's athletes in Atlanta, I suppose sometime in the next month or two, and I have to only envision that we would not be able to resolve all these agreements until the moment of the games, which would not allow for the appropriate planning and disposition of resources that have already been agreed upon.

Madam President, I will urge my colleagues not to vote for this amendment at the time we take the yeas and nays, not in disagreement to the intent or purpose of the Senator from Arizona. But in this case, to introduce this kind of interruption in the process of planning for the World Olympics I believe is not appropriate given the timing that we are facing.

Madam President, I yield the floor.

Mr. McCAIN addressed the Chair.

The PRESIDING OFFICER. Is there further debate?

Mr. BRYAN addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. BRYAN. Madam President, I ask unanimous consent that the amendment be temporarily set aside so that I might offer an amendment.

Mr. McCAIN. I object. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. McCAIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. McCAIN. Madam President, I say to my friend from Nevada, we are in the middle of the debate on this amendment, and I ask his indulgence. I am sure we can get it finished very quickly, return to the original amendment which was set aside, dispense with that, because I am sure it has been agreed to, and then my friend from Nevada can proceed.

I hope he understands I just wanted to respond to the Senator from Georgia.

Mr. BRYAN. Will the Senator yield for a further question?

Mr. McCAIN. I will be glad to yield.

Mr. BRYAN. My only concern is that at 6:50 the time for offering amendments is cut off unless one does so through the managers.

Mr. McCAIN. Madam President, I understand better now the concern of the Senator from Nevada, and I would remove my objection to the unanimous consent request of the Senator from Nevada.

Mr. BRYAN. I thank my friend from Arizona.

I ask unanimous consent that the pending amendment be set aside.

The PRESIDING OFFICER. Is there objection? The Chair hears none, and it is so ordered. The Senator from Nevada is recognized.

AMENDMENT NO. 2502

(Purpose: To withhold funds allocated for construction of the headquarters buildings of the National Reconnaissance Office which were unobligated as of the date of enactment of this act until a review of that construction project is completed and Congress is informed of the results of the review)

Mr. BRYAN. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Nevada [Mr. BRYAN], for himself, Mr. BOREN, and Mr. GRAHAM, proposes an amendment numbered 2502.

Mr. BRYAN. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following new section:

SEC. . Of the funds made available by this Act for the National Reconnaissance Office under the classified Schedule of Appropriations accompanying this Act, funds allocated for construction of the headquarters buildings of the National Reconnaissance Office which were unobligated as of the date of enactment of this Act may not be obligated or expended until the Director of Central Intelligence and the Secretary of Defense have completed a review of that construction project and the results of such review have been disclosed to the Select Committee on Intelligence of the Senate and the Permanent Select Committee on Intelligence of the House of Representatives.

Mr. BRYAN. Madam President, I will be brief because I know there are other amendments pending. I think most of my colleagues were as surprised as I was yesterday morning in reading the Washington Post story on page 1 entitled, "Spy Unit's Spending Stuns Hill."

I have reference, Madam President, to the $310 million facility that is being used to house the National Reconnaissance Office. This is a project of incredible magnitude, a million square feet, which will cost us about $175 per square foot, well beyond what any comparable commercial building might require.

Let me just say, Madam President, that the genesis of this building dates back to the late 1980's when the Senate Intelligence Committee and its counterpart in the other body encouraged the National Reconnaissance Office to begin planning to colocate facilities that were scattered around the country. There is no objection in concept to that.

I was not on the committee until last year, so when I saw this in the paper yesterday, I asked for a briefing from the staff.

BRYAN AMENDMENT ON THE NRO HEADQUARTERS FACILITY

Mr. WARNER. Madam President, I am pleased to join Senator BYRAN as a cosponsor of his amendment concerning the NRO headquarters facility in northern Virginia. In my opinion, this amendment represents a reasonable check on this construction project.

Twenty-five years ago, as under Secretary of the Navy, I first started my public service responsibilities of overseeing Intelligence functions. Throughout my 5 years plus in DOD I was specifically tasked to operate the Department of the Navy's program which are now part of the NRO.

The NRO is essential to our Nation's security. To the extent that the United States is a superpower today, that status is dependent to a large part on the work of the NRO.

But the question before the Congress and the executive branch is whether the plans for consolidation and expansion of the NRO facility, as conceived in the cold war era, were properly reviewed in the aftermath of the demise of the Soviet Union.

Given that the DOD budget, which contains the overall Intelligence budget, has gone down from 15 to over 25 percent in various categories over the past 5 years, to what extent was the NRO facility scaled back?

Or, conversely, given that Intelligence is a force multiplier of our Defense forces, is there justification for level or increased NRO funding?

How did this controversy of today start?

On July 26, I chaired a Senate Intelligence Committee briefing on the NRO facility. Chairman DECONCINI joined that briefing later and reviewed the same facts. We jointly agreed to send a letter to the Secretary of Defense and the Director of Central Intelligence demanding more information. That letter was sent on July 29.

Then, on August 4, the chairman and I decided to have a formal hearing and seed declassification of as much material as possible. We joined in a letter to that effect on August 4.

Next, we made a field trip to the NRO construction site this Monday. Later that day, you informed me that public disclosure of this project would be immediate because of White House, DOD, and CIA decisions. Only today did I learn that the President was involved in this decision. The administration issued press releases at 5:00 on Monday. Our press conference followed shortly thereafter.

It had been my intention that the Intelligence Committee would at least have an opportunity to gain a full understanding of the executive branch response to our inquiry of July 29 before public disclosure. That, in my judgment, would have lessened to some extent the public confusion that exists today.

The NRO facility which I toured on Monday morning is truly a massive installation—a series of four modern towers comprising 1 million square feet. By rough comparison, the Pentagon consists of 5 million square feet of usable space.

I am concerned that this facility, which was conceived during the cold war, is now disproportionate to the needs of the NRO. I have been unable to find any information which indicates that a scrub was done of this project following the collapse of the Soviet Union. At every step along the way, this project continued to expand. For example, in the summer of 1992, long after the dissolution of the Soviet Union and the collapse of the Warsaw Pact, the NRO decided to expand this project from three to four towers.

I am also concerned about the basic issue of fairness to other Government employees, intelligence as well as others, who are working in facilities which are not as comfortable. In the Pentagon, I know from personal association, most employees work in cramped, aged quarters. Some perform the same high-level intelligence work as to the NRO employees. Why should NRO personnel be treated differently?

These are some of the issues which we must explore in detail.

Madam President, I would like to take this opportunity to correct a misperception which I have seen in press reporting on this issue. It has been reported that the Congress knew nothing about this construction project—that the CIA built this facility without informing the Congress. In fairness, that is simply not true. We knew that the NRO was building a new headquarters facility in northern Virginia. In fact, I played a role in bringing the NRO building to my State. Our complaint is that we were not adequately informed about the scope or the cost of the facility.

In fairness to the executive branch, this raises a legitimate question of whether the Intelligence Committee and perhaps other committees were forceful enough in their requests for more details. We, as the Congress, had the ultimate leverage to cut off funding until our informational needs were met. So we have a measure of self-examination to perform. I add that as a question to this debate.

Let us look at a specific example. The fiscal year 1991 Intelligence Authorization Act conference report stated that the NRO's "land and facility acquisition will remain subject to the prior approval of the appropriate congressional committees." This did not happen with regard to this facility. The NRO did not seek specific prior congressional approval for the Westfields project—instead, funding for the facility was buried in the base portion of the budget, an unspecified aggregate of various O&M costs.

This base funding for the Westfields project continued despite specific congressional direction to the NRO in the fiscal year 1994 intelligence authorization act conference report which stated, "The conferees also explicitly stipulate that each individual program must provide complete details for the entire request—not simply any changes from the base level provided in the prior fiscal year. Despite this requirement, the fiscal year 1995 budget request for the new NRO facility was once again buried in the base budget. Following this, the staff of the Intelligence Committee acted to initiate our audit and recommended a full briefing for committee members.

The NRO decided to bypass both GSA regulations and military construction procedures for the construction of the headquarters facility, opting instead to operate under the DCI's "special authorities." Did the Intelligence Committee sanction this approach? If so, under what conditions? Were those conditions followed? We need answers to these questions.

Madam President, does the Congress share a measure of responsibility for this problem? Could we have been more diligent in following up on our demands for more detailed and complete information at an earlier stage? Perhaps, but we should not have to be investigators. It is incumbent on the executive branch to be forthcoming in providing budget details to the Congress. We do not have the resources to conduct in-depth investigations on every item in the budget, nor should we have to. Detailed information on this project should have been provided to the Intelligence Committee and the Appropriations Committee.

In my opinion, this project should and will go forward. The facility is nearing structural completion. It will be an asset to the Intelligence Community, and indeed to the Nation, upon completion. Our task now is to ensure that the remaining construction on this facility is conducted in the most cost effective manner for the American taxpayer.

Fortunately, this project is at a stage where decisions can be made to invoke savings, achieve greater efficiency, and maximize utilization of this prime space by additional defense or Intelligence-related activities. During a hearing on this issue earlier today, the Intelligence Committee received assurances from top NRO officials that the NRO will allow maximum utilization of this facility by other elements of the Defense and Intelligence communities. Indeed, the NRO has already begun work on such options. It is now our responsibility to monitor the completion of this project and ensure that cost-saving options are pursued.

Mrs. FEINSTEIN. Mr. President, I rise today as an original cosponsor of the Bryan amendment to withhold funds for the construction of a National Reconnaissance Office [NRO] headquarters.

Frankly, I was extremely troubled to learn that more than $300 million is being spent to secretly construct an NRO facility in northern Virginia to consolidate personnel located in California and throughout the country.

Apparently, construction of the NRO facility was begun in 1990 and undertaken without the full knowledge and approval of Congress. This raises serious concerns about congressional oversight of this project and the entire NRO organization. In my opinion, the credibility of the NRO has been damaged, and Congress will be forced to more closely scrutinize its budget and activities.

Last week, my staff contacted Pentagon offices to inquire about speculation that NRO personnel were moving from offices at Los Angeles Air Force Base [AFB] in California to a new NRO headquarters building near Dulles International Airport. The Air Force denied all knowledge of such a proposed consolidation, and inquiries to the NRO went unanswered. The way these inquiries were handled leads me to believe that the intelligence community was trying to deceive Congress or, at a minimum, me. This is simply unacceptable.

Still today, after Pentagon officials testified before the Senate Intelligence Committee, the NRO has not provided me or my office any information, except a joint statement that was released to the press.

Apparently, construction of the NRO facility was originally planned for a partial consolidation of NRO headquarters personnel that are scattered throughout the Washington area. This would have allowed for construction of a building with two office towers at substantially less cost than current estimates.

However, sometime in 1992, after the fall of the Soviet Union—the primary target of NRO activities—the intelligence community decided to proceed with a full consolidation of NRO personnel nationwide. This decision caused the estimated cost for the new facility to near $350 million as two additional office towers were added, for a total of four huge towers. I am unclear why additional funds were allocated for this new structure at a time when defense and intelligence budgets were declining.

My staff still has not been able to determine exactly what type of consolidation is being proposed or the details of the approval process. Specifically:

When and how was the decision made to shift from only partial consolidation to full consolidation?

How many military, civilian and contractor personnel are being affected?

Where are these personnel currently located?

When is the proposed consolidation occurring?

What implications does the proposed consolidation have on the base realignment and closure [BRAC] process?

Because NRO is partly a Defense Department agency, is it subject to the BRAC process?

Was a true cost-benefit analysis completed to determine whether the associated costs of the NRO facility and full consolidation justified any national security or fiscal gain?

I have already written to Defense Secretary Perry expressing my concern over this matter and submitted some of these questions to him. I expect answers to these questions as soon as possible. I also expect the review currently being undertaken by the Director of the CIA and Deputy Secretary of Defense to address these and other issues.

In addition to my concerns regarding general congressional oversight of the project, I am particularly troubled that, though the consolidation was approved years ago and the Intelligence Committee was notified, I was never made aware that jobs would be moved out of California. Also, I am concerned that the consolidation of personnel from Los Angeles AFB may have an adverse impact—direct or indirect—on the upcoming 1995 base closure process, especially considering that this is just one of a number of planned consolidations out of Los Angeles AFB.

Mr. President, this matter needs to be thoroughly looked into and I hope that much of the information surrounding the project can be declassified so the public and taxpayers will have full knowledge of what is being built near Dulles International Airport.

I fully support this amendment which withholds unobligated funds for the NRO headquarters building until a full review has been completed and questions have been answered.

The PRESIDING OFFICER. The Chair would state to the Senator that under a previous order, in 30 seconds, the floor will return to the Senator from Alaska, who will be able to offer amendments for the Republicans for 5 minutes, and then it will go to the Senator from Hawaii.

So the Senator from Nevada has 30 seconds remaining to present the case for his amendment.

Mr. BRYAN. May I make a parliamentary inquiry?

The PRESIDING OFFICER. The Senator will state it.

Mr. BRYAN. Am I protected under the previous unanimous-consent agreement by having offered my amendment in a timely fashion? If so, I would be happy to yield the floor and simply ask unanimous consent that Senator FEINSTEIN be added as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Alaska is recognized under a previous order for 5 minutes in which to present the Republican amendments.

Mr. McCAIN. Madam President, could I ask the Senator from Alaska to yield for a request?

Mr. STEVENS. I only have 5 minutes. I am happy to yield to my friend.

Mr. McCAIN. Would it be in order to go ahead and dispose of my previous amendment that I understand is agreed to?

Mr. STEVENS. It would be contrary to the time agreement. We must get these done by 7 o'clock.

Madam President, I have a series of amendments. Let me just read them by name of the sponsor. If there are any further ones to come, we will put them in.

I have an amendment by Senator SPECTER; another amendment by Senator SPECTER; a third amendment by Senator SPECTER; an amendment by Senator DOMENICI and Senator BINGAMAN; another by Senator DOMENICI; an amendment proposed by Senator HELMS; an amendment proposed by Senator CHAFEE; another amendment by Senator GRASSLEY; an amendment by Senator MURKOWSKI for himself and Senator DOLE; an amendment by Senator HATCH; an amendment by Senator McCONNELL; an amendment proposed by Senator DOLE; another by Senator DOLE for himself and Senator McCAIN; an amendment by Senator COHEN; a second amendment by Senator COHEN; an amendment by Senator DOLE for himself, Senator LIEBERMAN, Senator McCAIN and others; an amendment by Senator COHEN; an amendment by Senator THURMOND and Senator DECONCINI; an amendment by Senator ROTH; and an amendment for myself.

That is the extent of the amendments that have been presented.

I also have an amendment by Senator McCONNELL.

I ask that all those amendments be submitted in accordance with the time agreement. I have 2 minutes remaining. I would like to reserve those.

The PRESIDING OFFICER. Without objection, it is so ordered. The time remaining will be reserved for the Senator from Alaska.

Under the previous order, the Senator from Hawaii is recognized.

Mr. INOUYE. Madam President, I have a series of amendments that I would like to submit in behalf of my Democratic colleagues. First, by Senators NUNN and MITCHELL on Bosnia and Herzegovina; second, by Senator HARKIN; third, by Senator LIEBERMAN; fourth, by Senator SHELBY; fifth, by Senator BOREN; sixth, by Senator SIMON; seventh, by Senator BINGAMAN; eighth, by Senator LEVIN; ninth, by Senator WELLSTONE; and another BINGAMAN amendment. Senator BINGAMAN has two amendments. I have another amendment by Senator FEINSTEIN; two by Senator INOUYE; and one proposed by Senator DODD.

Mr. STEVENS. May I have time back?

The PRESIDING OFFICER. The Senator will send those amendments to the desk. Without objection, they will remain in order. Does the Senator from Hawaii reserve the remainder of his time.

Mr. INOUYE. If I may.

Mr. STEVENS. Madam President, I have an amendment by Senator KEMPTHORNE and two separate amendments by Senator HELMS. I send those to the desk and add those to the ones I previously submitted.

I, too, would like to reserve the remainder of my time.

The PRESIDING OFFICER. Without objection, those amendments will be added to the list of amendments to be considered.

The Senator reserves the remainder of his time.

The Chair informs the Senators that Senator INOUYE has 3½ minutes remaining and Senator STEVENS has 2 minutes 20 seconds remaining.

Mr. STEVENS. Madam President, I send an amendment to the desk for Senator DOLE.

The PRESIDING OFFICER. Without objection, it will remain in order.

Mr. INOUYE. Madam President, I send to the desk an amendment proposed by Senator MITCHELL and Senator COHEN.

The PRESIDING OFFICER. Without objection, it is in order. That will be added to the list of amendments.

Mr. INOUYE. I have an amendment proposed by Senator JOHNSTON.

The PRESIDING OFFICER. Without objection, it is in order.

Mr. INOUYE. I have an amendment by Senator BUMPERS.

The PRESIDING OFFICER. Without objection, it is in order.

Mr. STEVENS. Madam President, I send an amendment to the desk in behalf of Senator WALLOP.

The PRESIDING OFFICER. Without objection, it will be in order.

Mr. INOUYE. Madam President, I send an amendment by Senator DECONCINI to the desk.

The PRESIDING OFFICER. Without objection, it will be in order.

Mr. STEVENS. Madam President, I send an amendment to the desk in behalf of Senator COHEN and state that it may be duplicative of the one I previously submitted, and I ask the clerk to eliminate it if it is a duplicate.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. INOUYE. Madam President, I have an amendment by Senator BREAUX.

The PRESIDING OFFICER. Without objection, Senator BREAUX's amendment will be added to the list of amendments to be considered by the Senate.

Mr. STEVENS. Parliamentary inquiry. It is my understanding that there will be a period after we have offered the amendments for review of the amendments. Will the Chair have these amendments indicated so that each of us may have the others' amendments as quickly as possible?

The PRESIDING OFFICER. That will be the normal course that will be followed.

Mr. STEVENS. I would state, Madam President, that to the best of our knowledge those are the submissions for this side of the aisle.

Mr. INOUYE. Madam President, I believe they are complete here.

The PRESIDING OFFICER. The Chair will state that the hour of 7 p.m. having arrived, there will be no further amendments allowed under the unanimous-consent agreement.

Mr. STEVENS. Parliamentary inquiry: Those amendments will be called up by the individual Senators under the time agreement. That is the understanding.

The PRESIDING OFFICER. The Chair has no agreement on how the amendments will be disposed of. But the Chair assumes they will be disposed of in due course.

Mr. STEVENS. It is this Senator's understanding that those are the only amendments that may be considered now under the bill as pending business, is that correct—subject to the leaders having the right to offer amendments if they desire to do so?

The PRESIDING OFFICER (Mrs. FEINSTEIN). The Senator from Alaska is entirely correct in his understanding.

Mr. STEVENS. I thank the Chair. If I might address, through the Chair, the Senator from Arizona; the majority manager and myself will be considering the amendment of the Senator from Arizona concerning the disability for retired members of the armed services.

AMENDMENT NO. 2500

Mr. McCAIN. I ask unanimous consent that we set aside the pending McCain amendment concerning the Olympics and return to the previous amendment on concurrent receipts, and I ask unanimous consent that Senator DOMENICI be added as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered. The question before the Senate is amendment No. 2500.

Mr. INOUYE. Madam President, the managers of the bill have had the opportunity to study the amendment of the Senator from Arizona, and we find it to be acceptable. It will not be subject to a point of order.

So accordingly, may we have a vote?

The PRESIDING OFFICER. Is there further debate?

Mr. NUNN. What amendment is this? I did not hear the Senator.

The PRESIDING OFFICER. Amendment No. 2500.

Mr. STEVENS. It deals with the retirement.

Mr. NUNN. Is this a new retirement program? I would like to ask a couple of questions. Is this a new entitlement program? And if it is, how much does it cost? I just heard about the amendment.

Mr. McCAIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Georgia has the floor. Is he yielding the floor or asking a question?

Mr. NUNN. Madam President, I would like to ask the Senator from Arizona if this is a new entitlement program.

Mr. McCAIN. Madam President, as the Senator from Georgia knows, current law requires a career military service member who retires after a length of service and is disabled to offset his or her retirement pay with any VA disability compensation that the member receives. I do not believe you would call this a new entitlement program. What it does is provides for concurrent payment of disability pay and retired pay if the following criteria are met: A veteran has completed 20 years of military service; the disability was incurred or was aggravated in performance of duty in the military service; the disability is rated 100 percent at the time of retirement or within 4 years of veteran's retirement date.

And in response to another question the Senator asked, the costs are approximately $55 million to $60 million in additional costs incurred with this change in the law. This is $55 million to $60 million additional.

Mr. NUNN. Is that per year?

Mr. McCAIN. That is correct.

Mr. NUNN. If the Senator will yield, I think I will ask a further question. Is this a 1-year program, or is this a program that is intended to continue?

Mr. McCAIN. It would be intended to continue right now. It affects approximately 7,000 military retirees who are rated 100 percent disabled and have completed 20 years of service. I would estimate that obviously there would be very few additional people, enrollees, in this program, since one of the criteria is that the disability was incurred or aggravated in the performance of duty. That, obviously, is a very small number of people.

Mr. NUNN. I understand. The way it is worded, it is only for 12 months, but it is the Senator's intent to continue it year after year?

Mr. MCCAIN. At this time, it is a temporary waiver. It is 12 months.

Mr. NUNN. So it is a 12-month period, but it is the intent to start this as a continuing program?

Mr. MCCAIN. That would be my intent.

Mr. NUNN. Where does the money come from—out of the Department of Defense? Is it Department of Defense money that would pay for this?

Mr. MCCAIN. I say to the Senator from Georgia, yes, it comes from travel pay of senior level officers, and civilian executive travel of Pentagon staff, estimated to be approximately $370 million a year at this time.

Mr. NUNN. I have not had a chance to study this amendment. I do not want to interfere with whatever the managers of the bill may decide on the amendment, but I hope they will take a very careful look at it now in the conference. I think we have to be extremely careful about starting programs which, though they are intended for even the most deserving possible beneficiaries, become entitlement programs.

We all know that the entitlement programs are eating us alive, eating the budget apart. We are really not going to have any discretionary money at all from year to year. We are going to have it all wrapped up in entitlement programs. I am not sure exactly what this one is and how it is going to be structured, where the money will come from. And what are the implications for people less than 100 percent disabled, say, 85 percent disabled or 90 percent? Do we exclude them? If they are 50 percent disabled, are they not counted? I do not know where this leads or how much money is involved.

I hope my friends from Alaska, Hawaii, and Arizona will look very carefully at this amendment—even if it is accepted here on the floor—in conference, because the cost implications could be rather serious, particularly when these programs have a tendency to grow and grow and grow and open up eligibility beyond original intent. Before you know it, you have a first-class, sure-enough entitlement program that costs millions each year, hundreds of millions, and it goes into billions, and then we wonder why we cannot get them under control.

I know the Senator from Arizona has looked at this, but I hope everybody will do so in terms of the fiscal consequences of it, and also what it does.

Mr. BYRD. Madam President, the amendment being offered today seeks to provide a temporary waiver of the prohibition on the concurrent payment of both disability compensation and retired pay for fiscal year 1995. The amendment would pay for these additional entitlement costs out of the discretionary funds appropriated in this bill. This amendment appears to address an inequity that is worthy of redress. However, this is an issue for the authorizing committee to decide, and to pay for, out of spending in its jurisdiction.

Last year, we had before the Congress a budget resolution and a reconciliation bill. My colleagues on the other side of the aisle voted against the resolution and the reconciliation bill. They argued that those measures cut defense too much, and other spending too little. Many came to the floor during that debate to decry that entitlement spending was out of control and that the President and Congress were not doing enough to control these mandatory programs.

The amendment, in effect, cuts other programs in the bill to pay for the increased benefit costs. So, let us be clear about this point, the effect of this amendment is to cut available discretionary defense funds to pay for an increase in an entitlement. It is hard for me to believe that this can be right. How many times have we been told that we cannot cut defense any further? How many times have our colleagues decried the growth in entitlement spending and chastised the majority for failing to control mandatory increases?

Madam President, the amendment by the Senator from Arizona is a well-meaning amendment. It promises only fairness to our well-deserving disabled, military retirees, by eliminating a disparity between military retirement and other Federal retirement programs. Who can fault the logic? Are not our disabled, military retirees worthy of the best benefits we can afford to provide? Of course they are.

I feel that if we establish a pattern of using discretionary funds to correct problems in mandatory programs, however, we will find ourselves entering a thicket that will impose increasing problems for us.

The PRESIDING OFFICER. Is there further debate?

The question is on agreeing to the amendment.

The amendment (No. 2500) was agreed to.

Mr. INOUYE. Madam President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2501

Mr. MCCAIN. Madam President, I think there is further debate on the amendment that was previously set aside on the Olympics. The Senator from Pennsylvania has three short amendments. I do not know if the Senator from Georgia wants to continue debate on that amendment. I would just as soon yield to the Senator from Pennsylvania.

Mr. NUNN. Madam President, I would like to be able to make a statement on the amendment of the Senator from Arizona that relates not just to the Olympics, but other international athletic events that are in the United States. I will do it whenever it is appropriate. I do not know when that one is going to be voted on.

Is there any order decided by the managers of the bill on this amendment?

Mr. INOUYE. Madam President, parliamentary inquiry. Under the unanimous-consent agreement, will the vote on the amendment of the Senator from Arizona come up at 9 o'clock tonight?

The PRESIDING OFFICER. Under the agreement, no votes are in order until 9 o'clock.

Mr. NUNN. Madam President, what would be the order of debate then? I would like to be recognized to make about a 5-minute statement if I could. I know the Senator from Pennsylvania may want to present other amendments.

The PRESIDING OFFICER. If all the Pastore time has expired, the debate need not be germane to the pending question.

Mr. NUNN. Madam President, I would like to make a statement on the Olympic amendment if I could be recognized.

The PRESIDING OFFICER. The Senator has the floor.

The Chair would like to add one thing. On amendment 2500, the motion to reconsider the motion to lay on the table is agreed to.

The Senator from Georgia is recognized.

Mr. NUNN. I thank the Chair.

Madam President, I oppose the amendment of the Senator from Arizona relating to international games and reimbursement.

The Armed Services Committee has been working very closely with the Defense Department for a number of years on the conditions and procedures under which the Department of Defense provides unique security support to major international athletic events held in the United States. These procedures have been refined over the years through DOD support for major international athletic competition in the United States going back to the Lake Placid Olympics in 1980.

The procedures are working well. They recognize a legitimate and very important, indeed, a unique Federal responsibility that cannot be carried out in any other level, and they should not be changed on the spur of the moment, as this amendment would do.

Ever since we had the attack on the Israeli athletes at the 1972 Munich Olympics, which was a terrible tragedy, it has been recognized that our large international athletic events pose unique and major security problems. Very few communities in the United States maintain the security and public safety resources to provide security for a major international athletic event.

DOD has unique resources and expertise that can be used to assist planners in staging international events in order to protect the U.S. national security interests and avoid incidents like the terrible and tragic 1972 terrorist attack in Munich.

DOD support consists primarily of security and public safety-oriented support that is not available from any other Federal, State, or local law enforcement agency. This support is provided only under conditions that do not affect the Department of Defense's ability to carry out its military mission particularly for National Guardsmen and reservists, such as military police and a communications unit. DOD support for these events is often carried out as a part of a unit's normal training cycle. And what we try to do is encourage the Department of Defense and the National Guard units to get out in front with their planning so that the Olympic event itself can be part of the annual training of the National Guard people, which does not add budgetary cost and which give themselves good training.

Examples of this support include communications, explosive ordnance details, aviation support, for security and emergency response, as well as training.

The Department of Defense does not provide direct funding to these events. What the Department does provide is in-kind support for DOD stocks of equipment that is returned to DOD after the event is completed.

The amendment mistakenly assumed that the Department of Defense provides security support for the organization or entity staging the event, such as Atlanta's Committee for the Olympic Games, called ACOG.

What DOD actually provides is security support directly to the State and local law enforcement agencies that are responsible for providing the security for the event. The support does not go through the organizing committee. In the case of the Olympics, DOD provides security support through the Olympic security support group. Any support provided by the Department of Defense to an organizing committee is generally provided on a different basis, a noncost or reimbursable basis.

If the intent of the McCain amendment is that any of the law enforcement agencies to which DOD provides security support must reimburse the Department of Defense, I think that would be a serious mistake. The unacceptable outcome would be that these agencies would only request the assistance from the Department of Defense that they were able to afford, that they were able to budget, instead of asking for what they need to provide a safe and secure environment for the games.

If the intent of the McCain amendment is somehow to require the organizing entity of an event like the Olympics to reimburse the Department for security support, I think that would also be a serious mistake. If we require the organizing entity to reimburse DOD for security support that goes to local and State law enforcement agencies, it would mean the ultimate decision for what security measures are needed would leave. That would put those decisions in the hands of the organizing committee rather than local law enforcement agencies. This could lead to a situation where the organizing committee makes a decision for security support based on what they can afford rather than what law enforcement agencies feel is needed to provide for a safe and secure environment for these events.

Madam President, the international climate has a huge effect on what kind of security we need, for instance, in the 1996 Olympics, but this amendment would apply to all international games. It would apply to games like the Goodwill Games that will be held in, I believe, New York in 2, 3, or 4 years. It will apply to events that have taken place in places like California. It would apply to any international event.

And I will assure anyone whoever aspires to have an international event will have a very hard time complying with the amendment here and still staging that event in a secure environment.

We should understand events like the 1996 Olympics are truly a national event involving the entire Nation. If we have a terrible tragedy of the kind of terrorist attack in 1996 or any other international games held in the United States, the damage is going to be done to the entire Nation, not simply to one State or one city.

The United States is the host for all of the countries of the Olympic movement. If security for the Olympics is not adequate, it reflects poorly on the U.S. ability to host international events in an environment where security is a concern.

If DOD support is provided on a reimbursable basis, it will, I think, leave some State and local governments in a position where they simply are not able to afford the security arrangement and the precautions that are truly needed based on terrorist threats and other threats.

This is not the time to send a message to the world that the U.S. Government is going to pinch pennies when it comes to providing essential security support for a major international event like the 1996 Summer Olympics. The Federal Government and all in this country have a major stake in and responsibility for the security of international athletic events held in the United States. The modest support the DOD provides to these events is a recognition of this Federal responsibility.

Madam President, the Defense Department supports the current process and opposes this amendment.

I urge our colleagues to vote against this amendment because it could be very destructive not only to the Olympics but to other international events.

The PRESIDING OFFICER. The Senator from Hawaii.

UNANIMOUS-CONSENT AGREEMENT

Mr. INOUYE. Madam President, I ask unanimous consent that the vote on or in relation to the McCain amendment No. 2501 occur at 9 p.m. this evening.

The PRESIDING OFFICER. Is there objection?

Mr. STEVENS. Madam President, reserving the right to object, I think there may be debate on it yet. I have no objection if all debate is over by that time.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The PRESIDING OFFICER. The Senator from Georgia.

Mr. NUNN. Madam President, I will just take a moment more. I will just give examples of the games that we have had help with from the Department of Defense in the past.

We had help in the Lake Placid Olympics in 1980. We had help from DOD for the Los Angeles Olympics in 1984. We had help from DOD for the Pan Am games in 1987. We had help for the Goodwill Games in 1990. We had help for the World University Games in 1993. We had help for the 1994 World Cup. We will have DOD help for the Special Olympics in 1995, and also we plan help for the Summer Olympics in 1996.

These are matters of I think great importance. I do not think the amendment really is an amendment that is appropriate under any conditions, but certainly we should put any effective date of this amendment way out in the future, because these events are already underway and are being planned.

I can assure anyone that this would have a disruptive effect not only on the Olympics in the State of Georgia that I represent but also on the forthcoming events like the Special Olympics in 1995 and other events that may be coming to this country.

I believe the Senators from Idaho will also have an interest on this based on their own aspirations for international events.

So, Madam President, I yield the floor. But I would ask clarification if the Senator from Alaska can tell me when this will be voted on and if the yeas and nays have been ordered.

Mr. STEVENS. Madam President, it is my understanding the yeas and nays have been ordered, and we will vote at 9 o'clock under the agreement just entered into.

The PRESIDING OFFICER. That is correct.

The Senator from Alaska is recognized.

Mr. STEVENS. Madam President, I ask unanimous consent that Senator DOMENICI be added as an original cosponsor of the amendment previously adopted offered by the Senator from Arizona.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. STEVENS. Madam President, with regard to the pending amendment that has been offered by the Senator from Arizona dealing with the Olympics, I have had the honor to be associated with the Olympic movement for many years and have made many trips to the sites where we have provided some military assistance to the Olympic movement that really is in the form of security of some type.

Much of that in the past has been done by National Guard units. Others have been done by arrangements with the basic sponsoring entity. I remember the Lake Placid games, for instance.

But, I must tell my friend from Arizona, I must oppose his amendment, because I believe that, as stated by the Senator from Georgia, one of our basic responsibilities as the host country is to assure the safety of the athletes who come to our country. And we have done this. We did it in the Indiana games. We have done it in the Los Angeles games. We have done it almost in every one of the international games I know of. And the reason is that in this country of ours, where there is great freedom and opportunity and openness, there is more of an opportunity for people to endanger the lives of some of these athletes or to disrupt the games in their own personal pursuits.

I do not believe we should have an amendment like this on this bill. We do have money in this bill. I would point out to the Senator, there is an appropriation of $10 million to cover the costs of providing logistical and other support for the 1996 Summer Olympics to be held in Atlanta. We also have funds in here for the Special Olympics, which have a different type of problem as far as the ability of the Department of Defense to assure the logistic support for those games in New Haven, CT.

This has been an ongoing arrangement. It does maintain the relationship of the Department of Defense to these Olympic sports and to our international games. I think it is absolutely essential that we maintain that relationship and that we have people involved in the planning process from the very beginning to assure that we do meet our national responsibility for assuring the safety of the people involved in the games and maintaining the peace of this country.

It is, in my opinion, one of the best functions the Department of Defense has, in terms of its relationship to international sports.

It is not, I must say, something that could be reimbursed. I remember one time when there was a force of the Department of Defense standing by in case something went wrong. Nothing went wrong. Who is going to pay for that? That is part of our national responsibility. I think it must be maintained. The moneys provided in this bill are to assure those responsibilities will be met in Atlanta. I support that wholeheartedly and hope that the Senate will take that into account when we vote at 9 o'clock.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SPECTER. Madam President, I had sought recognition and have been here for a little more than an hour to take a few minutes on three accepted amendments. I wonder if my colleague from Arizona would yield for that purpose.

Mr. MCCAIN. I will not. I have to respond to the Senator.

The PRESIDING OFFICER. I have just recognized the Senator from Pennsylvania. If you wish to yield, that is up to you.

Mr. SPECTER. Madam President, I ask unanimous consent that, at the conclusion of Senator MCCAIN's comments, I be recognized for a few moments to offer three amendments, setting the present amendment aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MCCAIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Very briefly, Madam President, I say to the Senator from Alaska, I do not disagree with anything that he said. I urge him to read the amendment. The amendment says that if the games make a profit, 25 percent of that profit would go to reimbursing the Department of Defense. Only if they made a profit.

In Los Angeles, they made a profit of $122 million; $50 million went for security. I am all for that security. The Special Olympics will not make a profit, the Senior Olympics will not make a profit, and they are saying that the Atlanta Olympics will not make a profit. So I do not see where they have a problem. It is only if they make a profit, then 25 percent of that.

None of us want any derogation of security. None of us want anything but the strongest possible security which only the Department of Defense can provide.

I am just saying, if they make a profit, 25 percent of that profit would go back to the main mission of the military, which is defending the national security interest, where we do not have enough ships. We have people on food stamps, we do not have enough ships, airplanes, and guns and we are spending this money on things like Olympics, which make $122 million in profit and do not reimburse the Government for it at all.

Let us be clear on what this amendment is Madam President. It is if they make a profit, which they say they are not going to do, and it is 25 percent of the profit, not the entire profit of these Olympic games, in order to reimburse the taxpayers of America for the Department of Defense money and equipment and manpower that was expended.

I want to apologize to my friend from Pennsylvania who has been very patient throughout this debate.

I yield the floor.

Mr. SPECTER addressed the Chair.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

AMENDMENT NO. 2503

(Purpose: To provide for the reassignment of members of the Army affected by the restructuring of the Army National Guard and the Army Reserve under the offsite agreement)

Mr. SPECTER. Madam President, consistent with the unanimous-consent agreement just entered into, having set aside the pending agreement under that agreement, I call up amendment No. 2503.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Pennsylvania [Mr. SPECTER] proposes an amendment numbered 2503.

Mr. SPECTER. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . IMPLEMENTATION OF AGREEMENT ON THE RESTRUCTURING OF THE ARMY NATIONAL GUARD AND THE ARMY RESERVE.

(a) FINDING.—Congress finds that the implementation of the off-site agreement may result in the loss to the Armed Forces of military personnel who have significant military experience and expertise.

(b) REASSIGNMENT OF MEMBERS.—(1) To the maximum extent practicable, the Secretary of the Army shall ensure that members of the Armed Forces who would otherwise be separated from service as a result of the deactivation of military units of the Army National Guard and the Army Reserve under the off-site agreement be reasigned instead to units that are not being deactivated.

(2) The reassignment of a member under paragraph (1) shall not affect the grade or rank in grade of the member.

(c) REPORTS.—Not later than 15 days after the end of each calendar quarter while the off-site agreement is in effect, the Secretary of the Army shall submit to the congressional defense committees a report on the number of members of the Armed Forces who were reassigned under subsection (b)(1) during the preceding calendar quarter.

(d) DEFINITIONS.—In this section:

(1) The term "congressional defense committees" means the Committees on Armed Services and the Committees on Appropriations of the Senate and the House of Representatives.

(2) The term "off-site agreement" means the agreement on the restructuring of the Army National Guard and the Army Reserve.

Mr. SPECTER. Madam President, this is an amendment which seeks to preserve military skills which might otherwise be lost under extensive arrangements which have been made by the Army Reserve and the Army National Guard.

The issue came to my attention as a result of the threatened loss of expertise and experience of some 4,000 dedicated troops who are members of the 157th Separate Infantry Brigade, which is an Army Reserve unit headquartered in Horsham, PA. Under the arrangement between the Army National Guard and the Army Reserve, this unit would be deactivated and these 4,000 troops, who have considerable expertise, would be lost for our national defense.

After looking into the issue, it had been proposed that the deactivation be delayed until there had been a GAO study, but the Department of the Army had a considerable problem with awaiting that GAO study to carry out this agreement, the agreement being necessary because of the reduction in the Department of Defense appropriations, something that I think is necessary and in the national interest. These arrangements between the Army Reserve and the Army National Guard are entirely understandable.

So this amendment would accomplish retaining the expertise to the maximum extent possible by calling upon the Department of the Army to see to it that there be a reassignment of those who would be deactivated, either from the Army National Guard or the Army Reserve. This would save the expertise and would accommodate the many people, not only among the 4,000 in Horsham, PA, but across the country. It would have applicability beyond my State and I think it would be very good for the national defense and accommodate the interests of many thousands of Army National Guard men and women, National Guard personnel, and Army Reserve personnel.

As I understand it, this amendment has been cleared by both managers.

The PRESIDING OFFICER. Is there further debate on the amendment?

If not, the question is on agreeing to the amendment.

The amendment (No. 2503) was agreed to.

Mr. INOUYE. Madam President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2504

(Purpose: To delay the implementation of the Antler Military Operations Area)

Mr. SPECTER. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Pennsylvania [Mr. SPECTER] proposes an amendment numbered 2504.

Mr. SPECTER. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection it is so ordered.

The amendment is as follows:

At the appropriate place, insert the following:

"No funds appropriated under this Act may be obligated or expended for the purpose of establishing the Antler Military Operations Area, Pennsylvania, for the purpose of conducting aerial combat training operations until:

"(1) Region III of the Environmental Protection Agency has completed its currently ongoing Environmental Impact Review."

Mr. SPECTER. Madam President, this is an amendment which would delay the implementation of low-altitude flights in a training corridor over central Pennsylvania until the regional office of the Environmental Protection Agency has reviewed the environmental impact of these flights.

This proposed flight pattern has caused enormous distress over some 1,200 square miles in central Pennsylvania where these low-level flights would have an enormous impact on the quality of life of the people who live there.

Central Pennsylvania is a beautiful place. It is essentially rural, although there are some cities in the Harrisburg, PA area. There has been an enormous public concern about how such flights would impact on the quality of life there.

And there is a study, which is being undertaken in region III of the Environmental Protection Agency, and the implementation of these low-level flights would be delayed until region III has an opportunity to review the environmental impact.

Again, it is my understanding that this amendment is acceptable to both of the managers.

THE PRESIDING OFFICER. If there be no further debate, the question is on agreeing to the amendment.

The amendment (No. 2504) was agreed to.

Mr. SPECTER. I thank the Chair. Another one-vote victory.

AMENDMENT NO. 2505

(Purpose: To designate funds for the Vectored thrust combat agility demonstrator)

Mr. SPECTER. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Pennsylvania [Mr. SPECTER] proposes an amendment numbered 2505.

Mr. SPECTER. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

In title IV of the bill, under the heading "Research, Development, Test and Evaluation, Navy", strike out the period at the end and insert in lieu thereof ": *Provided further*, That of the amount of funds appropriated under this paragraph to be allocated to the aircraft technology program element, $5,000,000 of this amount may only be obligated for the completion of Phase I of the Vectored Thrust Combat Agility Demonstrator".

Mr. SPECTER. Madam President, this amendment calls for the allocation of some $5 million, which is now appropriated under this bill from the aircraft technology development funds within the Department of the Navy, to be used to complete phase I of the advanced rotorcraft vectored thrust combat agility demonstrator. This is a program which was established in 1991 to assess the capability of the Piasecki ringtail to improve helicopter speed, range and survivability and reduce operations and support costs.

This technology has already been subjected to very considerable expenditures, some $11.76 million of public funds and approximately $15 million by the private contractor.

This is a very highly sophisticated technology which has been developed by Mr. Frank Piasecki, whose company is conducting the research and development on this technology. Mr. Piasecki is a world-renowned developer of the helicopter. Indeed, the first helicopter a visitor encounters in the helicopter section of the Smithsonian Air and Space Museum is a Piasecki machine. He is world renowned and has done an enormous amount of work, and this technology, if it proves effective and reliable—and that is the purpose of these tests—would be crucial to protect troops transported by the new V–22's. It would turn more tightly, thereby enabling it to survive potential enemy attack and be operated at lower cost than existing helicopters and at a considerably greater speed.

This is an issue which I think would be very, very important for combat operations, as I say, especially in support of the new V–22's. And the $5 million will enable this technology to go forward. It does not call for the appropriation of any new funds, but will come out of appropriations already in existence from the aircraft technology development funds within the Department of the Navy.

Madam President, I ask unanimous consent my colleague Senator WOFFORD be added as a cosponsor of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SPECTER. I thank my colleague from Arizona for yielding time for these brief amendments.

Madam President, I am advised the managers find this amendment acceptable.

The PRESIDING OFFICER. If there be no further debate, the question is on agreeing to the amendment.

The amendment (No. 2505) was agreed to.

Mr. SPECTER. Madam President, I note another one-vote victory. I thank my colleagues for that, and I move to reconsider.

Mr. INOUYE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Oklahoma.

AMENDMENT NO. 2528

(Purpose: To require specific authorization and appropriations for construction projects for intelligence facilities and improvements to such facilities having an estimated Federal cost of more than $300,000)

Mr. BOREN. Madam President, I ask unanimous consent the amendment originally sent to the desk by the Senator from Hawaii, amendment No. 2528, be modified under the terms of the modification I will send to the desk.

The PRESIDING OFFICER. The amendment will be so modified.

AMENDMENT NO. 2528, AS MODIFIED

Mr. BOREN. Madam President, I ask unanimous consent the amendment as modified be considered under the previous request and the pending amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BOREN. Madam President, I ask the clerk read the amendment.

The bill clerk read as follows:

On page 142, between lines 7 and 8, insert the following new section:

SEC. . (a) No project for the construction of any facility, or improvement to any facility, having an estimated Federal cost in excess of $300,000, may be undertaken in any fiscal year unless specifically identified as a separate item in the President's annual fiscal year budget request, if such facility or improvement would be used primarily by personnel of the intelligence community.

(b) As used in this section, the term "intelligence community" has the same meaning given that term in section 3(4) of the National Security Act of 1947 (50 U.S.C. 401a(4)).

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. BOREN. Madam President, this amendment, which is offered on behalf of myself and the distinguished chairman of the Senate Intelligence Committee, Senator DECONCINI, is aimed at preventing the situation which has recently developed and which is well known to all of us now because of media coverage of these events. I refer to the project, the headquarters project under construction for the National Reconnaissance Office, which has now run to approximately $300 million, in excess of $300 million, in projected costs.

I have endeavored to go back over the record on this matter, some of which is still classified, as to how this project could have grown to such proportions. I must say it alarms me, and I was appalled to find that the project had grown to these proportions. In reviewing the record, I am convinced that the reason for this project becoming this large without sufficient congressional control is that in every year, starting in 1990 until the present time, no itemized request was made for this construction project. Instead, the costs of this construction project were buried in the budget of the agency in question under more generalized functional groupings.

Madam President, this has never been the case with other intelligence agencies. We always had separate items. We looked at those items. We considered the request for construction and for land acquisition. We had task forces within the Intelligence Committee, and I know the Appropriations Committee as well carefully reviewed all of these projects. That process was, in my opinion, subverted in a way by not having specific itemized requests for these construction projects presented by the NRO. The CIA, the National Security Agency, the Defense Intelligence Agency—all other intelligence agencies in the past have gone through the normal procedures of requesting items of appropriations for construction projects and have in essence gone through the same procedures required by military construction projects.

This amendment which I have just offered, which I have discussed with the ranking member and the chairman and staffs of both, would in no way want to cause these projects to be considered in a way that would not protect classified information. I think it is just essential, whether we are dealing with a classified project which cannot be openly discussed on the Senate or House floor or whether we are dealing with a project that can be openly discussed, that the taxpayers' interests must be protected. I think, for us to be able to protect the taxpayers' interests, we have to make sure separate itemized requests are made.

So, that is the reason for this amendment. I have discussed it with the current chairman of the Intelligence Subcommittee. It is based on my own experience of 6 years with that committee trying to make sure funds were appropriately appropriated and we kept tight control over any unnecessary spending. I think this is simply legislation that is needed to prevent in the future what has happened over the past 4 years because of the failure of this agency to make an itemized request, which actually did not come to the attention of the Senate Intelligence Committee fully until the independent audit unit which we established some 3 years ago began its own inquiry into the matter.

Madam President, I think this is a matter that has been cleared in terms of general agreement by both sides. I urge its adoption.

Mr. STEVENS. Will the Senator yield?

The PRESIDING OFFICER. The Senator from Alaska is recognized.

AMENDMENT NO. 2528, AS FURTHER MODIFIED

Mr. STEVENS. Madam President, I suggested an addition to the Senator's amendment if he would consider it. I do believe there is another area that should be mentioned in this amendment and there are buildings that are specifically authorized and for which money has been appropriated that could be commenced. Would the Senator consider my suggested modification to his amendment?

Mr. BOREN. I will be happy to consider that modification. Could the Senator tell me what the language would be? I see, "unless specifically identified as a separate item in the President's annual fiscal year appropriation budget request or otherwise specifically authorized and appropriated."

Mr. STEVENS. Right.

Mr. BOREN. I ask unanimous consent to modify the amendment further by adding after the word "request," the words, "or otherwise specifically authorized and appropriated."

The PRESIDING OFFICER. Without objection, it is so ordered.

Will the Senator please send a copy of that to the desk.

The PRESIDING OFFICER. Will the Senator please send a copy of that to the desk?

Mr. BOREN. I send a copy to the desk.

The amendment, with its modification, is as follows:

On page 142, between lines 7 and 8, insert the following new section:

SEC. . (a) No project for the construction of any facility, or improvement to any facility, having an estimated Federal cost in excess of $300,000, may be undertaken in any fiscal year unless specifically identified as a separate item in the President's annual fiscal year budget request or otherwise specifically authorized and appropriated, if such facility or improvement would be used primarily by personnel of the intelligence community.

(b) As used in this section, the term "intelligence community" has the same meaning given that term in section 3(4) of the National Security Act of 1947 (50 U.S.C. 401a(4)).

Mr. BOREN. Madam President, I now urge the adoption of the amendment, as further modified.

Mr. WALLOP addressed the Chair.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. WALLOP. Madam President, I have no intention of mounting a ferocious opposition to this. But I will say to my friend who was the chairman and to the existing chairman and to the committee that this is as much the committee's fault as it is the fault of the National Reconnaissance Organization.

To begin with, it was the committee that told the National Reconnaissance Organization to consolidate its budget. But most important, Madam President, there was a time on those committees when subcommittees were responsible for the oversight of specific elements. That now no longer exists. The chairman and vice chairman have held unto themselves the whole budget process, and now we go in and listen to budget presentations and none of us have the information—none of us have the information—upon which to make a judgment.

So the change in the committee from the time when all of us had a little area of responsibility and, in fact, could have been asked why we allowed this to take place—this no longer exists.

I have tried this year on the Intelligence Committee to get them to understand—our leadership on both sides; it is not a partisan issue—that it is really important that we reestablish some element of accountability amongst the members of that committee. As it has evolved, it is a catastrophe, one of which has resulted in the way we now do it.

In the old days, in the original time of the Intelligence Committee, we sat and we had areas of specific responsibility through subcommittees, and we had staff that could oversee and overlook these things.

What has happened now is a harvest that was planted and sown when out of whatever reason, the past committee chairman—and I do not even know when it started, subsequent to the time I left there. And I am not blaming anybody. I am just telling the Senate that until we go back to the time when the rest of the committee is involved in the decisions of the Intelligence Oversight Committee, we are going to have more of these, not fewer.

Mr. BOREN addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. BOREN. Madam President, I cannot comment on what the practice was of the past or the practice is now on the Intelligence Committee. I do not believe the Senator from Wyoming was serving on the Intelligence Committee during that period of time that I was chairman.

But I say to my good friend from Wyoming, during the time that I was chairman, I felt there had been very insufficient budgetary oversight and, therefore, the full committee met en banc hour after hour. Let me say, we had extraordinary attendance in which we started looking at the budgets of all the various elements of the intelligence community. That was the number one item on our agenda for the full committee. We went over every one of them. We did not just look at the baseline from prior years. We made them start with their justifications from the beginning. And we divided up our staffs into separate sections that would look at the budgets for particular agencies.

We then went further on construction projects, and I suppose the Senator from Wyoming might call this a subcommittee, but we set up a special task force of members at that time—I do not know if that practice is continuing—to particularly oversee construction projects and facilities decisions.

Every single facilities decision, except this one, and the progress on those construction projects, except this one, as far as I know, was brought before that task force which was composed of some of the members of the Intelligence Committee. They looked at cost by square footage; they looked at the prevailing commercial costs of similar facilities. And in all of these cases—and I can remember CIA facilities; I can remember DIA facilities, NSA facilities—the agencies in question, Madam President, submitted specific requests for these facilities, accompanied by specific budgets, and year by year, asked by item for an amount of money to be appropriated for that project.

We then, in addition, established during the time that I was chairman an independent audit unit for the first time so that we were simply not at the mercy of the Central Intelligence Agency or of the intelligence community to know if the money was being spent for the purpose for which we appropriated it.

That special audit unit that was approved in legislation and signed into law by then President Bush was given the authority to move anywhere in the world to examine intelligence accounts and to oversee the spending of those funds.

I might say, it was that independent audit unit that finally uncovered the full scope of what appeared to me to be significant cost overruns in this particular construction project. That was discovered only this year.

But I say to my friend from Wyoming, I feel that the National Reconnaissance office, in this case, bears a very heavy responsibility for what has happened because, unlike all of the others—and I must say that I as chairman assumed that if they were expending significant sums, they would request line items of appropriations for these sums. They did not do so.

I believe and, in fact, the very first briefing of any scale to the committee staff, interestingly, occurred in the period of time after the November 1992 elections when I was leaving the chairmanship, our staff members were leaving, our staff director, in fact, was working on a transition team, and the new staff of the new chairman was just not yet in place.

So we have a very significant project in which year by year the agency in question did not identify any line item in its budget and the amount of money it was requesting for this construction project.

So I think there was a significant lapse. That is the reason I am saying this, and I am not entering into what should now be the structure of the Intelligence Committee. I think that is appropriate for the current members.

Mr. WALLOP. If the Senator will yield, I am not, either. But I am here to say that this is not entirely and exclusively the fault of the National Reconnaissance Organization. There is at least some level of blame to be placed within the committee and its lack of oversight.

I say to the Senator, and I am not going to go on and debate the structure of it, but those budget hearings in which I participated this year were designed more to titillate than to inform, to show us the most amazing of the most amazing, and they were too short and they simply did not inform us.

I am just saying that the Senate should, as it goes into its next year's oversight responsibility, take a look at what it was that was its part of the fault that allowed this to happen. There is no exclusive blame, and I am certainly not trying to assign any to any one person, the chairman or anyone else. But the structure now does not lend itself to finding out items of this kind.

Mr. BOREN. Madam President, I will simply say to my good friend, at least during the period of time I was chairman, I would say the most significant part of my time, which averaged 4 to 5 hours a day, was spent trying to oversee the budget of the intelligence community and to make sure all the members of the committee had that information.

I also have to tell the Senator that I feel, in this case, I was misled, and I think artfully misled, by the National Reconnaissance agency, and I think the members of the committee at that time were misled, because we were given only a very generalized idea, in spite of specific report language by our committee stating that that agency should come to the relevant committees and seek prior specific approval for their construction programs. They never came, and I think we had the right to assume they would come.

Mr. WALLOP. I am not arguing the amendment, and I am certainly not trying to assign or lay blame. But this is not an exclusive problem.

Mr. BOREN. I say to my good friend, I believe it is an exclusive problem in this particular individual case because I think when an agency does not come forward and specify where it is spending its money in construction programs, that that is a responsibility that they have. Now, it is certainly the responsibility of the committee then—and as I say, we had a task force that looked at construction of capital projects. I think it is appropriate. I think there should be a task force to look at it, composed of members, as well as having staff look at it.

But I do think the National Reconnaissance office, just as the CIA, just as the NSA, just as the DIA, just as every other single intelligence organization itemizes construction requests down to the level of $300,000 or greater, the same standard followed in military construction projects. They should not be exempted from that requirement.

Mr. WALLOP. Madam President, if the Senator will yield one more time, I am not quarreling with the conclusion or the solution that he presents. I just do believe that we in the Senate, if we seek only to assign blame and never to accept, will probably not get to the point where all things are fixed.

Mr. WARNER. Madam President, will the Senator yield to the Senator from Virginia?

Mr. BOREN. I would be happy to yield.

Mr. WARNER. The committee today held a hearing, somewhat in excess of 3 hours, on this precise issue. As the Senator from Wyoming stated—and I think quite correctly—I acknowledged in my opening statement and in the course of my questioning that there were options that our committee, possibly under the Senator's jurisdiction as chairman, possibly under the period that I have shared the responsibility with Senator DECONCINI, could have taken to force the National Reconnaissance Office to be more forthcoming. An example was the specific language contained in the intelligence authorization bill in 1992. When the answers were not forthcoming, we could have simply said, "Not one dollar more until you do this." But for certain reasons, we did not do that.

So I think the Senator from Wyoming is correct in his observation. However, in the course of the hearing, I think in a spirit of fairness, both the Department of Defense through the Deputy Secretary, Mr. Deutch, and to some degree the Director of the Central Intelligence Agency, and later the Assistant Secretary of the Air Force, Mr. Harris, and others, acknowledged that perhaps there was not that degree of communication that is essential to enable the legislative branch, which has a small staff, to evaluate this project. Madam President, in this instance we had one staff person, Art Grant, a very fine individual, versus, as elicited from the NRO, 25 persons they have dealing with the budget.

So there is some limitation imposed by virtue of the size of the staff of the Senate Committee on Intelligence as to its ability to get into the details if the information is not forthcoming on a voluntary basis from the NRO.

So somewhere between these two poles lies the true story, and as yet, we are still trying to ascertain the full range of facts. And I would hope that all interested would reserve final judgment until such time as all those facts are before this body.

Madam President, if I might just say, I will have further comment—

The PRESIDING OFFICER. The Senator from Oklahoma has the floor.

Mr. BOREN. I will yield further to the Senator.

Mr. WARNER. Madam President, I was simply going to add I will ask unanimous consent to include a statement, and that I should like to have my statement appear with that given by the Senator from Nevada as it relates to his amendment, which I support as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. BOREN. Madam President, again I do not want to quarrel or prolong this discussion, but let me say the Senator from Virginia has just made the point, that the staff, even though we established a new independent audit unit during the time the Senator from Virginia was a member of the committee, a very important addition, because it left us some device of our own to be able to check to see how the agencies were spending the funds that were appropriated, an ability we never had before, we had a limited staff.

That independent audit unit has two people to try to go out and spot-check the entire intelligence budget to see if there was compliance on an independent basis on the part of the committee. In this case, one person on the staff was trying to oversee a functional area that included the National Reconnaissance Office. Let me say that we had 2 years in a row—and I quote this language—2 years in a row at least during the time I was there, and I do not know if this language was repeated later after I left the chairmanship, but the last 2 years I was chairman and this matter began to move, we had the language:

> Facility acquisition will remain subject to the prior approval of the appropriate Congressional committees.

Now, there was never a line item or a specific request made by this organization for facility acquisition or improvement and therefore none was ever submitted to us to give prior approval.

Now, we worked very hard during the time that I was chairman, and other members worked very diligently with me, to establish a bipartisan atmosphere in that committee, and an atmosphere of mutual trust between the intelligence community and the committee which was charged with oversight so that we would never be in a position again in which we had to ask exactly the right question and we had to know a lot of information in advance, some information we could not possibly have known, to have asked exactly the right question to have found out the information.

I think in this case this is clearly an example in which the community put us in the position of having to know a lot of information to ask exactly the right question in order to elicit the required information, and when we had report language directing them to come back to us and make specific requests for facilities improvements and acquisitions, I think that clearly the NRO was derelict in not meeting those requests of the committee.

And as one who has tried year in and year out to support the legitimate requests of the intelligence community, let me say that I think this was a total lapse on their part, and I do not think it was a course of action aimed at allowing the Congress to play its appropriate role in the oversight or in the appropriation of funds.

So, Madam President, I would urge the adoption of the amendment. We can argue about the past. We can argue about affixing blame in the past. I think the important thing is that we assure that the NRO, like every other intelligence agency, will have to submit requests on construction projects in the future whenever they are undertaking projects in excess of $300,000, a standard now being followed by all of the other intelligence agencies which worked very well. We were able to give complete oversight over the others because they made such requests.

I think it needs to be put in place as a matter to prevent this kind of thing from happening in the future.

The PRESIDING OFFICER. Is there further discussion?

The question is on agreeing to the amendment.

The amendment (No. 2528), as further modified, was agreed to.

Mr. BOREN. Mr. President, I move to reconsider the vote.

Mr. INOUYE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2545

(Purpose: To provide additional funds for certain Ballistic Missile Defense activities)

Mr. WALLOP addressed the Chair.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. WALLOP. Madam President, I call up my amendment numbered 2545.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

> The Senator from Wyoming [Mr. WALLOP] proposes an amendment numbered 2545.

Mr. WALLOP. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 39, line 2, strike out the period at the end and insert in lieu thereof ": *Provided further*, That not less than $120,000,000 shall be available for Sea-Based Wide Area Defense System (Navy Upper Tier): *Provided further*, That not more than $522,725,000 shall be available for Defense Reinvestment Programs.".

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. INOUYE. Madam President, will the Senator from Wyoming yield?

Mr. WALLOP. I would be happy to yield to the chairman.

Mr. INOUYE. Madam President, I ask unanimous consent that there be 40 minutes on the amendment, 20 minutes to each side, 20 minutes to be under the control of the Senator from Wyoming, and 20 minutes under the control of the Senator from Hawaii or his designee.

The PRESIDING OFFICER. Is there objection?

The Chair hears none, and it is so ordered.

Mr. WALLOP. Madam President, I ask for the yeas and nays on my amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. WALLOP. Madam President, I yield myself 12 minutes of the time allotted.

The PRESIDING OFFICER. Without objection, the Senator is recognized for 12 minutes.

Mr. WALLOP. Madam President, I offer an amendment to increase funding for a critical theater missile defense program: the Sea-Based Wide Area Defense Program, also known as Navy upper tier. The budget request for this program is $17.7 million. At that level of funding this highly promising program is essentially standing still. This was not a serious budget request, and if we fund the program at this level we will send the message that we too are not serious about this program.

My amendment would increase funding for Navy upper tier by $102 million, for a total of $120 million in fiscal year 1995. This is the exact level provided by the House Appropriations Committee—and it is the amount needed if this program is to become a coherent and high-priority part of our theater missile defense efforts.

To offset this funding increase, my amendment would reduce by the same amount funds available for defense reinvestment programs—the so-called Defense Conversion Program. Even after this cut, this appropriations bill would still provide over $520 million for defense conversion. By any honest measure, this is plenty, even excessive, given the likely benefits of the conversion program and the many other defense requirements that remain underfunded.

Let me briefly describe why the Navy Upper Tier Program needs more money and why it makes sense to take these funds from the Defense Conversion Program.

First of all, let us be clear that the administration's budget request for Navy Upper Tier in no way represents a serious effort to proceed with the program. At this level of funding, the most we can accomplish is a series of modest tests and studies. Recognizing this, and wanting Navy Upper Tier to become a genuine Theater Missile Defense Development and Acquisition Program, three of the four committees with oversight responsibility made additional funds available for this program.

The Senate Appropriations Committee did not provide additional funds for this program largely due to a concern that such a plus-up was premature. I have examined one program closely and consulted with the Navy, and I am here to tell the Senate that additional funds are not premature; in fact they are badly needed if we want to get moving any time soon.

The Navy, the Ballistic Missile Defense Organization and several major aerospace contractors have already produced detailed studies of what it would take to modify the existing Aegis Air Defense System into a wide-area theater missile defense system. It is important to emphasize that we are not talking about reinventing the wheel. One of the great advantages of a sea-based theater missile defense is that it relies on an existing system and infrastructure. The Navy's Aegis Air Defense System is already developed, deployed and proven. With minor modification—mostly in software—this system can become a highly effective wide-area theater missile defense system.

The Navy Upper Tier Program also builds on progress already made in the Navy's lower tier effort and BMDO's Lightweight Excatmospheric Projectile [LEAP] Program. Later this year, the Navy will conduct two LEAP tests using a terrier missile booster. None of these efforts are fundamentally new—all are well underway and well understood.

If we keep Navy upper tier funding at $17.7 million, as requested, the Navy will be able to do little more than concept exploration. With $120 million, on the other hand, the Navy could take the following important steps during fiscal year 1995:

Conduct one additional Terrier/LEAP test—which would reduce the technical risk of developing a tactically capable LEAP kill vehicle and would improve lethality and guidance accuracy.

Initiate aegis combat system engineering development for theaterwide capability.

Initiate integration of the standard missile-2—(SM-2)—block IV and LEAP to allow earlier fielding of capability.

Provide an option for a deployable prototype system—known as UOES—by 1998.

Provide an option to deploy an operational system by the year 2000.

Provide an integrated, two-tier sea-based theater missile defense system by the turn of the century.

As you can see, Madam President, we can get a tremendous theater missile defense capability with a relatively modest investment, and we can have it relatively soon if only we start now. This is not to say that the Navy Upper Tier Program faces no challenges or that we will be able to have a deployed system overnight. It is to say, however, that we are in no way prevented by technology from moving forward now, only by money and level of commitment.

Why do we need such a capability? The answer should be obvious to anyone who takes a serious look at the expanding threat posed by theater ballistic missiles. The trend is toward longer range missiles with more and more countries in possession of such a capability. We now know that North Korea is developing three new ballistic missiles—the No Dong, which can reach much of Japan, and two longer range systems that may cover much of the Pacific—potentially even threatening United States territory there. Many other potentially hostile countries are also developing or otherwise acquiring such ballistic missiles.

Madam President, the Navy Upper Tier Program promises to be both a highly affordable and capable theater missile defense system that could be developed before the turn of the century. Operating in conjunction with the Army's THAAD and advanced Patriot systems, the Navy upper tier system would give the United States a genuinely effective capability to defend against ballistic missiles.

A Navy missile defense system could be forward deployed and would not depend on any special basing rights. Moreover, it would not occupy scarce air- and sea-lift resources that would be much in demand at the beginning of any future conflict. For these and many other operational reasons—to say nothing of the modest cost—we would be irresponsible for not aggressively pursuing this option.

But of course funds are limited, as the distinguished chairman of the subcommittee has reminded us. My amendment, however, offers a means for paying for this important program. I propose to reduce funds for the Defense Conversion Program from $625 to $522 million in order to offset the increase in Navy upper tier.

My personal belief is that the Defense Conversion Program is an unaffordable luxury that could be cut back even further. Although there may be some useful research conducted under this program, it is pretty clear that it benefits defense capability only marginally. I have been told by numerous people in industry—including some who have directly benefited by defense conversion contracts—that this money would be better spent on real defense development and acquisition programs.

The Defense Conversion Program is intended in large part to be a means of preserving the defense industrial base. Instead, it has become a drain on limited resources. The Senator from Hawaii has correctly pointed out the inadequacy of the funds now available for defense procurement. I join him in expressing alarm over the erosion of the defense industrial base. Quite simply, we are eating our seed corn and hoping that we will not face another major threat in the future.

At the same time, however, this bill proposes to spend $625 million on a whole range of interesting, but not particularly useful, hobby horses in the name of defense conversion. We simply cannot afford to spend this kind of money on projects that have little or no direct benefit to the national security of the United States. Projects that are truly meritorious should rise to the top and be selected for funding based on the normal DOD process. By making available a huge pot of money and simply saying come and get it, we are sure to waste much of it.

Virtually every expert that I have consulted with regarding the defense industrial base has confirmed that the best way to preserve that base is to keep it busy working on real defense research, development; and acquisition efforts. To the extent that the Defense Conversion Program takes away money from these activities, it actually is detrimental to the defense industrial base and national security.

My amendment proposes to take just over $100 million away from this fund and use it for something that will not only contribute to the defense industrial base but also will beef-up our inadequate efforts in the area of theater missile defense. To illustrate this point, let me just list the contractors that are already working on the Navy Upper Tier Program:

Hughes Missile Systems Co.—Canoga Park, CA.

Boeing Aircraft Co.—Seattle, WA.

Rockwell International—Canoga Park, CA.

Thiokol Corp.—Elkton, MD.

Raytheon Corp.—Bedford, MA.

Aerojet Corp.—Sacramento, CA.

If the Navy upper tier program gets off the ground, this list is sure to grow, as contractors, subcontractors and vendors realize that this is a dedicated effort.

I would be willing to bet that any one of these companies would rather be working on a contract to build real defenses against ballistic missiles than taking defense conversion contracts that don't create any defense capability at all. And I would also be willing to bet that each of these companies would confirm that money spent on a program such as Navy upper tier is more likely to preserve key elements of their productive base than anything that they could get from a defense conversion contract.

In sum, Madam President, this amendment would transfer $102 million from a wasteful and overfunded program to one that is highly meritorious and woefully underfunded. The choice is clear: Dedicate these funds to a program that will defend Americans against a dangerous and growing threat—and at the same time help preserve the defense industrial base—or spend it on an ill-defined and bloated barrel of pork.

(Mr. ROBB assumed the chair.)

Mr. WALLOP. Mr. President, interesting to note and very probably hard to see. But here is a map of what would take place if we had such a program. Here is what we can potentially do now. This is the Sea of Japan and the aegis cruiser, and we can barely touch a piece of the Japanese mainland against the North Korean threat. Were we to do this upper tier program, we would take all of the Japanese islands. Mr. President, the only way we can defend Hawaii, the only way we can defend Alaska, the only way we can defend either of our coasts, and many of our allies, is through this program.

I reserve the remainder of my time.

Mr. WARNER addressed the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. WARNER. I would like to ask for a minute or 2 in support of the Senator's amendment.

Mr. WALLOP. I yield 2 minutes to the Senator from Virginia.

Mr. WARNER. Mr. President, I commend the distinguished Senator from Wyoming. Perhaps no one in recent history of the Senate Armed Services Committee, to my knowledge, has had a better grasp of the whole concept of strategic defenses, and particularly those involving theater nuclear defenses, than the distinguished Senator from Wyoming. As he departs the Senate this year, he will be sorely missed. Many of us are doing our very best to fill the void that he will leave.

This is an amendment that the two of us have discussed. I strongly support it. I asked that I be made a cosponsor because it would be unconscionable for our Nation, given the experience we had in the gulf with those short-range Scud missiles, to ever again forward deploy men and women in the Armed Forces without adequate protection from theater ballistic systems. And this is precisely what this amendment does. It begins to bring back up that measure of funding that is essential to keep this program alive and at a level that will properly provide this Nation with that deterrent at sea that is needed.

Mr. WALLOP. The Senator will agree with me that when three of the four committees of jurisdiction have said, A, that the request is underfunded and that, B, this is the only means by which we hope to achieve the goal and the deterrent that we have; this is the only way we are ever going to get it done.

Mr. WARNER. Mr. President, I concur in that observation.

The PRESIDING OFFICER. Who yields time?

The Chair recognizes the Senator from Hawaii.

UNANIMOUS-CONSENT AGREEMENT

Mr. INOUYE. Mr. President, I ask unanimous consent that the vote on or in relation to the Wallop amendment No. 2535 occur without any intervening action or debate immediately following the disposition of the McCain amendment No. 2501.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. INOUYE. Mr. President, I ask unanimous consent that the Wallop amendment be temporarily set aside for no more than 2 minutes to take up consideration of the Breaux amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendment by the Senator from Wyoming is temporarily laid aside.

The Chair recognizes the Senator from Louisiana, Senator BREAUX.

Mr. BREAUX. Mr. President, I first of all thank the distinguished chairman of the appropriations subcommittee for his consideration and also the Senator from Wyoming.

AMENDMENT NO. 2547

Mr. BREAUX. Mr. President, I send an amendment to the desk numbered 2547 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Louisiana [Mr. BREAUX] proposes an amendment numbered 2547.

Mr. BREAUX. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place, insert:

SEC. Notwithstanding any other provision of law, the Secretary of the Navy shall obligate, within thirty days of this Act becoming law, not less than $29,750,000 from the funds appropriated in this Act or previous Acts under the heading "Aircraft Procurement, Navy", solely to procure, on an urgent basis, AN/USH-42 mission recorders modified for use in S-3B aircraft.

Mr. BREAUX. Mr. President, I say to my colleagues briefly in fiscal year 1992 and fiscal year 1993 the Congress in the defense appropriations bill appropriated funds for the AN/USH-42 mission recorder program to be used within the A-6 aircraft program.

In the 1994 appropriations bill, the Congress ordered the Navy to verify that that mission recorder is required in the future for Navy aircraft for peacetime training involving damage assessment in combat.

The assessment by the Navy is completed, and the Navy said there is no particular requirement for the mission recorder based primarily on the decision to retire the A-6 aircraft. However, Mr. President, the Navy has conducted in their own words an independent review to examine other platforms for possible use of the AN/USH-42 and have determined that a modified AN/USH-42 could beat the S-3 attack aviation mission recorder requirements. In other words, the Navy is saying it cannot use it on the A-6 that is being phased out, but they can use it for their S-3 attack aviation operations.

Mr. President, my amendment simply directs the Navy to, in fact, use these mission recorders on S-3B aircraft, as I have explained, and I will ask for approval of my amendment.

The PRESIDING OFFICER. Is there further debate?

Mr. INOUYE. We have no objection.

The PRESIDING OFFICER. Is there further debate? If not the question occurs on the amendment offered by the Senator from Louisiana.

The amendment (No. 2547) was agreed to.

Mr. BREAUX. Mr. President, I move to reconsider the vote.

Mr. INOUYE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Who yields time?

Mr. WALLOP addressed the Chair.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. WALLOP. Mr. President, the time situation being the Senator from Wyoming has used up something in the neighborhood of 12 or 13 minutes of his time, I would ask he be allowed to reserve his time if you want to go to another amendment.

The PRESIDING OFFICER. The Chair will remind the Senator he has 8 minutes and 35 seconds under his control remaining.

Mr. WALLOP. Mr. President, in view of the fact there no opposition time has been utilized, I would not like to share it equally. I do not think that is quite appropriate.

I ask unanimous consent that until such time as someone is prepared to oppose it, unless the two leaders would like to drop the time agreement and vitiate the yeas and nays and they would accept it.

The PRESIDING OFFICER. Is there objection to the unanimous-consent request propounded by the Senator from Wyoming to allocate time equally?

Mr. INOUYE. Mr. President, the Senator from New Mexico should be coming shortly to discuss this matter in opposition. But in the meantime, I ask unanimous consent that the Wallop amendment be temporarily set aside to accommodate the Senator from Nevada for no more than 5 minutes.

Mr. BRYAN. Six minutes at the outset.

Mr. WALLOP. Mr. President, reserving the right to object, and I shall not object, I want the Chair to make clear my request was not to divide the time equally.

Mr. INOUYE. Without the time running on either side.

The PRESIDING OFFICER. Is there objection to the unanimous-consent request propounded by the Senator from Hawaii?

If not, it is so ordered, and the Senator from Nevada, Senator BRYAN, is recognized.

Mr. BRYAN. I thank the Chair and I thank the floor manager.

I might inquire of the Presiding Officer the amendment number of the Bryan amendment which was offered earlier this evening.

The PRESIDING OFFICER. The Chair will inform the Senator that the number is 2502.

Mr. BRYAN. Mr. President, I ask unanimous consent that Senator DECONCINI and Senator WARNER be added as original cosponsors to the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Arizona and Virginia are added as original cosponsors.

NATIONAL RECONNAISSANCE OFFICE

Mr. BRYAN. Mr. President, I earlier commented before the time pursuant to the unanimous consent had expired on another matter to begin explaining the nature of this amendment. It deals with the National Reconnaissance Office, which most of us were startled to learn yesterday morning, is now estimated to cost between $310 million and $350 million.

The genesis of this building dates back to the early 1990's and late 1980's in which the intelligence committees of the respective bodies were encouraging the colocation of some facilities that were scattered all over the country into a single facility.

I was not a member of the committee at that time, having just joined last year.

But earlier this afternoon, as part of a Senate Intelligence Committee hearing, I had occasion to review the record as I did yesterday with staff. Suffice it to say that the distinguished senior Senator from Virginia, the ranking member of the Intelligence Committee, who was a member of the committee during all of the times that are relevant to the construction of this National Reconnaissance Office made the assertion that at no time did the National Reconnaissance Office indicate to the Senate Intelligence Committee that it was preparing to build a building of a magnitude of a million square feet, the cost of which is about $175 per square foot, and that what really occurred is it was incrementally included in the baseline but never specifically authorized prior to its commencement.

Mr. President, I say that my reading of the RECORD reaches the same conclusion as the distinguished Senator from Virginia.

Now, in the hearing this afternoon we learned that the head of the CIA and the Under Secretary for the Department of Defense are conducting a review.

The purpose of the amendment which I have offered is to seek to withhold any unobligated funds to be committed to the further expenditures in this building until such time as that review is completed and a report made back to the Intelligence Committees of the Senate and of the other body.

Let me emphasize it is not my purpose to in any way interfere with any contractural relationship that currently exists, but we know that at least $50 million is unobligated for such items prospectively, furnishings and fixtures of these elaborate facilities.

It is absolutely shocking, Mr. President, because four towers are under construction. The fourth tower, the most elaborate, the fanciest, which has huge office space and has very, very extravagant provisions in it, was authorized in 1992 by the National Reconnaissance Office. That is after the implosion of the former Soviet Union, after the Berlin Wall came down, after the Warsaw Pact had disintegrated.

This is highly irresponsible conduct and, in my judgment, is an absolute outrage to the taxpayers.

One of my colleagues during the course of this afternoon's hearing referred to it as a goldplated palace, and it is that.

So the purpose of this amendment is simply to say that before you spend any more unallocated moneys for any aspect of this project, since it has never been before the Senate Intelligence Committee, for a preauthorization from start to finish, that the committee have an opportunity to look into it. We have an opportunity, Mr. President, to save tens of millions of taxpayers' dollars if we act promptly, and I am hoping that the distinguished floor managers can support this amendment.

I emphasize we do not in any way impinge upon existing contractual rights, and this money would be subject to review after this executive agency review which I have described.

I yield the floor and thank the floor managers for accommodating me and thank my colleagues who joined as sponsors.

AMENDMENT NO. 2502, AS MODIFIED

Mr. INOUYE addressed the Chair.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. INOUYE. Mr. President, will the Senator from Nevada yield?

Mr. BRYAN. The Senator from Nevada would be happy to do so.

Mr. INOUYE. May I suggest that the amendment be modified so that on page 2, on the last line, line 6, we add a comma after "Representatives" and add the following: "and the House and Senate Committees on Appropriations."

Mr. BRYAN. I am agreeable with such an amendment.

Mr. INOUYE. With that modification, the managers will accept the amendment.

The PRESIDING OFFICER. Is there objection to the modification.

If not, the amendment is modified accordingly.

The amendment (No. 2502), as modified, is as follows:

On page 142, between lines 7 and 8, insert the following new section:

SEC. . Of the funds made available by this Act for the National Reconnaissance Office under the classified Schedule of Appropriations accompanying this Act, funds allocated for construction of the headquarters buildings of the National Reconnaissance Office which were unobligated as of the date of enactment of this Act may not be obligated or expended until the Director of Central Intelligence and the Secretary of Defense have completed a review of that construction project and the results of such review have been disclosed to the Select Committee on Intelligence of the Senate and the Permanent Select Committee on Intelligence of the House of Representatives, and the Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives.

The PRESIDING OFFICER. Is there further debate?

Mr. BRYAN. Mr. President, I simply want to express my appreciation to the distinguished Senators from Hawaii and Alaska for accepting the amendment. I do think we have an opportunity to correct what is clearly an excessive expenditure.

I thank them both for their responsible action.

The PRESIDING OFFICER. Is there further debate?

If not, the question is on agreeing to amendment No. 2502, as modified, offered by the Senator from Nevada.

The amendment (No. 2502), as modified, was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Who yields time?

Mr. INOUYE addressed the Chair.

The PRESIDING OFFICER. The Senator from Hawaii, Senator INOUYE.

AMENDMENT NO. 2545

Mr. INOUYE. Mr. President, I believe I should respond to the Senator from Wyoming to explain to the Senate the reasons for the action taken by the committee.

The committee, in studying the request by the Ballistic Missile Defense Organization, provided the full budget request amount that the BMDO had suggested, $18 million, and we could not go beyond that.

It is true that the House has added funds for this program and we felt that it could be considered in conference. It may interest my colleagues to know that in a memo dated July 11 of this year, the Chief of Naval Operations, Admiral Boorda, stated that the lower tier system was the Navy's first priority. The Department is just now beginning a cost and operational effectiveness analysis of this upper tier program.

Therefore, adding funds or accelerating this program before this cost and operational effectiveness analysis is complete would be premature and prejudges the outcome of the DOD analysis, which itself will cost about $5 million to complete.

So, all in all, because of the technical concerns and the ongoing analysis, the committee felt that any acceleration in the Navy upper tier missile program would be premature.

Mr. WALLOP addressed the Chair.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. WALLOP. Mr. President, I yield myself 2 minutes.

The PRESIDING OFFICER. The Senator is recognized accordingly.

Mr. WALLOP. Mr. President, I feel as though I am being done in; that the opposition to this amendment is reserving all of its time and sort of calling on me to waste mine.

But let me just say, I realize the Navy requested only the $17.6 million. But the problem is that the Navy was instructed to request—and this would not be the first time in the experience of the Senator from Wyoming—that the Appropriations Committee, specifically the subcommittee headed by the distinguished chairman, ignore what the Navy requested or the Army and Air Force requested, and ignore, in fact, what the Senate Armed Services Committee did.

We once had a rather gruesome little fight on the floor, which I will admit that I lost. One of the reasons I lost was because they appropriated things for which we had no authorizations. They appropriated things for which there were higher authorizations.

The purpose of the amendment of the Senator from Wyoming is to do one thing: To take the money, the $100 million, out of defense conversion, which is nothing but a corporate entitlement program, and put it into something that buys some defense for Americans. And three of the four committees of oversight have recommended this.

Mr. President, it is a question, when the administration and everybody says the only thing really threatening Americans and their allies now is missile proliferation, that we say we are going to spend a piddly little $17.6 million, which even the Navy now says is a waste of money and will get us nowhere nearer our goal. We will have some reports made and some lovely bound books printed, and other kinds of things, but we will not be able to defend ourselves from anything.

What the Senator from Wyoming is trying to do is to take the money that has been said to be useful and to provide a defense. And, keep in mind, Mr. President, that the Army THAAD and other kinds of things have to be moved overseas or through the air; the Air Force's programs are not yet available to us; the Navy's can be deployed with all the kinds of confrontation that took us how many months to make a piddly decision to move an inadequate system to Korea called the Patriot.

The Navy—again, let me show the map of what it can do. Here is what Aegis can now do. This is Korea and all of this under here is Japan. Look at what would happen if we had the Navy upper tier, the kidney-shaped thing. You can take care of all of Japan, and most of the western Alaskan islands down through Korea and Taiwan. We will either be able to do something useful about defending Americans and American allies from missiles or we will waste money spending $17.6 million and $100 million buying no defense.

Mr. President, almost two-thirds of $1 billion has gone into this corporate thing called defense conversion, which buys Americans nothing. And it is supposed to sustain the defense industrial base. How can you defend the defense industrial base by wasting money on things that do not result in weapons or security?

This is a small little thing. In case the Senator from Wyoming is wrong, $100 million out of two-thirds of $1 billion going into something that all of us know is of use, can produce, and has the technology. We merely need to know how to integrate it.

Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. INOUYE. Mr. President, I ask unanimous-consent that I be permitted to yield a minute to the Senator from Maine.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Maine is recognized for up to 1 minute.

AMENDMENT NO. 2548

Mr. COHEN. Mr. President, yesterday I advised Senator INOUYE that I intended to offer an amendment to this appropriations bill dealing with the Conventional Forces in Europe Treaty.

My understanding is that my staff submitted the language itself about a few minutes after 7 o'clock, and so it would not qualify under the unanimous consent agreement. So I now ask unanimous consent that this amendment be allowed to be considered during the debate before the conclusion of the bill.

The PRESIDING OFFICER. Is there objection to the unanimous-consent request propounded by the Senator from Maine to consider the amendment?

If not, the amendment is in order.

Mr. COHEN. I thank my friend from Hawaii.

AMENDMENT NO. 2545

The PRESIDING OFFICER. Who yields time.

Mr. STEVENS. Does the Senator have any time left?

Mr. WALLOP. Would the Chair state the time circumstance?

The PRESIDING OFFICER. The time remaining chargeable to the Senator from Wyoming is 4 minutes and 20 seconds. The time remaining to the Senator from Hawaii is 17 minutes and 4 seconds.

Who yields time?

Mr. INOUYE. I yield 5 minutes to the Senator from Alaska.

The PRESIDING OFFICER. The Senator from Alaska, Senator STEVENS, is recognized for up to 5 minutes.

Mr. STEVENS. Mr. President, the chairman of the subcommittee is generous, because I rise to support the amendment of the Senator from Wyoming, which I know that the Senator from Hawaii does not support.

I believe that Senator WALLOP has correctly noted the emergency situation in the ballistic missile threats that face us in the northern Asia area. I do believe that we have reviewed these intensively in the Intelligence and Appropriations Committees. The flexibility that would be afforded by a sea base system is essential. In my judgment, we should proceed now.

While I have joined the chairman in supporting the defense reinvestment budget, I do believe that Senator WALLOP's amendment addresses a much greater need. He addresses the acute shortfall in our missile defense effort. Development of Patriot, ERINT, and THAD meet the land-based requirements. The Senator correctly noted there is this emergency in the Asian area, and I believe his amendment should be adopted.

I yield the remainder of the time that was yielded me.

The PRESIDING OFFICER. Who yields time?

Mr. WALLOP. Mr. President, I ask unanimous consent Senator MCCAIN be listed as a cosponsor and reserve the remainder of my time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WALLOP. Mr. President, I suggest the absence of a quorum.

Mr. STEVENS. Will the Senator withhold that? Would it be in order to set aside this amendment and turn to the amendment of the Senator from Idaho? Could we set aside the Wallop amendment? We are still waiting for one person to speak on that. I ask unanimous consent the pending amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered. The time allotted under the previous order is set aside, and the Senator from Idaho, Senator KEMPTHORNE, is recognized for up to 5 minutes.

AMENDMENT NO. 2538

(Purpose: To restrict funding for United States military personnel in Somalia)

Mr. KEMPTHORNE. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Idaho [Mr. KEMPTHORNE], for himself, Mr. WARNER and Mr. CRAIG, proposes an amendment numbered 2538.

Mr. KEMPTHORNE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, insert the following new section:

RESTRICTION ON FUNDING UNITED STATES MILITARY PERSONNEL IN SOMALIA

SEC. . None of the funds appropriated by this Act may be used for the continuous presence in Somalia of United States military personnel after September 30, 1994.

Mr. KEMPTHORNE. Mr. President, I ask unanimous consent that Senator WARNER and Senator CRAIG be added as original cosponsors.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KEMPTHORNE. Mr. President, in January of this year I visited Mogadishu. I was astounded at what I saw there in Somalia. An effort that had begun for relief purposes, for humanitarian purposes, to feed starving people at that point in time had become a situation where you were stepping into a war zone. It was absolutely apparent that it was a dangerous place to be.

Of course, it is there we lost 18 very brave Rangers.

Last year the Senator from West Virginia offered an amendment that was adopted by Congress. It said we prohibit the deployment of United States combat troops in Somalia after March 31, 1994. That was accomplished. But it did allow for a small contingent of United States military to remain there in order to provide protection for United States diplomats who would also remain there. We have 58 marines who are members of the fleet antiterrorist security team who are in place, and 20 diplomats. I have to say with regard to these Americans—the marines, the diplomats—it takes guts to be there. They have it. I also should note offshore we have an amphibious ready group, a Marine expeditionary unit. So we have about 4,000 United States military personnel off the coast of Somalia who are there in the event we need to go in for rapid extraction of United States personnel.

We were assured that after June 30 of this year, all of the military personnel would be out of Somalia. It was by happenstance I learned that June 30 came and went and our military personnel were not out of Somalia. I discussed this with the Armed Services chairman, Senator NUNN, and with the ranking member, Senator THURMOND. We held a hearing on July 21, 1994. As a result of that hearing, where we were briefed by the Department of Defense and by the State Department, 16 of the 22 members of the Armed Services Committee sent a letter immediately to the President of the United States urging him to withdraw all United States military personnel from Somalia by August 14.

We can see that date is not going to be met. But let me just read the names of those Senators who signed this letter urging that withdrawal: Senators NUNN, THURMOND, BYRD, WARNER, SHELBY, COATS, LEVIN, SMITH, GRAHAM, COHEN, MCCAIN, LOTT, LIEBERMAN, FAIRCLOTH, HUTCHISON and myself.

So why do I raise this issue? When you have an embassy in a country, are you not normally going to have a Marine detachment that is there to protect your diplomats? The problem is there is no embassy. There is no embassy and there is no one to protect that because there is no government in Somalia.

Normally, a host government provides protection in the streets surrounding the area where your personnel are located. This is what is in the streets of Somalia. This is a picture of one of the technicals. These are the vehicles that are roaming throughout Somalia with a concentration in Mogadishu. You can see here a .50 caliber machinegun. You can see this individual is holding a rocket-propelled grenade launcher. This is the same sort of equipment that was used to down the aircraft when the firefight erupted that caused the death of the Rangers. That is what is roaming the streets of Mogadishu.

Is it just one faction? Absolutely not. You have Aideed and you have Ali Mhadi—two factions. And it is very clear that they are back at war. It is very clear, according to the State Department, that their attitude is winner take all, no reconciliation in sight.

Where are our marines staying? Where are the diplomats? Here is a photograph of Mogadishu. The compound where they are located. This fence is what separates them. Repeatedly—repeatedly the U.S. Government has complained to the United Nations of the lack of security of the perimeter of this facility. It is not being addressed. So what is the assessment?

The Honorable Chas Freeman, who is the Assistant Secretary of Defense, has stated with regard to Somalia: "The situation has continued to deteriorate. Prospects for national reconciliation are bleak. And U.S., UNISOM, and relief organization personnel are increasingly in danger."

Let me remind this body of what President Clinton stated with regard to our goals in Somalia. He said, "It is not our job to rebuild Somalia's society or even to create a political process that can allow Somalia's clans to live and work in peace. The Somalis must do that for themselves."

So what is the assessment, then, of the Joint Chiefs of Staff of the Armed Services of the United States? They say that there is: A high threat of attacks, banditry, looting for all unsecured movements and facilities; No political settlement in sight; Large scale interclan fighting expected; High threat of spillover violence against U.S./U.N. personnel; The United Nations are selectively targeted. The United States is also now being selectively targeted. Chance will attack when they perceive U.S. and U.N. interference.

Mr. President, 58 marines are in that situation. They are the best fighting individuals of any armed service in the world. But 58 marines in that situation are a token force. And one of the lessons that we have learned is, you go in with an overwhelming force or you simply get yourself in a real dilemma; 58 marines in that environment is just enough to get in trouble.

The amendment I offer would cut off funds for the continuous deployment of United States military personnel in Somalia after September 30, 1994. The amendment would result in the withdrawal of United States military personnel from Somalia by October 1, 1994. But after consultation with various experts, it would not tie the President's hands regarding any future military deployments to Somalia.

As a member of the Armed Services Committee, I remember the hearing we held where we listened to the fathers of the Rangers who were killed in Somalia. I remember every one of us was deeply moved by that. And I remember they raised the question as to whether or not their sons had died in vain. But they said they hoped we have learned something from that and, if we had learned something from that that might protect other personnel in Somalia, it would not be in vain.

Mr. President, every assessment that you will look to from the Joint Chiefs of Staff, from the Department of Defense, from the State Department say that there is no reconciliation in sight in Somalia. Why then are we continually leaving at risk U.S. personnel?

It is absolutely time for them to be withdrawn from Somalia and for us to move that 4,000 amphibious-ready group from the coast of Somalia. That is what this amendment will accomplish, Mr. President.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator's time has expired.

Who yields time?

Mr. INOUYE. Mr. President, I yield whatever time is necessary to the Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico is recognized for up to 15 minutes and 42 seconds.

AMENDMENT NO. 2545

Mr. BINGAMAN. Mr. President, I very much appreciate the time. I will not use the full 15 minutes, but I would like to make a few statements, at least, in opposition to the amendment that the Senator from Wyoming has offered.

As I understand his amendment, he is proposing to take, I believe it is, $102 million out of the technology reinvestment project and transfer that money to an activity designated the Navy Upper-Tier Ballistic Missile Defense Program.

Let me start by giving some background about the technology reinvestment project. This is a subject that many of us in the Senate worked very hard on in the last few years. I think it has been a successful program.

The TRP, or technology reinvestment project, is a program that was established to accomplish some of the defense conversion activity which we felt was important at this time after the end of the cold war. A specific amount of research and development funding has been set aside in the Department of Defense budget for initiatives that industry comes forward with that are defense related but that have a dual-use purpose.

The idea was that industry would know better than the Government where the opportunities were to use defense-related technology in a dual-use capacity. So the technology reinvestment project was designed with that in mind, and it is important to note that the project is one that requires a cost share, a 50-percent cost share, by industry, and it also requires the industry initiative in order for a program to be funded under this TRP.

It is administered by the Advance Research Projects Agency, ARPA, in the Department of Defense but in cooperation with the Department of Energy, with NASA, with the Department of Commerce, the Advance Technology Program people at NIST in the Department of Commerce. They all work together to administer this program, and it is a very successful program, Mr. President.

This last year, the amount available was somewhere in the range of $500 million. There were 2,800 proposals last year from industry for that funding. When the analysis had been done of the various proposals, right at 5 percent of the proposals were actually able to be funded.

So this is a program which is substantially oversubscribed by industry. There is a tremendous pent-up demand by industry that has been involved in the defense effort to pursue activities that can be funded through the technology reinvestment project—half funded through the technology reinvestment project, half funded by those industrial partners themselves.

This technology reinvestment effort has the strong support of Secretary Perry and Deputy Secretary Deutch. It has the strong support of the President and the Vice President. It has continued to have overwhelming demand in various of the focus competition areas. There is clearly a need here, and that need is one that this committee is trying to meet in the bill that it has presented to the Senate for consideration.

I commend the Senator from Hawaii and the Senator from Alaska for the funding that they have proposed for the technology reinvestment project. I think it is very consistent with what we have tried to do in the authorization bill. It is certainly consistent with the desires of the Department of Defense, and it is something we should not be reducing in order to fund the program which is specified by the Senator from Wyoming.

Just to say a few words about the alternative use of this money that the Senator from Wyoming has come up with, my information on this is that the committee has provided the exact amount of funds that the Navy and the Department of Defense requested for this activity, this Navy upper-tier program. The House added funds for it, and clearly the matter will be open for consideration in conference. But our own committee in the Senate, the Defense Appropriations Subcommittee, has funded it at the level that the administration asks.

Clearly, the first priority, as I understand it, of the Navy in this area is the lower-tier system, not the upper-tier system. They have made that clear. Admiral Boorda, the Chief of Naval Operations, signed a memo on July 11 stating that the lower-tier system was the Navy's first priority.

The Department of Defense is just now beginning a cost and operations effectiveness analysis on this Navy upper-tier program. And, accordingly, they did not think this kind of high-level funding that is being requested by the Senator from Wyoming was appropriate at this time.

Adding funds or accelerating this program before this analysis is complete is premature and prejudges the outcome of the Department of Defense analysis which itself will cost about $5 million to complete. It is not a cursory analysis.

The Department of Defense study may well recommend a naval version of the theater high-altitude area defense, or THAAD Interceptor. Thus, no well-defined program exists which would support the addition of these funds at the expense of other valid Department of Defense programs.

I also point out that we watched the administration negotiate for months with Russia on changes in the Anti-Ballistic Missile Treaty, and we know that the Russians oppose the Navy upper-tier system as it is presently proposed.

The recent United States offer to the Russians under the Anti-Ballistic Missile Treaty negotiations could preclude deployment of this Navy upper-tier system for which the Senator from Wyoming wants to increase funding. These funds could be wasted if the United States negotiates ABM Treaty restrictions which prohibit this Navy upper-tier system from being deployed.

The Navy upper-tier program is a very risky program relying on technologies which have not been proven or demonstrated. Significant questions exist about the lethality of the lightweight exo-atmospheric projectile and its ability to precisely impact a reentry vehicle.

Nora Slatkin, who is the Assistant Secretary of the Navy for research, development and acquisition, testified that the Navy upper-tier technology is not mature enough to be demonstrated for at least another 5 years. Technical concerns and the ongoing analysis I earlier referred to and the U.S. stance in the ABM Treaty negotiations—all of those factors argue strongly against any acceleration of this Navy upper-tier missile defense program.

Mr. President, to summarize, the technology reinvestment project is an extremely important initiative that was started under the Bush administration. It is being carried on by the Clinton administration. It needs to be continued. It needs to be supported. We have a long way to go to make the conversion for our defense sector from the cold war era to the post-cold-war era. They are working hard at it. These funds, through the technology reinvestment project, are an extremely important part of them making that transition. We need to support that program. We should not be taking funds away from it and earmarking it for other activities. Particularly, we should not be earmarking these funds for this particular program that the Senator from Wyoming is championing here tonight.

For the reasons I have stated, that program is not mature enough to justify the kind of funding he is requesting. I urge my colleagues in the Senate to resist his amendment.

I appreciate the time that has been granted to me by the Chair, and I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. INOUYE. Mr. President, I am pleased to yield time to the Republican leader.

The PRESIDING OFFICER. The Chair recognizes the Republican leader, Senator DOLE.

Mr. DOLE. Mr. President, I did not have any comment on the amendment. Is the amendment going to be accepted? Why not go ahead and do that and then maybe I can be recognized.

Mr. INOUYE. Mr. President, I ask unanimous consent that Senator WOFFORD be named as a cosponsor of amendment No. 2505.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. INOUYE. Mr. President, I also ask unanimous consent that Senator DOLE be permitted to submit an amendment at this time.

The PRESIDING OFFICER. Without objection——

Mr. WALLOP. Mr. President, reserving the right to object, and I shall not object——

The PRESIDING OFFICER. Is there objection?

Mr. WALLOP. I would like to have 2 minutes before the hour of 9 o'clock comes along to answer some of the points that were raised by the Senator from New Mexico.

Mr. STEVENS. Mr. President, pursuant to the time agreements previously entered into, I send an amendment to the desk for the minority leader, Mr. DOLE.

Mr. WALLOP. Mr. President, what is the pending business?

The PRESIDING OFFICER. The pending business is the amendment submitted by the Senator from Wyoming. There is 4 minutes and 20 seconds remaining. The Chair also observes that there are about 3 minutes remaining until 9 o'clock, and under the previous order, all the time on that amendment would expire at that time.

Mr. WALLOP. Mr. President, I ask that I might regain the floor in behalf of my amendment.

Mr. STEVENS. Mr. President, would it not be better order for us to let the Senator from Wyoming complete his time before we start the time at 9 o'clock?

I ask unanimous consent we just extend this so he can finish his 4 minutes, and then we have the votes.

Mr. WALLOP. I am perfectly willing to complete at 9 o'clock, if I can just get on with it.

The PRESIDING OFFICER. The Senator from Wyoming is recognized for up to 3 minutes.

Mr. WALLOP. Mr. President, the Senator from New Mexico was describing a pet project of his, TRP, or defense conversion. Let me just explain to Senators that it buys no defense. It really buys no technology. And it buys no hardware. It does buy some stockholder good will, and it does buy some corporate souls. It is, in effect, nothing more than a defense industry entitlement.

Mr. President, the amendment that I have submitted takes $100 million out of a program that has two-thirds of $1 billion in it. It has more money than the entire money for the Marine Corps. It has as much money in it as all of the combat aircraft procurement. It has $200 million plus more than the entire national missile defense budget, and $150 million more than THAAD.

The argument is that we ought to go on something on which we are spending money that buys us nothing because the Russians oppose it.

Now, Mr. President, the administration has said if we are serious about defense—and they say they are—the one thing that is threatening to America and her allies is missiles and missile proliferation.

The Navy has said that we can have a prototype by the year 1998 and an operational system by 2000 if we fund it at this level. At least, for heaven's sake, Senators, if we are going to spend any money on defense and out of the defense budget, let us spend it on something that achieves a level of defense that Americans can have.

The Senator from New Mexico said there are significant questions about the capability. Of course, there are. That is the purpose of my amendment, to resolve those questions and buy American defense.

Mr. President, time is up. I yield back the remainder of whatever it may.

The PRESIDING OFFICER. All time is yielded back. Under the previous order, the question is on agreeing to amendment No. 2501, offered by the Senator from Arizona.

Mr. STEVENS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The absence of a quorum has been suggested. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MITCHELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER OF PROCEDURE

Mr. MITCHELL. Mr. President, the managers have suggested that the Senate now complete debate on the Kempthorne amendment, and then have three votes in succession. I believe their suggestion is appropriate. It has been cleared on both sides.

So I now ask unanimous consent that there be 10 minutes of debate on the Kempthorne amendment No. 2538, 5 minutes under the control of Senator SIMON, 5 minutes under the control of Senator KEMPTHORNE, and that the vote on the Kempthorne amendment occur following the two votes previously scheduled; and that for the three votes that would then be scheduled the first be for the regular time, 15 minutes, and the second and third votes be for 10 minutes.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. MITCHELL. Mr. President, the vote on the Kempthorne amendment will be the last vote today. So there will be three votes beginning in approximately 10 minutes, the first 15 minutes, the second and third 10 minutes, and those will be the only votes remaining this evening.

I thank my colleagues. I thank the managers for their suggestion.

The PRESIDING OFFICER. Who yields time?

Mr. SIMON. Mr. President, I ask for the yeas and nays on the Kempthorne amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. Who yields time?

Mr. SIMON addressed the Chair.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. SIMON. Mr. President, I rise in opposition to the Kempthorne amendment. It is well-intentioned. But I think it is unwise.

We have roughly—I am not sure of the amount exactly—but roughly 300 American personnel in Somalia. This amendment would say we have to pull all of these people out. The people who are there are protecting our liaison office, and some are providing some technical assistance on such things as pure water and that sort of thing. We have asked other nations to have troops there. And we have pulled out almost all of our troops.

I was asked by a representative of the administration to talk to one of the leaders of Africa who has troops there urging that he keep his troops there pointing out that we would keep a residue of troops there.

I do not think we ought to be sending a signal to terrorists that, if you cause some problems, American troops will pull out. There are problems in Somalia. But let us leave it up to the administration, up to the Defense Department, when to pull those troops out.

I would add we have to be willing to take some risks. I wish we lived in a risk-free society. But when people enlist in the Armed Forces, there are risks that have to be taken just as people who enlist in the Chicago police department know that there are certain risks that have to be taken.

Somalia was not a disaster from the viewpoint of the United States. We saved who knows how many lives. Well over a million lives I believe were saved by our action there. It has not turned out the end product politically as well as we had hoped. But frankly, it was one of George Bush's finest hours when we used the U.S. military to see that desperate people in a land that was ungoverned got the food that was needed. Senator METZENBAUM and I were in Somalia. Before we entered we saw the devastation like devastation I have never seen before.

Finally, I would add. Yes. There were casualties in Somalia. But there were fewer people, American service personnel, killed in Somalia than cab drivers killed in New York City last year. I do not want one additional person to be killed unnecessarily. But I think we have to recognize that when you enlist in the Armed Forces there are risks, and we should be a force for stability in that area of the world.

I do not think we should micromanage this from the U.S. Senate. We ought to leave it up to the administration, up to the Defense Department, to make this decision.

I hope the Kempthorne amendment will be defeated.

The PRESIDING OFFICER (Mr. AKAKA). Who yields time?

Mr. MITCHELL. Mr. President, I suggest the absence of a quorum. I withhold my request. The Senator from Idaho I understand is now here and prepared to debate. I withhold my request.

Mr. KEMPTHORNE addressed the Chair.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. KEMPTHORNE. Mr. President, thank you very much.

I would like to acknowledge the comments made by the senior Senator from Illinois. Much of what I was able to hear I have to say I fully respect, and acknowledge that when you deploy military personnel you know that there may be in fact casualties. When you do that, though, Mr. President, you need to know what the mission is. The mission in Somalia changed on us. It went from humanitarian relief to trying to apprehend Aideed. Then there is the statement that I read by the President of the United States who said that our goal is not to establish a new society in Somalia. We must leave that to the Somalis. Our job is done in Somalia.

It has been stated, Mr. President, by the Department of Defense, by the State Department—if I had my papers here I would read to you—that the prospect of a peaceful settlement is zero, and that they are moving at a glacial pace to achieve this.

Mr. SIMON. Will my colleague yield for a question?

Mr. KEMPTHORNE. I am happy to.

Mr. SIMON. My understanding is that we only have about 300 personnel there. They are there primarily to protect our diplomatic mission and to serve as technicians. Is that correct, first?

Then my second question is: Does the Senator not think that we would be wise to leave this decision up to the administration and the Defense Department rather than making this decision on the floor of the U.S. Senate?

Mr. KEMPTHORNE. Mr. President, in response to that, there are currently 58 members of what is called the fleet antiterrorist security team, FAST marines. Normally, we have Marine detachments with embassies. There is no government to have an embassy for. I showed, moments ago, what is parading around through the streets of Mogadishu, the technicals with .50 caliber machine guns. They are beginning to target our U.S. military personnel. They are targets. For what? What are we trying to accomplish?

There is no mission. There is no stated mission today of anything further that the United States can accomplish.

Therefore, why do we not pull them out?

I also acknowledge that these diplomats—I think they are just as brave as the marines, but I am not dictating that those people must be pulled out. They have said they would go to a contract security system if that was necessary. But this is a very different situation. Mission accomplished.

If there is a lesson learned that we were supposed to learn from Vietnam, it was how do you exit. We do not know how to exit from Somalia. I also say to the distinguished Senator from Illinois that just offshore are 4,000 other U.S. military in an amphibious ready group, ready to go in and extract U.S. personnel if they get into a real problem. We are tying up a lot of assets, and there is no mission in Somalia.

Mr. SIMON. If my colleague will yield again, I believe in every diplomatic situation I know of there are a few marines. They have used military personnel to protect diplomatic personnel. I do not know why Somalia should be an exception to that general rule.

Mr. KEMPTHORNE. I say there is no government to provide further protection for the installation and for the diplomats. I would like to see all Americans out of Somalia.

I yield back the remainder of my time.

Mr. President, I ask for the yeas and nays on my amendment.

The PRESIDING OFFICER. The yeas and nays have been ordered.

AMENDMENT NO. 2501

Mr. STEVENS. We are now proceeding with the McCain amendment; is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. STEVENS. This is an amendment to refund the costs in connection with Olympic games to DOD, which I oppose.

Atlanta is not the only one who could potentially make a profit from the games. But does this amendment ask anyone else to pay back the DOD for services which we should be glad to contribute?

Should NBC, the network which won the bid to cover the 1996 Olympics, have to pay 25 percent of its profits back to DOD to pay for the benefits it receives from DOD? Should United Parcel Service have to pay back DOD for the profit it makes from being the "official" express-delivery company of the games? Should the many other sponsors have to pay 25 percent of their profits back to DOD for the services DOD provides?

It is an honor to win the privilege of hosting the games, and takes a lot of hard work by a city. The Federal Government should continue to fully support our cities when they are able to get these games. Atlanta already has committed much of the profits it receives—if there are any—in accordance with its host city contract.

According to the host city contract, Atlanta already has to pay the International Olympic Committee [IOC] and United States Olympic Committee [USOC] 10 percent each of any surplus after the games. According to the Atlanta Journal and Constitution, the Atlanta Committee for the Olympic Games will have to split any remaining money with the IOC as well. So Atlanta already will only keep a small portion of the profits if there are any.

The 1984 Los Angeles Games were a huge success story in terms of making profit; Los Angeles took that profit and created the $100 million Amateur Athletic Foundation [AAF], a nonprofit organization which has already provided more than $50 million to create, sustain, and encourage sports programs in California. This program has already taught more than 100,000 children how to swim, and introduced thousands more inner-city kids to sports like cycling, volleyball, and other sports.

Atlanta should have the same opportunity to create a legacy from any profits it makes for its children to remember the 1996 games by, and to be introduced to sports.

VOTE ON AMENDMENT NO. 2501

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The yeas and nays have been ordered, and the clerk will call the roll.

The bill clerk called the roll.

Mr. FORD. I announce that the Senator from Maryland [Ms. MIKULSKI] and the Senator from Arkansas [Mr. PRYOR] are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 21, nays 77, as follows:

[Rollcall Vote No. 276 Leg.]

YEAS—21

Chafee
Coats
D'Amato
Faircloth
Feingold
Glenn
Gorton
Helms
Hutchison
Jeffords
Kohl
Lugar
Mack
McCain
Metzenbaum
Nickles
Pressler
Reid
Smith
Specter
Wallop

NAYS—77

Akaka
Baucus
Bennett
Biden
Bingaman
Bond
Boren
Boxer
Bradley
Breaux
Brown
Bryan
Bumpers
Burns
Byrd
Campbell
Cochran
Cohen
Conrad
Coverdell
Craig
Danforth
Daschle
DeConcini
Dodd
Dole
Domenici
Dorgan
Durenberger
Exon
Feinstein
Ford
Graham
Gramm
Grassley
Gregg
Harkin
Hatch
Hatfield
Heflin
Hollings
Inouye
Johnston
Kassebaum
Kempthorne
Kennedy
Kerrey
Kerry
Lautenberg
Leahy
Levin
Lieberman
Lott
Mathews
McConnell
Mitchell
Moseley-Braun
Moynihan
Murkowski
Murray
Nunn
Packwood
Pell
Riegle
Robb
Rockefeller
Roth
Sarbanes
Sasser
Shelby
Simon
Simpson
Stevens
Thurmond
Warner
Wellstone
Wofford

NOT VOTING—2

Mikulski
Pryor

So the amendment (No. 2501) was rejected.

Mr. INOUYE. Mr. President, I move to reconsider the vote by which the amendment was rejected.

Mr. NUNN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

VOTE ON AMENDMENT NO. 2545

The PRESIDING OFFICER. The question is on agreeing to amendment No. 2545 of the Senator from Wyoming [Mr. WALLOP].

The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

Mr. FORD. I announce that the Senator from Maryland [Ms. MIKULSKI] and the Senator from Arkansas [Mr. PRYOR] are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 38, nays 60, as follows:

[Rollcall Vote No. 277 Leg.]

YEAS—38

Bennett
Bond
Brown
Burns
Coats
Cochran
Cohen
Coverdell
Craig
D'Amato
Danforth
Dole
Faircloth
Gorton
Gramm
Grassley
Gregg
Hatch
Helms
Hutchison
Kassebaum
Kempthorne
Lott
Lugar
Mack
McCain
McConnell
Murkowski
Nickles
Packwood
Pressler
Roth
Simpson
Smith
Stevens
Thurmond
Wallop
Warner

NAYS—60

Akaka
Baucus
Biden
Bingaman
Boren
Boxer
Bradley
Breaux
Bryan
Bumpers
Byrd
Campbell
Chafee
Conrad
Daschle
DeConcini
Dodd
Domenici
Dorgan
Durenberger
Exon
Feingold
Feinstein
Ford
Glenn
Graham
Harkin
Hatfield
Heflin
Hollings
Inouye
Jeffords
Johnston
Kennedy
Kerrey
Kerry
Kohl
Lautenberg
Leahy
Levin
Lieberman
Mathews
Metzenbaum
Mitchell
Moseley-Braun
Moynihan
Murray
Nunn
Pell
Reid
Riegle
Robb
Rockefeller
Sarbanes
Sasser
Shelby
Simon
Specter
Wellstone
Wofford

NOT VOTING—2

Mikulski
Pryor

So the amendment (No. 2545) was rejected.

Mr. STEVENS. Mr. President, I move to reconsider the vote by which the amendment was rejected, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

VOTE ON AMENDMENT NO. 2538

The PRESIDING OFFICER. Mr. President, the question now occurs on agreeing to the Kempthorne amendment No. 2538.

The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

Mr. FORD. I announce that the Senator from Maryland [Ms. MIKULSKI] and the Senator from Arizona [Mr. PRYOR] are necessary absent.

The PRESIDING OFFICER (Mr. LEVIN). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 54, nays 44, as follows:

[Rollcall Vote No. 278 Leg.]

YEAS—54

Baucus
Bennett
Biden
Bond
Brown
Bumpers
Burns
Byrd
Coats
Cochran
Cohen
Coverdell
Craig
D'Amato
Dole
Domenici
Faircloth
Feingold
Ford
Gorton
Gramm
Grassley
Gregg
Hatch
Hatfield
Heflin
Helms
Hollings
Hutchison
Kempthorne
Kohl
Lautenberg
Levin
Lieberman
Lott
Lugar
Mack
Mathews
McConnell
Murkowski
Nickles
Nunn
Packwood
Pressler
Roth
Sasser
Shelby
Simpson
Smith
Specter
Stevens
Thurmond
Wallop
Warner

NAYS—44

Akaka
Bingaman
Boren
Boxer
Bradley
Breaux
Bryan
Campbell
Chafee
Conrad
Danforth
Daschle
DeConcini
Dodd
Dorgan
Durenberger
Exon
Feinstein
Glenn
Graham
Harkin
Inouye
Jeffords
Johnston
Kassebaum
Kennedy
Kerrey
Kerry
Leahy
McCain
Metzenbaum
Mitchell
Moseley-Braun
Moynihan
Murray
Pell
Reid
Riegle
Robb
Rockefeller
Sarbanes
Simon
Wellstone
Wofford

NOT VOTING—2

Mikulski
Pryor

So the amendment (No. 2538) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. STEVENS addressed the Chair.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. STEVENS. I ask unanimous consent that amendment No. 2500 previously adopted today be modified, and I send to the desk a modification.

I ask unanimous consent that Senator CHAFEE be added as an original cosponsor of this amendment.

The effect of this amendment that I am sending to the desk will make that amendment which was previously adopted subject to modification.

The PRESIDING OFFICER. Without objection, it is so ordered.

The modification is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a) The prohibition on concurrent award of compensation and retirement pay (including naval pension) set forth in section 5304(a)(1) of title 38, United States Code, does not apply to a person who has a service-connected disability if—

(1) the person has completed at least 20 years of service in the uniformed services that is creditable for purposes of computing the amount of retirement pay to which the member is entitled;

(2) the disability was incurred or aggravated in the performance of duty as a member of a uniformed service, as determined by the Secretary concerned; and

(3) the disability is a disability rated as total—

(A) by the Secretary concerned as of the date on which the person is retired from the uniformed services; or

(B) by the Secretary of Veterans Affairs within four years following the date on which the person is retired from the uniformed services.

(b) Notwithstanding section 1463(a) of title 10, United States Code, the amount of retirement pay paid in accordance with subsection (a) concurrently with the payment of disability compensation to the recipients of such retirement pay shall be paid out of funds appropriated by this Act.

(c) Subsection (a) is not applicable to a person for any period for which the disability of such person is not a disability rated as total as described in paragraph (3) of such subsection.

(d) In this section:

(1) The terms "compensation", "service-connected", and "Secretary concerned" have the meanings given such terms in section 101 of title 38, United States Code.

(2) The term "disability rated as total"—

(A) means a disability that is rated as total under the standard schedule of rating disabilities in use by the Department of Veterans Affairs; and

(B) does not include a disability for which the schedular rating is less than total but for which a rating of total is assigned by reason of inability of the disabled person concerned to secure or follow a substantially gainful occupation as a result of service-connected disabilities or by reason of any other factor.

(3) The term "uniformed services" has the meaning given such term in section 101(a)(5) of title 10, United States Code.

(e) This section shall take effect on October 1, 1994, and shall apply to months that begin on or after that date and before October 1, 1995, upon authorization in an Act other than this Act.

Mr. MCCAIN. Mr. President, with reference to amendment No. 2500, which was adopted a short time ago in the Senate, I want to bring to the attention of the Senate a correction to that amendment.

The amendment I offered, and which was accepted, sought to appropriate funds for a program which is not authorized. As soon as I realized that the program was not authorized, I sought the assistance of the managers of the bill in correcting the amendment. I thank the managers for promptly offering a technical amendment to amendment No. 2500 to make this program subject to authorization.

As my colleagues know, I do not support the appropriation of funds for any unauthorized program, project, or activity. I apologize to my colleagues for my inadvertent violation of this important principle.

I intend to ask the conferees on this bill to retain the language in amendment No. 2500, as corrected by the managers. In no case will I support expenditure of funds for this program in the absence of a specific authorization.

I also intend to work in the Armed Services Committee and appropriate authorizing committees to seek authorization for this program, as is required under the Senate's procedures.

Mr. INOUYE. Mr. President, I ask unanimous consent that Joe Sanchez be allowed access to the Senate floor during the remainder of the debate on this appropriations bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. INOUYE. Mr. President, I ask unanimous consent that the committee amendments be adopted en bloc.

The PRESIDING OFFICER. Is there objection?

Mr. STEVENS. I reserve the right to object.

The PRESIDING OFFICER. Is there objection?

Mr. STEVENS. Reserving the right to object, may I take the opportunity to check that?

Mr. INOUYE. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. INOUYE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. INOUYE. Mr. President, I withdraw my request.

I ask unanimous consent to consider and adopt en bloc amendments numbered 2535, 2536, and 2542.

Mr. STEVENS. Mr. President, I ask unanimous consent that we add to that No. 2513 by Senator MCCONNELL.

The PRESIDING OFFICER. Is there objection?

Mr. INOUYE. And that upon the adoption of these amendments, amendment 2517 be withdrawn.

Mr. STEVENS. I ask unanimous consent that the Mitchell amendment 2542 be cosponsored by Senator COHEN.

The PRESIDING OFFICER. Does the Senator from Hawaii accept the modification as proposed by the Senator from Alaska?

Mr. INOUYE. I do.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

So the amendments (No. 2513, 2535, 2536, and 2542) were agreed to, as follows:

AMENDMENT NO. 2513

At the appropriate place in the bill insert the following

SEC. . (a.) Within 60 days of enactment of this Act, the President, in consultation with NATO, shall submit a report to the Committee on Appropriations defining specific military, economic, and political standards required to gain admission to NATO: Provided further, that such report shall not be limited to the principles enunciated in the Partnership for Peace; Provided further, such report shall include an assessment of measures which would be necessary to guarantee the armed services of Poland, Hungary, the Czech Republic, Slovakia, Lithuania, Latvia and Estonia are capable of military cooperation and interoperability with NATO and fulfilling other member responsibilities.

AMENDMENT NO. 2513

Mr. MCCONNELL. Mr. President, In 1949 a remarkable treaty was signed by 12 nations. The North Atlantic Treaty was a document of vision and flexibility—a collective covenant to safeguard freedom, democracy, individual liberty, and the rule of law—a pact to "promote stability and well being in the North Atlantic area."

NATO joined in common cause nations of disparate economic resources and strength, differing governing institutions, diverse ideologies and dissimilar military capabilities. Yet, differences have not divided the organization nor compromised the unambiguous and united determination to defend against any attack.

NATO has worked. It has been remarkably successful for more than four decades in preserving peace, security and stability.

Given the track record, it is completely understandable that nations so recently liberated from Soviet aggression now seek the security of participating in NATO. I can think of no more clear or compelling U.S. interest than the expansion of NATO's stabilizing influence.

Unfortunately, no nation seems to be able to crack the NATO admission code. They have been told that participation in the Partnership for Peace pact may lead to NATO admission, but there are no guarantees. They have been offered the cold comfort that if attacked, they have an "opportunity to consult with NATO" with no follow on commitments.

Why? because according to the administration these nations do not meet

NATO's admission standards. When I pursued the question of just what the standards of eligibility were with Secretary Christopher in a hearing before the Foreign Operations Subcommittee, he told me they had to meet the standards in the NATO charter. Well, the only standard spelled out in the charter is a commitment to the alliance and collective defense.

Mr. President, during consideration of the Foreign Operations bill I offered an amendment to clarify NATO eligibility standards. The amendment lost narrowly. During the debate there appeared to be two principal concerns which I believe I have addressed in this revised revision.

This amendment will require a report from the President in 60 days defining specific military, political or economic standards required to gain admission to NATO. During the last debate Senator LEVIN pointed out since NATO was a collective body, decisions regarding admission standards should be collective—the President does not have the unilateral authority to grant admission. I agree and presumed such consultation would occur, but to satisfy Senator LEVIN and others I added language to the amendment clarifying the President should prepare the report "in consultation with NATO leaders."

The amendment also requires an assessment of the capabilities of the Visegrad and Baltic nations to meet those admission standards and provides the President permissive authority to offer excess defense articles to assist these nations in achieving military cooperation and interoperability with NATO.

My earlier amendment required the transfer of excess defense articles to these seven nations. I decided to delete this provision in response to some of my colleagues who argued the President could not unilaterally mandate NATO EDA recipients and, more importantly, such a directive many undermine the security requirements of other current beneficiaries.

Mr. President, I believe the amendment before the Senate responds to the concerns raised by the chairman of the Armed Services Committee and others with a strong interest in NATO and European security policy. No doubt, Deputy Secretary Talbott will continue to object to the provision because it singles out several nations, thus "drawing lines" in Europe. Frankly, by default the administration has already drawn lines—NATO is on one side, Russia the other, and Central and Eastern Europe have been relegated to the gray ambiguous, no-man's land of Partnership of Peace.

Unfortunately, the victims of the administration's ambiguity consider their circumstances as an open invitation to Russia. In 1823, the U.S. established the imperatives of the Monroe Doctrine, Now, the perception from Warsaw to Kiev, is the U.S. supports a new, variation on their historical theme—the Moscow mandate. Leaders throughout Central Europe have publicly and privately criticized the administrations's willingness to cede their economic sovereignty and political independence to the sphere of Russian influence.

A July 24 column in the Washington Post by Lally Weymouth drew our attention to the profound concerns shared across Europe. Ms. Wymouth writes, "Recently, the Russian Ambassador to the United Nations Yuli Vorontsov, asked the world to bless the Russian deployment of peacekeepers to Georgia. Vorontsov said without some sort of U.N. endorsement of Russian peacekeepers in Georgia, Moscow would veto a resolution authorizing the dispatch of troops to Haiti * * * as a consequence, the Clinton Administration entered into a cynical deal with Russia which at least one U.N. diplomat compares with the controversial 1945 "spheres of influence Yalta pact * * *. What this means is that the United States has given Russia the right to reoccupy the Caucasus and other former Soviet Republics in return for Russian acquiescence in the U.N. Security Council Resolutions on Haiti."

Senior State Department officials have expressed concern about drawing lines dividing Europe—I think this is an artful dodge. In fact, avoiding drawing lines is avoiding making important decisions, avoiding the responsibilities of leadership, and avoiding the definition of American policy and interests in Europe. In effect, we concede to the Moscow mandate.

During his recent visit to Poland, President Clinton addressed the Parliament. In discussing NATO membership, he said there is "no longer a question of whether, but when and how."

This was a very encouraging statement which I hope to build on with the amendment I am offering today. The amendment before the Senate begins the process of defining "when and how" nations can join. It is a small first step in the direction of expanding stability and security in Europe, a goal so clearly and unambiguously in American interests.

AMENDMENT NO. 2535

On page 9, on line 13 of the Committee-reported bill, insert before the period the following: ": *Provided further*, That of the funds appropriated under this heading, not less than $39,674,000 shall be made available only for the Pacific Missile Range Facility, Hawaii".

AMENDMENT NO. 2536

On page 29, on line 15 of the Committee-reported bill, insert before the period the following: ": *Provided*, That of the funds appropriated under this heading, not less than $30,100,000 shall be made available only for the Pacific Missile Range Facility, Hawaii".

AMENDMENT NO. 2542

On page 53, line 13, after the period insert: "Funds appropriated in Title III of this Act may be used for multiyear procurement contracts as follows: MK19–3 grenade machine guns; M16A2 rifles; M249 squad automatic weapons; and M4 carbine rifles for the Army."

So the amendment (No. 2517) was withdrawn.

Mr. INOUYE. Mr. President, the managers of the bill are ready to go to bed.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2505

Mr. WOFFORD. Mr. President, I am pleased to cosponsor this important amendment that will provided $5 million in fiscal year 1995 for the completion of phase I of the vectored thrust combat agility demonstrator [VTCAD].

The VTCAD program is designed to assess the benefits of the ring tail vectored thrust dected propeller [VTDP] for existing and future combat helicopters. This research has the potential of increasing the speed, range, and endurance of conventional helicopters for more effective combat productivity.

I appreciate the efforts of Senator INOUYE and the members of the Defense Appropriations Subcommittee for their acceptance of this amendment. As a strong supporter of the VTCAD research, I am very glad that my colleagues have agreed with my request to provide $5 million in funding for the completion of phase I of this important effort in fiscal year 1995.

HARKIN AMENDMENT NO. 2525 ON THE COMPREHENSIVE TEST BAN

Mr. BRYAN. Mr. President, I rise today in opposition to the amendment by the Senator from Iowa. This amendment, while only a sense of the Senate amendment, takes an irresponsible position in relation to our nuclear weapons stockpile, and our future need to maintain nuclear weapons that are safe and reliable.

We cannot turn a blind eye to the reality that we have a nuclear stockpile of thousands of weapons. As the cold war has come to a close, we have made substantial progress in reducing the number of nuclear weapons. I support these efforts.

What concerns me about the approach of this amendment and the ongoing Comprehensive Test Ban negotiations, is the lack of focus on the long-term needs of our nuclear weapons scientists to monitor our stockpile. It is hard to imagine why we would want to maintain thousands of the most dangerous weapons known to mankind, but eliminate the ability to test them. In the past, we have been able to replace old nuclear warheads with newer and safer designs. We now have no new nuclear warheads under development, and so the task of our nuclear scientists is to ensure the stockpile remains safe and reliable as the various components age and deteriorate.

Nuclear weapons are complex devices. The interaction that occurs in a warhead between the highly energetic explosive and the nuclear material will never be completely mimicked by testing simulation. As these devices age, we must have a complete understanding of their deterioration, and how this affects their safety and reliability.

In fact, as our stockpile of nuclear weapons is reduced, the reliability of each nuclear weapon becomes even more critical to an effective deterrence. Only through testing at the Nevada test site can we have adequate assurance that our nuclear weapons will function as expected in a time of crisis. Stockpile surveillance, above ground experiments, and modeling often uncover flaws that cannot be resolved without the use of a nuclear test.

The Washington Post ran a story in May 1990, which explained a disturbing incident occurring in 1988, only 6 years ago. The Department of Defense unexpectedly discovered a defect in a type of nuclear weapon after it had been deployed throughout Europe. Urgent orders were issued not to move the warheads, and repair teams had to hurry to the nuclear ammunition depots to disable the weapons so they could not accidently be detonated. Computer calculations and underground tests before the start of production had indicated no safety problems. Yet, a new safety analysis in 1988 raised concerns that were confirmed by actual underground nuclear tests.

Again, it is plain reckless for our Nation to hold thousands of the most powerful and dangerous weapons known to mankind, and destroy the ability to monitor and test them.

Mr. President, no one in this body can state with certainty that the nuclear weapons created by the United States have, suddenly, become completely safe and reliable for the foreseeable future. No one in this body can say with certainty that we will never again discover a dangerous flaw in a nuclear weapon, like that found less than 6 years ago.

Without a doubt, the goal of nonproliferation is vitally important, particularly maintaining controls on nuclear materials. However, I have yet to see a compelling argument that the United States nuclear testing moratorium has furthered that goal. China continues to test and modernize its nuclear weapons at will. Renegade nations, such as Libya and N. Korea, could continue to develop nuclear weapons even if they signed and abided by the provisions of a comprehensive test ban.

I also want to address the issue of the Comprehensive Test Ban and how it would affect the Nevada Test Site. The Nevada testing facility is a unique resource, and the Nation's investment in it must be protected.

Some of America's greatest technological resources have been devoted to design, production, and testing of our nuclear weapons. Personnel at the Nevada test site are a small community of highly specialized workers, with expertise found nowhere else in the world.

Mr. President, 2 years ago, a one kiloton conventional explosion occurred in the tunnels at the Nevada test site. The nonproliferation experiment was conducted in the general vicinity of previous low-yield nuclear tests, and provided vital data on the different seismic signals between a conventional explosion and a nuclear explosion. By furthering our ability to distinguish between conventional explosions and low-yield nuclear explosions, we greatly expanded our ability to monitor the proliferation of nuclear weapons. This test has had far reaching consequences in the ability of the United States to prevent renegade nations from disguising low-yield nuclear tests.

No other facility in the world has recorded data from low-yield nuclear explosions that made this test possible. No other facility in the world has the unique tunneling capability that enabled this conventional test to occur efficiently and without undue expense.

Most Members recognize the unique assets and expertise of the personnel at the Nevada test site. What my colleagues may not realize is that a wide variety of activities, such as the nonproliferation experiment, are now occurring at the test site, and many more activities are being planned for the future.

One of the most promising future uses for the Nevada test site is in the production of solar energy. Because of its size and location, the test site is ideally suited for research in solar energy development, which I believe should have a very high priority in supplying our future energy needs. Even a small portion of the test site, devoted to solar electric generation, could supply substantial energy resource.

Mr. President, as long as dictatorships are striving to acquire weapons of mass destruction, we must be vigilant. Our nuclear deterrence, tested time and again in the Nevada desert, helped prevent the tensions between the Soviet Union and the West from ever resulting in a nuclear conflict. Testing was part of that success, and we must not lightly discard such a proven capability.

Again, I urge my colleagues to vote against this amendment, and I yield the floor.

NUCLEAR TEST BAN RESOLUTION

Mr. HARKIN. Mr. President, the amendment at the desk is on behalf of myself, Senator JEFFORDS, Senator DECONCINI and Senator DASCHLE. This is a sense of the Congress resolution, basically praising the President for extending the nuclear testing moratorium until September, 1995, and calling on the President and the other nuclear powers to complete negotiations for a comprehensive nuclear testing ban treaty before the extension conference for the Non-Proliferation Treaty [NPT] begins in April 1995.

Some may say "Why the rush?"

Why not wait until 1996, which China and France seem to prefer?

I would list two primary reasons for President Clinton to take a strong leadership position now to assure completion of the CTBT by 1995: to complete the CTBT before the NPT extension conference begins in April, 1995 and to complete a CTBT before new presidents are elected in Russia, France and the United States.

First, the Non-Proliferation Treaty is up for renewal in 1995. The conference to strengthen, expand and extend the NPT begins in April 1995.

Mr. President, the NPT is becoming ever more important in the post cold war era. In the past, our focus has been on the former Soviet Union, with their enormous nuclear arsenal of over 20,000 nuclear weapons, and their plans and missiles to deliver many of those weapons of mass destruction to the United States homeland with less than half an hour warning.

But now we may have more to fear from one or two crude nuclear weapons in the hands of Saddam Hussein or Kim Il Sung's son in North Korea than 20,000 much larger nuclear weapons in the Soviet arsenal.

Paranoid leaders from rogue nations may be much more inclined to use nuclear weapons in a crisis. And paranoid leaders are not deterred by the massive U.S. nuclear arsenal.

Hence the Non-Proliferation Treaty takes on much greater significance. Our national security interests are severely undermined by the proliferation of nuclear weapons. So much so that at least one active-duty military officer, General Horner, has even suggested that we seriously consider the eventual elimination of all nuclear weapons.

He reasoned that nuclear weapons are the ideal "equalizers" for weak third world nations. Only nuclear weapons could severely damage U.S. interests, given our current and projected overwhelming conventional military superiority.

Under these circumstances, the extension and strengthening of the NAT should be a primary priority of U.S. defense policy.

For better or worse, the comprehensive test ban has become almost a prerequisite for extension of the NPT in the eyes of most of the nuclear weapons have-not nations.

They reason that stopping all nuclear testing is the least the nuclear weapons states can do to demonstrate our resolve not to continue the qualitative nuclear arms race. They reason that only if we agree to stop all testing will they, the nuclear have-nots, agree to forego development or acquisition of nuclear weapons.

Hence, to maximize our chances of strengthening and extending the NPT, we should make every possible effort to complete the CTBT by 1995. It will take a major, concerted effort by the United States to achieve this objective. This amendment encourages the President to undertake such a dedicated effort to complete the CTBT before April, 1995.

Second, the political landscape in several key nations may change significantly after 1995. Francois Mitterrand will be stepping down in May, 1995, and new presidential elections will be held in Russia and the United States in 1996.

While President Mitterrand's successor may eventually support a CTBT, I fear that France may want to conduct a flurry of nuclear tests before agreeing to sign the CTBT. The two current French candidates are vying with each other to see who can be the most supportive of the French nuclear arsenal. So we cannot be assured that the next French Government will support the CTBT at all.

In other words, we have three of the five nuclear powers supporting the completion of the CTBT now, but no assurance that any of the three will be as enthusiastic by 1996 or later. The CTBT now, but no assurance that any of the three will be as enthusiastic by 1996 or later. The CTBT and the NPT are too important to the national security of the United States to let this current opportunity pass by.

While we would certainly like France and China to join the CTBT initially, this is not necessary. After all, both France and China were not party to the NPT initially, but are now supportive.

At this moment, negotiations are continuing in Geneva on the CTBT. The current session began on July 25, and is scheduled to end on September 7. This is the last scheduled negotiating session. But a draft treaty has not even been tabled in Geneva.

I therefore urge the President to encourage the session chairman to at least lay down a draft treaty, so that the negotiators can begin narrowing down differences. I urge the President to avoid last minute complications, such as submitting endless verification or other technical suggestions which slow down the process without yielding significant increased security assurances.

I was pleased to learn that John Holum, the director of ACDA, stated on August 4 in Geneva at the U.N. Conference on Disarmament that the U.S. delegation will be willing to work after September 7, "continuously" if necessary.

This is a hopeful sign that the Clinton administration is willing to work with all diligence to complete the negotiations by April 1995.

This resolution merely signifies to the administration that we in Congress consider rapid progress essential to our national security.

I encourage my colleagues to support this resolution, urging the President and other nuclear powers to complete negotiations on the nuclear testing moratorium before the Non-Proliferation Treaty extension conference begins in April 1995.

AMENDMENT NO. 2525

Mr. REID. Mr. President, I rise to oppose the amendment offered by my colleague from Iowa, Senator HARKIN.

Once again, I see an effort to continue to undermine our nuclear deterrent and our nuclear stockpile while ignoring the real danger that faces our world today. That danger is the danger of the proliferation of weapons of mass destruction and, in particular, the spread of nuclear weapons and nuclear weapons technology.

Our national security will be served by negotiating an extension of the Nuclear Non-Proliferation Treaty, but the amendment offered by my friend from Iowa focuses on the negotiation of a Comprehensive Test Ban Treaty, which may or may not play a roll in gaining the extension of the Non-Proliferation Treaty.

A Comprehensive Test Ban Treaty carries with it several clear risks to national security and worldwide security that have been recognized by the Senate, President Clinton, and past Presidents.

The Senate in passing the Hatfield-Exon-Mitchell amendment recognized that the safety and security of our nuclear weapons and, presumably those of other countries, could be improved by a limited continuation of nuclear testing. The Hatfield-Exon-Mitchell amendment permitted continued testing for safety and reliability until 1996 and longer if other nations continued to conduct nuclear tests.

President Bush's national security advisors recommended a veto of the legislation containing the testing restrictions because of its serious consequences to national security. If the amendment had not been tied to a larger bill, it most likely would have been vetoed.

President Clinton, in extending the moratorium, expressed his concerns about the risk that a moratorium posed to our stockpile, but accepted the risk as the apparent cost of establishing the right atmosphere to promote the extension of the Nuclear Non-Proliferation Treaty.

The Chinese and the French have both stated the importance of a limited number of additional nuclear tests before a Comprehensive Test Ban Treaty would be in their national interests. A premature effort to push a Comprehensive Test Ban Treaty before next April may cause the Chinese and the French to withhold their support.

Do we want a Comprehensive Test Ban Treaty that the Chinese will not sign?

I do not support a Comprehensive Test Ban Treaty because I do not believe that it really contributes to making the world safer.

If there is to be an amendment, it should encourage the President to continue his efforts to get an indefinite extension of the Nuclear Non-Proliferation Treaty. A Non-Proliferation Treaty without a Comprehensive Test Ban Treaty is a significant step to a safer world. A comprehensive Test Ban Treaty without an extension of the Nuclear Non-Proliferation Treaty is a failure.

The Chinese will likely continue testing beyond April 1995, the time when the Non-Proliferation Treaty Extension Conference will be held. I suspect that the United States will, and should, push for an extension of the Non-Proliferation Treaty whether or not China or anyone else is testing.

Testing is not the issue. Limiting, or stopping proliferation of nuclear weapons is the issue.

The extension of the Nuclear Non-Proliferation treaty is in the interests of every nation, be they a nuclear power or a nonnuclear state. Most nations know this. No nation will gain from the termination of the Nuclear Non-Proliferation Treaty, although many may threaten not to sign to advance some separate agenda.

I believe that the sense of the Senate resolution offered by my friend from Iowa is in fact an attempt to advance a separate agenda.

That agenda is the delegimitization of nuclear weapons and, in particular, the U.S. nuclear arsenal as fast as possible.

As the chairman of the Defense Appropriation Committee said so eloquently on the floor earlier in this debate, this is not time to let the euphoria of the end of the cold war lead us into thinking that we can abandon our Armed Forces, and in this case our nuclear forces.

The world is still a dangerous place. The nuclear threat has changed, but it has not disappeared. We must maintain our nuclear stockpile, our nuclear deterrent capability, and our nuclear expertise. The capacity to resume testing is a critical element of that capability.

I am very concerned about efforts like this amendment that undermine the support for our own national security without securing assurances that the external nuclear threats are being reduced.

Look at Korea. The Non-Proliferation Treaty did not guarantee that they could not develop nuclear weapons. Our moratorium did not stop them from continuing their program. Our continuing efforts to promote a Comprehensive Test Ban Treaty and a the extension of the Nuclear Non-Proliferation Treaty have not convinced them to reject a nuclear program.

For another example of the continuing external threat, look at the recent discovery of weapons-grade plutonium being diverted from the former Soviet Union and offered for sale in Germany. The news media reports that the buyer for this material was to be Iraq. Does anyone here think that the extension of any treaty will end the threat from Iraq?

An extension of the Nuclear Non-Proliferation Treaty will help address these threats. A Comprehensive Test Ban Treaty will not.

Let us not forget the arguments that have been used to advance the Comprehensive Test Ban Treaty argument. Originally, we needed to stop testing to stop the arms race. In fact, the arms race ended while we were testing. The end came because the Soviet Union collapsed.

Another argument was that we need to stop testing to promote disarmament. The United States and Russia are both in the process of drastically reducing our nuclear arsenals. A testing program for reliability and safety does not preclude a weapons reduction.

Now they are saying that we need to end testing to get an extension of the Non-Proliferation Treaty. This is highly unlikely. The vast majority of responsible nations realize the great progress that has been made by the United States and the former Soviet Union to reduce the nuclear tension and the nuclear stockpiles.

These same nations realize that giving up the Non-Proliferation Treaty solely because there is no Comprehensive Test Ban Treaty is not in their national security interests.

The Comprehensive Test Ban Treaty is, at best, a debatable element of the Non-Proliferation Treaty extension.

If we want to send our President a sense of the Senate, let's tell him that we support his efforts to stop the proliferation of weapons of mass destruction. Let's not divert his attention to secondary issues that may or may not contribute to the ultimate goal.

I ask my colleagues to oppose the Harkin amendment.

AMENDMENT NO. 2526

Mr. LIEBERMAN. Mr. President, at a time of heightened concerns about terrorist attacks such as the World Trade Center bombing and recent incidents in Argentina and London, the Senate has an important opportunity to increase efforts of the United States Government and our allies to help counter these threats.

Several years ago, in response to the bombing of Pan Am 103, the Department of State and the Department of Defense established the Technical Support Working Group [TSWG], an interagency body that coordinates counterterrorism research and development efforts. Since its creation, the TSWG has made valuable contributions to enhancing the security of persons and property both inside the United States as well as beyond our borders by orchestrating and funding the development of innovative technology. For example, the TSWG has already improved the security of people flying on the world's airways by developing advanced methods for postblast detection and postblast containment of chemical explosives.

In the aftermath of the attacks in Argentina and London, it is clear that the world continues to be a dangerous place where terrorism will be used to strike at the heart of civilized peoples everywhere. We should do more to bolster the promising start of the technologies and techniques already developed by the TSWG. As President Clinton recently stated, "I think everyone in the United States would want us to do more against terrorism."

President Clinton requested $6.321 million as the Defense Department's contribution to the TSWG. This amount has been authorized by the Senate and House, appropriated by the House, and is in the Senate Defense appropriations bill we are currently discussing. Virtually all of this is required to continue projects identified in fiscal year 1993 and fiscal year 1994 and already underway. Thus, only about $2 million—the amount provided by the State Department in its funding share—is available for new projects, of which there are many which appear quite promising. Moreover, the $6.321 will limit the TSWG's ability to follow up the excellent start permitted by the fiscal year 1993 congressional initiative for an international program.

In the Defense authorization bill passed by the Senate, an additional $3 million was authorized for TSWG to enable it to continue and expand its promising international cooperative efforts. The additional funding which we seek today in this Defense appropriations will go along with the additional amount authorized and will go a considerable distance in funding important new counterterrorist technologies. Three areas are particularly promising and important: nonlethal technologies; border security; and strategies against advanced shoulder-launched surface-to-air missiles, radio-controlled explosive devices, and weapons of mass destruction. We will not solve the problems posed by these terrorist strategies with the funds we are adding today, but it is vital to keep up the momentum which has developed.

All of us recognize the constrained resources era in which we are currently operating. The distinguished chairman and his staff have worked with us on this amendment and have agreed to accept an additional $2 million for this program. I appreciate the chairman's cooperation and believe that this $2 million investment is both worthwhile and timely. We cannot wait until the next terrorist strike takes innocent lives here or abroad. We should move forward now with efforts which will enable us to prevent these kinds of attacks in the future. We have a responsibility to do all we can. This $2 million is an excellent beginning.

AMENDMENT NO. 2526

Mr. HATCH. Mr. President, I rise as a cosponsor of this amendment because of the importance in providing funds to fight terrorism. This earmark would further enable the Pentagon to contribute funds for the valuable work of the Technical Support Working Groups [TSWG], an interagency group that helps cover collaborative research projects designed to counter terrorist activity.

Mr. President, we have signed a series of Memorandums of Understanding [MOU] with three countries for 15 different counter terrorism programs. These programs cover a range of projects, including improved explosive detection and better perimeter security at a variety of facilities. Unfortunately, the MOU's were signed after budget was submitted, and subsequently the costs of these international R&D programs are not covered in the current budget. While the DOD bill authorized $3 million for the international programs, there is the need for a specific appropriation to cover these international projects.

There is not a single Member of this Chamber prepared to suggest that terrorism is not a serious challenge or threat to American interests or security. The recent bombing attacks in Buenos Aires, Panama, and two incidents in London only underscore the importance of developing the tools and resources to counter terrorism, and I am pleased to see that the TSWG is taking an important role in this process.

If we believe that we need to confront the threat posed by terrorism, then we need to will the means to fight it. I urge my colleagues to support the adoption of the amendment.

AMENDMENT NO. 2527

Mr. SHELBY. Mr. President, I am joined today by Senators HEFLIN and GLENN in offering an amendment to H.R. 4650, the Department of Defense Appropriations Act for fiscal year 1995, that would provide $3 million in much needed additional funding to modernize Air Force management/maintenance information systems. As our forces decline in numbers, it is incumbent on the Department of Defense to ensure that our Armed Forces are in a high state of readiness. In today's military, this often falls to the automated programs which keep maintenance information at technicians' fingertips.

The CAMS/REMIS system is the major Air Force system which provides technicians with up-to-date information about the maintenance and supply status of missiles, aircraft, and other equipment. It is in use at virtually every Air Force base throughout the United States and abroad.

The CAMS/REMIS system was created under a contract awarded in 1986. While funding has been available to create and operate CAMS/REMIS, and to consolidate other systems into this comprehensive system, funding constraints unfortunately have precluded upgrading the system to keep up with developments in this fast-growing field. I believe it is critically important to our readiness, and to the safety of our air men and women, that the Air Force provide a modern, fully capable maintenance management information system. A total of $8 million for these programs would permit the Air Force to upgrade the system adequately.

Mr. President, I urge the adoption of this amendment.

AMENDMENT NO. 2530

Mr. BINGAMAN. Mr. President, on behalf of myself and Senator DOMENICI I rise to offer an amendment which will ensure adequate funding for a critical safety modification of the F–111 aircraft. The amendment adds $1.296 million, for a total of $2.8 million, to the F–111 squadrons program element in the Air Force RDT&E budget.

As the Senator from Hawaii and the Senator from Alaska know, these aircraft are stationed at Cannon Air Force Base in New Mexico and provide a critical capability to deliver precision munitions deep within an adversary's territory, a capability that was demonstrated repeatedly and was vitally needed during the Persian Gulf war. The amendment I am proposing is consistent with action taken in the conference committee on the defense authorization bill.

During the authorization conference the Air Force told us that additional funds were needed in this program element to correct deficiencies found in operational testing of a modification to the digital flight control system of the F–111 and EF–111 aircraft. These problems include nuisance warnings, warning light anomalies, autopilot release level faults, and a terrain following radar/central air data computer interface fault. The program office at McClellan Air Force Base proposes to fix these problems through an engineering change proposal, the total cost of which is estimated to be $4.3 million. The Air Force informed us they had a requirement for $2.8 million in fiscal year 1995 for the overall program element, $2.5 million of which they intend to use for the digital flight control system upgrade. The remaining $1.8 million for the digital flight control system upgrade will be incorporated in the fiscal year 1996 request.

In light of this information, I hope our amendment is acceptable to the managers and I urge its adoption. I would note before closing that the House version of the fiscal year 1995 Defense Appropriations' Act provides $11.019 million for the F–111 squadrons program element, $9.5 million of which is to be used for safety modifications of the F–111 and EF–111 aircraft if the Secretary of the Air Force submits a report that such modifications are needed. I am not aware of other modifications needed at this time, but if further requirements for modifications in the F–111 fleet are identified by the Air Force, I would urge my colleague from Hawaii and my colleague from Alaska to move toward the higher level in the conference.

Mr. INOUYE. Mr. President, I appreciate the information provided by the Senator from New Mexico. I support the amendment he is offering to insure the digital flight control system is fully funded in this bill. I know the Senator from New Mexico is a very vigorous proponent of the F–111 aircraft and the capabilities it brings to our forces and I know that he takes a personal interest in insuring that upgrades needed by the aircraft, such as the digital flight control system modification, stay on track and get deployed on the aircraft.

With regard to the conference, I will be happy to consult with the Air Force to ascertain the actual funding needs with respect to maintaining the important capabilities of the F–111 fleet. As the Senator points out, there will be ample opportunity for us to bring this matter to the attention of the House conferees with the objective of satisfying the highest priority operational needs of the F–111. It is difficult at this time to predict what will be the amount acceptable to the House conferees for F–111 modifications, but we will do our utmost.

Mr. BINGAMAN. Mr. President, I thank the Senator from Hawaii for his support of my amendment and his promise to look into this matter further in the upcoming conference. I thank him also for his strong support for New Mexico's military installations and laboratories, ad the people who serve in them, support which is reflected in numerous provisions in this bill.

Mrs. FEINSTEIN. Madam President, I rise today to offer an amendment that would require the Secretary of Defense to report to Congress on a very important issue that involves not only congressional oversight of a defense program, but also proliferation concerns and stability in the Middle East: A Department of Defense proposal to codevelop the Advanced Threat Radar Jammer [ATRJ] with the United Arab Emirates [UAE].

I understand that the U.S. Army and Defense Security Assistance Agency [DSAA] are prepared to offer the UAE a proposal to codevelop the ATRJ—the Army's net generation radar receiver and jamming system. Under this proposal, the UAE would provide funding for research and development of the ATRJ and then be allowed to purchase the sophisticated systems for installation on recently acquired AH–64 Apache helicopters.

I and many of my colleagues are concerned about this proposal for several reasons. First, this agreement would establish an arrangement wherein a foreign nation would fund a U.S. defense program in an apparent circumvention of the normal authorization and appropriations process, and beyond the effective oversight of Congress. The Congress has repeatedly voiced its objections to executive branch efforts to solicit funds in support of U.S. foreign policy or defense initiatives that were not first made subject to the scrutiny of the legislative branch.

Second, I believe this agreement would undermine the President's own efforts to constrain weapons proliferation. It provides the UAE with a quantum improvement in its war fighting capability which could provoke other hostile nations to seek advanced systems to counter the new perceived UAE threat.

Third, this arrangement would violate a departmental policy, recently reaffirmed by the Deputy Secretary of Defense on March 15, 1994, which states that "the Department of Defense remains committed to the policy of no foreign military sales or commitments for foreign sales of defense systems prior to the successful completion of OT&E [operational test and evaluation], and the specific approval of the Under Secretary of Defense. This policy remains in effect today."

Finally, I am deeply concerned that if this new weapons system were introduced into a volatile region and ever fell into the hands of a U.S. adversary, its state-of-the-art jamming capability could pose a serious threat to U.S. forces. When fully operational, this system will be capable of friend or foe identification, pulsed radar jamming, extreme radio frequency sensitivity and processing capability, as well as multi-band situational awareness.

I see little justification for proceeding with an arrangement that is fraught with so many questionable funding practices and policy implications. While I and many of my colleagues believe that the United States shares an interest in the security of the UAE, the ATRJ would provide a level of jamming capability significantly greater than that possessed by many of our close NATO and major non-NATO allies. The possible threats to the UAE are no greater than those faced by other nations in the region, none of which have been asked to participate in the ATRJ program.

I have already contacted the Defense Department on this issue, expressing my concern over the codevelopment of the ATRJ with the UAE. Unfortunately, I found the response to my concerns to be inadequate.

Therefore, I have offered this amendment that directs the Department of Defense not to proceed with the co-development of the ATRJ with any foreign entity until the Department has fully consulted with Congress, and evaluated both legal and policy implications. The amendment exempts our NATO and major non-NATO allies.

Specifically, the report to be submitted by the Secretary of Defense should include the following:

(1) The legal basis for seeking for the program funds that are neither authorized to be appropriated nor appropriated.

(2) The consistency of the program with the Department of Defense policy that no foreign military sale of a defense system, and no commitment to foreign military sale of a defense system, be made before operational test and evaluation of the system is successfully completed and the Under Secretary of Defense for Acquisition of Technology has specifically approved the system for sale to a foreign government.

(3) The mission requirement for an advanced threat radar jammer for combat helicopters.

(4) An assessment of each threat for which an advanced threat radar jammer would be developed, particularly with regard to each threat to a foreign country with which the United States would jointly develop an advanced threat radar jammer.

(5) The potential for sensitive electronic warfare technology to be made available to potential adversaries of the United States as a result of United States participation in the program.

(6) The availability of other nondevelopmental items and less sophisticated technologies for countering the emerging radar detection threats to United States combat helicopters and combat helicopters of United States allies.

(7) A capability assessment of similar technologies available from other foreign countries and the consequences of proliferation of such technology.

I urge my colleagues to support this common sense amendment and I urge its adoption. I now ask unanimous consent that my previous correspondences with DOD be printed in the RECORD at this time.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
Washington, DC, April 13, 1994.

Lt. Gen. THOMAS RHAME,
Director, Security Assistance Agency,
Washington, DC.

DEAR GENERAL RHAME: I am concerned that the Department of Defense is considering a co-development program with the United Arab Emirates (UAE) for the Army's Advanced Threat Radar Jammer (ATRJ). This action follows the sale of AH–64 Apache helicopters to the UAE.

Apparently, the UAE would provide funding for research and development of the ATRJ and then be allowed to purchase the sophisticated systems for installation on the recently required Apache helicopters. Specifically, I am concerned that the proposed program could have serious implications for U.S. national security by providing the UAE with an ultra-sophisticated capability to detect enemy radar and equip UAE helicopters with an advanced, high-powered radar jamming system.

This precedent may represent a major departure from U.S. Middle East policy and our commitment to Israel's qualitative edge in its national defense. To my knowledge, ATRJ technology has not been offered to other U.S. allies and would likely surpass similar technologies currently employed by other countries. By allowing the UAE to assist with research and development costs, the Defense Department may be granting a foreign country access to the most advanced version of a weapon system used by U.S. forces. In addition, the ATRJ co-development program may cause a new round of high technology proliferation in a very volatile region of the world.

I urge you to fully investigate the ATRJ co-development program, and carefully consider the implications to U.S. national security and U.S. Middle East policy. Thank you for your attention to this matter and I look forward to your reply.

Sincerely yours,

DIANNE FEINSTEIN,
U.S. Senator.

DEFENSE SECURITY
ASSISTANCE AGENCY,
Washington, DC, May 10, 1994.

Hon. DIANNE FEINSTEIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR FEINSTEIN: This responds to your April 13, 1994, letter concerning the electronic warfare (EW) suite for the United Arab Emirates' (UAE) AH–64 Apache helicopter program.

The UAE has for some time been considering several United States and foreign EW systems for its AH–64 Apache helicopters. The Department of Defense and the UAE are exploring a two-phased approach under which the UAE would purchase a standard U.S. Army EW suite for its short-term needs, with a possible cooperative development program providing hardware for its long-term requirements. These discussions are still at an early stage, and no final decisions have been reached.

It is premature to speculate about the configuration and capabilities of any hardware that may result from a cooperative program several years hence, though it assuredly would not exceed the capabilities of equipment in use with our own forces. Should the United States and the UAE agree on such a program, you can be assured that all sensitive technologies would be protected and precautions taken against unauthorized disclosures.

The central objectives of our security assistance programs throughout the region are to enhance the self-defense capabilities of our friends and allies and to build the interoperability that will enable us to fight together should it ever become necessary. If successfully implemented, this program will fulfill both these objectives by providing UAE aircrafts with a defensive system that will be interoperable with U.S. systems and supportable through the U.S. logistics system.

I can assure you that our commitment to Israel's security remains unshakable. We would not even be considering such a program with the UAE if we believed that it would affect Israel's qualitative edge, which we are committed to maintaining. Please contact me if I can provide any additional information.

Sincerely,

THOMAS G. RHAME.

CENTER FOR MANUFACTURING SCIENCES

Mr. RIEGLE. Mr. President, I am concerned that the Defense appropriations bill deletes funding for the National Center for Manufacturing Science [NCMS]. I would also note that the committee report contains language questioning the appropriateness of continued DoD funding for NCMS. I recognize and support the need for close scrutiny of programs funded by the Department of Defense, especially in this time of constrained budgetary resources. However, this Senator believes that the best way to ensure effective use of DoD research and development funding is through the dual-use technology and manufacturing policy currently being followed by the Department. As Anita Jones, Director of DDR&E, stated in her testimony before the Senate Armed Service Committee, "our vision for the 21st century manufacturing is for an integrated civil/military industrial base that can provide a flexible response to our needs for a variety of product demands at varying rates, and can reduce the cost of defense products by getting components and subsystems from dual-use production lines." Mr. President, the NCMS is designed specifically to accomplish just such a dual-use objective, and therefore is highly appropriate for DoD funding.

As to the concerns that have been raised as to the defense benefits of NCMS, it is my understanding that the Department and NCMS signed an agreement that provided that all funded projects must have a defense application and that DoD would receive royalty-free licenses to all technologies developed. It is also my understanding that more than 20 weapon systems currently utilize NCMS developed technologies, including the V–22 Osprey and the C–17.

Given the benefits accruing to DoD through NCMS' research projects, I hope that the Chairman of the Defense Subcommittee will reconsider this issue during Conference with the House.

INTENT OF SEC. 8096

Mrs. FEINSTEIN. I would like to engage the distinguished Chairman of the Defense Appropriations Subcommittee in a colloquy to clarify Section 8096 of this bill regarding defense reinvestment programs. Is it the Chairman's intent that this section should in no way impact the small business defense conversion guaranteed loan program?

Mr. INOUYE. The senior Senator from California is correct. Service 8096 does not impact the small business defense conversion guaranteed loan program.

BRAIN AND SPINAL CORD INJURY RESEARCH

Mr. GRAHAM. Mr. President, I would like to express my deep concern for those suffering from injuries to the brain and spinal cord. I have spoken with my distinguished colleague from Hawaii, Senator INOUYE, who appreciates the seriousness of this medical problem. And I would like an opportunity to further express my thoughts on this issue.

There are approximately 180,000 individuals in the United States who suffer from chronic spinal cord injury, with between 10 and 12 thousand new cases added each year. A substantial number of these individuals, approximately 45,600, are veterans—men and women who have served our Nation with honor and distinction. Sixty percent of these veterans receive treatment for these injuries exclusively from VA facilities, while another 23 percent use a secondary medical provider in addition to the VA.

We know that combat service can be very hazardous, and that injuries to the brain and spinal cord can occur both during combat-related operations and noncombat-related activities. They can and do occur from shell blasts, armed combat, bullet wounds, and sometimes, common accidents. Very often such injuries are fatal. For those who survive, the injuries are usually seriously debilitating.

Currently, our Nation spends approximately $1.4 billion per year for initial spinal cord injury medical treatment. And an additional $4 billion is spent each year for subsequent spinal cord injury treatment.

Our moral obligation to help our veterans, the need to help prevent deaths and aggravated injuries among active duty military personnel, as well as the costs associated with such injuries and treatment, are compelling reasons for us to invest in research efforts to develop effective treatment for those afflicted with such injuries.

That is why I believe that it is important that the Departments of Defense and Veterans' Affairs work together on this medical problem to assist both members in uniform and our veterans in this regard.

I am pleased that the Senate Armed Services Committee, on which I serve, recommended $20 million for a collaborative Department of Defense and Department of Veterans' Affairs research initiative for brain and spinal cord injury, with cost sharing as a prerequisite. I am confident that the authorization conference committee will support the Senate-passed provision.

Knowing that we share a similar concern in this area, I would like to ask the chairman questions to clarify the intent of his subcommittee with respect to the Defense appropriations bill for fiscal year 1995.

Mr. INOUYE. I would be happy to respond to the Senator from Florida.

Mr. GRAHAM. I thank the Senator. It is my understanding that the chairman shares a similar concern regarding brain and spinal cord injury, and believes that such research should be considered a high priority for the two departments. Is that understanding correct?

Mr. INOUYE. Yes, it is. I am well aware of the problems the Senator spoke of, and would support the use of funds appropriated in the bill for this research.

Mr. GRAHAM. I thank the Senator. Is the distinguished chairman aware of the cost-shared brain and spinal cord injury research program authorized in S. 2182, the Defense authorization bill; and if so, is this a program that the chairman would support?

Mr. INOUYE. Yes, I am aware of the action taken by the Senate Armed Services Committee, on which the Senator from Florida serves, and I fully support their recommendations with regard to this brain and spinal cord injury initiative.

Mr. GRAHAM. Again, I thank my colleague for those words of support. Given the clear intent of the authorizing committee in the Senate to provide full funding for this collaborative initiative between the Departments of Defense and Veterans' Affairs, is it the intent of the distinguished floor manager that full funding would be available in the Defense appropriations bill to carry out this meritorious program?

Mr. INOUYE. Yes, it is our intent and desire to provide the full amount authorized for the brain and spinal cord injury research initiative.

Mr. GRAHAM. Finally, is it also the desire of the appropriators for the Departments of Defense and Veterans' Affairs to act promptly to ensure that authorized and appropriated monies are directed to brain and spinal cord injury research?

Mr. INOUYE. Yes, it is.

Mr. GRAHAM. I thank the distinguished Senator from Hawaii and look forward to working with him during further consideration of the Defense appropriations bill for fiscal year 1995.

Mr. BOND. I would like to address the provision in the bill regarding the Air Force's 60K aircraft loader program.

There has been a lot of talk in recent months about the concept of buying commercial-derivative aircraft either to replace or supplement military aircraft such as the C–17 and C–5B. Despite one's views on that subject—and I am one who has strong views—it is clear that the Air Force needs a new aircraft loader to replace its current inventory of Vietnam-era loaders. This new loader—the 60K loader—will be used to load and unload all types of cargo aircraft, however, it will be absolutely essential for operating any commercial-derivative aircraft we buy, as well as the Civil Reserve airfleet aircraft. The new system will allow the Air Force to load supplies rapidly on its aircraft for vital military missions and humanitarian relief missions. Given the daily commitments we face in airlift needs, the 60K loader is a vital part of the airlift master plan.

In its report, the committee has exercised its oversight responsibility and raised several valid concerns regarding the Air Force's progress on the 60K loader program. My office has been in contact with the Air Force on this matter, and they have said that any decrement in fiscal year 1995 funding could result in higher costs and possible delay for the program. In the Air Force appeal of our mark, they say our bill "actually increases risk as well as cost" of this program which the Air Mobility Command ranks second only to the C–17 in terms of requirements. I believe it is essential that we work with the Air Force to find a solution that meets the committee's concerns without causing harm or delay to the program. I hope the chairman will work with me and the Air Force to craft an equitable solution.

Mr. INOUYE. I thank my colleague for his statement. I understand his concerns about this program. I, too, believe the 60K loader is a vital part of this Nation's future airlift capability. The committee has, indeed, voiced concerns about the structuring of the program. However, I would be glad to work with my colleague from Missouri in the conference committee to ensure that this program stays on an appropriate track. I will also direct the committee staff to work with the Air Force to resolve committee concerns. I believe we can work together to help the Air Force make this vital program a success.

Mr. BOND. Mr. President, I would like to commend the chairman and ranking member for including in the committee report accompanying this bill an important provision directing a study of the Air Force's strike airpower requirements. I have been concerned for some time about the Air Force's plans regarding the future of our interdiction aircraft force. These aircraft—the F–117, F–111, and F–15E—played a key role in the Gulf war, and would certainly play a similar role in any future conflict.

The aircraft that make up the long-range interdiction force are the primary ones that can deliver precision guided munitions. In the Gulf war, we used them for striking hardened targets, for Scud hunting, and other priority strikes. Unfortunately, the future of the interdiction force appears to be bleak.

The Air Force reportedly has considered plans to retire the entire F–111 strike force. Although there are currently two full wings of F–15E's, normal attrition will take us below that amount in the near future. And there are only 56 F–117's remaining in the inventory at this time.

The F–117 line has been shut down for years. The Air Force has no current plans to buy additional F–15E's. And, in a development that only increases my concern, the Air Force has said that they plan to fill the eventual gap left by the F–111 with the F–16—an aircraft that does not have the range required to perform the mission, the ability to carry a similar weapons load, nor the same ability to deliver precision-guided munitions as the F–111. Moreover, the ability of long range bombers to deliver precision-guided munitions will be limited until about the turn of the century when these weapons begin to become available in adequate numbers.

It seems clear to me, that we face a major shortfall in interdiction aircraft as we enter the next century. The study ordered by the committee report on this bill will help us to focus on what that shortfall is, and how best to address it.

In my view, I believe the study ought to focus in on several specific points including:

First, the impact of the eventual retirement of F–111 aircraft on the Air Force's ability to conduct interdiction missions; second, the outlook for the interdiction force, assuming an eventual F–111 retirement and the expected attrition of F–15E and F–117 aircraft, and the ability of that force to meet planned requirements; third, the ability of existing aircraft (F–117, F–15E, F–16) to perform the mission currently being performed by the F–111—that is, the delivery of precision-guided munitions in the long-range interdiction role; fourth, the costs and operational effectiveness of continuing to operate the F–111 aircraft for the long-range interdiction role through the end of their expected service life; and fifth, the possible need for additional aircraft to fulfill the interdiction role.

I believe that a review of these issues will help both the Air Force and Congress to understand the challenge we face and begin to address it.

Mr. INOUYE. I thank the Senator from Missouri for his comments. I believe he has focused on an important issue—one that we will have to face in future budgets. I agree that the specific questions he has outlined are ones that, among other important considerations, should be covered in the independent strike airpower study to be performed by the Institute for Defense Analysis. I will do my best in conference to see that these issues are to be addressed comprehensively in the required study. I also intend to seek approval by the conference committee of the requirement that the full results of this study shall be submitted, in both classified and unclassified versions, to the congressional defense committees no later than June 1, 1995.

JOINT TRAINING, ANALYSIS AND SIMULATION CENTER FOR U.S. ATLANTIC COMMAND

Mr. GLENN. Mr. President, this amendment would provide up to $10.5 million in fiscal year 1995 for the Navy to begin procurement of equipment to outfit the new Joint Training, Analysis and Simulation Center for U.S. Atlantic Command. The amendment does not add funds to the bill—it simply provides the authority for the Navy to use funds within the Other Procurement, Navy account to initiate this exciting new simulation Center.

Earlier this year, the Subcommittee on Military Readiness and Defense Infrastructure which I chair visited the Norfolk Naval complex to discuss readiness concerns with front-line operating units. During our visit, we met with Adm. Paul David Miller, the Commander in Chief of U.S. Atlantic Command to discuss readiness within USACOM.

During that discussion, Admiral Miller briefed the Subcommittee on the Command's plans for a Joint Training, Analysis and Simulation Center. The purpose of this Center will be to provide cost-effective joint training to support U.S. Atlantic Command's program for training joint task forces through simulation.

Mr. President, in June the Defense Science Board Task Force on Readiness, chaired by former Army Chief of Staff General Shy Meyer, issued its final report on readiness in the Department of Defense. This Task Force found that the Defense Department did not have good systems for measuring joint readiness, and urged DOD to provide "increased emphasis on Joint and Combined readiness and requirements, including development of joint mission essential task lists."

The Readiness Task Force also called for enhanced use of modeling and simulation. Their final report recommends that "Modeling and simulation technology should be exploited to enhance joint and combined training and doctrine. It offers tremendous opportunity to leverage our existing training at all levels through enhancement or even replacement where appropriate after thorough review."

In my view, Mr. President, this new Joint Training, Analysis and Simulation Center is exactly the kind of effort that is called for by the Defense Science Board Task Force on Readiness. This Center will serve to improve and measure joint readiness, and provide a laboratory for the improvement of joint tactics, throughout U.S. Atlantic Command.

This new facility will be located in the building which was constructed for the Naval Undersea Warfare Center in Suffolk, VA. This building is under long-term lease to the Navy. Since the Naval Undersea Warfare Center is leaving this building as a result of the Base Realignment and Closure process, the use of the facility as the site for the Joint Training, Analysis and Simulation Center will make cost-effective use of this facility.

Mr. President, I ask unanimous consent that a letter from Mr. Louis Finch, the Deputy Under Secretary of Defense (Readiness), to Senator NUNN describing the Joint Training, Analysis and Simulation Center be included in the RECORD at the conclusion of my remarks.

I urge my colleagues to support this amendment.

Without objection, the letter was ordered to be printed in the RECORD, as follows:

PENTAGON,
Washington, DC, June 23, 1994.

Hon. SAM NUNN,
Chairman, Committee on Armed Services, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: This is in response to your recent inquiries regarding the Joint Training, Analysis and Simulation Center (JTASC). The purpose of this Center is to provide cost-effective joint training to support the United States Atlantic Command's (USACOM) program for training joint task forces via simulation. This program will serve to improve and measure joint readiness, provide a laboratory for the improvement of joint tactics, and establish a secure CONUS joint environment for the demonstration of new technologies. It will occupy and use as a hub for these efforts the facility in Suffolk, Virginia, that is being vacated by the Naval Undersea Warfare organization.

To ensure there is no duplication of efforts, the JTASC fully intends to coordinate its efforts with those of the Services and other joint training efforts including those of the Joint Warfighting Center and the Armed Forces Staff College in Tidewater, Virginia, and those of the United States Special Operations Command for Special Operations Forces. It is my understanding that $10.548 million is required to finance the initial phase of this effort which is to procure command, control, communications and computer equipment for the Center.

Thank you for inquiry on this cost-effective program to improve joint readiness and other defense matters.

Sincerely,

LOUIS C. FINCH,
Deputy Under Secretary of Defense, (Readiness).

Mr. INOUYE. Mr. President, since we have finished our work for this evening, and we will be returning at or about 1:30 tomorrow afternoon, may I suggest the absence of a quorum.

Mr. FORD. Will the Senator withhold.

Mr. INOUYE. Certainly.

MORNING BUSINESS

Mr. FORD. Mr. President, I ask unanimous consent that there now be a period for morning business with Senators allowed to speak therein up to 5 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

THE SENIOR SENATOR FROM VERMONT

Ms. MIKULSKI. Mr. President, I rise today to honor one of the true leaders of the U.S. Senate, the senior Senator from Vermont.

I have had the privilege of serving with the distinguished senior Senator from Vermont on the Foreign Operations Subcommittee. As chairman, he is a champion of reason and compassion in the debate over foreign aid reform. He is presiding very effectively over the transition from a cold war foreign aid program to a new policy that addresses the challenges of the post-cold-war world.

I am happy to say that the senior Senator from Vermont has also been a champion of women's rights and reproductive health care. In a time of shrinking budgets, he has managed to increase the funding for these areas in recent foreign aid bills. This is a remarkable tribute to his effectiveness as subcommittee chairman, and to his sense of fairness.

I could go on at length praising the senior Senator from Vermont's accomplishments, but instead I will submit an article for the record from the Daily Herald of Rutland, VT. This article clearly explains why the senior Senator from Vermont commands such respect in this body and throughout the Government. He is a leader in every sense of the word, and I am proud to serve with him. Mr. President, I ask unanimous consent that this article be included in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Rutland Daily Herald, July 6, 1994]

LEAHY'S NEW WORLD

(By Melrose E. Huff)

Vermont may be a haven from the world for some, but the senior Senator from Vermont is helping to redefine America's role in the New World Order.

Sen. Patrick Leahy, now in his fourth term, has emerged as one of Washington's most influential voices on foreign policy and the reform of foreign aid.

"Leahy has been both a key leader and a key adviser on foreign policy" to the Clinton administration, according to Wendy Sherman, Assistant Secretary of State for legislative affairs. "The Secretary (of State), the President, and the Vice President see him as a keen observer and * * * someone they look to for counsel."

Sherman, the liaison between Secretary of State Warren Christopher and the congressional leadership, observed, "What is unique about Senator Leahy is that he has a policy perspective, intellectual know-how and understanding, and the appropriator's tools."

Leahy's influence derives from his chairmanship of an appropriations subcommittee that provide the funds for foreign aid. The appropriations are considered cardinals in the Senate," Sherman said. "They are seen as extraordinarily powerful because they have the power of the purse."

Leahy has chaired the foreign operations subcommittee of the Senate Appropriations Committee since 1989, and both Republican and Democratic administrations have had to rely on him to win passage of their foreign assistance requests.

Leahy's foreign aids subcommittee has come to play a role that is vastly disproportionate to the usual process, another official observed. That's because since the mid-1980s the Senate Foreign Relations Committee has been unable to produce an authorization bill, which in the bill that draws the general outlines of programs and sets spending levels.

The leadership of the Foreign Relations Committee has been deadlocked for years. Its chairman, Claiborne Pell, a liberal Democrat from Rhode Island, won a zero percent approval rating from the American Conservative Union last year. Its vice chairman, North Carolina Republican Jesse Helms received a 100 percent rating. The result has been to delegate that committee's power to reshape policy.

"Your budget is your policy," said Marianne O'Sullivan, who is chief of appropriations and budget for the legislative bureau of the Agency for International Development. And Leahy "has played the lead role in the Senate in reprioritizing where foreign aid funds are spent," she said.

Leahy has cut military and security assistance while increasing funds for such programs as population planning, international environmental assistance, child survival assistance and AIDS prevention, O'Sullivan said.

In 1989, the first year Leahy was chairman of the foreign operations subcommittee, he cut the administration's $5 billion foreign military financing request by $300 million; last year he cut a $4 billion request by $110 million. During those same years he increased development and economic assistance to sub-Saharan Africa from $565 million to $784 million, she noted.

Funding for disaster aid and development assistance—the kinds of programs usually thought of as "foreign aid"—makes up 46 percent of the current year's nearly $19 billion budget. Foreign military financing has dropped to 23 percent. Contributions to multilateral lending institutions, such as the International Monetary Fund and the World Bank, account for another 14 percent. Appropriations for the Peace Corps, narcotics control, refugee aid, anti-terrorism assistance and promotion of U.S. exports make up the remaining 17 percent.

Although year-to-year comparisons are difficult because of changes in accounting methods, this year's allocation for foreign military financing is roughly 25 percent smaller than 1989's, while development assistance is nearly 25 precent greater. Leahy likens the slow process of making these changes to reversing the course of a supertanker.

"My concern is that foreign aid, as such, continues by inertia and policy neglect. Nobody wants to stop and say why we're doing this," Leahy said.

By the end of Leahy's first year as chairman of the foreign operations subcommittee, it had become clear to him that foreign aid was in need of fundamental reform. Leahy called upon President Bush in a 1990 Senate speech to "confront the enormous global problems that have replaced communism as the greatest threat to our security" and submit a foreign aid budget that would address "the momentous changes * * * sweeping the world since the fall of the Berlin Wall." The Bush administration did not respond.

During the last presidential campaign, O'Sullivan said, Leahy wrote to candidate Clinton and to Bush calling for the reform of foreign aid. Then, during the first hundred days the Clinton presidency, he delivered a series of speeches on the Senate floor proposing major reforms in the foreign assistance act—the permanent law that authorizes funding for foreign aid—and calling for a total overhaul of AID.

"Frankly," Leahy said in the fourth and final speech, "it is the last chance. I do not intend to bring foreign aid bills to the floor of the Senate and ask senators to vote on them" unless reforms are undertaken. That widely cited warning was heard throughout the Clinton administration.

The problem in the past, Leahy told the Senate, was that we expected foreign aid to work in the developing world as the Marshall Plan had in Europe, where democratic institutions already existed. "By placing such a high priority on political stability and anti-communist credentials, we failed to insist on the establishment of democratic forms and instititions * * * nor did we penalize recipient governments that did not produce better lives for their own people."

Leahy singled out aid to Somali and Zaire as examples of U.S. support for repressive and corrupt governments that not only did "not prevent anarchy, it actually promoted it by allowing dictators to avoid the need to build workable institutions."

Patchwork attempts to reform the Foreign Assistance Act of 1961, a piece of Cold War legislation that sanctioned aid as a weapon in the fight against communism, failed because of "inadequate political, bureaucratic, or intellectual preparation," Leahy charged.

The result has been increasing congressional disenchantment with foreign aid. Leahy noted that it was impossible to pass an appropriation for the 1992 fiscal year: The entire foreign assistance program was funded through a year-long continuing resolution. The 1993 appropriation passed only because it included a highly popular Israeli loan guarantee program.

Leahy told the Senate that a foreign aid program advancing our national interests in the post-Cold War era would be one that "protects the environment, curbs runaway international population growth, promotes democracy and human rights, and stimulates sustainable economic growth with equity." He pointed out that foreign aid "aimed at promoting sustainable growth in the Third World offers a way to stimulate rapid growth in U.S. exports sales," which in turn creates U.S. jobs.

Leahy outlined a plan for restructuring aid that abandoned allocations for specific countries and focussed instead on broad policy objectives promoting sustainable development, building democratic institutions, encouraging respect for human rights, protecting the global environment, stabilizing world population growth, providing humanitarian aid and disaster assistance and advancing private enterprise and market economies.

Leahy also recommended a number of structural changes in AID, the agency that implements the foreign assistance program. He called for reducing the number of its overseas missions and implementing programs through private voluntary organizations, international organizations and the private sector when possible. He also urged increased local participation in planning and implementing AID programs.

In response to calls by Leahy's subcommittee and other Senate and House oversight committees, Christopher created a task force in the spring of 1993 to rethink the role of foreign assistance. In addition, President Clinton ordered the National Security Council to conduct a review.

The result was the first blueprint in more than a quarter of a century for U.S. engagement with the developing world. The Peace, Prosperity, and Democracy Act of 1994 was submitted to Congress in February and, if passed, will replace the Cold War Foreign Assistance Act of 1961.

The bill's new policy objectives are set forth in its six major divisions, or titles: promoting sustainable development; building democracy; promoting peace; providing humanitarian assistance; promoting growth through trade and investment; and advancing diplomacy.

According to AID's Kelly Kammerer, who helped draft the new legislation, if you compare Leahy's Senate speeches on foreign aid reform to the NSC and State Department reports and to the new bill, you'll see "that almost point by point Senator Leahy's recommendations have been incorporated." He observed, "It is a remarkable tribute to Senator Leahy."

It's also why, as O'Sullivan said, Leahy's "name is practically synonymous with foreign aid reform in this town."

SOCIAL SECURITY REFORM ACT OF 1994

Mr. SARBANES. Mr. President, last week the Senate approved important legislation which would make the Social Security Administration an independent agency. While this measure has been overshadowed by other issues, it is my view that it will positively affect the lives of every working American. Establishing the Social Security Administration as an independent agency appropriately frees social security from the economic and budgetary decisions affecting the rest of the Government, thereby increasing the agency's integrity.

Polls indicate that a majority of younger Americans believe that they will be unable to collect social security benefits by the time they reach retirement age. This bill reinforces the principle of the trust fund, ensures adequate administrative funds to operate the system for future generations, and returns to the system some of the public confidence that has eroded since the program's inception in 1935.

Today, the Social Security Administration has an annual budget of $300 billion, making it the third largest agency after the Department of Health and Human Services and the Treasury Department. More than 42 million individuals receive Social Security benefits and the Social Security Administration is responsible for maintaining earnings records for 132 million workers. Given the magnitude of its workload and operation, it makes sense to establish the Social Security Administration as an independent agency.

Separating the Social Security Administration from the Department of Health and Human Services was first recommended in the 1983 National Commission on Social Security reform. Following the committee's recommendation, Congress commissioned a study of how to make the Social Security Administration independent. The study was conducted by Elmer Staats, former Comptroller General of the General Accounting Office, and recommended that an independent Social Security Administration should be headed by a single administrator with a bipartisan panel to permit independent review. In 1989, the GAO assessed the most appropriate management structure for an independent Social Security Administration and came to the same conclusion.

The legislation passed by the Senate follows these recommendations. This measure will establish a bipartisan advisory board which will work with the Commissioner in determining policies which affect social security programs. It will increase the Social Security Administration's visibility and credibility. It will improve administrative efficiency, and it will provide the agency with more autonomy to direct and protect the Social Security trust fund.

As a direct result of reports that some disabled individuals have been using their benefit check to support their drug and alcohol habits, this bill also includes measures aimed at preventing fraud and abuse. Through the SSA's Social Security Disability Insurance [SSDI] and Supplemental Security Income [SSI] programs, 250,000 drug addicts and alcoholics receive $1.4 billion in cash benefits annually. However, the Social Security Administration can only verify that three percent of these beneficiaries receive treatment. This bill would require disabled substance abusers to be in treatment as a condition of receiving benefits, and will end all benefits after three years. A responsible third party, such as a community service agency, will manage their benefits. This is a common-sense way to make certain that drug addicts and alcoholics get the treatment they need without abusing the system.

In his 1944 address to Congress, President Roosevelt observed that this country had "accepted a second bill of rights under which a new basis of security and prosperity can be established for all, regardless of station, race or creed." Among these, he said, is the right of every American to have "adequate protection from the economic fears of old age, sickness, accident and unemployment."

President Roosevelt's words are still true today. We have a vested interest in preserving the stability of the trust funds for Social Security and Medicare and a responsibility to ensure access to quality services for all Americans today and in the years to come. I am pleased that Congress has taken steps to this end and I look forward to President Clinton signing this measure into law.

GODFATHERS OF RHODE ISLAND RENAISSANCE

Mr. PELL. Mr. President, I would like to share with my colleagues a thoughtful article expressing appreciation of two Rhode Island philanthropists and the far-reaching effect of their generosity.

The two philanthropists are Alan Shawn Feinstein and John Hazen White. Both men have focused their considerable resources on providing improved educational opportunities.

Each, in their own way, have helped to fuel what may yet become a Rhode Island renaissance. Our experience in Rhode Island may well serve as an inspiration to other philanthropists in other regions of our nation.

This article, by the way, is by someone who knows of the impact of Mr. White's philanthropy—Thomas J. Farrell, dean of the John Hazen White School of Arts and Sciences at Johnson & Wales University.

Mr. President, I ask unanimous consent that this article, entitled "Two godfathers of a Rhode Island renaissance," which appeared in the Providence Journal of August 5, 1994, appear in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

TWO GODFATHERS OF A RHODE ISLAND RENAISSANCE

Henry David Thoreau said, "Philanthropy is almost the only virtue that is sufficiently appreciated by mankind." Thoreau's comment is a useful reminder to Rhode Islanders that we need to recognize and value the philanthropists in our midst who have recently taken the lead in what has the promise of being a political, economic and social renaissance in our state.

Two of those philanthropists are Alan Shawn Feinstein and John Hazen White.

Although the philanthropic spirit is as old as recorded history, the term was first used in the 18th Century, when the state and private individuals began to take over charitable works previously done by religious organizations. Philanthropy is generally understood as being characterized by a spirit of goodwill toward humanity, usually expressed by activities that promote human welfare. While particular acts of generosity will vary in the amount of good they do for society, we can be certain that Mr. Feinstein and Mr. White surely represent philanthropy at its very best.

In late March, the Rhode Island Cnapter of the American Red Cross honored Mr. Feinstein with a Longfellow Humanitarian Award. Among Mr. Feinstein's many accomplishments singled out that evening, the Red Cross applauded his committing millions of dollars to starting programs in community and public service in Rhode Island high schools. Providence College has established a degree program in public service with a Feinstein grant and "through his vision and financial support," the first high school in the country to have public and community service as its central theme will open in Rhode Island this year. Mr. Feinstein also founded the World Hunger Program at Brown University, the first university center for research and education addressing the root causes of world hunger.

A month later, 250 persons gathered at a reception to recognize John Hazen White's $1 million gift to the School of Arts and Sciences at Johnson & Wales University. The president and chief executive officer of TACO Inc. had previously provided Brown University with the funding to set up the Public Opinion Laboratory that bears his name. But it is "Red Alert!," Mr. White's grass-roots movement to bring about political reform and enhance the quality of life in Rhode Island, that is his most widely recognized activity.

His frequent full-page newspaper ads call citizens to periodic town meetings at which healthy debates take place on issues ranging from integrity in state government to the problems of adolescents. On a quieter scale, all of Mr. White's employees at his Cranston-based manufacturing firm are able to attend free classes in the TACO Learning Center built just for their use. Employees can take classes—on company time—in anything from English as a Second Language to accounting for nonprofessionals, from parenting to customer service, from Weight Watchers to GED training.

Both Alan Shawn Feinstein and John Hazen White have philanthropic interests other than those mentioned here. It is worth noting, however, that a common thread runs through much of their gift-giving. That common thread is the conviction that education is the key to a better society. They accept Plutarch's notion that "the very spring and root of honesty and virtue lie in good education."

Astute businessmen that they are, these two Rhode Islanders instinctively realize that certain investments are apt to reap greater dividends. Both seem to share with Vaclav Havel, the playwright/president of the Czech Republic, the knowledge that "consciousness precedes action." In other words, people need to understand what something is about before they can do anything to change it.

Fortunately, there is considerable evidence that a new consciousness is spreading throughout the state, that there is a feeling of renewal caused by something other than balmy spring weather, that indeed we may be in the early stages of a Rhode Island renaissance.

Cynics may scorn such optimism and point to recent actions of the judiciary, the state Lottery Commission, or individual members of the state legislature to argue that business goes on as usual. That is what cynics do. In some cases, they may have a point, but ultimately, cynicism does not solve problems; nor is it psychologically satisfying.

What Rhode Islanders need most of all is to regain their self-esteem and confidence. Thus it is necessary to recognize and appreciate all the good things that are taking place. Consider the work of members of the various reform groups: Right Now, Common Cause, GAP, USPAC, Clean Sweep, Council of Churches, etc. Put partisan politics aside and acknowledge that Gov. Bruce Sundlun and the new state officers have restored a sense of trust and integrity to government.

Walk through downtown Providence and visualize the city that may yet come to be as a result of the efforts of the mayor and a number of planning groups. Witness the communication and cooperation between the city's colleges and hospitals and Mayor Vincent Cianci resulting in a pact that will benefit the children of Providence for years to come. All of these are signs of renaissance, a time for change, a time for new beginnings.

Is it premature to use the term "renaissance" to describe these recent events? perhaps, but the rebirth of optimism, and thinking positively, can often help actualize aspirations. We owe at least this much to Feinstein, White, and all of the many citizens who strive to make Rhode Island a better place.

TRIBUTE TO JOYCE RIDE

Mr. LIEBERMAN. Mr. President, I rise to recognize the exceptional efforts of Joyce Ride whose years of public service have enriched both the communities of Los Angeles and Capitol Hill.

Ms. Ride's work through the Ride Internship Program at Santa Monica College provides deserving students with the opportunity to intern on Capitol Hill for the summer. This program enhances the education of our leaders of tomorrow. Ms. Ride sponsored Ramin Youssefzadeh, an Iranian Jew who contributed a unique international perspective and was a tremendous asset to our office this summer.

In addition, as chair of the Subcommittee on Women in the Justice System which is included in the State Senate Women's Advisory Commission, Joyce Ride continues championing the rights of incarcerated women. Her efforts include an attempt to eliminate gender bias in prison healthcare and shield children from the tolls incarceration often takes on families.

I commend her outstanding work as Chair of Friends Outside, an organization that advocates the rights of incarcerated women. Also, I applaud the dedication to these women and their children apparent from Ms. Ride's many years of work on their behalf.

Joyce Ride is an exemplary citizen who makes a difference in the lives of many. I wish to honor her accomplishments.

IS CONGRESS IRRESPONSIBLE? YOU BE THE JUDGE ABOUT THAT

Mr. HELMS. Mr. President, anyone even remotely familiar with the U.S. Constitution knows that no President can spend a dime of Federal tax money that has not first been authorized and appropriated by Congress—both the House of Representatives and the U.S. Senate.

So when you hear a politician or an editor or a commentator declare that "Reagan ran up the Federal debt" or that "Bush ran it up," bear in mind that it was, and is, the Constitutional duty and responsibility of Congress to control Federal spending. Congress has failed miserably in that task for about 50 years.

The fiscal irresponsibility of Congress has created a Federal debt which stood at $4,641,220,157,276.19 as of the close of business Tuesday, August 9. Averaged out, every man, woman and child in America owes a share of this massive debt, and that per capita share is $17,802.16.

SHEEP PROMOTION, RESEARCH, AND INFORMATION ACT OF 1994

Mr. BURNS. Mr. President, I rise today to speak on behalf of the Sheep Promotion, Research, and Information Act of 1994, and the ability of wool producers to market their product in the United States and around the world.

One year ago, a majority of this body voted to abolish the Wool support system over the next two years, a system that was established almost 50 years ago. However, I did not vote in favor of that provision. Congress left our wool producers high and dry in funding to promote the many products that are derived from sheep.

What the producers are asking of us is the ability to develop a legislative measure that will allow them a way to collect funds, from their own pockets, to promote the sheep and wool industry. The men and women that raise and market sheep are not asking for a hand out, they are asking for Congress's support in establishing a board that will allow them the chance to compete on a field that is sometimes slanted against them.

In Montana, where we have 2,900 farms and ranches that are in the sheep and wool producing industry, there is a concern about the ability to remain a viable and active industry. I ask you to support these families and give them the chance to compete with the world market by providing them the opportunity to establish this board for the future of the Wool industry.

Thank you, Mr. President.

HEALTH CARE REFORM

Mr. DOLE. Mr. President, the phones are ringing off the hook in my office today—and I suspect that is true of all Senate offices, as the American people call in to register their opinions on health care.

And their opinions is pretty clear. They do not like Senator MITCHELL's bill. They do not like Government-run health care. And they want Congress to be very very careful before trading in the best health care delivery system in the world for something else.

When I last checked, my office had received about 160 calls on health care today. One hundred and thirty-five of them said that they either opposed the Mitchell bill and that we should take our time; 25 expressed support for the Mitchell bill—that is about a 6–1 ratio.

And according to a CNN/USA Today/Gallup Poll released this evening, those numbers are part of a nationwide consensus. Let me just mention a few interesting results from the poll.

Sixty-eight percent of Americans believe that Congress should reform health care gradually over a number of years. Only 28 percent believe we should pass a comprehensive bill this year.

By a 2 to 1 ration—53 to 26 percent, Americans trust Congress rather than President Clinton to do a better job at reforming health care.

Fifty-nine percent believe that the bills currently before Congress are the same thing as President Clinton's failed proposal. Only 20 percent believe they are different.

The survey also asked Americans whether they were more concerned that Congress would pass a bill with too much Government, or more concerned that Congress would pass a bill that did not contain universal coverage. The results were 53 percent too much Government, 40 percent no universal care.

Finally, the survey asked Americans whether they believe they would be worse off if Congress passed a bill, or worse off if Congress didn't pass a bill.

Fifty-four percent said they would be worse off if Congress passed a bill. Only 30 percent said they would be worse off if Congress didn't pass a bill.

Mr. President. The American people are speaking. I only hope that Congress is listening.

TRIBUTE TO BILL SCALLY

Mr. DOLE. Mr. President, let me take a moment to honor Bill Scally, Reuters' senior Capitol Hill correspondent, who yesterday became an American citizen.

From what I understand, this native Englishman's desire to become a U.S. citizen is due in no small part to his adventurous spirit and uncommon determination. More than 30 years ago this spirit and determination brought him in a small leaky boat from the shores of England to the Canary Islands, and finally to his new home in America.

The same spirit and determination carried him throughout the world of journalism in Britain, the Middle East, and the United States. Since 1963, this talented journalist has reported for Reuters from the steps of the State Department to both ends of Pennsylvania Avenue.

Perhaps the most remarkable part of Bill's story is the fact that, after covering Congress night and day for several years, he still wanted to become a U.S. citizen.

We certainly congratulate and send best wishes to Bill, his wife Lori, and daughter Gwynnyth.

SALUTE TO VICTORIA HRUSKA

Mr. DOLE. Mr. President, all of us who are privileged to stand in the political arena know that we do not stand there alone. Our families also stand there with us. They put up with the late hours and the missed dinners. Our victories are their victories, and our defeats are their defeats.

One lady who handled the ups and downs of this life with great grace was Victoria Hruska, who passed away last week at the age of 88.

Victoria was the wife of our former colleague, Senator Roman Hruska of Nebraska, and was at his side throughout his 2 years in the House of Representatives, and his 22 years in the U.S. Senate.

Senator Hruska described Victoria as "indispensable," and her daughter, Jane, said she was "The foundation rock of the family."

During her years in Washington, Victoria would serve as the official hostess for events held for Nebraskans in Washington. She was also a member of the Senate Wives Club and the Red Cross unit.

I know all Members of the Senate join with me in extending our condolences to Senator Hruska, and to the entire Hruska family.

THE FISCAL YEAR 1995 ENERGY AND WATER APPROPRIATIONS BILL

Mr. SASSER. Mr. President, the Senate Budget Committee has examined H.R. 4506, the energy and water appropriations bill, and has found that the bill is under its 602(b) budget authority allocation by $20 million and under its 602(b) outlay allocation by $59 million.

I compliment the distinguished manager of the bill, Senator JOHNSTON, and the distinguished ranking member of the Energy and Water Subcommittee, Senator HATFIELD, on their hard work.

Mr. President, I have a table prepared by the Budget Committee which shows the official scoring of the energy and water appropriations bill and I ask unanimous consent that it be inserted in the RECORD at the appropriate point.

There being no objection, the table was ordered to be printed in the RECORD, as follows:

SENATE BUDGET COMMITTEE SCORING OF H.R. 4506—

Fiscal year 1995 Energy and Water Appropriations—Conference Bill.

[In millions of dollar]

Bill summary	Budget authority	Outlays
Discretionary totals:		
New spending in bill	$20,493	$12,083
Outlays from prior years appropriations		8,916
Permanent/advance appropriations	0	0
Supplementals	0	−115
Subtotal, discretionary spending	20,493	20,884
Mandatory totals	0	0
Bill total	20,493	20,884
Senate 602(b) allocation	20,513	20,943
Difference	−20	−59
Discretionary totals above (+) or below (−):		
President's request	−20	−56
House-passed bill	137	31
Senate-reported bill	−20	0
Senate-passed bill	−20	−1
Defense	10,319	10,449
International affairs	0	0
Domestic discretionary	10,174	20,884

SERVICE OF REAR ADM. MICHAEL W. CRAMER, DIRECTOR FOR INTELLIGENCE, J2

Mr. WARNER. Mr. President, I rise today to commend Adm. Michael W. Cramer for his service as the Joint Staff Director for Intelligence, J2. He served with distinction in this position from June 15, 1992, until August 5, 1994. His achievements to operational intelligence support resulted in significant improvements in this area. Admiral Cramer developed numerous initiatives which have advanced intelligence support and enhanced intelligence communications.

Admiral Cramer has been approved for the Intelligence Community Distinguished Service Medal and the National Intelligence Distinguished Service Medal. These illustrious medals were awarded not only for his outstanding service as the Joint Staff Director for Intelligence, J2, but for extraordinary service to our Nation during his entire military career. Admiral Cramer will continue to serve the U.S. Navy as Director of Naval Intelligence. He will assume these responsibilities later this month.

Mr. President, I would ask that a narrative of Admiral Cramer's military service along with citations for the above awards be included in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

NARRATIVE

Rear Admiral Michael W. Cramer, United States Navy, demonstrated exceptionally distinguished service from 15 June 1992 to 5 August 1994 while assigned as The Joint Staff Director for Intelligence, J2. Carrying out the responsibilities of the office, Admiral Cramer set new standards for the quality of current and crisis intelligence support to the Chairman, Joint Chiefs of Staff, the Secretary of Defense, and the Joint Staff. He also initiated numerous highly successful programs that have already resulted in tangible improvements to operational intelligence support for the warfighter in the field. His achievements as the Director for Intelligence, J2 are broad in scope and long-lasting in their impact.

In his primary function as Intelligence Officer to The Joint Staff, Admiral Cramer's legacy is his genius for concise, graphically powerful presentations of complex situations. His briefings on current and crisis intelligence topics have become the national standard; they were requested by and delivered to the President and the National Security Advisor, the Secretary of Defense, several Committees of the Congress, and numerous other policymakers. His impact was equally as profound on the occasions when he represented the Intelligence Community directly to the American people, conducting televised, live press conferences during crisis situations to explain the background of U.S. involvement by military forces.

Admiral Cramer's masterful crisis management was evident throughout his assignment as J2. He took unprecedented initiative in leading the Intelligence Community toward improved, standardized, modern intelligence support to tactical, national, and international consumers. Admiral Cramer was the principal driver behind Intelligence Community and operational acceptance of the Joint Deployable Intelligence Support System (JDISS). JDISS is the common intelligence workstation software recognized throughout the Community, the Defense Department, and by Congress as the standard intelligence dissemination system. The JDISS initiative was a personal project of Admiral Cramer, aimed at resolving the interoperability shortfalls recognized in the aftermath of Operation DESERT STORM. Under his close supervision, JDISS has become not only the

U.S. national intelligence standard, but has been embraced by NATO and the United Nations for specialized intelligence support requirements. In two short years, Admiral Cramer literally changed the way the business of intelligence is done worldwide, at all levels.

Concurrent with the JDISS initiative, Admiral Cramer carried the intelligence dissemination challenge to the next level by directing that a broad-bandwidth, all-media intelligence support system be developed and implemented to provide comprehensive, worldwide command support. The Joint Worldwide Intelligence Communications System (JWICS) was swiftly fielded and became the "core architecture" for joint worldwide intelligence communications. Centered in the National Military Joint Intelligence Center, JWICS permits video-teleconferencing and numerous other applications with Unified Commands and subelements, down to the Joint Task Forces deployed in the field or aboard ship. It is now in continuous use by U.S. operational commanders worldwide and is employed in very successful bilateral links with key allies.

Making significant headway in the arena of documenting joint military operations, Joint Intelligence Doctrine was written and approved under Admiral Cramer's leadership. Before Admiral Cramer assumed direction of this task, "joint" military intelligence doctrine was a disparate collection of non-validated local practices and personal opinion. In the past two years, Admiral Cramer has created a structure for the joint intelligence process, has supervised the drafting of a whole series of approved, community-wide products and has, for the first time, breathed operational and intelligence life into joint doctrine.

Under the policy direction of the Director of Central Intelligence and the Director of the Defense Intelligence Agency, Admiral Cramer oversaw the implementation of an unprecedented, history-making process for providing military intelligence support to the United Nations and to its peacemaking and peacekeeping forces deployed around the world. He directly supervised the vast interagency coordination involved in this herculean effort, personally guided the dissemination architecture, and achieved on-line intelligence support within months of the concept approval. Drawing assets from within his own organization, he assumed personal responsibility for ensuring that this historic initiative succeeds.

Admiral Cramer worked aggressively to resolve theater and tactical intelligence collection capability shortfalls. He brainstormed an unmanned aerial vehicle (UAV) concept and, by force of will and professional determination, saw vehicles flying operational missions in less than one year. Using commercial off-the-shelf technology, high-quality sensors, common ground stations and interoperable dissemination system and then mustering community consensus, the UAV has achieved all its goals due to its grounding in common sense and Admiral Cramer's intense personal commitment.

In sum, Admiral Cramer is the consummate intelligence officer, and his service to the Joint Chiefs of Staff and to the Nation, in peace and conflict, stands as the benchmark against which all other military intelligence professionals will measure their success. Admiral Cramer has achieved more of lasting significance to military intelligence and the Intelligence Community over a two year period than any officer of his generation. Assuming the broad, national intelligence community leadership responsibilities that come with his position, he aggressively exercised his mandate with creativity, determination, and skill and has made significant and lasting contributions to the Department of Defense and to the United States of America. Admiral Cramer's exemplary professional competence, initiative, leadership, dedication to duty, and sustained distinguished performance reflect great credit upon himself, the Joint Staff and the Department of Defense.

CITATION TO ACCOMPANY THE AWARD OF THE DEFENSE DISTINGUISHED SERVICE MEDAL TO MICHAEL W. CRAMER

Rear Admiral Michael W. Cramer, United States Navy, distinguished by exceptional service during the period 15 June 1992 to 5 August 1994 as Joint Staff Director for Intelligence, J2. During this period he set new standards for the quality of current and crisis intelligence support to the Chairman, Joint Chiefs of Staff, and the national leadership. Through his performance in peace and conflict, Admiral Cramer has recast the mold and defines a new standard of excellence in the Intelligence Community. As Director for Intelligence, J2, Admiral Cramer initiated numerous highly successful programs that have resulted in tangible improvements to operational intelligence support for the warfighters in the field. His unique vision and intense commitment led to the unparalled success of the Joint Deployable Intelligence Support System and the Joint Worldwide Intelligence Communications System. Drawing upon his creativity, determination, and skill, Admiral Cramer personally directed the development of the history-making process for providing intelligence support to the United Nations. The distinctive accomplishments of Admiral Cramer reflect the highest credit on himself, the United States Navy, the Joint Staff, and the Department of Defense.

Award nominated for: Distinguished Service Medal.

Name: Rear Admiral Michael W. Cramer, USN.

Organization: Joint Staff Director for Intelligence, J2.

SUMMARY OF ACCOMPLISHMENTS

Rear Admiral Michael W. Cramer, USN, is nominated for the award of the Intelligence Community Distinguished Service Medal for extraordinary service to the nation throughout his career, culminating in his assignment as Joint Staff Director for Intelligence, J2. Carrying out the responsibilities of the office he set new standards for the quality of current intelligence support to the Secretary of Defense, the Chairman, Joint Chiefs of Staff, and the Joint Staff. He initiated numerous highly successful programs that already have broad Intelligence Community impact, including tangible improvements to operational intelligence support in the field. His achievements in the Intelligence Community have been broad in scope and longlasting in their impact.

Admiral Cramer has served at the center of operations throughout his career, providing intelligence support to military operators and at the highest staff levels. His career began with two combat cruises off Vietnam, and quickly transitioned to management of targeting operations and later of Operation HOMECOMING. He also served in the Soviet Union as Assistant Naval Attache during the height of the Cold War, setting new standards of performance in that key billet. Returning to the Office of Naval Intelligence, he put his fresh insights on the Soviet Union to use as Deputy Director of the Directorate for Soviet Strategy, Policy, and Tactics, participating in the comprehensive review of U.S. Navy strategy that culminated in the "Maritime Strategy." As his seniority increased he has assumed the most responsible positions available, including the top intelligence officer positions for Commander Sixth Fleet (during combat operations), Commander in Chief, U.S. Atlantic Fleet, Commander in Chief, U.S. Atlantic Command, and the Joint Staff.

Admiral Cramer's legacy in his primary function as Intelligence Officer to the Joint Staff will lie in his genius for concise, graphically powerful presentations of complex situations. His briefings on current intelligence topics have become the national standard; they were requested by and delivered to the President and the national Security Advisor, the Secretary of Defense, several Committees of the Congress, and numerous other policymakers. As importantly, he represented the Intelligence Community directly to the American people, conducting televised live press conferences during crisis situations to explain the background of involvement by U.S. military forces.

Beyond his primary function as intelligence officer to the Joint Staff, he took unprecedented initiative in leading the Intelligence Community toward improved, standardized, modern intelligence support to tactical, national, and international intelligence consumers. The following are specific examples of initiatives for which Admiral Cramer has been the creator and prime mover within the Intelligence Community:

THE JOINT DEPLOYABLE INTELLIGENCE SUPPORT SYSTEM (JDISS)

JDISS is the common intelligence workstation and software recognized throughout the Community, and by the Congress, as the standard intelligence dissemination system. The JDISS initiative was a personal project of Admiral Cramer, aimed at resolving the interoperability shortfalls recognized in the aftermath of operation DESERT STORM. Under his close supervision, JDISS has become not only the national intelligence standard, but has been embraced by NATO and by the United Nations for specialized intelligence support requirements. In two short years Admiral Cramer literally changed the way the business of intelligence is done, worldwide, at all levels.

THE JOINT WORLDWIDE INTELLIGENCE COMMUNICATIONS SYSTEM (JWICS)

Carrying the intelligence dissemination challenge to the next level, Admiral Cramer concurrently with the JDISS initiative directed that a broad-bandwidth, all-media intelligence support system be developed and implemented to provide comprehensive, worldwide command support. SWICS, swiftly fielded, because the "core architecture" for joint worldwide intelligence communications. Centered in the National Military Joint Intelligence Center, JWICS permits videoteleconferencing with Unified Commands and subelements, down to the JTF deployed in the field or aboard ship. It is in continuous use now worldwide, and in very successful bilateral links with key allies.

MILITARY INTELLIGENCE SUPPORT TO THE UNITED NATIONS

Under the policy direction of the Director of Central Intelligence and the Director, Defense Intelligence Agency, Admiral Cramer oversaw the implementation of an unprecedented, history-making process for providing military intelligence support to the United

Nations. He directly supervised the vast interagency coordination involved in the effort, personally directed the dissemination architecture, and achieved on-line intelligence support within months of the concept approval. Drawing assets from within his own organization, he has assumed personal responsibility for ensuring that this historic initiative succeeds.

UNMANNED AERIAL VEHICLES (UAV)

Responding to theater intelligence collection capability shortfalls, Admiral Cramer personally brainstormed a UAV concept, and by force of will and professional determination saw vehicles flying operational missions in less than one year. Using commercial off-the-shelf technology, high quality sensors, common ground stations and an interoperable dissemination system, the UAV has achieved all its goals due to its grounding in common sense and Admiral Cramer's personal commitment.

Rear Admiral Cramer has achieved more of lasting significance to the Intelligence Community over a two-year period than any officer of his generation. Assuming the broad, national intelligence community leadership responsibilities that come with his position, he has aggressively exercised his mandate with creativity, determination and skill.

CITATION

Rear Adm. Michael W. Cramer, United States Navy is hereby awarded the National Intelligence Distinguished Service Medal in recognition of his extraordinary contribution to the Intelligence Community's continuing efforts to improve support to joint and combined military forces. Assuming a primary role in devising and implementing critical intelligence support initiatives, Admiral Cramer is personally responsible for the success of programs and systems that have become Community standards. He changed the nature of intelligence dissemination for all time by implementing the Joint Deployable Intelligence Support System and the Joint Worldwide Intelligence Communications System. These systems revolutionized intelligence dissemination throughout the Community, and have been effective tools in the unprecedented level of intelligence support Admiral Cramer has pioneered with the United Nations and its peacekeeping forces around the world. His creative and aggressive approach to problem solving is exemplified by the successful fielding, within months, of a successful aerial collection vehicle to meet a recognized Intelligence Community requirement. Admiral Cramer's brilliance as a current intelligence officer, and his vision as an architect of the future of intelligence support to operations, bring credit upon himself, the United States Navy, the Defense Intelligence Agency, the Department of Defense, and the Intelligence Community.

PASSAGE OF THE NATIONAL FLOOD INSURANCE REFORM ACT OF 1994

Mr. KERRY. Mr. President. Yesterday with the Senate's agreement to the conference report on H.R. 3474, the Riegle Community Development and Regulatory Improvement Act of 1994, which includes, as Title V, The National Flood Insurance Reform Act, Congress passed the most sweeping reforms to the flood insurance program since its inception a quarter-century ago. I can say confidently and with a sense of personal satisfaction that Congress has acted appropriately, wisely and with vision to correct the chronic flaws in the NFIP, and as a result has taken a significant step toward protecting the nation's taxpayers and floodplains.

A new, sensible course for the flood insurance program has been charted, and with it a new era of more sound, cost-effective and environmentally benign floodplain management. Due to the late hour when the conference report was agreed to by voice vote, I was unable to comment on the passage of this important legislation at that time, but I now would like to discuss the significance of this legislation.

In 1942, Dr. Gilbert White, one of the founding fathers of floodplain management in this country observed that floods may be an act of God, but flood damages are an act of man. Dr. White also might have observed that flood damages are just as much an act of Congress.

Four years ago I began my efforts to reform the National Flood Insurance Program [NFIP], an important but beleaguered part of our Federal floodplain management and disaster assistance matrix, in order to save taxpayers millions of dollars in disaster assistance and to increase coastal and river floodplain environmental protection. I considered this a necessary task because we simply can no longer afford to abide by our costly past policies and practices which actually encourage, not discourage, risky development in areas we know through experience to be hazardous, dangerous and altogether unfit to occupy.

Reform has not come easy. But then it is never easy to challenge the status quo and propose changes to a program which has evolved over years of mismanagement to the point that many perceive it to be an entitlement—another Federal giveaway shouldered by the taxpayer—that minimizes personal responsibility and public accountability.

I have been concerned about the flood insurance program for years and have spoken out to my colleagues about the need for program reform on numerous occasions: after Hurricane Andrew and Iniki in 1992, after the 1993 East Coast Winter Blizzard; and last summer after the Great Midwest Flood. And with each disaster, my concerns have grown.

We have known for years that the flood insurance program was a huge financial liability and that Federal costs for flood disaster assistance have continued to skyrocket despite the NFIP. We have documented that participation by individuals in the NFIP has lagged far behind reasonable expectations and left the program chronically under-capitalized, and that the program has suffered from adverse selection and costly repetitive losses. Mr. President, under these circumstances a private sector insurer surely would fail.

It also has become clear to me and to many of my colleagues on the Banking Committee that the floodplain management requirements and incentives of the NFIP simply were not doing enough to encourage sound community floodplain management—consisting of sensible, prudent and environmentally conscious land-use and development practices envisioned by Congress when it created the NFIP in 1968.

Most importantly, we have been reminded painfully that low participation in the NFIP has meant that thousands of individuals in hazardous floodplains go uninsured and exposed to risk—a reality made so tragically clear during the Great Midwest Flood of 1993, and once again this summer during the destructive flooding in the Southeast.

Fortunately, Congress in the form of this legislation has chosen to move in a direction which should reduce over time the magnitude of human misery following flood disasters. Title V of the conference agreement on H.R. 3474 closely resembles the compromise flood insurance reform legislation that passed the Senate on March 17, 1993. It provides a sensible, fair and balanced schedule of reforms that establishes a workable framework for program improvement without jeopardizing those communities or individuals with an interest in the flood insurance program.

Increasing the number of people participating in the flood insurance program has long been regarded as a key element of any effort to improve the financial soundness of the flood insurance fund, control disaster assistance costs, and get the federal taxpayer off the hook. Greater participation should better spread the risk, generate greater premium income and bring the program closer to an actuarially sound condition.

Subtitle B of this legislation cracks down reasonably on compliance violations and will ensure that those required to purchase flood insurance actually buy it and maintain coverage. The compliance subtitle also should ensure that those individuals and institutions who try to free-ride off the system and not pay for their assumed risk are identified and required to comply with the law.

Improved hazard notification procedures and standard flood hazard determination forms will provide convenient methods to track compliance with flood insurance purchase requirements. Other compliance measures such as the establishment of escrow accounts for flood insurance premiums, and the allowance for lenders to force place the purchase of flood insurance for uninsured mortgages when coverage is required, provide common sense tools that work within existing lending practice and will boost participation.

I would not be surprised to see a sharp increase in the number of insurance policies once these and other provisions in the legislation take hold.

Yet, greater participation will not by itself ensure financial soundness of the NFIP. Greater emphasis on loss reduction activities to reduce the amount of risk insured under the NFIP also vital and included in this legislation.

James Lee Witt, the Director of the Federal Emergency Management Agency [FEMA], has testified that mitigation is essential to improving our national floodplain management strategy. This bill gives Mr. Witt and his agency new incentives and strategies to encourage communities and individuals at risk to adopt more responsible and environmentally sound floodplain management measures to avoid or lessen future damages.

Subtitle C of this legislation creates a Community Rating System [CRS] as a new incentive to encourage communities to adopt floodplain management measures beyond NFIP minimum requirements in exchange for premium rate reductions. Significantly, communities that adopt measures that protect against flood and erosion hazards, and measures that preserve and protect natural and beneficial floodplain functions, are to be rewarded with credits that result in lower premiums for their residents who participate in the NFIP. Communities that have participated in CRS on a trial basis such as Tulsa, Oklahoma have seen premium rates go down nearly 40 percent and I hope that FEMA now will promote CRS aggressively nationwide.

This legislation also creates in Subtitle D—for the first time—a flexible and comprehensive mitigation strategy as an additional incentive for communities to reduce risk. Under this program $20 million will be available to states and communities to develop flood and erosion hazard mitigation plans and for mitigation grants to implement cost-saving mitigation activities for flood-prone structures such as relocation, elevation, floodproofing, and acquisition, if cost-effective. Importantly, NFIP loss leaders such as repetitive loss communities and substantially damaged structures are given priority consideration for mitigation grants.

Another key element of the mitigation strategy is the creation of a new insurance coverage, "mitigation insurance," in Subtitle F. Using the more convenient and timely insurance mechanism, this new coverage will pay up to $25,000 for the additional costs necessary to rebuild flood-damaged buildings to existing NFIP code requirements. Although FEMA will be allowed to add up to a $75 surcharge to policies to fund this additional coverage, FEMA advises that it estimates that the average surcharge for over 85 percent of NFIP policyholders will be $6. By any measure that I am aware, $6 for $25,000 of coverage is a great deal.

This legislation stimulates loss reduction with three new incentives: CRS, mitigation grants and mitigation insurance. Cumulatively, these incentives will encourage better and more thoughtful community floodplain management, reduce risks and make structures more floodworthy before the next flood, and make sure that structures, once damaged by a flood, are rebuilt as lesser risks to the NFIP and the taxpayer.

This legislation also provides numerous other provisions that will improve the flood insurance program, especially measures to increase the amounts of insurance coverage that people may purchase, improve flood insurance rate maps and enhance hazard identification. In addition, the act will stimulate FEMA to investigate and study some of the lingering questions that went unanswered for lack of data or appropriate analysis—the most important study being an evaluation of the extent and effect of erosion on the flood insurance program.

The identification of erosion hazard areas has been an especially prickly issue. Evidence and experience in several states conclusively demonstrate that erosion is a hazard which no longer can remain an unidentified, subsidized benefit in the NFIP. Just as clearly, the identification of erosion hazards has stimulated legitimate concerns by coastal communities, property owners and development interests which could not be answered completely.

The compromise contained in this legislation is to evaluate the effect of erosion, and not to direct FEMA to map erosion hazard areas as many coastal States already have done. We certainly can benefit from better data regarding the effects of erosion on the flood insurance fund and affected communities. Over the next two years, FEMA will begin the process of mapping erosion in a representative sample of communities where erosion risks are high, will assess the effects on the flood insurance fund, respective communities and the coastal environment, and will come back to Congress to make the case that erosion hazard mapping should, or should not, be implemented nationwide.

I am confident that if FEMA properly conducts this study, Congress finally will have the information to make a fully informed judgment on how best to address this costly hazard.

Is this legislation perfect? I am confident it is not, but then what legislation is? Certainly, during the give and take of the legislative process I agree to drop provisions that I considered quite important components of reform, and still contend that these provisions would have made beneficial contributions. But in the end, it is important for Congress to realize that with the passage of this legislation we set in motion a process to guarantee responsible reform today and purposeful refinement in the near future.

Mr. President, several Members of Congress contributed significantly to this effort and before ending I would like to take a moment to thank my colleagues who worked long and hard to bring us to this successful conclusion. I want to thank the Chairman of the Banking Committee, Senator RIEGLE, for his dedication, support and steady hand throughout this process and particularly during the conference.

I also want to acknowledge my Republican colleagues, the ranking member of the Banking Committee, Senator D'AMATO, the Senator from Florida, Senator MACK, and the Senator from Missouri, Senator BOND, and their staffs for the tremendous amount of time and energy they have committed to this bipartisan effort. In particular, I want to thank Senator MACK for his personal, good-faith efforts to forge a workable compromise.

I also want to commend our colleagues in the House, notably the distinguished Banking Committee Chairman, Mr. GONZALEZ, for concluding a successful conference and his support for flood insurance reform. I want to commend especially my good friend and colleague from Massachusetts, Mr. KENNEDY, for taking up the fight for NFIP reform, and his colleague on the Banking Committee, Mr. BEREUTER, who has brought so much expertise to this debate over the years.

Congress now has acted to address the ills affecting the NFIP, an accomplishment that is something in which we can and should take great pride. Obviously, any change in a program such as the NFIP is contentious, perhaps even more so than in the past due to heightened sensitivities on the part of some interests towards private property rights. It will be vital for Congress to work closely with FEMA to ensure that these reforms are properly implemented. My sincere aspiration is that once implemented this legislation will restore common sense and responsibility when people decide where to build, and when government decides what to insure.

In closing, Mr. President, I believe this legislation is fair, reasonable and balanced and will implement essential reforms. It should improve the financial soundness of the nation's flood insurance program by increasing participation and by lowering the potential for excessive flood damages through an incentive-based approach. I applaud my colleagues for recognizing the need to protect the Federal Treasury, protect the property at risk along the Nation's floodplains through encouragement of more environmentally aware floodplain management. I am delighted to send this measure to the President for his signature and hope he will sign it expeditiously.

MILCON ADD-ONS

Mr. McCAIN. Mr. President, After I spoke on the fiscal year 1995 military construction appropriations bill on August 9, 1994, I received a letter from another of America's well-known watchdog groups, the National Taxpayers Union. I feel their views are of great importance, and that my colleagues should be aware of them. Therefore, I request unanimous consent that this letter be entered into the RECORD.

The National Taxpayers Union is another group which feels that unnecessary add-ons and earmarks squander funds that the National Taxpayers Union says should be directed to more pressing problems.

As the National Taxpayers Union says,

> The pork-barrel spending contained in the Conference Report is outrageous. At a time when our nation must streamline not only its military, but also its budget, such a wasteful spending shows a gross neglect for the American taxpayer.

In addition, I ask unanimous consent that the two letters I cited in my speech yesterday—from Citizens Against Government Waste and Citizens for a Sound Economy—also be included in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CITIZENS FOR A SOUND ECONOMY,
Washington, DC, August 4, 1994.

Hon. JOHN McCAIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR McCAIN: Citizens for a Sound Economy (CSE), a 250,000-member grassroots organization that promotes free market economic policies, supports you in your opposition to the pork-barrel spending contained in the FY 1995 Military Construction Appropriations Conference Report (H.R. 4453 and H. Rpt. 103-624).

The conference report eliminated language in the Senate bill that established criteria for making military spending more fiscally responsible. Moreover, it added a slew of unrequested and expensive new projects to the bill, most of which would simply funnel money to specific states and congressional districts. Although it purports to cut $137 million from the original bill, the report prohibits the Department of Defense from eliminating any project—including the new pork-barrel items—to make this cut.

The unnecessary new spending items included in the conference report constitute yet another burden on American taxpayers. As an advocate of fiscal responsibility in all areas of government, CSE urges the members of Congress not to pass the conference report on the military appropriations bill until all unnecessary spending programs have been removed.

Sincerely,

PAUL BECKNER,
President.

COUNCIL FOR CITIZENS AGAINST GOVERNMENT WASTE,
Washington, DC, August 8, 1994.

Hon. JOHN McCAIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR McCAIN: Coincidentally, at the moment we were asked by your staff to review your amendment to delete nearly $1 billion in pork-barrel spending from the FY95 Military Construction Appropriations conference report, we were finishing a letter to Senators concerning the pork-laden crime bill conference report.

The Council for Citizens Against Government Waste fully endorses your effort to send the conference report back for some serious liposuction, and our more than 600,000 members across the nation appreciate and applaud your leadership.

In only one respect would we disagree with you. In the talking points prepared for the bill, you say that the add-ons and earmarks are "an embarrassment for the Congress as a whole." Senator, in the ten years since Peter Grace gave to the American people his report on government waste, and founded this organization, the one thing that is clear is that Congress sadly seems to be beyond embarrassment when it comes to pork-barrel spending.

Your efforts will receive not only our gratitude but also a salutary report in the next issue of Government Waste Watch, due to arrive in our members' homes in October.

Sincerely,

JOE WINKELMANN,
Government Affairs Director.

NATIONAL TAXPAYERS UNION,
Washington, DC, August 4, 1994.

Hon. JOHN McCAIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR McCAIN: The 250,000-member National Taxpayers Union fully supports your efforts to defeat the FY 1995 Military Construction Appropriations Conference Report with the intent of eliminating approximately $1 billion of add-ons and earmarks from the Appropriations Committee.

The pork-barrel spending contained in the Conference Report is outrageous. At a time when our nation must streamline not only its military, but also its budget, such wasteful spending shows a gross neglect for the American taxpayer.

The National Taxpayers Union commends you on your efforts on behalf of taxpayers and applauds your dedication to changing business as usual in Washington.

Sincerely,

PETE SEPP,
Director of Media Relations.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Thomas, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session, the Presiding Officer laid before the Senate message from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 4:02 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 4217. An act to reform the Federal crop insurance program, and for other purposes.

H.R. 4590. An act to provide conditions for renewing nondiscriminatory (most-favored-nation) treatment for the People's Republic of China.

The message also announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 250. Concurrent resolution expressing the sense of the Congress in support of efforts by the Government of Mexico, and the major political parties and concerned members of civil society in Mexico, to reform Mexico's political and electoral processes and ensure free and fair elections.

The message further announced that the House has passed the following bill, with amendments, in which it requests the concurrence of the Senate:

S. 1927. An act to increase the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for the survivors of certain disabled veterans.

The message also announced that the House disagrees to the amendment of the Senate to the bill (H.R. 4603) making appropriations for the Departments of Commerce, Justice, and State, the Judiciary, and related agencies programs for the fiscal year ending September 30, 1995, and making supplemental appropriations for these departments and agencies for the fiscal year ending September 30, 1994, and for other purposes, and agrees to the conference asked by the Senate on the disagreeing votes of the two Houses thereon; and appoints Mr. MOLLOHAN, Mr. SMITH of Iowa, Mr. CARR, Mr. MORAN, Mr. SKAGGS, Mr. PRICE of North Carolina, Mr. OBEY, Mr. ROGERS, Mr. KOLBE, Mr. TAYLOR of North Carolina, and Mr. McDADE as the managers of the conference on the part of the House.

The message further announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 4506) making appropriations for energy and water development for the fiscal year ending September 30, 1995, and for other purposes; that the House recedes from its disagreement to the amendments of the Senate numbered 6, 9, 15, 16, 21, 33, 35, and 39 and concurs therein; and that the House recedes from its disagreement to the amendments of the Senate numbered 2, 4, 8, 28, 48, 49, and concurs therein, each with an amendment in which it requests the concurrence of the Senate.

At 5:46 p.m., a message from the House of Representatives, delivered by

Ms. Goetz, one of its reading clerks, announced that the House has passed the following joint resolution, in which it requests the concurrence of the Senate:

H.J. Res. 188. Joint resolution designating November 22, 1993, as "National Military Families Recognition Day."

ENROLLED BILLS AND JOINT RESOLUTIONS SIGNED

At 8:07 p.m. a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the Speaker has signed the following enrolled bills and joint resolution:

H.R. 2739. An act to amend the Airport and Airway Improvement Act of 1982 to authorize appropriations for fiscal years 1994, 1995, and 1996, and for other purposes;

H.R. 4429. An act to authorize the transfer of naval vessels to certain foreign countries; and

S.J. Res. 204. Joint resolution recognizing the American Academy in Rome, an American overseas center for independent study and advanced research, on the occasion of the 100th anniversary of its founding.

MEASURES REFERRED

The following bill and joint resolution were read the first and second times by unanimous consent and referred as indicated:

H.R. 4590. An act to provide conditions of renewing nondiscriminatory (most-favored-nation) treatment for the People's Republic of China; to the Committee on Foreign Relations.

H.J. Res. 188. Joint resolution designating November 22, 1993, as "National Military Families Recognition Day"; the Committee on the Judiciary.

The following concurrent resolution was read and referred as indicated:

H. Con. Res. 250 Concurrent resolution expressing the sense of the Congress in support of efforts by the Government of Mexico, and the major political parties and concerned members of civic society in Mexico, to reform Mexico's political and electoral processes and ensure free and fair elections; to the Committee on Foreign Relations.

MEASURES PLACED ON THE CALENDAR

The following bill was read the first and second times by unanimous consent and placed on the calendar:

H.R. 4217. An act to reform the Federal crop insurance program, and for other purposes.

The following bills were read the first and second times by unanimous consent and ordered to be placed on the calendar:

H.R. 4455. An act to authorize the Export-Import Bank of the United States to provide financing for the export of nonlethal defense articles and defense services the primary end use of which will be for civilian purposes.

H.R. 4653. An act to settle Indian land claims within the State of Connecticut, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–3172. A communication from the Administrator of the United States Agency For International Development, transmitting, pursuant to law, a report of a violation of the Antideficiency Act which occurred on September 30, 1991; to the Committee on Appropriations.

EC–3173. A communication from the Comptroller of the Department of Defense, transmitting, pursuant to law, a report of a violation of the Antideficiency Act, case number 93–10; to the Committee on Appropriations.

EC–3174. A communication from the Comptroller of the Department of Defense, transmitting, pursuant to law, a report of a violation of the Antideficiency Act, case number 92–6; to the Committee on Appropriations.

EC–3175. A communication from the Assistant to the Secretary of Defense (Atomic Energy), transmitting, pursuant to law, notice relative to a report on management of chemical and biological defense programs; to the Committee on Armed Services.

EC–3176. A communication from the Assistant Secretary of State (Legislative Affairs), transmitting, pursuant to law, a report covering certain properties with the Panama Canal Treaty and its related agreements; to the Committee on Armed Services.

EC–3177. A communication from the Secretary of the Treasury, transmitting, pursuant to law, the report on the operations of the Exchange Stabilization Fund for fiscal year 1993; to the Committee on Banking, Housing, and Urban Affairs.

EC–3178. A communication from the Acting Director, Office of Thrift Supervision, transmitting, pursuant to law, the report on enforcement actions and initiatives for calendar year 1993; to the Committee on Banking, Housing, and Urban Affairs.

EC–3179. A communication from the Acting Director of the Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, a report to Congress on appropriations legislation within five days of enactment; to the Committee on the Budget.

EC–3180. A communication from the Acting Director of the Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, a report to Congress on appropriations legislation within five days of enactment; to the Committee on the Budget.

EC–3181. A communication from the Acting Director of the Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, a report to Congress on appropriations legislation within five days of enactment; to the Committee on the Budget.

EC–3182. A communication from the Secretary of the Interior, transmitting, a draft of proposed legislation to approve the location of a World War II Memorial; to the Committee on Energy and Natural Resources.

EC–3183. A communication from the Chief of the Forest Service, Department of Agriculture, transmitting, pursuant to law, the report of boundary descriptions and maps; to the Committee on Energy and Natural Resources.

EC–3184. A communication from the Inspector General of the Department of Health and Human Services, transmitting, pursuant to law, the report of the Superfund financial activities for toxic substances and disease registry for fiscal year 1992; to the Committee on Environment and Public Works.

EC–3185. A communication from the Inspector General of the Department of Health and Human Services, transmitting, pursuant to law, the report of the Superfund financial activities at the National Institute of Environmental Health Services; to the Committee on Environment and Public Works.

EC–3186. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the report on particpation, assignment, and extra billing in the Medicare program; to the Committee on Finance.

EC–3187. A communication from the Director, Defense Security Assistance Agency, transmitting, pursuant to law, notice relative to the Foreign Military Financing program; to the Committee on Foreign Relations.

EC–3188. A communication from the Director, Defense Security Assistance Agency, transmitting, pursuant to law, notice relative to Foreign Military Financing Grant funds; to the Committee on Foreign Relations.

EC–3189. A communication from the Director, Defense Security Assistance Agency, transmitting, pursuant to law, a report relative to the Congressional Presentation Document for fiscal year 1994; to the Committee on Foreign Relations.

EC–3190. A communication from the Assistant Secretary of State (Legislative Affairs), transmitting, pursuant to law, the report of United States contributions to international organizations for fiscal year 1993; to the Committee on Foreign Relations.

EC–3191. A communication from the Assistant Secretary of State (Legislative Affairs), transmitting, pursuant to law, the report of a Presidential Determination relative to Rwanda and Burundi; to the Committee on Foreign Relations.

EC–3192. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a copy of D.C. Act 10–314 adopted by the Council on July 19, 1994; to the Committee on Governmental Affairs.

EC–3193. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a copy of D.C. Act 10–315 adopted by the Council on July 19, 1994; to the Committee on Governmental Affairs.

EC–3194. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a copy of D.C. Act 10–316 adopted by the Council on July 19, 1994; to the Committee on Governmental Affairs.

EC–3195. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a copy of D.C. Act 10–317 adopted by the Council on July 19, 1994; to the Committee on Governmental Affairs.

EC–3196. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a copy of D.C. Act 10–318 adopted by the Council on July 19, 1994; to the Committee on Governmental Affairs.

EC–3197. A communication from the Manager (Employee Benefits), Agribank, the report relative to the Retirement Plan for the Employees of the Seventh Farm Credit District for calendar year 1993; to the Committee on Governmental Affairs.

EC–3198. A communication from the Chair of the Federal Energy Regulatory Commission, transmitting, pursuant to law, the annual report for calendar year 1993; to the Committee on Governmental Affairs.

EC–3199. A communication from the Assistant Secretary of State (Legislative Affairs), transmitting, pursuant to law, the report on the Foreign Service Retirement and Disability Fund for fiscal year 1992; to the Committee on Governmental Affairs.

EC–3200. A communication from the Secretary of Education, transmitting, pursuant to law, the final regulations on the Chapter 1 Program in Local Educational Agencies; to the Committee on Labor and Human Resources.

EC–3201. A communication from the Assistant Secretary of Education (Office of Special Education and Rehabilitative Services), transmitting, pursuant to law, the report of final regulations—State Vocational Rehabilitation Unit In-Service Training; to the Committee on Labor and Human Resources.

EC–3202. A communication from the Comptroller General of the United States, transmitting, pursuant to law, the report of the financial audit of the Capitol Preservation Fund for the period March 31, 1993 through September 30, 1993; to the Committee on Rules and Adminstration.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. INOUYE, from the Committee on Indian Affairs, with an amendment in the nature of a substitute:

S. 1526. A bill to improve the management of Indian fish and wildlife and gathering resources, and for other purposes (Rept. No. 103–329).

By Mr. GLENN, from the Committee on Governmental Affairs, with an amendment in the nature of a substitute and an amendment to the title:

S. 993. A bill to end the practice of imposing unfunded Federal mandates on States and local governments and to ensure that the Federal Government pays the costs incurred by those governments in complying with certain requirements under Federal statutes and regulations (Rept. No. 103–330).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. KOHL:

S. 2376. A bill to provide for the appointment of 1 additional Federal district judge for the eastern district of Wisconsin, and for other purposes; to the Committee on the Judiciary.

By Mrs. HUTCHISON (for herself, Mr. FAIRCLOTH, Mr. COATS, Mr. SIMPSON, and Mr. BURNS):

S. 2377. A bill to establish a national advisory referendum on limiting the terms of members of Congress at the general election of 1994; to the Committee on Rules and Administration.

By Mr. DOLE (for himself, Mr. SIMON, Mr. D'AMATO, Mr. GRAMM, and Mr. KENNEDY):

S. 2378. A bill to prohibit United States assistance to countries that prohibit or restrict the transport or delivery of United States humanitarian assistance; to the Committee on Foreign Relations.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. KOHL:

S. 2376. A bill to provide for the appointment of one additional Federal district judge for the Eastern District of Wisconsin, and for other purposes; to the Committee on the Judiciary.

WISCONSIN EASTERN DISTRICT JUDGESHIP ACT OF 1994

Mr. KOHL. Mr. President, I rise today to introduce legislation that would create an additional Federal judgeship for the Eastern District of Wisconsin to be located in Green Bay. Let me tell you why an extra judge is crucially needed.

Suppose that you are a litigant from Oconto and you need to use the Federal courts to seek compensation for an injury. Or suppose that you are a retailer in Appleton and you want to charge an out-of-State manufacturer with price fixing. Or suppose that you are the key witness in a Federal drug prosecution that is centered around activities in the northeastern part of the State. In each instance, you will have to go to Milwaukee, where all four full-time Federal district judges hold court. And in each instance, the additional travel time—up to 6 hours in each direction—and cost may make justice less available, less affordable and, ultimately, less likely to the people who need it most.

Indeed, prosecuting cases on the Menominee Indian Reservation causes specific problems that alone may justify a Federal judge in Green Bay. Under current law, the Federal Government is required to prosecute all felonies committed by Indians that occur on the Menominee Reservation. However, the reservation's distance from the Federal prosecutors and courts—more than 150 miles—makes these prosecutions problematic. And because the Justice Department compensates attorneys and investigators—and sometimes witnesses—for travel expenses, the existing system also costs the taxpayers money as well.

Mr. President, law enforcement officials tell me that some criminal cases are never brought in Federal court because of the expense and inconvenience. Sadly, this should not be too surprising: as one group of Wisconsin law enforcement officers analogized:

> Imagine the district attorney of Milwaukee being located in Keshena, or Green Bay, or Marinette and trying to coordinate witness interviews, case preparation, and testimony.

Placing a Federal judge in Green Bay will not resolve all of these problems overnight, of course. But it will begin to reduce some of these needless obstacles to the fair and efficient administration of Justice.

And don't take my word for it, ask the sheriffs and district attorneys in northeastern Wisconsin: each and every one of them has urged me to create a Federal district court in Green Bay. Mr. President, I ask unanimous consent that a letter from these law enforcement officials be included in the RECORD at the conclusion of my remarks. I also ask unanimous consent that a letter from the U.S. attorney for the Eastern District of Wisconsin, Tom Schneider, also be included. This letter expresses the support of the entire Federal law enforcement community in Wisconsin—including the FBI, the DEA and the BATF—for the legislation I am introducing today.

Mr. President, the creation of an additional judgeship in the Eastern District of Wisconsin is clearly justified on the basis of caseload. In 1993, the Judicial Conference, the administrative and statistical arm of the Federal judiciary, recommended the creation of additional Federal judgeships in 14 different judicial districts. In determining where to place these judges, the Conference looked primarily at "weighted filings;" that is, the total number of cases filed modified by the average level of case complexity. New positions were justified where the court's workload exceeded 400 weighted filings per judge. In 5 of the 14 districts where additional judgeships were recommended, however, the number of weighted filings per judge was actually fewer than in the Eastern District of Wisconsin. Indeed, from 1991 through 1993 the eastern district consistently averaged 440 weighted filing per judge, which is substantially in excess of the 400 weighted filings "cutoff."

Mr. President, this legislation is simple, effective and straightforward. It would create an additional judgeship for the eastern district, require that one judge hold court in Green Bay, and give the chief judge the flexibility to designate which judge holds court there. And it would increase the number of Federal district judges in Wisconsin for the first time since 1978. During that time, while more than 140 new Federal district judgeships have been added nationwide, not a single one has been created for Wisconsin.

In conclusion, Mr. President, having a Federal judge in Green Bay will reduce inconvenience and increase judicial efficiency. But most importantly, it will help ensure that justice is more available and more affordable to the people of Wisconsin. For these sensible reasons, I urge my colleagues to support this legislation.

Mr. President, I ask unanimous consent that the text of the bill and additional material be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2376

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ADDITIONAL FEDERAL DISTRICT JUDGE FOR THE EASTERN DISTRICT OF WISCONSIN.

(a) IN GENERAL.—The President shall appoint, by and with the advice and consent of the Senate, 1 additional district judge for the eastern district of Wisconsin.

(b) TABLES.—In order that the table contained section 133 of title 28, United States Code, shall reflect the change in the total number of permanent district judgeships authorized under subsection (a), such table is amended by amending the item relating to Wisconsin to read as follows:

"Wisconsin:	
"Eastern	5
"Western	2".

(c) HOLDING OF COURT.—The chief judge of the eastern district of Wisconsin shall designate 1 judge who shall hold court for such district in Green Bay, Wisconsin.

AUGUST 8, 1994.

Senator HERB KOHL,
Hart Senate Office Building, Washington, DC.

DEAR SENATOR KOHL: We are writing to urge your support for the creation of a Federal District Court in Green Bay. The Eastern District of Wisconsin includes the 28 eastern-most counties from Forest and Florence Counties in the north to Kenosha and Walworth Counties in the south.

Green Bay is central to the northern part of the district which includes approximately one third of the district's population. Currently, all Federal District Judges hold court in Milwaukee.

A federal court in Green Bay would make federal proceedings much more accessible to the people of northern Wisconsin and would alleviate many problems for citizens and law enforcement. Travel time of 3 or 4 hours each way makes it difficult and expensive for witnesses and officers to go to court in Milwaukee. Citizen witnesses are often reluctant to travel back and forth to Milwaukee. It often takes a whole day of travel to come to court and testify for a few minutes. Any lengthy testimony requires an inconvenient and costly overnight stay in Milwaukee. Sending officers is costly and takes substantial amounts of travel time, thereby reducing the number of officers available on the street. Many cases are simply never referred to federal court because of this cost and inconvenience.

In some cases there is no alternative. For example, the Federal government has the obligation to prosecute all felony offenses committed by Indians on the Menominee Reservation. Yet the Reservation's distance from the Federal Courts and prosecutors in Milwaukee poses serious problems. Imagine the District Attorney of Milwaukee being located in Keshena or Green Bay or Marinette and trying to coordinate witness interviews, case preparation, and testimony.

As local law enforcement officials, we try to work closely with other local, state and federal agencies, and we believe establishing a Federal District Court in Green Bay will measurably enhance these efforts. Most important, a Federal Court in Green Bay will make these courts substantially more accessible to the citizens who live here.

We urge you to introduce and support legislation to create and fund an additional Federal District Court in Green Bay.

Gary Robert Bruno, Shawano and Menominee County District Attorney.

Jay Conley, Oconto County District Attorney.

John DesJardins, Outagamie County District Attorney.

Douglas Drexler, Florence County District Attorney.

Guy Dutcher, Waushara County District Attorney.

E. James FitzGerald, Manitowoc County District Attorney.

Kenneth Kratz, Calumet County District Attorney.

Jackson Main, Jr., Kewaunee County District Attorney.

David Miron, Marinette County District Attorney.

Joseph Paulus, Winnebago County District Attorney.

Gary Schuster, Door County District Attorney.

John Snider, Waupaca County District Attorney.

Ralph Uttke, Langlade County District Attorney.

Demetrio Verich, Forest County District Attorney.

John Zakowski, Brown County District Attorney.

William Aschenbrener, Shawano County Sheriff.

Charles Brann, Door County Sheriff.

Todd Chaney, Kewaunee County Sheriff.

Michael Donart, Brown County Sheriff.

Patrick Fox, Waushara County Sheriff.

Bradley Gehring, Outagamie County Sheriff.

Daniel Gillis, Calumet County Sheriff.

James Kanikula, Marinette County Sheriff.

Norman Knoll, Forest County Sheriff.

Thomas Kocourek, Manitowoc County Sheriff.

Robert Kraus, Winnebago County Sheriff.

William Mork, Waupaca County Sheriff.

Jeffrey Rickaby, Florence County Sheriff.

David Stegar, Langlade County Sheriff.

Kenneth Woodworth, Oconto County Sheriff.

Richard Awonhopay, Chief, Menominee Tribal Police.

Richard Brey, Chief of Police, Manitowoc.

Patrick Campbell, Chief of Police, Kaukauna.

James Danforth, Chief of Police, Oneida Public Safety.

Donald Forcey, Chief of Police, Neenah.

David Gorski, Chief of Police, Appleton.

Robert Langan, Chief of Police, Green Bay.

Michael Lien, Chief of Police, Two Rivers.

Nike Nordin, Chief of Police, Sturgeon Bay.

Patrick Ravet, Chief of Police, Marinette.

Robert Stanke, Chief of Police, Menasha.

Don Thaves, Chief of Police, Shawano.

James Thome, Chief of Police, Oshkosh.

DEPARTMENT OF JUSTICE, U.S. ATTORNEY, EASTERN DISTRICT OF WISCONSIN,
Milwaukee, WI, August 9, 1994.

To: The District Attorney's, Sheriffs and Police Chiefs Urging the Creation of a Federal District Court in Green Bay.

From: Thomas P. Schneider, U.S. Attorney, Eastern District of Wisconsin.

Thank you for your letter of August 8, 1994, urging the creation of a Federal District Court in Green Bay. You point out a number of facts in your letter:

(1) Although 1/3 of the population of the Eastern District of Wisconsin is in the northern part of the district, all of the Federal District Courts are located in Milwaukee.

(2) A federal court in Green Bay would be more accessible to the people of northern Wisconsin. It would substantially reduce witness travel time and expenses, and it would make federal court more accessible and less costly for local law enforcement agencies.

(3) The federal government has exclusive jurisdiction over most felonies committed on the Menominee Reservation, located approximately 3 hours from Milwaukee. The distance to Milwaukee is a particular problem for victims, witnesses, and officers from the Reservation.

I have discussed this proposal with the chiefs of the federal law enforcement agencies in the Eastern District of Wisconsin, including Federal Bureau of Investigations, Federal Drug Enforcement Administration, Bureau of Alcohol, Tobacco and Firearms, Secret Service, U.S. Marshall, U.S. Customs Service, and Internal Revenue Service-Criminal Investigation Division. All express support for such a court and give additional reasons why it is needed.

Over the past several years, the FBI, DEA, and IRS have initiated a substantial number of investigations in the northern half of the district. In preparation for indictments and trials, and when needed to testify before the Grand Jury or in court, officers regularly travel to Milwaukee. Each trip requires 4 to 6 hours of round trip travel per day, plus the actual time in court. In other words, the agencies' already scarce resources are severely taxed. Several federal agencies report that many cases which are appropriate for prosecution are simply not charged federally because local law enforcement agencies do not have the resources to bring these cases and officers back and forth to Milwaukee.

Nevertheless, there have been a substantial number of successful federal investigations and prosecutions from the Fox Valley area and other parts of the Northern District of Wisconsin including major drug organizations, bank frauds, tax cases, and weapons cases.

It is interesting to note that the U.S. Bankruptcy Court in the Eastern District of Wisconsin holds hearings in Green Bay, Manitowoc, and Oshkosh, all in the northern half of the district. For the past four years approximately 29% of all bankruptcy filings in the district were in these three locations.

In addition, we continue to prosecute most felonies committed on the Menominee Reservation. Yet, the Reservation's distance from the federal courts in Milwaukee poses serious problems. A federal court in Green Bay is critically important if the federal government is to live up to its moral and legal obligation to enforce the law on the Reservation.

In summary, I appreciate and understand your concerns and I join you in urging the creation of a Federal District Court in Green Bay.

THOMAS P. SCHNEIDER,
U.S. Attorney, Eastern District of Wisconsin.

By Mrs. HUTCHISON (for herself, Mr. FAIRCLOTH, Mr. COATS, Mr. SIMPSON, and Mr. BURNS):

S. 2377. A bill to establish a national advisory referendum on limiting the terms of Members of Congress at the general election of 1994; to the Committee on Rules and Administration.

CONGRESSIONAL TERM LIMITS LEGISLATION

Mrs. HUTCHISON. Madam President, I rise today to introduce a bill to conduct a national referendum on the question of term limits for Members of Congress. It is a companion bill to H.R. 3835, sponsored in the House by Mr. HOEKSTRA of Michigan.

I have nothing against the senior Members of this Senate. Indeed, I respect them as some of the wisest legislators our Nation has. But the seniority system makes government a game of waiting—waiting for the right committee, waiting for the right chair, waiting sometimes for decades. And we expect our constituents to wait with us. I recently read an article which complained that a certain State might lose more than a century of seniority in the other Chamber next year. Seniority is displacing ideas as a commodity for citizens to value and to preserve.

We have created a system where it is better for our constituents to keep electing us, no matter how we vote, so that we can rack up seniority for our States. With all due respect, that is not what this Chamber, or the other one, is about. We pride ourselves, rightly, as the world's greatest deliberative body. And I think my fellow freshmen agree with me that our voices are heard and respected on this floor. But the seniority system tends to create career politicians, whereas our Founding Fathers wanted citizen-legislators. It was envisioned that people who had trades, professions, or businesses would serve for a period of time, bringing their business experience to shape the laws that would govern commerce and quality of life.

How can the citizens of one State or one district change their representation without losing out on this game? They can do it only if they can impose a limit on the tenure of all other Members of the Congress.

Madam President, I think the solution is to limit our terms. But do not take my word for it. We should ask the people what they think. This bill would add a nonbinding referendum to the election ballots in November, asking voters whether we should amend the Constitution to limit the time we can serve, just as it limits the term of the President of the United States. Amending the Constitution is a serious process, one that we debated last winter on the question of a balanced budget. Before we take that step on term limits, we should invoke the communicative power of democracy and ask the people what they think.

By Mr. DOLE (for himself, Mr. SIMON, Mr. D'AMATO, Mr. GRAMM, and Mr. KENNEDY):

S. 2378. A bill to prohibit U.S. assistance to countries that prohibit or restrict the transport or delivery of U.S. humanitarian assistance; to the Committee on Foreign Relations.

HUMANITARIAN AID CORRIDOR ACT

Mr. DOLE. Mr. President, I rise to introduce legislation with the distinguished senior Senator from Illinois, Senator SIMON, and Senator D'AMATO, Senator GRAMM, and Senator KENNEDY. Our legislation will further an important American principle: Humanitarian aid should not be restricted for political reasons. The legislation we are introducing today provides that no U.S. foreign aid shall be provided to countries which prohibit or restrict U.S. foreign aid to other countries.

It seems this is a principle that could be accepted by everyone—how could we give money to a country which prevents our aid from reaching other needy people? The legislation names no names, it simply affirms a basic principle: A government does not deserve our aid if it obstructs efforts to aid others.

While our legislation is drafted as a generic principle, there is one country that would clearly be affected. Turkey receives large amounts of United States assistance while it continues to enforce the embargo on Armenia. For the past, present, and next fiscal year, 1993–95, Turkey will receive roughly $1.75 billion in grants and concessional loans financed by the United States taxpayer. At the same time, Turkey prevents even care packages from the American Red Cross from entering Armenia.

Mr. President, the suffering of the democratic nation of Armenia under the immoral and illegal embargo are well-known: Food and energy supplies range from scarce to nonexistent. Outside relief supplies must travel circuitous and dangerous routes due to Turkey's blockage. Many never make it at all. Due to Turkey's official government policy of blockading Armenia, Armenians freeze, Armenians suffer, and Armenians go hungry. United States aid to Armenia is far more expensive and far less effective because of Turkey's blockade. In such circumstances, it is wrong to provide Turkey with one and three-quarters billion of American tax dollars.

Earlier today, I met with President Ter-Petrossian—Armenia's first democratically-elected head of State. President Ter-Petrossian knows the price of freedom, having been imprisoned under the Soviet Union for advocating Armenian nationalism. The President spoke about the terrible consequences of the Armenian embarbo. He spoke about how there has been no positive sign from Turkey, no movement toward opening routes into land-locked Armenia. President Ter-Petrossian thanked us for our efforts to help the long-suffering Armenian people.

The legislation Senator SIMON and I are introducing today would help change the Turkish policy of strangling Armenia. It would provide the administration with an effective tool to use with the Turkish Government. And it would provide a powerful incentive for Turkey to end its contribution to the suffering of the Armenian people.

I have nothing against the Turkish people. I met Prime Minister Ciller when she was in Washington last fall, and had a useful discussion. And I recognize that Turkey has been a valuable ally of the United States in NATO, and in Operation Desert Storm. The legislation we are introducing recognizes that there may be a compelling national interest which could override the principle of non-interference with humanitarian aid. For this reason, we have included Presidential waiver authority in section 3(b) of the bill.

The legislation could apply to many other relief situations. There are occasional reports of aid obstruction by Kenya, Russia, and other countries. This legislation would make one principle very clear: If a government plays political games with aid destined to help people in need, they will no longer get U.S. foreign assistance. This legislation will help deter interference with humanitarian relief, and it will provide for appropriate response in the case of interference.

Mr. President, this legislation will be referred to the Committee on Foreign Relations. I hope it will get rapid consideration. Similar legislation has been introduced in the House. I hope the Congress will enact this legislation and send it to the White House before the end of this Congress.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 2378

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Humanitarian Aid Corridor Act".

SEC. 2. FINDINGS.

The Congress makes the following findings:

(1) The United States' Federal budget deficit and spending constraints require the maximum efficiency in the usage of United States foreign assistance.

(2) The delivery of humanitarian assistance to people in need is consistent with the fundamental values of our Nation and is an important component of United States foreign policy.

(3) As a matter of principle and in furtherance of fiscal prudence, the United States should seek to promote the delivery of humanitarian assistance to people in need in a manner that is both timely and cost effective.

(4) Recipients of United States assistance should not hinder or delay the transport or delivery of United States humanitarian assistance to other countries.

SEC. 3. LIMITATION ON ASSISTANCE TO COUNTRIES THAT RESTRICT THE TRANSPORT OR DELIVERY OF UNITED STATES HUMANITARIAN ASSISTANCE.

(a) PROHIBITION ON ASSISTANCE.—Notwithstanding any other provision of law, funds appropriated or otherwise made available for United States assistance may not be made available for any country whose government prohibits or otherwise restricts, directly or indirectly, the transport or delivery of United States humanitarian assistance.

(b) WAIVER.—The prohibition on United States assistance contained in subsection (a) shall not apply if the President determines and notifies Congress in writing that providing such assistance to a country is in the national security interest of the United States.

(c) RESUMPTION OF ASSISTANCE.—A suspension or termination of United States assistance for any country under subsection (a) shall cease to be effective when the President certifies in writing to the Speaker of the House of Representatives and the Committee on Foreign Relations of the Senate that such country is no longer prohibiting or otherwise restricting, either directly or indirectly, the transport or delivery of United States humanitarian assistance.

SEC. 4. REPORT.

(a) IN GENERAL.—At the time of the annual budget submission to Congress, the President shall submit a report to Congress describing any information available to the President concerning prohibitions or restrictions, direct or indirect, on the transport or delivery of United States humanitarian assistance by the government of any country receiving or eligible to receive United States foreign assistance during the current or preceding fiscal year.

(b) APPLICABILITY OF LAW.—The President shall include in the report required by subsection (a) a statement as to whether the prohibition in section 3(a) applies to each country for which the President has information available to him concerning prohibitions or restrictions, direct or indirect, on the transport or delivery of United States humanitarian assistance.

SEC. 5. DEFINITION.

As used in this Act, the term "United States assistance" has the same meaning given that term in section 481(e)(4) of the Foreign Assistance Act of 1961.

ADDITIONAL COSPONSORS

S. 823

At the request of Mr. GRAHAM, the name of the Senator from New Jersey [Mr. BRADLEY] was added as a cosponsor of S. 823, a bill to amend the National Wildlife Refuge System Administration Act of 1966 to improve the management of the National Wildlife Refuge System, and for other purposes.

S. 1208

At the request of Mr. WOFFORD, the name of the Senator from Massachusetts [Mr. KENNEDY] was added as a cosponsor of S. 1208, a bill to authorize the minting of coins to commemorate the historic buildings in which the Constitution of the United States was written.

S. 1822

At the request of Mr. HOLLINGS, the name of the Senator from Tennessee [Mr. MATHEWS] was added as a cosponsor of S. 1822, a bill to foster the further development of the Nation's telecommunications infrastructure and protection of the public interest, and for other purposes.

S. 2053

At the request of Mr. BRADLEY, the name of the Senator from New Jersey [Mr. LAUTENBERG] was added as a cosponsor of S. 2053, a bill to prevent handgun violence and illegal commerce in firearms.

SENATE JOINT RESOLUTION 165

At the request of Mr. COCHRAN, the name of the Senator from Iowa [Mr. GRASSLEY] was added as a cosponsor of Senate Joint Resolution 165, a joint resolution to designate the month of September 1994 as "National Sewing Month."

SENATE RESOLUTION 243

At the request of Mr. LOTT, the name of the Senator from North Carolina [Mr. HELMS] was added as a cosponsor of Senate Resolution 243, a resolution recognizing the REALTORS Land Institute on the occasion of its 50th Anniversary.

AMENDMENT NO. 2481

At the request of Mr. BUMPERS the names of the Senator from Tennessee [Mr. MATHEWS] and the Senator from North Dakota [Mr. DORGAN] were added as cosponsors of amendment No. 2481 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

AMENDMENTS SUBMITTED

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT FOR FISCAL YEAR 1995

BROWN (AND OTHERS) AMENDMENT NO. 2491

Mr. BROWN (for himself, Mr. SIMON, Mr. MURKOWSKI, and Mr. LIEBERMAN) proposed an amendment to the bill (H.R. 4650) making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes; as follows:

At the end of the pending amendment, add the following new section:

"SEC. . VISAS FOR OFFICIALS OF TAIWAN.

Section 4(b)(6) of the Taiwan Relations Act (22 U.S.C. 3302(b)(6)) is amended—

(1) by inserting "(A)" immediately after "(6)"; and

(2) by adding at the end the following:

"(B) Whenever the president of Taiwan or any other high-level official of Taiwan shall apply for a temporary visa to visit the United States for the purposes of:

(i) Discussions with United States federal or state government officials concerning trade or business with Taiwan or the reduction of the U.S.-Taiwan trade deficit;

(ii) Discussions with United States federal or state government officials concerning nuclear federal government officials concerning U.S. national security or the national security of Taiwan; or

(iv) Discussions with United States federal or state government officials concerning the provision of humanitarian relief and assistance for regional disasters;

The official shall be admitted to the United States, unless the official is otherwise excludable under the immigration laws of the United States.".

BROWN (AND OTHERS) AMENDMENT NO. 2492

Mr. BROWN (for himself, Mr. SIMON, Ms. MIKULSKI, Mr. ROTH, Mr. DOLE, and Mr. DOMENICI) proposed an amendment to the bill H.R. 4650, supra; as follows:

At the end of the pending amendment insert the following new section:

SEC. . ADDITIONAL COUNTRIES ELIGIBLE FOR PARTICIPATION IN ALLIED DEFENSE COOPERATION.

(a) SHORT TITLE.—This section may be cited as the "NATO" Participation Act".

(b) TRANSFER OF EXCESS DEFENSE ARTICLES.—The President may transfer excess defense articles under section 516 of the Foreign Assistance Act of 1961 or under the Arms Export Control Act to Poland, Hungary, the Czech Republic, and Slovakia.

(c) LEASES AND LOANS OF MAJOR DEFENSE EQUIPMENT AND OTHER DEFENSE ARTICLES.—Section 63(a)(2) of the Arms Export Control Act (22 U.S.C. 2796b) is amended by striking "or New Zealand" and inserting "New Zealand, Poland, Hungary, the Czech Republic, or Slovakia".

(d) LOAN MATERIALS SUPPLIES, AND EQUIPMENT FOR RESEARCH AND DEVELOPMENT PURPOSES.—Section 65(d) of the Arms Export Control Act (22 U.S.C. 2796d(d)) is amended—

(1) by striking "or" after "United States" and inserting a comma; and

(2) by inserting before the period at the end of the following ", Poland, Hungary, the Czech Republic, or Slovakia".

(e) COOPERATIVE MILITARY AIRLIFT AGREEMENTS.—Section 2350c(e)(1)(B) of title 10, United States Code, is amended by striking " and the Republic of Korea" and inserting "the Republic of Korea, Poland, Hungary, the Czech Republic, and Slovakia".

(f) PROCUREMENT OF COMMUNICATIONS SUPPORT AND RELATED SUPPLIES AND SERVICES.—Section 2350f(d)(1)(B) is amended by striking "or the Republic of Korea" and inserting "the Republic of Korea, Poland, Hungary, the Czech Republic, or Slovakia".

(g) STANDARDIZATION OF EQUIPMENT WITH NORTH ATLANTIC TREATY ORGANIZATION MEMBERS.—Section 2457 of title 10 United States Code, is amended by adding at the end the following new subsection:

"(g) It is the sense of the Congress that, in the interest of maintaining stability and promoting democracy in Eastern Europe, Poland, Hungary, the Czech Republic, and Slovakia, those countries should, on and after the date of enactment of this subsection, be included in all activities under this section related to the increase standardization and enhanced interoperability of equipment and weapons systems, through coordinated training and procurement activities, as well as other means, undertaken by the North Atlantic Treaty Organization members and other allied countries.".

(h) INCLUSION OF OTHER EUROPEAN COUNTRIES EMERGING FROM COMMUNIST DOMINATION.—The President should recommend legislation to the Congress making eligible under the provisions of law amended by this section such other European countries emerging from communist domination as the President may determine if such countries—

(1) have made significant progress toward establishing democratic institutions, free market economies, civilian control of their armed forces, and the rule of law; and

(2) are likely, within 5 years of such determination, to be in a position to further the principles of the North Atlantic Treaty and to contribute to the security of the North Atlantic area.

(i) CERTIFICATION REQUIRED.—Before exercising the authority in subsection (a), or in section 63(a)(2) of the Arms Export Control Act, with respect to Poland, Hungary, the Czech Republic, or Slovakia, the President shall determine and certify to the appropriate congressional committees that no such country is selling or transferring defense articles to a state that has repeatedly provided support for acts of international terrorism, as determined by the Secretary of State under section 6(j) of the Export Administration Act of 1979.

BROWN AMENDMENT NO. 2493

Mr. BROWN proposed an amendment to the bill H.R. 4650, supra; as follows:

At the appropriate place in the Committee amendment, add the following new section:

"SEC. . SENSE OF THE CONGRESS CONCERNING THE REPUBLIC OF BULGARIA.

(a) FINDINGS.—The Congress finds that:

(1) In the spring of 1990, Bulgaria held its first round-table discussions and held its first free, democratic elections in June, 1990;

(2) In August 1990, the Bulgarian Grand National Assembly elected Dr. Zhelyu Zhelev as President of the Republic;

(3) On July 12, 1991 the Parliament of Bulgaria adopted the new Constitution of the Republic of Bulgaria, which proclaims that Bulgaria is governed by the rule of law;

(4) In addition, the Bulgarian Constitution establishes the principles of a market economy in Bulgaria, including Article 17 which guarantees and protects the right to property and inheritance and proclaims the inviolability of private property, and Article 19 which states that the economy of Bulgaria is based on free economic enterprise;

(5) In October 1991, Bulgaria held its second parliamentary elections;

(6) Since 1990, the Bulgarian parliament has passed more than 220 laws establishing legal protections for a free market economy including the Law on Land Ownership, the Law on the Protection of Competition, the Law on Commerce, the Law on Privatization, the Law on Accounting and the Law on Banking;

(7) The Bulgarian private sector has grown from 5 percent of GNP in 1990 to 22 percent of GNP in 1993, and by the end of 1993, 47 percent of Bulgarian farm land had been returned to its owners prior to 1948;

(8) In June 1990, Bulgaria established diplomatic relations with NATO and on February 14, 1994, joined the Partnership for Peace;

(9) Since October 1991, the Bulgarian minister of defense has been a civilian and this practice is scheduled to be institutionalized when the Bulgarian Law on Armed Forces is adopted in September 1994.

(b) SENSE OF CONGRESS.—Therefore, it is the sense of the Congress that:

(1) The Republic of Bulgaria is making swift and important progress to join the West and should be strongly commended for its efforts;

(2) The Republic of Bulgaria is making significant progress toward establishing democratic institutions, a free market economy, civilian control of the armed forces and the rule of law;

(3) As the President evaluates increased defense cooperation with central and eastern Europe, Bulgaria's extensive reform efforts should be given every possible consideration.

BROWN (AND CAMPBELL) AMENDMENTS NOS. 2494–2495

Mr. BROWN (for himself and Mr. CAMPBELL) proposed two amendments to the bill H.R. 4650, supra; as follows:

AMENDMENT NO. 2494

At the appropriate place in the bill, add the following new section:

"SEC. . STUDY OF C–130S.

(a) REPORT.—Within six months of enactment of this Act, the Chairman of the Joint Chiefs of Staff (JCS) shall recommend to the Secretary of Defense a master stationing plan for C–130 aircraft for the active and reserve components based on the National Military Strategy and current contingency plans of the Joint Chiefs of Staff. The report shall include:

(i) a review of existing Air Reserve Components C–130s;

(ii) a master plan for basing future Air Reserve Component C–130s over the next twenty years.

(b) INTERIM REDUCTIONS.—No reductions of primary authorized C–130 aircraft (PAA) shall be permitted until after completion of the report.

(c) APPROVAL.—Within 2 months of receipt of the report from the Chairman of the JCS, the Secretary of Defense shall approve the final master stationing plan for C–130 aircraft and shall provide it to the congressional defense committees. The Secretary shall also provide the final report to the Air Force and to the National Guard Bureau for implementation.

AMENDMENT NO. 2495

At the appropriate place in the bill, add the following new section—

"SEC. . SENSE OF THE SENATE CONCERNING LOWRY AFB.

It is the sense of the Senate that—

(a) in issuing any lease, permit or deed of conveyance for use to assist the homeless under the Stewart B. McKinney Assistance Act concerning Lowry Air Force Base, Colorado, the Secretary of Health and Human Services, representatives of the City of Denver, Colorado, representatives of the City of Aurora, Colorado and representatives of homeless providers whose applications have been approved by the Secretary of Health and Human Services should jointly determine that such use is reasonable under the redevelopment plan for Lowry Air Force Base, Colorado; and

(b) the Department of Defense and the Department of Health and Human Services, in coordination with the appropriate committees of Congress and appropriate state and local authorities, should develop a reform proposal to address the many difficulties created for local communities by existing laws relating to the loan, lease or conveyance for use of government property during the base closure process.

GORTON (AND OTHERS) AMENDMENT NO. 2496

Mr. INOUYE (for Mr. GORTON, for himself, Mrs. MURRAY, and Mr. INOUYE) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 19, line 19, after the period, insert the following: "The Secretary may not pay the Muckleshoot Indian Tribe the reimbursement otherwise required by the preceding sentence unless the Tribe waives in writing all claims that the Tribe may have against the United States or any agency or official of the United States (in the official capacity of that official), against the State of Washington or any agency or official of the State of Washington (in the official capacity of that official), and against the City of Seattle, Washington, or any agency or official of the City of Seattle, Washington (in the official capacity of that official), regarding the disposal of the Puget Sound Naval Air Station.".

DANFORTH (AND BOND) AMENDMENT NO. 2497

Mr. INOUYE (for Mr. DANFORTH, for himself and Mr. BOND) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following:

Sec. . Funds appropriated for the Army by this Act may not be expended to deactivate or to take any action necessary to deactivate any Army Reserve Officers' Training Corps unit, or to reduce any such unit for the purpose of eventually deactivating that unit, unless the Secretary of the Army has determined that the unit has been placed in, and has been evaluated for a full evaluation period under, the Effective Management Program of the Army Cadet Command.

AKAKA AMENDMENT NO. 2498

Mr. INOUYE (for Mr. AKAKA) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. 8121. PREFERENCE FOR LOCAL AND SMALL BUSINESSES TO CARRY OUT ENVIRONMENTAL RESTORATION AND REMEDIATION OF KAHO'OLAWE ISLAND, HAWAII.

(a) PREFERENCE REQUIRED.—In entering into contracts with private entities to carry out environmental restoration and remediation of Kaho'olawe Island, Hawaii, and the waters surrounding that island, the Secretary of the Navy shall, to the maximum extent practicable, give a preference to small business concerns and small disadvantaged business concerns located in the State of Hawaii. In giving the preference, the Secretary shall give especial preference to businesses owned by Native Hawaiians.

(b) DEFINITIONS.—In this section:

(1) The Term "small business concern" means a business concern meeting the requirements of section 3 of the Small Business Act (15 U.S.C. 632).

(2) The Term "small disadvantaged business concern" means the business concerns referred to in section 7(d)(1) of such Act (15 U.S.C. 637(d)(1)).

(3) The Term "Native Hawaiian" means any individual who is a descendent of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now comprises the State of Hawaii.

NICKLES AMENDMENT NO. 2499

Mr. STEVENS (for Mr. NICKLES) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 11, line 19, before the period, insert the following: ": *Provided further*, That the Undersecretary of Defense for Policy, shall, not later than October 15, 1994, transmit, in unclassified and classified forms, the Rand Corporation Study, published on or about December 1993, on The U.S. Role in Possible Middle East Peace Settlements to the congressional defense, intelligence and foreign affairs committees."

MCCAIN (AND OTHERS) AMENDMENT NO. 2500

Mr. MCCAIN (for himself, Mr. GRAHAM, Mr. DOLE, Mr. GRAMM, Mr. FORD, Mr. PRESSLER, Mr. BINGAMAN, Mr. MACK, Mr. AKAKA, Mr. DASCHLE, Mr. SARBANES, Mr. LAUTENBERG, Mr. CHAFEE, and Mr. DOMENICI) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a) The prohibition on concurrent award of compensation and retirement pay (including naval pension) set forth in section 5304(a)(1) of title 38, United States Code, does not apply to a person who has a service-connected disability if—

(1) the person has completed at least 20 years of service in the uniformed services that is creditable for purposes of computing the amount of retirement pay to which the member is entitled;

(2) the disability was incurred or aggravated in the performance of duty as a member of a uniformed service, as determined by the Secretary concerned; and

(3) the disability is a disability rated as total—

(A) by the Secretary concerned as of the date on which the person is retired from the uniformed services; or

(B) by the Secretary of Veterans Affairs within four years following the date on which the person is retired from the uniformed services.

(b) Notwithstanding section 1463(a) of title 10, United States Code, the amount of retirement pay paid in accordance with subsection (a) concurrently with the payment of disability compensation to the recipients of such retirement pay shall be paid out of funds appropriated by this Act.

(c) Subsection (a) is not applicable to a person for any period for which the disability of such person is not a disability rated as total as described in paragraph (3) of such subsection.

(d) In this section:

(1) The terms "compensation", "service-connected", and "Secretary concerned" have the meanings given such terms in section 101 of title 38, United States Code.

(2) The term "disability rated as total"—

(A) means a disability that is rated as total under the standard schedule of rating disabilities in use by the Department of Veterans Affairs; and

(B) does not include a disability for which the schedular rating is less than total but for which a rating of total is assigned by reason of inability of the disabled person concerned to secure or follow a substantially gainful occupation as a result of service-connected disabilities or by reason of any other factor.

(3) The term "uniformed services" has the meaning given such term in section 101(a)(5) of title 10, United States Code.

(e) This section shall take effect on October 1, 1994, and shall apply to months that begin on or after that date and before October 1, 1995.

MCCAIN AMENDMENT NO. 2501

Mr. MCCAIN proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. 8121. REIMBURSEMENT FOR FUNDS PROVIDED IN SUPPORT OF CIVILIAN SPORTING EVENTS.

(a) AGREEMENT FOR REIMBURSEMENT.—Notwithstanding any other provision of law, funds made available to the Department of Defense under title II of this Act may not be expended either directly or indirectly to support the World Cup Soccer Games, the Goodwill Games, an Olympiad, or any other civilian sporting event until the Secretary of Defense—

(1) enters into an agreement with the entity or entities that are to receive the funds to provide for such funds to be reimbursed to the Department under terms and conditions established by the Secretary; and

(2) certifies to Congress that the agreement ensures that such reimbursement will be made.

(b) TERMS OF AGREEMENT.—An agreement entered into under subsection (a)—

(1) may not require any reimbursement until after the sporting event is complete and all event-related contractual obligations have been met by the entity or entities with which the agreement was made;

(2) shall provide that the amount reimbursed may not exceed 25 percent of surplus funds; and

(3) shall provide that no reimbursement is required if the entity or entities with which the agreement was made has no surplus funds after all other contractual obligations have been met.

(c) DEFINITION.—In this section, the term "surplus funds" means the amount equal to the excess of the total amount of revenues (other than tax revenues) and * * *.

BRYAN (AND OTHERS) AMENDMENT NO. 2502

Mr. BRYAN (for himself, Mr. BOREN, Mr. GRAHAM, Mr. DECONCINI, Mr. WARNER, Mrs. FEINSTEIN, and Mr. DORGAN) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following new section:

SEC. . Of the funds made available by this Act for the National Reconnaissance Office under the classified Schedule of Appropriations accompanying this Act, funds allocated for construction of the headquarters buildings of the National Reconnaissance Office which were unobligated as of the date of enactment of this Act may not be obligated or expended until the Director of Central Intelligence and the Secretary of Defense have completed a review of that construction project and the results of such review have been disclosed to the Select Committee on Intelligence of the Senate and the Permanent Select Committee on Intelligence of the House of Representatives.

SPECTER (AND WOFFORD) AMENDMENTS NOS. 2503-2505

Mr. STEVENS (for Mr. SPECTER and Mr. WOFFORD) proposed three amendments to the bill H.R. 4650, supra; as follows:

AMENDMENT NO. 2503

On page 142, between lines 7 and 8, insert the following:

SEC. . IMPLEMENTATION OF AGREEMENT ON THE RESTRUCTURING OF THE ARMY NATIONAL GUARD AND THE ARMY RESERVE.

(A) FINDING.—Congress finds that the implementation of the off-site agreement may result in the loss to the Armed Forces of military personnel who have significant military experience and expertise.

(b) REASSIGNMENT OF MEMBERS.—(1) To the maximum extent practicable, the Secretary of the Army shall ensure that members of the Armed Forces who would otherwise be separated from service as a result of the deactivation of military units of the Army National Guard and the Army Reserve under the off-site agreement be reassigned instead to units that are not being deactivated.

(2) The reassignment of a member under paragraph (1) shall not affect the grade or rank in grade of the member.

(c) REPORTS.—Not later than 15 days after the end of each calendar quarter while the off-site agreement is in effect, the Secretary of the Army shall submit to the congressional defense committees a report on the number of members of the Armed Forces who were reassigned under subsection (b)(1) during the preceding calendar quarter.

(d) DEFINITIONS.—In this section:

(1) The term "congressional defense committees" means the Committees on Armed Services and the Committees on Appropriations of the Senate and the House of Representatives.

(2) The term "Off-site agreement" means the agreement on the restructuring of the Army National Guard and the Army Reserve.

AMENDMENT NO. 2504

At the appropriate place, insert the following:

"No funds appropriated under this Act may be obligated or expended for the purpose of establishing the Antler Military Operations Area, Pennsylvania, for the purpose of conducting aerial combat training operations until:

(1) Region III of the Environmental Protection Agency has completed its currently ongoing Environmental Impact Review.

AMENDMENT NO. 2505

In title IV of the bill, under the heading "Research, Development, Test and Evaluation, Navy", strike out the period at the end and insert in lieu thereof ": *Provided further*, That of the amount of funds appropriated under this paragraph to be allocated to the aircraft technology program element, $5,000,000 of this amount may only be obligated for the completion of Phase I of the Vectored Thrust Combat Agility Demonstrator."

DOMENICI (AND BINGAMAN) AMENDMENT NO. 2506

Mr. STEVENS (for Mr. DOMENICI for himself and Mr. BINGAMAN) proposed an amendment to the bill H.R. 4650, supra; as follows:

At the appropriate place in the bill, insert:

SEC. . No funds appropriated by this Act may be obligated or expended during fiscal year 1995 for retiring, or preparing to retire, any B-52H, B-1B, or F-111 bomber aircraft.

DOMENICI AMENDMENT NO. 2507

Mr. STEVENS (for Mr. DOMENICI) proposed an amendment to the bill, H.R. 4650, supra; as follows:

On page 19, line 10, delete the period, and add the following new proviso: ": *Provided further*, That to the extent that Congress fails to approve the transfer of any part of $400,000,000 originally provided in section 9110(a) of the Department of Defense Appropriations Act, 1993, authority is provided for the Secretary of Defense to transfer funds made available in this Act, or for the President to transfer funds available for assistance to the Russian Federation in any other Appropriations Act, to this account for the Cooperative Threat Reduction "Nunn-Lugar" program: *Provided further*, That any transfer made by the Secretary of Defense under the foregoing proviso shall be subject to the limitations and the reporting requirements stipulated in section 8005 of this Act: *Provided further*, That the authority to make transfers pursuant to this provision is in addition to any other transfer authority of the President and the Secretary of Defense."

HELMS AMENDMENT NO. 2508

Mr. STEVENS (for Mr. HELMS) proposed an amendment to the bill, H.R. 4650, supra; as follows:

At the appropriate place in the committee amendment, insert the following:

SEC. . None of the funds appropriated to the Department of Defense may be used to enter into any agreement or to pay any logistical or support costs, including air transportation, for foreign military participation in any multilateral military activity or in any United Nations sanctioned multilateral force unless the President provides notification 5 days in advance to the appropriate Committees of Congress.

CHAFEE AMENDMENT NO. 2509

Mr. STEVENS (for Mr. CHAFEE) proposed an amendment to the bill, H.R. 4650, supra; as follows:

From the Defense Environmental Restoration Account, $1 million for environmental restoration of the Derecktor Shipyard, Newport, Rhode Island, owned by the U.S. Department of the Navy.

GRASSLEY AMENDMENT NO. 2510

Mr. STEVENS (for Mr. GRASSLEY) proposed an amendment to the bill, H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a)(1) The Secretary of Defense shall develop a plan for establishing and implementing a requirement for disbursing officials of the Department of Defense to match disbursements to particular obligations before making the disbursements. The Secretary shall transmit the plan to Congress not later than March 1, 1995.

(2) The Inspector General of the Department of Defense shall review the plan and submit the Inspector General's independent assessment of the plan to the congressional defense committees.

(b)(1) Not later than July 1, 1995, the Secretary of Defense shall require that each disbursement by the Department of Defense in an amount in excess of $5,000,000 be matched to a particular obligation before the disbursement is made.

(2) Not later than October 1, 1995, the Secretary of Defense shall require that each disbursement by the Department of Defense in an amount in excess of $1,000,000 be matched to a particular obligation before the disbursement is made.

(c) The Secretary shall ensure that a disbursement in excess of the threshold amount applicable under subsection (b) is not divided into multiple disbursements of less than that amount for the purpose of avoiding the applicability of such subsection to that disbursement.

(d) The Secretary of Defense may waive a requirement for advance matching of a disbursement of the Department of Defense with a particular obligation in the case of (1) a disbursement involving deployed forces, (2) a disbursement for an operation in a war declared by Congress or a national emergency declared by the President or Congress, or (3) a disbursement under any other circumstances for which the waiver is necessary in the national security interests of the United States, as determined by the Secretary and certified by the Secretary to the congressional defense committees.

(e) This section shall not be construed to limit the authority of the Secretary of Defense to require that a disbursement not in excess of the amount applicable under subsection (b) be matched to a particular obligation before the disbursement is made.

MURKOWSKI (AND DOLE) AMENDMENT NO. 2511

Mr. STEVENS (for Mr. MURKOWSKI for himself and Mr. DOLE) proposed an amendment to the bill H.R. 4650, supra; as follows:

At the appropriate place in the bill, insert the following new section:

SEC. . PROHIBITION ON ASSISTANCE FOR NORTH KOREA.

(a) PROHIBITION.—No funds appropriated under this Act or any other Act may be made available to the Democratic People's Republic of Korea until the President certifies and reports to Congress that the Democratic People's Republic of Korea—

(1) does not possess nuclear weapons;

(2) has halted its nuclear weapons program; and

(3) is not exporting weapons-grade plutonium.

(b) NATIONAL SECURITY WAIVER.—The President may waive the prohibition in this section if he determines and certifies in writing to the Congress that to do so is vital to the national security interest of the United States, and notifies the appropriate Committees of Congress 15 days in advance in accordance with the regular notification procedures of such Committees. Such notification shall include the nature, purpose and amount of the proposed assistance.

HATCH AMENDMENT NO. 2512

Mr. STEVENS (for Mr. HATCH) proposed an amendment to the bill (H.R. 4650) supra; as follows:

At the appropriate place in the bill, add the following new section:

"SEC. . Notwithstanding any other provision of law, the Department of Defense shall pay the appropriate amount of Aviation Continuation Pay authorized by 37 U.S.C. Sec. 301(b) to the survivors of persons who have signed reenlistment contracts but whose service connected death predates the effective date of such reenlistment contract by less than 14 days."

MCCONNELL AMENDMENT NO. 2513

Mr. STEVENS (for Mr. MCCONNELL) proposed an amendment to the bill, H.R. 4650, supra; as follows:

At the appropriate place in the bill insert the following SEC. .

(a) Within 60 days of enactment of this Act, the President, in consultation with NATO, shall submit a report to the Committee on Appropriations defining specific military, economic, and political standards required to gain admission to NATO; Provided further, that such report shall not be limited to the principles enunciated in the Partnership for Peace; Provided further, such report shall include an assessment of measures which would be necessary to guarantee the armed services of Poland, Hungary, the Czech Republic, Slovakia, Lithuania, Latvia and Estonia are capable of military cooperation and interoperability with NATO and fulfilling other member responsibilities.

DOLE AMENDMENT NO. 2514

Mr. STEVENS (for Mr. DOLE) proposed an amendment to the bill, H.R. 4650, supra; as follows:

At the appropriate place insert the following new section:

SEC. . REQUIREMENT TO INCLUDE IN THE ADMINISTRATION'S DEFENSE BUDGET REQUEST FOR THE COMING FISCAL YEAR THE COST OF INVOLVEMENT BY ARMED FORCES OF THE UNITED STATES IN HUMANITARIAN, PEACEKEEPING, PEACEMAKING OPERATIONS, AND OPERATIONS OTHER THAN WAR.

(a) REQUIREMENT.—The President shall, when submitting to the Congress the budget for the United States Government for the coming fiscal year, include in the budget the cost of involvement and participation by the Armed Forces of the United States in ongoing or anticipated operations outside the United States as specified below—

(1) operations to provide humanitarian aid;

(2) peacekeeping operations;

(3) peacemaking operations;

(4) operations other than war;

(5) and any operation, other than normal troop movements, rotations, or exercises, in which U.S. military involvement during the fiscal year is anticipated.

(b) CLASSIFIED ANNEX.—If the President or the Secretary of Defense determine that disclosure of the information required in paragraph (a) of this section could reasonably be expected to damage the national security of the United States, the President shall provide the information in a classified annex.

DOLE (AND MCCAIN) AMENDMENT NO. 2515

Mr. STEVENS (for Mr. DOLE for himself and Mr. MCCAIN) proposed an amendment to the bill H.R. 4650, supra, as follows:

At the appropriate place insert the following new section:

SEC. . REVIEW OF THE BOTTOM UP REVIEW AND THE FUTURE YEAR DEFENSE PROGRAM AND ESTABLISHMENT OF NEW FUNDING REQUIREMENTS AND PRIORITIES.

(A) FINDINGS.—Congress finds as follows:

(1) Whereas the Administration commissioned the Bottom Up Review to properly structure the Armed Forces of the United States for the Post-Cold War Era;

(2) Whereas the Joint Staff officer responsible for force planning testified on March 1, 1994, that the Bottom Up Review force structure exposes U.S. troops to a "high element of risk;"

(3) Whereas the Secretary of Defense has testified that the Department of Defense's Future Years Defense Program includes $20 billion more in program funding requests during fiscal years 1996 through 1999 than the defense funding levels in the Administration's budget can support;

(4) Whereas the General Accounting Office reported in July 1994 that the Administration's Future Years Defense Program may be underfunded by as much as $150 billion;

(5) Whereas, the Secretary of the Navy has testified that the Department of the Navy

will only operate 330 ships rather than the 346 ships required by the Bottom Up Review;

(6) Whereas, in January 1994, in his Annual Report to the President and the Congress, the Secretary of Defense reported that the Air Force will field approximately 100 heavy bombers rather than the 184 required by the Bottom Up Review;

(7) Whereas the Department of Defense's plans for a major regional contingency in the Far East call for 5 Army divisions and the plans for a major regional contingency in Southwest Asia call for 7 Army divisions, while the Bottom Up Review plans for an Army of only 10 active divisions;

(8) Whereas the Administration's budget assumes the Department of Defense will save at least $6 billion from procurement reform;

(9) Whereas the first and second rounds of the Base Realignment and Closure Commission have not yet achieved the level of savings initially estimated, and the 1995 base closure round may cost significantly more than is assumed in the Administration's budget;

(b) REQUIREMENT.—

(1) The Secretary of Defense shall, within 30 days after enactment of this legislation, initiate a review of the assumptions and conclusions of the President's Budget, the Bottom Up Review, and the Future Years Defense Program;

(2) not more than 60 days after the review described in (b)(1) is initiated, the Secretary of Defense shall submit to the President and to the Congress a report detailing the funding level required for the defense and national security of the United States;

(3) The President shall, when submitting to the Congress the budget of the United States Government for Fiscal Year 1996, submit a defense budget for fiscal year 1996 and a Future Years Defense Plan which represents the funding level described in (b)(2).

COHEN AMENDMENTS NOS. 2516–2517

Mr. STEVENS (for Mr. COHEN) proposed two amendments to the bill H.R. 4650, supra; as follows:

AMENDMENT NO. 2516

At an appropriate place in the bill, insert the following section:

SEC . SENATE ADVICE AND CONSENT TO CHANGES IN OBLIGATIONS UNDER THE CFE TREATY.

(a) FINDINGS.—

(1) On November 25, 1991, the Senate gave its advice and consent to ratification of the CFE Treaty.

(2) The President would need to seek the Senate's advice and consent to any change in obligation of the states parties under the CFE Treaty, unless such change were a minor matter of an administrative or technical nature.

(3) A change in the allowed holdings of treaty limited equipment in the area of application or any geographic sub-zone of the area of application would constitute a change in obligation for which the Senate's advice and consent would be required.

(b) REAFFIRMATION OF SENATE'S TREATY-MAKING POWERS.—The President shall submit for the Senate's advice and consent any change in the obligations of any state party under the CFE Treaty, unless such change is a minor matter of an administrative or technical nature.

(c) CFE TREATY DEFINED.—For the purpose of this section, the CFE Treaty means the Treaty on Conventional Armed Forces in Europe, signed in Paris on November 19, 1990, and associated protocols.

AMENDMENT NO. 2517

At the appropriate place, insert:

SEC. 114. [S114]. SMALL ARMS INDUSTRIAL BASE.

(a) FUNDING FOR PROCUREMENT.—Of the funds authorized to be appropriated pursuant to section 101(3), $93,683,000 is available for procurement of small arms weapons as follows:

(1) $38,902,000 for the MK19-3 grenade machine gun.

(2) $13,000,000 for the M16A2 rifle.

(3) $28,616,000 for the M249 squad automatic weapon.

(4) $13,165,000 for the M4 carbine.

(b) MULTIYEAR CONTRACTS AUTHORIZED.—(1) During fiscal year 1995, the Secretary of the Army may, in accordance with section 2306(h) of title 10, United States Code, enter into multiyear contracts to meet the following objectives for quantities of small arms weapons to be procured for the Army:

Weapon	*Quantity*
MK19–3 grenade machine gun	21,217
M16A2 rifle	1,002,277
M249 squad automatic weapon	71,769
M4 carbine	132,510.

(2) If the Army does not enter into contracts during fiscal year 1995 that will meet all the objectives set forth in paragraph (1), the Secretary shall, to the extent provided for in appropriations Acts, enter into multiyear contracts during subsequent fiscal years to meet those objectives.

(c) FOLLOW-ON WEAPONS.—The Secretary of the Army shall provide for procurement of product improvements for existing small arms weapons and may do so within multiyear contracts entered into pursuant to subsection (b).

(d) JOINT SMALL ARMS MASTER PLAN.—(1) The Secretaries of the military departments shall jointly develop a master plan for meeting the immediate and future needs of the Armed Forces for small arms. The Secretary of the Army shall coordinate the development of the joint small arms master plan. The joint small arms master plan shall include—

(A) an examination of the relative advantages and disadvantages of improving existing small arms weapons as compared to investing in new, advanced technology weapons; and

(B) an analysis of the effects of each such approach on the small arms industrial base.

(2) Not later than April 1, 1995, the Under Secretary of Defense for Acquisition and Technology shall—

(A) review the joint small arms master plan and the results of the examination of relative advantages and disadvantages of the two courses of action described in paragraph (1); and

(B) transmit the plan, together with any comments that the Under Secretary considers appropriate, to Congress.

(e) FUNDING FOR RDT&E.—Of the funds authorized to be appropriated under section 201(1)—

(1) $5,000,000 shall be available for the Objective Crew-Served Weapons System; and

(2) $3,000,000 shall be available for product improvements to existing small arms weapons.

DOLE (AND OTHERS) AMENDMENT NO. 2518

Mr. STEVENS (for Mr. DOLE for himself and Mr. LIEBERMAN, Mr. MCCAIN, Mr. MOYNIHAN, Mr. WELLSTONE, Mr. EXON, Mr. FEINGOLD, Mr. HATCH, Mr. DECONCINI, Mr. LUGAR, and Mr. HELMS) proposed an amendment to the bill, H.R. 4650, supra; as follows:

At the appropriate place, add the following:

SEC . TERMINATION OF ARMS EMBARGO.

(1) TERMINATION.—The President shall terminate the United States arms embargo of the Government of Bosnia and Herzegovina no later than November 15, 1994 so that Government may exercise its right of self-defense under Article 51 of the United Nations Charter.

(2) DEFINITION.—As used in this section, the term 'United States arms embargo of the Government of Bosnia and Herzegovina' means the application to the Government of Bosnia and Herzegovina of—

(A) the policy adopted July 10, 1991, and published in the Federal Register of July 19, 1991 (58 F.R. 33322) under the heading "Suspension of Munitions Export Licenses to Yugoslavia"; and

(B) any similar policy being applied by the United States Government as of the date of receipt of the request described in paragraph (1) pursuant to request described in paragraph (1) pursuant to which approval is denied for transfers of defense articles and defense services to the former Yugoslavia.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be interpreted as authorization for deployment of United States forces in the territory of Bosnia and Herzegovina for any purpose, including training, support, or delivery of military equipment.

COHEN AMENDMENT NO. 2519

Mr. STEVENS (for Mr. COHEN) proposed an amendment to the bill, H.R. 4650, supra; as follows:

At an appropriate place in the bill, insert the following section:

SEC. . SENATE ADVICE AND CONSENT TO CHANGES IN OBLIGATIONS UNDER THE CFE TREATY.

(a) FINDINGS.—

(1) On November 25, 1991, the Senate gave its advice and consent to ratification of the CFE Treaty.

(2) The President would need to seek the Senate's advice and consent to any change in obligation of the states' parties under the CFE Treaty, unless such change were a minor matter of an administrative or technical nature.

(3) A change in the allowed holdings of treaty limited equipment in the area of application or any geographic sub-zone of the area of application would constitute a change in obligation for which the Senate's advice and consent would be required.

(b) REAFFIRMATION OF SENATE'S TREATY-MAKING POWERS.—The President shall submit for the Senate's advice and consent any change in the obligations of any state party under the CFE Treaty, unless such change is a minor matter of an administrative or technical nature.

(c) CFE TREATY DEFINED.—For the purpose of this section, the CFE Treaty means the Treaty on Conventional Armed Forces in Europe, signed in Paris on November 19, 1990, and associated protocols.

THURMOND (AND DECONCINI) AMENDMENT NO. 2520

Mr. STEVENS (for Mr. THURMOND for himself and Mr. DECONCINI) proposed an amendment to the bill, H.R. 4650, supra; as follows:

At the end of Title VIII, General Provisions, add the following new section:

SEC. . Of the funds appropriated by title VIII of Public Law 102-396 (106 Stat. 1899) for defense reinvestment for economic growth, the unobligated balance of the funds made available by such title for military service members occupational conversion and training shall remain available until September 30, 1995.

ROTH AMENDMENT NO. 2521

Mr. Stevens (for Mr. ROTH) proposed an amendment to the bill, H.R. 4650, supra; as follows:

At the appropriate place in the bill, insert the following:

SEC. . Sense of the Senate concerning Japan fulfilling its commitments under the Host Nation Support Agreement it signed with the United States on January 14, 1991:

That, the U.S.-Japan Security Treaty continues to be a strong bond between our two countries, serving as a main pillar of the bilateral relationship;

That, the bilateral relationship is of vital importance to both countries and to the stability of the Asia Pacific region and the entire world;

That, Japan's willingness to share the costs of maintaining forces in Japan is an important contribution to strengthening our security partnership;

That, it has often been asserted that Japan's host nation support for American forces provides a model defense burden-sharing arrangement for our allies;

That, Japan and the United States signed a new Host Nation Support Agreement on January 14, 1991, providing for Japan to assume—over five years beginning in Japanese Fiscal Year 1991 and ending in FY 1995—virtually all yen-based costs of maintaining U.S. forces in Japan;

That, Japan voluntarily entered into that agreement more than a year before the expiration of the previous Host Nation Support Agreement which was not as generous;

That, the Government of Japan hailed the new agreement as "a step of great significance for the overall relationship between the two countries;"

That, Japan's Defense Agency appears to have decided to decrease expenses for bearing the cost of stationing U.S. forces in Japan in its FY 1995 budget request, thereby failing to fulfill its obligations under the 1991 Host Nation Support Agreement;

That, should Japan fail to fulfill those obligations, the bilateral relationship may suffer negative consequences, particularly as current problems on the Korean peninsula may pose a critical challenge to U.S.-Japan security ties; Now, therefore, be it *resolved*, That:

(1) It is in the interest of both Japan and the United States to fully comply with all the provisions of the Host Nation Support Agreement of 1991; and

(2) Should Japan take actions that prevent it from fulfilling any of its obligations under that Agreement, the bilateral relationship, may suffer harmful consequences.

STEVENS AMENDMENT NO. 2522

Mr. STEVENS proposed an amendment to the bill, H.R. 4650, supra; as follows:

At the appropriate place, add the following: "None of the funds appropriated in this Act may be transferred to or obligated from the Pentagon Reservation Maintenance Revolving Fund, if the total cost over the life of the project for the replacement or renovation of the Pentagon Reservation shall exceed $1,009,000,000."

MCCONNELL AMENDMENT NO. 2523

Mr. STEVENS (for Mr. MCCONNELL) proposed an amendment to the bill, H.R. 4650, supra; as follows:

At the appropriate place in the bill insert the following:

SEC. . (a) Within 60 days of enactment of this Act, the President, in consultation with NATO, shall submit a report to the Committee on Appropriations defining specific military, economic, and political standards required to gain admission to NATO: *Provided further*, That such report shall not be limited to the principles enunciated in the Partnership for Peace; *Provided further*, Such, report shall include an assessment of measures which would be necessary to guarantee the armed services of Poland, Hungary, the Czech Republic, Slovakia, Lithuania, Latvia and Estonia are capable of military cooperation and interoperability with NATO and fulfilling other member responsibilities.

NUNN (AND MITCHELL) AMENDMENT NO. 2524

Mr. INOUYE (for Mr. NUNN for himself and Mr. MITCHELL) proposed an amendment to the bill H.R. 4650, supra; as follows:

SEC. . BOSNIA AND HERCEGOVINA.

(A) PURPOSE.—To express the sense of Congress concerning the international efforts to end the conflict in Bosnia and Hercegovina, and to establish a process to end the arms embargo on the Government of Bosnia and Hercegovina.

(B) STATEMENT OF SUPPORT.—The Congress supports the efforts of the so-called "contact group" composed of representatives of the United States, Russia, France, Britain, and Germany to bring about a peaceful settlement of the conflict in Bosnia and Hercegovina based upon the contact's group proposal of July 6, 1994 that has been agreed to by the Government of Bosnia and Hercegovina and rejected by the Bosnian Serb faction.

(C) SENSE OF THE CONGRESS.—It is the sense of the congress that:

(1) The United States should work with the NATO Member nations and other permanent Member of the United Nations Security Council to bring about a peaceful settlement of the conflict in Bosnia and Hercegovina which maintains the territorial integrity of Bosnia and Hercegovina.

(2) A peaceful settlement of the conflict must preserve an economically, politically and militarily viable Bosnian state capable of exercising its rights under the United Nations Charter as part of a peaceful settlement, including the lifting of the arms embargo on the Government of Bosnia and Hercegovina so that it can exercise the inherent right of a sovereign state to self-defense.

(3) The acceptance of the contact group's peace proposal by the Government of Bosnia and Hercegovina should lead to the lifting of the international arms embargo on that Government.

(4) In providing weapons to the Bosnian Government or taking other actions, care should be taken to provide for the safety of the United Nations Protection Force (UNPROFOR) and the civilian personnel working for the United Nations or non-governmental volunteer organizations.

(5) The United States should immediately seek to organize an international effort to provide assistance to the nations bordering Serbia and Montenegro to bring about more effective enforcement by those nations of the international economic sanctions on the Government of Serbia and Montenegro.

(D) POLICY.—The United States should exercise leadership within the international community to cause the Bosnian Serb faction to accept the contact's group's proposal. Such action should be taken on separate but complimentary international and unilateral tracks. Accordingly:

(1) International: If the Bosnian Serbs have not accepted the contact group's proposal of July 6, 1994 within 10 days after the enactment of this Act or by October 15, 1994, whichever is later, the President or his representative should formally introduce and support a resolution in the United Nations Security Council, within fourteen (14) days thereafter, to terminate the international arms embargo on the Government of Bosnia and Hercegovina. The termination of the arms embargo on the Government of Bosnia and Hercegovina may be accomplished in stages but should result in a lifting of the arms embargo no later than December 1, 1994.

(2) Unilateral: If the United Nations Security Council has not voted to lift the international arms embargo on the Government of Bosnia and Hercegovina in accordance with paragraph 1 within 15 days after the President or his representative has formally introduced such a resolution or by November 15, 1994, whichever is earlier, and the Bosnian Serbs have not accepted the contact group's proposal of July 6, 1994 by that date:

(a) None of the funds available to the Department of Defense for any fiscal year shall thereafter be used for the purpose of participation in, support for, or assistance to the enforcement of the arms embargo on the Government of Bosnia and Hercegovina but the President may waive this provision in the case of U.S. military personnel serving in NATO headquarters staff positions. Nothing in this provision is intended to impede sanctions enforcement against Serbia;

(b) The President shall submit a plan to and consult with the Congress on the manner in which the armed forces of the United States and other friendly nations would provide training to the armed forces of the Government of Bosnia and Hercegovina outside of the territory of Bosnia and Hercegovina; and

(c) The President shall submit a plan to and consult with the Congress regarding unilateral lifting by the United States of the arms embargo on the Government of Bosnia and Hercegovina.

(3) Interim: If the Bosnian Serb faction attacks the United Nations declared safe areas, the President or his representative should promptly introduce and support a resolution in the United Nations Security Council that authorizes a selective lifting of the arms embargo on the Government of Bosnia and Hercegovina to provide defensive weapons, such as anti-tank weapons, counter-battery radars, and mortars, to enable the forces of the Government of Bosnia and Hercegovina to defend the safe areas.

HARKIN AMENDMENT NO. 2525

Mr. INOUYE (for Mr. HARKIN) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. 8121. SENSE OF CONGRESS ON NEGOTIATION OF LIMITATIONS ON NUCLEAR WEAPONS TESTING.

(a) FINDINGS.—Congress finds the following:

(1) On January 25, 1994, the United States joined with 37 other nations to begin negotiations for a comprehensive treaty to ban permanently all nuclear weapons testing.

(2) On March 14, 1994, the President decided to extend the current United States nuclear testing moratorium at least through September 1995.

(3) Germany and the Group of 21 Non-Aligned States have publicly stated their support for the completion of a comprehensive nuclear test ban treaty by 1995.

(4) On June 6, 1994, the People's Republic of China conducted its second nuclear weapons test explosion since the United States, Russia, and France initiated their current nuclear test moratoria.

(5) On September 7, 1994, the third and final test ban negotiating session of the year will end.

(6) While some progress toward a comprehensive nuclear test ban treaty has been achieved, there is little chance that an agreement will be reached before April 1995 at the current rate of negotiation.

(7) The United States is seeking to extend indefinitely the Non-Proliferation Treaty at the April 1995 Extension Conference.

(8) Conclusion of a comprehensive nuclear test ban treaty could contribute toward successful negotiations to extend the Non-Proliferation Treaty.

(9) Agreements to eliminate nuclear testing and control the spread of nuclear weapons could contribute to national security of the United States, its allies, and other nations around the world.

(b) SENSE OF CONGRESS.—The Congress—

(1) applauds the President for maintaining the United States nuclear testing moratorium and for supporting the negotiation of a comprehensive nuclear test ban treaty;

(2) encourages the People's Republic of China and all other nuclear powers to refrain from conducting nuclear explosions prior to conclusion of a comprehensive nuclear test ban treaty; and

(3) urges the President and the other nuclear powers to take measures necessary to achieve a multilateral comprehensive nuclear test ban treaty before the Non-Proliferation Treaty Extension Conference.

(c) DEFINITION.—As used in this section, the term "Non-Proliferation Treaty" means the Treaty on the Non-Proliferation of Nuclear Weapons, done at Washington, London, and Moscow on July 1, 1968 (21 U.S.T. 483).

LIEBERMAN (AND HATCH) AMENDMENT NO. 2526

Mr. INOUYE (for Mr. LIEBERMAN for himself and Mr. HATCH) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 39, after the words "such section" on line 2, insert: *:Provided further*, That of the funds appropriated in this paragraph, not less than $2,000,000 shall be made available for International Cooperative projects to be funded under the Counterterror Technical Support program element".

SHELBY (AND OTHERS) AMENDMENT NO. 2527

Mr. INOUYE (for Mr. SHELBY for himself, Mr. HEFLIN, Mr. GLENN, Mr. COCHRAN, and Mr. LOTT) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 10, line 17, before the period insert the following: "*Provided*, That, of the amount appropriated under this paragraph, not less than $8,000,000 shall be available only for the upgrading of the Air Force's Core Automated Maintenance System/Reliability and Maintainability Information System (CAMS/REMIS)"

BOREN (AND DECONCINI) AMENDMENT NO. 2528

Mr. INOUYE (for Mr. BOREN for himself and Mr. DECONCINI) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following new section:

SEC. . (a) No project for the construction of any facility, or improvement to any facility, having an estimated Federal cost in excess of $300,000, may be undertaken in any fiscal year except to the extent and in the amounts specifically provided for it as a separate item provided in an appropriation Act, if such facility or improvement would be used primarily by personnel of the intelligence community.

(b) As used in this section, the term "intelligence community" has the same meaning given that term in section 3(4) of the National Security Act of 1947 (50 U.S.C. 401a(4)).

SIMON (AND OTHERS) AMENDMENT NO. 2529

Mr. INOUYE (for Mr. SIMON for himself, Mr. JEFFORDS and Mr. HELMS) proposed an amendment to the bill, H.R. 4650, supra; as follows:

At the end of the bill, add the following new title:

TITLE —AFRICAN CONFLICT RESOLUTION

SEC. 01. SHORT TITLE.

This Act may be cited as the "African Conflict Resolution Act".

SEC. 02. FINDINGS AND STATEMENT OF POLICY.

(a) FINDINGS.—The Congress makes the following findings:

(1) It is in the national interest of the United States to help build African capability in conflict resolution. A relatively small investment of assistance in promoting African conflict resolution—

(A) would reduce the enormous human suffering which is caused by wars in Africa;

(B) would help the United States avoid huge future expenditures necessitated by Somalia-like humanitarian disasters; and

(C) would reduce the need for United Nations intervention as African institutions develop the ability to resolve African conflicts.

(2) Africa, to a greater extent than any other continent, is afflicted by war. Africa has been marred by more than 20 major civil wars since 1960. Rwanda, Somalia, Angola, Sudan, Liberia, and Burundi are among those countries that have recently suffered serious armed conflict.

(3) In the last decade alone, between 2,000,000 and 4,000,000 Africans have died because of war. There were 5,200,000 refugees and 13,100,000 displaced people in Africa in 1993. In Angola, relief organizations estimated that 1,000 people were dying each day at the end of 1993. In Rwanda, more than 200,000 people died in less than 5 weeks of fighting during 1994, while 300,000 people fled to other countries to escape war.

(4) Millions more Africans are currently at risk of war-related death. Looming or ongoing conflicts in Zaire, Angola, Sudan, Rwanda, and other countries threaten Africa's future.

(5) War has caused untold economic and social damage to the countries of Africa. Food production is impossible in conflict areas, and famine often results. Widespread conflict has condemned many of Africa's children to lives of misery and, in certain cases, has threatened the existence of traditional African cultures.

(6) Conflict and instability in Africa, particularly in large, potentially rich countries such as Angola, Sudan, and Zaire, deprive the global economy of resources and opportunities for trade and investment. Peace in these countries could make a significant contribution to global economic growth, while creating new opportunities for United States businesses.

(7) Many African armies are far too large, threatening political and economic stability while diverting scarce resources from development needs. Military expenditures in Africa average over twice the level in Latin America. Demobilization and other measures to reduce military expenditures are thus a critical need for many African countries.

(8) Conflict prevention, mediation, and demobilization are prerequisites to the success of development assistance programs. Nutrition and education programs, for example, cannot succeed in a nation at war. Billions of dollars of development assistance have been virtually wasted in war-ravaged countries such as Liberia, Somalia, and Sudan.

(9) Africans have a long tradition of informal mediation. This tradition should be built upon to create effective institutions through which Africans can resolve African conflicts.

(10) The Organization of African Unity, under the leadership of Secretary General Salim Salim, has established a conflict resolution mechanism and has been active in mediation and conflict resolution in several African countries. Various subregional organizations have also become active in conflict resolution efforts. These are encouraging developments.

(b) UNITED STATES POLICY.—The Congress declares, therefore, that a key goal for United States foreign policy should be to help institutionalize conflict resolution capability in Africa.

SEC. 03. IMPROVING THE CONFLICT RESOLUTION CAPABILITIES OF THE ORGANIZATION OF AFRICAN UNITY.

(a) AUTHORIZATION OF ASSISTANCE.—The President is authorized to provide assistance to strengthen the conflict resolution capability of the Organization of African Unity, as follows:

(1) Funds may be provided to the Organization of African Unity for use in supporting its conflict resolution capability.

(2) Funds may be used for expenses of sending individuals with expertise in conflict resolution to work with the Organization of African Unity.

(b) FUNDING.—Of the foreign assistance funds that are allocated for sub-Saharan Africa, significant sums for each of the fiscal years 1995 through 1998 should be used to carry out subsection (a).

SEC. 04. IMPROVING CONFLICT RESOLUTION CAPABILITIES OF MULTILATERAL SUBREGIONAL ORGANIZATIONS IN AFRICA.

(a) AUTHORIZATION OF ASSISTANCE.—The President is authorized to provide assistance to strengthen the conflict resolution capabilities of subregional organizations established by countries in sub-Saharan Africa, as follows:

(1) Funds may be provided to such an organization for use in supporting its conflict resolution capability.

(2) Funds may be used for the expenses of sending individuals with expertise in conflict resolution to work with such an organization.

(b) FUNDING.—Of the foreign assistance funds that are allocated for sub-Saharan Africa, up to $1,500,000 for each of the fiscal years 1995 through 1998 may be used to carry out subsection (a).

SEC. 05. AFRICAN DEMOBILIZATION AND RETRAINING PROGRAM.

(a) AUTHORIZATION OF ASSISTANCE.—In order to facilitate reductions in the size of the armed forces of countries of sub-Saharan Africa, the President is authorized to provide assistance for—

(1) encampment and related activities associated with demobilization of such forces, and

(2) the retraining for civilian occupations of military personnel who have been demobilized.

(b) FUNDING.—Of the foreign assistance funds that are allocated for sub-Saharan Africa, up to $25,000,000 for each of the fiscal years 1995 and 1996 should be used for the assistance described in subsection (a), if conditions permit.

SEC. 06. TRAINING FOR AFRICANS IN CONFLICT RESOLUTION AND PEACEKEEPING.

(a) AUTHORIZATION OF ASSISTANCE..—The President is authorized to establish a program to provide education and training in conflict resolution and peacekeeping for civilian and military personnel of countries in sub-Saharan Africa.

(b) FUNDING.—Funds made available for military education and training activities under chapter 5 of part II of the Foreign Assistance Act of 1961 may be used to carry out the program provided for in subsection (a).

SEC. 07. BUILDING MEDIATION CAPABILITY IN AFRICA.

(a) AUTHORIZATION OF ASSISTANCE.—The President is authorized to provide assistance to nongovernmental organizations that are engaged in mediation and reconciliation efforts in Africa.

(b) FUNDING.—Of the foreign assistance funds that are allocated for sub-Saharan Africa, funds for each of the fiscal years 1995 and 1996 should be used to carry out subsection (a).

SEC. 08. DEFINITION.

As used in this title, the term "foreign assistance funds" means funds made available—

(1) under chapters 1 and 10 of part I of the Foreign Assistance Act of 1961 (relating to development assistance and the Development Fund for Africa),

(2) under chapter 4 of part II of the Foreign Assistance Act of 1961 (relating to the economic support fund), and

(3) under section 23 of the Arms Export Control Act (relating to foreign military financing),

and includes unobligated funds in such accounts which remain available from previous fiscal years.

BINGAMAN (AND PRYOR) AMENDMENT NO. 2530

Mr. INOUYE (for Mr. BINGAMAN for himself and Mr. PRYOR) proposed an amendment to the bill H.R. 4650, supra; as follows:

Strike section 8096 and insert in lieu thereof:

Amendment No. : None of the funds appropriated or otherwise made available by this Act may be used for a defense technology reinvestment project that is not selected pursuant to the applicable competitive selection and other procedures set forth in chapter 148 of title 10, United States Code: *Provided*, That notwithstanding any other provision of law, funds appropriated for defense reinvestment programs under the heading "Research, Development, Test and Evaluation, Defense-Wide" shall not be obligated until the Secretary of Defense has ensured that the Assistant Secretaries for Research, Development, and Acquisition of the separate Military Departments are full members of the Defense Technology Conversion Council: *Provided further*, That notwithstanding any other provision of law, of the funds appropriated for defense reinvestment programs under the heading "Research, Development, Test and Evaluation, Defense-Wide", $150,000,000 may only be obligated for projects selected as a result of a focused competition held in subject areas selected by the Assistant Secretaries for Research, Development, and Acquisition of the separate Military Departments in coordination with the Director of the Advanced Research Projects Agency: *Provided further*, That in addition to the restriction contained in the preceding provisos, the focused competitions shall be conducted in accordance with other unaffected statutory provisions of the Defense Conversion, Reinvestment, and Transition Assistance Amendments of 1993.

LEVIN AMENDMENT NO. 2531

Mr. INOUYE (for Mr. LEVIN) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 11, line 10, before the period insert the following: ": *Provided further*, That, of the total amount appropriated under this title, $1,224,309,000 shall be available for the Defense Contract Management Command".

WELLSTONE AMENDMENT NO. 2532

Mr. INOUYE (for Mr. WELLSTONE) proposed an amendment to the bill H.R. 4650, supra; as follows:

At the appropriate place in the bill, insert the following:

"SEC. . The Senate finds:

a. In 1953, the U.S. Army conducted chemical and biological warfare tests in Minneapolis, MN, involving the spraying of zinc cadmium sulfide particles.

b. Members of the Senate have requested the Department of Defense to provide full disclosure of all documents pertaining to this and similar tests conducted nationwide.

c. The Department of Defense has thus far failed to provide even a time certain at which such documents will be made available.

SEC. . It is the sense of the Senate that the Department of Defense shall immediately provide, in writing, a schedule of production for the requested documents.

BINGAMAN (AND DOMENICI) AMENDMENT NO. 2533

Mr. INOUYE (for Mr. BINGAMAN for himself, and Mr. DOMENICI) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 37, line 21, of the Committee reported bill before the period insert the following: ": *Provided further*, That of the funds appropriated in this paragraph, $2,800,000 shall be made available only for the F-111 Squadrons program element".

FEINSTEIN (AND OTHERS) AMENDMENT NO. 2534

Mr. INOUYE (for Mrs. FEINSTEIN for herself, Mr. SASSER, Mr. BINGAMAN, and Mr. ROTH) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a) None of the funds available to the Department of Defense during fiscal year 1995 may be used for negotiating or entering into any agreement with, nor for accepting funds from, a foreign government or an entity controlled by a foreign government for a joint program for the development of an advanced threat radar jammer for combat helicopters until 30 days after the Secretary of Defense, in consultation with the Secretary of State, the Secretary of the Army, and the Director of the Defense Security Assistance Agency, conducts a comprehensive review of the program and submits a report on the results of that review to the congressional defense committees.

(b) This section does not apply with respect to a major ally of the United States.

(c) In this section:

(1) The term "entity controlled by a foreign government" includes—

(A) any domestic or foreign organization or corporation that is effectively owned or controlled by a foreign government, and

(B) any individual acting on behalf of a foreign government,

as determined by the Secretary of Defense. Such term does not include an organization or corporation that is owned, but is not controlled, either directly or indirectly, by a foreign government if the ownership of that organization or corporation by that foreign government was effective before October 23, 1992.

(2) The term "major ally of the United States" has the meaning given such term in section 2350a(i)(2) of title 10, United States Code.

INOUYE AMENDMENTS NOS. 2535–2536

Mr. INOUYE proposed two amendments to the bill H.R. 4650, supra; as follows:

AMENDMENT NO. 2535

On page 9, on line 13, of the Committee-reported bill, insert before the period the following: ": *Provided further*, That of the funds appropriated under this heading, not less than $39,674,000 shall be made available only for the Pacific Missile Range Facility, Hawaii".

AMENDMENT NO. 2536

On page 29, on line 15 of the Committee-reported bill, insert before the period the following: ": *Provided*, That of the funds appropriated under this heading, not less than $30,100,000 shall be made available only for the Pacific Missile Range Facility, Hawaii".

DODD AMENDMENT NO. 2537

Mr. INOUYE (for Mr. DODD) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . The Secretary of Commerce, acting through the Commissioner of Patents, shall, upon expiration of United States patent numbers 4,428,744 and 4,683,889 (relating to a photopheresis method involving collection and exposure of extracorporeally circulating leukocyte-enriched blood to long-wave ultraviolet energy in the presence of a photoactive drug 8-methoxypsoralen), or as soon thereafter as practicable, extend such patents for four and one-half years, with all the rights pertaining thereto.

KEMPTHORNE (AND OTHERS) AMENDMENT NO. 2538

Mr. STEVENS (for Mr. KEMPTHORNE for himself, Mr. WARNER, and Mr. CRAIG) proposed an amendment to the bill H.R. 4650, supra; as follows:

At the appropriate place in the bill, insert the following new section:

RESTRICTION ON FUNDING UNITED STATES MILITARY PERSONNEL IN SOMALIA

SEC. . None of the funds appropriated by this Act may be used for the continuous presence in Somalia of United States military personnel after September 30, 1994.

HELMS AMENDMENTS NOS. 2539–2540

Mr. STEVENS (for Mr. HELMS) proposed two amendments to the bill H.R. 4650, supra; as follows:

AMENDMENT NO. 2539

At the appropriate place in the Committee amendment, insert the following:

SEC. . LIMITATION ON THE USE OF FUNDS FOR THE SANDINISTA POPULAR ARMY AND SECURITY FORCES OF NICARAGUA.

(a) IN GENERAL.—None of the funds appropriated under this Act may be obligated or expended for the armed forces or security forces of Nicaragua, and none of the funds appropriated by this Act may be obligated or expended to pay the salaries of United States military personnel to provide assistance for the armed forces or security forces of Nicaragua, until the President determines and certifies to the Congress that—

(1) Nicaraguan military officers implicated for committing human rights violations, including those involved in the murders of Enrique Bermudez, Arges Sequeira, and Jean Paul Genie, have been removed or suspended from the military and judicial proceedings have commenced;

(2) officers of the Nicaraguan armed forces or security forces are not involved in the illicit trafficking of military equipment, including those seized by Colombian authorities on the San Andres Islands on July 24, 1994;

(3) civilian control over the military and security forces, including control over the budget and expenditures of such forces, has been clearly established; and

(4) there has been a full and independent investigation conducted relating to issues raised by the May 23, 1993 discovery of the Santa Rosa arms cache of the existence of a terrorist/kidnapping ring and any individuals identified by the investigation as being part of such ring are being prosecuted.

AMENDMENT NO. 2540

At the appropriate place in the committee amendment, insert the following:

SEC. . PROHIBITION ON U.S. MILITARY PARTICIPATION IN ANY MULTILATERAL MILITARY FORCE WHICH INCLUDES NICARAGUA ARMED FORCES.

None of the funds appropriated or otherwise made available by this Act may be provided for any U.S. military participation in any multilateral operation which also involves elements of the military or security forces of Nicaragua unless the President certifies and reports in writing to the Congress that—

(1) Nicaraguan military officers implicated in human rights abuses by the Tripartite Commission, the Inter-American Commission on Human Rights, the Nicaraguan Association for Human Rights, the Permanent Commission for Human Rights, or the judiciary in Nicaragua, have been removed or suspended from military service, as the case may be, and judicial/legal proceedings have commenced;

(2) officers of the Nicaraguan armed forces or security forces are not involved in the illicit sale, transport, or trafficking of weapons and military equipment, including those seized by Colombian authorities on the San Andres Islands on July 24, 1994;

(3) civilian control over the military and security forces by the democratically-elected President and Congress of Nicaragua, including control over the budget and expenditures of the military and security forces, has been clearly established and evidence that such control is respected by such forces; and

(4) fair and impartial civilian judicial proceedings have been completed against those involved in the murders of Enrique Bermudez, Arges Sequeira, and Jean Paul Genie.

DOLE AMENDMENT NO. 2541

Mr. STEVENS (for Mr. DOLE) proposed an amendment to the bill H.R. 4650, supra; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Megan Kanka Sexually Violent Predators Act".

SEC. 2. FINDINGS.

Congress finds that—

(1) there exists a small but extremely dangerous group of sexually violent persons who do not have a mental disease or defect;

(2) persons who are sexually violent predators generally have antisocial personality features that—

(A) are not amenable to mental illness treatment modalities in existence on the date of enactment of this Act; and

(B) render the persons likely to engage in sexually violent behavior;

(3) the likelihood that sexually violent predators will repeat acts of predatory sexual violence is high; and

(4) the prognosis for curing sexually violent predators is poor and the treatment needs of the population of the predators are very long-term.

SEC. 3. DEFINITIONS.

As used in this Act:

(1) MENTAL ABNORMALITY.—The term "mental abnormality" means a congenital or acquired condition of a person that affects the emotional or volitional capacity of the person in a manner that predisposes the person to the commission of criminal sexual acts to a degree that makes the person a menace to the health and safety of other persons.

(2) PREDATORY.—The term "predatory", with respect to an act, means an act directed towards a stranger, or a person with whom a relationship has been established or promoted, for the primary purpose of victimization.

(3) SEXUALLY VIOLENT OFFENSE.—The term "sexually violent offense" means an act that is a violation of title 18, United States Code or State criminal code that—

(A) involves the use or attempted or threatened use of physical force against the person or property of another person; and

(B) is determined beyond a reasonable doubt to be sexually motivated.

(4) SEXUALLY VIOLENT PREDATOR.—The term "sexually violent predator" means a person who has been convicted of a sexually violent offense and who suffers from a mental abnormality or personality disorder that makes the person likely to engage in predatory sexually violent offenses.

SEC. 4. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—

(1) STATE GUIDELINES.—In accordance with this section, the Attorney General shall establish guidelines for State programs to require a sexually violent predator to register a current address with a designated State law enforcement agency upon release from prison, being placed on parole, or being placed on supervised release. The Attorney General shall approve each State program that complies with the guidelines.

(2) STATE COMPLIANCE.—

(A) IMPLEMENTATION DATE.—A State that does not implement a program described in paragraph (1) by the date that is 3 years after the date of enactment of this Act, and maintain the implementation thereafter, shall be ineligible for funds in accordance with subparagraph (B).

(B) INELIGIBILITY FOR FUNDS.—

(i) IN GENERAL.—A State that does not implement the program as described in subparagraph (A) shall not receive 10 percent of the funds that would otherwise be allocated to the State under section 506 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3756).

(ii) REALLOCATION OF FUNDS.—Funds made available under clause (i) shall be reallocated, in accordance with such section, to such States as implement the program as described in subparagraph (A).

(b) REGISTRATION REQUIREMENT UPON RELEASE, PAROLE, OR SUPERVISED RELEASE.—

(1) IN GENERAL.—An approved State program established in accordance with this section shall contain the requirements described in this section.

(2) DETERMINATION.—The determination that a person is a "sexually violent predator" and the determination that a person is no longer a "sexually violent predator" shall be made by the sentencing court after receiving a report by a board of experts on sexual offenses. Each State shall establish a board composed of experts in the field of the behavior and treatment of sexual offenders.

(3) NOTIFICATION.—If a person who is required to register under this section is anticipated to be released from prison, paroled, or placed on supervised release, a State prison officer shall, not later than 90 days before the anticipated date of the release or commencement of the parole—

(A) inform the person of the duty to register;

(B) inform the person that if the person changes residence address, the person shall give the new address to a designated State law enforcement agency in writing not later than 10 days after the change of address;

(C) obtain the name of the person, identifying factors, anticipated future residence, offense history, and documentation of any treatment received for the mental abnormality or personality disorder of the person; and

(D) require the person to read and sign a form stating that the duty of the person to register under this section has been explained.

(4) TRANSFER OF INFORMATION TO STATE AND THE FBI.—Not later than 3 days after the receipt of the information described in paragraph (3)(C), the officer shall forward the information to a designated State law enforcement agency. As soon as practicable after the receipt of the information by the State law enforcement agency, the agency shall—

(A) enter the information into the appropriate State law enforcement record system and notify the appropriate law enforcement agency that has jurisdiction over the area in which the person expects to reside; and

(B) transmit the information to the Identification Division of the Federal Bureau of Investigation.

(5) QUARTERLY VERIFICATION.—

(A) MAILING TO PERSON.—Not less than every 90 days after the date of the release or commencement of parole of a person required to register under this section, the designated State law enforcement agency shall mail a nonforwardable verification form to the last reported address of the person.

(B) RETURN OF VERIFICATION FORM.—

(i) IN GENERAL.—The person shall return, by mail, the verification form to the agency not later than 10 days after the receipt of the form. The verification form shall be signed by the person, and shall state that the person continues to reside at the address last reported to the designated State law enforcement agency.

(ii) FAILURE TO RETURN.—If the person fails to mail the verification form to the designated State law enforcement agency by the date that is 10 days after the receipt of the form by the person, the person shall be in violation of this section unless the person proves that the person has not changed the residence address of the person.

(6) NOTIFICATION OF LOCAL LAW ENFORCEMENT AGENCIES OF CHANGES IN ADDRESSES.—Any change of address by a person required to register under this section that is reported to the designated State law enforcement agency shall as soon as practicable be reported to the appropriate law enforcement agency that has jurisdiction over the area in which the person is residing.

(7) PENALTY.—A person required to register under a State program established pursuant to this section who knowingly fails to register and keep the registration current shall be subject to criminal penalties in the State. It is the sense of Congress that the penalties should include imprisonment for not less than 180 days.

(8) TERMINATION OF OBLIGATION TO REGISTER.—The obligation of a person to register under this section shall terminate on a determination made in accordance with the provision of paragraph (2) of this section that the person no longer suffers from a mental abnormality or personality disorder that would make the person likely to engage in a predatory sexually violent offense.

(c) COMMUNITY NOTIFICATION.—The designated State law enforcement agency shall release relevant information that is necessary to protect the public concerning a specific sexually violent predator required to register under this section.

(d) IMMUNITY FOR GOOD FAITH CONDUCT.—Law enforcement agencies, employees of law enforcement agencies, and State officials shall be immune from liability for any good faith conduct under this section.

MITCHELL (AND COHEN) AMENDMENT NO. 2542

Mr. INOUYE (for Mr. MITCHELL for himself and Mr. COHEN) proposed an amendment to the bill H.R. 4650, supra; as follows:

On Page 53, Line 13, after the period insert: "Funds appropriated in Title III of this Act may be used for multiyear procurement contracts as follows: MK19–3 grenade machine guns; M16A2 rifles; M249 squad automatic weapons; and M4 carbine rifles for the Army."

JOHNSTON AMENDMENT NO. 2543

Mr. INOUYE (for Mr. JOHNSTON) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between 7 and 8, insert the following:

SEC. . (a) Notwithstanding any other provision of law, the Secretary of a military department may enter into a contract for use of commercial or proprietary credit card services for augmenting or replacing any in-house account receivable system in use by a nonappropriated fund instrumentality under the jurisdiction of that Secretary if the Secretary determines that such contract is in the best interest of that department.

(b) No official of the Department of Defense outside a military department may, by regulation or otherwise, limit or control the exercise of authority under this section by the Secretary of that military department.

BUMPERS AMENDMENT NO. 2544

Mr. INOUYE (for Mr. BUMPERS) proposed an amendment to the bill H.R. 4650, supra; as follows:

At the appropriate place in the bill, add the following:

"SEC. . None of the funds made available under this Act may be obligated or expended for the relocation or reduction of the functions specified in the 1991 Report to the President of the Defense Base Closure and Realignment Commission to be maintained at Fort Chaffee, Arkansas, including all civilian management, support personnel and operations associated with these functions that are in existence as of September 30, 1994."

WALLOP (AND McCAIN) AMENDMENT NO. 2545

Mr. STEVENS (for Mr. WALLOP for himself and Mr. McCAIN) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 39, line 2, strike out the period at the end and insert in lieu thereof ": *Provided further*, That not less than $120,000,000 shall be available for Sea-Based Wide Area Defense System (Navy Upper Tier): *Provided further*, That not more than $522,725,000 shall be available for Defense Reinvestment Programs.".

DECONCINI AMENDMENT NO. 2546

Mr. INOUYE (for Mr. DECONCINI) proposed an amendment to the bill H.R. 4650, supra; as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a) No funds may be obligated for a second low rate initial production of the HUNTER Unmanned Aerial Vehicle (UAV) system until the Secretary of Defense submits to the Committees on Armed Services and Appropriations of the Senate and the House of Representatives, the Select Committee on Intelligence of the Senate, and the Permanent Select Committee on Intelligence of the House of Representatives the Secretary's certification of the following:

(1) That the Logistics Support Analysis Report required by contract to be submitted to the Department of Defense has been received by the Department and is sufficient to fully support a determination to field the system.

(2) That 200 hours of flight time have been successfully logged on a Phase II UAV airframe for the system as part of "OPTEMPO" testing.

(b) The Secretary shall submit to the committees referred to in subsection (a), with the certification submitted pursuant to that subsection, a copy of the Logistics Support Analysis Report and the OPTEMPO testing reports relating to the HUNTER UAV system.

BREAUX AMENDMENT NO. 2547

Mr. INOUYE (for Mr. BREAUX) proposed an amendment to the bill H.R. 4650, supra; as follows:

At the appropriate place, insert:

SEC. . Notwithstanding any other provision of law, the Secretary of the Navy shall obligate, within thirty days of this Act becoming law, not less than $29,750,000 from the funds appropriated in this Act or previous Acts under the heading "Aircraft Procurement, Navy", solely to procure, on an urgent basis, AN/USH–42 mission recorders modified for use in S–3B aircraft.

COHEN AMENDMENT NO. 2548

Mr. COHEN proposed an amendment to the bill H.R. 4650, supra; as follows:

At an appropriate place in the bill, insert the following section:

SEC. . SENATE ADVICE AND CONSENT TO CHANGES IN OBLIGATIONS UNDER THE CFE TREATY.

(a) FINDINGS.—

(1) On November 25, 1991, the Senate gave its advice and consent to ratification of the CFE Treaty.

(2) The President would need to seek the Senate's advice and consent to any change in obligation of the states parties under the CFE Treaty, unless such change were a minor matter of an administrative or technical nature.

(3) A change in the allowed holdings of treaty limited equipment in the area of application or any geographic sub-zone of the area of application would constitute a change in obligation for which the Senate's advice and consent would be required.

(b) REAFFIRMATION OF SENATE'S TREATY-MAKING POWERS.—The President shall submit for the Senate's advice and consent any change in the obligations of any state party under the CFE Treaty, unless such change is a minor matter of an administrative or technical nature.

(c) CFE TREATY DEFINED.—For the purpose of this section, the CFE Treaty means the Treaty on Conventional Armed Forces in Europe, signed in Paris on November 19, 1990, and associated protocols.

DOLE AMENDMENT NO. 2549

Mr. STEVENS (for Mr. DOLE) proposed an amendment to the bill H.R. 4650, supra; as follows:

At the appropriate place insert the following new section:

SEC. . PROHIBITION ON THE USE OF FUNDS.

(a) REQUIREMENT.—None of the funds appropriated for Fiscal Year 1994 or Fiscal Year 1995 for the Joint Primary Aircraft Training System shall be obligated or expended for any other purpose.

HISTORICALLY BLACK COLLEGES AND UNIVERSITIES HISTORIC BUILDING RESTORATION AND PRESERVATION ACT

DOLE (AND GRASSLEY) AMENDMENT NO. 2550

Mr. BENNETT (for Mr. DOLE for himself and Mr. GRASSLEY) proposed an amendment to the bill (H.R. 2921) to authorize appropriations for the preservation and restoration of historic buildings at historically black colleges and universities; as follows:

On page 1, after line 2, insert the following:

"TITLE I—HISTORICALLY BLACK COLLEGES AND UNIVERSITIES HISTORIC BUILDING RESTORATION AND PRESERVATION.".

On page 1, line 3, strike "SECTION 1." and insert in lieu thereof "SECTION 101." and redesignate the following sections accordingly.

On page 1, line 4, strike "Act" and insert in lieu thereof "title".

On page 5, line 23, strike "Act" and insert in lieu thereof "title".

On page 5, line 25, strike "Act" and insert in lieu thereof "title".

On page 6, after line 8, insert the following new title:

"TITLE II—COOPER HALL AND SCIENCE HALL PRESERVATION AND RESTORATION.

"SEC 201. AUTHORITY TO MAKE GRANTS.

The Secretary of the Interior (hereinafter in this title referred to at the "Secretary") is authorized to make grants in accordance with this title to preserve and restore Cooper Hall at Sterling College located in Sterling, Kansas and Science Hall at Simpson College located in Indianola, Iowa. Such grants shall be made, subject to the availability of appropriations therefore, from the amounts authorized to be appropriated to carry out the National Historic Preservation Act.

"SEC. 202. MATCHING EQUIPMENT.

The Secretary may obligate funds made available under this title only if the grantee agrees to match, from funds derived from non-Federal sources, the amount of the grant with an amount that is equal or greater than the grant.

SEC. 203. FUNDING PROVISIONS.

Not more than $3,600,000 may be made available for grants for Cooper Hall and not more than $1,500,000 may be made available for grants for Science Hall under this title.".

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. FORD. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet at 2 p.m. on Wednesday, August 10, 1994, in open session, to consider the following pending nominations: Mr. Walter B. Slocombe, to be Under Secretary of Defense for Policy; Mr. Jan M. Lodal, to be Deputy Under Secretary of Defense for Policy; Dr. Joseph S. Nye, Jr., To be Assistant Secretary of Defense for International Security Affairs; Ms. Sandra K. Stuart, to be Assistant Secretary of Defense for Legislative Affairs; Ms. Judith A. Miller, to be General Counsel, Department of Defense; and Mr. Philip Edward Coyle III, to be Director of Operational Test and Evaluation, Department of Defense.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. FORD. Mr. President, I ask unanimous consent that the Committee on Foreign Relations, be authorized to meet during the session of the Senate on Wednesday, August 10, at 2 p.m. to hold nomination hearings on Richard Holbrooke to be Assistant Secretary for European and Canadian Affairs; Eileen Malloy, to be Ambassador to the Kyrgyz Republic; and James W. Swihart, Jr., to be Ambassador to the Republic of Lithuania.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. FORD. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet on Wednesday, August 10, 1994, beginning at 2 p.m. in 216 Hart Senate Office Building to consider for report to the Senate S. 2036, the Indian Self-Determination Contract Reform Act of 1994; S. 2150, the Native Hawaiian Housing Assistance Act of 1994; S. 2259, the Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act; S. 2269, the Native American Cultural Protection and Free Exercise of Religion Act of 1994; S. 2329, the Mohegan Nation of Connecticut Land Claims Settlement Act; H.R. 4228, the Auburn Indian Restoration Act; and, for other purpose to be followed immediately by confirmation hearings for Harold Monteau to serve as the Chairman of the National Indian Gaming Commission and Gary Kimble to serve as the Commissioner for the Administration for Native Americans.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON SMALL BUSINESS

Mr. FORD. Mr. President, I ask unanimous consent that the Small Business Committee be authorized to meet during the session of the Senate on Wednesday, August 10, 1994, at 1:30 p.m. The committee will hold a full committee mark-up of S. 2060, the Small Business Administration Reauthorization and Amendment Act of 1994.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. FORD. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Wednesday, August 10, 1994, at 10:30 a.m. to hold a closed hearing on intelligence matters.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

TRIBUTE TO GRETCHEN WAGGY, NATIONAL NAVAL SCIENCE AWARD WINNER

• Mr. ROCKEFELLER. Mr. President, at this time, I would like to recognize an outstanding West Virginian for becoming a National Naval Science Award winner. Miss Gretchen Waggy of Franklin, WV, was 1 of 25 science students selected by the Navy to receive an all-expense paid, 12-day science-oriented trip to San Diego, CA.

The Naval Science Awards Program, which is administered by the Chief of Naval Research, has been in existence for 36 years. For the past 18 years, the top winners across the Nation have been invited to submit scientific and engineering project abstracts to the Naval National Science Award Competition.

In the spring of 1994, approximately 400 regional and State science fairs were held and several first place winners were chosen to advance in the awards competition. These winners received an invitation to submit their project abstracts before a panel of judges. Miss Waggy's project was selected from among nearly 600 finalists.

Her project examined the territory of eastern box turtles. By using radio transmitters, Gretchen mapped the range of the individual turtles. Through her project we are able to understand the natural habitat of this species.

Miss Waggy exemplifies the true West Virginia spirit of hard work, dedication, and participation. These attributes enable her to be a winner and will ensure her future success. She has distinguished herself as a member of a special group of America's youth, who will be the leaders of tomorrow.

It is with great pride and pleasure that I share her accomplishments with each of you today. Outstanding students deserve our recognition and encouragement to continue their high level of achievement.•

ANCIENT WATER WOES LOOM IN THE MIDEAST

• Mr. SIMON. Mr. President, recently, our former colleague, Tim Wirth, now Under Secretary of State for Global Affairs, sent me a copy of an article by Holger Jensen from the Washington Times titled, "Ancient water woes loom in the Mideast."

Since Mr. Jensen is international editor of the Rocky Mountain News in

Denver, I assume the article may have originally appeared in that newspaper.

It outlines, in brief, some of the water problems in the Middle East.

It is of more than casual interest that Ben-Gurion University in Beer-Sheva, Israel was asked by the United Nations to take a look at the water situation in the Middle East, and they came back with a study that says that short-term various answers can be found, but, long-term, the Middle East will have to rely on desalinated water from the ocean.

That is why the bill that passed the Senate recently, that I had the honor to be the chief sponsor of, calling for increased research on converting salt water to fresh water at less expense, is so important.

I ask to insert Mr. Jensen's observations into the RECORD at this point.

The article follows:

[From the Washington Times, July 29, 1994]

ANCIENT WATER WOES LOOM IN THE MIDEAST

(By Holger Jensen)

The handshake in Washington between Jordan's King Hussein and Israeli Prime Minister Yitzhak Rabin is another milestone on the road to Middle East peace, though the two countries have had secret contacts for years.

It puts added pressure on Syria to stop stalling and end its state of belligerence with Israel. And it further isolates Iraq—Saddam Hussein cannot be happy that his most important Gulf war ally, and sanctions busting neighbor, is back in the American camp.

Much of the groundwork for the Hussein-Rabin summit was laid at negotiations last week in an air-conditioned tent straddling the border between Israel and Jordan. And one incident there illustrated that not all their problems will be easily solved.

Munther Haddadin, a senior Jordanian delegate, refused to eat lunch provided by the Israelis because it contained vegetables he claimed were irrigated with Jordanian water. He flatly said "no" to the Israeli food and admonished others who ate it.

Water, or rather the lack of it, has caused more conflict in the arid Middle East than religion, oil or the quest for a Palestinian homeland. Water-stressed countries have traditionally taken up arms to capture neighboring oases, and every peace agreement in the region requires provisions for water-sharing.

The Code of Hammurabi, written in 1790 BC, contains among other things the world's first known water-sharing agreement in ancient Sumeria. The Arab-Israeli peace talks that began in Madrid two years ago created a working group on water resources. And the peace pact Israel signed with the PLO also addresses water rights.

Unfortunately, few disputes have been resolved so far. Peter Gleick, a water expert with the Pacific Institute for Studies in Development, Environment and Security in Oakland, Calif., warned Congress recently that there had been "a depressing lack of progress" in this arena, "which contains the seeds of another war."

At present, Israel gets two-thirds of its water from the occupied territories. So much of the Jordan River has been diverted, it is a trickle by the time it reaches the Red Sea. Now the Israelis are drilling deep into the underground aquifers beneath the West Bank, piping away the lifeblood of what will one day become a Palestinian state.

The same is happening on the Mediterranean coast. Overpumping has so depleted aquifers beneath the Gaza Strip, all the well water there is brackish and nearly unfit for human consumption.

In June, the U.N. Economic and Social Commission for Western Asia issued a report harshly criticizing Israel for stealing water from the Arabs. It named Lebanon, the West Bank, Gaza and the Golan Heights as being the chief victims of a "continued and abnormal increase in Israeli consumption."

The outlook is not all bleak, however. Normalization of ties between Israel and Jordan may revive an ambitious scheme—mothballed by Arab opposition a decade ago—to build opposition a decade ago—to build three canals from the Red Sea and the Mediterranean to the Dead Sea.

The Dead Sea, shared by Jordan and Israel, is actually a great lake lying 1,320 feet beneath sea level. The drop in elevation could generate enough electricity to run massive desalinization plants that would produce more than half the fresh water consumed by both Israelis and Palestinians.

Italy has offered to fund a feasibility study for one or the canals and the World Bank is willing to underwrite part of the $5.5 billion cost. Anything that removes water from the list of things to fight over will be worth the price.•

NOTICE OF DETERMINATION BY THE SELECT COMMITTEE ON ETHICS UNDER RULE 35, PARAGRAPH 4, REGARDING EDUCATIONAL TRAVEL

• Mr. BRYAN. Mr. President, it is required by paragraph 4 of rule 35 that I place in the CONGRESSIONAL RECORD notices of Senate employees who participate in programs, the principal objective of which is educational, sponsored by a foreign government or a foreign educational or charitable organization involving travel to a foreign country paid for by that foreign government or organization.

The select committee received notification under rule 35 for Elizabeth Lambird, a member of the staff of Senator HELMS, to participate in a program in Taiwan sponsored by the Chinese Culture University from August 29 to September 5, 1994.

The committee determined that no Federal statute or Senate rule would prohibit participation by Ms. Lambird in this program.

The select committee received notification under rule 35 for Mary Irace, a member of the staff of Mr. KWEISI MFUME, to participate in a program in Vienna, sponsored by the Austrian Federal Economic Chamber from August 27 to September 2, 1994.

The committee determined that no Federal statute or Senate rule would prohibit participation by Ms. Irace in this program.

The select committee received notification under rule 35 for Phil Thoden, a member of the staff of Senator COATS, to participate in a program in Taiwan, sponsored by the Chung Yuan Christian University from August 22–29, 1994.

The committee determined that no Federal statute or Senate rule would prohibit participation by Mr. Thoden in this program.

The select committee received notification under rule 35 for Michael G. Harper, a member of the staff of Senator KASSEBAUM, to participate in a program in China, sponsored by the Chinese People's Institute of Foreign Affairs from August 20 to September 6, 1994.

The committee determined that no Federal statute or Senate rule would prohibit participation by Mr. Harper in this program.

The select committee received notification under rule 35 for Katherine Brunett, a member of the staff of Senator SIMPSON, to participate in a program in Singapore, sponsored by the Singapore International Foundation from August 28 to September 3, 1994.

The committee determined that no Federal statute or Senate rule would prohibit participation by Ms. Brunett in this program.

The select committee received notification under rule 35 for Brad Figel, a member of the staff of Senator PACKWOOD, to participate in a program in Hong Kong, sponsored by the Hong Kong General Chamber of Commerce from August 29 to September 5, 1994.

The committee determined that no Federal statute or Senate rule would prohibit participation by Mr. Figel in this program.•

MESSAGES FROM THE HOUSE

Mr. FORD. Mr. President, I ask unanimous consent it be in order for the Chair to lay before the Senate en bloc messages from the House on the following concurrent resolutions: S. Con. Res. 38, 39, 40, and 41; that the Senate proceed en bloc to their immediate consideration; that the Senate concur en bloc in the House amendments to the concurrent resolutions; that the motions to reconsider be laid upon the table en bloc; and that the consideration of these items appear individually in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

"THE U.S. CAPITOL: A BRIEF ARCHITECTURAL HISTORY"—MESSAGE FROM THE HOUSE

The PRESIDING OFFICER laid before the Senate the following message from the House of Representatives:

Resolved, That the resolution from the Senate (S. Con. Res. 38) entitled "Concurrent resolution to authorize the reprinting of the book entitled 'The United States Capitol: A Brief Architectural History'", do pass with the following amendments:

Page 1, strike out line 10, and all that follows through page 2, line 2, and insert:

SEC. 3. In addition to the usual number, there shall be printed, for the use of the Commission on the Bicentennial of the United States Capitol, the lesser of—

(1) 56,500 copies of the document; or

(2) such number of copies of the document as does not exceed a total production and printing cost of $69,206.

Amend the title so as to read: "Concurrent resolution authorizing the printing of the book entitled 'The United States Capitol: A Brief Architectural History'.".

So the Senate concurred in the amendments of the House.

"HISTORY OF THE U.S. CAPITOL"—MESSAGE FROM THE HOUSE

The PRESIDING OFFICER laid before the Senate the following message from the House of Representatives:

Resolved, That the resolution from the Senate (S. Con. Res. 39) entitled "Concurrent resolution to authorize the printing of a new annotated edition of Glenn Brown's 'History of the United States Capitol', originally published in two volumes in 1990 and 1903, prepared under the auspices of the Architect of the Capitol", do pass with the following amendments:

Page 1, line 3, strike out "entitled" and all that follows through "as" on line 4, and insert: *entitled "History of the United States Capitol", by Glenn Brown, as*

Page 1, strike out line 12 and all that follows through page 2, line 2, and insert:

SEC. 3. In addition to the usual number, there shall be printed, for the use of the Senate and the House of Representatives, the lesser of—

(1) 6,500 copies of the document, to be allocated as determined jointly by the Secretary of the Senate and the Clerk of the House of Representatives; or

(2) such number of copies of the document as does not exceed a total production and printing cost of $112,265, with distribution to be allocated as described in paragraph (1).

Amend the title so as to read: "Concurrent resolution authorizing the printing of the book entitled 'History of the United States Capitol'.".

So the Senate concurred in the amendments of the House.

PRINTING OF "CONSTANTINO BRUMIDI: ARTIST OF THE CAPITOL"—MESSAGE FROM THE HOUSE

The PRESIDING OFFICER laid before the Senate the following message from the House of Representatives:

Resolved, That the resolution from the Senate (S. Con. Res. 40) entitled "Concurrent resolution to authorize the printing of the book entitled 'Constantino Brumidi: Artist of the Capitol', prepared by the Office of the Architect of the Capitol", do pass with the following amendments:

Page 1, strike out lines 10 through 15, and all that follows through page 2, line 2, and insert:

SEC. 3. In addition to the usual number, there shall be printed, for the use of the Senate and the House of Representatives, the lesser of—

(1) 15,000 copies of the document, to be allocated as determined jointly by the Secretary of the Senate and the Clerk of the House of Representatives; or

(2) such number of copies of the document as does not exceed a total production and printing cost of $55,489, with distribution to be allocated as described in paragraph (1).

Amend the title so as to read: "Concurrent resolution authorizing the printing of the book entitled 'Constantino Brumidi: Artist of the Capitol'."

So the Senate concurred in the amendments of the House.

"THE CORNERSTONES OF THE U.S. CAPITOL"—MESSAGE FROM THE HOUSE

The PRESIDING OFFICER laid before the Senate the following message from the House of Representatives:

Resolved, That the resolution from the Senate (S. Con. Res. 41) entitled "Concurrent resolution to authorize the printing of the book entitled 'The Cornerstones of the United States Capitol'", do pass with the following amendments:

Page 1, strike out line 10, and all that follows through page 2, line 2, and insert:

SEC. 3. In addition to the usual number, there shall be printed, for the use of the Commission on the Bicentennial of the United States Capitol, the lesser of—

(1) 50,000 copies of the document; or

(2) such number of copies of the document as does not exceed a total production and printing cost of $59,697.

Amend the title so as to read: "Concurrent resolution authorizing the printing of the book entitled 'The Cornerstones of the United States Capitol'.".

So the Senate concurred in the amendments of the House.

PRINTING OF RICHARD M. NIXON EULOGIES AND ENCOMIUMS

Mr. FORD. Mr. President, I ask unanimous consent that Rules Committee be discharged from further consideration of H. Con. Res. 248, a concurrent resolution providing for the printing of the eulogies of the late President of the United States, Richard M. Nixon; that the concurrent resolution be agreed to; that the motion to reconsider be laid upon the table; and that any statements relating thereto appear in the RECORD at the appropriate place.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 248) was agreed to.

EXECUTIVE CALENDAR

Mr. FORD. Mr. President, as if in executive session, I ask unanimous consent that on Thursday, August 11, following disposition of the DOD appropriations bill, the Senate proceed to executive session to consider the nomination of Janet L. Yellen to be a Member of the Board of Governors of the Federal Reserve System (Ex. Cal. 1117); that there be 45 minutes for debate on the nomination to be divided as follows: 15 minutes under the control of the chairman of the Committee on Banking, Housing and Urban Affairs, or his designee; 15 minutes under the control of the ranking member or his designee; and 15 minutes under the control of the Senator from North Dakota [Mr. DORGAN]; that when time is used or yielded back, the Senate, without any intervening action, vote on the nomination; that if confirmed, the motion to reconsider be tabled and the President be immediately notified of the Senate's action; and that the Senate then return to legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURE PLACED ON CALENDAR—H.R. 4653

Mr. FORD. Mr. President, I ask unanimous consent that H.R. 4653, relating to the Mohegan Nation of the Connecticut land claims, just received from the House, be placed on the calendar.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURE PLACED ON CALENDAR—H.R. 4455

Mr. FORD. Mr. President, I ask unanimous consent that H.R. 4455, a bill relating to the Export-Import Bank, just received from the House, be placed on the calendar.

FEDERAL EMERGENCY FOOD AND SHELTER PROGRAM

Mr. FORD. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 544, S. 2218, a bill to authorize appropriations for the Federal Emergency Food and Shelter Program, that the bill be deemed read the third time, passed, and the motion to reconsider laid upon the table, that any statements relating to this item be placed in the RECORD at the appropriate place as if read.

The PRESIDING OFFICER. Without objection, it is so ordered.

So the bill (S. 2218) was deemed read the third time, and passed, as follows:

S. 2218

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. AUTHORIZATION OF APPROPRIATIONS.

Section 322 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11352) is amended to read as follows:

"SEC. 322. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated to carry out this title $187,560,000 for each of fiscal years 1995 and 1996.".

HOUSE JOINT RESOLUTION 175—"ITALIAN-AMERICAN HERITAGE AND CULTURE MONTH"

HOUSE JOINT RESOLUTION 131—"NATIONAL PEARL HARBOR REMEMBRANCE DAY"

Mr. FORD. Mr. President, I ask unanimous consent that the Senate proceed, en bloc, to the immediate consideration of House Joint Resolution 175, House Joint Resolution 131, just received from the House; that the joint resolutions be deemed read the third time, passed, and the motion to reconsider be laid upon the table, en bloc, and that the consideration of these items appear separately in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

So the joint resolutions (H.J. Res. 175 and H.J. Res. 131) were deemed read the third time, and passed.

PRESIDENT JOHN F. KENNEDY ASSASSINATION RECORDS COLLECTION EXTENSION ACT

Mr. FORD. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of calendar No. 538, H.R. 4569, a bill to extend the John F. Kennedy Assassination Records Collection Act of 1992; that the committee amendments be agreed to, and the bill, as amended, be deemed read the third time, passed, the motion to reconsider be laid on the table, that any statements relating to this item be placed in the RECORD at the appropriate place as if read.

The PRESIDING OFFICER. Without objection, it is so ordered.

The committee amendments were agreed to.

So the bill (H.R. 4569), as amended, was deemed read the third time, and passed.

HISTORICALLY BLACK COLLEGES AND UNIVERSITIES HISTORIC BUILDING RESTORATION AND PRESERVATION ACT

Mr. FORD. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of calendar No. 450, H.R. 2921, a bill relating to the preservation of the historically black colleges and universities and that the committee amendments be agreed to.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senate proceeded to consider the bill (H.R. 2921) to authorize appropriations for the preservation and restoration of historic buildings at historically Black colleges and universities, which had been reported from the Committee on Energy and Natural Resources, with amendments; as follows:

(The parts of the bill intended to be stricken are shown in boldface brackets and the parts of the bill intended to be inserted are shown in italic.)

H.R. 2921

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Historically Black Colleges and Universities Historic Building Restoration and Preservation Act".

SEC. 2. FINDINGS.

Congress finds that—

(1) the Nation's historically black colleges and universities have contributed significantly to the effort to attain equal opportunity through postsecondary education for African-American, low-income, and educationally disadvantaged Americans;

(2) over our Nation's history, States and the Federal Government have discriminated in the allocation of land and financial resources to support these institutions, thus forcing them to rely on the generous support of private individuals and other charitable organizations;

(3) the development of this source of private and charitable financial support for historically black colleges and universities has resulted in structures and buildings of historic importance and architecturally unique design on the campuses of these institutions; and

(4) many of these structures and buildings are national treasures worthy of preservation and restoration for future generations of all Americans as well as for the students and faculty of these institutions.

SEC. 3. PRESERVATION AND RESTORATION GRANTS FOR HISTORIC BUILDINGS AT HISTORICALLY BLACK COLLEGES AND UNIVERSITIES.

[(a) AUTHORITY TO MAKE GRANTS.—From the amounts made available to carry out the National Historic Preservation Act for the fiscal years 1995 through 1998, the Secretary of the Interior shall make grants in accordance with this section to eligible historically black colleges and universities for the preservation and restoration of historic buildings and structures on the campus of these institutions.**]**

(a) AUTHORITY TO MAKE GRANTS.—The Secretary of the Interior shall administer a program of grants-in-aid in accordance with this section to eligible historically black colleges and universities for the preservation and restoration of historic buildings and structures on the campuses of these institutions. Such grants shall be made, subject to the availability of appropriations therefore, from the amounts authorized to be appropriated to carry out the National Historic Preservation Act for the fiscal years 1995 through 1998.

(b) GRANT CONDITIONS.—Grants made under subsection (a) shall be subject to the condition that the grantee covenants, for the period of time specified by the Secretary, that—

(1) no alteration will be made in the property with respect to which the grant is made without the concurrence of the Secretary; and

(2) reasonable public access to the property with respect to which the grant is made will be permitted by the grantee for interpretive and educational purposes.

(c) MATCHING REQUIREMENT FOR BUILDINGS AND STRUCTURES LISTED ON THE NATIONAL REGISTER OF HISTORIC PLACES.—(1) Except as provided by paragraph (2), the Secretary may obligate funds made available under this section for a grant with respect to a building or structure listed on the National Register of Historic Places only if the grantee agrees to match, from funds derived from non-Federal sources, the amount of the grant with an amount that is equal or greater than the grant.

(2) The Secretary may waive paragraph (1) with respect to a grant if the Secretary determines from circumstances that an extreme emergency exists or that such a waiver is in the public interest to assure the preservation of historically significant resources.

(d) FUNDING PROVISIONS.—(1) Not more than $20,000,000 for fiscal year 1995 and not more than $15,000,000 for each of the fiscal years 1996, 1997, and 1998 may be made available under this section.

(2) Of the amounts made available under this section for fiscal year 1995, $5,000,000 shall be available only for grants under subsection (a) to Fisk University.

(3) Of the amounts made available under this section for fiscal year 1995, $10,000,000 shall be available only for grants under subsection (a) to those historically black colleges and universities identified for inclusion in the Department of the Interior Historically Black College and University Historic Preservation Initiative.

(4) If less than $20 million is made available in fiscal year 1995 for the purpose of paragraph (1), such amount shall be allocated as follows:

(A) 25 percent of such amount shall be made available for grants to Fisk University as provided in paragraph (2).

(B) 50 percent of such amount shall be made available as provided in paragraphs (3).

(C) 25 percent of such amount shall be made available for grants under subsection (a) to other eligible historically black colleges and universities.

(e) REGULATIONS.—The Secretary shall promulgate such regulations as may be necessary to carry out this Act.

SEC. 4. DEFINITIONS.

For the purposes of this Act:

(1) The term "historically black colleges and universities" has the same meaning given the term "part B institution" by section 322 of the Higher Education Act of 1965 (20 U.S.C. 1061).

(2) The term "historic building and structures" means a building or structure listed on the National Register of Historic Places or designated a National Historic Landmark.

The committee amendments were agreed to.

AMENDMENT NO. 2550

(Purpose: To authorize grants to assist in the restoration and preservation of Cooper Hall at Sterling College in Sterling, Kansas and Science Hall at Simpson College in Indianola, Iowa)

Mr. BENNETT. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Utah [Mr. BENNETT], for Mr. DOLE, for himself and Mr. GRASSLEY, proposes an amendment numbered 2550.

Mr. BENNETT. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 1, after line 2, insert the following: "TITLE I—HISTORICALLY BLACK COLLEGES AND UNIVERSITIES HISTORIC BUILDING RESTORATION AND PRESERVATION.".

On page 1, line 3, strike "SECTION 1." and insert in lieu thereof "SECTION 101." and redesignate the following sections accordingly.

On page 1, line 4, strike "Act" and insert in lieu thereof "title".

On page 5, line 23, strike "Act" and insert in lieu thereof 'title'.

On page 5, line 25, strike "Act" and insert in lieu thereof "title".

On page 6, after line 8, insert the following new title:

"TITLE II—COOPER HALL AND SCIENCE HALL PRESERVATION AND RESTORATION.

"SEC. 201. AUTHORITY TO MAKE GRANTS.

The Secretary of the Interior (hereinafter in this title referred to as the "Secretary") is authorized to make grants in accordance with this title to preserve and restore Cooper Hall at Sterling College located in Sterling, Kansas and Science Hall at Simpson College located in Indianola, Iowa. Such grants shall be made, subject to the availability of appropriations therefore, from the amounts authorized to be appropriated to carry out the National Historic Preservation Act.

"SEC. 202. MATCHING REQUIREMENT.

The Secretary may obligate funds made available under this title only if the grantees agrees to match, from funds derived from non-Federal sources, the amount of the grant with an amount that is equal or greater than the grant.

"SEC. 203. FUNDING PROVISIONS.

Not more than $3,600,000 may be made available for grants for Cooper Hall and not more than $1,500,000 may be made available for grants for Science Hall under this title.".

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 2550) was agreed to.

Mr. BENNETT. Mr. President, I move to reconsider the vote.

Mr. FORD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Are there further amendments?

If not, the bill is considered read the third time and passed.

So the bill (H.R. 2921), as amended, was agreed to, and passed.

Mr. BENNETT. Mr. President, I move to reconsider the vote.

Mr. FORD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. DASCHLE. Mr. President, I ask unanimous consent to speak as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. DASCHLE. Mr. President, I know the hour is late, but I have not yet had the opportunity to make opening comments on the health reform debate.

It is with great anticipation that we begin this debate. It has been stated already that this is a historic occasion, in part, because it is the first time that a bill of this magnitude has reached the floor of the U.S. Senate. Never before has health reform legislation been this close to enactment.

I think it is safe to say that for many of us the vote on health reform will be the most important vote that we may cast on any domestic issue.

I must say I admire the President and the First Lady, for their dedication, their deep commitment, and their leadership on this issue. The White House staff and all of those who assisted the President and the First Lady in bringing the bill to the floor also share their dedication.

And as others have done, I commend the senior Senator from Massachusetts for his remarkable dedication to health reform over the past 25 years, and the majority leader for his tenacity, and his willingness to compromise as he crafted this health reform bill.

Finally, of course, I commend the chairman of the Finance Committee for the work that he has done to bring us to this point in the process. This legislation has been 2 years in the making, Mr. President, it represents 2 years of effort, 2 years of consultation, 2 years of hearings, meetings, committee deliberation, debate, and discussion.

But it is not just for the last 24 months that we have been consumed with this issue. The debate goes back 40 times in 24 months, back to the turn of the century, back to Teddy Roosevelt's time. Teddy Roosevelt may have been the first President to propose a national solution for American health care. He reminded us then—and I think it is as appropriate today as it was at the turn of the century—that the measure of the quality of a society is how it treats those in the dawn of life, the young; in the twilight of life, the old; and in the shadow of life, the sick. For 80 years that test has stood. For 80 years I think we could have measured our progress as a society by how well we met his test.

In the 1930's we began to recognize that we needed to treat those in the twilight of life, and we passed the most extraordinary piece of social legislation in history, the Social Security Program. In the 1960's, we saw another historic moment with the passage of Medicare. And over the decades we have recognized the need to help the youngest Americans with passage of the Women, Infants and Children Program, school lunches, immunization programs, and enhanced access to prenatal care. We enacted these programs with the recognition that this society will be judged by how we treat the youngest.

But it is those in the shadow of life, those who are sick, who today are the subject of countless stories of misfortune, neglect, and despair. It is those in the shadow of life who have not been given the opportunities that we have afforded others. We hear their voices in this debate. We see them in the halls as they petition us for help. We remember them long after our debates because of their tragic accounts of life in America without health insurance.

For six decades this country has grappled with solutions to this problem. Franklin Roosevelt recognized the problem in the 1930's and proposed what he called the "Second Bill of Rights" for America. He called for "The right to adequate medical care and opportunity to achieve and enjoy fundamental good health." He called health care a right, not a privilege.

And Harry Truman, his successor, was the first to recommend comprehensive health care reform. Harry Truman in a proposal to Congress said:

> The health of the American people must ever be safeguarded: it must be improved. As long as people are stricken by a disease which we have the ability to prevent, as long as people are chained by a disability which can be reversed, as long as needless death takes a toll, then American health will be unfinished business.

Little did he know how long the business would be unfinished, because in virtually every decade of this century, especially those following President Truman's reign, Presidents have tried but failed to reform our health care system. They failed not because of a lack of effort and not because of opposition from the American people. These efforts failed, Mr. President, one by one, because of the orchestrated opposition of powerful special interests who simply fear change. The major exception, of course, was the fight for Medicare and Medicaid 30 years ago.

The fight for Medicare, frankly, is instructive. President Kennedy, referring to the criticism that he had to confront, said very simply: These are the same arguments that they used against Social Security at the time of Franklin Roosevelt. We overcame them then. We ought to overcome them now.

That was President Kennedy's advice to Congress in the 1960's. That has, frankly, been President Clinton's advice to this Congress. We overcame the opposition then. We understood the ramifications of failure then. And we recognized that we had an opportunity to improve the quality of life, not only for those in the shadow of life, not only for those in the twilight of life, not only for those who so desperately cried out for help today, but for all Americans.

Because back then we heard some of the same criticisms leveled today in the health reform debate. Back in 1963, a Congressman from California said of Medicare, "Let me tell you here and now this is socialized medicine." A Senator from the Midwest said, "The cold, hard facts are simply that we cannot afford costly and unnecessary health care now or ever."

Decade after decade on the Senate floor we have heard the same naysaying, the same speeches, the same criticisms, the same excuses for why we must stay paralyzed. Opponents of reform use the same recycled arguments. They call health reform socialized medicine though real socialized systems spend half of what we spend on health care. "Too costly," we are told, while our health costs have doubled in the last 10 years. "It will cost jobs," we are told, while businesses now must choose between salaries and premiums.

I had a hope this year, Mr. President, that somehow it would be different. Now, because the problems which were bad before are even worse now and the overwhelming consensus across America is that we need comprehensive change. 80 percent of the American people support universal coverage, 65 percent of the American people support shared responsibility, 70 percent of all the people in this country today want real insurance reform. Yet some, particularly the special interests who now feel threatened, want this to be business as usual.

I was disappointed, frankly, with some of the Republican strategists. One of those who was most visible, most aggressive in his criticism, most determined to obfuscate the Democratic approaches is Bill Kristol.

In a recent report to his colleagues on the Republican side, Mr. Kristol said: "Sight unseen, the Republicans should oppose it. The appropriate Republican response is to take the noble road of opposing any alternative that Democrats offer and insist on starting over in 1995. We should do so with pride and not a speck of guilt. We should send them to the voters emptyhanded."

On October 28, 1993, Mr. Kristol's recommendation to the Republicans on the Clinton plan was: "Kill it. We don't want to wound the plan; we want to kill it. We don't want to confuse matters or weaken the cause by debating whether aspects of the Clinton plan will work or not."

In December of 1993, he added: "Any Republican urged to negotiate a less bad compromise with the Democrats and thereby gain momentary public credit for helping the President do something about health care should be resisted. Republicans must recognize the policy and tactical risk involved in near-term advocacy of sweeping change, however right it may be in principle."

And finally, on March 22 of this year, he urged Republicans that they should "not now or ever seek to work together with this President."

Mr. President, I have great admiration for those who have confronted Mr. Kristol, for those on both sides of the aisle who have said this is not the way to solve problems; this is not the bipartisan approach we all say we want.

And of all of those for whom I have admiration, perhaps the majority leader ranks at the top of the list, because of his determined effort to reach out. In spite of the attitude expressed by Mr. Kristol and others, the majority leader has made a remarkable effort in recent weeks and, frankly, to this very day, continues to do so.

But I have noted with great frustration that every time we move an inch their way, they move 2 inches away, finding fault, encouraging delay, and pressing partisanship.

When I first arrived in 1979, I was deeply affected by a man for whom I have had incredible admiration and respect, a man that I considered a mentor for many years, Congressman Claude Pepper of Florida.

I remember a wonderful conversation I had with Senator Pepper in the early 1980's, when he said: "Tom, we really ought not look at people once they get here as Democrats or Republicans. As hardcore a Democrat as I am, I think we really ought to look at people as constructive or destructive—C's or D's, not R's or D's."

He said, "All to often, I see people who do things for short-term political gain, and they have an incredible destructive power to change the course of good in Washington. But then I see the constructives, who continue to reach out and build bridges, who recognize the short time we are here and the opportunities we have to make things better. I hope you will be a constructive."

I have thought about that a lot during this health care debate. If ever there was a time for constructive leadership, if ever there was a time to reach out and build bridges, this is it.

I remember a conversation I had just in the past couple of months with a South Dakotan. We talked for about a half hour. As I was walking away, he said, "Tom, prove to me you can govern. Prove to me that Democrats and Republicans can put it all aside, recognize the problems we are facing in health care, and govern."

It is not just a question of whether we are going to achieve meaningful health care reform this year. In my view, Mr. President, it is a test of our ability to govern, a test of whether we are going to learn from history.

In the next 2 weeks, I am absolutely determined that we pass a health reform bill that achieves universal coverage, that achieves meaningful cost containment, that achieves real access in rural and urban America. And I am absolutely convinced that this will be the last time this century that we have the opportunity to pass comprehensive health care reform—the last time.

These may be the 2 most important weeks many of us will ever serve. Let us use them wisely to pass real reform—not as Democrats, not as Republicans, but as Americans who recognize, as Teddy Roosevelt said, that we will be judged by how we treat those in the dawn of life, the twilight of life, the shadow of life.

Improving the quality of our society and the opportunities that all Americans have is what this debate is all about.

I yield the floor.

ORDERS FOR TOMORROW

Mr. DASCHLE. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand adjourned until 9:30 a.m., Thursday, August 11; that when the Senate reconvenes on that day, the Journal of proceedings be deemed to have been approved to date, the call of the calendar be waived, and no motions or resolutions come over under the rule; that the morning hour be deemed to have expired; that the time for two leaders be reserved for their use later in the day; and that immediately thereafter, the previous order regarding consideration of S. 2351 be executed; provided further, that the remaining provisions of that previous order remain in effect.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL TOMORROW AT 9:30 A.M.

Mr. DASCHLE. Mr. President, if there is no further business to come before the Senate today, I now move that the Senate stand adjourned, as previously ordered.

The motion was agreed to; and the Senate, at 10:37 p.m., adjourned until Thursday, August 11, 1994, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate August 10, 1994:

AMTRAK

THOMAS R. CARPER, OF DELAWARE, TO BE A MEMBER OF THE AMTRAK BOARD OF DIRECTORS FOR A TERM OF 4 YEARS, VICE TOMMY G. THOMPSON, TERM EXPIRED.

DEPARTMENT OF STATE

ROBERT L. GALLUCCI, OF VIRGINIA, A CAREER MEMBER OF THE SENIOR EXECUTIVE SERVICE, TO BE AMBASSADOR AT LARGE.

DEPARTMENT OF JUSTICE

EDDIE J. JORDAN, JR., OF LOUISIANA, TO BE U.S. ATTORNEY FOR THE EASTERN DISTRICT OF LOUISIANA FOR THE TERM OF 4 YEARS VICE HARRY A. ROSENBERG, RESIGNED.

IN THE ARMY

THE FOLLOWING NAMED OFFICERS, ON THE ACTIVE DUTY LIST, FOR PROMOTION TO THE GRADE INDICATED IN THE U.S. ARMY IN ACCORDANCE WITH SECTION 624, TITLE 10, UNITED STATES CODE. THE OFFICERS INDICATED BY ASTERISK ARE ALSO NOMINATED FOR APPOINTMENT IN THE REGULAR ARMY IN ACCORDANCE WITH SECTION 531, TITLE 10, UNITED STATES CODE:

DENTAL CORPS

To be major

*CURTIS G. ABATE, [redacted]
*WILLIAM P. BAKER, [redacted]
*FRANKLIN S. BONASSO, [redacted]
*RICHARD L. BROWN, [redacted]
*STEVEN S. BYRD, [redacted]
*DUANE D. CALLAHAN, [redacted]
*JEFFREY D. COHEN, [redacted]
*GRIFFIN L. DEEN, [redacted]
*PATRICIA A. DUNGAN, [redacted]
*KIMBERLY C. ENGLISH, [redacted]
*JANA FRANCIS, [redacted]
*MATTHEW P. GAWORSKI, [redacted]
*GEORGE M. GIBSON, [redacted]
*MICHAEL E. GRADY, [redacted]
*WILLIAM T. GRASK, [redacted]
*ROBERT T. HALL, [redacted]
*MICHAEL P. HARRIS, [redacted]
*MICHAEL L. HEMKER, [redacted]
*CURTIS R. HENLEY, [redacted]
*SCOTT D. HERRMANN, [redacted]
*JAMES R. HONEY, [redacted]
*TERRY L. JOHNSON, [redacted]
*CHRISTOPHER JONES, [redacted]
*JOHN A. JUNGHANS, [redacted]
*DENNIS F. KELLY, [redacted]
*ERIN F. KIYUNA, [redacted]
*CHRISTOP LAURITZEN, [redacted]
*JOHNNY S. LEE, [redacted]
*CORNELIUS C. LEHAN, [redacted]

*HENRY W. MARCANTONI, [redacted]
*CHARLES MIDDLETON, [redacted]
*ERICH S. MOCK, [redacted]
*GREGORY M. MORGAN, [redacted]
*JOSEPH A. NARDE [redacted]
*RALPH W. OGILVIE [redacted]
*GINO A. ORLANDI, [redacted]
*DARIUS P. OSHIDAR, [redacted]
*PATRICIA H. PECK [redacted]
*KAREN M. PHILLIPS [redacted]
*SANDFORD W. PRINCE, [redacted]
*CUMMINGS SANTIAGO, [redacted]
*DONALD K. SCALES, [redacted]
*BRADLEY G. SHERN, [redacted]
*STEPHANIE J. SIDOW [redacted]
*GREGORY W. SILVER, [redacted]
*MICHAEL D. SIMS, [redacted]
*STEVEN R. WALLS [redacted]

MEDICAL CORPS

To be major

BRUCE D. ADAMS, [redacted]
*DOUGLAS W. ADAMS, [redacted]
*STEPHEN D. ADAMS [redacted]
*NADINE H. ALEX, [redacted]
*LARRY K. ANDREO, [redacted]
*RICHARD J. ANTAYA [redacted]
*CLINT W. ANTHONY, [redacted]
*MARC H. APPLEBAUM, [redacted]
*RICHARD L. ARMFIELD [redacted]
*WILLIAM F. ARNDT [redacted]
*CHERYL AYLESWORTH, [redacted]
*MICHAEL D. BAGG, [redacted]
*RICHARD L. BAILEY [redacted]
*EDWARD L. BALDWIN, [redacted]
*CINDY M. BARTER [redacted]
*DONALD S. BATTY [redacted]
*MARJORIE M. BEEBE [redacted]
*PAUL F. BELLIVEAU, [redacted]
*CHRISTOPHER BENSON, [redacted]
*VICTOR J. BERNET [redacted]
STEPHEN BERNSTEIN [redacted]
*REGINALD J. BLABER [redacted]
*SEAN M. BLAYDON, [redacted]
*PATRICA K. BONNER [redacted]
*CRAIG R. BOTTONI, [redacted]
MICHAEL R. BOWEN, [redacted]
*JOAN E. BOWES, [redacted]
DONALD J. BOWLING, [redacted]
JOHN C. BRADLEY, [redacted]
*RICHARD D. BRANTNER, [redacted]
*DEBRA S. BRESCAN, [redacted]
*KEVIN E. BRIGHT, [redacted]
*STEVEN E. BRILLIANT [redacted]
*BRUCE A. BRITTON, [redacted]
*JIMMY J. BROWN, [redacted]
*MICHAEL L. BROWN, [redacted]
*ROBERT S. BROWN, [redacted]
*WALLACE B. BRUCKER, [redacted]
ALAN D. BRUNS, [redacted]
CHESTE BUCKENMAIER, [redacted]
*WILLIAM J. BULLIS [redacted]
THOMAS F. BURKE, [redacted]
*J. CAMPAGNA, [redacted]
DAVID A. CANCELADA, [redacted]
*JEFFERS. CARTWRIGHT [redacted]
MATTHEW G. CARY, [redacted]
LAWRENCE M. CASHA, [redacted]
PAUL H. CASTELLO, [redacted]
MARY C. CHANG, [redacted]
*BARRETT L. CHAPIN [redacted]
JACK J. CHAVEZ [redacted]
*TARA L. CHRONISTER, [redacted]
DOUGLAS L. CLARK, [redacted]
*MARGARET L. CLARK, [redacted]
MARK E. CLYDE, [redacted]
*KYLE L. COLVIN, [redacted]
LESLIE M. CONE [redacted]
*MARCO COPPOLA, [redacted]
WILLIAM P. CORR, [redacted]
*DONNA M. CORVETTE, [redacted]
*TRINKA S. COSTER, [redacted]
KEVIN M. CREAMER, [redacted]
*ANDREW R. CUKIER, [redacted]
CHRISTINE A. CULLEN [redacted]
*DEIRDRE C. CURRAN, [redacted]
ROBERT C. DEAN, [redacted]
*THOMAS DEBERARDINO, [redacted]
SUSAN J. DEGUIDE [redacted]
*RONALD D. DEGUZMAN, [redacted]
EVERETT S. DEJONG [redacted]
*MARK H. DEPPER, [redacted]
*WILLIAM H. DEVRIES, [redacted]
*JOSEPH W. DOOLEY, [redacted]
*BRUCE M. DOPLER, [redacted]
*THOMAS H. DOUGLAS, [redacted]
*JAMES J. DOYLE [redacted]
PAUL DUCH, [redacted]
*WALTER J. DUFFY [redacted]
*CARY L. DUNN, [redacted]
JAN R. DUNN, [redacted]
ANDREW S. EISEMAN [redacted]
*STEPHEN M. ELKSNIS [redacted]
*AMY R. ELLINGSON, [redacted]
*VERMON S. ESPLIN [redacted]
*CARLOS R. ESQUIVEL [redacted]
*DAVID L. FACTOR, [redacted]
*JAMAL D. FARHAN, [redacted]
*WALTER P. FARRELL [redacted]
*JAMES M. FEELEY [redacted]
*PATRICK FERNICOLA, [redacted]
*DAVID R. FINGER [redacted]
*DANIEL R. FISK [redacted]
GRANT A. FOSTER, [redacted]
*KRISTIN FREESTONE [redacted]
DAVID M. FREY, [redacted]
*RENEE Y. FRIDAY, [redacted]
STEVEN P. FRIEDEL [redacted]
*SUSAN R. GAIRE, [redacted]
ROGER G. GANO, [redacted]
*KAREN L. GARRISON, [redacted]
*BRIAN A. GERACI, [redacted]
BRIAN J. GERONDALE, [redacted]
*SEAN D. GHIDELLA, [redacted]
*LYNDA S. GILLIAM, [redacted]
*KATHRYN A. GIZA, [redacted]
*KEVIN L. GLASS, [redacted]
*JAMES M. GOFF [redacted]
*THOMAS W. GOLDEN, [redacted]
*MICHAEL GOLDFINGER, [redacted]
BRIAN J. GOLDSMITH, [redacted]
*CARL GOOLSBY, JR., [redacted]
*ROBERT L. GORE, [redacted]
*MICHAEL P. GRANT, [redacted]
*VINCENT X. GRBACH, [redacted]
*SPENCER D. GREGG [redacted]
*WILLIAM G. GUTHEIM, [redacted]
*JOHN W. HAEBERLIN, [redacted]
*BRENT HAGEMEISTER [redacted]
JOHN B. HALLIGAN [redacted]
*ROBERT W. HANDY, [redacted]
CURTIS K. HANST, [redacted]
*ROBIN C. HARDIMAN, [redacted]
*EUGENE L. HARDIN [redacted]
*MICHAEL B. HARKINS, [redacted]
*DAVID J. HARRINGTON, [redacted]
*DAVID T. HARRINGTON, [redacted]
*MARK J. HARRISON, [redacted]
*PHILIP S. HARRY [redacted]
*ELEANOR R. HASTINGS, [redacted]
*JEFFREY S. HEIER [redacted]
*ANNA I. HEISSER, [redacted]
KEVIN S. HENNING, [redacted]
*JAMES M. HERROLD, [redacted]
*KEITH L. HIATT, [redacted]
*RICHARD B. HILBURN, [redacted]
JON A. HINMAN, [redacted]
*NATHAN J. HOELDTKE [redacted]
*BRADLEY W. HOOVER, [redacted]
*MILFORD HUFFNAGLE, [redacted]
CURTIS J. HUNTER [redacted]
LESLIE M. HUNTER [redacted]
MICHAEL A. HUOTT, [redacted]
LONNIE L. IMLAY, [redacted]
*RICHARD B. JACKSON, [redacted]
*SCOTT E. JACOBS, [redacted]
*TERESA W. JACQUES, [redacted]
*MARK J. JAREK [redacted]
*JOHN A. JIULIANO [redacted]
*CLYDE L. JOHNSON, [redacted]
*BLAINE R. JONES [redacted]
*BRYAN T. JONES [redacted]
*LAWRENCE H. JONES, [redacted]
*PAUL L. JONES [redacted]
*PAUL R. JONES, [redacted]
PERRY E. JONES [redacted]
*SCOTT A. JOSLIN [redacted]
*ARON M. JUDKIEWICZ, [redacted]
*OLAN B. KEMP, [redacted]
*JULIE R. KENNER [redacted]
*FRANCIS X. KILKELLY [redacted]
DAVID H. KIM, [redacted]
*LEROY K. KIM, [redacted]
*SUN KIM, [redacted]
*JEFFREY D. KIN [redacted]
*NICHOLAS A. KING, [redacted]
JEFFREY KINGSBURY [redacted]
*DAVID G. KLOCK, [redacted]
SARA W. KNUTSON, [redacted]
*ERIK J. KOBYLARZ [redacted]
*DEBRA A. KONTNY, [redacted]
*ARNOLDAS S. KUNGYS, [redacted]
*JOHN P. LACEY, [redacted]
*BEVERLY C. LAND, [redacted]
*JON D. LARSON, [redacted]
*KATHLEEN M. LAVIGNE [redacted]
*NANCY P. LAWLESS, [redacted]
*EDWARD J. LEGARE, [redacted]
*PETER M. LEHMANN [redacted]
*ROBERT A. LEIBOLD [redacted]
KEVIN L. LEWIS, [redacted]
*JULIANNE C. LIN [redacted]
*RICHARD K. LING, [redacted]
*J. D. LITTLETON [redacted]
*VINCENT A. LOMBARDI, [redacted]
DAVID LONGENECKER, [redacted]
*DOUGLAS J. LOUGHEAD, [redacted]
*THOMAS M. LOUGHNEY, [redacted]
*GLYNDA W. LUCAS, [redacted]
*DAVID P. LUX, [redacted]
*ANNE N. LYON, [redacted]
*ROBERT D. LYON, [redacted]
WILLIAM P. MAGDYCZ, [redacted]
*DAVID J. MALIS, [redacted]
*DANIEL MANSFIELD, [redacted]
CHRISTINA MANTHOS, [redacted]
*LINDA A. MARDEN [redacted]
*JENNIFER S. MARSDEN [redacted]
*ROBERT A. MASSA [redacted]
*KAREN L. MATHEWS, [redacted]
*PAUL R. MAYNARD, [redacted]
ROBERT A. MAZUR, [redacted]
*CHARLES E. MCBRIDE [redacted]
*MICHAEL J. MCCLURE, [redacted]
*BRIAN C. MCCORMICK, [redacted]
JOHN M. MCGRATH, [redacted]
*TRUDI K. MCGRATH [redacted]
*SCOTT T. MCGRAW, [redacted]
*NEAL P. MCNERNEY [redacted]
*JEFFREY J. METER [redacted]
DAVID C. MEYER, [redacted]
*ANNA MILLER, [redacted]
JOSEPH P. MILLER [redacted]
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*TODD V. PANARESE [redacted]
*JAMES E. PARKER [redacted]
*DWAYNE E. PATTERSON [redacted]
CHARLES E. PAYNE, [redacted]
*LEANDRO G. PENA, [redacted]
*RAYMOND F. PETERS, [redacted]
*CLARK E. PETERSEN [redacted]
*MYRON J. PETRUSKA, [redacted]
KAREN S. PHELPS [redacted]
*ROBERT M. PLEMMONS, [redacted]
*SANDY S. POPHAM, [redacted]
MARY E. PORISCH, [redacted]
*ROBERT O. POSCH [redacted]
*DAVID R. POWELL, [redacted]
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*VICKY L. RHOLL, [redacted]
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*CHRISTO RICHARDSON, [redacted]
*TROY K. RICHEY, [redacted]
*WILLIAM B. RICHMOND, [redacted]
*CLIFF A. ROBERTSON [redacted]
*THOMAS M. ROE, [redacted]
*PATRICIO ROSA, JR., [redacted]
*ELIZABETH A. ROSS, [redacted]
*SCOTT L. ROSSOW, [redacted]
*EUGENE H. RYAN [redacted]
*SHEILA E. RYAN, [redacted]
*GREGORY D. SAFFELL [redacted]
*KEITH L. SALZMAN, [redacted]
*SCOTT A. SAMPLE, [redacted]
*JEFFREY SAMUELSON [redacted]
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*JOHN D. SCHICK, [redacted]
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*CATHERINE SHAFFREY [redacted]
*STUHLDREHER SHAH [redacted]
*ELLEN G. SHAVER, [redacted]
*MARK E. SHAVES, [redacted]
*RICHARD J. SHEA, [redacted]
*ENID Q. SHEELEY [redacted]
*STUART D. SHELTON [redacted]
CYNTHIA H. SHIELDS, [redacted]
*MICHAEL E. SHIVERS, [redacted]
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*DANNY O. STENE, [redacted]
*DONNA L. STEWARD, [redacted]

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*DAVID M. SUHRBIER, [redacted]
*THERESA A. SULLIVAN [redacted]
*JAMES D. SWENSON, [redacted]
*RONALD SZYJKOWSKI, [redacted]
*PHILIP E. TANNER, [redacted]
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*PAULA R. TAYLOR, [redacted]
*PAUL J. TEIKEN [redacted]
*ANDREW H. TEKLINSKI, [redacted]
*LYLE R. TESKA [redacted]
*DAVE H. THACKER, [redacted]
*CAROL S. THOMAS, [redacted]
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*MARK W. THOMPSON, [redacted]
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*CAROLYN A. TIFFANY, [redacted]
*JOHN F. TIGHE [redacted]
*VICTOR A. TORANO, [redacted]
*GLENN M. UBER, [redacted]
*ROBERT T. UNDERHILL, [redacted]
*MONTE C. UYEMURA, [redacted]
*THERESA VANDERLINDE, [redacted]
*STEVEN C. VANSCOY, [redacted]
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*RICKY L. VISOR, [redacted]
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*JOHN R. WENDT, [redacted]
*LORI H. WERTHEIMER, [redacted]
*PAUL M. WEST, [redacted]
*ANTHONY L. WHEELER, [redacted]
MALCOLM A. WHITAKER, [redacted]
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*KEITH D. WILKEY, [redacted]
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MORGAN WILLIAMSON, [redacted]
*JAMES S. WILLIFORD [redacted]
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*LISA L. ZACHER, [redacted]
*KAREN E. ZAVADSKY, [redacted]
*DANIEL W. ZIMMERMAN, [redacted]
*DAVID M. ZLOTNICKI, [redacted]
*MIMI A. ZUMWALT, [redacted]
*ANTHONY ZYDLEWSKI, [redacted]

HOUSE OF REPRESENTATIVES—*Wednesday, August 10, 1994*

The House met at 10 a.m.

The Chaplain, Rev. James David Ford, D.D., offered the following prayer:

We are grateful, O God, for those to whom great responsibility has been given and from whom much is required. For leaders of our Nation who have been set aside with special obligations and duties, we offer this prayer of support and intercession. May they sense more fully than anyone the tasks of their office, the commitment toward justice, a fervor for doing the works of peace, a devotion to the neediest among us, and an appreciation to strengthen the resources of the land. May each of us sense our own obligation to be good stewards of the traditions given to us to do justice, to love mercy, and to walk humbly with You. Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER. The gentleman from Indiana [Mr. JACOBS] will lead us in the Pledge of Allegiance.

Mr. JACOBS led the Pledge of Allegiance as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Hallen, one of its clerks, announced that the Senate agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3474) "An Act to reduce administrative requirements for insured depository institutions to the extent consistent with safe and sound banking practices, to facilitate the establishment of community development financial institutions, and for other purposes.".

LIBERTY AND JUSTICE FOR ALL

(Mr. JACOBS asked and was given permission to address the House for 1 minute.)

Mr. JACOBS. Mr. Speaker, wow. Fifteen hours of questioning under hot lights—2 o'clock in the morning.

Oh, by the way, speaking of recusing oneself, if you were President, how would you like to be officially investigated by someone with no experience in investigation, and with prior demonstrated hostility toward you?

Character assassination by unprincipled partisans is one thing, and a reprehensible thing at that. But using the authority of the courts to stack the deck, compromises the meaning of the Constitution which is the underpinning of our mutual covenant of "liberty and justice for all."

Mr. Speaker, this new arrangement is not quite like the Spanish Inquisition about which Samuel Shellabarger wrote, "No one was too innocent to be proved guilty." Not quite. But close.

ONE THUMBS DOWN

(Mr. BALLENGER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BALLENGER. Mr. Speaker, the Congressional Budget Office took a look at the Clinton-Mitchell bill and gave it one thumbs down.

According to their estimates, the plan would add at least $9 billion to the national deficit. According to one news report, CBO "also found the plan would be difficult if not impossible for individual States to implement."

No wonder. This latest version would add 175 additional unfunded mandates to the States, who are already struggling under the weight of Federal mandates.

Throw in the 47 new Federal bureaucracies created in the Clinton-Mitchell bill and you have a recipe for Government-run health care. Mr. Speaker, there is a better way to health care reform. We should fix what is wrong with our health care system, without breaking what is right. I urge my colleagues to work in a bipartisan fashion to craft a commonsense solution to health care reform.

WILL KENNETH STARR BE FAIR-MINDED?

(Mr. TRAFICANT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. TRAFICANT. Mr. Speaker, Kenneth Starr is the new investigator of President Clinton and Whitewater. Will he be objective and fair-minded? Only time really will tell.

But one thing they know for sure is Kenneth Starr is a Republican. Kenneth Starr was appointed Solicitor General by a Republican President. Kenneth Starr has made a number of political contributions, in the thousands, all to Republican candidates, and all to the Republican Party.

We also know that Kenneth Starr got himself involved in a lawsuit involving the President and Paula Corbin Jones. He did so voluntarily, and Kenneth Starr has openly criticized President Clinton.

Is it is any wonder the Democrats believe that Kenneth Starr is a Republican hit man, appointed by Republican judges who were themselves appointed by a Republican President, Ronald Reagan? I do not know, but I find it hard to believe, Mr. Speaker, that in all of America there has only been one capable, fair-minded lawyer able to investigate Whitewater and Democrat President Bill Clinton, and that happens to be Kenneth Starr.

Beam me up.

WHITE HOUSE SHOULD NOT BE AFRAID TO ANSWER QUESTIONS

(Mr. BURTON of Indiana asked and was given permission to address the House for 1 minute.)

Mr. BURTON of Indiana. Mr. Speaker, today on the House floor and over the weekend, numerous Democrats have been complaining about the appointment of Mr. Starr as the new independent counsel. They have been raising all kinds of questions about political contributions he may have made.

Well, Mr. Fiske made political contributions, as well.

What they are not telling you is that Attorney General Janet Reno had Mr. Starr on the short list. He was one of the people that she considered previously for the special counsel position.

What they are not telling you is the three-judge Federal panel contained a judge appointed by L.B.J., and there was a unanimous decision made to appoint Mr. Starr the independent counsel.

The problem is there are many, many unanswered questions, and the Federal judges felt they were compelled to make a change. Mr. Frank indicated there was a secret letter that went to the judges. There was a letter sent by 10 Congressmen that had been made public and sent to the press. All he has

☐ This symbol represents the time of day during the House proceedings, e.g., ☐ 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

to do is read the newspapers. I will give him a copy if he wants one.

The problem with the Democrats on this floor and in the White House right now is they are very, very concerned that questions that have not been asked are going to be asked, and that Mr. Starr is going to do the job that he was appointed to do. The problem is this: If there is nothing to hide, then the White House should not be afraid to come forward and answer these questions.

VOTES AGAINST CRIME BILL MAY BE HARD TO EXPLAIN

(Mr. MENENDEZ asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MENENDEZ. Mr. Speaker, back in April I read from a letter circulated among House Republicans on the crime bill. In it, the writer said that if Republicans can defeat the crime bill, they can give the crime issue back to Republicans for the upcoming elections.

Now, aside from the callous disregard for the welfare of the American people which this letter displays, there is the question of how Republican incumbents intend to pull this little trick off.

How will Republican Members explain to their voters that they are tough on crime, after having voted against putting 100,000 more police officers on the streets?

How will they explain to their voters that they are tough on crime, after having voted against more money for prison construction?

How will they explain to their voters that they are tough on crime, after having voted against taking street sweepers, AK-47's, and TEC-9's out of the hands of drug dealers and gang members?

How will they explain that they are tough on crime, after having voted against the "three strikes" provision?

There was a great Republican President who issued a warning about trying to fool all the people all the time. They ought to keep that advice closer to their hearts.

THE CRIME BILL: NOT A GOOD DEAL FOR THE AMERICAN PEOPLE

(Mr. PAXON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PAXON. Mr. Speaker, the social worker employment bill that is currently being disguised as a crime bill has been unmasked, unmasked by none other than the FBI Director, Louis Freeh, an appointee of the President of the United States.

Director Freeh, in the Buffalo News this morning, says, and I will quote, "Dollars being used to finance the crime bill are being financed from cuts in the DEA and the FBI." He says specifically, and I am quoting here, "Downsizing the FBI and DEA"; he said that mayors and police chiefs he has talked with say they are worried the crime bill does not fully pay for the programs included, and that funds for the new officers will be eliminated after 1997. Quoting Director Freeh, "We feel very strongly that the extra police forces and the local support structures are vital and essential. We do question the wisdom of financing that by cutting back on FBI and DEA resources. In our view," quoting again Director Freeh, "this is not consistent with our expanding mission. Finally," he said, "you should know we supply the State and local organizations with important training and laboratory functions."

FBI Director Freeh says the crime bill is not a good deal for the American people.

□ 1010

HEALTH CARE REFORM: EVERY HARDWORKING AMERICAN, DEMOCRATS AND REPUBLICANS, NEED IT

(Mr. FAZIO asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. FAZIO. Mr. Speaker, just this week the GOP drill sergeant, Bill Kristol, unleashed the latest of his obstructionist manifestos on health care. In a memo on that subject to the Republican leadership, Mr. Kristol said the GOP should mount, and I quote, "a cold-eyed effort to tip the Democratic leadership into the abyss where they belong." He urged Republicans, and I quote again, "Drive, (Senator George) Mitchell into a ditch." Not what I would call a thoughtful policy recommendation.

He advised his charges to, and I quote again, "Throw as much sand into the gears as possible." And Kristol has never been repudiated by any Republican leadership.

I think I speak for all Americans when I say to the Republican partisans, "It is time to come out of your sandbox. It is time to abandon the phony politics, the policy-by-pollster approach you seem to embrace, and do something for the people, for a change. And when you are ready to bury your obstructionist battle plans, we look forward to working with you in a spirit of true bipartisanship to insure we get a health plan for every hardworking American family, Democrats and Republicans alike."

DEMOCRAT HEALTH REFORM PLANS DRAFTED IN SECRET

(Mr. HEFLEY asked and was given permission to address the House for 1 minute.)

Mr. HEFLEY. Mr. Speaker, here it is, the Clinton-Mitchell health care package, all 1,410 pages of it, which arrived on my desk yesterday morning, the very morning that the Senate began debate on it.

Why now? We have not even seen the Clinton-Gephardt bill at this point, and yet in a week from now we are to digest all of this and be able to make intelligent decisions about something that will affect the American public for generations to come.

Why not in September? Why not after we have gone home on the break? Why not after we have had a chance to digest it? Why not after the people of America have had a chance to digest this document? And then come back and make an intelligent decision.

But there lies the rub. If we go home and people find out what is in this, they will not want it. The more we know about it the less we like it.

Mr. Speaker, it was written in secret by Hillary and her group; it was rewritten in secret by MITCHELL, it was rewritten in secret by GEPHARDT.

A good rule to follow, my friends, is if it must be done in secret, we do not want it.

HEALTH CARE

(Ms. SHEPHERD asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. SHEPHERD. Mr. Speaker, in 4th grade, Teddy Gardner was diagnosed as manic depressive. His dad had two jobs and two health insurance policies. Despite treatment, Ted's condition deteriorated to the point where he needed inpatient mental health care. Neither of their policies covered it. Now Ted is 14. His parents owe $15,000 to Primary Children's Hospital in Salt Lake. Another $20,000 in bills has already been forgiven and transferred to paying insurers. They spent $7,336 for out-of-pocket medical expenses last year. They no longer have any credit. They no longer have any savings. If Ted is hospitalized again they will most certainly lose everything.

This family could be any of us. The only way to make our families secure is to pass legislation that guarantees all our constituents an affordable health policy with comprehensive coverage that protects them against financial ruin. Teddy's life depends on it, and I will not vote for anything less.

DEMOCRAT HEALTH CARE PLANS CONTAIN TOO MANY TAXES AND TOO MANY JOB-KILLING MANDATES

(Mr. BOEHNER asked and was given permission to address the House for 1 minute.)

Mr. BOEHNER. Mr. Speaker, my colleagues, I have good news and bad news. The good news is that the Democrat leaders on Capital Hill killed the Clinton bill because the American people thought it had too many new taxes, too much bureaucracy and job-killing mandates. The bad news is that the proposals being floated here on Capitol Hill, in the other body and here in the House, have the same big Government bureaucracies and job-killing mandates. I do not think the liberals here in Congress get it yet. The American people know that Government is too big and spends too much.

If you begin to look at the so-called moderate Senate proposal, the so-called Clinton-Mitchell bill, it has 17 new taxes and 35 new Government bureaucracies. If you look at the Clinton-Gephardt bill—if you can find it—it does not exist yet—we hear it has at least 17 new taxes, maybe 50 Government bureaucracies.

The American people said "no" to the Clinton plan, and if we ever get to see the Clinton-Gephardt plan, they will say "no" to that as well.

AARP SEES GEPHARDT PLANS AS BEST FOR SENIOR CITIZENS

(Ms. DELAURO asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. DELAURO. Mr. Speaker, during the course of this health care debate, we have listened to horror story after horror story from senior citizens who have been forced to squander their life savings to pay for health care.

As we speak, the American Association of Retired Persons is holding a press conference to endorse the Gephardt Health Care reform bill. The AARP represents 33 million senior citizens and is endorsing the Gephardt plan because it is the best plan for senior citizens.

The Gephardt plan preserves Medicare and plows savings into new benefits for seniors.

The Gephardt bill is the only plan that includes prescription drug coverage and a new long-term care benefit to help our seniors with the burdensome costs of health care.

In the next few weeks this body will note on health care reform. I urge my colleagues not to ignore the voices of 33 million senior citizens. Vote for the Gephardt bill.

LEADERSHIP HEALTH CARE PLAN MYTHS

(Mr. SAM JOHNSON of Texas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Mr. Speaker, it is no myth that the Clinton-Gephardt and Clinton-Mitchell plans do create huge new bureaucracies. It is no myth that these same plans both contain massive amounts of taxes and spending that America just cannot afford.

Now, how about myth No. 3? They claim there are no employer mandates. Guess again. The Clinton-Mitchell bill acts as a big brother and comes in to impose mandates to reach universal coverage if it has not already happened by the year 2000. And in the Clinton-Gephardt bill those same mandates are forced on large employers in 1996 and smaller employers by 1998.

It looks a duck, walks like a duck, quacks like a duck, this one even talks like a duck, it is a duck.

If the Government is forcing business to cover employees, that is a mandate, and Americans do not want mandates.

Americans do know the difference between myth and reality.

SOCIAL SECURITY, MEDICARE, AND, NOW, HEALTH CARE REFORM

(Mr. TORRICELLI asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. TORRICELLI. Mr. Speaker, hardly a day goes by where Republican Members in this institution do not come to the floor with great indignation about why it is they have been in the minority for 40 years. Well, once again you are about to get a demonstration.

Fifty years ago when Social Security came to this floor, not a single Republican voted for it; 30 years ago when Medicare came to the floor, the overwhelming burden was on the Democratic Party.

They have spent a generation apologizing for it. Now Americans, 80 million of them with preexisting illnesses, need health insurance; 50 million need portability so they can change their jobs; 40 million have no health insurance at all; 100,000 per month are losing their health insurance while a million Americans a year go bankrupt. And the Republican Party claims no responsibility, sees no crisis and, in the other body, is threatening a filibuster, lest we do something to help the American people.

Mr. Speaker, for a generation they have denied their role in stopping social security and Medicare, and I predict a generation from now they will regret, they will deny, they will go to new lengths to claim they were not on this floor fighting national health insurance.

REPUBLICANS DID VOTE FOR SOCIAL SECURITY, MEDICARE, CIVIL RIGHTS, ET CETERA

(Mr. EHLERS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. EHLERS. Mr. Speaker, I hope the previous speaker remains in the room to hear the fact that he is all wrong. However, he has gotten his information from the Vice President, who is also wrong, when they said that Republicans did not support Social Security and Republicans did not support Medicare.

I am here to talk about the pluses and minuses of the health care bill but simply to point out the erroneous assumption. If you look at the chart, you discover that 83 percent of the Republicans voted for the Social Security Act and more Republicans than Democrats voted for the Civil Rights Act and 47 percent of the Republicans voted for Medicare.

□ 1020

Now, when I went to school, that is considerably more than zero percent, and yet we are being forced by the Democrats in this Congress, we are being forced out of the discussion, and we may have a situation where only 2 percent, or even less, of the Republicans vote for the health care bill simply because the majority party has refused to share the information with us, has refused to give us a copy of the bill, and more or less they have told us they do not want us involved, and they want to pass their bill on their terms and ignore us.

Mr. Speaker, that is what I am objecting to as a Member of the body who supports health care reform. I want the opportunity to work with them and work on the health care bill.

RISE ABOVE PETTY PARTISANSHIP AND PASS THE CRIME BILL

(Mr. SCHUMER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SCHUMER. Mr. Speaker, for over 200 years ordinary Americans have brought their fears and their hopes to this House. In its finest hour this House has heard them. It has acted boldly and courageously to attend to their needs, and bind the Nation's wounds, and bring us together in hope.

The American people are in need today, Mr. Speaker. They are in anguish from the bloody scourge of violent crime that terrorizes our Nation from the poorest neighborhoods to the richest, and everything in between, and we have before them an answer. We have a bold crime bill that answers their calls for help that has been 6 years in the making.

However, Mr. Speaker, a stubborn few are falling back on a bitter call to partisanship and demagoguery. Having failed on the merits, they hurl the empty charge that this bill has one thing or another that they do not like.

Yes, there are things in this bill that I do not like. There are things in this bill the President does not like. There are things in this bill that the majority leader or the minority leader do not like. But if we all say we will not vote for a bill because there are one or two things in it we do not like we will end up with gridlock, and the Nation will hold us to account.

Rise above the petty passions of the moment, and pass the crime bill that American people are urgently pleading with us to pass.

CRIMINALS SAY "MAKE MY DAY"

(Mr. EVERETT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. EVERETT. Mr. Speaker, who could forget Clint Eastwood's classic line: Make my day? Unfortunately, it is the bad guys saying it now. It is the Nation's 10,000 convicted drug pushers who are saying, "Congress, pass the pork-ridden crime bill so we can walk."

That is right. Under the liberal crime bill, Mr. Speaker, mandatory sentencing for drug dealers is all but eliminated. While this crime bill issues get-out-of-jail-free cards for drug criminals, it boasts placing a hundred thousand additional policemen on the street. Yet, when we read between the lines, only 20,000 are actually funded.

No wonder criminals are saying, "Make my day," and just what is the crime bill's answer to the growing violence and murder rocking America? Nine billion dollars in increased social spending instead of mandatory sentencing and tougher punishment.

Mr. Speaker, I say, "Washington is spending your tax dollars for inner-city pork projects, and dance lessons, and self-esteem classes, and midnight basketball, and arts and crafts lessons. This is no crime bill. This is pure pork and pure deception."

SENIOR CITIZENS SHOW APPROVAL OF THE DEMOCRATIC HEALTH CARE PLAN

(Mr. HOYER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HOYER. Mr. Speaker, through the din of special interest hue and cry comes a reassuring sound—America's senior citizens have taken a good look at the Democratic proposal, and they like what they see. And here is why.

Mrs. Jones receives her health coverage through Medicare today, and she does not want that taken away.

Under our plan, she will stay on Medicare if she chooses, and she will continue to have the choice of any doctor or provider or plan she wants.

We go one step further—we add coverage for prescription drugs, because no older American should have to choose between the medicine she needs and paying rent or buying food. She will also be able to get annual mammograms and long-term home or community-based care if and when she needs it.

Let us listen to Mrs. Jones.

Let us keep this debate on the highest level—and that level is this:

How does this affect real Americans who play by the rules and pay the bills?

SUPPORT THE CONGRESSIONAL ACCOUNTABILITY ACT

(Mr. BARTLETT of Maryland asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BARTLETT of Maryland. Mr. Speaker, today the House is scheduled to vote on H.R. 4822, the Congressional Accountability Act. As 1 of 4 who offered such a bill on the first day of this Congress and 1 of the 10 core freshmen who have been active in congressional reform since day one of the 103d Congress, I heartily support H.R. 4822.

But we cannot let this be our last step. It is only the first in the long road to reform.

The House can and must take the lead. The Constitution established the House to be the body closer and more responsive to the people. And now we need to respond by reforming ourselves.

Each time someone sees a reserved parking spot at the airport, it reminds them of how they hate Congress. My bill, H.R. 4444, does away with airport parking. It finishes the job the Senate left incomplete.

My bill brings us in line with the American people in health care, pensions, and travel guidelines, among others.

Vote for H.R. 4822 as a first step and support H.R. 4444 for total congressional reform.

THE GEPHARDT PLAN PROVIDES HOME HEALTH CARE FOR OUR SENIOR CITIZENS

(Mr. DURBIN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DURBIN. Mr. Speaker, one of the reasons AARP has endorsed the Gephardt plan and rejects the Republican alternatives is home health care, home health care which allows seniors to stay at home and receive basic needed health care, seniors in their homes where they can stay in comfort with dignity and at a cost much lower than nursing homes.

Mr. Speaker, I have been out with visiting nurses. I encourage my colleagues to do the same. Find out how important home health care is to seniors. While the big business interests spend millions of dollars to defeat health care reform, Members would be well advised to pay attention to the real-life struggles of their parents and retired friends that they face every day.

AARP is right. When it comes to health care reform, my advice to my colleagues is:

"Listen to your mother, not to the special interest groups."

CRIME BILL TOUGH ON TAXPAYERS AND SOFT ON CRIMINALS

(Mr. GRAMS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GRAMS. Mr. Speaker, $270 million to fund arts and crafts and dance programs? Another $100 million for tutoring and job placement initiatives? And $40 million for midnight basketball leagues?

Sound like the budget for the Departments of Health and Human Services? Housing and Urban Development?

Wrong. Believe it or not, this is Congress' latest idea for a crime bill. And there is even more pork and wasteful Government spending yet to come.

Nine billion dollars, in fact. Tutoring centers. Revenue sharing.

But hardly a word about closing the loopholes that allow death row inmates to escape capital punishment or ensuring that other criminals serve out their full sentences.

The bill is tough, but tough on taxpayers and soft on criminals, giving them special treatment rather than punishment for their crimes. Mr. Speaker, just as he lost on the failed stimulus package last year, President Clinton will find this a tough sell with the American taxpayer this year.

President Clinton said over the weekend no one should play political games with our Nation's safety. He called for a shoot out at high noon on this bill. I agree. Let us pull this bill apart and let the taxpayer get a good look at what political favors the President can buy for $33 billion.

□ 1030

THIS CRIME BILL FIGHTS CRIME

(Mr. RICHARDSON asked and was given permission to address the House for 1 minute.)

Mr. RICHARDSON. Mr. Speaker, the American people are fed up with crime and want us to act now. We cannot once again let gridlock prevail. Tomorrow the vote on the rule for the crime bill will be perhaps the most important vote of the session.

Our constituents know that claims that this is a pork-barrel bill are nothing but partisan ranting. They know that this bill is tough and well-balanced. They know that it punishes criminals and works intelligently to prevent crime.

Here is what is in this bill: 100,000 new cops; three strikes you're out; the death penalty for over 60 Federal crimes; providing States with $6.5 billion to build much needed prisons; and funds for prevention programs that we know work, programs that are working in communities that deal with young people, keeping them away from crime.

Mr. Speaker, the American people are not fooled by rhetoric and special interests. The American people want us to act on crime now. It will be a long, hot summer if we let this bill die.

A MANDATORY JAIL SENTENCE FOR THOSE WHO LAUNDER MONEY FOR POLITICAL CAMPAIGNS

(Mr. STRICKLAND asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. STRICKLAND. Mr. Speaker, I think that perhaps we should have included a provision in the crime bill enacting a mandatory-minimum jail sentence for anyone who violates Federal election law by illegally laundering money for political campaigns. I think it is time we got serious about this issue.

Quite frankly, Mr. Speaker, I don't care who is involved. Even if it is a Governor—Members of Congress—employees of State departments of transportation or national political parties—anyone who is involved in this practice ought to be held accountable. They need to know that they are going to be caught and serve jail time for this type of activity.

To put it very clearly—they need to know if they commit the crime, they will do the time.

Mr. Speaker, we need to spread the word loud and clear: So that every Tom, Dick, or Barry in this country understands when they engage in the illegal laundering of political contributions they will be identified and they will pay a severe price.

WAIT A WHILE

(Mr. LINDER asked and was given permission to address the House for 1 minute.)

Mr. LINDER. Mr. Speaker, the Democrat leadership has decided to push back 1 week the August recess for the House in order to vote on health care. Apparently, the majority believes the less contact Members have with their constituents, the better chance they have of passing their health care bill.

That might make sense to the chief vote counters of the Democrat leadership, but it makes little political or policy sense.

Mr. Speaker, we have been elected here to represent the views of the American people, not to ignore them.

The best way to hear those concerns is to go home before we vote on health care reform, give the media and the Members a chance to explain the alternatives, and get the voters' reactions.

For the life of me, I just do not understand why we can't take this route to health care reform.

Fanaticism has been defined as redoubling your efforts when you have forgotten your goal. It seems the Democrat majority has forgotten the goal of health care reform while redoubling their efforts to jam a plan down the throats of the American people.

THE CASE AGAINST EMPLOYER MANDATES

(Mr. KIM asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KIM. Mr. Speaker, the proponents of the Gephardt plan are trying to convince the American people that they will be getting a free ride through employer mandates. Employer mandates give an impression that all employers get freebies. These mandates give the impression that we are getting something for nothing paid for by somebody else. Let me tell the Members the truth about employer mandates.

Employer mandates are nothing more than a tax on jobs. They are nothing more than a job-killing payroll tax, a tax that American workers will pay in the form of reduced wages and lost jobs. In other words, there is no such thing as a free lunch.

Members do not have to take my word for this. Almost every credible study predicts substantial job loss because of employer mandates. Even the White House's own economic adviser predicted that such mandates would cause over 600,000 job losses.

The Gephardt plan would guarantee you health coverage at work, but only if you are lucky enough to have a job after this plan goes into effect. The truth is that employer mandates are just another huge step toward the power-hungry liberals real agenda—Government-run health care.

FREE THE CRIME BILL

(Ms. HARMAN asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. HARMAN. Mr. Speaker, free the Crime bill.

From my district, those urging passage of this legislation include Los Angeles County Sheriff Sherman Block, Los Angeles County District Attorney Gil Garcetti, and the Los Angeles County Police Chiefs Association. It has been endorsed by Los Angles Mayor Richard Riordan, the Los Angeles City Council and PORAC—a California association of 37,000 peace officers.

Mr. Speaker, there are too many in America who can speak to the ravages of crime. When seeking crime's remedy we should first hear the voices of those who are charged with its eradication. And it is these individuals who contend that the crime bill will reduce the availability of semiautomatic weapons, get more police officers on the streets, stem the flow of illegal immigration, punish perpetrators of domestic violence and help its victims, provide for tougher sentencing including three strikes and you're out and more prisons.

Like our law enforcement officials, I do not believe this is a perfect bill. There are provisions I believe to be unnecessary and even wasteful. But to reject this legislation for its imperfections is to reject those men and women who fight crime for a living.

Instead, let us support these Americans. Let us support the crime bill.

CRIME BILL FOUND WANTING, WEAK ON FIGHTING CRIME

(Mr. MICA asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MICA. Mr. Speaker, when the crime bill originally came before the House, I supported the crime bill and some of its provisions—more prisons, a swifter death penalty, and tougher punishment. Now, the conference report has produced a crime bill that I cannot support.

Even after the conference committee has taken out the racial quota provision, President Clinton promises to enact it by Executive order. This will kill the death penalty.

This bill has grown from a $22 billion bill in the Senate for prisons and police to $33 billion for more than 40,000 new social workers, pork and political patronage.

This bill will release 10,000 convicted drug felons on our streets and in our neighborhoods. This bill creates a vast array of new social programs. The Members have heard some of them—midnight basketball and dance programs.

Mr. Speaker, this crime bill is part of the problem. It is not the solution sought by me or by the American people. I regret that I can not support this crime conference report in its present form.

AS THE COUNTRY MOVES FORWARD, THE OPPOSITION PREDICTS CALAMITY

(Mr. GEJDENSON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GEJDENSON. Mr. Speaker, there they go again. Every time this country takes a step forward, a significant portion of the people on the other side of the aisle announces that calamity is just around the corner.

When we passed the Budget Act that has created more jobs in the last 16 months than in the previous 4 years, they told us we would see more unemployment, we would see higher deficits, and we would see an economic crisis. The reality is that this country has moved forward steadily, with more new jobs than ever before, more economic growth, and less inflation.

These are the same tired old arguments against any step forward in society.

Go and tell some of the mothers and fathers who watch their children getting inadequate health care that the present system is good enough.

□ 1040

We need to make sure that every child in America has decent coverage. AARP has stepped forward and joined the call to follow the Gephardt plan, to make sure that every citizen has decent coverage, has access to drugs that are needed to deal with their illnesses, and not left by the wayside. It is wrong to leave the middle class at risk, while the rich and the poor take the free ride.

TUNE OUT, TURN OFF, DROP OUT

(Mr. HOBSON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HOBSON. Mr. Speaker, the President has decided to support the Senate majority leader's health care reform bill, saying it is a good start.

It is a good start, all right. It is a good start to the complete takeover of our economy by the Government. In fact, the Clinton-Mitchell bill creates 47 brandnew bureaucracies to administer his plan.

You have to wonder if the Democrats got Timothy Leary's advice all wrong: Instead of turn on, tune in, drop out, it is tune out, turn off, drop out.

It seems the President and the Senate majority have decided to tune out the advice of the American people: Government is too big and spends too much.

And by tuning out the wishes of the people, the President has turned off the electorate. That explains why the name Clinton is enough to kill any health care reform bill and why the Democrat leadership is so anxious to change the name of the President's bill.

Most voters wish that the President would drop out of the health care debate.

GET DEMOCRATS OFF SOAPBOXES

(Mr. HOKE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HOKE. Mr. Speaker, Democrat White House surrogates in the Congress who have been criticizing the selection of Ken Starr as the independent prosecutor should get off their soapboxes. Not only because it is so unseemly in light of all of the attempts at White House manipulation and influence over this investigation already, but because Ken Starr is precisely the kind of independent prosecutor they should have asked for in the first place. That he is not a buddy of Bernie Nussbaum's that he hasn't even the most tenuous of relationships to this administration, and that he did contemplate filing an amicus brief for Paula Jones, makes him perfectly suited for the job.

Nobody has suggested that Mr. Starr will act unfairly. Nobody has attacked his reputation for probity or impartiality as a Federal judge. They have merely suggested that he creates an appearance of partisanship.

Well, when the President and the First Lady are cleared of all the wrongdoing, as they have emphatically stated they will be, then this suggestion of partisanship will make Starr's conclusions unimpeachable. So pipe down, relax, and let the process take its course. And be careful, because all of this whining and protesting about Starr is going to sound an awful lot like another attempt to influence, manipulate, and divert to the American public.

HOUSE BILL GUARANTEES HEALTH SECURITY FOR SENIORS

(Ms. PELOSI asked and was given permission to address the House for 1 minute and to revise and extend her remarks and include extraneous material.)

Ms. PELOSI. Mr. Speaker, every time I call home to my mother, at the end of the conversation she says:

> Take care of your health. As you grow older you learn that if you do not have your health, you do not have anything.

That statement I am sure many of us hear from our parents, older parents, more and more these days. And that means that health care reform is not a luxury, but a necessity for our senior citizens, and, indeed, for all Americans.

That is why I was so pleased to see that the AARP came out so strongly for the House health care reform bill. They did so because the bill includes new unlimited drug benefits for seniors in the Medicare Program, which means seniors will no longer have to tighten their belts to buy their medicine. It includes new preventive health benefits for seniors and new benefits for mammograms for women over 65 years of age, features that could save millions of elderly lives. And, for the very first time, long-term care would be available for the many seniors who need it the most. In addition to that, in an overall way, it guarantees health care that may never be taken away, health care that is always there for all Americans, including you, mom, our seniors.

REPUBLICANS RALLY AROUND PRESIDENT ON CORRECT POLICIES

(Mr. DREIER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DREIER. Mr. Speaker, at a time when the President of the United States is attempting to launch a Government takeover of one-seventh of the economy and the Democrat leadership in this House is attempting to obliterate something the American people have called for, that being Congressional reform, I find it very interesting that yesterday Republicans in this House stepped forward with nearly 75 percent of our membership supporting the cause of human rights in China and job creation here in the United States.

Yes, the President has had a pattern of criticizing Republicans for partisanship. But when the President is right, Republicans step forward and do everything that we possibly can to support those correct policies. I think it is very important, Mr. Speaker, that the record show that.

PASS THE CRIME BILL AND MAKE AMERICA SAFER

(Mr. MAZZOLI asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MAZZOLI. Mr. Speaker, there might be a difference of opinion in our districts on whether Congress should address the health care problem today or soon, but there is certainly no difference of opinion on whether Congress should address the issue of crime in our country immediately or very soon.

I have had conversations with Mayor Jerry Abramson of my own town of Louisville, and County Judge/Executive David Armstrong. Both of them are very dedicated to the idea that Congress pass this crime bill.

Tomorrow there will be an opportunity for this House to take up first the rule which permits us to deal with the crime bill conference report, and then the conference report itself. And while there may be problems and each one of us may find some flaw in and some detriment or some lack of completeness in this bill, it is at least a generally approved step forward in the national fight against crime.

So, Mr. Speaker, I hope that we can, first, adopt the rule tomorrow, and then pass the crime bill and address the issue of crime and make America safer.

SUPPORT THE CONGRESSIONAL ACCOUNTABILITY ACT

(Mr. CAMP asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CAMP. Mr. Speaker, I rise today in strong support of the Congressional Accountability Act, which asks Congress to live by the same rules we make for the American people. How can we make laws for others, but exempt ourselves? Thomas Jefferson called for this body to be made up of citizens leaving normal careers for short periods of time and then going back to live under the rules they made.

I ask my colleagues, how can we know the true implications of our laws if we do not experience the benefit and the burden of these laws? H.R. 4822 will help restore some confidence in this body by making us abide by the Fair Labor Standards Act, the Americans with Disability Act, the Age Discrimination in Employment Act, the Family and Medical Leave Act, the Occupational Safety and Health Act, to name a few.

Mr. Speaker, we must abide by the laws we place on others. Perhaps if we are forced to abide by the rules we pass, this body might take the time to understand the full implication of legislation before it becomes law.

ENDORSEMENT OF HOUSE LEADERSHIP HEALTH CARE PLAN BY AARP

(Mr. WISE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WISE. Mr. Speaker, as the health care debate moves forward during the next couple of weeks, I think it is extremely significant to note an important endorsement today. That endorsement of the House leadership plan by the American Association of Retired Persons. Yes, the AARP, one of the leading spokespersons for senior citizens in our country, because the AARP and the 33 million people they represent know that the House leadership plan protects that most important program to seniors, Medicare.

They know that the House leadership plan does indeed provide outpatient prescription drugs. They know that the House leadership plan begins to make some inroads into that knotty problem of long-term health care, home health care. And, finally, senior citizens know that Medicare, without the kind of action proposed by the House leadership plan, will keep getting squeezed more and more and more.

So what the important action of today by the AARP means is that the grandparents of this country are standing up to say we want our grandchildren to have the same kind of coverage.

CRIME BILL: UNFUNDED MANDATES AND TOO MUCH PORK

(Mr. STEARNS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. STEARNS. Mr. Speaker, the Clinton crime bill says it will put 100,000 new police officers on the streets. In reality, this bill guarantees funding for only 20,000 permanent new cops over the next 6 years. That is only 20 percent of the total number of police officers promised by the bill's supporters.

The Clinton crime bill assumes that State and local governments will pick up $33 billion in new expenditures over the next 6 years. They will have to if they want to meet the target of 100,000 new police officers.

This bill will place another huge, unfunded mandate on our cities and towns, which are already overburdened by too many Federal rules and too much red tape.

This bill gives the attorney general the discretion to decide which cities and States receive new community policing funds. Do not be surprised if we see handouts given to well-connected big-city politicians. And, of course, there is nearly $9 billion in new, Great Society-type social welfare spending.

Mr. Speaker, if we have learned anything from the past, we see that our Nation has poured over 5 trillion tax dollars into our current welfare system since the so-called war on poverty was started in 1965. This is a bill that puts two social workers on the street for every one cop.

Mr. Speaker, there is more wrong with this bill than right, such as unfunded mandates and too much social spending. We should go back to the drawing board and address the real concerns of the American people.

□ 1050

GRASSROOTS SUPPORT FOR HEALTH CARE REFORM

(Mr. DERRICK asked and was given permission to address the House for one minute.)

Mr. DERRICK. Mr. Speaker, health care reform is a quintessential grassroots issue. Literally everyone has a stake in it. That is why Americans overwhelmingly support universal coverage and insurance that cannot be taken away.

The American will for reform speaks in a loud, clear voice. Listen to just a few of the health advocacy organizations representing millions of Americans who support the Guaranteed Health Insurance Act: Healthright, Families USA, The Center for Medicare Advocacy, The National Mental Health Association, Interreligious Health Care Access, The Protestant Health Alliance, The Consortium for Citizens with Disabilities, The National Multiple Sclerosis Society, The National Breast Cancer Coalition, The Community Health Access Coalition, The Epilepsy Foundation of America, The American Foundation for the Blind, The American Parkinson's Disease Association, and The Association for Retarded Citizens.

These groups give voice to the grassroots. Listen to the people. Support health care reform.

THE CRIME BILL

(Mr. GINGRICH asked and was given permission to address the House for 1 minute.)

Mr. GINGRICH. Mr. Speaker, every Member who is looking at the crime bill should understand why we are so concerned and why we want this bill to go back to conference.

The Buffalo News reports this morning that the Federal Bureau of Investigation Director is openly worried. In a page 1 story entitled "FBI Chief Criticizes Crime Bill," on the inside it is "Proposed Cuts Worry FBI Director," he says that the funding comes from downsizing the Federal Government and specifically from devastating the FBI and the DEA.

I do not think Members realize that the crime bill, which has still not been reported, which has still not been filed, which some Democratic leaders are still trying to rewrite, even though it is supposedly out of conference, that bill specifically cuts the Federal Bureau of Investigation and the Drug enforcement Agency.

I do think Members realize that the so-called crime bill is a social work bill that takes money away from the FBI to spend more money on social work. I hope that every Member will look at this kind of real issue and not vote for the rule on the crime bill.

APPOINTMENT OF CONFEREES ON H.R. 4603, DEPARTMENTS OF COMMERCE, JUSTICE, AND STATE, THE JUDICIARY, AND RELATED AGENCIES APPROPRIATIONS ACT, 1995 AND FISCAL YEAR 1994 SUPPLEMENTAL APPROPRIATIONS

Mr. MOLLOHAN. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the bill—H.R. 4603—making appropriations for the Departments of Commerce, Justice, and State, the Judiciary, and related agencies' programs for the fiscal year ending September 30, 1995, and making supplemental appropriations for these departments and agencies for the fiscal year ending September 30, 1994, and for other purposes, with Senate amendments thereto, disagree to the Senate amendments, and agree to the conference asked by the Senate.

The SPEAKER pro tempore (Mr. MONTGOMERY). Is there objection to the request of the gentleman from West Virginia?

There was no objection.

MOTION TO INSTRUCT OFFERED BY MR. ROGERS

Mr. ROGERS. Mr. Speaker, I offer a motion to instruct.

The clerk read as follows.

Mr. ROGERS moves that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the bill H.R. 4603 be instructed to agree to the Senate amendments numbered 125 and 127.

Mr. ROGERS (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Kentucky?

There was no objection.

The SPEAKER pro tempore. The gentleman from Kentucky [Mr. ROGERS] will be recognized for 30 minutes, and the gentleman from West Virginia [Mr. MOLLOHAN] will be recognized for 30 minutes.

The Chair recognizes the gentleman from Kentucky [Mr. ROGERS].

Mr. ROGERS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, my motion instructs the conferees to accept the Senate funding levels for contributions to the U.N. general budget and U.N. peacekeeping.

Mr. Speaker, we have had to cut in this bill crimefighting money from the Justice Department. We had to cut job-producing programs in the Commerce Department. And we have had to cut peace dollars at the State Department; in order to fully fund U.N. contributions, we did those cuts.

My motion, Mr. Speaker, will partially correct what I count as a mistake. This motion would reduce funding to the United Nations by $74 million below the House level by two different means.

First, it would make a very modest cut in the peacekeeping arrearage payments by $33 million. By the way, that is out of a total of $1.2 billion so it is less than a 3-percent cut.

Second, it would cut $41 million in arrearage payments to the general budget at the United Nations. That is out of a total of $914 million that we pay to the United Nations and related agencies. So that is around a 4-percent cut to the general budget.

The savings though, Mr. Speaker, the $74 million then could be added back to crimefighting in America, to producing jobs in America, and to furthering America's peace initiatives around the world.

Mr. Speaker, these are modest trends. I would have liked to have seen much, much more. In fact, I tried to get more cuts on a motion on the bill when it passed through the House. We did not succeed. But these are very, very modest cuts: 3 percent peacekeeping, 4 percent to the general budget of the United Nations.

More importantly, those moneys can be directed to America's problems which we all know are excessive.

We have to make choices. The President's budget request for this bill was almost $800 million over what we were given to spend by the budget process. So we had to make trims.

We cut, as I said, Commerce Department funding. We cut Justice Department funding. We have cut State Department funding. In fact, we are cutting State Department below their current services in order to fund the U.N. contributions. We cannot fully fund every important program in this bill because of that.

The United Nations, Mr. Speaker, should not be held harmless from the budget cuts that we have to endure. We should not favor a United Nations over domestic priorities in this country.

Many would argue that U.N. spending is out of control. The number and the cost of the peacekeeping missions that the United Nations has undertaken have exploded. Just 6 years ago, Mr. Speaker, we only were involved in two peacekeeping missions in the world, the United Nations. Now, we are involved in 16, 8 times the number of peacekeeping missions we had just 6 years ago.

What is the cost of that to us, the United States? Then we were paying $30 million a year. Now it is costing us $1.2 billion a year, and just 30 million 6 years ago.

The American taxpayer, Mr. Speaker, is billed to much for peacekeeping missions because our allies are not being billed enough. We are paying a disproportionate share of the total U.N. cost for peacekeeping. We are paying or being billed for, at least, almost a third of the total cost of these peacekeeping missions.

Japan is only being billed for 12.5 percent; Germany only 9 percent; Great Britain, 6.5 percent. That is unfair. It may have been fair in the immediate post-World War II world. It is not fair in today's world with lots of economic giants out there more able to pay really than we are in many cases.

☐ 1100

Third, the United Nations is a bloated bureaucracy, Mr. Speaker, rampant with waste, fraud, and abuse. Let me make a couple of points.

Eighty percent of the U.N. general budget, 80 percent, is used to pay some 14,000 U.N. employees, employees who receive, one, tax-free salaries guaranteed to be 20-percent higher than in the private sector in this country; guaranteed cost-of-living increases; guaranteed paid vacations of up to 2 months per year; virtually free education for all of their children through college. That is what employees at the United Nations get, subsidized by the large payments that the U.S. taxpayer makes to the general budget, which is 25 percent.

Can we justify, Mr. Speaker, can we justify fully funding the United Nations and all of those guaranteed perks and benefits, when we cannot fully fund the FBI in this country, or the State Department, or the job production programs at the Commerce Department? I say no, we cannot justify that. Therefore, these very small cuts, 3 or 4 percent at the United Nations, are the least we should be able to do.

Yes, Mr. Speaker, we do have a commitment to pay our bills to the United Nations, but we also have a commitment, Mr. Speaker, to the American people, a commitment to fight the war on crime in this country, a commitment to economic growth through technology and economic development programs in this country.

This motion, Mr. Speaker, allows us to fulfill both of these commitments the best we can, given our budget constraints. The dollars my motion would cut from the United Nations could be reallocated in conference, Mr. Speaker, to fighting crime here at home, producing jobs here at home, and furthering the cause of peace on America's behalf around the world.

I urge Members to address America's crime problems, while doing no harm to the United Nations.

Mr. Speaker, I urge the adoption of my motion, and I reserve the balance of my time.

Mr. MOLLOHAN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in opposition to the gentleman's motion to instruct conferees on our 1995 Commerce, Justice, State, and Judiciary appropriation bill. I understand that the gentleman's amendment really goes to our obligations.

This amendment would prevent us from funding arrearages, both in peacekeeping and in international organizations at the United Nations. It means we would not meet our obligations to the extent that the House, when we passed our bill, thought that we should meet those obligations.

Mr. Chairman, I think that the House, when they consider that, want to meet those responsibilities in as timely as fashion as we possibly can.

Mr. Speaker, we have debts to the U.N. right now which we are trying, in a phased way, to meet. We have debts to the international organizations that we need to honor. This motion would, if acted upon in conference, prevent us from meeting those obligations.

Mr. Speaker, the cuts that would be made by the gentleman's instructions, would come, ironically, Mr. Speaker, at a time when the United States is making real progress in addressing some of the concerns, legitimate concerns, that the gentleman spoke to. Right now, the United Nations has taken action to create an independent inspector general. That is an issue that the gentleman who is making this motion to instruct has been very concerned with and very articulate in bringing his concerns to the House for a number of years now.

However, the United Nations is addressing that, and they are appointing an inspector general, and there has been constructive cooperation between the United States and the United Nations on these problems. We are moving to address them. Those are legitimate concerns. We want the United Nations to operate carefully, we want them to operate in a fiscally prudent manner, and we are taking actions in the authorizing bill that we passed earlier this year to encourage the United Nations to move in that direction, and they are.

In addition, Mr. Speaker, the United Nations and the United States are right now in serious negotiations. They are under way, as we speak, to reduce the share of peacekeeping costs that the United States is obligated for, from 31 to 25 percent. That is also a goal that the gentleman from Kentucky [Mr. ROGERS] has advanced and has put forward on numerous occasions before this body, so they are addressing two of his most pressing concerns. We are very pleased that they are doing that.

At the time that the United Nations is indicating that they want to be responsible, we do not want to be irresponsible. We do not want to be pikers in the eyes of the world and not meet our financial obligations with regard to these arrearages.

Mr. Speaker, with regard to the gentleman's instruction, if it were to prevail and we were to effect it in conference, the instructions, as far as it relates to cutting the funding for arrearages for international organizations, would cut from such activities as the Food and Agricultural Organization. It would cut from the International Labor Organization our obligation to pay arrearages. It would cut from the U.N. Industrial Development Organization. I do not think that the gentleman or the body or this country wants the United States to pull back from its obligations in these areas.

In addition, Mr. Speaker, this amendment would cut our contribution to cleaning up our arrearages for the World Health Organization. I do not think that is an organization that we want to indicate to the world that we do not support, or that we do not want to pay up our obligations for our arrearages; also, for the Organization of American States, an organization very close to home that we ought to be supporting, and that we ought to be indicating that we want to meet our part of the obligation to fund that organization. In addition, the Pan American Health Organization, Mr. Speaker, would be one of the organizations that would receive a cut in our obligation for arrearages if this motion to instruct went forward.

Mr. Speaker, I would point out, finally, that the United States is bound by treaty to make payments that have been included in the House bill, have been carefully considered by our committee during the committee process, have been carefully considered on this House floor, and supported by the body when we passed our bill. The bill includes funding which would allow the United States to make those payments soon, permitting vital peacekeeping operations to continue, and fostering the reforms that the gentleman from Kentucky is so concerned about.

Therefore, Mr. Speaker, I would hope that the body would reject the gentleman's motion to instruct, and I trust that we will.

Mr. Speaker, I reserve the balance of my time.

Mr. ROGERS. Mr. Speaker, I yield such time as he may consume to the gentleman from Pennsylvania [Mr. MCDADE], the able Republican on the full Committee on Appropriations.

Mr. MCDADE. Mr. Speaker, I want to begin by extending my deep appreciation to my friend, the gentleman from Kentucky [Mr. ROGERS] for yielding me this time, and for all the members of this subcommittee who have worked so hard to bring us this bill.

Mr. Speaker, I rise in support of this motion, and I want to commend the gentleman from Kentucky, who has labored as long as any Member of this House to bring some semblance of discipline to the United Nations and our country's relationship with it.

Mr. Speaker, I support this motion because it helps send a signal—to both the United Nations and the administration. It sends a signal the current path we are on with respect to peacekeeping and other U.N.-sanctioned missions is full of confusion, inconsistencies, and a disregard for the actions needed to realistically deal with a series of growing problems abroad.

Nothing more graphically demonstrates these problems than the tragedy which continues to unfold in Rwanda. All of us can, and should, Mr. Speaker, point with pride to the magnificent actions of our military and relief workers in bringing some measure of assistance to the hundreds of thousands of refugees in that troubled area. They have performed miracles.

But the fact remains this immense tragedy unfolded in front of all of us while the United Nations failed to act in a timely or effective manner. It took nearly 2 months after the slaughter began in Rwanda for the United Nations to approve a peacekeeping contingent—and today, nearly 3 months after the United Nations finally acted, there are only 500 peacekeepers on the ground as part of that force, only 500 troops.

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That, Mr. Speaker, is less than 10 percent of what the United Nations announced it would send to Rwanda. Not only has the United Nations failure to act contributed to this tragedy but it may cause even more suffering and more calamities. The French, Mr. Speaker, who have sent 2,000 peacekeepers to Rwanda, are going to leave in less than 2 weeks. Most observers who are in the country believe that unless they are replaced by United Nations as peacekeepers, it will spark additional violence and another mass migration of Rwandans, perhaps, Mr. Speaker, as many as 1 million more refugees, and there are 1.2 million in Goma alone in Zaire, as we speak.

Without question, Mr. Speaker, this threatens our efforts in Rwanda. There, our initial strategy seems straightforward: Have our military provide sustenance for more than 1 million refugees near Goma, Zaire, for a short period until they are returned to Rwanda. But, Mr. Speaker, the entire strategy depends on convincing the refugees to return home. Unhappily, they are not doing so. But why, Mr. Speaker? They are not doing so because the former Rwandan Government and its military have refused to concede defeat, sowing fear and confusion among the refugees. They are not doing so, they are not returning home, because there is no sign that the international community will provide for their safety if they return to their homes.

All this, Mr. Speaker, points to an unravelling of the administration's planning for Rwanda, meaning, I regret to suggest, an extended stay for our troops, an increase in the cost required; a continued stretching of our military as it struggles to meet this mission as well as the demands of Haiti, of Bosnia, of Korea, of Iraq, of Somalia, not to mention, Mr. Speaker, areas of passing interest such as Japan, Western Europe, and the former Soviet Union.

Yet, Mr. Speaker, have we seen this unfortunate turn of events dealt with by the administration? As of today, we have not. Have we seen the administration attempt to explain this deteriorating situation and the challenges posed to our mission, to the American people and, Mr. Speaker, to the Congress? We have not, Mr. Speaker. Have we seen the administration describe an exit strategy which lays the foundation for our troops to conclude their mission? We have not, Mr. Speaker. Have we seen any concerted, high profile effort in the United Nations by our representatives to bring together peacekeeping contingents to prevent further tragedy in Rwanda and enable our troops to come home? We have not, Mr. Speaker. Instead we see our forces—our efforts focused on getting the United Nations to approve a United Nations invasion of Haiti.

Mr. Speaker, it is clear that both our Government and the community of nations must take decisive actions soon to prevent the Rwandan tragedy from descending into even greater depths of despair.

Mr. Speaker, I see the gentleman's motion as a means to send a signal today, a warning shot across the bow, indeed, that we believe the administration and the United Nations have to refocus on Rwanda as well as all the other peacekeeping missions we have embarked on. They must level with the American people. They must level with the Congress. We must refocus and get our House in order. We must enlist the community of nations to solve this problem.

And, oh, yes, Mr. Speaker, the United Nations needs reform immediately.

Mr. MOLLOHAN. Mr. Speaker, I yield back the balance of my time.

Mr. ROGERS. Mr. Speaker, I urge the adoption of the motion to instruct conferees.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. MONTGOMERY). Without objection, the previous question is ordered on the motion to instruct.

There was no objection.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky [Mr. ROGERS].

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. ROGERS. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 177, nays 250, not voting 7, as follows:

[Roll No. 384]

YEAS—177

Allard
Archer
Armey
Bachus (AL)
Baker (CA)
Baker (LA)
Ballenger
Barrett (NE)
Bartlett
Barton
Bateman
Bentley
Bilirakis
Bliley
Blute
Boehner
Bonilla
Bunning
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Clinger
Coble
Collins (GA)
Combest
Condit
Cooper
Costello
Cox
Crane
Crapo
Cunningham
DeLay
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
Everett
Ewing
Fawell
Fields (TX)
Fowler
Franks (CT)
Franks (NJ)
Gallegly
Gallo
Gekas
Gilchrest
Gillmor
Gingrich
Goodlatte
Goodling
Goss
Grams
Grandy
Green
Greenwood
Gunderson
Hall (TX)
Hancock
Hansen
Hastert
Hayes
Hefley
Hobson
Hoekstra
Hoke
Horn
Huffington
Hunter
Hutchinson
Hyde
Inglis
Inhofe
Istook
Jacobs
Johnson, Sam
Kasich
Kim
King
Kingston
Klug
Knollenberg
Kolbe
Kyl
Lazio
Levy
Lewis (CA)
Lewis (FL)
Lewis (KY)
Lightfoot
Linder
Livingston
Lucas
Machtley
Manzullo
Mazzoli
McCandless
McCollum
McCrery
McDade
McHugh
McInnis
McKeon
McNulty
Meyers
Mica
Michel
Miller (FL)
Molinari
Moorhead
Myers
Nussle
Oxley
Packard
Paxon
Petri
Pombo
Portman
Poshard
Pryce (OH)
Quillen
Quinn
Ramstad
Regula
Ridge
Roberts
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Royce
Santorum
Saxton
Schaefer
Schiff
Sensenbrenner
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Snowe
Solomon
Spence
Stearns
Stump
Sundquist
Talent
Tauzin
Taylor (MS)
Taylor (NC)
Thomas (CA)
Thomas (WY)
Torricelli
Traficant
Upton
Vucanovich
Walker
Walsh
Weldon
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NAYS—250

Abercrombie
Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Baesler
Barca
Barcia
Barlow
Barrett (WI)
Becerra
Beilenson
Bereuter
Berman
Bevill
Bilbray
Bishop
Blackwell
Boehlert
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Byrne
Cantwell
Cardin
Carr
Chapman
Clay
Clayton
Clement
Clyburn
Coleman
Collins (IL)
Collins (MI)
Conyers
Coppersmith
Coyne
Cramer
Danner
Darden
de la Garza
Deal
DeFazio
DeLauro
Dellums
Derrick
Deutsch
Dicks
Dingell
Dixon
Dooley
Durbin
Edwards (CA)
Edwards (TX)
Engel
English
Eshoo
Evans
Farr
Fazio
Fields (LA)
Filner
Fingerhut
Fish
Flake
Foglietta
Ford (MI)
Ford (TN)
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Gilman
Glickman
Gonzalez
Gordon
Gutierrez
Hall (OH)
Hamburg
Hamilton
Harman
Hastings
Hefner
Hilliard
Hinchey
Hoagland
Hochbrueckner
Holden
Houghton
Hoyer
Hughes
Hutto
Inslee
Jefferson
Johnson (CT)
Johnson (GA)
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy
Kennelly
Kildee
Kleczka
Klein
Klink
Kopetski
Kreidler
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Leach
Lehman
Levin
Lewis (GA)
Lipinski
Lloyd
Long
Lowey
Maloney
Mann
Manton
Margolies-Mezvinsky
Markey
Martinez
Matsui
McCloskey
McCurdy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Mfume
Miller (CA)
Mineta
Minge
Mink
Moakley
Mollohan
Montgomery
Moran
Morella
Murphy
Murtha
Nadler
Neal (MA)
Neal (NC)
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Parker
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Peterson (MN)
Pickett
Pickle
Pomeroy
Porter
Price (NC)
Rahall
Rangel
Reed
Reynolds
Richardson
Roemer
Rose
Rostenkowski
Rowland
Roybal-Allard
Rush
Sabo
Sanders
Sangmeister
Sarpalius
Sawyer
Schenk
Schroeder
Schumer
Scott
Serrano
Sharp
Shepherd
Sisisky
Skaggs
Skelton
Slattery
Slaughter
Smith (IA)
Spratt
Stark
Stenholm
Stokes
Strickland
Studds
Stupak
Swett
Swift
Synar
Tanner
Tejeda
Thompson
Thornton
Thurman
Torkildsen
Torres
Towns
Tucker
Unsoeld
Valentine
Velazquez
Vento
Visclosky
Volkmer
Waters
Watt
Waxman
Wheat
Williams
Wilson
Wise
Woolsey
Wyden
Wynn
Yates

NOT VOTING—7

Dornan
Herger
McMillan
Ravenel
Roukema
Washington
Whitten

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Mr. HOYER and Mr. STRICKLAND changed their vote from "yea" to "nay."

Mr. HALL of Texas changed his vote from "nay" to "yea."

So the motion to instruct was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore (Mr. LAROCCO). Without objection, the Chair appoints the following conferees: Messrs. MOLLOHAN, SMITH of Iowa, CARR of Michigan, MORAN, SKAGGS, PRICE of North Carolina, OBEY, ROGERS, KOLBE, TAYLOR of North Carolina, and MCDADE.

There was no objection.

GENERAL LEAVE

Mr. MOLLOHAN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on the motion to instruct House conferees on H.R. 4603.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from West Virginia?

There was no objection.

GENERAL LEAVE

Mr. BEVILL. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on the conference report on the bill (H.R. 4506) making appropriations for energy and water development for the fiscal year ending September 30, 1995, and for other purposes, as well as the Senate amendments reported in disagreement, and that I may include extraneous material and tables.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Alabama?

There was no objection.

CONFERENCE REPORT ON H.R. 4506, ENERGY AND WATER DEVELOPMENT APPROPRIATIONS ACT, 1995

Mr. BEVILL. Mr. Speaker, I call up the conference report on the bill (H.R. 4506) making appropriations for energy and water development for the fiscal year ending September 30, 1995, and for other purposes.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to the rule, the conference report is considered as having been read.

(For conference report and statement, see proceedings of the House of August 4, 1994, at page 19681).

The SPEAKER pro tempore. The gentleman from Alabama [Mr. BEVILL] will be recognized for 30 minutes, and the gentleman from Indiana [Mr. MYERS] will be recognized for 30 minutes.

The Chair recognizes the gentleman from Alabama [Mr. BEVILL].

Mr. BEVILL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am pleased to present the conference report on the fiscal year 1995 energy and water development appropriations bill for your favorable consideration. Our colleagues will recall that debate on this bill occurred in the House on June 14, and the bill was passed by a vote of 393 to 29. The Senate passed the bill on June 30 by a vote of 91 to 8.

Mr. Speaker, our conference committee meeting was held on Thursday, August 4. I wish to compliment our friends from the other body, particularly the Senator from Louisiana [Mr. JOHNSTON], the chairman of the Senate subcommittee, for the fine spirit of compromise displayed in the conference meeting. I also wish to thank my colleagues, the House conferees, for their support and their valuable contributions during the conference deliberations.

Mr. Speaker, I would like to address the action which the conference committee took on two items of interest of the House—the superconducting super collider and the advanced liquid metal reactor program.

For the superconducting super collider, no additional funds have been provided for termination in fiscal year 1995. Language has been included which will permit the use of funds appropriated last year for SSC termination costs to be used to finalize the outstanding claims of the State of Texas. This will conclude the Federal Government's liability to the State of Texas and no additional funds will be required. No additional funds are provided to the Department of Energy for other termination costs. All termination costs are to be paid from previously appropriated funds.

With respect to the advanced liquid metal reactor program, on August 1 the House instructed the conferees to maintain the House position on terminating the advanced liquid metal reactor program. As you can see from the conference agreement, only the House proposed funding to terminate this program in fiscal year 1995 has been provided.

Now I would like to comment on other aspects of the conference agreement.

In total the conference agreement is $19,751,000 below the President's budget request, just $1,000 below the subcommittee's 602(b) allocation for budget authority, and $4,236,000 below the 602(b) allocation for outlays.

Mr. Speaker, for the various agencies and programs under the jurisdiction of the Energy and Water Development Subcommittee, the committee of conference recommends $20,492,999,000 in new-budget authority. This amount is $137,377,000 above the House bill and $19,894,000 below the Senate bill.

The conference agreement we present to you today is the culmination of many months of effort on the part of the House committee and the same review by the Senate committee. During this period we have heard testimony from hundreds of witnesses—contained in eight hearing volumes of thousands of pages.

The Senate had a total of 50 numbered amendments to the bill. But, within those 50 amendments, there were approximately 400 individual items in disagreement. The conference agreement represents the best efforts of the House and Senate conferees to achieve consensus on each of those items. Many items had to be reduced or changed to accomplish agreement with the Senate. In addition, we had to keep in mind the need to have a bill that was acceptable to the administration.

Your House conferees did their best to maintain the House position. However, to bring back a conference report that is within the budget allocation for the energy and water development programs, a great many items had to be compromised.

We would like more money for energy and the water projects. But, we have only limited funds for these items, and therefore, we cannot provide all of the funds for all of the programs and projects to the extent we would like.

Mr. Speaker, the conference agreement contains $3,408,919,000 in title I for the Army Corps of Engineers. This $43,515,000 below the bill as passed by the House and $17,354,000 higher than the Senate-passed bill. These funds will finance 528 water resources projects in the planning or construction phase, and provide for urgently needed operation and maintenance activities at completed projects.

For title II, the Department of the Interior and the Bureau of Reclamation, the conferees recommend a total of $881,399,000 which is $2,221,000 below the House-passed bill and $11,985,000 more than the Senate-passed bill. This will fund 93 water resources projects in the planning or construction phase and provide funds for operation and maintenance of 39 projects.

In my view, the conference agreement provides for a financially prudent and environmentally sound water resources development program.

The conference agreement contains $15,901,676,000 for the Department of Energy programs in title III. This includes $3,314,548,000 for energy supply, research, and development activities; $272,526,000 for power marketing administrations; $392,800,000 for the nuclear waste disposal fund; and $984,031,000 for general science and research activities. The energy accounts include $388,108,000 for solar and other renewable energy programs; $293,228,000 for nuclear energy; $372,563,000 for magnetic fusion; and $747,296,000 for basic energy sciences. The conference agreement provides a total of $10,300,847,000 for atomic energy defense activities. Within this bill, $6,138,059,000 is provided for defense and nondefense environmental restoration and cleanup activities.

Mr. Speaker, the conference agreement includes $470,408,000 for nine independent agencies and commissions in title IV, including the Appalachian Regional Commission, the Nuclear Regulatory Commission, and the Tennessee Valley Authority.

Mr. Speaker, there are several people who made it possible to complete the conference agreement. I want to make special note of the contributions made by two appropriations committee staff members. Lori Whipp has worked tirelessly and with incredible skill in putting this conference report together. All of the tables and scorekeeping computations needed to develop this bill were prepared by Tim Buck who consistently works under very tight deadlines imposed by the subcommittee. I would also like to thank Kyle Jones, who has been on detail to the Subcommittee on Energy and Water Development from the Corps of Engineers, for his assistance during the entire fiscal year 1995 appropriations process. Lori, Tim, and Kyle deserve our very special thanks for their help in bringing this bill to the House for its consideration today.

Mr. Speaker, I strongly urge the Members to support the hard work of my subcommittee and pass the conference report and amendments which will be presented to the House.

Mr. Speaker, at this point I include in the RECORD a table which summarizes the financial aspects of the conference agreement, as follows:

ENERGY AND WATER APPROPRIATIONS BILL, 1995 (H.R. 4506)

	FY 1994 Enacted	FY 1995 Estimate	House	Senate	Conference	Conference compared with enacted
TITLE I - DEPARTMENT OF DEFENSE - CIVIL						
DEPARTMENT OF THE ARMY						
Corps of Engineers - Civil						
General investigations	207,540,000	147,850,000	179,062,000	161,199,000	161,199,000	-26,341,000
Construction, general	1,400,875,000	956,147,000	1,023,595,000	977,660,000	983,668,000	-417,207,000
Flood control, Mississippi River and tributaries, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee	348,875,000	319,918,000	334,138,000	328,138,000	328,138,000	-20,737,000
Operation and maintenance, general	1,688,990,000	1,608,184,000	1,646,535,000	1,631,434,000	1,646,535,000	-42,455,000
Regulatory program	92,000,000	109,916,000	101,000,000	101,000,000	101,000,000	+9,000,000
Flood control and coastal emergencies	20,000,000	14,979,000	14,979,000	14,979,000	14,979,000	-5,021,000
Emergency supplemental appropriations	70,000,000					-70,000,000
General expenses	148,500,000	156,255,000	152,500,000	156,255,000	152,500,000	+4,000,000
Oil spill research	350,000	625,000	625,000	900,000	900,000	+550,000
Total, title I, Department of Defense - Civil	3,977,130,000	3,313,874,000	3,452,434,000	3,391,565,000	3,408,919,000	-568,211,000
TITLE II - DEPARTMENT OF THE INTERIOR						
Central Utah Project Completion Account						
Central Utah project construction	14,920,000	22,839,000	22,839,000	22,839,000	22,839,000	+7,919,000
Fish, wildlife, and recreation mitigation and conservation	4,850,000	11,133,000	11,133,000	11,133,000	11,133,000	+6,283,000
Utah reclamation mitigation and conservation account	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	
Program oversight and administration	1,000,000	1,191,000	1,191,000	1,191,000	1,191,000	+191,000
Total, Central Utah project completion account	25,770,000	40,163,000	40,163,000	40,163,000	40,163,000	+14,393,000
Bureau of Reclamation						
General investigations	13,819,000	12,800,000	14,190,000	14,340,000	14,190,000	+371,000
Construction program	464,423,000	380,906,000	432,727,000	425,727,000	432,727,000	-31,696,000
Operation and maintenance	282,898,000	284,165,000	286,521,000	282,165,000	284,300,000	+1,402,000
Loan program	13,500,000	3,600,000	9,600,000	6,800,000	9,600,000	-3,900,000
(Limitation on direct loans)	(21,000,000)	(10,915,000)	(23,000,000)	(20,000,000)	(23,000,000)	(+2,000,000)
General administrative expenses	54,034,000	54,191,000	54,034,000	54,034,000	54,034,000	
Emergency fund	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	
Colorado River Dam fund (by transfer, permanent authority)	(-7,168,000)	(-7,472,000)	(-7,472,000)	(-7,472,000)	(-7,472,000)	(-304,000)
Central Valley project restoration fund	45,000,000	45,385,000	45,385,000	45,385,000	45,385,000	+385,000
Total, Bureau of Reclamation	874,674,000	781,847,000	843,457,000	829,251,000	841,236,000	-33,438,000
Total, title II, Department of the Interior	900,444,000	822,010,000	883,620,000	869,414,000	881,399,000	-19,045,000
(By transfer)	(-7,168,000)	(-7,472,000)	(-7,472,000)	(-7,472,000)	(-7,472,000)	(-304,000)
TITLE III - DEPARTMENT OF ENERGY						
Energy Supply, Research and Development Activities:						
Operating expenses	2,812,840,000	2,969,841,000	2,869,527,000	2,953,085,000	2,936,905,000	+124,065,000
Plant and capital equipment	411,070,000	454,343,000	432,643,000	376,643,000	377,643,000	-33,427,000
Total	3,223,910,000	3,424,184,000	3,302,170,000	3,329,728,000	3,314,548,000	+90,638,000
Uranium Supply and Enrichment Activities:						
Operating expenses	246,992,000	68,108,000	72,210,000	68,108,000	68,108,000	-178,884,000
Plant and capital equipment	100,000	5,102,000	1,000,000	5,102,000	5,102,000	+5,002,000
Subtotal	247,092,000	73,210,000	73,210,000	73,210,000	73,210,000	-173,882,000
Gross revenues	-70,000,000	-9,900,000	-9,900,000	-9,900,000	-9,900,000	+60,100,000
Net appropriation	177,092,000	63,310,000	63,310,000	63,310,000	63,310,000	-113,782,000
Uranium enrichment decontamination and decommissioning fund	286,320,000	301,327,000	301,327,000	301,327,000	301,327,000	+15,007,000
General Science and Research Activities:						
Operating expenses	1,329,785,000	798,161,000	713,570,000	702,171,000	708,570,000	-621,215,000
Plant and capital equipment	285,329,000	275,461,000	275,461,000	271,461,000	275,461,000	-9,868,000
Total	1,615,114,000	1,073,622,000	989,031,000	973,632,000	984,031,000	-631,083,000
Nuclear Waste Disposal Fund	260,000,000	254,800,000	304,800,000	402,800,000	392,800,000	+132,800,000
Isotope production and distribution fund	3,910,000		11,800,000			-3,910,000
Environmental Restoration and Waste Management:						
Defense function	(5,181,855,000)	(5,194,424,000)	(5,128,211,000)	(5,083,691,000)	(5,092,691,000)	(-89,164,000)
Non-defense function	(1,003,798,000)	(1,045,368,000)	(1,045,368,000)	(1,045,368,000)	(1,045,368,000)	(+41,570,000)
Total	(6,185,653,000)	(6,239,792,000)	(6,173,579,000)	(6,129,059,000)	(6,138,059,000)	(-47,594,000)

ENERGY AND WATER APPROPRIATIONS BILL, 1995 (H.R. 4506), continued

	FY 1994 Enacted	FY 1995 Estimate	House	Senate	Conference	Conference compared with enacted
Atomic Energy Defense Activities						
Weapons Activities:						
Operating expenses	3,248,656,000	2,967,316,000	2,893,417,000	2,941,316,000	2,919,117,000	-329,539,000
Plant and capital equipment	346,542,000	333,052,000	307,952,000	309,952,000	309,952,000	-36,590,000
Total	3,595,198,000	3,300,368,000	3,201,369,000	3,251,268,000	3,229,069,000	-366,129,000
Defense Environmental Restoration and Waste Management:						
Operating expenses	4,552,278,000	4,537,010,000	4,530,547,000	4,501,961,000	4,503,961,000	-48,317,000
Plant and capital equipment	629,577,000	657,414,000	597,664,000	581,730,000	588,730,000	-40,847,000
Total	5,181,855,000	5,194,424,000	5,128,211,000	5,083,691,000	5,092,691,000	-89,164,000
Materials Support and Other Defense Programs:						
Operating expenses	1,654,246,000	1,703,015,000	1,677,309,000	1,694,015,000	1,677,762,000	+23,516,000
Plant and capital equipment	309,509,000	195,895,000	164,895,000	171,895,000	171,895,000	-137,614,000
Total	1,963,755,000	1,898,910,000	1,842,204,000	1,865,910,000	1,849,657,000	-114,098,000
Defense Nuclear Waste Disposal	120,000,000	129,430,000	129,430,000	129,430,000	129,430,000	+9,430,000
Total, Atomic Energy Defense Activities	10,860,808,000	10,523,132,000	10,301,214,000	10,330,299,000	10,300,847,000	-559,961,000
Departmental Administration:						
Operating expenses	393,458,000	389,792,000	400,417,000	400,417,000	400,417,000	+6,959,000
Plant and capital equipment	7,780,000	6,895,000	6,895,000	6,895,000	6,895,000	-885,000
Subtotal	401,238,000	396,687,000	407,312,000	407,312,000	407,312,000	+6,074,000
Miscellaneous revenues	-239,209,000	-161,490,000	-161,490,000	-161,490,000	-161,490,000	+77,719,000
Net appropriation	162,029,000	235,197,000	245,822,000	245,822,000	245,822,000	+83,793,000
Office of the Inspector General	30,362,000	26,465,000	26,465,000	26,465,000	26,465,000	-3,897,000
Power Marketing Administrations						
Operation and maintenance, Alaska Power Administration	4,010,000	6,494,000	6,494,000	6,494,000	6,494,000	+2,484,000
Operation and maintenance, Southeastern Power Administration	29,742,000	22,431,000	22,431,000	22,431,000	22,431,000	-7,311,000
Operation and maintenance, Southwestern Power Administration	33,587,000	21,316,000	21,316,000	21,316,000	21,316,000	-12,271,000
Construction, rehabilitation, operation and maintenance, Western Area Power Administration	277,956,000	225,085,000	224,085,000	222,285,000	222,285,000	-55,671,000
(By transfer, permanent authority)	(7,168,000)	(7,472,000)	(7,472,000)	(7,472,000)	(7,472,000)	(+304,000)
Total, Power Marketing Administrations	345,295,000	275,326,000	274,326,000	272,526,000	272,526,000	-72,769,000
Federal Energy Regulatory Commission						
Salaries and expenses	165,375,000	166,173,000	166,173,000	166,173,000	166,173,000	+798,000
Revenues Applied	-165,375,000	-166,173,000	-166,173,000	-166,173,000	-166,173,000	-798,000
Total, title III, Department of Energy	16,964,840,000	16,177,363,000	15,820,065,000	15,945,909,000	15,901,676,000	-1,063,164,000
(By transfer)	(7,168,000)	(7,472,000)	(7,472,000)	(7,472,000)	(7,472,000)	(+304,000)
TITLE IV - INDEPENDENT AGENCIES						
Appalachian Regional Commission	249,000,000	187,000,000	187,000,000	267,000,000	282,000,000	+33,000,000
Defense Nuclear Facilities Safety Board	16,560,000	17,933,000	17,933,000	17,933,000	17,933,000	+1,373,000
Delaware River Basin Commission:						
Salaries and expenses	333,000	343,000	343,000	343,000	343,000	+10,000
Contribution to Delaware River Basin Commission	488,000	478,000	478,000	478,000	478,000	-10,000
Total	821,000	821,000	821,000	821,000	821,000	....
Interstate Commission on the Potomac River Basin:						
Contribution to Interstate Commission on the Potomac River Basin	498,000	511,000	511,000	511,000	511,000	+13,000
Nuclear Regulatory Commission:						
Salaries and expenses	542,900,000	540,501,000	540,501,000	535,501,000	520,501,000	-22,399,000
Revenues	-520,900,000	-518,501,000	-518,501,000	-513,501,000	-498,501,000	+22,399,000
Subtotal	22,000,000	22,000,000	22,000,000	22,000,000	22,000,000	....
Office of Inspector General	4,800,000	5,060,000	5,060,000	5,060,000	5,060,000	+260,000
Revenues	-4,800,000	-5,060,000	-5,060,000	-5,060,000	-5,060,000	-260,000
Subtotal	....	....	....	....	....	....
Total	22,000,000	22,000,000	22,000,000	22,000,000	22,000,000	....

ENERGY AND WATER APPROPRIATIONS BILL, 1995 (H.R. 4506), continued

	FY 1994 Enacted	FY 1995 Estimate	House	Senate	Conference	Conference compared with enacted
Susquehanna River Basin Commission:						
Salaries and expenses	308,000	318,000	318,000	318,000	318,000	+10,000
Contribution to Susquehanna River Basin Commission	298,000	288,000	288,000	288,000	288,000	-10,000
Total	606,000	606,000	606,000	606,000	606,000	
Tennessee Valley Authority: Tennessee Valley Authority Fund	140,473,000	136,856,000	136,856,000	142,873,000	142,873,000	+2,400,000
Nuclear Waste Technical Review Board	2,160,000	2,664,000	2,664,000	2,664,000	2,664,000	+504,000
Office of the Nuclear Waste Negotiator	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	
Total, title IV, independent agencies	433,118,000	369,391,000	369,391,000	475,408,000	470,408,000	+37,290,000
Scorekeeping adjustments	-586,165,000	-169,888,000	-169,888,000	-169,403,000	-169,403,000	+416,762,000
Grand total:						
New budget (obligational) authority	21,689,347,000	20,512,750,000	20,355,622,000	20,512,893,000	20,492,999,000	-1,196,348,000
(By transfer)						

Mr. Speaker, I would like to call the Members' attention to several minor printing errors in the conference report printed in the August 4, 1994, CONGRESSIONAL RECORD.

On page 19682, column one, under Amendment No. 2, "Horbart" should be "Hobart" and "Calument" should be "Calumet."

On page 19735, column one, eighth line from bottom, insert the word "disposition" after plutonium.

On page 19735, column two, the heading "Department" should be "Departmental."

One page of the Department of Energy tables is out of order. The table on page 19766 should be inserted before page 19767.

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Mr. Speaker, I reserve the balance of my time.

Mr. MYERS of Indiana. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I join Chairman BEVILL in thanking the staff and the committee members for the diligence and hard work that they put in to bringing this conference report to the floor.

However, I rise in somewhat reluctant support and some reserved support for the conference report. The chairman of the subcommittee and I and our staffs have come to the floor a great many times in the past the with energy and water development appropriation bills and the conference reports. I must say, regretfully, that this is the weakest and the poorest bill we have ever brought to the floor, but through no fault of this subcommittee. To begin with, our 602(b) allocation was cut way below last year's levels and way below meeting the needs for the responsibility that this committee has to fund for our executive branch and our Federal Government. This is the best we could come up with.

There are a couple of items I do have some disagreement with, and I will talk about those items later.

The bill is $137 million over our own House figure, and it is $20 million below the Senate figure. It is about $1.3 billion under last year's figure.

I am a conservative, and I certainly believe we ought to reduce spending whenever we have the opportunity but there are certain areas that we fund here that offer an investment in our future. As an example, for the Corps of Engineers, we have cut about half a billion dollars out of the Corps of Engineers for projects for keeping open the inland waterways, of which we have more than 25,000, and maintaining them so we will have a transportation system to move the products that are necessary to move on the inland waterways. Funding to maintain the deep seaports that we have on three coasts and the Great Lakes is reduced and we do not have the money this year to adequately maintain them. So we are really being penny-wise and pound-foolish here in cutting some of these programs.

We have cut $19 million from the Bureau of Reclamation that has responsibility for the Western area, particularly the Western States, in operating some of our waterways and management for Federal lands. This, too, will reduce our ability to do an efficient and effective job in maintaining and operating these lands.

The really big one, though, is the Department of Energy. About a billion dollars is cut out of the $16 billion we appropriate for the Department of Energy. These are investments in the research that will provide the energy for our children and grandchildren. Should we jeopardize our children's future and our grandchildren's future by denying them the access to having the cheapest and the most available resources that we take for granted every day? I think not.

There is one area the chairman did mention that I will talk about later on, and that is amendment No. 35, on which I have some serious reservations and some serious questions.

But, Mr. Speaker, I do support the bill, and I support the conference report with a lot of reluctance.

Mr. Speaker, I reserve the balance of my time.

Mr. BEVILL. Mr. Speaker, I yield such time as he may consume the gentleman from Texas [Mr. FROST].

Mr. FROST. Mr. Speaker, I rise in support of the conference report on the energy and water development appropriations for fiscal year 1995.

Recently, the State of Texas and the Department of Energy reached a settlement dealing with the termination of the superconducting super collider. After several months of negotiations, Texas and DOE worked out the terms of an agreement that settles several outstanding issues arising from the decision to terminate the SSC, including the ownership of assets and Federal reimbursement to the State.

One of the terms of the settlement provides that the Federal Government will help complete the linear accelerator that was substantially built at the time the SSC was shut down. The linear accelerator, once complete, can be utilized as a proton beam cancer treatment facility, only the third such facility in the United States.

The conference agreement will enable the Department of Energy to carry out its obligations under the settlement by permitting it to use up to $65 million in previously appropriated funds to help complete the linear accelerator.

Mr. Speaker, this settlement is good for the Federal Government and for the State of Texas. It makes the best of a bad situation, and will eliminate the likelihood of years of expensive litigation.

Adoption of the conference report will let us put the controversies surrounding the SSC behind us once and for all. I commend Chairman BEVILL and the House conferees for their work, and urge Members to support passage of this measure.

Mr. BEVILL. Mr. Speaker, I yield 1 minute to our good friend, the gentleman from Iowa [Mr. SMITH].

Mr. SMITH of Iowa. Mr. Speaker, I thank the gentleman for yielding this time to me.

Mr. Speaker, I rise in very strong support of this bill. We had a huge flood in Iowa last year, and if you have gone through one of those floods, you would then understand how important this bill is. It is more important to be prepared for a flood than it is to try to clean up after one.

We were prepared out there. Thanks to this subcommittee, over the years we have established some flood control measures. But for that we would have had several billions of dollars probably in flood damages that did not occur. We were able to at least reduce the damages that resulted out there.

This is a very, very important bill. A dollar spent for maintenance and repairing is a lot better than spending money for emergency programs and for cleanup efforts.

I also want to say that many of the Members probably do not realize this, but the Energy Department has some very important research in this bill. The Ames laboratory is no longer in the district I represent, but it has a very important project there. It has been going on since World War II, and that has helped to prepare us to be competitive in this world today. So that is a very important part of the bill, and I do rise in strong support of the bill.

Mr. MYERS of Indiana. Mr. Speaker, I yield 2 minutes to the ranking member emeritus of the Committee on Rules, the gentleman from Tennessee [Mr. QUILLEN], a Member of this Congress who has worked frequently with this committee.

Mr. QUILLEN. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I would like to engage in a colloquy with the distinguished chairman of the Energy and Water Appropriations Subcommittee. I was delighted to see that the conferees on this bill agreed to appropriate $50 million for fissile materials disposition, even though the administration requested only $9 million. It is much to their credit that the conferees want the administration to advance its pace on developing and implementing approaches relating to the disposal and utilization of excess weapons grade material. I noticed, however, that while the conference report on this issue specifically referred to a number of fissile material projects, there was no specific mention of the need to make and implement decisions on the disposition of highly enriched uranium. I would like to confirm that the action of the conferees is aimed at the disposition of highly enriched uranium as well as other fissile materials and that the conferees wish to assign a high priority to all fissile material disposition activities, including those regarding H.E.U. Is that in fact the case?

Mr. BEVILL. Mr. Speaker, will the gentleman yield?

Mr. QUILLEN. I yield to the gentleman from Alabama.

Mr. BEVILL. Mr. Speaker, in answer to the question, yes, the gentleman is correct.

Mr. QUILLEN. Mr. Speaker, I thank the chairman of the subcommittee.

Mr. BEVILL. Mr. Speaker, I yield 3 minutes to the gentleman from Arizona [Mr. PASTOR], a very distinguished member of this subcommittee.

Mr. PASTOR. Mr. Speaker, I rise today in strong support of the conference report for H.R. 4506. Both my colleagues on the subcommittee and our counterparts in the Senate have worked hard to create a bill that meets the needs of this country. Budgetary constraints made this an especially difficult task—the conference report is nearly $1.2 billion below last year's level. In addition, nearly one-third of the money in this bill is dedicated to environmental restoration and waste management activities at DOE weapons and defense sites, and at our national labs. Given these facts, there were many good, deserving projects and programs that did not receive funding. But this is a situation that we must live with today, and learn to live with for several more years.

This conference report, Mr. Speaker, is good for the American people. It contains money to clean up the environment, provide flood protection for tens of millions of people, reduce our dependence on foreign fuel, and research areas of science whose applications will improve the quality of life.

Funding for solar and renewable energy initiatives is nearly 12 percent higher than last year's appropriation. This increase will enable the Department of Energy to aggressively pursue the further development of renewable energy technologies and put our country firmly on the path to international leadership in this field. The future belongs to renewable energy. This bill will help the industry to make even greater gains and bring us closer to the day when we can harness the forces of nature to meet our energy demands.

Funding from the nuclear waste disposal fund received a massive increase of over 51 percent from last year's level. The additional dollars will help us to move closer to the day when the Federal Government can fulfill its obligation to safely store civilian nuclear waste. Pro- or anti-nuclear, everyone acknowledges the need to safely dispose of high level, civilian nuclear waste. This bill acknowledges this urgent need and provides the funding to help meet it.

The conference report also preserves, as best it can, our commitment to preserving a fuel mix. It provides money to continue nuclear research and development, as well as fusion research. In addition, it continues high energy and nuclear physics research, isotope production, and other important scientific endeavors.

Finally, the bill provides over $4.2 billion in flood control and water reclamation projects. From protecting life and property to researching innovative methods of water conservation, every State in the country benefits from these dollars.

Mr. Speaker, as I said before, this was an especially difficult year for the subcommittee. I would like to acknowledge the efforts of my colleagues on the subcommittee, especially Chairman BEVILL and Congressman MYERS. The fine leadership they provided helped to make the House bill, and now the conference report, the best it could be under our constraints. In addition, I want to thank the subcommittee staff, both minority and majority, who all have worked very hard on the bill over the past several months.

□ 1200

Mr. MYERS of Indiana. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey [Mr. GALLO]. I might say at this point I thank the gentleman, for during the period of time we were working on this bill and the conference report, the gentleman was experiencing a lot of severe physical discomfort because of hip replacement, but he never missed any of the important meetings. He was always there to help us. We thank the gentleman on behalf of the committee.

Mr. GALLO. Mr. Speaker, I rise today in support of the conference report for H.R. 4506 making appropriations for energy and water development for fiscal year 1995 and I urge my colleagues to support this report.

As a member of this subcommittee, I would like to thank Chairman BEVILL and Ranking Member JOHN MYERS for all their hard work and leadership. I would also like to thank the subcommittee staff for assisting me and adding their expertise in crafting this important bill.

This year the subcommittee had a difficult task balancing the needs of our Nation with the need for fiscal responsibility. However, the subcommittee found that balance and was able to craft a bill that will provide energy security, keep our waterways open and protect our citizens from devastating floods.

This conference report is $19.8 million below the President's budget request for fiscal year 1995 and $1.2 billion below this year's level.

This is not a perfect bill, however, it does allow the United States to move forward in meeting our Nation's needs. We have provided a commitment toward the long-term development of new energy sources and have continued the impressive progress toward the development of our conventional energy sources.

I am particularly pleased that this conference report provides $388 million for solar and renewable energy sources, an increase of about 12 percent above this year's funds. We must continue this investment and we must continue our commitment to funding valuable research and development initiatives.

I am also pleased that the committee was able to provide an increase in funding for the activities at Yucca Mountain. This report provides $392.8 million. It is essential that we continue to move toward our goal of providing a national repository for our high level waste. I am concerned, however, that the administration does not share this goal and I urge them to take a close look at providing additional funding for this program in the future.

An important element of this year's report is the money provided for magnetic fusion research. It is difficult to think of a more worthwhile Federal investment than research and development into future energy alternatives. Fusion holds the promise of an environmentally benign and safe source of energy and it is an investment that I am happy to support.

This report contains funds for the Tokamak physics experiment [TPX] that will replace the country's largest fusion device at Princeton. We have not built a major fusion machine in this country since the 1970's and TPX is unique in world fusion efforts. I am anxious that Congress will authorize construction of this important machine in the near future so that we can continue to make world-record breakthroughs in fusion research.

In addition, this report provides funding for a number of critical flood control projects throughout the United States. It also provides necessary funding to keep our navigable waterways open for business. We cannot have a strong export market unless we are able to use our ports. This report allows us to dredge our ports and allows us to stay competitive with our trading partners.

Preparing for our future needs is never easy, but the conference report for H.R. 4506 provides the insight and programs that will make it a little easier. I urge the adoption of the conference report.

Mr. BEVILL. Mr. Speaker, I yield 2 minutes to our good friend and colleague, the gentleman from California [Mr. FAZIO].

Mr. FAZIO. Mr. Speaker, I rise in strong support of the conference agreement on the energy and water development appropriations for fiscal year 1995. I urge my colleagues to support the agreement hammered out with the Senate.

Mr. Speaker, the conferees have done an excellent job of reaching agreement on a wide variety of issues. I think it is important to note that this subcommittee has once again been asked to do more with less. Despite the adjustment in the subcommittee's 602(b) number, this bill is still $1.6 billion below our fiscal year 1994 allocation.

Many deserving projects have been delayed due to fiscal constraints. The agreement reached with the Senate reflects the many hard choices we were forced to make. We are all asked to do more with less. I believe that this bill represents the most we could do with much less than we need.

Mr. BEVILL and Mr. MYERS have once again moved our panel forward in a bipartisan manner, looking at each project on the merits. I want to thank them for their hard work and efforts. I also want to thank the subcommittee staff for finding ways to do the nearly impossible with such regularity.

Mr. Speaker, this bill deals with the tough choices we are faced with and does so in a thoughtful and reasonable way. The conferees have dealt with contentious issues like the termination of the advanced liquid metal reactor and the Supercollider in ways that maximize the federal investment while following the will of the House.

In consultation with the authorizing committees, the conferees have allowed for a sensible, fiscally-responsible development of important research programs like the magnetic fusion program. We also reaffirm our commitment of solar and renewable energy, providing funding that sends a signal that these important environmentally sound technologies are an integral part of our energy security.

Every Member in this Chamber has an interest in making sure that we protect our water systems, the lifeblood of our communities. The conference agreement provides the U.S. Army Corps of Engineers with the resources it needs to prevent flooding by planning flood control projects. In short, the agreement helps protect our constituents in times of too much water.

In times of too little water, the U.S. Bureau of Reclamation looks to fill needs created by drought conditions. The conference agreement reflects the changing role of the Bureau of Reclamation and recognizes the value of our natural resources.

Mr. Speaker, this bill is a balanced approach. It is the product of hard work and tough choices. We have been asked to do more with less. The conference agreement has met that mandate. I strongly urge a yes vote.

Mr. FAZIO. I would ask the gentleman from Alabama, the chairman of the subcommittee, to engage in a brief colloquy.

At my request and that of Mr. HAMBURG the conference report includes language expressing support for the Geysers wastewater effluent project as well as funding for the project at the level approved by the House. By adopting this language, is it correct that it is the intent of the conferees to do nothing to preclude the Department of Energy from working with the project sponsors to identify additional resources to ensure the timely completion of this important project?

Mr. BEVILL. Mr. Speaker will the gentleman yield?

Mr. FAZIO. I yield to the gentleman from Alabama.

Mr. BEVILL. The gentleman is correct.

Mr. FAZIO. I understand that if the Department of Energy determines that it can further assist in the timely completion of this project, then it should take such steps as it deems necessary, as long as such steps do not conflict with other spending priorities approved in the conference report. Is this correct?

Mr. BEVILL. Yes; the gentleman is correct.

Mr. FAZIO. Mr. Speaker, I thank the gentleman for this clarification and his strong support for this important project.

Mr. MYERS of Indiana. Mr. Speaker, I yield 5 minutes to the gentleman from Kentucky [Mr. ROGERS], a member of the subcommittee.

Mr. ROGERS. Mr. Speaker, I thank the ranking member, Mr. MYERS, for this time.

Mr. Speaker, I rise in strong support of the fiscal year 1995 energy and water development appropriations conference report and urge its quick adoption.

I want to thank the distinguished chairman of the subcommittee, the gentleman from Alabama, and the ranking member, the gentleman from Indiana, for the fine work that they and their staffs have put into this bill over the spring and summer. As we all know, it is difficult to balance limited resources when there are so many legitimate and competing needs which deserve federal support.

Nonetheless, this subcommittee has done its best to strike that delicate balance and to provide funding for such diverse items as flood protection, nuclear waste clean-up, and next-generation energy production technologies.

Clearly, Mr. Speaker, this is the most austere allocation for this subcommittee in the recent past. Still, the subcommittee listened intently to the interests of hundreds of local and State officials, and to many colleagues here from this body who were concerned about important local and national projects.

This subcommittee protects these interests, and, consequently, those of our country, Mr. Speaker, as they develop this bill every year.

The collective experience of the chairman and ranking member and the other members of the subcommittee is one of the great assets, in my opinion, of this House. This bill deserves the support of the Members for a number of reasons, and I will briefly mention a few.

First and foremost, this bill is fiscally responsible. We are more than $19 million below the President's request and $1.2 billion below last year's level. And that $1.2 billion is in real dollars Mr. Speaker. It is not adjusted for inflation, growth, or any other budget terminology which may cloud the difficult spending cuts we must make every year. This subcommittee operates as fairly as possible with a shrinking budget.

Second, this bill continues to invest in our Nation's future through basic and applied research into science and technology that will keep the United States competitive in the next century. It is important to remember that this country greatly benefits today from research and development which was conducted in the past.

While it is sometimes difficult to justify programs which have long-term payoffs when there are so many immediate needs, this country's economic security is dependent on a scientific community which is as strong and as healthy as that of our competitors.

To be sure, we won the cold war because of our superior knowledge and technology. We must also be prepared to make a similar investment today so that we can win the economic competition of tomorrow.

Finally, this bill funds vital projects and programs that protect and promote American citizens today. Flood control is of particular importance to the Appalachian region of the country, and I am grateful that the committee has seen fit to provide adequate funding in this area. Flood protection is a wise investment that ultimately saves Federal monies. As we all know, an ounce of prevention in flood control will be vastly cheaper than a ton of cure in emergency assistance spending.

Moreover, I want to commend the conferees for including funds which will continue the work of the Appalachian Regional Commission, an agency that helps needy areas in our neck of the woods and throughout the 13 diverse Appalachian States of the country.

ARC's basic resources for education, infrastructure, and other initiatives permit our Nation's poorest rural communities to help themselves pursue economic development and security. In recent months, this body has devoted great attention to the needs of our inner cities. However, our impoverished rural communities have similar needs and I am grateful that this subcommittee has remembered them in this bill.

For all these reasons, Mr. Speaker, this bill deserves the support of all the Members in the body. While it does not meet every goal, as our panel would have preferred, we have been fiscally responsible and have struck the proper balance between the many important needs we must address with the limited funds we have available.

Again, I salute the subcommittee members for the fine work they have done in this bill, and urge its final adoption.

□ 1210

Mr. BEVILL. Mr. Speaker, I yield 1 minute to the gentleman from Florida [Mr. PETERSON].

Mr. PETERSON of Florida. Mr. Speaker, I will not reiterate all the accomplishments of this committee that have been noted by my other colleagues, but I do want to take a minute to thank the gentleman from Alabama [Mr. BEVILL] and the gentleman from Indiana [Mr. MYERS] for leading us in the right direction in a year when we had a very, very tough project of trying to determine the priorities. I am also very pleased to say that we did reduce spending overall, but in the process of reducing that spending we, I think, are leaving out some of the very important things that we have got to focus on. And that is in that research area that was noted by the previous speaker.

We need to work on that, and we will have to look at that again next year.

I am also happy to say that we did the renewal energy side of the House. We put enough money in there to keep that focused, and we also worked very hard to work on the flood containment that was obvious during the Midwest floods and just recently in the area of my district in northwest Florida.

I thank the staff, and I thank the Members for their diligent work and look forward to working on this project again next year.

Mr. MYERS of Indiana. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. COMBEST].

Mr. COMBEST. Mr. Speaker, I would like to enter into a brief colloquy with the chairman of the subcommittee relative to the Lake Meridith Salinity Control Project in Texas. Unfortunately, due to an apparent misunderstanding in the conference on the Energy and Water Development Appropriations bill for fiscal year 1995, funding for this project was omitted. To supplement the shortfall created by this oversight, I would like to request that the Bureau of Reclamation utilize any unused funds from fiscal year 1994 for the Lake Meridith project. Directing those unused funds from fiscal year 1994 would enable this project to move forward.

I thank the chairman for his consideration of this request. As the gentleman knows, managers of the bill in the other body will engage in a similar colloquy.

Mr. BEVILL. Mr. Speaker, will the gentleman yield?

Mr. COMBEST. I yield to the gentleman from Alabama.

Mr. BEVILL. Mr. Speaker, I appreciate this being brought to my attention, and I certainly agree with the gentleman from Texas.

Mr. COMBEST. Mr. Speaker, I thank the gentleman very much for his comments.

Mr. BEVILL. Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida [Mrs. MEEK], a very distinguished member of this subcommittee.

Mrs. MEEK of Florida. Mr. Speaker, I rise in strong support of the conference report for energy and water development for this year. I also stand to congratulate the two leaders of our committee, the gentleman from Alabama [Mr. BEVILL], and the ranking member, the gentleman from Indiana [Mr. MYERS], for the fine work that they did in leading this committee.

This was a difficult task and there were more needs than there were resources. About 1 year ago the Congress passed the President's economic plan and program. At the time opponents of this plan said it was all smoke and mirrors and that the deficit would not decrease. They were flat wrong and it has been proven to be in good shape. Discretionary spending is down, and this conference report is one of the examples.

The report is about $1.6 billion under fiscal year 1994. Even with these stiff constraints, Mr. Speaker, which are the direct result of the action of the Congress 1 year ago, it has been possible to continue to improve our ports and inland waterways, to provide for flood control, to restore and protect the environment and to address the energy needs of the next century, all because of the work of this committee.

This bill will help our Nation move into a global economy. Modern, efficient ports are critical to being able to ship our goods to foreign markets; foreign trade is booming.

Let me give you a parochial example. A decade ago there was very little cargo running from the Port of Miami. Today if we look out over the port as we drive across the causeway, we can see acres and acres of containers stacked 4 and 6 feet high. In 1993, 26.5 billion dollars' worth of goods passed through the south Florida ports and airports, and this was a 9-percent increase, Mr. Speaker, over 1992. Tens of thousands of jobs have been created by this activity.

The improvement to ports and inland waterways is a direct result of the work of this committee. It has made possible the economic activity such as we have seen demonstrated here today, Mr. Speaker.

This bill continues this modernization so that transportation costs for American products will be kept as low as possible.

This bill is a jobs creator, and I would like to say again, Mr. Speaker, this subcommittee and its members and its leadership should be congratulated.

The SPEAKER pro tempore (Mr. LAROCCO). The gentleman from Alabama [Mr. BEVILL] has 11 minutes remaining, and the gentleman from Indiana [Mr. MYERS] has 17 minutes remaining.

Mr. MYERS of Indiana. Mr. Speaker, I yield 4 minutes to the gentleman from New York [Mr. BOEHLERT], who works very closely with this subcommittee on almost every facet.

Mr. BOEHLERT. Mr. Speaker, the conference report before us today in effect approves the tentative agreement reached to settle the claims of Texas against the Department of Energy for shutdown of the superconducting super collider [SSC].

Much about this settlement disturbs me—and should disturb every Member of this body. Under the settlement, taxpayers will be forced to shell out more money for a dead project to pay off spurious claims by Texas—claims that were expressly rejected by this body in 1990.

Worse still, the agreement sets up a mock peer review process to provide additional funds to the State. The review process in the settlement has more in common with a shotgun wedding than with normal scientific merit evaluation.

Under the settlement, if the reviewers—whom Texas will have a say in selecting—do not approve the $65 million grant, the entire settlement is nullified. This sounds more like peer pressure than peer review. I hope no potential source of future funds for the linear accelerator is taken in by this unusual arrangement.

Finally, I'm concerned that the Department of Energy already seems to be sidling away from its initial statements that the settlement can be funded entirely from fiscal 1994 appropriations. I hope the Department proves more capable of living within cost estimates than it has in the past.

Still, despite all this, and despite the covert way the Department has proceeded, I will reluctantly go along with this settlement because I believe delaying the shutdown now will cost taxpayers even more money. There's a benefit to be gained simply in putting this entire episode behind us.

In addition, my two primary concerns have been addressed. In a letter that I will include in the RECORD, the Department has pleaded that this will be the last Federal money going to the SSC site and that termination costs should be held to the level already appropriated.

□ 1220

Mr. Speaker, I would like to engage the gentleman from Alabama [Mr. BEVILL] for a moment in a colloquy on these points.

I would ask the gentleman from Alabama, is it his intention to hold the

Department to this commitment to limit Federal expenditures related to the SSC to the $735 million already available?

Mr. BEVILL. Mr. Speaker, will the gentleman yield?

Mr. BOEHLERT. I yield to the gentleman from Alabama.

Mr. BEVILL. Yes, Mr. Speaker, it is.

Mr. BOEHLERT. In addition, I think we all agree that any future uses for the site are the sole responsibility of Texas and not the Federal Government. This agreement brings to an end Federal commitments to future use of the linear accelerator and other projects. Is this correct?

Mr. BEVILL. If the gentleman will continue to yield, yes, that is correct.

Mr. BOEHLERT. Mr. Speaker, I thank the gentleman.

With these understandings, I will support the conference report.

Mr. Speaker, I include for the RECORD a letter to the Secretary of the Department of Energy setting forth this agreement, and a letter to me from the Secretary of Energy:

HOUSE OF REPRESENTATIVES,
Washington, DC, July 29, 1994.

Hon. HAZEL R. O'LEARY,
Secretary of Energy, U.S. Department of Energy, Washington, DC.

DEAR MADAM SECRETARY: I appreciated the briefing I received from the deputy secretary and your staff last week on the terms of agreement with Texas. I hope the lines of communication can remain open in the future.

I do continue to have several concerns about the agreement with Texas that I hope you can allay.

First, the agreement seems to set up a situation in which Texas could be coming back quickly to the federal government for additional funds to operate former Superconducting Super Collider (SSC) facilities. The grant to complete the Linear Accelerator (LINAC) with its unusual peer review provisions and the continuation of the planning grant to Texas—also awarded under unusual procedures—would seem to indicate that Texas still wishes to encumber the federal government in the future with projects unrelated to national scientific priorities. Has the Department agreed—either in the agreement or in any other documents or discussions—to any future funding of former SSC facilities? I believe it is imperative that the federal government sever all ties (except those concerning liability) with the SSC site.

Second, I remain concerned that the settlement costs could exceed the funding available from existing appropriations. The uncertainties associated with environmental cleanup at the site, the proposed elimination of contingency funds and the continuing threat of claims and litigation from local authorities in Texas raise questions about the adequacy of the $735 million on hand to implement the settlement. And quite frankly, our experience with Department of Energy cost estimates is not good. How certain are you that the settlement outlined in the terms of agreement can be paid for out of existing appropriations?

The Department's proposed settlement with Texas goes much further toward satisfying the state's unreasonable claims than I would prefer. Still, like you, I would prefer to put this whole sorry chapter behind us. (And in bills like the one Congressman Boucher and I have drafted, providing for high energy and nuclear physics, we are indeed looking toward the future.) I hope you can offer me the reassurances I need to back the proposed settlement on the House floor. I look forward to hearing from you.

Sincerely,

SHERWOOD BOEHLERT,
Member of Congress.

THE SECRETARY OF ENERGY,
Washington, DC, August 8, 1994.

Hon. SHERWOOD BOEHLERT,
U.S. House of Representatives, Washington, DC.

DEAR CONGRESSMAN BOEHLERT: I was very pleased to receive the advice contained in your letter of July 28, 1994 that the briefing on the Department's settlement terms with Texas conducted by Under Secretary Curtis was helpful to you. I share your hope that our lines of communication remain open and constructive.

Turning to your specific questions, the Department has made no commitment for future Federal funding of former Superconducting Super Collider facilities. To the contrary, the $65 million grant toward completion of the Linear Accelerator as a medical facility is described explicitly as a one-time contribution. The settlement terms clearly state that the Department is to have no continuing or additional obligation in financing this or any other former Superconducting Super Collider facility.

The full scope of termination activities includes costs of a settlement of the Texas reimbursement claim and the above-mentioned grant associated with Texas' future use of the Linear Accelerator. During negotiations with Texas, the Department has emphasized the importance of minimizing the prospect of requiring any additional appropriations for Super Collider activities. Based upon our current cost estimates and planning assumptions, the Department fully expects that all anticipated termination expenses—including settlement with Texas and a $65 million one-time Federal contribution toward completion of the LINAC—can be accommodated with existing appropriated funds. We will work aggressively to achieve this goal through management efficiencies and, to the extent possible, changing the scope of termination activities.

Your letter notes concerns regarding the reliability of prior Department of Energy cost estimates regarding the Superconducting Super Collider project. I share those concerns. Therefore I must acknowledge that judgments about estimated costs of termination necessarily will be reassessed as our knowledge increases while project termination progresses. Nonetheless our actions are directed to the goal, which thus far seems an achievable one, of concluding all termination activities—including the settlement—from within the current appropriations of $735 million.

In order to maximize our prospects of meeting our goals of funding all termination activities from within the $735 million we are conducting a complete rebaselining in order to identify the management efficiencies and potential changes in scope of work described above. We will provide you a supplemental report on this work when it is concluded.

I hope this information will help allay the concerns that you have raised, and that they will enable you to conclude, as I have, that these settlement terms are in the national interest and merit your support.

Sincerely,

HAZEL R. O'LEARY.

Mr. BEVILL. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. CHAPMAN], a very distinguished member of this subcommittee.

Mr. CHAPMAN. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I want to take just a minute to, as others have done, both thank and congratulate the chairman of the Committee, the gentleman from Alabama [Mr. BEVILL], and the ranking member, the gentleman from Indiana [Mr. MYERS], for another year of extremely good work under extremely difficult circumstances.

I note, I think, Mr. Speaker, as has already been perhaps placed in the RECORD, that the funds for this subcommittee's work in this appropriation bill once again have been reduced, and I think the necessary requirements of funding the vital programs of this country are successfully balanced in this bill, and I ask my colleagues to please support it.

Mr. Speaker, in the context of the gentleman from New York [Mr. BOEHLERT] who just spoke, I will not characterize his endorsement of the settlement on the SSC, other than to say it was an endorsement, and urging the House to move forward. I might take issue with some of his conclusions about it being overly generous, and note that even after the House and Senate and the President approve this agreement, the State of Texas will owe $250 million in general obligation bonds that over the next 35 years will cost the taxpayers of Texas a half a billion dollars that are not reimbursed in this agreement, so I think it is the best of what has been an unfortunate situation. I think the Congress made a mistake, but it has the right to make mistakes, when it terminated this project.

Mr. Speaker, the bill is a good one. It deserves the support of this body, it deserves the support of the Senate, the signature of the President, and I hope that we will all join together in supporting it.

Mr. SARPALIUS. Mr. Speaker, will the gentleman yield?

Mr. CHAPMAN. I yield to the gentleman from Texas.

Mr. SARPALIUS. Mr. Speaker, I just wanted to thank the gentleman for his hard work, and thank the gentleman from Alabama [Mr. BEVILL], the chairman, and his staff, for the work they have done on the Pantex facility, where all nuclear weapons are dismantled, and especially for the work the House has done with Lake Meredith in cleaning up the salt. There are 100 pounds of salt dumped in that lake every minute, and it is unfortunate that the Senate is where they dropped the ball.

Mr. CHAPMAN. The gentleman, I think, makes a correct observation. I would join in the comments from the other gentleman from Lubbock, TX, in hopes that the Bureau of Reclamation, perhaps from other funds, can pick up the ball that was dropped in the Senate. I urge adoption of the conference report.

Mr. MYERS of Indiana. Mr. Speaker, I yield 3 minutes to the gentleman from Nebraska [Mr. BEREUTER].

Mr. BEREUTER. Mr. Speaker, this Member rises in strong support of the conference report, and to commend the distinguished gentleman from Alabama [Mr. BEVILL], the chairman of the Energy and Water Development Subcommittee, and the distinguished gentleman from Indiana [Mr. MYERS], the ranking member of the subcommittee and all the subcommittee members for their exceptional work in bringing this conference report to the floor. Extremely tight budgetary constraints have made the chairman and the ranking members' task more difficult by enforcing this subcommittee to recommend over a 6-percent reduction in spending for the Department of Energy, a 14-percent reduction for the Army Corps, and a 4-percent reduction for the Bureau of Reclamation. Therefore, in light of these budgetary constraints, this Member would like to express his appreciation to the subcommittee and formally recognize that the Energy and Water Development Appropriations Conference Report for fiscal year 1995 includes funding for several related water projects that are important to Nebraska.

Most importantly, I want to note that the conference report provides funding for flood-related projects of tremendous importance to residents of Nebraska's First Congressional District. Mr. Speaker, last year's flooding temporarily closed Interstate 80 and seriously threatened the Lincoln municipal water system which is located along the Platte River near Ashland, NE. Therefore, this Member is extremely pleased the conference committee agreed to provide $160,000 in funding or the Lower Platte River and Tributaries Flood Control Study. This study should help to formulate and develop feasible solutions which will alleviate future flood problems along the Lower Platte River and tributaries.

Additionally, the conference report provides continued funding—$75,000—for a flood plain study of the Antelope Creek which runs through the heart of Nebraska's capital city, Lincoln.

Mr. Speaker, this Member is responsible for initiating the 1994 House-passed appropriation for Antelope Creek and for coordinating the City of Lincoln, the Lower Platte South Natural Resources District, and the University of Nebraska-Lincoln's work with the Army Corps of Engineers to identify a flood control system for downtown Lincoln.

Antelope Creek, which was originally a small meandering stream, became a straightened urban drainage channel as Lincoln grew and urbanized. Resulting erosion has deepened and widened the channel and created an unstable situation. A 10- by 20-foot closed underground conduit that was constructed between 1911 and 1916 now requires significant maintenance and major rehabilitation. A dangerous flood threat to adjacent public and private facilities exists.

The goals of the study are to anticipate and provide for the flooding of Antelope Creek, map the floodway, evaluate the underground conduit and provide for any necessary repair, stimulate neighborhood and UNL city campus development within current defined boundaries, eliminate fragmentation of the city campus, minimize vehicle/pedestrian/bicycle conflicts while providing adequate capacity, and improve bikeway and pedestrian systems.

The conference report also provides funding for two Missouri River projects which are designed to remedy problems of erosion, loss of fish and wildlife habitat, and sedimentation. First, it provides $10.1 million for the four-State Missouri River Mitigation project. This funding is needed to restore fish and wildlife habitat lost due to the federally sponsored channelization and stabilization projects of the Pick-Sloan era. The islands, wetlands, and flat flood plains needed to support the wildlife and waterfowl that once lived along the river are gone. An estimated 475,000 acres of habitat in Iowa, Nebraska, Missouri, and Kansas have been lost. Today's fishery resources are estimated to be only one-fifth of those which existed in predevelopment days.

The conference report provides $100,000 for operation and maintenance and $100,000 for construction of the Missouri National Recreation River Project. This project addresses a serious problem in protecting the river banks from the extraordinary and excessive erosion rates caused by the sporadic and varying releases from the Gavins Point Dam. These erosion rates are a result of previous work on the river by the Federal Government.

Finally, Mr. Speaker, this Member recognizes that the conference report enables the completion of a flood control study—$20,000—of the Burt Water Drainage District in Burt and Washington Counties and provides operation and maintenance funding for the Missouri River Water Control Manual as well as funding for Army Corps and Bureau of Reclamation projects in Nebraska's other two congressional districts.

Again, Mr. Speaker, this Member commends the distinguished gentleman from Alabama [Mr. BEVILL], the chairman of the subcommittee, and the distinguished gentleman from Indiana [Mr. MYERS], the ranking member of the subcommittee for their continued support of these projects which are important to Nebraska and the 1st Congressional District, as well as to the people living in the Missouri River Basin.

Mr. BEVILL. Mr. Speaker, I yield 2 minutes to the very distinguished gentleman from California [Mr. BROWN], the chairman of the Committee on Science, Space, and Technology.

Mr. BROWN of California. Mr. Speaker, I thank the gentleman very much for yielding me this time.

Mr. Speaker, I rise in support of the energy and water appropriations conference report on H.R. 4506, and I commend the chair of the subcommittee, the gentleman from Alabama [Mr. BEVILL], the gentleman from Indiana [Mr. MYERS], the ranking Republican, and all the conferees for their efforts.

I am pleased with the substance of the bill as it pertains to programs in the jurisdiction of the Committee on Science, Space, and Technology and gratified that it does not try to bypass the proper authorizing committees with inappropriate legislative language. And I am also encouraged that the bill itself is free of earmarks—although I will have more to say in a moment about earmarks in the report language.

The committee has produced a bill that is fundamentally responsive to the administration's request for energy R&D and to the policy directions set by the Energy Policy Act of 1992. The conference report is also consistent with the policies and authorization levels set in H.R. 4908, the Hydrogen, Fusion, and High Energy and Nuclear Physics Research Act, which we will be considering on the floor later this week.

H.R. 4908 provides direction and authorizes appropriations for some of our most important nonfossil energy alternatives. It also establishes a strong framework for reinvigorating the Nation's high energy and nuclear physics programs in the wake of the cancellation of the superconducting super collider. The conference report before us today provides the funding necessary to get us off to a good start toward achieving these goals.

I am strongly supportive, for example, of the position the conferees have taken with respect to the fusion R&D program. The Committee on Science, Space, and Technology addressed the critical policy options facing the U.S. fusion program in H.R. 4908 and this report provides the funding to support the policy options laid out in that bill.

H.R. 4908 would accelerate the U.S. commitment to participate in the international thermonuclear experimental reactor [ITER]. It provides authorization for the tokamak physics experiment [TPX], the logical next step in the U.S. tokamak physics program, in addition to a more robust program in alternative fusion technologies, several of which are being aggressively pursued internationally. The bill also provides for consideration of a more practical redesign of TPX in the event that the ITER program is cancelled. Finally, H.R. 4908 provides for a National Academy of Sciences study of the U.S. fusion program and specifies that selection of a possible ITER site in the United States should occur only after selection of the host country through an international site-selection process.

I am very pleased that the conference report before us today allows full funding of ITER and substantial funding, $42 million, for TPX design work. Construction funds for TPX will hopefully come as the ITER project matures. The conference report also provides about $9 million in funding for alternative fusion technologies. I look forward to working with the conferees to ensure that these alternatives are funded somewhat more vigorously in the future, perhaps through conversion of existing defense R&D expenditures.

The statement of managers also contains a directive that the President's Advisory Council on Science and Technology review and evaluate both the magnetic and inertial fusion programs to shape the direction of the Nation's effort on these important energy sources for the future. H.R. 4908 provides that the National Academy of Sciences conduct a similar review. In my view, the fusion program is of sufficient importance, and the membership and thrust of the two advisory bodies in question are sufficiently complementary, that a dual review of this sort would be entirely appropriate.

With respect to high energy and nuclear physics, H.R. 4908 recognizes that the United States has underfunded the Department of Energy's High Energy and Nuclear Physics base programs for the past several years in order to accommodate funding for the SSC. The bill authorizes a funding pattern recommended by the expert panel commissioned by the Department of Energy—known as the Drell panel—and reflects the needs expressed by the high energy physics community, including a $50 million increase over current levels and an adjustment for inflation starting in fiscal year 1996. The conference report before us today makes a similar recognition of past underfunding and provides $25 million above the President's request for fiscal year 1995. I look forward to working with the appropriations committee in future years to continue to provide adequate funding for this valuable program.

H.R. 4908 also authorizes funding for the nuclear science program for fiscal year 1996 through fiscal year 1999 based on the fiscal year 1995 appropriation plus inflation. This funding provides sufficient operating moneys for current DOE nuclear science facilities and for the construction of the relativistic heavy ion collider at Brookhaven National Laboratory. The conference report provides a good base for this program.

As Members know, I remain concerned about the level of academic earmarking effected through our appropriations bills and reports. As with last year's Energy and Water appropriation, this bill comes back from conference free of any earmarks. Earmarks in the legislative reports and statement of managers are in the same range as they were last year.

To be specific, last year there were 10 academic earmarks that we could identify worth approximately $35 million. This year we can identify 16 earmarks worth a total of almost $43 million. A list is included for the RECORD. While I would prefer to see these numbers declining, I am relieved that they remain at a relatively low level. I say relatively low because 2 years ago there were almost $180 million in identifiable academic earmarks in the energy and water appropriation.

The Secretary of Energy should be reminded—and I know the distinguished chairman of the Energy and Water Appropriations Subcommittee would join me on this point—that report language is not binding upon the Department. None of us here on the floor can offer amendments to that language, nor do we vote on it. Report language does not represent the law of the land, nor is it explicitly or implicitly endorsed by the House when we vote in favor of passage of the conference report.

I have asked the Secretary of Energy to establish a rigorous inhouse review process for determining which report-language earmarks fit with DOE's missions and which do not. In those cases where an earmark does not fit with the Department's research priorities or fails to measure up in importance to ongoing research projects, the Secretary should not fund the earmarks.

In this tight budget climate, whenever the Department funds an earmarked project, it must also terminate, postpone, or cut back worthy research projects that contribute to the Department's important missions. For every university that benefits from an earmark, many other researchers at other institutions are victimized by a loss of funding. Such lost opportunities are a high price to pay when the project that the Department is being asked to fund contributes nothing to DOE's mission or national needs.

I will work with the Secretary of Energy to ensure that those earmarks which are funded in fiscal year 1995 make sense and bring a return for the Federal taxpayer's investment.

Despite these concerns about earmarks, Mr. Speaker, I believe that this is a good report, and one that follows the policy recommendations contained in authorization legislation quite consistently. I urge all members to support it.

Mr. Speaker, I include the following document regarding academic earmarks in the bill:

ACADEMIC EARMARKS IN THE ENERGY & WATER FISCAL YEAR 1995 APPROPRIATIONS BILL

Agency	School	Amount
Army Corps of Engineers.	Indiana University, South Bend St. Joseph River project.	300K.
Do	Indiana State University, Construction Technology Transfer project.	300K.
Do	University of Miami, aquatic plant control.	2.5K.
Department of Energy.	Research Institutions in the Northern Gulf Coast Region, oilspill research.	275K.
Do	Florida Solar Energy Center, University of Oregon, and University of Central Florida.	600K.
Do	University of Miami electron beam sterilization.	1K.
Do	University of Nebraska Med. Center development of a transplant center.	5K.
Do	Oregon Health Sciences University second phase of Biomedical Information Center.	5K.
Do	Midwest Superconductivity Consortium—Indiana University, Iowa State University, Ohio State University, Purdue University, University of Missouri, University of Notre Dame, and University of Nebraska.	3.7K.
Do	Super Computations Research Institute at Florida State University.	5.9K.
Do	Jackson State University—Ana G. Mendez Educational Foundation and Lawrence Berkeley Lab.	4K.
Do	Louisiana systemic initiative—Southern University and others.	500K.
Do	Center for Minorities in Science, Engineering, and Technology/Southern University and A&M College System in Baton Rouge, LA.	5K.
Do	University Research Program in Robotics—University of Florida, University of Michigan, University of Tennessee, Knoxville, and University of Texas, Austin.	4K.
Do	International Center for Groundwater Remediation Design, University of Vermont.	Unspecified.
Do	University of Oklahoma, hydrogen research.	250K.
Do	Yucca Mountain infrastructure studies, University of Nevada-Reno, University of Nevada-Las Vegas, the Desert Research Institute, and Community College of Southern Nevada.	3.7K.
Total		42.025M.

□ 1230

Mr. MYERS of Indiana. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. BARTON] who has worked with this committee very diligently in the last week to make sure that some of the language is in the bill.

Mr. BARTON of Texas. Mr. Speaker, I had not intended to speak on the bill but as I have sat in here and listened to the debate, I felt that it was necessary. I first want to thank the chairman and the ranking member and the other members of the subcommittee. The funding level in this bill represents a real cut. Any time an appropriation bill allocates not just less than some artificially projected spending level but less than was actually spent last year, that is a cut in anybody's book, and I think the Members are to be commended for making those tough choices necessary to report a bill that spends less than was spent last year.

I would like to speak about the proposed settlement on the SSC between the State of Texas and the Department of Energy. No one wins in this settlement in the long run because we have terminated one of the world-class basic research projects that would have brought, I think, tremendous benefits to all of mankind. Having said that, this agreement does live within the spirit of the agreement in last year's appropriation bill when Congress voted to terminate the project. There is no new money in this year's bill for termination costs. The State of Texas gives up its right to sue for litigation purposes. The Federal Government agrees to do the environmental remediation that may be necessary at the site. The bits and pieces of the collider are going to be put to the best possible alternative uses that can be found for them. Apparently that is going to be a medical treatment center for cancer, one of three of its kind in the United States, a regional computing center that will help hundreds of thousands of schoolchildren and researchers in a seven-State region and Mexico, and the possibility that some of the physics equipment can be used in conjunction with a project that is being considered in Europe at the CERN facilities. So all in all it is a good ending to a project that had the best of intentions and I would hope the conference and the Congress would support this agreement.

Mr. BEVILL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Indiana [Mr. SHARP], the chairman of the Subcommittee on Energy and Power.

Mr. SHARP. Mr. Speaker, I will not take all that time. I simply wanted to rise in strong support of the conference report and commend the gentleman from Alabama [Mr. BEVILL] for his ongoing, solid, and effective leadership over many years of this subcommittee and dealing with the science development for this country and the energy resources and the water resources of this country, and I know he has had a great deal of help from our colleague, the gentleman from Indiana [Mr. MYERS]. I particularly want to pay a tribute to his staff who are extraordinarily hardworking and cooperative folks. This country owes the gentleman from Alabama, the chairman, a great deal of credit.

Mr. MYERS of Indiana. Mr. Speaker, I yield 2 minutes to the gentleman from Idaho [Mr. CRAPO], who has for the last 2 years worked very diligently with the committee on the IFR.

Mr. CRAPO. Mr. Speaker, as I come before the House today, I also had not expected to speak, but as I have followed the debate, I felt that I ought to make one point very clear. There has been a lot of talk about the importance of the many projects and the support that this legislation gives to the energy and water needs of our country. I do not disagree with that and I recognize that this report is going to be accepted by this House.

I think I should state that I am very concerned that in the area of our nuclear energy research, the decision of the House and the decision that is reflected in this conference report to eliminate funding for the integral fast reactor effectively eliminates our long-term nuclear research capability in this country. The studies that I have seen show now that as the existing short-term nuclear research plays out beyond 1998, we will have shifted our energy research focus, which was a policy decision that was made, away from nuclear energy and into other sources of energy, such as wind and solar and other types of renewables.

I do not object to moving our research into the wind and solar and other renewable areas, but I think that we have made a shortsighted decision to eliminate our long-term nuclear options in the country in terms of our research.

I would hope that in future years, we will be able to revisit this issue and assure that the United States remains a leader in all of our areas of nuclear energy research.

Mr. MYERS of Indiana. Mr. Speaker, I yield myself the remainder of my time.

Mr. Speaker, in response to the gentleman from Idaho [Mr. CRAPO], his subcommittee in conference with the Senate insisted upon the House position, not because our committee thought it was the right direction or the proper action to take, but we had little choice considering the direction that the House gave us last week when the gentleman gave us instructions that we must terminate the IFR immediately. It was a mistake, no question about it.

The thing that really brothers me is the fact that after that vote, a number of Members came up to me and said, "We voted wrong. We thought we were saving money." When they found out it was going to cost more the way we are going now to terminate this project and get absolutely nothing for the money, they had made a mistake. But be that as it may, we stood by the House position, the Senate tried to prevail upon us, we were morally obligated to do, if not legally.

Mr. Speaker, I do not want to speak about the bill as a whole. I will speak later about amendment 35, but it is a good bill. It is not the best bill this committee should come forward with, but I think it is a bill that everyone can support. I wish it were better, but the tools were reduced because of the restrictions on the 602(b) allocation and we had to cut some programs way below the need.

When the chairman and I first came on this committee years ago, many times we could take care of most Members that came to us and said, "We need a project in our district," there was money back then that we could do things like that. That luxury has been gone for a good many years. But this year we cut deeper than that. I do not think any Member got what they wanted this year, let alone what is needed. The important thing is, we did fund the programs at the best level we could. I hope that, particularly in the energy field, we have not cut research beyond the needs for the future. I hope we have not cut too deeply.

Mr. Speaker, I yield back the balance of my time.

Mr. BEVILL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Kentucky [Mr. MAZZOLI], chairman of one of our very outstanding subcommittees.

Mr. MAZZOLI. Mr. Speaker, I want to thank the chairman very much for yielding me the time.

I am really taking this time to salute him and commend him and the gentleman from Indiana [Mr. MYERS] and all Members of this distinguished subcommittee. I do want to include by name the gentleman from Kentucky [Mr. ROGERS].

In this bill, Mr. Speaker, is money to complete a very important part of our waterfront development in the city of Louisville, which is part of the McAlpine Dam Development project, and three separate programs for flood control and, of course, as the gentleman from Alabama, our chairman, remembers, the city of Louisville has been devastated by floods from time to time over the years. We appreciate that flood control money and the additional money to complete Louisville's Bellvedere Connector.

This is the last time the gentleman from Kentucky will appear as a sitting member of Congress before the gentleman from Alabama's panel, and I thought I would take a few seconds to reflect on all the years during which I have had the honor of joining first with Chairman Perkins and then with Chairman Natcher, coming before the gentleman's subcommittee and always, but always the Kentucky delegation received with courtesy and with affability, with charm, with that courtliness which I think is maybe indigenous to Alabama and the South. The chairman was always attentive to our needs, and working in collaboration with my friend from across the river, the gentleman has been very helpful.

I want to mention Mr. Spillan and the staff member of the Energy and Water Subcommittee because they have been very much associated with all of this.

I want to thank my friends for what you have done for the Third District and for Kentucky over the years. While I will not be importuning you and knocking on your door in the future, I will be here in spirit and I want to thank the chairman.

Mr. BEVILL. Mr. Speaker, I yield 2 minute to the distinguished gentleman from Pennsylvania [Mr. MCDADE], our ranking member of the Committee on Appropriations.

□ 1240

Mr. MCDADE. Mr. Speaker, I take just a brief moment on a very busy day for all of us to extend our heartfelt congratulations to my distinguished friend, the able chairman of the committee, Mr. BEVILL, and to my friend from Hoosierville, Mr. JOHN MYERS, who has been here about as long as I have and done superb work in shepherding the Nation's resources. I like to look at the quotation that is inscribed on the wall over the Speaker's chair by Daniel Webster:

> Let us develop the resources of our land, call forth its powers, build up its institutions, promote all its great interests, and see whether we also in our day and generation may not perform something worthy to be remembered.

Nobody does it better than my friend, the distinguished gentleman from Alabama and my friend, the distinguished gentleman from Indiana.

Mr. SANDERS. Mr. Speaker, I rise in support of the conference report on H.R. 4506, the Energy and Water Appropriations Conference Report. As in past years, this $21 billion appropriation is a strange hybrid of good and bad projects. On the one hand, it includes billions of dollars for defense nuclear energy projects, which continue to be funded at high levels even though the cold war is over and the Soviet Union no longer exists. Perhaps the most absurd example of this nuclear weapons spending is the fact that we are budgeting over a hundred million dollars for nuclear testing, even though we aren't going to do any nuclear testing this year. President Clinton, to his credit, has declared a moratorium on nuclear testing through the end of the next fiscal year—yet the Department of Energy still needs $150 million for nontesting.

Nevertheless, if the persistence of cold war spending for nuclear weapons in this bill is troubling, at least the trend is downward. Defense nuclear spending this year is down by 5 percent. And in fact, this year nearly half of the defense nuclear money is for cleaning up the horrible pollution problems created by past nuclear weapons production, and restoring the contaminated environment created by the cold war. For decades, poisoning of the soil and water—and of workers in the defense industry—was excused in the name of national security. Even the most disgusting cases of environmental degradation were ignored, as long as they were being produced by the Pentagon and its defense contractors. Now the bill has to be paid. It is not pleasant to be spending billions of dollars of our money to restore an environment that never should have been polluted in the first place—but it is necessary, and this conference report helps provide the money to do it.

If the nuclear weapons part of this conference report is the most disturbing aspect, perhaps the most hopeful sign is the increase, to $388 million, in funding for solar and renewable energy. Although slight less than the amount we passed in the House, this still represents an increase of 12 percent over fiscal 1994. Nuclear energy research, on the other hand, is cut by 14 percent, and boondoggle projects such as the advanced liquid metal reactor are terminated.

These shifts in spending priorities demonstrate that the Department of Energy and the Congress are serious about moving our energy system away from dangerous, polluting and costly nuclear and fossil fuels, and toward a clean economy based on renewable sources and energy conservation. They are not moving as fast as I would like to see, but at least they are moving.

On balance, Mr. Speaker, I find more positive than negative signs in this conference report, and I will vote for it. And I, and other Members of Congress and grassroots activists all across the Nation, will continue to fight for a new energy policy—one that recognizes that the cold war is over, the era of wasteful, polluting energy sources is over, and the time for a clean, renewable energy economy has arrived.

Mr. FAWELL. Mr. Speaker, I rise in opposition to the Fiscal Year 1995 Energy and Water Development Act conference report, which terminates the Department of Energy's Advanced Liquid Metal Reactor/Integral Fast Reactor [ALMR/IFR] Program.

I want to make two points.

First, the conference report's 4-year plan to shut down the program at the end of fiscal year 1998 would cost $332 million. On the other hand, the Senate's plan, which would also shut-down the program at the end of fiscal year 1998, would have provided for $60 million in Japanese cost-sharing and would have allowed for completion of the authorized research at a cost of $327.8 million, a savings of $4.2 million, including a savings of $5.9 million in fiscal year 1995. Thus, the conference report's plan makes no economic or fiscal sense.

Second, the Senate's plan was sound science and sound nuclear nonproliferation policy. There is an expanding amount of plutonium in the world today. The United States and Russia alone plan to retire thousands of nuclear weapons over the next decade, making available 100 metric tons or more of pure weapons plutonium metal.

By the year 2000 over 1,000 tons of LWR-produced plutonium will exist in spent LWR fuel over and above some 900 tons of LWR-produced plutonium in spent fuel which exists today.

And the world inventory of reactor plutonium will continue to escalate at an ever-increasing rate as the use of nuclear power inevitably expands in many countries world-wide. This is so even if this Nation never builds another nuclear power plant.

The ALMR/IFR is the only nuclear technology under research today that offers the world the prospect of totally destroying plutonium while safely and efficiently producing electricity. Indeed, I know of no technology of any sort which promises to fully destroy plutonium.

The ALMR/IFR's fuel cycle is also strongly proliferation resistant because first, it efficiently recycles and burns highly radioactive wastes, including plutonium, on-site and second, because the plutonium in the system never exists in its pure form and is recycled as a fuel and ultimately destroyed on site.

In contrast, conventional LWR's use an off-site Purex reprocessing to separate plutonium from spent fuel waste where diversion of pure plutonium is a proliferation concern.

More important, the ALMR/IFR is good science because, while destroying plutonium, it can generate electricity and cut the volume of nuclear waste to one-fourth of that produced by the current conventional LWR. In addition, what low-level waste is left will decay in 100 years rather than many thousands of years, and this low-level-low-volume waste could be stored at the reactor site. Also, the ALMR/IFR reactor, unlike the conventional LWR, will be passively safe; that is, if an accident were to occur and a nuclear chain reaction were to start, as at Chernobyl, it would shut itself off without any human intervention.

Thus, the ALMR/IFR Program is both a sound U.S. energy policy as well as a sound nonproliferation policy. Yet opponents condemn the ALMR/IFR because one of the fuels it uses is plutonium, while ignoring all of the sound scientific principles just referred to.

There are, of course, other options to dispose of plutonium that are under review. These include: indefinitely storing nuclear warheads; cycling plutonium once through a reactor and burying the highly radioactive spent fuel in a repository; vitrifying plutonium with high-level waste and burying it in a repository; dropping canisters of plutonium in deep boreholes in the Earth's crust; burying it under the seabed; detonating nuclear warheads underground; launching it into space; diluting it in the ocean, and so forth. All of these options have their own set of difficulties and none have the long-term promise of the ALMR/IFR.

I urge my colleagues to vote "no" on this conference report. Let us not turn our backs on this long-term technology. It is fiscally sound as well as being significant energy and nonproliferation policy.

Mr. BEVILL. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. LAROCCO). Without objection, the previous question is ordered on the conference report.

There was no objection.

The SPEAKER pro tempore. The question is on the conference report.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. PENNY. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 393, nays 34, not voting 7, as follows:

[Roll No. 385]

YEAS—393

Abercrombie
Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Bachus (AL)
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barca
Barcia
Barlow
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bateman
Becerra
Beilenson
Bentley
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Blackwell
Bliley
Blute
Boehlert
Bonilla
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Bunning
Buyer
Byrne
Callahan

Calvert
Camp
Canady
Cantwell
Cardin
Carr
Castle
Chapman
Clay
Clayton
Clement
Clinger
Clyburn
Coleman
Collins (GA)
Collins (IL)
Collins (MI)
Combest
Condit
Conyers
Cooper
Coppersmith
Costello
Cox
Coyne
Cramer
Cunningham
Danner
Darden
de la Garza
Deal
DeFazio
DeLauro
DeLay
Derrick
Deutsch
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Dooley
Doolittle
Dornan
Dunn
Durbin
Edwards (CA)
Edwards (TX)
Ehlers
Emerson
Engel
English
Eshoo
Evans
Everett
Ewing
Farr
Fazio
Fields (LA)
Fields (TX)
Filner
Fingerhut
Fish
Flake
Foglietta
Ford (MI)
Ford (TN)
Fowler
Frank (MA)
Franks (CT)
Franks (NJ)
Frost
Furse
Gallegly
Gallo
Gejdenson
Gekas
Gephardt
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Glickman
Gonzalez
Goodlatte
Goodling
Gordon
Goss
Grandy
Green
Greenwood
Gunderson
Gutierrez
Hall (OH)
Hall (TX)
Hamburg
Hamilton
Hansen
Harman
Hastert
Hastings
Hayes
Hefner
Hilliard
Hinchey
Hoagland
Hobson
Hochbrueckner
Hoekstra
Hoke
Holden
Horn
Houghton
Hoyer
Huffington
Hughes
Hunter
Hutchinson
Hutto
Hyde
Inhofe
Inslee
Istook
Jefferson
Johnson (CT)
Johnson (GA)
Johnson (SD)
Johnson, E.B.
Johnson, Sam
Johnston
Kanjorski
Kaptur
Kasich
Kennedy
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klein
Klink
Knollenberg
Kolbe
Kopetski
Kreidler
Kyl
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lazio
Leach
Lehman
Levin
Levy
Lewis (CA)
Lewis (FL)
Lewis (GA)
Lewis (KY)
Lightfoot
Linder
Lipinski
Livingston
Lloyd
Long
Lowey
Lucas
Machtley
Maloney
Mann
Manton
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCandless
McCloskey
McCrery
McCurdy
McDade
McDermott
McHale
McInnis
McKeon
McKinney
McMillan
McNulty
Meehan
Meek
Menendez
Meyers
Mfume
Mica
Michel
Miller (CA)
Mineta
Mink
Moakley
Molinari
Mollohan
Montgomery
Moorhead
Moran
Morella
Murphy
Murtha
Myers
Nadler
Neal (MA)
Neal (NC)
Nussle
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Oxley
Packard
Pallone
Parker
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Pickett
Pickle
Pombo
Pomeroy
Porter
Portman
Poshard
Price (NC)
Pryce (OH)
Quillen
Quinn
Rahall
Rangel
Reed
Regula
Reynolds
Richardson
Ridge
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Rostenkowski
Roth
Roukema
Rowland
Roybal-Allard
Rush
Sabo
Sanders
Sangmeister
Santorum
Sarpalius
Sawyer
Saxton
Schenk
Schiff
Schroeder
Schumer
Scott
Serrano
Sharp
Shaw
Shepherd
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slattery
Slaughter
Smith (IA)
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Snowe
Spence
Spratt
Stark
Stearns
Stenholm
Stokes
Strickland
Studds
Stupak
Sundquist
Swett
Swift
Synar
Talent
Tanner
Tauzin
Taylor (MS)
Tejeda
Thomas (CA)
Thomas (WY)
Thompson
Thornton
Thurman
Torkildsen
Torres
Torricelli
Towns
Traficant
Unsoeld
Upton
Valentine
Velazquez
Vento
Visclosky
Volkmer
Vucanovich
Walker
Walsh
Waters
Watt
Waxman
Weldon
Wheat
Whitten
Wilson
Wise
Wolf
Woolsey
Wyden
Wynn
Yates
Young (AK)
Young (FL)
Zimmer

NAYS—34

Allard
Archer
Armey
Burton
Coble
Crane
Crapo
Dreier
Duncan
Fawell
Grams
Hancock
Hefley
Inglis
Jacobs
Klug
Manzullo
McHugh
Miller (FL)
Minge
Paxon
Penny
Peterson (MN)
Petri
Ramstad
Royce
Schaefer
Sensenbrenner
Shays
Solomon
Stump
Taylor (NC)
Tucker
Zeliff

NOT VOTING—7

Boehner
Dellums
Herger
McCollum
Ravenel
Washington
Williams

□ 1301

Messrs, ALLARD, HEFLEY, TUCKER, ZELIFF, and McHUGH changed their vote from "yea" to "nay."

So the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

AMENDMENTS IN DISAGREEMENT

The SPEAKER pro tempore (Mr. LAROCCO). Pursuant to the rule, the amendments in disagreement are considered as read.

The Clerk will designate the first amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 2: Page 2, strike out all after line 20 over to and including line 13 on page 3, and insert:

Red River Navigation Study, Arkansas, $500,000;

Indianapolis, White River, Central Waterfront, Indiana, $4,000,000;

Little Calumet River Basin (Cady Marsh Ditch), Indiana, $150,000;

Kentucky Lock and Dam, Kentucky, $2,000,000;

Hazard, Kentucky, $500,000;

Grand Marais Harbor, Michigan, $100,000;

Hartsville, Trousdale County, Tennessee, $95,000;

West Virginia Comprehensive, West Virginia, $350,000; and

West Virginia Port Development, West Virginia, $800,000.

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 2 and concur therein with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment insert:

Red River Navigation Study, Arkansas, $300,000;

Los Angeles County Water Conservation and Supply, California, $500,000;

Norco Bluffs, California, $200,000;

Indianapolis, White River, Central Waterfront, Indiana, $4,000,000;

Lake George, Hobart, Indiana, $200,000;

Little Calumet River Basin (Cady Marsh Ditch), Indiana, $150,000;

Ohio River Greenway, Indiana, $500,000;

Hazard, Kentucky, $500,000;

Kentucky Lock and Dam, Kentucky, $2,000,000;

Mussers Dam, Pennsylvania, $100,000;

Hartsville, Trousdale County, Tennessee, $95,000;

West Virginia Comprehensive, West Virginia, $350,000; and

West Virginia Port Development, West Virginia, $800,000.

Mr. MYERS of Indiana (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate Amendment No. 4: Page 4, strike out all after line 5 over to and including "$1,500,000" in line 18 on page 6 and insert:

Red River Emergency Bank Protection, Arkansas and Louisiana, $6,000,000;

Red River below Denison Dam Levee and Bank Stabilization, Arkansas and Louisiana, $1,500,000;

West Sacramento, California, $500,000;

Sacramento River Flood Control Project (Glenn-Colusa Irrigation District), California, $400,000;

Sacramento River Flood Control Project (Deficiency Correction), California, $3,700,000;

San Timoteo Creek (Santa Ana River Mainstem), California, $5,000,000;

Kissimmee River, Florida, $3,000,000;

Savannah Harbor Deepening, Georgia (Reimbursement), $11,585,000, of which $2,083,000 is for a cost-shared Savannah River recreation enhancement and public access project along 900 linear feet of shoreline in the City of Savannah;

Casino Beach, Illinois, $1,000,000;

Des Moines Recreational River and Greenbelt, Iowa, $2,000,000;

Harlan (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $20,000,000;

Middlesborough (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $1,200,000;

Williamsburg (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $3,000,000;

Pike County (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $5,000,000;

Lake Pontchartrain and Vicinity (Jefferson Parish), Louisiana, $800,000;

Lake Pontchartrain and Vicinity (Hurricane Protection), Louisiana, $12,500,000;

Ouachita River Levees, Louisiana, $4,500,000;

Ste. Genevieve, Missouri, $3,000,000;

Ramapo River at Oakland, New Jersey, $600,000;

Broad Top Region, Pennsylvania, $1,000,000;

Lackawanna River, Olyphant, Pennsylvania, $1,100,000;

Lackawanna River, Scranton, Pennsylvania, $1,000,000;

South Central Pennsylvania Environmental Restoration Infrastructure and Resource Protection Development Pilot Program, Pennsylvania, $2,000,000;

Wallisville Lake, Texas, $1,000,000;

Richmond Filtration Plant, Virginia, $2,000,000;

Southern West Virginia Environmental Restoration Infrastructure and Resource Protection Development Pilot Program, West Virginia, $1,500,000;

Hatfield Bottom (Levisa and Tug Fork of the Big Sandy River and Upper Cumberland River), West Virginia, $500,000;

Upper Mingo (Levisa and Tug Fork of the Big Sandy River and Upper Cumberland River), West Virginia, $250,000; and

Allendale Dam, Rhode Island, $67,500

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 4 and concur therein with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

Red River Emergency Bank Protection, Arkansas and Louisiana, $6,000,000;

Red River below Denison Dam Levee and Bank Stabilization, Arkansas, Louisiana and Texas, $2,100,000;

West Sacramento, California, $500,000;

Sacramento River Flood Control Project (Glenn-Colusa Irrigation District), California, $400,000;

Sacramento River Flood Control Project (Deficiency Correction), California, $3,700,000;

San Timoteo Creek (Santa Ana River Mainstem), California, $5,000,000;

Central and Southern Florida, Florida, $8,624,000;

Kissimmee River, Florida, $4,000,000;

Savannah Harbor Deepening, Georgia (Reimbursement), $11,585,000, of which $2,083,000 is for a cost-shared Savannah River recreation enhancement and public access project along 900 linear feet of shoreline in the City of Savannah;

Casino Beach, Illinois, $1,000,000;

Des Moines Recreational River and Greenbelt, Iowa, $4,000,000;

Harlan (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $20,000,000;

Middlesborough (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $1,200,000;

Williamsburg (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $3,000,000;

Pike County (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $5,000,000;

Lake Pontchartrain and Vicinity (Jefferson Parish), Louisiana, $800,000;

Lake Pontchartrain and Vicinity (Hurricane Protection), Louisiana, $12,500,000;

Quachita River Levees, Louisiana, $4,500,000;

Ste. Genevieve, Missouri, $3,000,000;

Hackensack Meadowlands Area, New Jersey, $2,500,000;

Ramapo River at Oakland, New Jersey, $600,000;

Salem River, New Jersey, $1,000,000;

Carolina Beach and Vicinity, North Carolina, $2,800,000;

Fort Fisher and Vicinity, North Carolina, $900,000;

Broad Top Region, Pennsylvania, $1,000,000;

Lackawanna River, Olyphant, Pennsylvania, $1,100,000;

Lackawanna River, Scranton, Pennsylvania, $1,000,000;

South Central Pennsylvania Environmental Restoration Infrastructure and Resource Protection Development Pilot Program, Pennsylvania, $7,000,000;

Allendale Dam, Rhode Island, $67,500;

Wallisville Lake, Texas $1,000,000;

Richmond Filtration Plant, Virginia, $2,000,000;

Southern West Virginia Environmental Restoration Infrastructure and Resource Protection Development Pilot Program, West Virginia, $1,500,000;

Hatfield Bottom (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), West Virginia, $500,000; and

Upper Mingo County (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), West Virginia, $250,000

Mr. MYERS of Indiana (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 6: Page 7, line 2, strike out all after "expended," down to and including "project" in line 4 and insert: "and of which funds are provided for the following projects in the amounts specified:

"Eastern Arkansas Region, Arkansas, $3,000,000;

"Yazoo Basin, Mississippi, Upper Yazoo Projects, Belzoni Bridge Removal, $640,000; and

"Tiptonville, Tennessee, Levee Extension, Mississippi River Levees, $1,000,000".

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 6, and concur therein.

Mr. MYERS of Indiana (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 8: Page 7, strike out all after line 24 over to and including "$5,330,000" in line 4 on page 8 and insert:

"Tucson Diversion Channel, Arizona, $2,500,000; and

"John H. Kerr Reservoir, Virginia and North Carolina (Mosquito Control), $40,000".

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 8 and concur therein with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

Tucson Diversion Channel, Arizona, $2,500,000;

Jeffersonville-Clarkville, Indiana, $750,000;

McAlpine Lock and Dam (Ohio River Locks and Dams), Kentucky, $1,000,000;

Raystown Lake, Pennsylvania, $5,330,000; and

John H. Kerr Reservoir (Mosquito Control), Virginia and North Carolina, $40,000

Mr. MYERS of Indiana (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate Amendment No. 9: Page 8, line 8, after "canceled" insert: *Provided further*, That the Secretary of the Army is directed during fiscal year 1995 to maintain a minimum conservation pool level of 475.5 at Wister Lake in Oklahoma

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 9, and concur therein.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate Amendment No. 15: Page 9, after line 25 insert:

GENERAL PROVISION

CORPS OF ENGINEERS—CIVIL

SEC. 101. In fiscal year 1995, the Secretary shall advertise for competitive bid at least 7,500,000 cubic yards of the hopper dredge volume accomplished with Government-owned dredges in fiscal year 1992.

Notwithstanding the provisions of this section, the Secretary is authorized to use the dredge fleet of the Corps of Engineers to undertake projects when industry does not perform as required by the contract specifications or when the bids are more than 25 percent in excess of what the Secretary determines to be a fair and reasonable estimated cost of a well equipped contractor doing the work or to respond to emergency requirements.

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 15, and concur therein.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 16: Page 9, after line 25 insert:

SEC. 102. The Secretary of the Army, acting through the Chief of Engineers, shall not collect fees at boat launching ramps located in undeveloped or lightly developed shorelands with minimum security and illumination.

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 16, and concur therein.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 21: Page 13, line 4, after "Act" insert: ": *Provided further*, That of the total appropriated, $4,827,000 shall be available for transfer to the State of New Mexico Irrigation Works Construction Fund for settlement of all claims associated with Costilla Dam".

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 21, and concur therein.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 28: Page 17, line 20, after "expended" insert: ": *Provided*, That the Secretary of Energy may transfer available amounts appropriated for use by the Department of Energy under title III of previously enacted Energy and Water Development Appropriations Acts into the Isotope Production and Distribution Program Fund, in order to continue isotope production and distribution activities".

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 28 and concur therein with an amendment, as follows:

In lieu of the matter inserted by said amendment, insert:

": *Provided*, That the Secretary of Energy may transfer available amounts appropriated for use by the Department of Energy under title III of previously enacted Energy and Water Development Appropriations Acts into the Isotope Production and Distribution Program Fund, in order to continue isotope production and distribution activities: *Provided further*, That the authority to use these amounts appropriated is effective from the date of enactment of this Act: *Provided further*, That fees set by the Secretary for the sale of isotopes and related services shall hereafter be determined without regard to the provisions of Energy and Water Development Appropriations Act (P.L. 101-101): *Provided further*, That amounts provided for isotope production and distribution in previous Energy and Water Development Appropriations Acts shall be treated as direct appropriations and shall be merged with funds appropriated under this head".

Mr. MYERS of Indiana (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 33: Page 19, line 2, after "expended" insert: ": *Provided*, That at least $41,700,000 of amounts derived from the funds for such expenses shall be expended in accordance with title X, subtitle A of the Energy Policy Act of 1992".

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 33, and concur therein.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 35: Page 19, line 19, after "tract" insert: ": *Provided further*, That of the amounts previously appropriated to orderly terminate the Superconducting Super Collider (SSC) project in the Energy and Water Development Appropriations Act, 1994, amounts not to exceed $65,000,000 shall be available as a one-time contribution to the completion, with modification, of partially completed facilities at the project site if the Secretary determines such one-time contribution (i) will assist the maximization of the value of the investment made in the facilities and (ii) is in furtherance of a settlement of the claims that the State of Texas has asserted against the United States in connection with the termination of the SSC project: Provided further, That no such amounts shall be made available as a contribution to operating expenses of such facilities".

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 35, and concur therein.

Mr. MYERS of Indiana. Mr. Speaker, I rise in opposition to amendment No. 35.

The SPEAKER pro tempore. The gentleman from Indiana [Mr. MYERS] will be recognized for 30 minutes. Does the gentleman from Alabama seek recognition?

If not, the Chair recognizes the gentleman from Indiana [Mr. MYERS].

Mr. MYERS of Indiana. Mr. Speaker, I yield myself such time as I may consume. I shall not use the entire 30 minutes.

Mr. Speaker, my opposition to this amendment is one of procedure rather than content of the amendment. This all came about because of the House's decision last year to discontinue the SSC in Texas. Under that agreement the House asked the Department of Energy to expedite, to move as rapidly as that agency could, to try to recover as much of the taxpayers' investment in Texas as possible. In so doing, the department struck an agreement on July 22 of this year with the State of Texas which makes provisions to which I think the House should object.

Under the terms of the agreement entered into between the Department of Energy and the State of Texas which neither the Senate nor the House nor any party whatsoever has any interest in—provides $210 million in cash from previously appropriated funds, not new dollars but part of the funds that were to terminate the SSC to Texas. It also returns the land back to the State of

Texas, all the real estate, land and property, as well as the investment therein, in buildings and equipment.

But the Department of Energy in this agreement went one step further. In providing the $210 million in cash, $65 million is earmarked to be used to upgrade the linear accelerator as a cancer treatment tool. I am not opposed, certainly, to that being done. My opposition is something that the authorizing committees have objected to with the Committee on Appropriations for years, that we should not earmark money, should not tell how the money should be spent, and should not authorize programs that are not authorized in existing law.

There is no existing law today directing anybody to build a linear accelerator or the cancer treatment by the University of Texas at this site, absolutely no authorization. The first we heard about it, in fact the first I heard of it was reading in the paper that the Senate had added this language.

Through questioning, we finally found out there was an agreement between the Department of Energy and the State of Texas providing that this be done. But, again, it did not call upon us in the agreement that we have to ratify it. In fact, Congress is not even mentioned in this agreement. I really do not understand why the authorizing committees are not standing up like they have so many times in the past, objecting to the Appropriations Committee authorizing something that is not authorized today.

Again, I am certainly not opposed to the cancer treatment center. But the chairman and I did meet with the lawyers, the attorneys from the Department of Energy as well as the lawyers from the State of Texas.

As far as the State of Texas is concerned they explained that they needed to have this language to make sure that the agreement was entered into, the lawyers for the Department of Energy said—and this is something I am not sure whether they are right or wrong—that they would find it very difficult to justify $210 million in cash.

True, Texas has advanced up to $539 million of money toward this project. But there was never an agreement that they would get this money back. I remember arguing about what State would get the superconducting super collider. If other States such as California, Illinois, Michigan, or some of the other States that were bidding at that time, if they would have known they were going to be held harmless on any investment they made, they would get it back, I think some of the other States would have bid probably even more. I cannot say that for sure, but I am sure a lot of the States would have bid higher to get that reactor if they knew they were not going to lose anything.

□ 1310

But again I am not opposed to Texas getting all these assets. I am opposed, and I do not understand why the authorizing committees have not objected, to telling the State of Texas how it must spend $65 million out of the $210 million. We are doing the job the Texas State legislature should do. It is not our role to tell them how to spend the money, so I do strongly oppose that.

Is it a fair settlement? Again, the Texas lawyers tell us it is a good settlement. DOE lawyers said, "We're not sure we can justify $210 million going back to Texas in this way when they get all the other assets." So I do not know whether it is right or wrong. I am not going to judge whether it is a good settlement or not. I am willing to accept that settlement. My objection is procedural. We should not be doing the legislature of Texas' job in this case.

The gentleman from New York [Mr. BOEHLERT] a moment ago in a colloquy with the chairman, asked whether this is the last we are going to appropriate. We all hope so but there is no way this Congress, this committee, can obligate future Congresses. We cannot ensure that there might not be a contingent liability coming up because in the terms of agreement with the Department of Energy and the State of Texas we have set aside any liability coming from the three counties that did put some money in, the communities that may have some damages because of loss of value of property. We may have some property owners under eminent domain, or several property owners have had their land taken from them, but have not been paid yet. There has been not a final settlement on eminent domain, so we have some questions here.

We also have the Environmental Protection Agency, which may have a claim against the State of Texas and the Department of Energy for damage to the property that will have to be remedially corrected. So, we cannot really tell the gentleman from New York [Mr. BOEHLERT] or anyone else that there will not be some future requirement. We all hope there will not be.

In closing I want to say that in adopting this provision, DOE says we have to do it. The State of Texas wants us to do it because I do not think they can get their legislature to do it, but the State of Idaho—we just talked about the IFR reactor. I understand Idaho would like to convert that reactor in Idaho for a different purpose, but they are told by the Department of Energy, who has entered into this deal, that they cannot do it, the reactor, we have already had three-quarters of a billion dollars invested in must be destroyed. Why? Why do we not save the taxpayers' investment in Idaho by letting them convert, if they would like to, to some other use for that reactor instead of destroying it in place?

There are just inconsistencies here. Procedurally it is a wrong thing to do. Even more importantly, precedence-wise we are making a terrible mistake here by telling Texas how they must spend this money even though Texas wants it. The precedence we will have to live with will go on forever from here on.

Mr. Speaker, I reserve the balance of my time.

Mr. BEVILL. Mr. Speaker, I yield back the balance of my time.

Mr. MYERS of Indiana. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. LAROCCO). The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 39: Page 20, line 14, after "Act" insert: ": *Provided further*, That the distribution of the funds herein provided among the affected units of local government shall be determined by the Department of Energy and made available to the State and affected units of local government by direct payment".

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion. The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 39, and concur therein.

Mr. MYERS of Indiana (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the next amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 48: Page 30, line 16, strike out "$540,501,000" and insert "$535,501,000".

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 48 and concur therein with an amendment, as follows:

In lieu of the sum stricken and inserted by said amendment, insert $520,501,000.

Mr. MYERS of Indiana (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

The SPEAKER pro tempore. The Clerk will designate the last amendment in disagreement.

The text of the amendment is as follows:

Senate amendment No. 49: Page 31, line 10, strike out "$518,501,000" and insert "$513,501,000".

MOTION OFFERED BY MR. BEVILL

Mr. BEVILL. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. BEVILL moves that the House recede from its disagreement to the amendment of the Senate numbered 49 and concur therein with an amendment, as follows:

In lieu of the sum stricken and inserted by said amendment, insert $498,501,000.

Mr. MYERS of Indiana (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Alabama [Mr. BEVILL].

The motion was agreed to.

A motion to reconsider the votes by which action was on the several motions and the conference report was laid on the table.

HOUR OF MEETING ON TOMORROW

Mr. BEILENSON. Mr. Speaker, I ask unanimous consent that when the House adjourns today it adjourn to meet at 11 a.m. on tomorrow.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

CONGRESSIONAL ACCOUNTABILITY ACT

Mr. BEILENSON. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 514 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 514

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 1(b) of rule XXIII, declare the House resolved into the Committee of the Whole House on the State of the Union for consideration of the bill (H.R. 4822) to make certain laws applicable to the legislative branch of the Federal Government. The first reading of the bill shall be dispensed with. General debate shall be confined to the bill and the amendments made in order by this resolution and shall not exceed one hour, with thirty minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Rules and thirty minutes equally divided and controlled by the chairman and ranking minority member of the Committee on House Administration. After general debate the bill shall be considered for amendment under the five-minute rule. In lieu of the committee amendments now printed in the bill, it shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule an amendment in the nature of a substitute consisting of the text of H.R. 4892 modified by the amendments printed in part 1 of the report of the Committee on Rules accompanying this resolution. That amendment in the nature of a substitute shall be considered as read. No amendment to the amendment in the nature of a substitute shall be in order except those printed in part 2 of the report of the Committee on Rules. Each amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment except as specified in the report, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole. All points of order against amendments printed in part 2 of the report are waived. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the amendment in the nature of a substitute made in order as original text. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. The gentleman from California [Mr. BEILENSON] is recognized for 1 hour.

Mr. BEILENSON. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman from California [Mr. DREIER], pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

House Resolution 514 is the rule providing for the consideration of H.R. 4822, the Congressional Accountability Act. The resolution provides for 1 hour of general debate, with 30 minutes equally divided and controlled by the chairman and the ranking minority member of the Committee on Rules and 30 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on House Administration.

For purposes of amendment, the rule makes in order as the original bill the text of H.R. 4892 with technical and clarifying amendments, as printed in part I of the report accompanying this resolution (House Report 103-691).

The rule makes in order the 14 amendments which are listed in part II of the report accompanying this resolution. Each amendment, which is to be offered in the order printed in the report, by the Member designated in the report, shall be debatable for 10 minutes. The amendments shall not be subject to further amendment or to demand for a division of the question. All points of order against the amendments are waived.

The amendments which are made in order address several issues concerning the way the new system of applying laws to Congress will operate. These include such matters as the qualification of, and requirements for, the Board of Directors and the Executive Director of the new Office of Compliance; the timing of the steps involved in applying the specified laws; requirements for reporting by the Office of Compliance; and the legal recourse aggrieved employees will have. Additional amendments address the issue of health care benefits provided for Members of Congress, and Members' use of frequent-flier mileage awards which accrue from official travel.

Finally, the rule provides for one motion to recommit, with or without instructions.

Mr. Speaker, the bill which this rule makes in order, the Congressional Accountability Act, is a long-overdue reform which will finally bring Congress under the same laws that apply to other Americans in a credible and effective manner. H.R. 4822 will ensure that congressional employees have the same employment rights and protections that other American workers have, and it will also ensure that Members of Congress are no longer insulated from the impacts and effects of the operation of these laws.

Briefly, H.R. 4822 would explicitly apply 10 employment-related laws to Congress:

The Fair Labor Standards Act;

Title VII of the Civil Rights Act of 1964;

The Americans with Disabilities Act;

The Age Discrimination in Employment Act;

The Family and Medical Leave Act;

The Occupational Safety and Health Act;

The Federal Labor Management Relations Act;

The Employee Polygraph Protection Act;

The Worker Adjustment and Retraining Act; and

The Rehabilitation Act of 1973.

The laws would be applied and enforced for the entire legislative branch by a new Office of Compliance. This office, which would replace the Office of Fair Employment Practices in the House as well as its Senate counterpart, would be overseen by an 8-member Board of Directors which would be appointed by the leadership of both parties in the House and Senate, and would be run by an executive director chosen by the Board.

The Board would conduct a study of the way in which the laws should be applied to the legislative branch, and then follow that study with proposed regulations prescribing the application of the laws to Congress. Unless Congress rejects the regulations by resolution of disapproval, those regulations will take effect. If they are rejected, the Board will reissue new regulations.

The Office will study and recommend additional laws to be applied on a continuing basis, and will be specifically required to study the possible application of the Freedom of Information Act and the Privacy Act.

The bill also provides a four-step process to resolve alleged violations of the law: counseling; mediation; formal complaint and hearing; and judicial review.

Mr. Speaker, there are many people who deserve to be recognized for their efforts in bringing forth this legislation, but chief among them are the two original sponsors of the Congressional Accountability Act, the gentleman from Connecticut [Mr. SHAYS] and the gentleman from New Hampshire [Mr. SWETT]. These two Members have worked tirelessly to get this legislation to the point where it is today.

I also want to recognize the work of the gentlewoman from Colorado [Mrs. SCHROEDER], the gentlewoman from Maine [Ms. SNOWE], and the gentlewoman from the District of Columbia [Ms. NORTON], who made many contributions to the development of this legislation.

And, I want to praise the Members of the freshman class, particularly their four leaders on reform issues, the gentleman from Ohio [Mr. FINGERHUT], the gentlewoman from Utah [Ms. SHEPHERD], the gentlewoman from Florida [Mrs. FOWLER], and the gentleman from Massachusetts [Mr. TORKILDSEN]. These Members made the application of laws to Congress a top priority among reform issues and were instrumental in bringing about our consideration of this legislation. Several of the freshman Members will be offering amendments today which will further refine this legislation.

Mr. Speaker, the charge that Congress exempts itself from laws it passes for everyone else is one of the most frequently heard criticisms of Congress, and understandably so. It is simply wrong to deny to congressional employees the same kinds of employment protections we grant to other employees, and it is wrong to insulate ourselves from the effects of these laws.

To our credit, both the House of Representatives and the Senate have attempted to apply employment-related laws to Congress. It has been a difficult endeavor because we have had to construct a way to do so without breaching the separation of powers doctrine under the U.S. Constitution, which could occur if the executive branch enforced these laws.

For the last 6 years, the House has applied several antidiscrimination measures and other protections to House employees through an internal enforcement system. And, as Congress has passed new laws, such as the Family and Medical Leave Act, we have applied those new measures to the House under the same system.

However, it has become quite clear that neither the range of laws we have applied to the House of Representatives, nor the manner in which they are applied, has been comparable to the private sector. Not all the laws that apply to the private sector apply to Congress, and our internal enforcement process does not provide adequate recourse for aggrieved employees. In addition, there are wide variations in the coverage of laws among different groups of legislative branch employees.

Establishing a new system for applying and enforcing these laws, and expanding and making uniform the range of laws covering the legislative branch, was one of the key recommendations of the Joint Committee on the Organization of Congress. The Joint Committee, drawing from the original bill authored by Mr. SHAYS and Mr. SWETT, recommended applying five laws to Congress, with the possibility of applying more, and establishing a new, more politically insulated entity, the Office of Compliance, which would be responsible for applying employment laws to the entire legislative branch. It also recommended new procedures, rights, and remedies for aggrieved employees.

Following hearings on this legislation by the Subcommittee on the Rules of the House last spring, and with further efforts by Representatives SHAYS and SWETT, and others, the Joint Committee's recommended legislation was revised in several respects. The result is that the bill before us—the bill reported by the House Administration Committee and the Rules Committee—is a much stronger version of the application of laws legislation included in H.R. 3801, the Joint Committee's bill.

This bill, H.R. 4822, is stronger in the following respects:

It explicitly provides for the application of 10 laws—twice as many laws as H.R. 3801 provided for. One of those additional laws is the Occupational Safety and Health Act [OSHA], whose omission by the Joint Committee was criticized by a number of witnesses at our subcommittee hearings, and which is probably the most visible example of laws which private-sector employers must comply with, but from which Congress has exempted itself.

This bill also ensures coverage of all employees of the legislative branch. H.R. 3801 simply provided for a study of the coverage of employees of the Library of Congress, the General Accounting Office, and other congressional instrumentalities.

It makes the Office of Compliance a more independent entity by providing that the Executive Director shall be appointed by the Board of Directors, rather than by the House and Senate leadership, as H.R. 3801 provided.

This bill ensures that congressional employees will continue to be covered under the various laws we already apply here in the House until the new regulations developed by the Office of Compliance take effect. H.R. 3801 left continuation of coverage in question.

It gives more authority to the Office of Compliance to apply the laws to Congress by providing that the regulations they issue will automatically take effect unless Congress rejects them by a resolution of disapproval. H.R. 3801 required Congress to act to approve the regulations before they could take effect.

Again, to emphasize—particularly for those Members who have criticized the delay in action on the Joint Committee's proposals—the bill we are considering today is a much stronger, and much more effective, version of the Joint Committee's proposal. And, the improvement is due in large part to the fact that we took the time over the last few months to hold several days of hearings on this legislation and to engage in many informal discussions on ways the Joint Committee's proposal could be strengthened.

Mr. Speaker, the Congressional Accountability Act is aptly named; it will in fact make Members of Congress significantly more accountable for our actions as employers of the thousands of legislative branch employees. Perhaps just as importantly, it will give us a better understanding of the effects of laws every private sector employer must live under and, hopefully, lead to more diligence and care and accountability for the laws we pass.

I urge the adoption of House Resolution 514 so that the House can proceed with consideration of this important bill.

Mr. Speaker. I reserve the balance of my time.

☐ 1320

Mr. DREIER. Mr. Speaker, I yield myself such time I might consume.

Mr. Speaker, adoption of this rule will mark the death of congressional reform. Yes, we all heard about the agreement between the Speaker and the gentleman from Indiana [Mr. HAMILTON]. It called for separating off the application of laws section from the report of the Joint Committee on the Organization of Congress, which has happened here with this rule, and holding a floor vote on the rest of the reform package sometime in September.

That agreement, like past agreements to allow the full House to debate congressional reform, was written in fool's ink. There is no way the Democrat leadership is going to allow an effective reform bill onto this House floor. The gentleman from Indiana [Mr. HAMILTON] was right the first time in referring to H.R. 3801 when he said, "Separating off the compliance proposal will kill the rest of the package."

Sure enough. Democrats on the Committee on Rules are upstairs now planning to gut H.R. 3801. Biennial appropriations, gone. Committee and subcommittee assignment limitations, gone. The de minimis rule to abolish unpopular committees, gone. The publication of committee attendance and voting records, gone. Allowing independent factfinders to investigate ethics violations, gone.

When the Committee on Rules gets done with the Joint Committee's recommendations, it will consist of just two provisions: The budget control bill that the House passed last month, and pay raises for House committee staff.

☐ 1330

Mr. Speaker, adoption of this rule will complete the Democrat leadership's divide and conquer strategy. It will allow them to kill two congressional reform birds with one stone. It is well known that the Joint Office of Compliance, which is contained in the Shays-Swett bill, is not popular with the other body. So there is little likelihood that Congress will have an effective compliance and enforcement law this year.

Mr. Speaker, our colleagues do not have to go along with this reform charade. If we defeat the previous question on this rule, I intend to offer an amendment to the rule that would allow for an amendment to the Shays-Swett bill consisting of H.R. 3801, the recommendations of the Joint Committee, which would be open to further amendment under the 5-minute rule.

In addition, if the previous question is defeated, my amendment also provides for an open rule—the ultimate congressional reform—for consideration of the Shays-Swett bill. An open rule would allow the gentleman from Loveland, CO [Mr. ALLARD] to offer his amendment to require congressional compliance with all of the laws, not just those that relate to the terms and conditions of employment.

An open rule would allow the gentleman from West Chester, OH [Mr. BOEHNER] to offer his amendment to apply the Freedom of Information Act to the nonlegislative offices of the Congress. It would allow the gentleman from Jacobus, PA [Mr. GOODLING] to offer his very thoughtful amendment on personal liability and punitive damages. It would allow the gentleman from Oklahoma City [Mr. ISTOOK] to offer his amendment to allow congressional employees to bring administrative and civil actions to enforce the application of laws.

Finally, an open rule would allow the gentleman from Shrewsbury, MA [Mr. BLUTE] to offer his amendment to require that all of the elements of any health care reform bill passed by Congress apply to all Members of Congress.

Mr. Speaker, many of these amendments, obviously, are controversial, but they deserve to be debated here on the House floor so that the American people will know who's serious about applying the laws to Congress, and who's not. More important, by voting to defeat the previous question, the American people will be able to distinguish between those who are serious about ending institutional inertia, and those who are only interested in reform as a public relations gimmick.

I urge my colleagues to defeat the previous question.

Mr. Speaker, I include for the RECORD the following information.

ROLL CALL VOTES IN THE COMMITTEE ON RULES DURING MARK-UP OF H.R. 4822, CONGRESSIONAL ACCOUNTABILITY ACT FRIDAY, JULY 29, 1994

1. Dreier Motion to Postpone to Date Certain—It is moved to postpone consideration of H.R. 4822 to the day on which the committee considers H.R. 3801, the Legislative Reorganization Act of 1994. Rejected: 3-4. Yeas: Solomon, Dreier and Goss. Nays: Moakley, Beilenson, Frost and Slaughter. Not Voting: Derrick, Bonior, Hall, Wheat, Gordon and Quillen.

2. Dreier Amendment—An amendment to clarify that committees may not amend bills implementing compliance regulations and that the process for considering implementing bills cannot be waived, altered or suspended by special rule, order, motion or unanimous consent. Rejected: 3-4. Yeas: Solomon, Dreier and Goss. Nays: Moakley, Derrick, Beilenson and Frost. Not Voting: Bonior, Hall, Wheat, Gordon, Slaughter and Quillen.

ROLLCALL VOTES IN THE RULES COMMITTEE ON AMENDMENTS TO THE RULE FOR H.R. 4822 CONGRESSIONAL ACCOUNTABILITY ACT OF 1994 TUESDAY, AUGUST 9, 1994

1. Substitute Open Rule Plus—The substitute rule would provide for two-hours of general debate divided between the Rules and House Administration Committee. Following an open amendment process on H.R. 4822 it would be in order for Reps. Hamilton or Dreier to offer a further amendment at the end of the bill consisting of the text of H.R. 3801, the Legislative Reorganization Act. All points of order against the amendment are waived. It would first be in order for Reps. Hamilton and Dreier to offer one amendment each in 8 specified subject areas of the bill. Any amendment adopted would become base text for the purpose of further amendment under the five-minute rule. If Rep. Hamilton offers an amendment as an alternative to an amendment by Rep. Dreier, both would be voted on and if both were adopted the one receiving the most votes would be considered the one adopted and would become base text for the purpose of amendment. Following the disposition of the Hamilton and Dreier amendments, the bill would be open to further amendment under the five-minute rule. (Vote: Defeated 3-6) Yeas—Solomon, Dreier, Goss. Nays—Moakley, Derrick, Beilenson, Frost, Wheat, Slaughter. Not Voting: Bonior, Hall, Gordon, Quillen.

2. Open Rule—Two-hour general debate divided between the Rules and House Administration Committees with an open amendment process. (Vote: Defeated 3-6) Yeas—Solomon, Dreier, Goss. Nays—Moakley, Derrick, Beilenson, Frost, Wheat, Slaughter. Not Voting: Bonior, Hall, Gordon, Quillen.

3. Dreier Amendment—Amendment #1 submitted by Rep. Dreier would be made in order in addition to the other amendments provided for in the rule and would be considered under the procedures described in #1 above. All points of order are waived against the amendment. (Vote: Defeated 3-6) Yeas—Solomon, Dreier, Goss. Nays—Moakley, Derrick, Beilenson, Frost, Wheat, Slaughter. Not Voting: Bonior, Hall, Gordon, Quillen.

4. Allard (CO)—Amends section 3(b) to require the Office of Compliance to study all laws from which Congress is exempt (not just those that relate to the terms and conditions of employment), and determine whether they should be applied to Congress. (Vote: Defeated 3-6) Yeas—Solomon, Dreier, Goss. Nays—Moakley, Derrick, Beilenson, Frost, Wheat, Slaughter. Not Voting: Bonior, Hall, Gordon, Quillen.

5. Boehner (OH)— Applies the Freedom of Information Act to the nonlegislative offices of the Legislative branch. (Vote: Defeated 3-6) Yeas—Solomon, Dreier, Goss. Nays—Moakley, Derrick, Beilenson, Frost, Wheat, Slaughter. Not Voting: Bonior, Hall, Gordon, Quillen.

6. Blute (MA)—Requires that any health reform bill passed by Congress may apply to all Members of Congress. (Vote: Defeated 3-6) Yeas—Solomon, Dreier, Goss. Nays—Moakley, Derrick, Beilenson, Frost, Wheat, Slaughter. Not Voting: Bonior, Hall, Gordon, Quillen.

7. Goodling (PA)—Authorizes hearing board to award punitive damages of up to $50,000; makes head of employing office (Including Members) personally liable. (Vote: Defeated 3-6) Yeas—Solomon, Dreier, Goss. Nays—Moakley, Derrick, Beilenson, Frost, Wheat, Slaughter. Not Voting: Bonior, Hall, Gordon, Quillen.

8. Istook (OK)—Substitute allows congressional employees to bring administrative and civil actions to enforce application of certain laws; permits the House and Senate to promulgate regulations governing indemnification. (Vote: Defeated 3-6) Yeas—Solomon, Dreier, Goss. Nays—Moakley, Derrick, Beilenson, Frost, Wheat, Slaughter. Not Voting: Bonior, Hall, Gordon, Quillen.

9. Adoption of Rule—(Vote: Adopted 6-3) Yeas—Moakley, Derrick, Beilenson, Frost, Wheat, Slaughter. Nays—Solomon, Dreier, Goss. Not Voting: Bonior, Hall, Gordon, Quillen.

OPEN VERSUS RESTRICTIVE RULES 95TH–103D CONG.

Congress (years)	Total rules granted[1]	Open rules		Restrictive rules	
		Number	Percent[2]	Number	Percent[3]
95th (1977–78)	211	179	85	32	15
96th (1979–80)	214	161	75	53	25
97th (1981–82)	120	90	75	30	25
98th (1983–84)	155	105	68	50	32
99th (1985–86)	115	65	57	50	43
100th (1987–88)	123	66	54	57	46
101st (1989–90)	104	47	45	57	55
102d (1991–92)	109	37	34	72	66
103d (1993–94)	89	24	27	65	73

[1] Total rules counted are all order of business resolutions reported from the Rules Committee which provide for the initial consideration of legislation, except rules on appropriations bills which only waive points of order. Original jurisdiction measures reported as privileged are also not counted.

[2] Open rules are those which permit any Member to offer any germane amendment to a measure so long as it is otherwise in compliance with the rules of the House. The parenthetical percentages are open rules as a percent of total rules granted.

[3] Restrictive rules are those which limit the number of amendments which can be offered, and include so-called modified open and modified closed rules, as well as completely closed rule, and rules providing for consideration in the House as opposed to the Committee of the Whole. The parenthetical percentages are restrictive rules as a percent of total rules granted.

Sources: "Rules Committee Calendars & Surveys of Activities," 95th–102d Cong.; "Notices of Action Taken," Committee on Rules, 103d Cong., through Aug. 9, 1994.

OPEN VERSUS RESTRICTIVE RULES: 103D CONG.

Rule number date reported	Rule type	Bill number and subject	Amendments submitted	Amendments allowed	Disposition of rule and date
H. Res. 58, Feb. 2, 1993	MC	H.R. 1: Family and medical leave	30 (D–5; R–25)	3 (D–0; R–3)	PQ: 246–176. A: 259–164. (Feb. 3, 1993).
H. Res. 59, Feb. 3, 1993	MC	H.R. 2: National Voter Registration Act	19 (D–1; R–18)	1 (D–0; R–1)	PQ: 248–171. A: 249–170. (Feb. 4, 1993).
H. Res. 103, Feb. 23, 1993	C	H.R. 920: Unemployment compensation	7 (D–2; R–5)	0 (D–0; R–0)	PQ: 243–172. A: 237–178. (Feb. 24, 1993).
H. Res. 106, Mar. 2, 1993	MC	H.R. 20: Hatch Act amendments	9 (D–1; R–8)	3 (D–0; R–3)	PQ: 248–166. A: 249–163. (Mar. 3, 1993).
H. Res. 119, Mar. 9, 1993	MC	H.R. 4: NIH Revitalization Act of 1993	13 (d–4; R–9)	8 (D–3; R–5)	PQ: 247–170. A: 248–170. (Mar. 10, 1993).
H. Res. 132, Mar. 17, 1993	MC	H.R. 1335: Emergency supplemental Appropriations	37 (D–8; R–29)	1(not submitted) (D–1; R–0)	A: 240–185. (Mar. 18, 1993).
H. Res. 133, Mar. 17, 1993	MC	H. Con. Res. 64: Budget resolution	14 (D–2; R–12)	4 (1-D not submitted) (D–2; R–2)	PQ: 250–172. A: 251–172. (Mar. 18, 1993).
H. Res. 138, Mar. 23, 1993	MC	H.R. 670: Family planning amendments	20 (D–8; R–12)	9 (D–4; R–5)	PQ: 252–164. A: 247–169. (Mar. 24, 1993).
H. Res. 147, Mar. 31, 1993	C	H.R. 1430: Increase Public debt limit	6 (D–1; R–5)	0 (D–0; R–0)	PQ: 244–168. A: 242–170. (Apr. 1, 1993).
H. Res. 149 Apr. 1, 1993	MC	H.R. 1578: Expedited Rescission Act of 1993	8 (D–1; R–7)	3 (D–1; R–2)	A: 212–208. (Apr. 28, 1993).
H. Res. 164, May 4, 1993	O	H.R. 820: Nate Competitiveness Act	NA	NA	A: Voice Vote. (May 5, 1993).
H. Res. 171, May 18, 1993	O	H.R. 873: Gallatin Range Act of 1993	NA	NA	A: Voice Vote. (May 20, 1993).
H. Res. 172, May 18, 1993	O	H.R. 1159: Passenger Vessel Safety Act	NA	NA	A: 308–0 (May 24, 1993).
H. Res. 173 May 18, 1993	MC	S.J. Res. 45: United States forces in Somalia	6 (D–1; R–5)	6 (D–1; R–5)	A: Voice Vote (May 20, 1993)
H. Res. 183, May 25, 1993	O	H.R. 2244: 2d supplemental appropriations	NA	NA	A: 251–174. (May 26, 1993).
H. Res. 186, May 27, 1993	MC	H.R. 2264: Omnibus budget reconciliation	51 (D–19; R–32)	8 (D–7; R–1)	PQ: 252–178. A: 236–194 (May 27, 1993).
H. Res. 192, June 9, 1993	MC	H.R. 2348: Legislative branch appropriations	50 (D–6; R–44)	6 (D–3; R–3)	PQ: 240–177. A: 226–185. (June 10, 1993).
H. Res. 193, June 10, 1993	O	H.R. 2200: NASA authorization	NA	NA	A: Voice Vote. (June 14, 1993).
H. Res. 195, June 14, 1993	MC	H.R. 5: Striker replacement	7 (D–4; R–3)	2 (D–1; R–1)	A: 244–176.. (June 15, 1993).
H. Res. 197, June 15, 1993	MO	H.R. 2333: State Department. H.R. 2404: Foreign aid	53 (D–20; R–33)	27 (D–12; R–15)	A: 294–129. (June 16, 1993).
H. Res. 199, June 16, 1993	C	H.R. 1876: Ext. of "Fast Track"	NA	NA	A: Voice Vote. (June 22, 1993).
H. Res. 200, June 16, 1993	MC	H.R. 2295: Foreign operations appropriations	33 (D–11; R–22)	5 (D–1; R–4)	A: 263–160. (June 17, 1993).
H. Res. 201, June 17, 1993	O	H.R. 2403: Treasury-postal appropriations	NA	NA	A: Voice Vote. (June 17, 1993).
H. Res. 203, June 22, 1993	MO	H.R. 2445: Energy and Water appropriations	NA	NA	A: Voice Vote. (June 23, 1993).
H. Res. 206, June 23, 1993	O	H.R. 2150: Coast Guard authorization	NA	NA	A: 401–0. (July 30, 1993).
H. Res. 217, July 14, 1993	MO	H.R. 2010: National Service Trust Act	NA	NA	A: 261–164. (July 21, 1993).
H. Res. 220, July 21, 1993	MC	H.R. 2667: Disaster assistance supplemental	14 (D–8; R–6)	2 (D–2; R–0)	PQ: 245–178. F: 205–216. (July 22, 1993).
H. Res. 226, July 23, 1993	MC	H.R. 2667: Disaster assistance supplemental	15 (D–8; R–7)	2 (D–2; R–0)	A: 224–205. (July 27, 1993).
H. Res. 229, July 28, 1993	MO	H.R. 2330: Intelligence Authority Act, fiscal year 1994	NA	NA	A: Voice Vote. (Aug. 3, 1993).
H. Res. 230, July 28, 1993	O	H.R. 1964: Maritime Administration authority	NA	NA	A: Voice Vote. (July 29, 1993).
H. Res. 246, Aug. 6, 1993	MO	H.R. 2401: National Defense authority	149 (D–109; R–40)		A: 246–172. (Sept. 8, 1993).
H. Res. 248, Sept. 9, 1993	MO	H.R. 2401: National defense authorization			PQ: 237–169. A: 234–169. (Sept. 13, 1993).
H. Res. 250, Sept. 13, 1993	MC	H.R. 1340: RTC Completion Act	12 (D–3; R–9)	1 (D–1; R–0)	A: 213–191–1. (Sept. 14, 1993).
H. Res. 254, Sept. 22, 1993	MO	H.R. 2401: National Defense authorization		91 (D–67; R–24)	A: 241–182. (Sept. 28, 1993).
H. Res. 262, Sept. 28, 1993	O	H.R. 1845: National Biological Survey Act	NA	NA	A: 238–188 (10/06/93).
H. Res. 264, Sept. 28, 1993	MC	H.R. 2351: Arts, humanities, museums	7 (D–0; R–7)	3 (D–0; R–3)	PQ: 240–185. A: 225–195. (Oct. 14, 1993).
H. Res. 265, Sept. 29, 1993	MC	H.R. 3167: Unemployment compensation amendments	3 (D–1; R–2)	2 (D–1; R–1)	A: 239–150. (Oct. 15, 1993).
H. Res. 269, Oct. 6, 1993	MO	H.R. 2739: Aviation infrastructure investment	N/A	N/A	A: Voice Vote. (Oct. 7, 1993).
H. Res. 273, Oct. 12, 1993	MC	H.R. 3167: Unemployment compensation amendments	3 (D–1; R–2)	2 (D–1; R–1)	PQ: 235–187. F: 149–254. (Oct. 14, 1993).
H. Res. 274, Oct. 12, 1993	MC	H.R. 1804: Goals 2000 Educate America Act	15 (D–7; R–7; I–1)	10 (D–7; R–3)	A: Voice Vote. (Oct. 13, 1993).
H. Res. 282, Oct. 20, 1993	C	H.J. Res. 281: Continuing appropriations through Oct. 28, 1993	N/A	N/A	A: Voice Vote. (Oct. 21, 1993).
H. Res. 286, Oct. 27, 1993	O	H.R. 334: Lumbee Recognition Act	N/A	N/A	A: Voice Vote. (Oct. 28, 1993).
H. Res. 287, Oct. 27, 1993	C	H.J. Res. 283: Continuing appropriations resolution	1 (D–0; R–0)	0	A: 252–170. (Oct. 28, 1993).
H. Res. 289, Oct. 28, 1993	O	H.R. 2151: Maritime Security Act of 1993	N/A	N/A	A: Voice Vote. (Nov. 3, 1993).
H. Res. 293, Nov. 4, 1993	MC	H. Con. Res. 170: Troop withdrawal Somalia	N/A	N/A	A: 390–8. (Nov. 8, 1993).
H. Res. 299, Nov. 8, 1993	MO	H.R. 1036: Employee Retirement Act–1993	2 (D–1; R–1)	N/A	A: Voice Vote. (Nov. 9, 1993).
H. Res. 302, Nov. 9, 1993	MC	H.R. 1025: Brady handgun bill	17 (D–6; R–11)	4 (D–1; R–3)	A: 238–182. (Nov. 10, 1993).
H. Res. 303, Nov. 9, 1993	O	H.R. 322: Mineral exploration	N/A	N/A	A: Voice Vote. (Nov. 16, 1993).
H. Res. 304, Nov. 9, 1993	C	H.J. Res. 288: Further CR, FY 1994	N/A	N/A	
H. Res. 312, Nov. 17, 1993	MC	H.R. 3425: EPA Cabinet Status	27 (D–8; R–19)	9 (D–1; R–8)	F: 191–227. (Feb. 2, 1994).
H. Res. 313, Nov. 17, 1993	MC	H.R. 796: Freedom Access to Clinics	15 (D–9; R–6)	4 (D–1; R–3)	A: 233–192. (Nov. 18, 1993).
H. Res. 314, Nov. 17, 1993	MC	H.R. 3351: Alt Methods Young Offenders	21 (D–7; R–14)	6 (D–3; R–3)	A: 238–179. (Nov. 19, 1993).
H. Res. 316, Nov. 19, 1993	C	H.R. 51: D.C. statehood bill	1 (D–1; R–0)	N/A	A: 252–172. (Nov. 20, 1993).
H. Res. 319, Nov. 20, 1993	MC	H.R. 3: Campaign Finance Reform	35 (D–6; R–29)	1 (D–0; R–1)	A: 220–207. (Nov. 21, 1993).
H. Res. 320, Nov. 20, 1993	MC	H.R. 3400: Reinventing Government	34 (D–15; R–19)	3 (D–3; R–0)	A: 247–183. (Nov. 22, 1993).
H. Res. 336, Feb. 2, 1994	MC	H.R. 3759: Emergency Supplemental Appropriations	14 (D–8; R–5; I–1)	5 (D–3; R–2)	PQ: 244–168. A: 342–65. (Feb. 3, 1994).
H. Res. 352, Feb. 8, 1994	MC	H.R. 811: Independent Counsel Act	27 (D–8; R–19)	10 (D–4; R–6)	PQ: 249–174. A: 242–174. (Feb. 9, 1994).
H. Res. 357, Feb. 9, 1994	MC	H.R. 3345: Federal Workforce Restructuring	3 (D–2; R–1)	2 (D–2; R–0)	A: VV (Feb. 10, 1994).
H. Res. 366, Feb. 23, 1994	MO	H.R. 6: Improving America's Schools	NA	NA	A: VV (Feb. 24, 1994).
H. Res. 384, Mar. 9, 1994	MC	H. Con. Res. 218: Budget Resolution FY 1995–99	14 (D–5; R–9)	5 (D–3; R–2)	A: 245–171 (Mar. 10, 1994).
H. Res. 401, Apr. 12, 1994	MO	H.R. 4092: Violent Crime Control	180 (D–98; R–82)	68 (D–47; R–21)	A: 244–176 (Apr. 13, 1994).
H. Res. 410, Apr. 21, 1994	MO	H.R. 3221: Iraqi Claims Act	N/A	N/A	A: Voice Vote (Apr. 28, 1994).
H. Res. 414, Apr. 28, 1994	O	H.R. 3254: NSF Auth. Act	N/A	N/A	A: Voice Vote (May 3, 1994).
H. Res. 416, May 4, 1994	C	H.R. 4296: Assault Weapons Ban Act	7 (D–5; R–2)	0 (D–0; R–0)	A: 220–209 (May 5, 1994).
H. Res. 420, May 5, 1994	O	H.R. 2442: EDA Reauthorization	N/A	N/A	A: Voice Vote (May 10, 1994).
H. Res. 422, May 11, 1994	MO	H.R. 518: California Desert Protection	N/A	N/A	PQ: 245–172 A: 248–165 (May 17, 1994).
H. Res. 423, May 11, 1994	O	H.R. 2473: Montana Wilderness Act	N/A	N/A	A: Voice Vote (May 12, 1994).
H. Res. 428, May 17, 1994	MO	H.R. 2108: Black Lung Benefits Act	4 (D–1; R–3)	N/A	A: VV (May 19, 1994).
H. Res. 429, May 17, 1994	MO	H.R. 4301: Defense Auth., FY 1995	173 (D–115; R–58)		A: 369–49 (May 18, 1994).
H. Res. 431, May 20, 1994	MO	H.R. 4301: Defense Auth., FY 1995		100 (D–80; R–20)	A: Voice Vote (May 23, 1994).
H. Res. 440, May 24, 1994	MC	H.R. 4385: Natl Hiway System Designation	16 (D–10; R–6)	5 (D–5; R–0)	A: Voice Vote (May 25, 1994).
H. Res. 443, May 25, 1994	MC	H.R. 4426: For. Ops. Approps, FY 1995	39 (D–11; R–28)	8 (D–3; R–5)	PQ: 233–191 A: 244–181 (May 25, 1994).
H. Res. 444, May 25, 1994	MC	H.R. 4454: Leg Branch Approp, FY 1995	43 (D–10; R–33)	12 (D–8; R–4)	A: 249–177 (May 26, 1994).
H. Res. 447, June 8, 1994	O	H.R. 4539: Treasury/Postal Approps 1995	N/A	N/A	A: 236–177 (June 9, 1994).
H. Res. 467, June 28, 1994	MC	H.R. 4600: Expedited Rescissions Act	N/A	N/A	PQ: 240–185 A:Voice Vote (July 14, 1994).
H. Res. 468, June 28, 1994	MO	H.R. 4299: Intelligence Auth., FY 1995	N/A	N/A	A: Voice Vote (July 19, 1994).
H. Res. 474, July 12, 1994	MO	H.R. 3937: Export Admin. Act of 1994	N/A	N/A	A: Voice Vote (July 14, 1994).
H. Res. 475, July 12, 1994	O	H.R. 1188: Anti. Redlining in Ins	N/A	N/A	A: Voice Vote (July 20, 1994).
H. Res. 482, July 20, 1994	O	H.R. 3838: Housing & Comm. Dev. Act	N/A	N/A	A: Voice Vote (July 21, 1994).
H. Res. 483, July 20, 1994	O	H.R. 3870: Environ. Tech. Act of 1994	N/A	N/A	A: Voice Vote (July 26, 1994).
H. Res. 484, July 20, 1994	MC	H.R. 4604: Budget Control Act of 1994	3 (D–2; R–1)	3 (D–2; R–1)	PQ: 245–180 A: Voice Vote (July 21, 1994).
H. Res. 491, July 27, 1994	O	H.R. 2448: Radon Disclosure Act	N/A	N/A	A: Voice Vote (July 28, 1994).
H. Res. 492, July 27, 1994	O	S. 208: NPS Concession Policy	N/A	N/A	A: Voice Vote (July 28, 1994).
H. Res. 494, July 28, 1994	MC	H.R. 4801: SBA Reauth & Amdmts. Act	10 (D–5; R–5)	6 (D–4; R–2)	PQ: 215–169 A: 221–161 (July 29, 1994).
H. Res. 500, Aug. 1, 1994	MO	H.R. 4003: Maritime Admin. Reauth.	N/A	N/A	A: 336–77 (Aug. 2, 1994).
H. Res. 501, Aug. 1, 1994	O	S. 1357: Little Traverse Bay Bands	N/A	N/A	A: Voice Vote (Aug. 3, 1994).
H. Res. 502, Aug. 1, 1994	O	H.R. 1066: Pokagon Band of Potawatomi	N/A	N/A	A: Voice Vote (Aug. 3, 1994).
H. Res. 507, Aug. 4, 1994	O	H.R. 4217: Federal Crop Insurance	N/A	N/A	A: Voice Vote (Aug. 5, 1994).
H. Res. 509, Aug. 5, 1994	MC	H.J. Res. 373/H.R. 4590: MFN China Policy	N/A	N/A	A: Voice Vote (Aug. 9, 1994).
H. Res. 513, Aug. 9, 1994	MC	H.R. 4906: Emergency Spending Control Act	N/A	N/A	
H. Res. 512, Aug. 9, 1994	MC	H.R. 4907: Full Budget Disclosure Act	N/A	N/A	
H. Res. 514, Aug. 9, 1994	MC	H.R. 4822: Cong. Accountability	33 (D–16; R–17)	16 (D–10; R–6)	

Note.—Code: C-Closed; MC-Modified closed; MO-Modified open; O-Open; D-Democrat; R-Republican; PQ: Previous question; A-Adopted; F-Failed.

Mr. Speaker, I reserve the balance of my time.

Mr. BEILENSON. Mr. Speaker, for purposes of debate only, I yield 4 minutes to the gentleman from New Hampshire [Mr. SWETT], one of the cosponsors of this bill.

Mr. SWETT. Mr. Speaker, first I want to thank the members of the Committee on Rules and particularly the members who are here officiating floor debate, the gentlemen from California, Mr. BEILENSON and Mr. DREIER, for the very good effort that they have put into this legislation. I understand the concerns of the member from the minority side. I certainly have privately and will publicly pledge my support to him in those things that he talked about achieving.

I believe September is a month in which we can accomplish the other half of H.R. 3801 that has not been brought forward with this piece of legislation, but today I want to speak about this rule.

Mr. Speaker, I rise in strong support of this rule. The Rules Committee has produced a good rule that brings a strong bill to the floor—a bill this body can be proud of and which we should pass.

The rule makes 14 amendments in order, almost all of which are strengthening amendments. It enables us to consider a comprehensive, even historic, bill that will bring Congress under 10 important laws from which we are now exempt, either wholly or in part. This is a long overdue step for the legislative branch, and this rule will enable us to take it.

There are amendments that were not made in order which Congressman SHAYS and I asked the Rules Committee to make in order. Application of FOIA was in our bill, for instance, and we asked the Rules Committee to make Mr. BOEHNER's amendment in order. The committee didn't do so. But the House Administration Committee did include study language in the bill on FOIA. So Mr. BOEHNER and the rest of us will live to fight that battle again another day. When that day comes, I may well be by his side. But, in my judgment, there is not a single amendment which has not been made in order which justifies torpedoing this rule and, by extension, this bill.

No structured rule will meet with everyone's approval. But we should not throw out the baby with the bathwater. Against all expectations and odds, a strong congressional compliance bill has reached the floor and is now before us. I urge my colleagues not to throw away this opportunity to keep faith with our constituents and bring Congress into full compliance with our Nation's laws.

Let us get this job done. Please support the rule.

Mr. DREIER. Mr. Speaker, I yield 5 minutes to the gentleman from Glens Falls, NY [Mr. SOLOMON], the ranking Republican on the Committee on Rules, a very hard-working member of the now defunct Joint Committee on the Organization of Congress.

Mr. SOLOMON. Mr. Speaker, I thank the gentleman, who is the vice chairman of the now defunct joint committee, which seems to be going nowhere.

I join my colleague in urging defeat of the previous question so that we can consider this bill and a congressional reform amendment under an open rule.

Mr. Speaker, my colleagues, here we are again, taking another piece out of the congressional reform bill on which our joint committee worked so long and so hard last year. This is the second attempt to gut this important bill and move it to the bottom of everybody's priority around here. I think it is ironic that the leadership inaction on congressional reform has brought us full circle to what gave birth to this joint reform committee back in 1992.

That committee was formed in the wake of scandals in this House and also in the other body. It had the full backing of the bipartisan and bicameral leadership in this House. And now the Democrat leadership is fully backing away from the modest set of reform proposals reported from that committee.

In so doing it is creating a new scandal in this House, a new scandal in this House.

Mr. Speaker, let me just say that the scandal of trying to sweep reform under the rug and avoid doing what needs to be done to overhaul the legislative structures and practices of this Congress is a shame.

In the joint committee's opening hearing, January 26 of last year, I want Members to listen to this, Mr. Speaker, listen to this, we had the unprecedented panel of the Speaker of the House and the majority and minority leaders of the House, of both houses appear before our joint committee. The Speaker did. And at that time the gentleman from Washington [Mr. FOLEY], and I quote, said this:

"I did take a strong position in support of this bipartisan, bicameral joint committee last year." He went on to say, "I have come to believe that this is a process that not only can work but must work."

Those are the Speaker's words. And the Speaker concluded his statement by saying, "I pledge to you my willingness to support you in any way that I can, and I wish you well."

Well, thanks a lot, Mr. Speaker.

Mr. Speaker, that congressional reform bill has been languishing in committees for the last 6 months. Where, Mr. Speaker, has that support gone? Deadline after deadline for House action has slipped from last fall to last spring, now to the late summer. How far can it slip?

Now we are told we may get to a token vote on this package sometime in September before we adjourn, when, of course, Mr. Speaker, it is too late to get anything through the conference and signed into law.

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So much for congressional reform. That is a scandal. The rule before us will allow us to consider just one piece of that comprehensive reform package, the so-called Congressional Accountability Act, under a modified closed rule. Members are being gagged. Legitimate amendments, filed from both sides of the aisle, Democrats and Republicans, have been shut out of this process today, while a nongermane Democrat amendment has been allowed.

Mr. Speaker, it never ceases to amaze me how the majority leadership, with a straight face, can jam so-called reform bills through this House under undemocratic procedures. Whose idea of reform is it to disenfranchise Members of this House from representing their constituents, and exercising their constitutional rights to make the rules of the House?

Mr. Speaker, this bill is entitled the Congressional Accountability Act of 1994. It is a meritorious proposal and it is long overdue. We are going to vote for it. We should have brought ourselves under the laws we impose on others long ago. That is what Madison had in mind in the Federalist Paper No. 57 when he said, and think about this, almost 200 years ago, he said, "One of the strongest bonds" that can connect the rulers with the people and restrain rulers from "oppressive measures" is that "they can make no law that will not have its full operation on themselves," that means us, "that will not have its full operation on themselves and their friends, as well as on the great mass of society."

Mr. Speaker, how far we have strayed from that principle. But we have other steps to take if we truly want to restore the kind of congressional accountability that will again bind us to our constituents and earn their respect and their approval of the Members and I in this Congress.

We need to act now on comprehensive congressional reform. That is why every man and woman in this body ought to vote down the previous question and bring this bill back on the floor under an open rule, so that each and every one of the 435 Members can represent their constituency on the floor of this House. I dare you to do that. You would be proud of yourselves.

Mr. BEILENSON. Mr. Speaker, for purposes of debate only, I yield 3 minutes to the gentlewoman from Colorado [Mrs. SCHROEDER].

Mrs. SCHROEDER. Mr. Speaker, I thank the gentleman for yielding time to me.

I just want to say, Mr. Speaker, as I am listening to this debate, I thought of something I heard on television this morning. One of the commentators said "The bad news is the baseball folks are going on strike, and the even worse news is that Congress canceled recess." If we listen to this debate, I think we would really believe it.

What we are doing here today, Mr. Speaker, is very historic, and people have been waiting for this a long time. I do not think there are very many people in the Chambers who have more scars than I do from waiting for this for such a long time.

Way back in 1976 a group of us tried to do this with the House Fair Employment Practices Act, because I think one of the things the American people wanted the most was to make sure we lived under the same laws we passed, very simple.

It was like we had worn a bathing suit to church. There were about 100 Members who signed up, and there were, obviously, a lot of Members who did not sign up, but we tried to run that year after year after year. We were not given space, we had to run it out of our own office, we had to run it through our own phone numbers, and every other such thing.

Finally, Mr. Speaker, Congresswoman Lynn Martin and I were able to get another office created that made it a broader base, but we had great suspicion that it had been weakened so much that it was not working very well. Last year when we asked the Government Accounting Office to look at that, they found that they agreed with us.

Here today we have the great ability to form this Office of Compliance that once and for all is going to end this issue, and be under some independent boards, and let us do that. I really, really salute the gentlemen from Connecticut, Mr. SHAYS and Mr. SWETT, and the gentlemen from California, Mr. BEILENSON and Mr. DREIER, who sat through all those hearings, too.

All of us want reform. We have to get this reform, which is first and foremost, I think, done.

If you are the American people listening to this debate, Mr. Speaker, it gets very confusing. When we come to health care reform, everybody says "We cannot do that. It is too broad." Today we are trying to do this reform, and everybody is saying "No, we cannot do that, it is not enough. It ought to be bigger."

This is a chance to do some very important reform that many of us have thought was long overdue, and it is now here. Mr. Speaker, I would hope we would all join together, get this done, bring this to closure, put the employees here on the Hill under the laws that we pass for everyone else, and that we can move on and do other reforms as they come forward.

However, this is not something that just popped up and it is just one little piece. This one is further developed. We have a much longer track record on it. We know the problems of what we have in place, and why it needs to be changed.

Mr. Speaker, many of the people sitting here listening to this debate sat through incredible long hearings understanding that, so we now have a real basis to make a change the American public has never understood was not there. So I urge everyone to vote for the rule and get on with it.

Mr. DREIER. Mr. Speaker, I am happy to yield 3 minutes to the gentleman from Jacobus, PA [Mr. GOODLING], the ranking minority member of the Committee on Education and Labor, who has a very thoughtful amendment that unfortunately was denied under this rule.

Mr. GOODLING. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, long before 70 percent of the Members in the House at this point came to the Congress of the United States, I was pushing for congressional accountability. In the Committee on Education and Labor, on which I have served the entire time, on every piece of labor legislation which has come before us, I said "What about us? What about those of us who are writing the law? Shouldn't we be covered?"

Mr. Speaker, I rise in opposition to the rule, as the Committee on Rules has offered it. I very much regret that the proposed rule does not allow me to offer an amendment, an amendment which was passed unanimously in the Committee on Education and Labor, the only committee that has dealt with the issue.

Mr. Speaker, there is no good reason in the world why Members of Congress and other legislative branch employers should be treated any differently than other employers. Nonetheless, without my amendment, while any private sector employer in any of our districts faces the possibility not only of being sued by an employee for back pay, compensatory damages, liquidated damages, in some cases, and punitive damages under civil rights laws, apparently the leadership of the House wants to shield us from that liability.

Every time we have had a debate on whether Congress should be covered or not, any time we have had a debate on we should have punitive damages and compensatory damages in all the legislation that we have passed, people get up and say "Yes, you must have it. Yes, you must have it. If you don't, no one will pay any attention to the law."

However, when it comes to us, that is a different story. We will pay attention to the law, because we are Members of Congress. Mr. Speaker, it will not work, and we positively need my amendment in this legislation.

If this bill's prohibition on punitive damages, which is what I am offering, remains, then let us not go home and tell our constituents, especially our employer constituents, that we are being treated the same way they are being treated. That is the farthest thing from the truth.

Mr. Speaker, I think it is particularly an abuse by the Committee on Rules to try to prevent my amendment when, as I said, it was passed unanimously in the Committee on Education and Labor, the only committee that dealt with the issue.

When we were discussing my amendment before the Committee on Rules, and the kind of liability and damages that every private sector employer faces every day, the suggestion was made by one of the members of the Committee on Rules that perhaps, instead of extending punitive damages and personal liability to the legislative branch, we ought to remove such damages from the employment laws as they apply to the private sector.

Mr. Speaker, I could not agree more. All I can say is that I hope that those who vote for the rule, and therefore against the inclusion of the same remedies and damages that private employers face, will indeed join me in seeking to repeal the same provisions as they apply against employers in our district. I would hope that we would have that open rule so we can treat ourselves just the same way we treat every private employer in this country.

Mr. BEILENSON. Mr. Speaker, for purposes of debate only, I yield 6 minutes to our friend, the distinguished gentleman from Massachusetts [Mr. FRANK].

Mr. FRANK of Massachusetts. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I do not see the gentleman from New York [Mr. SOLOMON] still in the Chamber. I must say that the gap between his rhetoric and reality was unusually large today, even for him.

I was struck by the theatrical force of his addressing Speaker FOLEY time and again as "Mr. Speaker" in the full knowledge that, of course, Speaker FOLEY was nowhere in the room, and that someone else was serving as Speaker. I am not surprised that the absent Speaker FOLEY was not able to respond to the gentleman's forceful invocation of his name.

Mr. Speaker, I yield to the gentleman from New York [Mr. SOLOMON], if he would like, since he has returned, unlike Speaker FOLEY.

Mr. SOLOMON. Mr. Speaker, I would be very happy to quote my good friend, the Speaker, the gentleman from Washington [TOM FOLEY], because he meant what he said. Now I want him to follow through on it. I thank the gentleman for allowing me to say that.

Mr. FRANK of Massachusetts. Mr. Speaker, I thank the gentleman. My point was that the gentleman was, with great theatrical flare, addressing remarks to a Speaker FOLEY who was absent, and unless the gentleman's eyesight has also deteriorated very substantially, he would have known that.

Mr. SOLOMON. If the gentleman will continue to yield, Mr. Speaker, I think the Speaker was watching it on TV, though.

Mr. FRANK of Massachusetts. The gentleman, of course, has no more idea about that than he has about the rest of what he said.

The point, Mr. Speaker——

Mr. SOLOMON. Be careful. You could have your words taken down.

Mr. FRANK of Massachusetts. Mr. Speaker, I do not believe that saying that someone has no clear idea of what he is talking about can be taken down. Factual discussions about the gap between reality and rhetoric are fully in order.

I do want to concede so the gentleman's error can be instructive.

□ 1350

Why did we get this kind of gap? Because we now know that there is something that makes Republicans angrier than Congress not applying the laws to itself. What is that? It is when Congress applies the laws to itself. Because what we are hearing is the desperately unhappy cry of people who see themselves losing an issue.

We are daring today to do the right thing, and that confounds my friends. I think it was Mark Twain who said, "Tell the truth. You will confound your enemies and astound your friends," something like that. He said it better.

Mr. Speaker, what we are doing today in a bipartisan way, this is the Swett-Shays bill, it is primarily offered by the gentleman from Connecticut, a Republican, and the gentleman from New Hampshire, a Democrat. It will contrary to what James Madison did, because the gentleman misunderstood James Madison, James Madison wrote into the U.S. Constitution precisely the sorts of exemptions the gentleman takes exception to.

The reason why the laws do not apply here, the reason we have some exemption from arrests, they were written into the Constitution by James Madison. We are changing hundreds of years of British and American parliamentary tradition by subjecting this institution to the laws. That is a drastic breakthrough for which all of us should be taking credit. But my Republican friends are terrified that someone might think that Congress did something good, and that would, of course, ruin their day. So they will denigrate unfairly this extraordinarily important achievement which will give the employees, and by the way, we are not on the whole talking about our individual congressional employees but the employees of the Architect and the police and those other people, but it will apply to everybody, they will get rights they have not previously gotten, thanks to the efforts of the gentleman from Connecticut, the gentleman from New Hampshire, I was glad to be able to help, and the Speaker agreed with that. That is where we are today. We are in fact changing hundreds of years.

The argument goes back to Queen Elizabeth and King Henry, when people felt that the executive would use the enforcement power to coerce the legislative branch. That is an outdated idea. It should be changed. By the way, enthusiasm for changing it is not always uniform.

A few years ago when the restaurant employees sought the right to organize and bargain collectively, myself, the gentleman from Missouri who chairs the Committee on Post Office and Civil Service, the gentleman from California who chairs the Subcommittee on Civil and Constitution Rights, and others, we tried to give them that right. We got no help on the Republican side. I approached Republicans, and they said, "Well, that's labor law, we don't agree with that. We're not going to support it." We pushed hard for it and we got no support. I am glad we are doing what we are doing.

Mr. Speaker, the question now is, are we doing something terrible because we are doing something good, but we are not doing something else the gentleman wants. And here is the argument. By separating whether or not the laws should apply to Congress as an institution, regarding discrimination and safety and health, et cetera, is that a terrible thing because we are not at the same time and in the same bill reforming committee procedure and voting? No, I think we are doing the right thing. In fact, it is the people on the other side who are trying to join two things which in my judgment have a great degree of separation. One question: Should the laws apply to people who work here? The answer to that, it seems to me, is clearly yes.

The second question: How many committees should we have? Should there be proxy voting? Et cetera. Those are not the same questions. To insist that we not extend the rights that we are now extending to thousands of people unless we simultaneously can achieve a consensus on how many committees there ought to be and whether or not there is proxy voting is in fact to denigrate those rights. And in fact I predict if we had done it the other way, we would have heard the same complaints, in fact more loudly. "How dare you hold up their rights until you solve the other problem." We are doing the right thing for once and my friends on the other side cannot stand it.

Mr. DREIER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would respond to my friend by saying that the gentleman from Indiana [Mr. HAMILTON] made it very clear, dividing up the issue of congressional compliance would kill congressional reform. That is what the chairman on the Joint Committee on the Organization of Congress said in his statement.

Mr. FRANK of Massachusetts. Mr. Speaker, will the gentleman yield?

Mr. DREIER. We do not have much more time on this side because there are so many Members who want to celebrate the victory on this.

Mr. FRANK of Massachusetts. I yielded to the gentleman from New York. The gentleman will not yield to me?

Mr. DREIER. If the gentleman from California [Mr. BEILENSON] would yield to the gentleman, I would be happy to engage the gentleman in a colloquy.

Mr. FRANK of Massachusetts. I yielded on my time to the gentleman.

Mr. DREIER. That is because the gentleman has very few requests because this is something that Members on this side are genuinely more concerned about it seems than the other side.

Mr. FRANK of Massachusetts. The gentleman will not yield to me?

Mr. DREIER. Possibly the gentleman from California [Mr. BEILENSON] might yield.

Mr. BEILENSON. Mr. Speaker, I yield an additional 1 minute to the gentleman from Massachusetts [Mr. FRANK].

Mr. FRANK of Massachusetts. Mr. Speaker, I thank the gentleman for yielding me the time.

I am impressed by the gentleman from California's example of openness by alluding to me and then refusing to yield to me as I had yielded to the gentleman from New York.

Mr. DREIER. I was confident my friend the gentleman from California would yield to the gentleman.

Mr. FRANK of Massachusetts. This is my time. I would ask the gentleman to withhold because I do want to use the time well.

The point that the chairman of the joint committee said something does not seem to me to be conclusive. I have as the gentleman from California has from time to time voted against the chairman. The invocation of authority is a poor logical argument. In fact what the gentleman is saying is do not extend the rights to these workers unless we can also come to an agreement on the unrelated complicated subject of committee procedure and structure. I think that is unfair to these workers.

They are entitled to have these rights, they should have had them a long time ago. And to say that they cannot get them until we and the Senate can come to another set of agreements on another set of issues is unfair to them.

Mr. DREIER. Mr. Speaker, the fact of the matter is we hope very much that we can deal with the issue of congressional compliance and all the other items that have been brought before us, and I would say that I did not hear the gentleman from Massachusetts testify before the Joint Committee on the Organization of Congress along with 130 some odd Members who did agree to testify before the joint committee.

Mr. Speaker, I yield 2½ minutes to my friend, the gentleman from Metairie, LA [Mr. LIVINGSTON], a hardworking member of the Committee on House Administration.

Mr. LIVINGSTON. Mr. Speaker, if I could paraphrase what I heard a minute ago, the question was whether there should be congressional accountability and reform over the way Congress does business, and the answer was yes, but not too much.

I rise today to urge the defeat of the previous question. Yet I support the underlying concept of H.R. 4822, the Congressional Accountability Act.

This bill will ultimately—we hope, and in a more improved fashion, if the previous question is defeated—force Congress to obey the same Federal employment labor laws that Congress has applied to the the private sector. American businesses face enormous challenges, securing an establishment, maintaining inventory, selling products, hiring employees, and complying with the Federal, State, and local regulations. While most of these challenges are expected, I think no business individual is ever adequately prepared for the devastating impact of Government regulations which seem to become ever more burdensome with each passing year. To legally operate a business, an entrepreneur must comply with literally thousands of Federal regulations under the Civil Rights Act of 1964, Equal Employment Opportunity Act of 1972, the Equal Pay Act, the Equal Labor Standards Act, the National Labor Relations Act, the Occupational Safety and Health Act, the Family Medical Leave Act, and the list goes on and on. Complying with these and other Federal mandates is no small endeavor. However, the Congress overlooking its own 40,000 employees, conveniently and routinely exempts itself from its own laws.

It pains me deeply to listen to entrepreneurs describe the tremendous burdens we place on them, costing the American people greatly in productivity and jobs. Perhaps some Members of Congress functioning under the same laws which they deem necessary for the private sector may learn firsthand what businesses have been experiencing for years.

I commend the various Members who have contributed so much to the issue of congressional compliance. However, I was very disappointed with the Democrat leadership's decision to separate the issue of congressional compliance from the Joint Committee on the Organization of Congress' comprehensive reform bill. This action has greatly jeopardized the passage of a complete JCOC reform package.

While H.R. 4822 is a significant step forward, the leadership has missed a tremendous opportunity to address some very important institutional reform matters. Let us defeat the previous question, allow the gentleman from California [Mr. DREIER], the gentleman from Colorado [Mr. ALLARD], the gentleman from Ohio [Mr. BOEHNER], the gentleman from Pennsylvania [Mr. GOODLING], the gentleman from Oklahoma [Mr. ISTOOK], the gentleman from Massachusetts [Mr. BLUTE], and perhaps others to offer their reformation amendments under a fully open rule.

Mr. DREIER. Mr. Speaker, I yield 2 minutes to the gentleman from Naperville, IL [Mr. FAWELL], another hard-working members of the Committee on Education and Labor.

Mr. FAWELL. Mr. Speaker, I thank the gentleman for yielding me the time.

I rise in opposition to the rule, but I am in strong support of the Congressional Accountability Act. We have all heard the old phrase that Congress would exempt itself from the law of gravity if we thought we could get away with it. We have tried to get away with it for a long, long time. We have a chance here, however, to go in the right direction. I am not so sure that this will survive over in the Senate, I think it will pass the House, and we shall be quite happy about that.

□ 1400

It is not perfect. It can be taking too great a first step in attempting to actually apply 10 separate labor law statutes at the same time, especially when we combine with the Senate and put them under the same administrative rules and under the same judicial remedies. But I repeat, it is in the right direction.

But also, we have to remember that at this time we do not know the specifics as to the manner in which these statutes will be made applicable to the Congress. We did not put that in the legislation. That has to be determined at a later date by the Office of Compliance.

But we do know at least that the employees will have the right to sue, the right to use the same remedies as authorized in the private sector when a Member of Congress may violate the provisions of any of these 10 statutes. That would include even the right of an aggrieved employee to sue a Member of Congress in Federal court before a jury, and compensatory damages, attorneys fees, et cetera, if the underlying statute allows this in the private sector.

But the bill, however, as the gentleman from Pennsylvania [Mr. GOODLING] pointed out, exempts Members of Congress from punitive damages. In addition, I ask Members to think about this, in addition, it has the taxpayers indemnifying Members of Congress whenever a compensatory damage, pain, and suffering judgment may be brought against them, or whenever they are obligated under a court order to pay for the attorneys fees of the employee who brings the lawsuit. The Members are also allowed to use the general counsel with nothing coming out of their own pockets in order to defend themselves. That does not exist in the private sector, but I rejoice yet in this bill because we can always come back and, I think, try to take care of those matters. We are not going to fool the public. They will understand, of course, that we are protecting ourselves by fully indemnifying ourselves from all damages which Members may incur—at taxpayer expense.

But I repeat, this is a very important day, and certainly the gentleman from Connecticut [Mr. SHAYS], and the gentleman from New Hampshire [Mr. SWETT] should be congratulated. They bipartisanly faced this problem, and they have done quite a job. I repeat, I do not think it probably will make it through the Senate, but next year we will have an even stronger case.

Mr. DREIER. Mr. Speaker, may I inquire of the Chair how much time is remaining on both sides?

The SPEAKER pro tempore (Mr. COPPERSMITH). The gentleman from California [Mr. BEILENSON] has 13 minutes remaining, and the other gentleman from California [Mr. DREIER] has 7 minutes remaining.

Mr. DREIER. Mr. Speaker, I yield 2½ minutes to my friend, the gentleman from Westchester, OH [Mr. BOEHNER].

Mr. BOEHNER. Mr. Speaker, first I would like to thank the gentleman from California [Mr. DREIER] for yielding the time on this very important debate.

Virtually 3 years ago today, I and the other 42 Members of my class, elected in 1990 and taking office in 1991, stood on the lawn of the Capitol with two very important Members of this body at that time, the gentleman from Indiana, Mr. HAMILTON, a Democrat, and Mr. GRADISON from Ohio, a Republican, pledging our support for this concept of creating a Joint Committee on the Reorganization of Congress. We had been here a mere 7 months and understood at that time pretty clearly that Congress is broken and something needs to happen.

What happened when we stood there on the lawn that day, several weeks later the House bank scandal came along, the House restaurant scandal came along, the post office scandal came along, a debate about the Ethics Committee on whether we were going to have full disclosure on what happened in the bank, and finally in June 1992, under heat, Congress passed a resolution setting up the joint committee.

We spent a year in the joint committee, held numerous hearings, hundreds of Members of Congress coming and testifying, over 40 different issues that we all know have to be addressed. And what happened? Nothing.

Today we are going to take one small part of that, an important part of that, but only one small part of that, and we are going to debate it in the Congressional Accountability Act, which I support.

One of the issues we were dealing with during that discussion was deliberation on the floor and Members' ability to come here with their ideas and to offer those ideas for the Members to vote on if they liked them. I was denied an amendment in this bill that would require Congress to adopt FOIA for the nonlegislative areas of this body. It was not made in order. And why should Congress come under FOIA? Because if we had the Freedom of Information Act like we have downtown in the executive branch we would have never had a House bank scandal, we would have never had a post office scandal, we would have never had a scandal in the House restaurant system. If the American people and the press could ask what happens here, if they could see how we spend our money day in and day out, Members might be little more careful. But because we do not have FOIA, those things have happened, and that is history. But to not allow me to offer the amendment on the floor today is exactly what is wrong with this body.

We should defeat the previous question and bring up real congressional reform today.

Mr. DREIER. Mr. Speaker, I yield 2 minutes to my friend, the gentleman from Loveland, CO [Mr. ALLARD], another member of the Joint Committee on the Reorganization of Congress.

Mr. ALLARD. Mr. Speaker, I thank the gentleman from California [Mr. DREIER] for yielding me the time, and compliment him for his fine leadership on this particular issue.

Mr. Speaker, I rise in opposition to the rule. I strongly support the concept that we need to change the way that Congress does business. I served in the Colorado State Legislature, as many Members here did, and having seen the way they do business, we come to the Congress and find many things we did in the State legislature that had accountability, that made citizens feel good about what was happening in the State legislature. Then we come to Congress and we find that things are not near as open as that; there is not near as much accountability.

I serve on the Joint Committee on the Reorganization of Congress, and I like the idea and pushed the concepts of making Congress live under the same laws as everybody else has to live under. I think it is in the concept of a citizen legislature, and something we need to preserve. I think we are losing that.

So I think this is a very important issue we have coming up, and there are a number of amendments that would address that. But our committee was set up on the reorganization of Congress, and I see a lot of issues that are not going to be addressed today. That is why I am opposed to the rule.

I think we ought to give our Members more opportunity to bring up issues that deal with how we are going to do business in the Congress. We are not talking that much about committee numbers, but what we are going to do to reduce the number of committees with proxy voting. The Ethics Committee—we took a lot of testimony on the Ethics Committee and what are we going to do about improving the management of the Congress. There is duplication of efforts on both the Senate and House side, and we do not have any means of looking at that in a serious manner to try and have some accountability.

What about the budget process and the floor process itself? These are all issues Members should have an opportunity to bring to the floor and talk about, but because of the modified open rule, many Members are not going to have an opportunity to do that.

We took hours and hours of testimony in the Committee on the Reorganization of Congress discussing these issues. So I just rise in opposition because I think we ought to have more opportunity to bring about really true, meaningful change in the House of Representatives.

Mr. DREIER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Bellevue, WA [Ms. DUNN], another member of the Joint Committee on the Reorganization of Congress, and a member of the House Administration Committee as well, a hard-working freshman.

Ms. DUNN. Mr. Speaker, I thank the gentleman for yielding the time.

Mr. Speaker, I rise to urge defeat of the previous question with the hope that the third time is the charm. This is the third time I have risen to ask my colleagues to deliver on what they promised: comprehensive congressional reform.

By this time we all know the story. The well-publicized Joint Committee on the Reorganization of Congress was created as a response to the internal crisis that wracked the House of Representatives. The bipartisan promise was for bold reforms to address a variety of shortcomings. The result would be a Congress that was more responsive, more deliberative in its lawmaking.

Now, as Paul Harvey would say, comes the rest of the story. The joint committee, of which I was a member, fizzled, but it still put forth a product that would at least be a proper starting point for debate on real congressional reform. The Congressional Accountability Act was a crucial component of that product.

Now, in a conscious effort to derail other crucial reforms, we are asked to consider the Congressional Accountability Act in splendid isolation.

Mr. Speaker, the Congressional Accountability Act is splendid, but it should not be considered in isolation. It should be considered as part of a complete overhaul of this institution: Scheduling reform to end the mindless and frenetic back and forth around this place, committee reforms to end the useless turf battles between committees, proxy reform to force Members to show up at committee meetings to hear the debate and maybe learn a thing or two and to vote on the topic.

☐ 1410

And lastly, Mr. Speaker, sunshine to end the defenseless practices of passing laws behind closed doors.

I urge my colleagues, and most especially my fellow freshmen Members who wrapped themselves in the mantle of reform, defeat the previous question, and bring to the floor the joint committee's entire bill, including congressional accountability, so we can reform this embattled institution.

Mr. DREIER. Mr. Speaker, I yield 1½ minutes to the gentleman from Wyoming [Mr. THOMAS], a real reformer, a hard worker in this House, my friend from Casper, WY.

Mr. THOMAS of Wyoming. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I rise in opposition to the rule. I am disappointed that reform could not have taken more change. We are absolutely certain we need to do more change here.

Almost everything has been said about the benefits of this bill. I support it.

I feel strongly about it and, therefore, I want to add my voice to that.

Let me say simply there is absolutely no justification for the Congress not to live under the same set of rules established for everyone else. One of the principles of good and fair governance is that those making the rules should live under them, and I strongly support the passage of this bill and again express my disappointment that it cannot be broader in terms of the reform mechanism.

Mr. DREIER. Mr. Speaker, I yield 2 minutes to the gentleman from Oklahoma City, OK [Mr. ISTOOK], a freshman Member who unfortunately was denied an opportunity to offer his amendment.

Mr. ISTOOK. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I rise in opposition to this rule.

I think it is important to mention what is really going on here, because frequently it has not been pointed out. On a scale of 1 to 10 this bill may merit a 3, but a lot of people are talking about it as though it is a 10.

They say this subjects Congress to the same rules that everybody else lives under. That is not true. This bill says, when it comes to labor and employment laws, that Congress will have an Office of Compliance set up by the Congress that will decide how things will apply to us. Everyone else in the country, Mr. Speaker, has to go before the Labor Department, and the bureaucrats. They have to go through thousands of pages of Federal regulations. They have to deal with the EEOC, the Equal Employment Opportunity Commission. Under this legislation, Congress would remain exempt. It continues a special, preferred status for Members of Congress.

Yes, the bill does have a good point where it does provide that a Member of Congress ultimately could be sued for violating labor standards as interpreted not by the same bureaucrats that interpret it for everyone else but by our internal Office of Compliance. It maintains special treatment.

Now, if you look at any businessman who has to deal with things, the problem is not just the law. The problem is also dealing with the administrative agencies, and Members of Congress would not have to do so under this bill.

I offered an amendment which the Committee on Rules refused to permit that would have said Members of Congress not only are covered by the same laws but by the same interpretations, no special Office of Compliance to filter out those laws for us, and we would have to be accountable before the same administrative agencies as everyone else.

Let me give you just one example which is in the bill: OSHA, Occupational Safety and Health Act, if there is a violation of OSHA under the interpretation of the Office of Compliance, instead of having to do something immediately, the bill says you get until the end of the fiscal year following the fiscal year in which the violation occurred, which means you have 2 years. Give a businessman that same break.

Congress will never respond to the problem of overregulation until we have to deal with the same laws and the same procedures, and if they scare us, imagine how they are scaring the businessmen.

I urge you to oppose the rule.

Mr. DREIER. Mr. Speaker, I yield 1 minute to my friend and classmate, the gentleman from Cape Girardeau, MO [Mr. EMERSON], a member of the Joint Committee on the Organization of Congress, who probably attended more hearings than any other member, who has been involved in the issue of reform for a long period of time, having started out as a page here on the House floor.

Mr. EMERSON. Mr. Speaker, I thank the gentleman for yielding to me.

I rise to urge defeat of the previous question so that H.R. 3801 can be made in order. We need to consider H.R. 3801 in its totality, because reform has many facets that really need attention, not just that which the Democratic leadership with its protective agenda deigns to allow.

I am somewhat puzzled as to why we are not permitting H.R. 3801 in its totality to be considered. As a matter of fact, it was six Democrats and two Republicans that voted to report out of the Joint Committee on the Organization of Congress; it is the substance of their recommendations that is contained in H.R. 3801.

The gentleman from California [Mr. DREIER] and I split with the other members of our party to report the recommendations of the committee so that we could get a full package before the House, because the chairman, the gentleman from Indiana [Mr. HAMILTON], optimistically indicated he thought we could achieve so that it would be considered under a generous rule and so that the House could work its will on many of the reform issues that I believe the House wants to work its will on.

So I urge all of my colleagues, particularly our more junior colleagues who ran on a reform platform in 1992, to join us in defeating the previous question.

Mr. DREIER. Mr. Speaker, I yield 2 minutes to my friend, the gentleman from Stamford, CT [Mr. SHAYS], who has worked long and hard on the issue of congressional compliance.

Mr. BEILENSON. Mr. Speaker, I yield 3 minutes to the gentleman from Connecticut [Mr. SHAYS].

Mr. SHAYS. Mr. Speaker, I would like to thank the gentleman for yielding and say to you that I have such ambivalent feelings because I know what it feels like to be in the minority and the frustrations of not having opportunities to offer amendments, and I have a sense of what it is like to be in the majority in the process of working on this legislation.

I have just been in awe during this process of how Republicans and Democrats have worked together to this point. It has been something that I get down on my knees mentally in gratitude for, and I wish the American people could have seen the House Administration work on this bill, the Committee on Rules work on this bill, the various Members from both sides of the aisle work on this bill.

I see the American flag behind me, and the American people love the American flag. It is cloth; it means so much, but my honest hope is that they will love the institution of Congress as much as they love the American flag, this institution that was established by our Founding Fathers.

We may come to some conclusion that 40 years of one-party rule is a process that needs to be changed, and we can talk about all of these things. But I have to say for the record that when it comes to the Congressional Accountability Act, Mr. FOLEY, Mr. MICHEL, Mr. GINGRICH have been so supportive, Mr. ROSE, Mr. THOMAS, Mr. MOAKLEY, Mr. SOLOMON, Mr. HAMILTON, Mr. DREIER. We would not be here, ironically, with the congressional accountability bill if it were not for the gentleman from California, Mr. DREIER, and others, Members on the Committee on House Administration, Mr. GOODLING, who has fought long and hard for this day that has come before us, the gentleman from Illinois, Mr. FAWELL, the gentleman from Massachusetts, Mr. FRANK, who helped move this bill along when there were certain points that did not move forward, the gentleman from Ohio, Mr. BOEHNER, in the work he did. I look at this, and I see 250 cosponsors for this legislation, 100 Members of the freshman class. We would not have this bill before us if it were not for the 100 Members of the freshman class, both parties. They have made all the difference in the world.

Now we come to this point. I look up there, and I see the cameos of the various philosophers, the legislators, and one looks at us straight on, and it is Moses. It is the only one. I see Moses look at us head on, and I cannot say to you that this is a perfect bill, and I certainly cannot say that I do not want my colleagues' amendments offered, because I ask that they be, but there is a point now where we have to decide whether we kill the rule and move forward or we take this rule.

Everyone is going to have to come to their own conclusion. On my side of the aisle, I would hate it if any Member was blamed for voting against the rule because they did not want congressional accountability. We will need some Members on our side of the aisle, in my judgment, to support this rule and move the debate forward.

I say to you, when I hear the gentleman from Oklahoma [Mr. ISTOOK], I would have loved to have had that debate. I would have loved to have confronted him at every point along the way, when he says the laws will not apply. Section 3 says, "The following laws shall apply," and it goes down all 10 of those laws. "They shall apply." The difference is we took into account we are a separate body. We established an Office of Compliance much like the EEOC. That Office of Compliance is independent, more independent than I ever dreamed.

The leadership, both sides, have to appoint it. They are given one term. They cannot be reappointed. They have to have experience, but they cannot be reappointed.

They will draft regulations that will conform to the law, and Congress only gets to reject them in a concurrent resolution. Those regulations will apply unless Congress, House and Senate, reject them both.

□ 1420

I urge my colleagues to trust your heart, do what you think is right. I look forward to the debate on the 14 amendments that will make this a better bill.

I will conclude by saying Mr. SWETT and I have learned one grand lesson: We do not own his bill, it is the House's bill. We have seen Members come forward with amendments that we did not know if we liked or not. We listened to the debate. We realized that they made the bill better.

This bill has been amended about 20 times. It is a better bill in the process.

This bill is your bill. I hope today we get to vote on it.

Mr. DREIER. Mr. Speaker, I yielded myself the balance of my time. I will say very simply that anyone who votes for the previous question on this issue is voting to kill congressional reform. There is a wide range of proposals that were debated in the joint committee.

We are attempting to markup H.R. 3801 in the Committee on Rules, and amendment after amendment is being killed. We have a chance on this vote right here to make H.R. 3801 in order. If we can defeat the previous question, I plan to do that, which would include the Shays-Swett language and other items.

So I urge a "no" vote on the previous question, and I yield back the balance of my time.

Mr. BEILENSON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, Members should know that the members of the Committee on Rules this very week started markup on the remainder of H.R. 3801 and there will be a further and broader reform bill brought before Members before this session ends.

This particular rule, as Members have heard, makes in order an excellent and long-overdue change in the law, a bill that would finally apply to Congress those laws which for too many years we have applied to other people but not to ourselves. I want to make it clear to Members who happen to be listening but have not understood all of the discussion that this is in fact a bipartisan bill. The principal cosponsors are from both parties.

I also want to make clear the fact that more than half of the amendments that were made in order here under this particular rule, which we will be voting on in a very short time, are sponsored by either members of the minority party or by bipartisan coalitions of majority and minority members.

Mr. Speaker, I have no further requests for time and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. SERRANO). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. DREIER. Mr. Speaker, I object to the vote on the ground of a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

This 15-minute vote may be followed by a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 247, nays 185, not voting 2, as follows:

[Roll No. 386]

YEAS—247

Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Baesler
Barca
Barcia
Barlow
Barrett (WI)
Becerra
Beilenson
Berman
Bevill
Bilbray
Bishop
Blackwell
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (OH)
Bryant
Byrne
Cantwell
Cardin
Carr
Chapman
Clay
Clayton
Clement
Clyburn
Coleman
Collins (IL)
Condit
Conyers
Coppersmith
Costello
Coyne
Cramer
Danner
Darden
de la Garza
Deal
DeFazio
DeLauro
Dellums
Derrick
Deutsch
Dicks
Dingell
Dixon
Dooley
Durbin
Edwards (CA)
Edwards (TX)
Engel
English
Eshoo
Evans
Farr
Fazio
Fields (LA)
Filner
Fingerhut
Flake
Foglietta
Ford (TN)
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Glickman
Gonzalez
Gordon
Green

Gutierrez
Hall (OH)
Hall (TX)
Hamburg
Hamilton
Harman
Hastings
Hayes
Hefner
Hilliard
Hinchey
Hoagland
Hochbrueckner
Holden
Hoyer
Hughes
Hutto
Inslee
Jefferson
Johnson (GA)
Johnson (SD)
Johnson, E.B.
Johnston
Kanjorski
Kaptur
Kennedy
Kennelly
Kildee
Kleczka
Klein
Klink
Kopetski
Kreidler
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lehman
Levin
Lewis (GA)
Lipinski
Lloyd
Long
Lowey
Maloney
Mann
Manton
Margolies-Mezvinsky
Markey
Martinez
Matsui
McCloskey
McCurdy
McDermott
McHale
McKinney
McNulty
Meehan
Menendez
Mfume
Miller (CA)
Mineta
Minge
Mink
Moakley
Mollohan
Montgomery
Moran
Murphy
Murtha
Nadler
Neal (MA)
Neal (NC)
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone

Parker
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Peterson (MN)
Pickett
Pickle
Pomeroy
Poshard
Price (NC)
Rahall
Rangel
Reed
Reynolds
Richardson
Roemer
Rose
Rostenkowski
Rowland
Roybal-Allard
Rush
Sabo
Sanders
Sangmeister
Sarpalius
Sawyer
Schenk
Schroeder
Schumer
Scott
Serrano
Sharp
Shays
Shepherd
Sisisky
Skaggs
Skelton
Slattery
Slaughter
Smith (IA)
Spratt
Stark
Stenholm
Stokes
Strickland
Studds
Stupak
Swett
Swift
Synar
Tanner
Tauzin
Tejeda
Thompson
Thornton
Thurman
Torres
Torricelli
Towns
Traficant
Tucker
Unsoeld
Valentine
Velazquez
Vento
Visclosky
Volkmer
Waters
Watt
Waxman
Wheat
Whitten
Williams
Wilson
Wise
Woolsey
Wyden
Wynn
Yates

NAYS—185

Abercrombie
Allard
Archer
Armey
Bachus (AL)
Baker (CA)
Baker (LA)

Ballenger
Barrett (NE)
Bartlett
Barton
Bateman
Bentley
Bereuter

Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Brown (FL)

Bunning
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Clinger
Coble
Collins (GA)
Collins (MI)
Combest
Cooper
Cox
Crane
Crapo
Cunningham
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Emerson
Everett
Ewing
Fawell
Fields (TX)
Fish
Ford (MI)
Fowler
Franks (CT)
Franks (NJ)
Gallegly
Gallo
Gekas
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Grams
Grandy
Greenwood
Gunderson
Hancock
Hansen
Hastert
Hefley

Hobson
Hoekstra
Hoke
Horn
Houghton
Huffington
Hunter
Hutchinson
Hyde
Inglis
Inhofe
Istook
Jacobs
Johnson (CT)
Johnson, Sam
Kasich
Kim
King
Kingston
Klug
Knollenberg
Kolbe
Kyl
Lazio
Leach
Levy
Lewis (CA)
Lewis (FL)
Lewis (KY)
Lightfoot
Linder
Livingston
Lucas
Machtley
Manzullo
Mazzoli
McCandless
McCollum
McCrery
McDade
McHugh
McInnis
McKeon
McMillan
Meek
Meyers
Mica
Michel
Miller (FL)
Molinari
Moorhead
Morella
Myers
Nussle
Oxley

Packard
Paxon
Petri
Pombo
Porter
Portman
Pryce (OH)
Quillen
Quinn
Ramstad
Ravenel
Regula
Ridge
Roberts
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Royce
Santorum
Saxton
Schaefer
Schiff
Sensenbrenner
Shaw
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Snowe
Solomon
Spence
Stearns
Stump
Sundquist
Talent
Taylor (MS)
Taylor (NC)
Thomas (CA)
Thomas (WY)
Torkildsen
Upton
Vucanovich
Walker
Walsh
Weldon
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NOT VOTING—2

Herger

Washington

☐ 1446

Ms. PRYCE of Ohio and Messrs. GREENWOOD, FISH, SMITH of Texas, TAYLOR of Mississippi, and ABERCROMBIE changed their vote from "yea" to "nay."

Mrs. COLLINS of Illinois and Messrs. STENHOLM, STOKES, CLAY, and LAUGHLIN changed their vote from "nay" to "yea."

So the previous question was ordered.

The result of the vote was announced as above recorded.

The resolution was agreed to.

A motion to reconsider was laid on the table.

PARLIAMENTARY INQUIRY

Mr. DREIER. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. DREIER. Mr. Speaker, House rule XI, in clause (1)(2)(A) reads: "No measure or recommendation shall be reported from any committee unless a majority of the committee was actually present, which shall be deemed the case if the records of the committee establish that a majority of the committee responded on a rollcall vote on that question."

Mr. Speaker, I realize that the rule goes on to say a point of order will lie in the House that a quorum was not present unless it was first made in the committee.

But my question is this: If the records of the committee show a quorum was not present on a rollcall vote to report a measure, can a committee still claim in its report that a quorum was present?

The SPEAKER pro tempore. The gentleman has correctly stated the rule.

Mr. DREIER. I know I have correctly stated the rule. I wonder if the committee can still claim in its report that a quorum was present?

The SPEAKER pro tempore. The Chair is giving the gentleman credit for stating the rule properly. In response to the gentleman's first inquiry, the Chair would state that, while it may not be accurate or proper for a committee to state in its report that a quorum was present if its records show a quorum was not actually present, that is an issue which must first be raised and preserved in the committee by a committee member for a point of order to survive in the House.

Mr. DREIER. Mr. Speaker, continuing my parliamentary inquiry, can a committee report a measure without a quorum being present, even when there is a rollcall vote, or must the committee then utilize a rolling quorum until an actual majority of the members respond to their names?

☐ 1450

The SPEAKER pro tempore (Mr. SERRANO). In response to the gentleman's second inquiry, the Chair would state that if a point of no quorum is raised by a committee member when the measure is ordered reported, then the chairman of the committee must either await the appearance of a quorum if there is not to be a rollcall vote, or a rollcall vote must reveal a majority of the committee having responded at some point in time before the measure is ordered reported.

Mr. DREIER. Mr. Speaker, if I could pose one final question on my parliamentary inquiry, if a committee can order a measure reported with less than a majority being present, can the committee report a bill with just the chairman present as long as he does not make a point of order against himself?

The SPEAKER pro tempore. In response to the third inquiry, the Chair would state that it would be the responsibility of any and all committee members, at a properly convened meeting of the committee, to remain available to assure that at the time the measure is ordered reported a point of order is made that a quorum is not present in order to preserve that point of order in the House.

Mr. DREIER. Mr. Speaker, I thank the Chair for that very cogent explanation.

The SPEAKER pro tempore. Pursuant to House Resolution 514 and rule XXIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 4822.

☐ 1451

IN THE COMMITTEE OF THE WHOLE

Accordingly the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 4822) to make certain laws applicable to the legislative branch of the Federal Government, with Mr. INSLEE in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from California [Mr. BEILENSON] will be recognized for 15 minutes; the gentleman from California [Mr. DREIER] will be recognized for 15 minutes; the gentleman from North Carolina [Mr. ROSE] will be recognized for 15 minutes; and the gentleman from California [Mr. THOMAS] will be recognized for 15 minutes.

The Chair recognizes the gentleman from California [Mr. BEILENSON].

Mr. BEILENSON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the Congressional Accountability Act, which is before us, is a strong and a good bill which deserves Members' support and vote. I pointed out earlier in the discussion on the rule itself that it, in fact, is a much stronger version of the application of laws legislation than that which was included originally in H.R. 3801, the reform bill of the joint committee.

This bill is stronger, may I reiterate, in the following respects:

First, it explicitly provides for the application of 10 laws, twice as many laws as H.R. 3801 provided for. One of those additional laws is the Occupational Safety and Health Act or OSHA, whose omission by the joint committee was criticized by a number of witnesses at our subcommittee hearings and which is probably the most visible example of laws which private-sector employers must comply with but from which Congress has heretofore exempted itself.

This bill also ensures coverage of all employees of the legislative branch, whereas the original bill, H.R. 3801, simply provided for a study of the coverage of employees of the various instrumentalities of the Congress.

Third, it makes the Office of Compliance a more independent entity than would H.R. 3801 by providing that the Executive Director be appointed by the Board of Directors rather than by the House and the Senate leadership.

The bill also ensures that congressional employees will continue to be covered by the various laws we already apply here in the House until the new regulations developed by the Office of Compliance take effect, whereas the original bill, 3801, left continuation of coverage in question.

Finally, it gives more authority to this new Office of Compliance to apply the laws to Congress by providing that the regulations they issue will automatically take effect unless Congress rejects them by a resolution of disapproval. The original bill, 3801, required Congress to act to approve the regulations before they could take effect.

Again, to emphasize, particularly for those Members who may have criticized the delay in action on the proposals of the joint committee, the bill that we are considering today is a much stronger, much more effective version than the original proposal of the joint committee. That improvement is due in large part to the fact that we have taken a few weeks. We have had some hearings. We have had a lot of help and input not only from the Committee on Rules but particularly from the Committee on House Administration, from a good many Members on both sides of the aisle. We have before us, this Member thinks, a bill of which we can be very, very proud and which will make a real difference.

Mr. Chairman, for purposes of debate only, I yield 6 minutes to the gentleman from New Hampshire [Mr. SWETT], one of the cosponsors of the bill along with the gentleman from Connecticut [Mr. SHAYS], to whom we owe credit for this bill before us today.

Mr. SWETT. Mr. Chairman, I want to thank Chairman ROSE for recognizing me and, more importantly, I want to thank him for all he and his staff have done to help get this legislation to the floor. Both the Committee on House Administration, and the Rules Committee under Chairman MOAKLEY, have reported out a strong bill for our consideration. This day could not have dawned without the support of both committees, and I and Congressman SHAYS want to express our appreciation to both the chairmen and ranking members of each.

Mr. Chairman, the bipartisan Congressional Accountability Act is simple in concept and broad in scope.

The simple concept behind the Congressional Accountability Act is that what's good for the private sector and executive branch is good for us here in Congress. Legislative branch employees deserve the same protections under the law as those enjoyed by their counterparts in the private sector or executive branch. As an employee, the legislative branch should bear the law's burdens just as other employers do.

This principle is as straightforward as it is just. That is why over 250 of our colleagues joined as cosponsors of an earlier version of the bill we will be voting on today.

H.R. 4822 applies, by statute, 10 employee protection and antidiscrimination laws to the legislative branch. These laws, by and large, are landmark pieces of legislation that Congress thought it important to pass; affording protections to employees that Congress thought it important they have. Today, if H.R. 4822 is approved, the House will go on record as supporting the full application of these same laws to our own employees. This step is a matter of simple fairness, and we should take it.

Our constituents expect that Congress will obey these laws just as they and their employees must. In the past, some have cited constitutional separation of power concerns as a reason for not extending the full protections of these laws to our own employees. Constitutional scholars differ on the validity of these concerns, but the bill before us today addresses them nonetheless by setting up a new and independent Office of Compliance within the legislative branch to enforce the laws on Congress. There will not be executive branch enforcement under this bill. What there will be, and ought to be, is the full and effective application of the protections afforded by these laws to legislative branch employees. No longer will Members of Congress sit in judgment of their colleagues on these matters. Outside hearing board officers will now determine when a violation of law has occurred and what the remedy for that violation should be.

Importantly, under the bill before us today aggrieved employees will be able to sue Members in district court where that right exists for private sector employees in the underlying statutes being applied. The right to a trial in district court is a fundamental step forward for congressional employees—one that empowers them and one that will keep the new internal process honest and effective.

Mr. Chairman, the Founders of our Constitution never intended that Congress should be exempt from laws enacted for the rest of the Nation. In Federalist Paper No. 57, James Madison made clear that the Founders fully understood the salutary benefits that would flow from having legislators join the public in conforming to the laws Congress would enact: he called it a guard against oppression and "one of the strongest bonds by which human policy can connect the rulers and the people together." The Founders intuitively understood the case we make here today: Congress will pass better laws if it knows it will be fully subject to them.

Mr. Chairman, everyone in this Chamber understands that a great deal of work needs to be done to repair the link between Congress and the people we represent, to close the gap that has opened up in recent years. The Congressional Accountability Act can be a key building block in that effort—a foundation from which a new span can be thrown across the chasm of mistrust which lies between all of us and the American people.

Congressman SHAYS and I have marveled at the bipartisan effort this bill represents. There are many colleagues and contributors, from the freshman class in Congress to constitutional experts in the think tanks to concerned constituents and citizens—all have shared in the shaping of this legislation. I, for one, am deeply grateful for the privilege of participating in such an effort and I thank all for their constructive contributions.

We have already begun building a bridge of cooperation and trust, modest as it might be, across the isle here in the House of Representatives. Passage of this legislation will extend that span from across the isle to across the beltway to the rest of the Nation.

Mr. Chairman, I urge all my colleagues to support final passage of the Congressional Accountability Act today.

□ 1500

Mr. DREIER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, as I stated during the debate on the rule, I have strong reservations about whether this legislation to apply the laws to Congress will, in fact, ever become law. Nevertheless, I want to express my strong support for H.R. 4822, as amended by the Rules Committee and the House Administration Committee.

Given the inclinations of the Democratic leadership to gut and kill this and other legitimate congressional reform initiatives, it is no small accomplishment that we are considering a strong compliance bill here today.

Credit also needs to be given to several of our colleagues for their contributions to this legislation.

They include, just to name a few: CHRIS SHAYS, BILL GOODLING, and HARRIS FAWELL on judicial review and OSHA compliance; OLYMPIA SNOWE on the integrity of the Office of Compliance; JOHN BOEHNER on the timely application of all employment laws; and WAYNE ALLARD, who played an instrumental role on the Joint Committee on the Organization of Congress.

Mr. Chairman, since the joint committee reported its reform recommendations last November, our colleagues have had an opportunity to review those recommendations dealing with congressional compliance, and they have raised genuine concerns that were not totally evident to the joint committee during our deliberations.

Most of those concerns, I believe, have been addressed in H.R. 4822.

For example, while the bill explicitly applies 10 laws to Congress, it also implicitly applies all other laws that relate to the terms and conditions of employment. The bill creates a Joint Office of Compliance, which will make it harder for either body to alter their internal rules if the application of laws becomes too burdensome.

More important, the bill provides for a "de novo" trial in district court in those cases where the de novo option would be available to employees in the private sector. Congress would not be complying with the laws if we are not subject to the same enforcement provisions available in the private sector.

I regret that the Democratic leadership will not allow us to debate a number of important amendments dealing with punitive damages, personal liability, and applying the Freedom of Information Act to Congress.

However, a number of good amendments are made in order that will improve an already strong bill. I urge my colleagues to support this legislation.

Mr. Chairman, I yield 1½ minutes to my very good friend, a freshman Member, the gentleman from Shrewsbury, MA [Mr. BLUTE].

Mr. BLUTE. Mr. Chairman, I thank my colleague, the gentleman from California, for yielding time to me.

Mr. Chairman, I rise in strong support of the Congressional Accountability Act. Next week we will be embroiled in a debate over how our future health care system will affect every American. In the past we have undertaken legislative tasks, comfortable in the acknowledge that we in the Congress were not affected by our own actions. When Members of Congress are not directly affected by the laws they pass, there is logically less incentive to pass rational legislation that works in the real world.

Our Founding Fathers envisioned a citizen Congress where Members would have to go home after their service and live under the laws that they have just passed. Unfortunately, Mr. Chairman, serving in Congress has become a career for many that has insulated them from the ramifications of their actions. Health care reform should not be developed in this insulated environment.

I have introduced legislation which would express our desire to see health care legislation applied to Congress. In fact, 90 bipartisan Members have cosponsored my bill and agree that health care reform should not be developed without congressional accountability.

While, unfortunately, that language is not part of this debate, it is imperative that we support the bill in front of us today, the Congressional Accountability Act. My New England neighbors, the gentleman from Connecticut [Mr. SHAYS] and the gentleman from New Hampshire [Mr. SWETT], have drafted legislation that will create a better environment for legislating and a better Congress for the American people. I strongly support its passage.

Mr. BEILENSON. Mr. Chairman, I yield 2 minutes to the gentlewoman from Florida [Mrs. THURMAN].

□ 1510

Mrs. THURMAN. Mr. Chairman, I thank the gentleman from California for yielding me the time.

Mr. Chairman, I rise today to voice my strong support for H.R. 4822, the Congressional Accountability Act. I congratulate my colleagues, Mr. SHAYS and Mr. SWETT for their diligent work on this bill. I also want to recognize Mr. KLINK's efforts on behalf of this important issue.

I came to this House with a mandate from my constituents to change the way that Congress conducts its business. This bill is another vital step in the drive to make Congress accountable to the American people. I believe it will bring greater integrity and accountability to this House.

It is important that we show the American people that we are in no way above the law and that we are not afraid to live under the same laws we impose on the public.

My constituents constantly tell me that we here in Washington must be most responsive to them. If a law is good enough for our citizens, then it is good enough for us. This is the great benefit of this legislation: since we will now have to live under the statutes we approve, we will be more sensitive to the impact of our actions on the American people.

With passage of the Congressional Accountability Act, we will place ourselves under 10 existing laws to protect our employees. This is long overdue: we will now be covered by the Fair Labor Standards Act; the Family and Medical Leave Act; the Age Discrimination in Employment Act, the Americans with Disabilities Act; OSHA and five other important worker protection and antidiscrimination laws.

I want to briefly mention another important issue contained in this bill. During committee consideration, legitimate constitutional concerns were raised about executive branch intrusion into legislation branch affairs. The separation of power doctrine, the very foundation of our Government, must be preserved. A conflict has been avoided through the creation of the independent Office of Compliance governed by a board of directors. This new office, not the executive branch, will enforce the laws that we will have to follow with passage of this bill. The members of board of directors will be independent from the influence of current and former Members and lobbyists.

This bill is just the first step in the reform process. Before the 103d Congress adjourns, I look forward to consideration of the other proposals of the Joint Committee on the Organization of Congress. Our work on lobbying and campaign finance reform must also be completed. The time has come to expand accountability to every part of the legislative branch. Our constituents deserve nothing less.

Mr. DREIER. Mr. Chairman, I yield 2 minutes to my friend, the gentleman from Aston, PA [Mr. WELDON].

Mr. WELDON. Mr. Chairman, 7 years is not a long time inside the beltway. It is a long time to most people. Corporate America would love to have 7 years to comply with Federal regulations that we have imposed over the course of the history of this institution. It was 7 years ago, my first term in Congress, when I had to offer a privileged resolution on the floor of the House to get the attention of my colleagues at that time that the buildings we were operating in were fire traps. They were unsafe for the people who live and work here every day. This had followed a devastating fire in the office of then Speaker of the House Jim Wright. The buildings had no alarm systems, no detection systems, no automatic recall of elevators and would violate any building code in any city in America.

Mr. Chairman, it has taken us 7 years to bring the Federal legislative branch into compliance with OSHA regulations and I say it is about time.

Over the past 7 years that I have been here, we have tried on every occasion to include Members of Congress in the legislative branch in these various Federal regulations that we apply to corporate America. It has taken us 7 years to get to this point in time.

I am happy to rise in support of this bill. I say it is long overdue, but I say we could have done better. If we would have agreed with the gentleman from California [Mr. DREIER] and defeated the motion that previously was voted upon, we could have adopted the entire package of congressional reform, including 2 items that I had approved by the joint commission, a measure to establish a citizen ethics panel to oversee ethics issues within the Congress and targeted tax relief that would prohibit Members from anonymously putting in targeted tax relief in tax bills for specific constituents or corporations.

I am very happy that one of my third initiatives that I introduced in two previous sessions of Congress dealing with frequent flier mileage will, in fact, be offered later on today by our colleagues, the gentleman from Arizona and I plan to support that.

Mr. Chairman, I will support this piece of legislation. I think it is a long time coming. I say to my colleagues and to our constituents across the country, we could have done much better.

Mr. BEILENSON. Mr. Chairman, for purposes of debate only, I yield 2 minutes to the gentleman from Maine [Mr. ANDREWS].

Mr. ANDREWS of Maine. Mr. Chairman, I thank the gentleman for yielding.

Mr. Chairman, these cards provide to me and my wife the guarantee of quality health care, guaranteed. The question that this Congress will be facing today and in the next few weeks is whether or not the Congress of the United States should provide to the families of America the same guarantee of health care coverage that the hard-working families of America provide to Members of Congress. We can say yes to that question by supporting universal coverage in the debate over health care reform, and we can say yes to that question today by supporting this legislation and by supporting the Byrne amendment to this legislation, which will establish in this statute the principle that the Congress of the United States in voting for health care for hard-working Americans will be voting for health care for their families at home.

Mr. Chairman, to too many Americans across this country, congressional accountability is an oxymoron, a contradiction in terms. I believe very strongly that taking the step in passing this bill and providing to the families of America the same guaranteed health care coverage that the families of America provide to Members of Congress will be an important step in reversing that perception, restoring faith to this institution, and providing to the families of this country the guarantee of health care that they want and the guarantee of health care that their families deserve.

I urge Members to support this legislation and to support the Byrne amendment when it comes to the floor.

Mr. DREIER. Mr. Chairman, I yield 1 minute to my friend, the gentleman from Ocala, FL [Mr. STEARNS].

Mr. STEARNS. Mr. Chairman, I want to thank my colleague from California very much, and I commend him for all he is doing on this bill and for his constant effort in bringing to the public's attention what has to be done in terms of congressional reform.

Mr. Chairman, I have been a longtime supporter of passing legislation making the laws Congress passes for the rest of the Nation apply to itself, and am pleased we have the opportunity to vote on this bill today.

I regret, however, that this minimal reform appears to be all we are going to get out of Congress this year. When the leadership of the House separated this part of the overall reform package from vital organizational, procedural and budgetary reforms, it ensured that public skepticism about the intentions of Congress would rise, not fall, by our actions today.

The bipartisan Joint Committee on the Organization of Congress proposed sweeping changes in the way we do business here in the House, but the leadership of the House has refused to consider their recommendations as a package.

So, Americans watching this debate today are faced with a confusing anomaly. The bill we are debating is called the Congressional Accountability Act, but there is very little of the accountability the public is demanding in this bill.

Let me give two examples. I offered an amendment to this bill to provide for the ultimate accountability. It said that members of Congress could not raise their own pay in a year following a budget deficit. It was not allowed under this rule. Check with your constituents if that is the type of accountability they want.

I also offered an amendment to require the House to take a recorded vote whenever we raise the debt ceiling, rather than doing so by stealth tactics. That also is real accountability, but it was not allowed.

We should not go home and tell our constituents that we passed the Congressional Accountability Act. Instead, to be accurate, we should say we passed the Very, Very Limited Congressional Accountability Act. See if that will make our constituents happy.

Mr. BEILENSON. Mr. Chairman, I yield 1 minute to the gentleman from Indiana [Mr. MCCLOSKEY].

Mr. MCCLOSKEY. I thank the distinguished gentleman from California for yielding me the time.

Mr. Chairman, I rise in strong support of the Congressional Accountability Act. As so many have talked so eloquently, I think we are very much moving in the right direction, but I guess at the cost of some political peril and with an attempt at wit to say that perhaps it is irrational for me to be making such a statement as I am about to make or pointing this out, it is definitely impolitic and I have the utmost regard for the gentleman from Maine and his concern to bring universal health care and health equity to all Americans.

I would counsel for some thought at least as to the Byrne amendment as we rush to in essence give ourselves less rights than other Americans similarly situated have. Under the Byrne amendment, there would be a uniform minimum package as passed for all Americans but in essence singling out the Congress, just Members of the Congress, as distinct from all other Federal employees to have in essence less benefits, less choice, less rights in regard to their employer. I think this should at least pose some thought for the long run.

Mr. BEILENSON. Mr. Chairman, I yield such time as she may consume to the gentlewoman from Indiana [Ms. LONG].

Ms. LONG. Mr. Chairman, I rise in support of this measure.

Mr. Chairman, I rise today to urge my colleagues to vote for this measure which will hold Congress to the same employment standards that we have imposed on businesses and other employers for years.

The process of coming to grips with this legislation has been cumbersome. A major stumbling block has been the issue of separation of powers between the legislative and the executive branches of Government.

Mr. Chairman, the Constitutional principle of separation of powers should be preserved to ensure that Congress—as a coequal branch of Government—can operate independently of any influence by the executive branch. A provision in this bill addresses that very real concern by establishing an independent enforcement arm within the legislative branch to guarantee compliance. The Members who worked on this provision have developed a thoughtful and independent mechanism—specifically the Office of Compliance—to promulgate regulations and respond to employee complaints. The Office of Compliance will be free from partisan politics and any influence from the executive branch.

Mr. Chairman, many have said that this bill is about fairness—that Congress has uniquely—and wrongly—preserved itself from the laws of the land. While I agree with that statement, it is my hope that the practical impact of passing this legislation will actually resonate more with Members of Congress than with the public at large. It is my hope that Members will, as a result of this legislation, pass laws which are more thoughtful in the future.

Congressional offices are not at all unlike small businesses. And what Member of Congress has not heard the regulatory concerns of small businesses? By holding ourselves to the same employment standards to which we hold American businesses, I am hopeful that all of us will better understand the laws we create, and have created already.

Mr. Chairman, now that a thoughtful mechanism which preserves the independence of the legislative branch has been developed—it is time to pass this legislation.

I commend all of the Members who worked so hard on this measure and urge my colleagues to vote for the bill.

Mr. DREIER. Mr. Chairman, I yield a full and generous 3 minutes to my friend, the gentleman from Sanibel, FL [Mr. GOSS], a hard-working member of the Committee on Rules.

Mr. GOSS. Mr. Chairman, I thank the distinguished gentleman from greater San Dimas, CA for yielding me the full 3 minutes. I appreciate the full measure.

Mr. Chairman, in the very first weeks of this Congress I introduced House Concurrent Resolution 18, which stated that "Congress [should not be] exempt from the laws that it enacts and should govern itself according to the laws that apply to the private sector and other branches of the Federal Government."

The American people have long suspected that lawmakers in Washington treat themselves better than the people they represent. This image is not helped by the fact that Congress under Democratic leadership routinely exempts itself from legislation it expects others to live by. Congress is not, and should not be, above the law. I am pleased that we will finally address this issue today, although I am sorry we are prevented from debating a comprehensive reform package. Yes, it is a good start to abide by the laws we pass—but, we cannot lose sight of changing the way we do all of our business here on the Hill, as Mr. DREIER has so articulately stated. As long as Congress plays by a different set of rules than the private sector, the credibility of the institution and the confidence in the laws it passes will continue to suffer. We are not above the law. Just ask any American.

I think everyone realizes that by splitting apart the package crafted by the Joint Committee on the Organization of Congress—a product of many hours of hearings and deliberations—we are scuttling the possibility of enacting overall congressional reform. I am afraid the leadership is engaged in an attempt to pull the wool over the eyes of the American public, which has demanded comprehensive reform of the House and Congress. By splitting off a few of the more popular measures and passing them with great fanfare, the leadership hopes that Americans will forget about the rest of the package. This is a very shortsighted strategy, one that is doomed to failure because we leave so much necessary reform undone.

□ 1520

The distinguished gentleman from Massachusetts in the debate on the rule said, "Well, we're getting off here to a great start." After Chairman HAMILTON and the ranking member, the gentleman from California [Mr. DREIER] proposed the whole loaf of reform, the gentleman from Massachusetts indicated that we should be satisfied with not half the loaf, not even a few slices, but just one thin slice.

Why are we always settling for just one thin slice of reform when we could be doing the whole loaf, which has been so beautifully presented to us by the gentleman from California [Mr. DREIER] and the gentleman from Indiana [Mr. HAMILTON]?

Mr. Chairman, I thank the gentleman from California for his leadership on this issue.

Mr. BEILENSON. Mr. Chairman, I yield my remaining 2 minutes to the distinguished gentleman from Maryland [Mr. HOYER].

Mr. HOYER. Mr. Chairman, I thank the gentleman for yielding the time.

Mr. Chairman, I rise today in support of H.R. 4822, the Congressional Accountability Act.

I am delighted that we are considering a bill today that enlarges provisions I originally included in the Americans with Disabilities Act 4 years ago, to include the Congress in the law's scope.

The Congressional Accountability Act accomplishes something we need, it assures that Congress will comply with laws we have made for American businesses. I applaud the efforts of the gentleman from New Hampshire and the gentleman from Connecticut to bring this important legislation to the floor.

I cannot tell you how many times I have heard the complaint from my constituents in town hall meetings and chamber of commerce luncheons that Congress makes laws from which it exempts itself. I look forward to assuring them that is no longer the case.

This is an opportunity to change the perception in the country that there are two sets of laws: one for Congress, and one for everybody else. We need to show that we do live up to the standards we have set for our business owners, and also afford our employees the same protections that every other worker in the United States has.

From OSHA to Fair Labor Standards to a variety of other workplace related laws, this legislation will complete the work of bringing Congress into line with the rest of America.

While the bulk of this bill deals with laws that apply only to the private sector, let me touch on a different kind of compliance issue that is also addressed. Although the Freedom of Information Act does not apply to the private sector, it does currently apply to the executive branch.

I believe that the unique complexities of this matter, pertaining to privacy laws and the difficulties in applying FOIA to the legislative process, requires further study.

Therefore, I am pleased the committee adopted a bipartisan amendment which provides for the board of directors to study the issue and make recommendations regarding future implementation. We must ensure that while appropriate documents are available to the public, and I believe most already are, that the privacy of our constituents is respected and protected.

The Congressional Accountability Act will not only make the U.S. Congress a better employer, but more important, it will give us an enhanced understanding of the implications of the workplace laws we make.

Mr. Chairman, I urge my colleagues to join me in supporting this legislation.

Mr. DREIER. Mr. Chairman, I yield 1½ minutes to my friend, the gentlewoman from Auburn, ME [Ms. SNOWE], a Member who has spent a great deal of time dealing with the issue of reform before both the Joint Committee on the Reorganization of Congress and the Rules Committee.

Ms. SNOWE. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, I would like to extend my appreciation and thanks to Congressman DREIER, the co-vice-chairman of the Joint Committee on the Organization of Congress, and to Congressmen SHAYS and SWETT, whose efforts have done so much to bring the Congressional Accountability Act to the floor of the House today.

In the elections of November 1992, the American people sent a loud and clear message to Congress that the status quo has simply got to go. But this message was more of a "wake-up" call to a "Rip Van Winkle"-type institution that has slept through years of change and reform around the world. Just think about it—while the House has been dominated by one-party rule for almost 40 years, democracy came to the former Soviet Union, Mikhail Gorbachev came and went as leader of the Soviet Union, the Berlin Wall was built and torn down, peaceful dialog came to the Middle East and South Africa, and Mick Jagger and the Rolling Stones became grandads. The tide of openness, reform, and progress has swept across the world—and yet our House of Representatives stands as a monument to the status quo, to perks and privileges, and to the fear of change. Our great Nation used to be at the forefront of openness and accountability; now, it appears that we lag far behind.

But, in 1994, Americans are angry. They are impatient. They want a different kind of Congress. The American people believe that Congress is out of touch with the lives of ordinary Americans. And people will no longer tolerate Congress setting itself above the law. And it's now time for us to meet their higher expectations.

Mr. Chairman, the time for serious reform of Congress has long since arrived. Given the clear mandate for change and accountability sent by the American people 2 years ago, I simply cannot understand why Congress has waited this long to tackle reform. By refusing to debate and consider congressional reform legislation prior to today, Congress showed that it was not serious about policing and reforming itself. Because of congressional inaction, the American people hold Congress in a historically low regard.

And who can blame them. What kind of message does Congress send to Americans when it sets itself above the law? What kind of message does Congress send to America when it believes it is beholden to different ethical or moral standards? And how can Congress claim to pass laws in the best interest of the American people if Congress refuses to abide by those very same laws?

This is not what James Madison, one of our Founding Fathers, had in mind when he said that Congress "can make no law which will not have its full operation on themselves and their friends, as well as on the great mass of society." Congress desperately needs to pass this bill as the first step of many toward regaining its credibility as a law-making, and law-abiding, institution.

The application of laws to Congress has been a chief objective of mine for many years. I have long been concerned about this issue, having spoken out on several occasions against the policy of Congress exempting itself from the laws it passes affecting the American people; in fact, almost 10 years ago, in 1985, I testified before the House Post Office and Civil Service Committee about the need for Congress to treat its employees the way it requires private businesses to treat their employees. In addition, I introduced legislation in the last two Congresses to extend coverage for House employees under the Civil Rights Act and the Age Discrimination Act, and to require the Committee on House Administration to make recommendations on extending coverage under the Occupational Safety and Health Act.

In the 103d Congress, the Congressional Caucus for Women's Issues, which I cochair with my colleague, Representative PAT SCHROEDER, has aggressively pursued the issue of applying Federal laws to Congress. We introduced the Congressional Employees Fairness Act, on behalf of the caucus to ensure that Congress is covered under five major civil rights laws, and to provide broad new protections for employees of the House and Senate. The major provisions of this bill were adopted by the Joint Committee on the Organization of Congress, which was established last year to review and improve the legislative process. The JCOC's broad recommendations, which included congressional compliance, committee reform, changes to floor procedures, budget process reforms, among others, were packaged as H.R. 3081.

I am dismayed that we are not considering H.R. 3081 today, or that the major provisions of H.R. 3081 will be considered separately by this Chamber. I strongly believe that the reform package should have been considered in its entirety, with a rule providing ample opportunities for perfecting amendments on the floor. However, I do believe that the reform Americans want most from Congress is congressional compliance with Federal laws. The bill we are considering today, H.R. 4822, will accomplish that for the American people.

This bill is an excellent bill. It is a timely bill. And it is a necessary bill. Like the Caucus bill, it would apply the Civil Rights Act, the Americans with Disabilities Act, the Fair Labor Standards Act, the Family Medical Leave Act, and the Age Discrimination Act to Congress. H.R. 4822, however, would also extend protection to the entire legislative branch, and would apply five additional laws, including

OSHA, the Federal Labor Management Act, the Employee Polygraph Protection Act, the Worker Adjustment and Retraining Notification Act, and the Rehabilitation Act.

Mr. Chairman, Congress has shown great skill over the last 20 years in passing laws barring discrimination. Unfortunately, Congress has shown even greater skill in avoiding these same laws. But no institution should be above the law—especially Congress. No institution should be exempted from the law—especially Congress. And no one should ignore the law—especially Congress. That is why passage of this bill is an absolutely critical first step to giving this institution the reform it desperately needs and the reform the American public so clearly desires. Let us put the faith back into Congress. Let us put the Representative back into the House of Representatives. And let us show the American people that, yes, we do listen. Let us pass this bill today.

Mr. DREIER. Mr. Chairman, I yield 1 minute to my friend, the gentlewoman from Bellevue, WA [Ms. DUNN], one of the hardest working members of our Joint Committee on the Reorganization of Congress.

Ms. DUNN. Mr. Chairman, I thank the gentleman from California for yielding me the time.

Mr. Chairman, as I stated earlier today in the debate on the rule, disservice to the Congress and to our constituents to disregard bipartisan advice and bring this bill to the floor absent the remainder of the congressional reform legislation.

Nevertheless, I support the provisions of a Congressional Accountability Act that will finally force Congress and Members to obey the laws that are passed for every American outside of the Capitol. This bill is important because current laws will not be applied to Congress. But, it is the future for which this bill offers the greatest promise, for now, a precedent has been established—Congress will follow the law.

From today forward, every piece of legislation will be considered with the knowledge that the included provisions will apply to Congress. This will be the great legacy of this bill. No more will Congress pass bills saying, "Great idea, but sorry, it's too expensive for Congress." No more will Congress say, "Good, good point, but, no, sorry, it's not practical for Congress." From now on, if it is the right law for the American people, it will be the right law for Congress.

I commend the efforts of the Congressmen SHAYS and SWETT. You've rectified a past inequity, but more important, you have set a new path for the Congress for the future.

Mr. DREIER. Mr. Chairman, I yield 1 minute to my friend, the gentleman from Osseo, WI [Mr. GUNDERSON].

Mr. GUNDERSON. Mr. Chairman, I rise in support of this legislation, and I do so not only because, as the gentleman from Maryland indicated earlier, this gives protection to the employees. Equally important I would suggest if this does begin to give credibility to this institution, and whether we are talking deficit reduction or we are talking heath care reform or we are talking entitlement reform or other important issues in front of this Congress and this Nation, this Congress will never be able to make the tough decisions until we have credibility in the eyes of the people, something that does not exist today, but something this bill takes a small step in the right direction.

□ 1530

I would point out the reason it takes that step in the right direction is because it creates an Office of Compliance, and it allows every one of those employees who is the victim of this discrimination not only to seek internal recourse but, most important, to take that to the courts when and if it is necessary.

And so this, along with some of the amendments we are going to reconsider in terms of programs making us subject to the same health plan of everybody else, will be another step in the right direction of credibility in the eyes of the public, and I encourage your support.

Mr. DREIER. Mr. Chairman, I yield the balance of our time to the gentleman from Pennsylvania [Mr. GOODLING], the distinguished ranking member of the Committee on Education and Labor, my friend from Jacobus, PA.

Mr. GOODLING. I thank the gentleman for yielding me this time.

Mr. Chairman, I will compliment those who have brought this legislation to the floor. We have come a long, long way since I have seen some of the other pieces of legislation earlier on.

We could have gone the whole way had my amendment been made in order, because my amendment merely said that we will treat Members of Congress and employers in the legislative branch as we treat the private sector; in other words, we can be taken to court as employers, and we can have punitive damages brought against us up to a cap of $50,000.

I chose the $50,000 because that is the cap that we have for small businesses. There is no reason why we should not receive the same punishment for our misdeeds as the private sector, and had we included that, then I think we would have an ideal piece of legislation.

I do want to make sure our taxpayers back home understand that this could be a very, very, very expensive piece of legislation for taxpayers, very expensive because if the Members or if the person who is bringing the suit decides to go to court, and naturally, they will drift to court rather than through the internal process, if they do go to court then, of course, and are successful, the taxpayer is the employer. So it is the taxpayer who picks up all of their expenses, the expenses for their attorneys, the damages, et cetera, and it is unclear in the legislation whether that is not also true for Members of Congress, that the taxpayer may pick up our expenses if we lose.

The CHAIRMAN. The gentleman from North Carolina [Mr. ROSE] is recognized for 15 minutes.

Mr. ROSE. Mr. Chairman, I yield myself such time as I may consume.

H.R. 4822, the Congressional Accountability Act was unanimously reported from the Committee on House Administration on July 28. This act marks a historic step in two ways.

I would certainly stop at this point and pay a special thanks to our colleagues, the gentleman from New Hampshire [Mr. SWETT] and the gentleman from Connecticut [Mr. SHAYS], for the work that they have done together in a very bipartisan way to bring this part of the legislation before our committee.

Our committee was not given jurisdiction over the whole of this congressional reform effort, but simply that part that was mainly called the Shays-Swett portion of the bill, and we started actually in June holding hearings on this legislation. We asked Members to testify in June and to talk about why they thought it was necessary. We held two hearings, and then a markup in July.

We had congressional scholars, separation-of-powers scholars, people from OSHA actually show us what they had discovered about our office buildings, people from the Library of Congress, and then our leadership decided that they wanted this to move forward and we moved it to a markup on the 28th and as I said it passed unanimously.

First, the act grants legislative branch employees the same protections and legal rights as employees of the private sector. Second, it makes Congress subject to the same laws as the private sector.

This act applies 10 existing employee protection and nondiscrimination laws to Congress. These include the Fair Labor Standards Act, the Americans with Disabilities Act, and parts of the Civil Rights Act. The legislation establishes a new, and independent, Office of Compliance within the legislative branch. And I want the gentleman from New Hampshire [Mr. SWETT] on our side in a few moments to discuss this with me. Many people have questions about this Office of Compliance.

The Office will issue regulations, and respond to employee grievances, just as occurs in the private sector. This new Office of Compliance will replace the existing Offices of Fair Employment

Practices, in both the House and Senate.

The Office will convene hearing boards, made up of three independent hearing officers. These hearing officers will be from the Federal Mediation and Conciliation Service, or the Administrative Conference of the United States, which will ensure their qualifications and their independence. And the Office itself will be independent of Representatives, Senators, and legislative branch agency heads. This independence will avoid possible or perceived conflicts in resolving congressional employee grievances.

Furthermore, if an aggrieved employee wants to go beyond the new hearing board process, the employee can proceed to the Federal district court. If the right is available to a private sector employee, it will be available to a congressional employee under this act, and the aggrieved employee will also have the right of appellate review by the U.S. Court of Appeals.

When implemented effectively, this act will have a salutary impact on Congress' relationships—not only with congressional employees—but also with the American people.

Several basic principles guided the formation of this act: First, fairness requires that congressional employees be accorded the same rights and protections as other employees; second, if a law is right, it should apply to the Congress as well as the private sector; third, if Congress lives by the same laws it applies elsewhere, it will write better laws; and fourth, the Constitutional separation of powers doctrine must be respected.

While some Members believe that executive branch enforcement must go hand-in-hand with these 10 laws, constitutional scholars do not speak with one voice on the issue. The objective of this act is to ensure effective enforcement—but not at the expense of the constitutional separation of powers doctrine.

Overall, the arguments against executive branch enforcement where compelling. An executive branch, armed with such enforcement powers, might attempt to manipulate the Congress.

This act clearly goes a long way toward closing the credibility gap, which exists between Congress and the American public regarding congressional compliance with laws. It also goes a long way in giving our employees the protections they deserve by law. It is an excellent start, and I urge my colleagues to support the bill.

The constitutional balance requires that the legislative branch be free from such potential initmidation—real or perceived—in both the execution of its constitutional role, and as a coequal branch of the Federal Government. I do not believe that Congress has ever purposefully abdicated its constitutional rights and responsibilities.

So the structure of the New Office, and the procedures in this act preserve the constitutional separation of powers, while empowering congressional employees with strong new protections against discrimination and harassment, and providing for a safer congressional working environment.

Mr. Chairman, I reserve the balance of my time.

Mr. THOMAS of California. Mr. Chairman, I yield myself 3 minutes.

Mr. Chairman, it is a pleasure to rise in support of H.R. 4822, despite the failure to look at fundamental congressional reform in all of the areas that the joint committee examined. At least in this one particular area, I am pleased to say that it has been marked singularly by bipartisanship.

Clearly the two authors of the bill, the gentleman from Connecticut [Mr. SHAYS] and the gentleman from New Hampshire [Mr. SWETT], have labored long and hard to make sure bipartisanism was the way in which they moved forward with their legislation.

I am pleased to say that on July 28 in the Committee on House Administration it was bipartisanism that was governing the discussion, the offering of amendments, and the acceptance of 14 amendments.

The bill was considered a positive change, and the amendments were offered in the context of a positive contribution to try to make the bill better. I was very pleased with the more than 4 hours of discussion that occurred over the bill and pleased with the unanimous vote at the end of the committee hearing to move this bill forward.

I believe that this is the beginning of a two-stage process. This is the first stage, and the first stage is getting Congress to understand what is actually going on out there in the real world.

After George McGovern left the U.S. Senate, he purchased a small hotel and restaurant in Statford, CT. On June 1, 1992, in a Wall Street Journal article entitled "A Politician's Dream is a Businessman's Nightmare," former Senator McGovern wrote,

> I also wish that during the years I was in public office, I had had this firsthand experience about the difficulties business people face every day. That knowledge would have made me a better United States Senator and a more understanding Presidential contender.

We are in stage 1. We need to get the U.S. Congress to understand what it has been doing to the private sector. I hope we will then move to stage 2.

□ 1540

Stage 2 is not to put us under the same laws; that is in Stage 1. The purpose of putting us under the same laws is to get us to realize how stupid and foolish we have been in many, many instances.

Stage 2 will be the redefining, restructuring, and repealing of a number of laws.

Mr. Chairman, I look forward to stage 2.

Mr. Chairman, I reserve the balance of my time.

Mr. ROSE. Mr. Chairman, I yield 1 minute to the gentleman from Tennessee [Mr. COOPER].

Mr. COOPER. Mr. Chairman, I thank the gentleman from North Carolina for yielding this time to me.

Mr. Chairman, Congress should be passing comprehensive reform legislation today. I voted, in fact, 3 times to force Congress to consider comprehensive reform legislation, but the least we can do is pass by overwhelming numbers today the Congressional Accountability Act.

It is high time Congress lives by the laws it passes for the people. It is high time that we end congressional hypocrisy when Congress, so often in the past, has passed special rules applying only to Congress. It is high time Congress lived by the Golden Rule, to do unto others as we would have done to ourselves.

It is my hope that we will, as the gentleman from California has pointed out, pass fewer laws, repeal bad laws once we feel the burden in our offices of these many laws.

If you walk a mile in the shoes of small business, you will find it is very, very good exercise for this Congress.

Mr. THOMAS of California. Mr. Chairman, I yield 2 minutes to the gentleman from Nebraska [Mr. BARRETT], a very valued member of the committee who has labored in this field.

Mr. BARRETT of Nebraska. Mr. Chairman, although I rise in support of H.R. 4822, the Congressional Accountability Act, it is not the bill we should be debating today. If the leadership was truly committed to real reforms, H.R. 3801, put forth by the Joint Committee on the Organization of Congress, would be the bill under consideration today.

Nevertheless, I do want to commend Mr. SHAYS and Mr. SWETT for their hard work on H.R. 4822. Their efforts helped force this issue to the floor, and they were more than helpful in working with our House Administration Committee to draft a comprehensive compliance bill.

Having been a small businessman for more than 30 years, I know full well the overregulation and the endless bureaucratic hoops through which private businesses are forced to jump. And when I travel my district, the burden of Government regulation is always—always—the major complaint from today's small business men and women.

H.R. 4822 will hopefully make Members more receptive to these challenges that small businesses encounter. By bringing congressional operations under the full force of laws that we selectively applied to ourselves, and by applying others, like OSHA, for the first time, perhaps the alarm will finally go off and wake Members up from dreamland.

Once our offices and support operations have to decipher, understand, comply with, and pay for the cost of these laws, then maybe we'll be more realistic in our approach to lawmaking. And wouldn't it be a miracle in la-la land if we discovered Congress had made a mistake in the past—that the Federal Government was being too heavyhanded, too paranoid about business operations—and we decided to repeal some regulations. I'd bet the ranch to be here for that.

Having said that, I want to stress again my disappointment that we aren't considering H.R. 4822 as part of the larger, more comprehensive reform package.

Mr. Chairman, it is no wonder that the people who watch our activities on C-SPAN don't understand how we get anything done around here.

The real issue here isn't congressional compliance—as there is broad, bipartisan support for that portion of congressional reform. The bitter pill to swallow is the change in how this House functions in its committees, on this floor, and when it goes behind closed doors and out of public view.

The system of rules we presently have in place always fixes the fight. It's a shootout at the OK Corral day after day, but the minority doesn't get to bring so much as a knife. It's more like the minority party is supplied with plastic forks and knives to defend themselves, while the majority party is supplied with all of the assault weapons banned under the crime bill.

I urge my colleagues to support H.R. 4822, and I look forward to additional reforms that will provide for a less combative, less partisan environment under which this House could move forward legislation—even legislation as complex and controversial as health care reform and a crime bill—in a fair and open manner that is befitting the integrity of this Chamber.

Mr. ROSE. Mr. Chairman, I yield 2 minutes to the gentleman from Pennsylvania [Mr. KLINK].

Mr. KLINK. Mr. Chairman, I thank the gentleman from North Carolina for yielding this time to me.

Mr. Chairman, let me begin by saying that H.R. 4822 is a fine piece of legislation. It has been crafted over a year and half and had the input of dozens of reform-minded Members. It is my belief, however, that this legislation can be perfected today. I believe that we can make certain that Congress comes into complete compliance with labor laws, in exactly the same way our constituents in the private sector must comply.

When I was running for Congress, only 2 short years ago, I listened to public discontent over the issues of congressional ethics and the inside-the-beltway, out-of-touch-with-the-mainstream perception. The public is very aware that Congress passes laws without any practicable knowledge of the problems inherent in implementing these laws, especially labor and civil rights laws. Why is that? Because we do not have to comply with the laws that we pass.

Some laws do not explicitly exclude coverage of Congress—some Members of Congress even attest that we do comply with laws like the Fair Labor Standards Act and the Family and Medical Leave Act. But there is no enforcement of our compliance. Effective enforcement of compliance is the only true way to restore integrity to Congress.

In May of last year, I sponsored my first piece of legislation. The title of the bill is the Equity for Congress Act. Simultaneous to the introduction of my congressional compliance bill, I was a cosponsor of H.R. 349, the first Congressional Accountability Act, sponsored by Mr. SWETT and Mr. SHAYS. I have worked diligently over the past year and a half to ensure that the recommendations made by the Joint Committee on the Organization of Congress were refined, especially to include the Occupational Safety and Health Act. In addition, I have successfully offered an amendment, H.R. 1280, the OSHA Revisions Act, to guarantee our employees are afforded the same standards of health and safety as employees in the private sector.

The bill that is before us today is the culmination of the efforts of all Members who believe Congress must be treated like the private sector. H.R. 4822 complements present practice in this House in the following ways: All instrumentalities of the Congress will have to abide by civil rights and labor laws; Congress will be accountable for the remedies that private citizens fear for not being in compliance; there is a provision that ensures the independence of the Board of Directors of the Office of Compliance by not allowing Members, former Members, nor staff or former staff of Members from serving as Board members; and, most significantly, there is a provision that allows employees aggrieved by Congress to seek retribution in the courts.

H.R. 4822 is not the end, however. It is just the beginning. In excess of 30 amendments were offered to the Rules Committee. What is important now is that we all commit to further refining this legislation in future Congresses to make certain that Congress comes into complete compliance with labor laws, in exactly the same way our constituents in the private sector must comply.

I urge my colleagues to support this bill.

Mr. THOMAS of California. Mr. Chairman, it is my pleasure to yield such time as he may consume to the gentleman from Georgia [Mr. GINGRICH], a member of the committee and the minority whip.

Mr. GINGRICH. Let me just say that I rise with very mixed emotions. First of all, I am very strongly supportive of the general bill. I think that as a general bill this is something I have talked about everywhere in the country, and as I have said, it is something we should pass and it is something I hope that the other body will take up.

I think the concept of applying the laws that apply to the rest of the country to the Congress is very, very important. James Madison was correct in the Federalist Papers in saying that one of our protections against Congress doing foolish things ought to be to require the Congress—the knowledge that the Congress ought to obey the same laws and Congress, therefore, would not do dumb things because congressmen would be under the same rules.

In the last 30 years that has been less and less true and it has been bad. So, on the one hand I really strongly support the general direction of this bill. I think it is generally right.

On the other hand I think that the rule that was adopted and the way this has been approached is profoundly wrong; that many efforts to reform the system at large are being blocked and that it is unfortunate that the Democratic leadership in a sense is using this bill as a screen behind which to hide from the fact that there are other key provisions. And I refer specifically to Mr. DREIER's efforts on reforming the committee structure which are not going to be made in order, which are not going to come to the floor. That makes me sad.

But then in addition to that, I must say that the Democratic leadership has made two amendments in order that I think are just silly and that I think demean the whole process.

Let me be blunt: I think to have an amendment made in order on behalf of two different freshmen as a reelection public relations device just demeans the whole system. The one, basically, would in a bizarre move eliminate Members from the Federal employee health benefits plan in a way that would worry me if I were a Federal employee. I would wonder if that amendment means that that Member is now going to be or ought to be willing to have any member of the Federal employees health benefit plan subjected to the lowest possible health standards.

And it is a very strange amendment. It does not say that the Congress should participate in general health reform; it does not say if we pass medical savings accounts, if we pass catastrophic insurance, if we pass group insurance, that we should be eligible. It says, instead, that the Congress would only provide the most minimum possible health care offered anywhere.

Let me tell you why that worries me. It does not worry me for JAY ROCKEFELLER; he is a millionaire. He will laugh at it, vote "yes," and then buy whatever he wants. It does not worry me about TEDDY KENNEDY. You can go down the list of Senators. There are more and more Senators who are millionaires because there are more and more seats being bought. They can afford it.

Then go out and you try to recruit an average middle-class citizen with two or three children, a normal person who understands normal life, and you say, "Hi, why don't you come to the Congress? By the way, we are now going to artificially restrict you to the lowest possible denominator of health."

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Now what this will do is drive this place into two groups: millionaires that do not care, and they can laugh, or they demagog, because they are just going to pay for it out of their personal account, and people who will suffer any burden to have power, who will give up anything to have power. I think the amendment is pernicious. I hope Members have the courage to vote against it. I think it is, frankly, silly and makes no sense in its current form, and, if my colleagues read it carefully, I do not think any Member would seriously apply that to the others.

There is a second amendment being offered by a Member who wants to make sure they can go out and say, "I'm for reform" and it refers to frequent flyer trips. Now I do not think frequent flyer trips are a big deal either way. I do note that in the private sector if one flies often enough, they get some frequent flyer miles. But let me note for that Member that Member does not say, "Let's block Members from paying with the taxpayers' money for first class." They just say, "You can't use your frequent flyer miles to upgrade." So, presumably they are willing to build a bias into the system that, as long as one is willing to charge directly to the taxpayer, one can fly first class because they certainly do not block that. They do not say to Members, "Let's list next to each name every trip you take in an Air Force plane so we can see how much you spend."

And by the way, Mr. Chairman, I have gone to Russia at the President's request, and I do not mind listing it. I can defend traveling officially as a member of a U.S. delegation, but one cannot find those documents very easily.

What this Member has done is found a great public relations gesture, an interesting little device to say, "Oh, I'm tough on reform," and I think it is sad because quite frankly the rest of this bill is a good bill. It is a serious bill. It does serious things. It does not play games. It gives the House a real effort to put the House and hopefully, if the other body will go along, to put the Congress under the same laws as the rest of the country.

Those two efforts, in the interest of public relations, those two efforts demean the institution. They are public relations gestures, and they have no real reform meaning.

Mr. CLAY. Mr. Chairman, will the gentleman yield?

Mr. GINGRICH. I yield to the gentleman from Missouri.

Mr. CLAY. Mr. Chairman, I want to commend the gentleman from Georgia [Mr. GINGRICH]. I agree with him totally in both instances. They are merely efforts at bashing this Congress.

We on the Committee on Post Office and Civil Service have worked day and night to fashion a piece of legislation to go into the health bill that will open up the Federal employees health plan to all American citizens, and for somebody to get up here and give the impression that Congress is getting something that the American people are not getting either has not read what is in that legislation, but she has read it because she is on the committee, and she was there when we voted for it, so she knows that, if the health bill passes, as we have designed the legislation, that Members of Congress will have the same health benefits as other people who choose to come into the plan that we are opening up for them.

Mr. GINGRICH. Mr. Chairman, I say to my friend, "I commend what you have done."

I want to protect the Federal employee benefits health plan. I do not want to see it undermined. I do not want to see it used for public relations purposes.

Mr. Chairman, I commend what the gentleman has been trying to do. Many of us are trying to do the same thing. I just hope the Members of this House have the courage occasionally, and I say this as somebody who has fought very hard for reform and is fighting very hard for this bill: I hope we have the courage occasionally to say enough is enough, no public relations gestures, no demagoguery.

My colleagues, let us pass real reform.

Mr. CLAY. Mr. Chairman, I thank the gentleman from Georgia [Mr. GINGRICH] for having yielded to me.

Mr. ROSE. Mr. Chairman, I yield 30 seconds to the gentleman from Pennsylvania [Mr. MCHALE].

Mr. McHALE. Mr. Chairman, I too, want to join in commending the courageous independence and consistent dedication of my colleagues, the gentleman from Connecticut [Mr. SHAYS] and the gentleman from New Hampshire [Mr. SWETT], in bringing this bill to the floor.

Mr. Chairman, 20 years ago, when I was a student at Georgetown Law School, I would routinely walk by the entrance to the U.S. Supreme Court where above that entrance I would read the phrase: "Equal justice under law."

Today, with the passage of the Congressional Accountability Act, we bring that ideal a bit closer to reality. I believe this Chamber today will act wisely and in an overwhelmingly bipartisan fashion bring the Congress of the United States under the equal justice of law applicable to all other American citizens.

I urge an affirmative vote.

Mr. THOMAS of California. Mr. Chairman, I yield such time as he may consume to the gentleman from Pennsylvania [Mr. CLINGER].

Mr. CLINGER. Mr. Chairman, I rise in support of the bill before us, the Congressional Accountability Act.

By all predictions, this was to have been the Congress that rewrote the laws and rules governing congressional operations. With the end of the 103d Congress rapidly approaching, it appears that those predictions will fall far short of the mark.

In fact, the only reform initiative given much of a chance of becoming law is contained in the bill before us today. Enactment of the Congressional Accountability Act would, as I see it, help Congress meet two important goals. First, it would end the hypocritical practice of telling the private sector to "do as I say, not as I do." Every day that we carry on this double standard is a day that our moral authority to govern is brought into question by good people all across this Nation.

Second, in the process of complying with the laws currently governing the private sector, Congress will have to face the same difficulties as those confronting every other employer. Consequently, we will know firsthand the money and, perhaps even more precious, the time that every other employer must part with in order to comply with Federal law. This experience can only make us better lawmakers.

In closing, Mr. Chairman, I would extend my congratulations to the sponsors of this measure, CHRIS SHAYS of Connecticut and DICK SWETT of New Hampshire. Were it not for their diligence and hard work, it is unlikely that this measure would have been progressed through the legislative maze to this point.

Mr. THOMAS of California. Mr. Chairman, I yield 1 minute to the gentleman from Ohio [Mr. BOEHNER], a Member who has worked diligently in committee on a number of very positive amendments.

Mr. BOEHNER. Mr. Chairman and my colleagues, I stand here today in support of the legislation that we have before us, and I want to commend the chairman of the full committee, the gentleman from North Carolina [Mr. ROSE], and our ranking member, the gentleman from California [Mr. THOMAS], for the efforts that they put into this bill and the manner in which it was considered in the Committee on House Administration.

Now we have had a lot of partisan battles in that committee, as Members well know, but I have to say that this piece of legislation, and the hearings that we had leading up to it, and the markup we had, was exemplary, and we have before us a piece of legislation that is good.

During that consideration I found it rather interesting, as we went through the legislation that should apply to Congress, that many Members around the table on both sides of the aisle decided that this was not a very smart law and why do we want to abide by it, and it is the real point of why we have the bill before us, because until the full weight of the law applies to all of us here in this Chamber, our willingness to be careful, our willingness to pursue the details of legislation we pass on the floor for the private sector, will never quite be there.

So I say to my colleagues, we have done a good job. The bill deserves the support of all of us, and again to the gentleman from North Carolina [Mr. ROSE] and the gentleman from California [Mr. THOMAS] I say, Thank you very much.

Mr. ROSE. Mr. Chairman, I yield 2 minutes to the gentlewoman from Connecticut [Mrs. KENNELLY].

Mrs. KENNELLY. Mr. Chairman, as we all well know, one of the criticisms of Congress is that we are out of touch with the American people. You and I know that this is not true—this body is made up of some of the finest Americans who work incredibly long hours and make tremendous efforts to give their neighbors a voice in this institution.

But it is true that Congress is exempted, from some laws, from many employment discrimination laws and health and safety laws by which the private sector and executive branch must abide. Laws such as the Occupational Safety and Health Act and the Federal Labor/Management Relations Act were put into place to protect Americans from unfair employment practices and to ensure their safety on the job, and it is in all fairness to our own legislative branch employees that Congress should now apply these to itself.

As a member of the Committee on House Administration and as a cosponsor of the original Shays-Swett bill, I strongly support H.R. 4822, the Congressional Accountability Act. It is important that Congress comply with these laws for the sake of accountability and fairness.

All of the laws and enforcement procedures would originate through the Office of Compliance, an independent body within the legislative branch created to implement all aspects of compliance, from rulemaking to enforcement, and created to be efficient, timely and fair.

However, before this legislation is passed, and I sincerely hope it will be, we must realize that complete compliance cannot take place without the necessary appropriations. For example—OSHA compliance could require costly abatement procedures such as asbestos removal. We must be prepared to pay for it, and I sincerely hope that all those who will vote so enthusiastically today will be just as enthusiastic when we have to foot the bill.

If we are serious about reform, we must pass this bill. I commend my colleague from Connecticut, Mr. SHAYS, and my colleague from New Hampshire, Mr. SWETT, on the effort to bring this important legislation to the floor before August recess. When we go back to our districts, we want to be able to say to our constituents that we have taken the necessary steps toward reform by passing compliance legislation and that we in Congress are no longer above the law.

Mr. THOMAS of California. Mr. Chairman, I yield 1 minute to the gentleman form Maryland [Mr. BARTLETT].

Mr. BARTLETT of Maryland. Mr. Chairman, one of my first acts when I came to the Congress was to submit legislation to reform the Congress, and so of course of am pleased that this bill is before us today. But I hope that the Members of the House and the American people understand that this bill is just a first small step down the road that we need to take to complete reform.

This Congress, this body, is held in ever-lower esteem by the American people, and a very large part of that is because of the congressional reform that is needed. I hope we accept this as just a down payment, just a first step on to true reform that is needed, so we can regain the stature we need with the American people so that we can effectively legislate so this Government can effectively govern.

Mr. ROSE. Mr. Chairman, I yield 1 minute to the gentleman from Minnesota [Mr. PENNY].

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Mr. PENNY. Mr. Chairman, I thank the gentleman for yielding.

Mr. Chairman, I rise in support of the Congressional Accountability Act, H.R. 4822, and I wish to congratulate the gentleman from New Hampshire [Mr. SWETT], and the gentleman from Connecticut [Mr. SHAYS] for their yeoman's work on this matter. Without their persistent leadership, we would not be on the House floor today preparing to pass this vital legislation.

Applying to ourselves the laws we in Congress impose on the private sector is the right thing to do and it is long, long overdue. Several years ago while I was a member of the Committee on Education and Labor I suggested that as we increased the minimum wage, extended family and medical leave laws, considered civil rise protections and reformed OSHA, that we simply apply these same laws to the Congress.

Those of us who supported and sponsored these amendments were told repeatedly that the Congress was special; that the constitutional separation of powers dictated that we should not be governed by the executive branch; and that we would be opening the Congress to numerous lawsuits.

Our point was this is a matter of accountability and trust. The American people cannot be expected to trust the Congress to do the work of the Nation if we exempt ourselves from the laws we apply to the rest of the Nation. Mr. SHAYS and Mr. SWETT have provided leadership on this issue. This legislation is long overdue. The bill deserves our support.

Mr. THOMAS. of California. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I want to once again commend the gentleman from Connecticut [Mr. SHAYS] and the gentleman from New Hampshire [Mr. SWETT]. Without them, we would not be where we are today. As is usually the case, it is someone who takes an inordinate interest and involves and invests an inordinate amount of time to bring us to the position that we are at today.

I want to underscore once again the very positive, bipartisanship that was obtained in the Committee on House Administration when we reviewed 14 amendments.

The rule, that made in order this bill, makes in order a number of amendments, and I would ask the Members to listen to the debate, pro and con, on most of these amendments. Frankly, the call could go either way on a number of these, and I may have my opinion, but other Members may have theirs. And clearly they are amendments that have merit. And whether they are voted into this bill or not, they are not pernicious. They are not there as Trojan horses. They are not their with a second agenda involved.

I have a personal concern about the amendment dealing with the court process, because it was brought up in committee, and I will discuss that when that amendment is made in order.

But I want to underscore the gentleman from Georgia's comments and the response of the gentleman from Missouri. I believe that this process is demeaned by the way in which the Committee on Rules made in order amendments that were clearly not designed to improve the underlying bill in terms of placing the Congress under those 10 laws that the private sector has to be placed under. I know arguments will be made as we come to the floor that these are in fact similar to the other amendments that are going to be offered. They are not.

I invite the Members' attention to the serious amendments, and that we should discuss them and make the House's will known, including or not including those. But I do hope the

House makes it known that the kind of amendments that were made in order, that clearly I think are political and pernicious, should be given the faith that they deserve, and that is that they should be rejected.

Mr. ROSE. Mr. Chairman, I yield such time as she may consume to the gentlewoman from Illinois [Mrs. COLLINS].

Mrs. COLLINS of Illinois. Mr. Chairman, if the gentleman would be so kind as to address a particular concern of mine regarding the duties of the Office of Compliance with respect to educating Members of this body as well as their staffs on their rights and responsibilities under the laws which will apply to them under this act, I would appreciate it.

Mr. ROSE. Mr. Chairman, if the gentleman will yield, I would be glad to do so.

Mrs. COLLINS of Illinois. Mr. Chairman, I rise in support of this long overdue legislation and strongly urge my colleagues to do the same.

I am extremely pleased that under section 6 of the bill the Office of Compliance is charged with carrying out educational programs so that Members, their staffs, and other legislative branch employees and agencies become informed of their duties under this legislation. The bill also broadly lays out ways in which the Office could implement educational initiatives, such as through mass mailings to Members and employees as well as through instructional seminars. Prior to learning that such provisions were included in the bill, I was planning to offer a similar amendment.

Nevertheless, it is my understanding that the bill does not specifically stress what I believe to be a vital component of the success of such educational efforts by the Office of Compliance, and that is the timeliness and regularity of these efforts, as well as any particular assurances that these educational efforts will be widely publicized and disseminated. In addition, I do not believe the bill offers the Office or the Board of Directors any real detailed suggestions as to how best to meet its educational requirements. I personally think that, if allowable, the Office of Compliance would be well served by a partnership with the Library of Congress for the purposes of carrying out its educational duties under this bill. It might also be beneficial for the Office of Compliance to ask each Member's office to designate a staffer responsible for oversight of the Office of Compliance activities, if the Member and their offices are so inclined.

My overall concern, Mr. Chairman, is that we don't end up learning about rules and regulations with which we must comply after the fact. The educational component of this bill is key to ensuring that this does not happen.

If the distinguished Chairman from North Carolina agrees with me on this merit of my concerns, I would be more than happy and willing to work with him and your staff in ensuring that the general thoughts I have just enunciated are conveyed through the proper channels, such as in possible report language to the bill, or through other means the gentleman may deem appropriate. I believe this would serve to clarify important congressional intent in this area.

Mr. ROSE. Mr. Chairman, I yield such time as he may consume to the gentleman from Illinois [Mr. FAWELL].

Mr. FAWELL. Mr. Chairman, I rise in enthusiastic support of this legislation.

Mr. Chairman, the concept of applying the laws of the land to Congress has been one which I have been fighting for since I first came to Congress. This is why I am pleased to finally see a bill on the floor of the House which attempts to achieve this goal. The bill before us today, H.R. 4822, the Congressional Accountability Act, has been a long time in coming.

The Hypocrisy of Congress in exempting itself from the very laws it imposes on others is so obvious, that one wonders how the practice so long managed to escape wide criticism. In the last few years, however, we have seen a change in the long-standing attitude that Congress is so unique and so different that it simply must be afforded special exemptions, even from employment laws, or it could not function; and those of us who once felt alone in the wilderness in urging congressional coverage now have welcome company. The reality is that the public is fed up, and Congress has been reacting.

In my years in the House, it has become increasingly clear that Congress, in its imperial wisdom, too cavalierly and too eagerly, continues to place layer upon layer of regulatory requirements on the private sector—without any deep understanding for what it is doing. Congressional coverage is vitally important because it will help Congress to adopt credible, effective, and workable laws which affect everyone else in the United States and will allow Congress to truly feel the pain of the impact of these laws. If the statutes don't apply to us, how in the world are we supposed to know how they will work in the real world outside of the beltway?

Mr. Chairman, H.R. 4822 sets up a congressional Office of Compliance which would be required to issue regulations to implement the application of 10 laws to Congress. I am pleased that the committee report language accompanying this bill directs that the Compliance Office should implement the specific provisions of the laws listed in the act to the greatest extent possible, and that it is not the act's intent that existing law be reinterpreted. I appreciate the fact that the authors of this bill, Mr. SHAYS and Mr. SWETT, agree with me on this point.

I am also heartened by the fact that the Occupational Safety and Health Act is one of the statutes which will be applied to Congress. Last year, I introduced the Congressional Safety and Health Act (H.R. 3458) to extend OSHA protections to employees of the House and its instrumentalities. The report language suggests an approach which is modeled after my bill, to ensure that OSHA enforcement mechanisms are applied to Congress that mirror, as closely as possible, those found in the private sector.

With regard to remedies available to aggrieved employees, H.R. 4822 copies the private sector process in allowing private law suits in court, with jury trials, where the underlying law allows for such law suits. In my view, this is a very important provision in the bill, because congressional employees should be entitled to the same type of damages as private sector employees under the relevant laws.

I must emphasize that if Members of Congress and Senators are not subjected to the same employee remedies which exist under many of the laws of the land, especially in the area of place-of-employment labor law, then we will not have true congressional coverage of these laws. This is not very well known, because Members are currently exempt from the most important aspect of many private sector laws, the right of employees to sue the employer in trial court for damages. In this day and age, these employee rights are what put the "teeth" into many of our private sector labor laws—and in ever increasing frequency, Congress is expanding these rights.

Mr. Chairman, with regard to one of the laws included in H.R. 4822, the Family and Medical Leave Act, I am pleased today to see that Members will be supporting the correct position on its application to Congress—a position which was not accepted when I offered my motion to recommit the FMLA bill when it was considered by the House last year. My motion would have allowed Congressional employees to use judicial remedies in the FMLA's enforcement and would have allowed Members to be sued in Federal court for violations of the Act. H.R. 4822 does, with the exception of allowing punitive damages and Member liability for wrongdoing, achieve the same result that I attempted to accomplish with my motion last year.

H.R. 4822, however, although it provides major improvements in terms of employee rights, it is still very deficient in the area of employer accountability. Under this bill, all Members of Congress, Senators, and heads of employing offices are totally shielded from any financial liability resulting from wrongdoing, even in proven cases of egregious violations of the law. This is a step back from the current procedures of the existing House Office of Fair Employment Practices, which provide for award payments for Members' office accounts. The bill also sets up a separate fund and provides for government-paid attorney representation, no matter how outrageous the behavior or allegations in question. In addition, H.R. 4822 expressly excludes awards of punitive damages. Where is the sting here? If only private sector companies were lucky enough to have this arrangement!

In the final analysis, the lack of employer accountability in this legislation will likely result in additional litigation against Congressional employers, because the deep pocket of the Government—the taxpayers—will pay for any damages of attorney fees which are awarded.

Mr. Chairman, despite these defects in the bill, it is still an improvement over the current situation. I would also hope that the shortcomings I mentioned can be addressed in conference with the Senate. There are many Members who should be thanked for their work on this issue, but I would like to specifically recognize several of my colleagues: Mr. SHAYS and Mr. SWETT for their perseverance in promoting their legislation; Mr. HAMILTON and Mr. DREIER for their work in the Joint Committee on the Organization of Congress, on which H.R. 4822 is based; and Mr. GOODLING, the ranking Member on the House Education and Labor Committee who introduced legislation last year which guided the authors of H.R. 4822 and ensured that we have a better product before us today. I only hope that the Senate will follow our lead and will pass similar legislation in the near future so that we may go to conference and send a bill to the President this year—one that provides a real and workable mechanism for making Congress subject to the same laws it mandates on the private sector.

Mr. ROSE. Mr. Chairman, to close debate on our side, I yield the balance of our time to the gentleman from New Hampshire [Mr. SWETT], who has done the yeoman's task of bringing this legislation to the point we are at today.

The CHAIRMAN. The gentleman from New Hampshire is recognized for 3 minutes.

Mr. SWETT. Mr. Chairman, I want to first thank the gentleman for the opportunity to close debate. I am somewhat humbled by all the numerous references to both myself and the gentleman from Connecticut [Mr. SHAYS]. I think that I can speak for the gentleman in saying that this is not our legislation. This is legislation that has been in this House for now 7 years, maybe longer. We have heard many people talk about different aspects of that, that they have worked on long before the gentleman or I made it into Congress.

We came into Congress recognizing in many respects the problems that this body faced because of the efforts of these people who came before us. We owe a great debt of gratitude to their efforts. They have educated us. We have taken what they have done and tried to expand upon it, include them in that expansion, and it has been certainly a great privilege to work with them.

First of all, what is this bill really about? This bill is about building back trust and confidence in a government that seems to have become the last plantation, that has no real sensitivity toward what is happening in the private sector. That is something that the gentleman from Connecticut [Mr. SHAYS] and I and all the other people that have worked on this bill have tried time and time again to incorporate.

How do we overcome these problems? How do we build this trust back in? How do we rebuild confidence in the Government? We do that by an open process. Every point on this bill was openly negotiated. It was a rule that we felt was important and had to be adhered to at all times, constructive dialog versus adversarial opposition. We negotiated with an unusual element that you rarely find in discussions in this country, let alone in this town of Washington, DC. That element was a fundamental adherence that there needed to be a basic building block of trust in everything that we discussed, trust that we could move forward to overcome our differences, trust to understand that we could ultimately agree on some kind of legislation that would help this body become more sensitive to the problems that people in this country face on a day-in and day-out basis.

We have brought Congress under the laws of the land. We have done it in a way that we feel protects the powers of separation. The constitutionalists have found satisfaction with what we have done. We have done it in a way that we hope will build some kind of community in this body that will enable us to go from here after this first step is taken and build upon it, as has been requested by the gentleman from California [Mr. THOMAS].

These are the milestones that make for effective government, and we are, today, accomplishing a milestone that was set out for the public by our predecessors nearly a decade ago.

Mr. ROSE. Mr. Chairman, will the gentleman yield?

Mr. SWETT. I yield to the gentleman from North Carolina.

Mr. ROSE. One of our colleagues asked, will this bill prohibit me from asking an employee that wants to go to work in my office, are you a Democrat, are you pro-life, are you pro-choice? Could you comment briefly on that?

Mr. SWETT. Mr. Chairman, Members will have the latitude to inquire of their employees on political grounds, domicile grounds. They have the opportunity to determine in those spectrums what is advantageous to their service.

I urge my colleagues to continue in this bipartisan spirit and to support this legislation.

Mr. PORTMAN. Mr. Chairman, I rise today to express my strong support for H.R. 4822, the Congressional Accountability Act. This long overdue reform would force Congress to abide by some of the same laws that it imposes on the private sector. I have no doubt this legislation will cause Congress to think twice about the impact new legislation will have on others and question the wisdom of previously passed laws as well. It's just common sense.

I am particularly pleased that we will be considering an amendment today to require that any standard benefits package approved as a part of health care reform apply to Members of Congress. On this subject, I have sponsored my own resolution that expresses the sense of Congress that any law pertaining to the reform of our Nation's health care system should apply to Members of Congress and all Federal employees. If Congress is to pass health care reforms that will affect the lives of every American, it's only fair that they should apply to Members of Congress, their staff, and all other Federal employees as well.

Regardless of what we do in Congress on health care reform or any other issue, there is no reason why laws should not apply to Congress. The likely outcome of such long overdue reform is that Members of Congress, by swallowing some of their own painful medicine, will become better lawmakers and begin to lead by example, not exemption. I urge my colleagues to support the Congressional Accountability Act.

Mrs. LLOYD. Mr. Chairman, I rise today in support of H.R. 4822, the Congressional Accountability Act, which applies 10 existing employee protection and antidiscrimination laws to the employees of Congress and other legislative branch agencies.

I have long maintained that Congress should also abide by the laws we pass for our citizens. H.R. 4822 specifies the following laws would apply to Congress: Fair Labor Standards Act, title VII of the Civil Rights Act of 1964, Americans With Disabilities Act, Age Discrimination in Employment Act, Family and Medical Leave Act, Occupational Safety and Health Act, Federal Labor Management Relations Act, Employee Polygraph Protection Act, Worker Adjustment and Retraining Notification Act, and the Rehabilitation Act of 1973.

This legislation avoids potential separation of powers conflicts by allowing Congress to promulgate its own rules and regulations, provided they are consistent with existing law, and administer the execution of these laws internally, through an Office of Compliance. This legislation establishes a process by which violations of these statutes may be remedied, including the option of judicial review.

I firmly believe that Congress needs to be held accountable for the laws it passes. This legislation is a solid, bipartisan step in the right direction and I will continue further efforts in the 103d Congress that promote legislative accountability.

Mr. BARCA. Mr. Chairman, I rise today to strongly support the amendment by Representative BYRNE to require that if Congress passes a health care plan with a standard health care benefits package that Congress will have the same benefits as the rest of the people in our country.

This amendment parallels House Concurrent Resolution 156 which I introduced last September. The resolution states that Members of Congress should participate on an equal basis with all other Americans in any health care system legislated by Congress.

During the past year I have conducted townhall meetings on health care reform throughout the First Congressional District of Wisconsin. The people attending these meetings had diverse opinions on the range of health care issues, but there was one unifying factor.

They unanimously supported my position that Members of Congress should have the same health care plan that is offered to the American people.

I am very pleased that we are acting today to pass a bill on congressional accountability to ensure that Congress will live by the laws we pass. This is a good addition to that act.

Mr. BUYER. Mr. Chairman, I rise in support of passage of H.R. 4822, the Congressional Accountability Act.

It is my preference that Congress would consider congressional reform as a whole, rather than as a piecemeal approach. Nonetheless, H.R. 4822 is a first step in the right direction.

It should be no surprise to anyone in this Chamber that Congress does not stand in high esteem among the general public. The public perceives an institution beset by privilege. This legislation, H.R. 4822, will help to put Congress on the same footing as the rest of the Nation.

The Congressional Accountability Act will apply 10 laws to Congress from which it is for the most part currently exempt. The bill creates a bicameral Office of Compliance to apply these laws to Congress and to enforce them. This office surmounts the separation of powers constitutional difficulty. The 10 laws under which Congress will now fall include:

Fair Labor Standards Act—governing minimum wage and overtime pay, as well as other labor standards as equal pay protections. Compliance time for Congress—1 year from enactment.

Title VII of the 1964 Civil Rights Act—prohibiting employment discrimination based on race, religion, sex, or national origin. Compliance time—1 year from enactment.

Americans With Disabilities Act—prohibiting employment discrimination against a qualified, but disabled individual. Compliance time—1 year from enactment.

Age Discrimination in Employment Act—prohibiting employment discrimination based on age. Compliance time—1 year from enactment.

Titles I and V of the Family and Medical Leave Act—title V of this act applied it to Congress. This bill revises the provisions to conform to the new procedures of compliance. It requires employers to provide up to 12 weeks of unpaid leave for the birth or adoption of a child or the illness of a close family member. Compliance time—1 year from enactment.

Occupational Safety and Health Act—governs workplace safety standards. Compliance time—2 years from enactment.

Chapter 71 of title 5 United States Code—permits Federal workers the right to unionize and bargain, but prohibits striking. Compliance time—2 years from enactment.

Employee Polygraph Protection Act—prohibits using lie detector tests on employees or job applicants with some exemptions, notably national security agencies. Compliance time—1 year, except the Capitol Police which are exempt.

Worker Adjustment and Retraining Notification Act—requires 60 days notice for plant closings that would cause 50 or more employees to lose their jobs and layoffs of longer than 6 months. Compliance time—1 year from enactment.

Rehabilitation Act—requires affirmative action plans for hiring disabled persons and prohibits discrimination on the basis of disability. Compliance time—2 years from enactment.

The Congressional Accountability Act sets forth a counseling and mediation process through which employees must attempt to seek redress of grievances. However, employees can bring civil suit in Federal district courts. The bill also establishes a fund to pay compensation if a violation has occurred and a monetary remedy is found to be appropriate.

Congress must live by the laws it passes for the rest of America. As a cosponsor of H.R. 349, originally introduced by Mr. SHAYS, I am pleased to support this legislation to improve the accountability of Congress.

Mr. FAZIO. Mr. Chairman, I rise in support of H.R. 4822, the Congressional Accountability Act. This important legislation would apply ten employee-protection laws to the employees of Congress.

H.R. 4822 fulfills our responsibility to grant the same protections and workplace standards that all other working Americans enjoy to our own employees in Congress. The Congressional Accountability Act continues the recent trend of Congress living by the rules we ask the rest of America to live by.

In recent years, we have enacted several major employee protection laws—the Americans with Disabilities Act, the Civil Rights Act of 1991 and the Family and Medical Leave Act. In each case, we applied the requirements of these laws to Congress just like they applied to the private sector. In addition, House rules provide House employees with protections afforded under the Fair Labor Standards Act and specify that House personnel actions shall be made "free from discrimination based on race, color, national origin, religion, sex—including marital or parental status—disability, or age."

H.R. 4822 continues our efforts to bring Congress into compliance with other significant employee protection statutes. The Congressional Accountability Act will also require Congress to comply with the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Occupational Safety and Health Act, the Federal Labor Management Relations Act, the Employee Polygraph Protection Act, the Worker Adjustment and Retraining Act and the Rehabilitation Act of 1973.

This legislation establishes a four-step complaint process, including counseling, mediation, formal complaint and hearing and judicial review, to deal with alleged violations of these laws. In short, it affords congressional employees a formal process to air their grievances, including access to the courts.

This Act represents a positive change in how Congress treats its own employees. I strongly support this legislation and urge my colleagues to vote for this landmark congressional reform bill.

Mr. SANDERS. Mr. Chairman, I rise in support of the Congressional Accountability Act, H.R. 4822, which I'm pleased to be cosponsoring. This bill, which applies to congressional employees the basic protections against discrimination, unsafe working conditions and unfair labor practices which are guaranteed to other American workers, is a long overdue reform. For many decades, Congress routinely exempted itself for laws which it passed to apply to the rest of America—a double standard which increased the contempt which most citizens have justifiably held for this institution. Capitol Hill was the last bastion of arbitrary bosses, long after the struggles of working men and women gained basic human and economic rights for workers in most of our Nation.

Finally, a few years ago, Congress finally started to get the message. The Americans with Disabilities Act, the Civil Rights Act of 1991, and the Family and Medical Leave Act were applied to the legislative branch when they were passed, as well as to the executive branch and private employers. Now, with this bill 10 basic employee protection laws, including those dealing with family and medical leave, nondiscrimination, privacy, occupational safety and health, and fair labor standards, will be applied to employees of the legislative branch.

I realize that the separation of powers among the legislative, executive and judicial branches is an important constitutional issue in terms of this bill. But the authors of the bill, and the committees which are bringing it to the floor, have worked long and hard to devise enforcement mechanisms which respect both the Constitution's provisions and the rights of workers, and I believe that they have succeeded. While an office of compliance in the legislative branch will develop the regulations and resolve complaints, this will not supersede the rights of workers to take their cases to court for judicial review. The constitutional separation of powers is respected, but not at the expense of workers' rights.

Mr. Speaker, the laws which are applied to the legislative branch by this bill were major victories for the civil rights and labor movements in this country. The Civil Rights Act of 1964, which prevents discrimination by employers, was one of the most significant milestones in the struggle against racism in the 1960's. The Occupational Safety and Health Act, although still not strongly enforced, recognizes the right of all workers to be protected against injuries and occupational diseases. The American with Disabilities Act prevents discrimination against people with disabilities, and establishes that workers have the right to be judged based on their real abilities to do the job. And the Family Medical Leave Act, while still falling short of what other industrialized countries guarantee, at least makes it possible for workers to take time off to care for an injured child or a sick parent, without losing their jobs.

Mr. Speaker, this bill extends protection only to a few thousand more workers, but its symbolic importance goes far beyond that. It is a recognition that Congress can no longer maintain a double standard on workers' rights, applying them to everyone but itself. It is a strong statement that every worker in America has the right to a safe workplace, to family and medical leave, and to protect against discrimination. I urge my colleagues to vote for this bill, and finally bring Capitol Hill into the 20th century.

Mr. TRAFICANT. Mr. Chairman, I rise in strong support of H.R. 4822, the Congressional Accountability Act. I believe this measure is long overdue and much needed. The bill would apply 10 existing employee protection and antidiscrimination laws to the employees of Congress and other legislative branch agencies. I am especially pleased to note that H.R. 4822 extends coverage to the brave and dedicated men and women of the U.S. Capitol Police.

I'd like to focus in on 1 of the 10 employee protection measures the bill extends to the legislative branch: the Federal Labor Management Relations Act [FLMRA]. Under this bill, the FLMRA would apply to the legislative branch within 2 years of the date of enactment—regardless of whether final regulations are issued.

The end result of applying FLMRA to the legislative branch will be to allow the rank and file of the U.S. Capitol Police to organize and form a union. This is a basic right that most of the more than 500,000 Federal, State, and local law enforcement officers across the country have.

For the past 2 years, I have been working to address the serious morale problems that exist on the Capitol Police. I have been pushing for adoption of a resolution creating an Ad Hoc Joint Congressional Committee to review the current labor relations policy for the U.S. Capitol Police and recommend changes to the Congress. H.R. 4822, by allowing the Capitol Police officers to unionize will—in the long run—help address the current problems on the force. However, I still believe that approval of my resolution, House Concurrent Resolution 84, would go a long way in addressing the current problems on the force.

Mr. Chairman, I have spoken with a number of officers about the force. Without question, there is a serious morale problem. The rank and file feel they have no rights, that they are treated like children. I have found instances of age, sex, and racial discrimination. I have found that in all too many instances management is petty, unsympathetic and incompetent. The bill before us today will go a long way in addressing these serious problems.

The Sergeant at Arms and the Capitol Police Board have made some important changes, but has done nothing to address the fundamental structural problems that exist. For example, the ombudsperson they established to hear complaints and grievances reports directly to management, and is perceived by the rank and file as a tool of management and not as an objective third party who can resolve problems.

If the rank and file could organize and establish a union, they could work cooperatively with management and create a grievance procedure that will have teeth, and one that everyone can have confidence in as being fair and objective.

The 3-day demonstration on the steps of the Capitol last February is proof positive that the morale problem is widespread and is not simply a matter of a few disgruntled officers making a lot of noise. There is a serious problem and Congress can't ignore it. Today, Congress is stepping up to the plate and addressing this problem, and other problems associated with its 200-year-old practice of exempting itself from the laws it passes for the rest of the country.

In conclusion, I applaud the distinguished gentleman from North Carolina [Mr. ROSE], the gentleman from Washington [Mr. SWIFT], and the gentleman from Connecticut [Mr. SHAYS], for their excellent work in moving this important legislation forward. I urge my colleagues to support the Capitol Police and vote for H.R. 4822.

Mr. FAWELL. Mr. Chairman, the concept of applying the laws of the land to Congress has been one which I have been fighting for since I first came to Congress. This is why I am pleased to finally see a bill on the floor of the House which attempts to achieve this goal. The bill before us today, H.R. 4822, the Congressional Accountability Act, has been a long time in coming.

The hypocrisy of Congress in exempting itself from the very laws it imposes on others is so obvious, that one wonders how the practice so long managed to escape wide criticism. In the last few years, however, we have seen a change in the long-standing attitude that Congress is so unique and so different that it simply must be afforded special exemptions, even from employment laws, or it could not function; and those of us who once felt alone in the wilderness in urging congressional coverage now have welcome company. The reality is that the public is fed up, and Congress has been reacting.

In my years in the House, it has become increasingly clear that Congress, in its imperial wisdom, too cavalierly and too eagerly, continues to place layer upon layer of regulatory requirements on the private sector—without any deep understanding for what it is doing. Congressional coverage is vitally important because it will help Congress to adopt credible, effective and workable laws which affect everyone else in the United States and will allow Congress to truly feel the pain of the impact of these laws. If the statutes do not apply to us, how in the world are we supposed to know how they will work in the real world outside of the beltway?

Mr. Chairman, H.R. 4822 sets up a Congressional Office of Compliance which would be required to issue regulations to implement the application of 10 laws to Congress. I am pleased that the committee report language accompanying this bill directs that the Compliance Office should implement the specific provisions of the laws listed in the act to the greatest extent possible, and that it is not the act's intent that existing law be reinterpreted. I appreciate the fact that the authors of this bill, Mr. SHAYS and Mr. SWETT, agree with me on this point.

I am also heartened by the fact that the Occupational Safety and Health Act is one of the statutes which will be applied to Congress. Last year, I introduced the Congressional Safety and Health Act (H.R. 3458) to extend OSHA protections to employees of the House and its instrumentalities. The report language suggests an approach which is modeled after my bill, to ensure that OSHA enforcement mechanisms are applied to Congress that mirror, as closely as possible, those found in the private sector.

With regard to remedies available to aggrieved employees, H.R. 4822 copies the private sector process in allowing private law suits in court, with jury trials, where the underlying law allows for such law suits. In my view, this is a very important provision in the bill, because congressional employees should be entitled to the same type of damages as private sector employees under the relevant laws.

I must emphasize that if Members of Congress and Senators are not subjected to the same employee remedies which exist under many of the laws of the land, especially in the area of place-of-employment labor law, then we will not have true congressional coverage of these laws. This is not very well known, because Members are currently exempt from the most important aspect of many private sector laws, the right of employees to sue the employer in trial court for damages. In this day and age, these employee rights are what put the teeth into many of our private sector labor laws—and in ever increasing frequency, Congress is expanding these rights.

Mr. Chairman, with regard to one of the laws included in H.R. 4822, the Family and Medical Leave Act, I am pleased today to see that Members will be supporting the correct position on its application to Congress—a position which was not accepted when I offered my motion to recommit the FMLA bill when it was considered by the House last year. My motion would have allowed congressional employees to use judicial remedies in the FMLA's enforcement and would have allowed Members to be sued in Federal court for violations of the act. H.R. 4822 does, with the exception of allowing punitive damages and Member liability for wrongdoing, achieve the same result that I attempted to accomplish with my motion last year.

H.R. 4822, however, although it provides major improvements in terms of employee rights, is still very deficient in the area of employer accountability. Under this bill, all Members of Congress, Senators, and heads of employing offices are totally shielded from any financial liability resulting from wrongdoing, even in proven cases of egregious violations of the law. This is a step back from the current procedures of the existing House Office of Fair Employment Practices, which provide for award payments from Members' office accounts. The bill also sets up a separate fund and provide for Government-paid attorney representation, no matter how outrageous the behavior or allegations in question. In addition, H.R. 4822 expressly excludes awards of punitive damages. Where is the sting here? If only private sector companies were lucky enough to have this arrangement.

In the final analysis, the lack of employer accountability in this legislation will likely result in additional litigation against congressional employers, because the deep pocket of the Government—the taxpayers—will pay for any damages or attorney fees which are awarded.

Mr. Chairman, despite these defects in the bill, it is still an improvement over the current situation. I would also hope that the shortcomings I mentioned can be addressed in conference with the Senate. There are many Members who should be thanked for their work on this issue, but I would like to specifically recognize several of my colleagues: Mr. SHAYS and Mr. SWETT for their perseverance in promoting their legislation; Mr. HAMILTON and Mr. DREIER for their work in the Joint Committee on the Organization of Congress, on which H.R. 4822 is based; and Mr. GOODLING, the ranking member on the House Education and Labor Committee who introduced legislation last year which guided the authors of H.R. 4822 and ensured that we have a better product before us today. I only hope that the Senate will follow our lead and will passs similar legislation in their near future so that we may go to conference and a send a bill to the President this year—one that provides a real and workable mechanism for making Congress subject to the same laws it mandates on the private sector.

Mr. RIDGE. Mr. Chairman, I believe by passing H.R. 4822, the Congressional Accountability Act, today, the House took the first step in bringing reform to this body. This bill applies 10 laws to Congress to which businesses in the private sector must already abide. It also provides a detailed process for congressional employees to raise allegations of violations to these laws. The intention of the bill is to provide legislative branch employees with the same employment rights and protections that are available to employees of the private sector or Federal branch of Government.

This legislation is long overdue. It is a privilege and honor to serve in Congress and this privilege should not be abused. Congress should hold themselves to at least the same standards that they enforce on others.

There is no reason that Congress should be exempted from laws such as the Civil Rights Act, the Equal Employment Opportunity Act, the Age Discrimination Act, and the American with Disabilities Act. These laws have been enacted to ensure that discrimination does not occur in the work place. Members of Congress should take the lead on such issues; not pass legislation which, in essence, ensures they do not even have to follow the rules they impose on other employers.

It is time that we, as Members of Congress, start acting as servants of those who elected us. We must stop placing ourselves above laws that we feel are necessary for others. Until we do—and to some degree rightly so—this institution's reputation with the American people will continue to erode.

I hope this is just a first step in reforming Congress. The Joint Committee on the Organization of Congress, which was established to make recommendations on how Congress can operate more efficiently and effectively, has made many other recommendations that need to be considered by this body. Only when the entire reform proposal is debated and passed will credibility begin to be truly restored to this body.

It is time for us to send a message to our constituents that we do not believe that we are above the laws we create.

Ms. FURSE. Mr. Chairman, I rise today in strong support of H.R. 4822, the Congressional Accountability Act. This is one of the most significant reforms this Congress can make to help break down barriers of government. It is illogical, and bad policy, for Congress to set a different standard for itself. We've heard the phrase over and over today, but it bears repeating: Congress will definitely write better laws if it has to live under the laws it passes.

When I came to Congress last year, the original Congressional Accountability Act was one of the first—and most important—reform measures I sponsored. The good work of my friends Mr. SHAYS and Mr. SWETT deserves recognition for making the bill before us today a reality. Because I came to Congress to change the way business is done, I urge all my colleagues to support this long overdue opportunity to bring citizens and their Government closer together, and vote for H.R. 4822, the Congressional Accountability Act.

Mr. SKAGGS. Mr. Chairman, I strongly support H.R. 4822, the Congressional Accountability Act. DICK SWETT and CHRIS SHAYS and many other Members have worked long and hard to bring this legislation before the House. As the chairman of the DSG Task Force on Congressional Reform, I appreciate the time and effort that's gone into it. The chairman and vice chairman of the Joint Committee on the Organization of Congress, Mr. HAMILTON and Mr. DREIER, also deserve much credit, and I thank them for all their work.

The DSG Task Force spent a great deal of time considering reform recommendations to make to the Joint Committee. We focused on five principal areas: the committee system; the budget process; floor deliberation and scheduling; ethics and institutional integrity; and staffing of Congress. These are important parts of the whole, and they are critical to true reform.

While some of these issues pertain exclusively to the operation of the House, others affect national policy. For example, could Members be more active in their committees if assignments were further limited? Would committee participation improve with a 4-day week? Would a 2-year budget process be more efficient, or just substitute many supplemental appropriations bills every other year?

These questions, and they're difficult ones, have been tackled by groups of Members, but not by the body as a whole. To function successfully, any organization has to periodically evaluate its operations and make appropriate changes. The evaluations have been made. We need to move on and make the corrections.

The package the Joint Committee put together is a good one because it's comprehensive. I believe we ought to be considering it in its entirety, and I regret that we aren't. But I in no way want to diminish the scope of the bill which we are considering today which requires congressional compliance with Federal workplace laws.

Quite simply, Congress should be subject to the same standards it applies to everyone else. And if we're going to pass laws that set rules for business, we ought to have to comply with them ourselves to the maximum extent practicable. That prospect no doubt will add a different and useful perspective to our deliberations on such laws.

With this bill, we will apply to Congress the Federal Labor Management Relations Act, the Age Discrimination in Employment Act, Title VII of the Civil Rights Act, the Occupational Safety and Health Act and six other employee-protection laws. Further, under this bill, Congress will be covered by other Federal laws relating to the terms and conditions of employment.

To ensure that Congress actually polices fair employment practices, and to respect the constitutional separation between the legislative branch and the executive branch, the DSG Task Force called for an independent enforcement agency within the legislative branch, with the right of appeal to the courts. The bill does this by establishing an Office of Compliance, made up of an eight-member Board of Directors and an Executive Director to develop regulations and to resolve complaints. Through a four-step process, legislative branch employees will be able to seek redress for alleged violations. A judicial review by the U.S. Court of Appeals can be requested, and, following a mediation stage, the employee can bring a civil suit in U.S. District Court. This complaint process is an effective way to ensure that Congress complies with the letter and spirit of workplace laws without violating the principle of separation of powers.

While this bill clearly demonstrates that the House is serious about congressional reform, a comprehensive reform package should be considered by the House this session. We've come too far not to complete the process, and I encourage the leadership to bring the rest of the Joint Committee's package to the full House for consideration. In the meantime, I urge my colleagues to support this bill.

Mr. KLECZKA. Mr. Chairman, I rise today in strong support of H.R. 4822, the Congressional Accountability Act.

The goal of H.R. 4822 is to better align public perception with reality. Although some Members may characterize this as a historic move, I would remind my colleagues that the reality is that Congress already adheres to the Civil Rights Act, the Fair Labor Standards Act, the Americans with Disabilities Act, and the Family and Medical Leave Act, among others.

Congress is not your typical workplace, it is a unique political institution. However, it is not above the law, and this legislation should clarify this point once and for all. The bill achieves the necessary balance between maintaining the legislative branch's independence and authority, and proving to taxpayers that this is an open and accountable body. It will lead to uniform enforcement between the two Chambers and among our support agencies like the Architect of the Capitol, the Congressional Budget Office, and the General Accounting Office.

The Congressional Accountability Act recognizes that Congress is already complying with the overwhelming majority of employment and labor laws. Yet, the bill upgrades existing congressional structures and creates an office of compliance to ensure that this institution continues to do so on an ongoing basis.

During consideration of this bill by the House Administration Committee, on which I serve, there was healthy debate on whether this bill should include the Freedom of Information Act. The committee decided that the Freedom of Information Act should not be included in this package because the bill compels compliance with labor and employment laws currently applicable to the private sector. As we all know, the Freedom of Information Act does not apply to the private sector, only to executive branch agencies.

In addition, I want to make it clear that the legislative branch is already the most open, most accountable branch of Government. The American people already have access to our debates, votes, speeches, testimony, salaries, investments, and official expenses. Moreover, with the arrival of the information age, just about everything we do and say is open to public scrutiny. Most of all, everyone in this Chamber must be reelected every other year. What could be more accountable than that?

Mr. Chairman, The Congressional Accountability Act is not a bill that will dramatically alter what is already an open, accountable institution. What it will go a long way toward doing is to improve the perception of this institution in the eyes of our taxpayers, which is something we could all use in this day and age.

Mr. RIDGE. Mr. Speaker, I believe by passing H.R. 4822, the Congressional Accountability Act, the House took the first step in bringing reform to this body. This bill applies 10 laws to Congress to which businesses in the private sector must already abide. It also provides a detailed process for congressional employees to raise allegations of violations to these laws. The intention of the bill is to provide legislative branch employees with the same employment rights and protections that are available to employees of the private sector or Federal branch of Government.

This legislation is long overdue. It is a privilege and honor to serve in Congress and this privilege should not be abused. Congress should hold themselves to at least the same standards that they enforce on others.

There is no reason that Congress should be exempt from laws such as the Civil Rights Act, the Equal Employment Opportunity Act, the Age Discrimination Act, and the American with Disabilities Act. These laws have been enacted to ensure that discrimination does not occur in the workplace. Members of Congress should take the lead on such issues; not pass legislation which, in essence, ensures they don't even have to follow the rules they impose on other employers.

It is time that we, as Members of Congress, start acting as servants of those who elected us. We must stop placing ourselves above laws that we feel are necessary for others. Until we do—and to some degree rightly so—this institution's reputation with the American people will continue to erode.

I hope this is just a first step in reforming Congress. The Joint Committee on the Organization of Congress, which was established to make recommendations on how Congress can operate more efficiently and effectively, has made many other recommendations that need to be considered by this body. Only when the entire reform proposal is debated and passed will credibility begin to be truly restored to this body.

It is time for us to send a message to our constituents that we do not believe we are above the laws we create.

Ms. SHEPHERD. Mr. Chairman, I rise today in proud support of the Congressional Accountability Act. This far-reaching legislation is overdue and warrants our enthusiastic support.

Many of the new Members of Congress came to this institution after campaigning on platforms that promised reform. Mr. Chairman, today the House is about to deliver on those promises.

Ending congressional exemptions from current labor, safety, and civil rights legislation is an important and substantive change in current practice. By bringing the Congress into compliance with the same laws that impact on the private sector and the executive branch, we will be taking an important step in regaining the faith of the American electorate. Feeling the full impact of each piece of legislation is also certain to result in the Congress being more sensitive to the concerns of the private sector. We will all be better legislators because of this effort.

Let me also say that this legislation has another lesson for us. When the freshmen Democrats and Republicans put together their respective reform recommendations last year, we were pleased to find several areas of agreement. One of the proposals that garnered our wholehearted support is the Congressional Accountability Act. For nearly 18 months ERIC FINGERHUT, TILLIE FOWLER, PETER TORKILDSEN and I—along with other freshmen Members—have worked on a bipartisan basis to support this congressional compliance legislation.

CHRIS SHAYS and DICK SWETT have provided a model for those of us who want to work together on a bipartisan basis. Our collaborative effort has made it possible to craft a bill which preserves the Constitution's mandate for the separation of powers and, at the same time, requires Congress to obey the same laws it passes for the rest of the country. This bill represents significant congressional reform. I urge this House to vote for its passage.

The CHAIRMAN. All time for general debate has expired.

Pursuant to the rule, the amendment in the nature of a substitute consisting of the text of H.R. 4892, modified by the amendments printed in part 1 of House Report 103-691, shall be considered as an original bill for the purpose of amendment and is considered read.

The text of the amendment in the nature of a substitute, as modified, is as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Congressional Accountability Act".

SEC. 2. DEFINITIONS.

As used in this Act:

(1) CONGRESSIONAL EMPLOYEE.—The term "congressional employee" means—

(A) an individual on the payroll of an employing office of the House of Representatives;

(B) an individual on the payroll of an employing office of the Senate;

(C) an individual on the payroll of an employing office of the Architect of the Capitol; and

(D) an individual on the payroll of an employing office of an instrumentality.

(2) EMPLOYEE IN THE HOUSE OF REPRESENTATIVES.—The term "individual on the payroll of an employing office in the House of Representatives" means—

(A) an individual who is covered under rule LI of the House of Representatives, as in effect on the day before the date of enactment of this Act;

(B) any applicant for a position that is to be occupied by an individual described in subparagraph (A); or

(C) any individual who was formerly an employee described in subparagraph (A) and whose claim of a violation arises out of the individual's employment.

(3) EMPLOYEE IN THE SENATE.—The term "individual on the payroll of an employing office in the Senate" means—

(A) any employee whose pay is disbursed by the Secretary of the Senate;

(B) any applicant for a position that is to be occupied by an individual described in subparagraph (A)); or

(C) any individual who was formerly an employee described in subparagraph (A) and whose claim of a violation arises out of the individual's employment.

(4) EMPLOYEE OF THE ARCHITECT OF THE CAPITOL.—The term "individual on the payroll of an employing office of the Architect of the Capitol" means—

(A) an employee of the Architect of the Capitol or an individual within the administrative jurisdiction of the Architect of the Capitol if such employee or individual is paid from funds under a law providing appropriations for the legislative branch;

(B) any applicant for a position that is to be occupied by an employee or individual described in subparagraph (A); or

(C) any individual who was formerly an employee or individual described in subparagraph (A) and whose claim of a violation arises out of the individual's employment.

(5) EMPLOYEE OF AN INSTRUMENTALITY.—The term "individual on the payroll of an employing office of an instrumentality" means—

(A) any individual on the payroll of an instrumentality of the legislative branch of the Federal Government;

(B) any applicant for a position that is to be occupied by an individual described in subparagraph (A); or

(C) any individual who was formerly an employee described in subparagraph (A) and whose claim of a violation arises out of the individual's instrumentality employment.

(6) HEAD OF AN EMPLOYING OFFICE.—The term "head of an employing office" means the individual who has final authority to appoint, hire, discharge, and set the terms, conditions, or privileges of the Congressional employment of an employee.

SEC. 3. APPLICATION OF LAWS.

(a) LAWS WHICH WILL APPLY.—The following laws shall apply, as prescribed by this subsection, to the legislative branch of the Federal Government:

(1) The Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.), effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 1 year after the date of the enactment of this Act.

(2) Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 1 year after the date of the enactment of this Act.

(3) The Americans With Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 1 year after the date of the enactment of this Act.

(4) The Age Discrimination in Employment Act of 1967 (29 U.S.C. 621 et seq.) (including remedies available to private employees), effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 1 year after the date of the enactment of this Act.

(5) Titles I and V of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611 et seq.), effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 1 year after the date of the enactment of this Act.

(6) The Occupational Safety and Health Act of 1970 (other than section 19) (29 U.S.C. 651 et seq.) (subject to subsection (c)), effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 2 years after the date of the enactment of this Act.

(7) Chapter 71 (relating to Federal labor management relations) of title 5, United States Code, effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 2 years after the date of the enactment of this Act.

(8) The Employee Polygraph Protection Act of 1988 (29 U.S.C. 2001 et seq.), effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 1 year after the date of the enactment of this Act, except that this Act shall not apply to the United States Capitol Police.

(9) The Worker Adjustment and Retraining Notification Act (29 U.S.C. 2101 et seq.), effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 1 year after the date of the enactment of this Act.

(10) The Rehabilitation Act of 1973 (29 U.S.C. 791), effective on the earlier of the effective date of applicable regulations of the Office of Compliance under section 5 or 1 year after the date of the enactment of this Act.

The laws referred to in this subsection which apply now to congressional employees shall continue to apply to such employees until the effective date such laws are made applicable in accordance with this subsection.

(b) LAWS WHICH MAY BE MADE APPLICABLE.—Any provision of Federal law shall, to the extent that it relates to the terms and conditions of employment (including hiring, promotion or demotion, salary and wages, overtime compensation, benefits, work assignments or reassignments, termination, protection from discrimination in personnel actions, health and safety of employees, and family and medical leave) of employees apply to the legislative branch of the Federal Government in accordance with this Act.

(c) COMPLIANCE WITH OSHA.—The legislative branch of the Federal Government shall comply with the Occupational Safety and Health Act of 1970 as follows: If a citation of a violation of such Act is received, action to abate the violation shall take place as soon as possible, but no later than the fiscal year following the fiscal year in which the citation is issued.

SEC. 4. OFFICE OF COMPLIANCE.

(a) ESTABLISHMENT.—There is established in the legislative branch an Office of Compliance (hereinafter in this Act referred to as the "Office").

(b) COMPOSITION.—

(1) BOARD OF DIRECTORS.—The Office shall have a Board of Directors. The Board of Directors shall consist of 8 individuals appointed jointly by the Speaker of the House of Representatives, the Majority Leader of the Senate, and the Minority Leaders of the House of Representatives and the Senate. Appointments of the first 8 members of the Board of Directors shall be completed not later than 120 days after the date of the enactment of this Act.

(2) EXECUTIVE DIRECTOR.—The Chairperson of the Board of Directors shall—

(A) appoint,

(B) establish the compensation of, and

(C) terminate,

an executive director (referred to in this Act as the "executive director"), subject to the approval of the Board of Directors. The compensation of the executive director may not exceed the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of title 5, United States Code.

(c) BOARD OF DIRECTORS QUALIFICATIONS.—

(1) IN GENERAL.—The members of the Board of Directors shall be individuals with training or expertise in—

(A) the application of the laws referred to in section 3 to employment, and

(B) employment in the Congress.

(2) SPECIFIC QUALIFICATIONS.—

(A) LOBBYING.—No individual who engages in, or is otherwise employed in, lobbying of the Congress and who is required under the Federal Regulation of Lobbying Act to register with the Clerk of the House of Representatives or the Secretary of the Senate shall be considered eligible for appointment to, or service on, the Board of Directors.

(B) OFFICE.—No member of the Board of Directors appointed under subsection (b)(1) may hold or may have held the position of Member of the House of Representatives, Senator, or employee of the House of Representatives or the Senate.

(3) HOLDING OFFICE.—If during a term of office a member of the Board of Directors engages in an activity described in paragraph (2)(A), such position shall be declared vacant and a successor shall be selected in accordance with subsection (b)(1).

(4) VACANCIES.—A vacancy in the Board of Directors shall be filled in the manner in which the original appointment was made.

(d) BOARD OF DIRECTORS TERM OF OFFICE.—

(1) IN GENERAL.—Except as provided in paragraph (2), membership on the Board of Directors shall be for 5 years. A member shall only be eligible for appointment for a single term of office.

(2) FIRST APPOINTMENTS.—Of the members first appointed to the Board of Directors—

(A) 2 shall have a term of office of 2 years,

(B) 2 shall have a term of office of 3 years,

(C) 2 shall have a term of office of 4 years, and

(D) 2 shall have a term of office of 5 years,

as designated at the time of appointment by the persons specified in subsection (b)(1).

(e) CHAIRPERSON.—The Chairperson of the Board of Directors shall be appointed from the members of the Board of Directors by the members of the Board.

(f) COMPENSATION OF MEMBERS.—

(1) PER DIEM.—Each member of the Board of Directors shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board.

(2) TRAVEL EXPENSES.—Each member of the Board of Directors shall receive travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, for each day the member is engaged in the performance of duties away from the home or regular place of business of the member.

(g) OFFICE STAFF.—The executive director may appoint and fix the compensation of such staff, including hearing officers, as are necessary to carry out this Act.

(h) DETAILEES.—The executive director may, with the prior consent of the Government department or agency concerned, use the services of any such department or agency, including the services of members or personnel of the General Accounting Office Personnel Appeals Board.

(i) CONSULTANTS.—In carrying out this Act, the executive director may procure the temporary (not to exceed 1 year) or intermittent services of individual consultants or organizations thereof.

SEC. 5. STUDY AND REGULATIONS.

(a) INITIAL ACTION.—

(1) IN GENERAL.—The Board of Directors shall conduct a study of the manner in which the laws made applicable to the legislative branch of the Federal Government under section 3(a) should apply. The Board of Directors shall complete such study and report the results to Congress not later than 180 days after the date of the first appointment of all the members of the Board of Directors.

(2) INSTRUMENTALITIES.—The Board of Directors shall include in its study under paragraph (1) an examination of the procedures used by the instrumentalities to enforce the application of laws applicable to the legislative branch of the Federal Government and a determination as to whether to direct the instrumentality to make improvements in its regulations and procedures so as to assure that procedures as effective as the procedures set forth in sections 7 through 12 will apply. If the instrumentality has no such regulations and procedures, the Board may direct the instrumentality to adopt the requisite regulations and procedures, or, if deemed necessary, in lieu thereof may itself adopt regulations pursuant to this section or authorize use of the procedures pursuant to sections 7 through 12.

(b) CONTINUING ACTION.—On an ongoing basis the Board of Directors—

(1) shall determine which of the laws referred to in section 3(b) should apply to the legislative branch of the Federal Government and if it should, the manner in which it should be made applicable;

(2) shall study the application to the legislative branch of the Federal Government of provisions of Federal law referred to in section 3 that are enacted after the date of the enactment of this Act; and

(3) may propose regulations with respect to such application in accordance with subsection (c).

(c) REGULATIONS.—

(1) LAWS MADE APPLICABLE.—

(A) GENERAL RULE.—Not later than 180 days after the date of the completion of the study under subsection (a), the Board of Directors shall, in accordance with section 553 of title 5, United States Code, propose regulations that specify the manner in which the laws made applicable to the legislative branch of the Federal Government under section 3(a) shall apply. The Board of Directors shall provide a period of at least 30 days for comment on the proposed regulations.

(B) CONGRESSIONAL NOTICE.— In addition to publishing a general notice of proposed rulemaking under section 553(b) of title 5, United States Code, the Board of Directors shall concurrently submit such notice for publication in the Congressional Record.

(C) AMENDMENTS AND REPEALS.—When proposing regulations under subparagraph (A) specifying the manner in which a law referred to in section 3(a) shall apply to the legislative branch of the Federal Government, the Board of Directors shall recommend to the Congress changes in or repeals of existing law to accommodate the application of such law to the legislative branch of the Federal Government.

(D) FINAL REGULATIONS.—The Board of Directors shall, in accordance with such section 553, issue final regulations not later than 60 days after the end of the comment period on the proposed regulations.

(2) CONTINUING ACTION.—

(A) GENERAL RULE.—Not later than 180 days after the date of the completion of the study or a determination under subsection (b), the Board of Directors shall, in accordance with section 553 of title 5, United States Code, propose regulations that specify which of the provisions of Federal law considered in such study shall apply to the legislative branch of the Federal Government. The Board of Directors shall provide a period of at least 30 days for comment on the proposed regulations.

(B) CONGRESSIONAL NOTICE.— In addition to publishing a general notice of proposed rulemaking under section 553(b) of title 5, United States Code, the Board of Directors shall concurrently submit such notice for publication in the Congressional Record.

(C) AMENDMENTS AND REPEALS.—When proposing regulations under subparagraph (A) specifying which of the provisions of Federal law referred to in section 3(b) shall apply to the legislative branch of the Federal Government, the Board of Directors shall recommend to the Congress changes in or repeals of existing law to accommodate the application of such law to the legislative branch of the Federal Government.

(D) FINAL REGULATIONS.— The Board of Directors shall, in accordance with such section 553, issue final regulations not later than 60 days after the end of the comment period on the proposed regulations.

(3) REGULATION REQUIREMENTS.—Regulations under paragraphs (1) and (2) shall be consistent with the regulations issued by an agency of the executive branch of the Federal Government under the provision of law made applicable to the legislative branch of the Federal Government, including portions relating to remedies.

(d) TRANSMITTAL.—A final regulation issued under subsection (c) shall be transmitted to the Congress for consideration under subsection (e).

(e) TAKING EFFECT OF REGULATIONS.—

(1) GENERAL RULE.—Subject to subsection (f), a final regulation which is issued under subsection (c) shall take effect upon the expiration of 60 days from the date the final regulation is issued unless disapproved by the Congress by concurrent resolution.

(2) CONCURRENT RESOLUTION.—A concurrent resolution referred to in paragraph (1) may be introduced in the House of Representatives or the Senate within 5 days of session after the date on which the Board of Directors issues the final regulation to which the concurrent resolution applies. The matter after the resolving clause of the resolution shall be as follows: "That Congress disapproves the issuance of final regulations of the Office of Compliance as issued on ________ (the blank space being appropriately filled in).''.

(3) PROCEDURE.—A concurrent resolution referred to in paragraph (1) shall be referred to the appropriate committee of the House involved. If no concurrent resolution is reported within 15 days of session after the Board of Directors issues final regulations under subsection (c)(1)(D) or (c)(2)(D), the committee to which the concurrent resolution was referred shall be discharged from further consideration of the first such concurrent resolution introduced and the concurrent resolution shall be placed on the appropriate calendar of the House involved. Within 5 days of session after the concurrent resolution is reported or discharged, it shall be in order as a matter of highest privilege to move to proceed to its consideration and such motion shall not be debatable. The concurrent resolution shall be debatable for not to exceed 4 hours equally divided between proponents and opponents and it shall not be subject to amendment. If, prior to the adoption of a concurrent resolution by one House, that House receives a concurrent resolution of the other House with respect to the same regulations, then the procedure in that House shall be the same as if no concurrent resolution had been received from the other House, but vote on final adoption shall be on the concurrent resolution of the other House. If a concurrent resolution is received by a House in which no identical concurrent resolution has been introduced, it shall be referred to the appropriate committee and the same procedures and 20-day period for action shall apply to the consideration of the concurrent resolution by that House as would apply to an introduced concurrent resolution.

(f) RULEMAKING POWER.—The provisions of subsection (e) of this section are enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such they shall be considered as part of the rules of each House, respectively, or of that House to which they specifically apply, and such rules shall supersede other rules only to the extent that they are inconsistent therewith; and

(2) with full recognition of the constitutional right of either House to change such rules (so far as relating to such House) at any time, in the same manner, and to the same extent as in the case of any other rule of such House.

SEC. 6. OTHER FUNCTIONS.

(a) RULES OF THE OFFICE.—The executive director shall adopt rules governing the procedures of the Office, including the procedures of hearing boards, which shall be submitted for publication in the Congressional Record. The rules may be amended in the same manner. The executive director may consult with the Chairman of the Administrative Conference of the United States, the Legal Counsel of the Senate, and the General Counsel of the House of Representatives on the adoption of rules.

(b) INVESTIGATIVE AUTHORITY.—The executive director shall have authority to conduct such investigations as the executive director requires to implement sections 8 through 10 and section 12.

(c) DUTIES.—The Office shall—

(1) carry out a program of education for Members of Congress and other employing authorities of the legislative branch of the Federal Government respecting the laws made applicable to them and a program to inform individuals of their rights under laws applicable to the legislative branch of the Federal Government and under sections 7 through 12,

(2) in carrying out the program under paragraph (1), distribute the telephone number and address of the Office, procedures for action under sections 7 through 12, and any other information the executive director deems appropriate for distribution, distribute such information to Members of Congress and other employing authorities of the legislative branch of the Federal Government in a manner suitable for posting, provide such information to new employees of the legislative branch of the Federal Government, distribute such information to the residences of congressional employees, and conduct seminars and other activities designed to educate employers and employees in such information,

(3) compile and publish statistics on the use of the Office by congressional employees, including the number and type of contacts made with the Office, on the reason for such contacts, on the number of employees who initiated proceedings with the Office under sections 7 through 12 and the result of such proceedings, and on the number of employees who filed a complaint under section 10, the basis for the complaint, and the action taken on the complaint, and

(4) within 180 days of the initial appointment of the executive director and in conjunction with the Clerk of the House of Representatives and the Secretary of the Senate, develop a system for the collection of demographic data respecting the composition of the congressional employees, including race, sex, and wages, and a system for the collection of information on employment practices, including family leave and flexible work hours, in Congressional offices.

SEC. 7. PROCEDURE FOR CONSIDERATION OF ALLEGED VIOLATIONS.

The procedure for consideration of alleged violations of laws made applicable to the legislative branch of the Federal Government under this Act consists of 4 steps as follows:

(1) Step I, counseling, as set forth in section 8.

(2) Step II, mediation, as set forth in section 9.

(3) Step III, formal complaint and hearing by a hearing board, as set forth in section 10.

(4) Step IV, judicial review if a congressional employee is aggrieved by a dismissal of a claim under section 10(c), a final decision under section 10(g), or an order under section 10(h) or if a head of an employing office is aggrieved by a final decision under section 10(g) or would be subject to an order issued under section 10(h).

(5) Step V, as an alternative to steps III and IV, a civil action in a district court of the United States in accordance with section 12.

A congressional employee may elect the procedure described in paragraph (3) or (5) but not both procedures.

SEC. 8. STEP I: COUNSELING.

(a) IN GENERAL.—A congressional employee alleging a violation of a law made applicable to the legislative branch of the Federal Government under this Act may request counseling through the Office. The Office shall provide the employee with all relevant information with respect to the rights of the employee. A request for counseling shall be made not later than 180 days after the alleged violation forming the basis of the request for counseling occurred.

(b) PERIOD OF COUNSELING.—The period for counseling shall be 30 days unless the employee and the Office agree to reduce the period. The period shall begin on the date the request for counseling is received.

SEC. 9. STEP II: MEDIATION.

(a) IN GENERAL.—Not later than 15 days after the end of the counseling period under section 8, the employee who alleged a violation of a law made applicable to the legislative branch of the Federal Government under this Act may file a request for mediation with the Office. Mediation—

(1) may include the Office, the employee, the employing office, and individuals who are recommended by organizations composed primarily of individuals experienced in adjudicating or arbitrating personnel matters, and

(2) shall be a process involving meetings with the parties separately or jointly for the purpose of resolving the dispute between the employee and the employing office.

(b) MEDIATION PERIOD.—The mediation period shall be 30 days beginning on the date the request for mediation is received and may be extended for an additional 30 days at the discretion of the Office. The Office shall notify the employee and the head of the employing office when the mediation period has ended.

SEC. 10. STEP III: FORMAL COMPLAINT AND HEARING.

(a) FORMAL COMPLAINT AND REQUEST FOR HEARING.—Not later than 30 days after receipt by the congressional employee of notice from the Office of the end of the mediation period under section 9, the congressional employee may file a formal complaint with the Office against the head of the employing office involved. No complaint may be filed unless the employee has made a timely request for counseling and has completed the procedures set forth in sections 8 and 9.

(b) HEARING BOARD.—A board of 3 independent hearing officers (hereinafter in this Act referred to as a "hearing board"), who are not Members of the House of Representatives, Senators, or officers or employees of the House of Representatives or Senate, chosen by the executive director (one of whom shall be designated by the executive director as the presiding hearing officer) shall be assigned to consider each complaint filed under subsection (a). The executive director shall appoint hearing officers from candidates who are recommended by the Federal Mediation and Conciliation Service or the Administrative Conference of the United States. A hearing board shall act by majority vote.

(c) DISMISSAL OF FRIVOLOUS CLAIMS.—Prior to a hearing under subsection (d), a hearing board may dismiss any claim that it finds to be frivolous.

(d) HEARING.—A hearing shall be conducted—

(1) in closed session on the record by a hearing board; and

(2) no later than 30 days after filing of the complaint under subsection (a), except that the Office may, for good cause, extend up to an additional 60 days the time for conducting a hearing.

(e) DISCOVERY.—Reasonable prehearing discovery may be permitted at the discretion of the hearing board.

(f) SUBPOENA POWER.—

(1) IN GENERAL.—A hearing board may authorize subpoenas, which shall be issued by the presiding hearing officer on behalf of the hearing board for the attendance of witnesses at proceedings of the hearing board and for the production of correspondence, books, papers, documents, and other records. The attendance of witnesses and the production of evidence may be required from any place within the United States.

(2) FAILURE TO OBEY A SUBPOENA.—If a person refuses to obey a subpoena issued under paragraph (1), the hearing board may apply to a United States district court for an order requiring that person to appear before the hearing board to give testimony, produce evidence, or both, relating to the matter under investigation. The application may be made within the judicial district where the hearing is conducted or where that person is found, resides, or transacts business. Any failure to obey the order of the court may be punished by the court as civil contempt.

(3) SERVICE OF SUBPOENAS.—The subpoenas of the hearing board shall be served in the manner provided for subpoenas issued by a United States district court under the Federal Rules of Civil Procedure for the United States district courts.

(4) SERVICE OF PROCESS.—All process of any court to which application is to be made under paragraph (2) may be served in the judicial district in which the person required to be served resides or may be found.

(5) IMMUNITY.—The hearing board is an agency of the United States for the purpose of part V of title 18, United States Code (relating to immunity of witnesses).

(g) HEARING BOARD DECISION.—As expeditiously as possible, but in no case more than 45 days after the conclusion of the hearing, the hearing board shall make a decision in the matter for which the hearing was held. The decision of the hearing board shall be transmitted by the Office to the employee and the employing office. The decision shall state the issues raised by the complaint, describe the evidence in the record, and contain a determination as to whether a violation of a law made applicable to the legislative branch of the Federal Government under this Act has occurred. Any decision of the hearing board shall contain a written statement of the reasons for the hearing board's decision. A final decision of the hearing board shall be made available to the public by the Office.

(h) REMEDY ORDER.—If the decision of the hearing board under subsection (g) is that a violation of a law made applicable to the legislative branch of the Federal Government under this Act, it shall order the remedies under such law as made applicable to the legislative branch of the Federal Government under this Act, except that no Member of the House of Representatives, Senator, any other head of an employing office, or agent of such a Member or Senator, shall be personally liable for the payment of compensation. The hearing board shall have no authority to award punitive damages. The entry of an order under this subsection shall constitute a final decision for purposes of judicial review under section 11.

(i) FUNDS.—There shall be established in the House of Representatives and in the Senate a fund from which compensation (including attorney's fees) may be paid in accordance with an order under subsection (h) or as a result of judicial review under section 11 or a civil action under section 12. From the outset of any proceeding in which compensation may be paid from a fund of the House of Representatives, the General Counsel of the House of Representatives may provide the respondent with representation.

SEC. 11. JUDICIAL REVIEW.

(a) IN GENERAL.—

(1) TYPES OF REVIEW.—Following any hearing under section 10 on a complaint relating to a provision of law described in section 3, any congressional employee aggrieved by a dismissal of a claim under section 10(c), a final decision under section 10(g), a final order under section 10(h), or any head of an employing office aggrieved by a final decision under section 10(g) or a final order under section 10(h), may petition for review by the United States Court of Appeals for the Federal Circuit in accordance with paragraph (2).

(2) PROVISIONS APPLICABLE TO REVIEW.—The following provisions apply to a review under paragraph (1):

(A) LAW APPLICABLE.—Chapter 158 of title 28, United States Code, shall apply—

(i) with respect to section 2344 of title 28, United States Code, service of the petition shall be on the House or Senate Legal Counsel, or the appropriate entity of an instrumentality, as the case may be, rather than on the Attorney General;

(ii) the provisions of section 2348 of title 28, United States Code, on the authority of the Attorney General, shall not apply;

(iii) the petition for review shall be filed not later than 90 days after the entry in the Office of a final decision under section 10(g), an order under section 10(h); and

(iv) the Office shall be an "agency" as that term is used in chapter 158 of title 28, United States Code.

(B) STANDARD OF REVIEW.—To the extent necessary for decision and when presented, the court shall decide all relevant questions of law and interpret constitutional and statutory provisions. The court shall set aside a dismissal under section 10(c), a final decision under section 10(g), or an order under section 10(h) if it is determined that the dismissal, decision, or order was—

(i) arbitrary, capricious, an abuse of discretion, or otherwise not consistent with law;

(ii) not made consistent with required procedures; or

(iii) unsupported by substantial evidence.

(C) RECORD.—In making determinations under subparagraph (B), the court shall review the whole record, or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error. The record on review shall include the record before the hearing board, the decision of the hearing board, and the order of the hearing board.

(b) ATTORNEY'S FEES.—If a congressional employee is the prevailing party in a proceeding under this section, attorney's fees for the judicial proceeding may be allowed by the court in accordance with the standards prescribed under section 706(k) of the Civil Rights Act of 1964 (42 U.S.C. 2000e-5(k)).

SEC. 12. CIVIL ACTION.

(a) IN GENERAL.—

(1) CIVIL ACTION.—A congressional employee may within 30 days after receipt of notice from the Office of the end of the mediation period under section 9 for a violation of a law made applicable to the legislative branch of the Federal Government bring a civil action in a district court of the United States seeking relief from the alleged violation of law if such a civil action is available under such law. In any such civil action, any party may demand a jury trial.

(2) EXHAUSTION REQUIREMENT.—No civil action may be filed under paragraph (1) unless the employee has made a timely request for counseling and has completed the procedures set forth in sections 8 and 9.

(3) COURT ORDER.—If a court determines that a violation of law occurred, the court may only enter an order described in section 10(h).

(b) ATTORNEY'S FEES.—If a congressional employee is the prevailing party in a proceeding under this section, attorney's fees may be allowed by the court in accordance with any standards prescribed under Federal law for the award of such fees in the event of a violation of such provision.

SEC. 13. RESOLUTION OF COMPLAINT.

If, after a formal complaint is filed under section 10, the employee and the head of the employing office resolve the issues involved, the employee may withdraw the complaint or the parties may enter into a written agreement, subject to the approval of the executive director.

SEC. 14. PROHIBITION OF INTIMIDATION.

Any intimidation of, or reprisal against, any employee by any Member of the House of Representatives, Senator, or officer or employee of the House of Representatives or Senate, by the Architect of the Capitol or anyone employed by the Architect of the Capitol, or by an instrumentality of the legislative branch of the Federal Government because of the exercise of a right under this Act constitutes an unlawful employment practice, which may be remedied in the same manner under this Act as is a violation of a law made applicable to the legislative branch of the Federal Government under this Act.

SEC. 15. CONFIDENTIALITY.

(a) COUNSELING.—All counseling shall be strictly confidential except that the Office and the employee may agree to notify the head of the employing office of the allegations.

(b) MEDIATION.—All mediation shall be strictly confidential.

(c) HEARINGS.—Except as provided in subsections (d) and (e), the hearings and deliberations of the hearing board shall be confidential.

(d) RELEASE OF RECORDS FOR JUDICIAL ACTION.—The records of hearing boards may be made public if required for the purpose of judicial action under section 9.

(e) ACCESS BY COMMITTEES OF CONGRESS.—At the discretion of the executive director, the executive director may provide to the Committee on Standards of Official Conduct of the House of Representatives and the Select Committee on Ethics of the Senate access to the records of the hearings and decisions of the hearing boards, including all written and oral testimony in the possession of the hearing boards, concerning a decision under section 10(g). The executive director shall not provide such access until the executive director has consulted with the individual filing the complaint at issue in the hearing, and until the hearing board has issued the decision.

(f) COORDINATION.—The executive director shall coordinate the proceedings with the Committee on Standards and Official Conduct of the House of Representatives and the Select Committee on Ethics of the Senate to ensure effectiveness, to avoid duplication, and to prevent penalizing cooperation by respondents in the respective proceedings.

SEC. 16. POLITICAL AFFILIATION AND PLACE OF RESIDENCE.

(a) IN GENERAL.—It shall not be a violation of a law made applicable to the legislative branch of the Federal Government under this Act to consider the—

(1) party affiliation,

(2) domicile, or

(3) political compatibility with the employing office,

of a congressional employee with respect to employment decisions.

(b) DEFINITION.—For purposes of subsection (a), the term "employee" means—

(1) an employee on the staff of the House of Representatives or Senate leadership,

(2) an employee on the staff of a committee or subcommittee,

(3) an employee on the staff of a Member of the House of Representatives or Senate,

(4) an officer or employee of the House of Representatives or Senate elected by the House of Representatives or Senate or appointed by a Member of the House of Representatives or Senate, other than those described in paragraphs (1) through (3), or

(5) an applicant for a position that is to be occupied by an individual described in paragraphs (1) through (4).

SEC. 17. OTHER REVIEW PROHIBITED.

No congressional employee may commence a judicial proceeding to redress practices prohibited under section 5, except as provided in this Act.

SEC. 18. STUDY.

(a) STUDY.—The Office shall conduct a study—

(1) of the ways that access by the public to information held by the Congress may be improved, streamlined, and made consistent between the House of Representatives and the Senate and of the application of section 552 of title 5, United States Code to the legislative branch of the Federal Government; and

(2) of the application of the requirement of section 552a of title 5, United States Code, to the legislative branch of the Federal Government.

(b) STUDY CONTENT.—The study conducted under subsection (a) shall examine—

(1) information that is currently made available under such section 552 by Federal agencies and not by the legislative branch of the Federal Government;

(2) information held by the non-legislative offices of the legislative branch of the Federal Government, including—

(A) the instrumentalities,

(B) the Architect of the Capitol,

(C) the Director of Non-Legislative and Financial Services of the House of Representatives,

(D) the Clerk of the House of Representatives,

(E) the Secretary of the Senate,

(F) the Inspector General of the House of Representatives,

(G) the Sergeant at Arms of the House of Representatives and the Sergeant at Arms of the Senate,

(H) the Doorkeeper of the House of Representatives,

(I) the United States Capitol Police, and

(J) the House Commission on Congressional Mailing Standards;

(3) financial expenditure information of the legislative branch of the Federal Government; and

(4) provisions for judicial review of denial of access to information held by the legislative branch of the Federal Government.

(c) TIME.—The Office shall conduct the study prescribed by subsection (a) and report the results of the study to the Congress not later than one year after the date of the initial appointment of the Board of Directors.

The CHAIRMAN. No amendment to the substitute shall be in order except the amendments printed in part 2 of the report. Each amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall not be subject to amendment except as specified in the report, and shall not be subject to a demand for a division of the question.

Debate time on each amendment will be equally divided and controlled by the proponent and an opponent of the amendment.

It is now in order to consider amendment No. 1 printed in part 2 of House Report 103–691.

AMENDMENT OFFERED BY MR. ROSE

Mr. ROSE. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment offered by Mr. ROSE: Page 21, insert after line 24 the following:

(d) REPORT.—Within one year of the date the system referred to in subsection (c)(4) is developed and annually thereafter, the Board of Directors shall submit to Congress a report on the information collected under such system. Each report after the first report shall contain a comparison and evaluation of data contained in the previous report.

The CHAIRMAN. Pursuant to the rule, the gentleman from North Carolina [Mr. ROSE] will be recognized for 5 minutes, and a Member opposed will be recognized for 5 minutes.

The Chair recognizes the gentleman from North Carolina [Mr. ROSE].

Mr. ROSE. Mr. Chairman, my amendment is a simple amendment to section 6 of the bill. It was not the amendment offered in my absence in the full committee markup, I would say to my colleague from California, Mr. THOMAS. This amendment does nothing more than require annual reporting to the Congress of the information required to be gathered under section 6 of the bill.

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The committee supported the information-gathering provisions in section 6 of the bill. My amendment simply requires that this information be transmitted to the Congress. I believe this should help us in the conduct of our oversight responsibilities.

Mr. THOMAS of California. Mr. Chairman, will the gentleman yield?

Mr. ROSE. I yield to the gentleman from California.

Mr. THOMAS of California. Mr. Chairman, having looked at this amendment, the chairman is correct. This is not the amendment that was presented in the Committee on House Administration, and we have no objection to this amendment.

Mr. BEILENSON. Mr. Chairman, will the gentleman yield?

Mr. ROSE. I yield to the gentleman from California.

Mr. BEILENSON. Mr. Chairman, the Committee on Rules members also say to the distinguished chairman that we have looked at the amendment of the gentleman and are supportive of it.

The CHAIRMAN. The question is on the amendment offered by the gentleman from North Carolina [Mr. ROSE].

The amendment was agreed to.

The CHAIRMAN. It is now in order to consider amendment No. 2 printed in part 2 of House Report 103–691.

AMENDMENT OFFERED BY MR. KLINK

Mr. KLINK. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 5, lines 8, 13, 18, and 24, strike "1 year" and insert in lieu thereof "120 days".

Page 6, lines 5 and 22, strike "1 year" and insert in lieu thereof "120 days".

Page 7, lines 5 and 10, strike "1 year" and insert in lieu thereof "120 days".

The CHAIRMAN. Pursuant to the rule, the gentleman from Pennsylvania [Mr. KLINK] will be recognized for 5 minutes, and a Member opposed will be recognized for 5 minutes.

The Chair recognizes the gentleman from Pennsylvania [Mr. KLINK].

Mr. KLINK. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the amendment I offer today to the Congressional Accountability Act changes the timeframe under which the Congress will comply with certain labor and civil rights laws listed in H.R. 4822 from 1 year to 120 days.

According to section 5 of the bill, the newly designed Office of Compliance will conduct a study of the manner in which the laws made applicable to the legislative branch should apply.

Once this bill is enacted, there will be a 120-day timeframe for the Board of

Directors of the Office of Compliance to be appointed. The Board then has to appoint an Executive Director. The Board has another 180 days to review and study the laws that Congress has already seen fit to impose on the private sector. At the end of this review period—we are close to a year gone by already—the Board will promulgate regulations for our future compliance. These regulations must be printed in the Congressional Record and there is a 30-day comment period. Final regulations will be issued no later than 60 days after the comment period ends. And finally—yes, ladies and gentlemen, finally 60 days from the date the final regulations are issued, we have to abide by the laws in this bill.

I would like to note at this point that comments have already been received collectively over the past 25 years on all of these laws. If employers an employees in the private sector do not have the privilege of revising the guidelines set forth in the Fair Labor Standards Act, the Family and Medical Leave Act, and all the laws we are discussing here today, why is Congress being given 450 days—the equivalent of 1 year and 3 months—to review and comment on laws that we have already seen fit to pass for our constituents?

It is my understanding that during the markup of H.R. 4822 at the House Administration Committee, Mr. Boehner, successfully offered an amendment to make Members of Congress comply with the laws contained in this bill no later than 1 year after enactment of this legislation, even if the Office of Compliance has not issued specific regulations on each law. I applaud the gentleman from Ohio and the House Administration Committee for acknowledging that there was a flaw in this provision of the bill and adopting the 1 year timeframe. However, much can happen in 1 year. It is possible—perhaps not probable, but possible—that an applicant for a position at the Library of Congress could be rejected based on his or her race or gender. It is possible that in 1 year—not probable, but possible—that the House could amend certain labor laws to explicitly exempt us from compliance or enforcement, just because we cannot figure out just how to apply these laws for our employees. You get the picture. A lot can happen in 1 year.

My amendment changes the date of Congress' mandatory compliance with the Fair Labor Standards Act, the Americans With Disabilities Act, the Age Discrimination in Employment Act, the Family and Medical Leave Act, the Employee Polygraph Protection Act, the Rehabilitation Act, and title VII of the Civil Rights Act to 120 days after enactment of H.R. 4822. That would bring those of us voting on this law—assuming it passes in the Senate relatively quickly—into compliance before the end of this calendar year, before the end of our elected term of office. Each of us here today would very quickly be responsible for the vote we each make today.

I believe H.R. 4822 is a fine piece of legislation. It was crafted over 1½ a year and had the input of dozens of reform-minded Members. It is my belief, however, that we can perfect this legislation and make certain that Congress comes into complete compliance with labor laws, in exactly the same way our constituents in the private sector must comply.

My amendment would assure that congressional compliance does not get lost in a quagmire while the Board of Directors of the Office of Compliance are studying laws that we have already approved and drafting regulations and receiving comment on them.

My amendment would almost immediately restore integrity to and public faith in the Congress.

My amendment would perfect an imperfection in this fine piece of legislation.

I urge your support.

Mr. BOEHNER. Mr. Chairman, will the gentleman yield?

Mr. KLINK. I yield to the gentleman from Ohio.

Mr. BOEHNER. Mr. Chairman, I rise to support the gentleman from Pennsylvania in his amendment.

The point I would like to make is this. We pass a lot of these labor laws and before there is time for the Departments to actually issue the regulations explaining to the private sector how they must comply, the law is already in effect in the private sector. So if we truly want to mirror what is going on in the private sector, we ought to adopt the amendment of the gentleman from Pennsylvania. It will put the regulations on top of this institution in 120 days after the Board is set up, even though the regulations may not in fact be issued. We should understand clearly what those in the private sector that we deal with day in and day out have to deal with when they have got a law in front of them and yet have no regulations so that they understand how to comply.

I congratulate the gentleman from Pennsylvania and urge the adoption of his amendment.

Mr. KLINK. Mr. Chairman, I thank my colleague from Ohio for his work in the committee and for his fine comments on this amendment.

The CHAIRMAN. Is the gentleman from North Carolina [Mr. Rose] opposed to the amendment?

Mr. ROSE. Mr. Chairman, I rise in rather gentle opposition to the amendment.

The CHAIRMAN. The gentleman from North Carolina [Mr. Rose] is recognized for 5 minutes.

Mr. ROSE. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise in opposition to the amendment, only to point out that the gentleman from Pennsylvania has stated that he wants this legislation in force 120 days after the bill is passed. Even his friendly speaker, the gentleman from Ohio [Mr. Boehner], observed it would be 120 days after the Board is set up. That may be much longer than 120 days.

We wrestled with this at great length in the committee. I personally believe, and I think the majority of the committee believe, that we should get it passed, get the Board set up as quickly as possible, and then urge the Board to very, very quickly put all the laws into place.

Mr. THOMAS of California. Mr. Chairman, will the gentleman yield?

Mr. ROSE. I yield to the gentleman from California.

Mr. THOMAS of California. Mr. Chairman, I thank the gentleman for yielding to me.

The chairman rises with some reluctance, as do I. The bill states that the members of the Board of Directors, in their selection process, shall be completed not later than 120 days after the date of the enactment of this act. So it means that at the same time the Board is completing its membership, these decisions will have had to have been made. It simply is not real world.

I understand the point of the gentleman from Pennsylvania, because oftentimes the laws that are passed are not real world.

If this amendment passes, it will, in fact, choke this bill. I am highly desirous of chocking certain things, but not this bill. What I want this bill to do is to chafe so that we begin to examine the ridiculous things we do as exemplified from the gentleman from Pennsylvania's amendment, so that we will not do it anymore, and we will review the various areas and change them.

So I am in reluctant opposition because he has clearly pointed out, very graphically, joined by the gentleman from Ohio, that what we do to the private sector, we ought to do it to ourselves. If we do, we cannot get the chafing effect involved which will bring about real change and, therefore, I reluctantly oppose the gentleman's amendment.

Mr. ROSE. Mr. Chairman, the heart and head of the gentleman from Pennsylvania are clearly in the right place on this amendment. I compliment him for his initiative. I, too, reluctantly ask that we not adopt the amendment at this time. In conference, I would certainly be willing to work with my colleagues, the gentleman from California [Mr. Thomas], and I, in conference to see if we could speed this up in some way, more in line with the thinking of the gentleman from Pennsylvania [Mr. Klink].

However, Mr. Chairman, reluctantly, I believe we should not adopt this amendment.

□ 1620

The CHAIRMAN. The question is on the amendment offered by the gentleman from Pennsylvania [Mr. KLINK].

The amendment was rejected.

The CHAIRMAN. It is now in order to consider amendment No. 3 printed in part 2 of House Report 103-691.

AMENDMENT OFFERED BY MRS. BYRNE

Mrs. BYRNE. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment Offered by Mrs. BYRNE: Page 7, line 25, insert before the period the following: "or, to the extent that it relates to any standard benefits package approved as part of the national health care reform enacted by Congress in the 103d Congress, apply to Members of Congress, as defined in section 2106 of title 5, United States Code, in accordance with this Act".

Mrs. BYRNE. Mr. Chairman, as we speak on the floor today about congressional accountability, we take an important step toward forcing Congress to live under the same laws it passes for others.

My amendment addresses one area that remains untouched in this bill—health care. The amendment is quite simple: it requires Congress to live under any health care reform bill we pass. As we embark on health care reform, it is neither wise nor prudent for Congress once again to excuse itself from a system it requires the rest of Americans to live with. The adoption of this amendment, lets us state upfront to our constituents that we are truly in this together.

From the onset of the debate over health care reform, we have heard from thousands of our constituents and read countless newspaper editorials that rightly charge Congress with being out of touch with the issues involved with health care reform. These charges stem from the perception that Members of Congress are sheltered from the current system because of the high quality of care and guaranteed benefits they receive.

When it comes time to debate health care reform, we have a choice: either keep the status quo for ourselves, regardless of what the public will have; or give Congress and the American people the exact same benefits. Providing the Nation's political leaders the same benefits will let them serve as canaries in the coal mine, experiencing the problems of shortfall in the benefits package first hand so that they will quickly address them.

It just makes sense to include this language in the Congressional Accountability Act, which is a long-overdue effort to ensure that Congress lives by the laws it passes. Today, we have a historic opportunity to finally apply laws, some over half a century old, to the legislative branch. However, our actions today will be even more historic if we stop being merely reactive, but begin to act proactively.

I would like to point out, Mr. Chairman, that the House has already shown widespread support to ensure that Members of Congress are not sheltered from the effects of health care reform. In fact, nearly 200 Members have signed onto various resolutions calling for a health care bill that covers Congress in the same manner that the private sector is covered.

If we do not apply to Congress one of the most important pieces of legislation it has addressed in decades, I am afraid that we will fall short of what we set out to accomplish with the Congressional Accountability Act. More important, it will make passage of any health care reform bill a hollow effort, since we will not be a part of it. The result will be a plan which lacks credibility, and a Congress which lacks accountability.

Let us make it clear to the American people before the debate gets underway that Members of Congress are ready, willing, and able to abide by the benefits package established under health care reform. I want to be able to tell my constituents in northern Virginia that when health care reform takes place, it will affect me the same way it affects them. The Byrne amendment will make that possible.

Mr. Chairman, I urge my colleagues to support the Byrne amendment.

Mr. Chairman, I reserve the balance of my time.

The CHAIRMAN. Does any Member rise in opposition to the amendment?

Mr. ROSE. Mr. Chairman, by default, I rise in opposition to the amendment.

The CHAIRMAN. The gentleman is recognized for 5 minutes.

Mr. ROSE. Mr. Chairman, I yield 2 minutes to the gentleman from Missouri [Mr. CLAY].

Mr. CLAY. Mr. Chairman, I thank the gentleman for yielding time to me.

Let me say, Mr. Chairman, that this amendment in itself is divisive. There is absolutely no need for us to even consider the amendment. Next week we are going to be considering national health care. Our committee, the Committee on Post Office and Civil Service, has reported out a piece of legislation that took us hours and hours of meetings with the Committee on Ways and Means, with the leadership, with the Committee on Energy and Commerce, with the Committee on Education and Labor, to construct.

In that piece of legislation that we constructed, which was comprehensive, it sets up a procedure for American citizens to join into the Federal Employees Health Benefit package. People who work for employers of 100 or less, those who work part-time, and other kinds of employees will be eligible to join the Federal employees plan, the same plan that Members of Congress are under now.

Mr. Chairman, I see no legislative reason whatsoever for considering or passing this amendment. There may be a political reason, I am not sure. In essence, what this is doing, Mr. Chairman, this amendment would override the jurisdiction of our committee. We have been working on this issue for many, many weeks. The gentlewoman who was offering the amendment is a member of the committee. She was there when we voted for the construct that has been accepted by the Democratic leadership, and is part of the overall health care plan. She supported it. If she wanted to offer this amendment, she should have offered it in committee and we would have had time to reasonably discuss it.

However, Mr. Chairman, to come forth without any hearings on it or whatever, without any knowledge of what damage it may or may not do to the total package of health insurance, health care, in my opinion, Mr. Chairman, is not worthy of our considering favorably on this floor.

Mrs. BYRNE. Mr. Chairman, I yield 1 minute to the gentleman from New Hampshire [Mr. SWETT].

Mr. SWETT. Mr. Chairman, I rise to state that I was, and rightfully so, a cosponsor of the amendment that the gentlewoman from Virginia [Mrs. BYRNE] had offered prior to putting together this amendment, and it is my hope and expectation, Mr. Chairman, that as we in the Congress become more accountable to the laws and regulations that we put on the rest of the country, that we might also make sure that there is a consistency between the Congress and the rest of the country with regard to health care.

It is my concern that we not go through the process in an inappropriate fashion, Mr. Chairman, in a fashion that is contrary to the rules and regulations established in the House. If there are inconsistencies in this language with that process, I hope that they will be resolved in the conference committee report. It is philosophically something that I can agree with, and I will support this amendment.

Mr. ROSE. Mr. Chairman, I yield 1 minute and 30 seconds to the gentleman from California [Mr. THOMAS].

Mr. THOMAS of California. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I have a statement to make, and then I have a series of questions to ask the gentlewoman from Virginia, because as the ranking Member of the Subcommittee on Health of the Committee on Ways and Means, we have been spending some time on the health care question, both in the subcommittee and in the full committee.

Mr. Chairman, currently the split on the Federal Employees Health Benefits package and the Federal Government share is roughly a 75-25 split. That is, the individuals and Members of Congress pay 25 percent of the health care costs. In the bill offered by the gentleman from Missouri [Mr. GEPHARDT], if it in fact reflects the Committee on Ways and Means structure, it is a 20–80 split. That is, individuals have to only pay 20 percent, so if in fact we conform to what goes on out there, that is a 5 percent break for Members of Congress and Federal employees. More importantly, it goes to the language of the amendment.

Mr. Chairman, I do not know whether the gentlewoman from Virginia understands that the term "standard benefits package" refers to a very specific set of benefits, as opposed to a high deductible policy, as opposed to a Medisave concept, which is contained in the Committee on Ways and Means provision.

The question I would ask of the gentlewoman from Virginia [Mrs. BYRNE] is in the reference to "standard benefits package," does she mean by that that the Members of Congress would be offered only the standard benefits package, as understood in the health care area, in the way in which it is defined in the legislation, or does she mean a standard benefits package to include all of the permutations that may be offered in the area of general health packages, including a high deductible policy, a Medisave concept, a catastrophic concept, or the myriad of policies that are offered?

□ 1630

Mrs. BYRNE. Mr. Chairman, will the gentleman yield?

Mr. THOMAS of California. I yield to the gentlewoman from Virginia.

Mrs. BYRNE. I would say the gentleman that the standard benefits package that is referred to in the amendment is whatever we come out with in this body. If we say that women over 65 can only have one mammogram a year, then Members of Congress who are 65 years old and female cannot have more than one. It is a very simple concept when boiled down to its essence, which is why should we be able to have a better benefits package than we are willing to enforce on the American people? I would also say to the gentleman that it has nothing to do with deductibility or anything else. It talks about the benefits package that is available to citizens through health care reform and that is what we are addressing in this amendment. Not the split, not anything else. If private employers can offer other packages, then we will be able to offer other packages, too. If they want to have a maintenance of effort, we will be able to offer a maintenance of effort, also. If the package says that we can have an 80–20 or a 75–25, it does not have anything to do with the benefits, which is clear in the language of this amendment, that is offered to the American people.

The CHAIRMAN. The gentlewoman from Virginia [Mrs. BYRNE] has 15 seconds remaining to close her portion of debate.

Mrs. BYRNE. Mr. Chairman, I yield myself the balance of my time.

In closing, Mr. Chairman, it seems to me that the concept here is one that fits perfectly with this bill. In congressional accountability, we are going to be talking in the next few weeks about the most important issue of the decade, which is how we deal with health care in this country, the benefit packages that people are going to be offered, and it makes sense that we offer those same benefit packages to Congress, no better, no worse, so we know what is going on with the health care system of the United States.

Mr. ROSE. Mr. Chairman, I yield myself 15 seconds.

Mr. THOMAS of California. Mr. Chairman, will the gentleman yield?

Mr. ROSE. I yield to the gentleman from California.

Mr. THOMAS of California. Mr. Chairman, in the bill, we have the Fair Labor Standards Act, very specific; title VII of the Civil Rights Act, very specific; Americans With Disabilities Act, very specific; Age Discrimination in Employment Act, very specific.

What we have here is the phrase "standard benefits package." The gentlewoman from Virginia has described a number of options that may or may not be available under a number of standards. It seems to me if we are going to do this, we should be precise in what we do. I have to tell Members that standard benefits package means standard benefits package. It does not mean the Medisave concept, it does not mean the high deductible. It means Members of Congress will be getting less than whatever everyone else gets because of this language.

Mr. ROSE. Mr. Chairman, I yield my remaining time to the gentleman from Indiana [Mr. McCLOSKEY] to close the debate.

The CHAIRMAN. The gentleman from Indiana [Mr. McCLOSKEY] is recognized for 30 seconds.

Mr. McCLOSKEY. Mr. Chairman, very briefly, and this has been discussed extensively, but this is not in essence a small "d" democratic package. It is a package really to diminish the status of elected officials in relation to all other people similarly situated. That includes staff, people in the Pentagon, Soil and Water Conservation Service, people working for IBM, et al. Why do we have to diminish ourselves to the point where we say we cannot have equal rights with the mailman? Let us be able to be in there with all our Federal employees and bring those who want into the Federal system.

The CHAIRMAN. The question is on the amendment offered by the gentlewoman from Virginia [Mrs. BYRNE].

The question was taken; and the Chairman announced that the noes appeared to have it.

Mrs. BYRNE. Mr. Chairman, I demand a recorded vote, and pending that, I make the point of order that a quorum is not present.

The CHAIRMAN. Evidently a quorum is not present. Pursuant to the provisions of clause 2, rule XXIII, the Chair announces that he will reduce to a minimum of 5 minutes the period of time within which a vote by electronic device, if ordered, will be taken on the pending question following the quorum call. Members will record their presence by electronic device.

The call was taken by electronic device.

The following Members responded to their names.

[Roll No. 387]

ANSWERED "PRESENT"—428

Abercrombie
Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Archer
Armey
Bacchus (FL)
Bachus (AL)
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barca
Barcia
Barlow
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bateman
Becerra
Beilenson
Bentley
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Blackwell
Bliley
Blute
Boehlert
Boehner
Bonilla
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Bunning
Burton
Buyer
Byrne
Callahan
Calvert
Camp
Canady
Cantwell
Cardin
Carr
Castle
Chapman
Clay
Clayton
Clement
Clinger
Clyburn
Coble
Coleman
Collins (GA)
Collins (IL)
Collins (MI)
Combest
Condit
Conyers
Cooper
Coppersmith
Costello
Cox
Coyne
Cramer
Crane
Crapo
Cunningham
Danner
Darden
de la Garza
de Lugo (VI)
Deal
DeFazio
DeLauro
DeLay
Dellums
Derrick
Deutsch
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Dooley
Doolittle
Dornan
Dreier
Duncan
Dunn
Durbin
Edwards (CA)
Edwards (TX)
Ehlers
Emerson
Engel
English
Eshoo
Evans
Everett
Ewing
Faleomavaega (AS)
Farr
Fawell
Fazio
Fields (LA)
Fields (TX)
Filner
Fingerhut
Fish
Flake
Foglietta
Ford (MI)
Ford (TN)
Fowler
Franks (CT)
Franks (NJ)
Furse
Gallegly
Gallo
Gejdenson
Gekas
Gephardt
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Glickman
Gonzalez
Goodlatte
Goodling
Gordon
Goss
Grams
Grandy
Green
Greenwood
Gunderson
Gutierrez
Hall (OH)
Hall (TX)
Hamburg
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings
Hayes
Hefley
Hefner
Hilliard
Hinchey
Hoagland
Hobson
Hochbrueckner
Hoekstra
Hoke
Holden
Horn
Houghton
Hoyer
Huffington
Hughes
Hunter
Hutchinson
Hutto
Hyde
Inglis
Inhofe
Inslee
Istook
Jacobs
Jefferson
Johnson (CT)
Johnson (GA)
Johnson (SD)
Johnson, E.B.
Johnson, Sam
Johnston
Kanjorski
Kaptur
Kasich
Kennedy
Kennelly
Kildee
Kim
King
Kingston
Kleczka

Klein
Klink
Klug
Knollenberg
Kolbe
Kopetski
Kreidler
Kyl
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lazio
Leach
Lehman
Levin
Levy
Lewis (CA)
Lewis (FL)
Lewis (GA)
Lewis (KY)
Lightfoot
Linder
Lipinski
Livingston
Lloyd
Long
Lowey
Lucas
Machtley
Maloney
Mann
Manton
Manzullo
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCandless
McCloskey
McCollum
McCrery
McCurdy
McDade
McDermott
McHale
McHugh
McInnis
McKeon
McKinney
McMillan
McNulty
Meehan
Meek
Menendez
Meyers
Mfume
Mica
Michel
Miller (CA)
Miller (FL)
Mineta
Minge
Mink
Moakley
Mollohan
Montgomery
Moorhead
Morella
Murphy
Murtha
Myers
Nadler
Neal (MA)
Neal (NC)
Norton (DC)
Nussle
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Oxley
Packard
Pallone
Parker
Pastor
Paxon
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pickle
Pombo
Pomeroy
Porter
Portman
Poshard
Price (NC)
Pryce (OH)
Quillen
Quinn
Rahall
Ramstad
Rangel
Ravenel
Reed
Regula
Reynolds
Richardson
Ridge
Roberts
Roemer
Rogers
Rohrabacher
Romero-Barcelo (PR)
Ros-Lehtinen
Rose
Rostenkowski
Roth
Roukema
Rowland
Roybal-Allard
Royce
Rush
Sabo
Sanders
Sangmeister
Santorum
Sarpalius
Sawyer
Saxton
Schaefer
Schenk
Schiff
Schroeder
Schumer
Scott
Sensenbrenner
Serrano
Sharp
Shaw
Shays
Shepherd
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slattery
Slaughter
Smith (IA)
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Snowe
Solomon
Spence
Spratt
Stenholm
Stokes
Strickland
Studds
Stump
Stupak
Sundquist
Swett
Swift
Synar
Talent
Tanner
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thomas (CA)
Thomas (WY)
Thompson
Thornton
Thurman
Torkildsen
Torres
Torricelli
Towns
Traficant
Tucker
Underwood (GU)
Unsoeld
Upton
Velazquez
Vento
Visclosky
Volkmer
Vucanovich
Walker
Walsh
Waters
Watt
Waxman
Weldon
Wheat
Whitten
Wilson
Wise
Wolf
Woolsey
Wyden
Wynn
Yates
Young (AK)
Young (FL)
Zeliff
Zimmer

☐ 1655

The CHAIRMAN. Four hundred twenty-eight Members have answered to their names, a quorum is present, and the Committee will resume its business.

RECORDED VOTE

The CHAIRMAN. The pending business is the demand of the gentlewoman from Virginia [Mrs. BYRNE] for a recorded vote.

A recorded vote was ordered.

The CHAIRMAN. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 374, noes 57, answered "present" 3, not voting 5, as follows:

[Roll No. 388]

AYES—374

Allard
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Archer
Armey
Bacchus (FL)
Bachus (AL)
Baesler
Baker (CA)
Ballenger
Barca
Barcia
Barlow
Barrett (NE)
Barrett (WI)
Bartlett
Becerra
Beilenson
Bentley
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Blackwell
Blute
Boehlert
Boehner
Bonilla
Bonior
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (OH)
Bryant
Bunning
Burton
Buyer
Byrne
Callahan
Calvert
Camp
Canady
Cantwell
Cardin
Carr
Castle
Chapman
Clement
Clinger
Clyburn
Coble
Coleman
Collins (GA)
Combest
Condit
Conyers
Cooper
Coppersmith
Costello
Cox
Coyne
Cramer
Crapo
Cunningham
Danner
Darden
de la Garza
Deal
DeFazio
DeLauro
Dellums
Derrick
Deutsch
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Dooley
Doolittle
Dornan
Dreier
Duncan
Dunn
Durbin
Edwards (TX)
Ehlers
Emerson
Engel
English
Eshoo
Evans
Everett
Ewing
Faleomavaega (AS)
Farr
Fawell
Fazio
Fields (LA)
Fields (TX)
Filner
Fingerhut
Fish
Foglietta
Ford (TN)
Frank (MA)
Franks (CT)
Franks (NJ)
Frost
Furse
Gallegly
Gallo
Gejdenson
Gekas
Gephardt
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Glickman
Goodlatte
Goodling
Gordon
Goss
Grams
Green
Greenwood
Gunderson
Gutierrez
Hall (OH)
Hall (TX)
Hamburg
Hamilton
Hancock
Harman
Hastert
Hayes
Hefley
Hefner
Hilliard
Hinchey
Hoagland
Hobson
Hochbrueckner
Hoekstra
Hoke
Holden
Horn
Hoyer
Huffington
Hughes
Hunter
Hutchinson
Hutto
Inglis
Inhofe
Inslee
Istook
Jacobs
Jefferson
Johnson (CT)
Johnson (GA)
Johnson (SD)
Johnson, E.B.
Johnson, Sam
Johnston
Kanjorski
Kasich
Kennedy
Kennelly
Kildee
Kim
Kingston
Kleczka
Klein
Klug
Knollenberg
Kolbe
Kopetski
Kreidler
Kyl
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lazio
Leach
Lehman
Levin
Levy
Lewis (GA)
Lewis (KY)
Lightfoot
Linder
Lipinski
Livingston
Lloyd
Long
Lowey
Lucas
Machtley
Maloney
Mann
Manzullo
Margolies-Mezvinsky
Markey
Matsui
Mazzoli
McCrery
McCurdy
McDermott
McHale
McHugh
McInnis
McKeon
McKinney
McNulty
Meehan
Menendez
Meyers
Mfume
Mica
Miller (CA)
Miller (FL)
Mineta
Minge
Moakley
Mollohan
Montgomery
Moorhead
Moran
Morella
Murphy
Myers
Nadler
Neal (MA)
Neal (NC)
Nussle
Oberstar
Olver
Ortiz
Orton
Owens
Pallone
Parker
Pastor
Paxon
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pickle
Pombo
Pomeroy
Porter
Portman
Poshard
Price (NC)
Pryce (OH)
Quillen
Quinn
Rahall
Ramstad
Rangel
Ravenel
Reed
Regula
Reynolds
Richardson
Ridge
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Rowland
Royce
Rush
Sabo
Sanders
Sangmeister
Santorum
Sarpalius
Sawyer
Saxton
Schaefer
Schenk
Schiff
Schroeder
Schumer
Scott
Sensenbrenner
Sharp
Shaw
Shays
Shepherd
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slattery
Slaughter
Smith (IA)
Smith (MI)
Smith (NJ)
Smith (TX)
Snowe
Solomon
Spence
Spratt
Stark
Stearns
Stenholm
Stokes
Strickland
Studds
Stump
Stupak
Sundquist
Swett
Synar
Talent
Tanner
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thomas (WY)
Thompson
Thornton
Thurman
Torkildsen
Torres
Torricelli
Towns
Traficant
Unsoeld
Upton
Velazquez
Vento
Visclosky
Volkmer
Vucanovich
Walker
Walsh
Waters
Weldon
Wheat
Whitten
Williams
Wilson
Wise
Wolf
Woolsey
Wyden
Wynn
Zeliff
Zimmer

NOES—57

Abercrombie
Ackerman
Baker (LA)
Barton
Bateman
Bliley
Borski
Clay
Clayton
Collins (IL)
Collins (MI)
Crane
de Lugo (VI)
DeLay
Edwards (CA)
Flake
Ford (MI)
Fowler
Gingrich
Gonzalez
Grandy
Hansen
Hastings
Houghton
Hyde
King
Klink
Lewis (CA)
Lewis (FL)
Manton
Martinez
McCandless
McCloskey
McCollum
McDade
McMillan
Meek
Michel
Mink
Murtha
Oxley
Packard
Romero-Barcelo (PR)
Rose
Rostenkowski
Roybal-Allard
Serrano
Smith (OR)
Swift
Thomas (CA)
Tucker
Underwood (GU)
Watt
Waxman
Yates
Young (AK)
Young (FL)

ANSWERED "PRESENT"—3

Brown (FL)
Kaptur
Norton (DC)

NOT VOTING—5

Herger
Molinari
Obey
Valentine
Washington

☐ 1704

Mr. ROSE and Mr. SWIFT changed their vote from "aye" to "no."

Mr. MCDERMOTT changed his vote from "no" to "aye."

Ms. NORTON changed her vote from "no" to "present."

So the amendment was agreed to.

The result of the vote was announced as above recorded.

The CHAIRMAN. It is now in order to consider amendment No. 4, printed in part 2 of House Report 103–691.

AMENDMENT OFFERED BY MR. BEILENSON

Mr. BEILENSON. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment offered by Mr. BEILENSON: Page 8, strike out line 22 and all that follows through line 7 on page 9 and insert the following:

(2) EXECUTIVE DIRECTOR.—

(A) IN GENERAL.—The Chairperson of the Board of Directors shall appoint, may establish the compensation of, and may terminate, subject to the approval of the Board of Directors, an Executive Director (referred to in this Act as the "executive director"). The compensation of the executive director may not exceed the compensation for level V of the Executive Schedule under section 5316 of title 5, United States Code. The executive director shall be an individual with training or expertise in the application of the laws referred to in section 3 to employment. The appointment of the first executive director shall be completed no later than 120 days after the initial appointment of the Board of Directors.

(B) OFFICE.—The executive director may not be an individual who holds or may have held the position of Member of the House of Representatives or Senator. The executive director may not be an individual who holds the position of employee of the House of Representatives or the Senate but the executive director may be an individual who held such a position at least 4 years before appointment as executive director.

Page 9, strike lines 9 through 14, in line 15 on page 9 strike "(2)" and insert "(1)", and redesignate paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

Page 9, strike line 24 and all that follows through line 4 on page 10 and insert the following:

(B) OFFICE.—No member of the Board of Directors appointed under subsection (b)(1) may hold or may have held the position of Member of the House of Representatives or Senator, may hold the position of employee of the House of Representatives or Senate, or may have held such a position within 4 years of the date of appointment.

Page 12, strike line 22 and insert "the first executive director".

The CHAIRMAN. Pursuant to the rule, the gentleman from California [Mr. BEILENSON] will be recognized for 5 minutes, and a Member opposed will be recognized for 5 minutes.

The Chair recognizes the gentleman from California [Mr. BEILENSON].

Mr. BEILENSON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the amendment I am offering would make several changes in the qualifications of the Board of Directors and the Executive Director of the Office of Compliance, and in the timing of the implementation of the bill's provisions. These changes are needed and intended to establish a more sensible and practicable process for achieving the bill's objectives and we believe they will strengthen the bill and make it work better.

These proposed changes developed from discussion about this legislation which followed the 5 days of hearing that the Subcommittee on Rules of the House held on H.R. 3801, the recommendations of the Joint Committee on the Organization of Congress. Our subcommittee's 5 days of hearings on that bill included testimony from many Members of the House and public witnesses specifically on the portion of H.R. 3801 dealing with the application of laws to Congress.

First, the amendment removes the requirement that the eight members of the Board of Directors have expertise or training in the laws to be applied to Congress, as well as in congressional employment. This requirement would severely limit the pool of potential Board members from which the House and Senate leadership will have to choose.

We hope and we expect that the leadership will appoint individuals to the Board who are knowledgeable about the applicable laws and about congressional employment, but if they are unable to consider appointing anyone who does not have true expertise in these areas, their task will be next to impossible, and the result might well be a major delay in the whole process of applying laws that this bill sets up.

The amendment also eliminates the prohibition on Board service by all former House or Senate employees, substituting, instead, a prohibition on individuals who have been congressional employees during the 4 years previous to their appointment. It maintains the bill's prohibition on service by current and former House and Senate Members, current congressional employees, and lobbyists.

This change, too, is intended to broaden the pool of potential candidates for the Board. Our concern is that, if every person who has ever served as a staff member of the House or Senate at any point in his or her life is ineligible to serve on the Board, a great many knowledgeable, capable individuals will automatically be disqualified.

Second, the amendment establishes qualifications for the Executive Director of the Office of Compliance—a subject the bill as reported is silent on. As this legislation has developed, it has become evident that the Executive Director is going to play a more fundamental and important role in applying laws to Congress than perhaps was originally envisioned, so we ought to provide some guidance on the kind of person who should be chosen for this role.

The amendment requires the Executive Director to have expertise or training in the application of laws to be applied to Congress. Because it is the Executive Director, rather than the Board, who will have principal authority and responsibility for determining how laws will be applied to Congress and for the day-to-day operations of the Office of Compliance, it makes more sense for that individual, rather than for the Board members, to be required to have such expertise or training.

Third, the amendment requires that the Board hire an Executive Director within 120 days after the Board itself is chosen. It then requires the study of the manner in which laws are to be applied to Congress to be completed 180 days after the Executive Director is hired.

□ 1710

The bill, as reported, lacks a time frame for hiring the first Executive Director and requires the Board to complete the study 6 months after initial Board members are appointed. This amendment will give the Board 4 months to hire an Executive Director before the 6-month period for conducting the study begins.

We would note that since the bill gives the Executive Director the authority to hire other staff for the Office of Compliance, the Board will not even be able to hire clerical help until the Executive Director is chosen. Practically speaking, the work required of the Board will not be able to get under way until the Executive Director is chosen, so it makes sense to build time into this process for that step.

Mr. Chairman, we believe strongly that all of these provisions will help the process of applying laws to Congress function more smoothly, and I urge adoption of the amendment.

AMENDMENT OFFERED BY MR. FINGERHUT TO THE AMENDMENT OFFERED BY MR. BEILENSON

Mr. FINGERHUT. Mr. Chairman, I offer an amendment to the amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment offered by Mr. FINGERHUT as an amendment to the amendment offered by Mr. BEILENSON:

In paragraph 4(b)(2) proposed to be inserted by the amendment, amend subparagraph (B) to read as follows:

"(B) OFFICE.—The executive director may not be an individual who holds or has held the position of Member of the House of Representatives or Senator or the position of employee of the House of Representatives or the Senate, or who engages in, or is otherwise employed in, lobbying of the Congress and is required under the Federal Regulation of Lobbying Act to register with the Clerk of the House of Representatives or the Secretary of the Senate.".

The CHAIRMAN. Pursuant to the rule, the gentleman from Ohio [Mr. FINGERHUT] will be recognized for 5 minutes, and a Member opposed to the amendment to the amendment will be recognized for 5 minutes.

Mr. FINGERHUT. Mr. Chairman, let me add my words of thanks to all those that have been involved in this very important piece of legislation, to the two principal sponsors, the gentleman New Hampshire [Mr. SWETT] and the gentleman from Connecticut [Mr. SHAYS], who have labored tirelessly, to the chairman of the committee, the gentleman from North Carolina [Mr. ROSE] and also to the chairman of the Committee on Rules, the gentleman from Massachusetts [Mr. MOAKLEY], and to my colleagues in the freshman reform task force, the gentleman from Massachusetts [Mr. TORKILDSEN], the gentlewoman from Florida [Mrs. FOWLER] as well as the gentlewoman from

Utah [Ms. SHEPHERD], all of whom worked diligently on this matter.

Mr. Chairman, I do believe this is a historic piece of legislation and responds to one of the principal concerns about the Congress that I hear from my constituents.

Let me also say that the amendment offered by the gentleman from California [Mr. BEILENSON] I believe is appropriate in that it understands that the success of the Office of Compliance is critical to the success of this legislation because it is the Office of Compliance that will see to it that the Congress indeed does abide by the laws in the same manner as that which the rest of the public abides by the laws.

The gentleman from California [Mr. BEILENSON] is also correct in noting that the position of the Executive Director is critical to the success of the Office of Compliance, and he is correct in pointing out that the Executive Director must be as independent as possible.

My amendment though would go one step further. My amendment would clarify and, in one sense, go one step further than the amendment offered by the gentleman from California [Mr. BEILENSON] with respect to the qualifications of the Executive Director.

First, it would clarify that the Executive Director may not be someone who is currently a registered lobbyist. That may or may not be clear under the language of the amendment offered by the gentleman from California. It is clarified in this secondary amendment.

Second, the amendment offered by the gentleman from California [Mr. BEILENSON] would allow a former staff member of the Congress to serve as Executive Director if that staff member has ceased employment with the Congress for a period of 4 years. In efforts to make clear that the Executive Director is totally independent of the Congress, totally independent of the function of their employment, we believe it is necessary to say that not only can a former Member not serve, not only can a lobbyist not serve, but a former staff member of the Congress may not serve as an Executive Director. This amendment would clarify that, and I believe in this case, if the amendment is adopted together with the amendment offered by the gentleman from California [Mr. BEILENSON], there would be no question as to the independence of the Executive Director of the independent Office of Compliance.

I reserve the balance of my time.

Mr. BEILENSON. Mr. Chairman, I rise to express general reservations about the gentleman's amendment. I understand where he is coming from. I commend him for his interest in all these matters. He has done a yeomanlike job along with the others, some of whom he mentioned.

If our experience with the House Director of Financial and Nonlegislative Services is any indication, it is likely that the executive director position is going to be a very difficult one to fill even without any restrictions. I think it is going to be a very difficult position to fill even without any restrictions on who can serve, and I think it is reasonable to exclude Members, and former Members and staff, as we would under either gentleman's proposal, and also staff members who have been employed on the Hill in recent years. But I am concerned that by eliminating everyone who has ever served as a staff member of the House or the Senate at any time in his or her life that we may be automatically disqualifying literally thousands of potential candidates, some of whom might make potentially excellent prospects as executive director. The same may be true of eliminating all lobbyists, although I support the gentleman's provision in that regard. If we cannot fill the position of executive director, the whole process of applying these laws, as the gentleman well understands and has just said, are making the enforcement aspect of it something that is going to break down. I think we can trust the board to choose an executive director who is not biased toward the staff without imposing what may be an unreasonable and onerous eligibility requirement for that position, and I would ask the gentleman also to remember, and colleagues to remember, that the bill, as originally reported, as developed by the gentleman from Connecticut [Mr. SHAYS] and the gentleman from New Hampshire [Mr. SWETT] themselves, does not contain any qualifications or requirements for the executive director, and with the amendment which I am offering, the base amendment, we are, in fact, imposing some new exacting qualifications for that position. With that, with Mr. FINGERHUT's well-intentioned offering of an amendment, those qualifications may be unreasonably difficult to find in a particular individual, so I do raise those qualms about the gentleman's proposal.

Mr. FINGERHUT. Mr. Chairman, I thank the gentleman from California [Mr. BEILENSON], and would briefly say in response that I believe there are many qualified individuals all over the country who have knowledge of these laws and can serve well. I do not believe that we would be unfairly limiting ourselves, but he is correct that his qualifications of the executive director position are well taken.

Mr. Chairman, I yield 1 minute to the gentleman from Connecticut [Mr. SHAYS].

Mr. SHAYS. Mr. Chairman, I would like to thank the gentleman for yielding this time to me and just weigh in on both amendments. I congratulate the gentleman from California [Mr. BEILENSON] for making an improvement to our amendment. We totally overlooked the qualifications of the executive director, a major flaw, but I think we go in the wrong direction if we in this one most powerful position allow either former Members, which is not being proposed, or a former staff person to be the executive director. I think that the amendment offered by the gentleman from California [Mr. BEILENSON] is far better, and I just hope we can have his amendment pass with the amendment offered by the gentleman from Ohio [Mr. FINGERHUT], and I hope that the body will concur.

Mr. FINGERHUT. Mr. Chairman, I yield 1 minute to the gentleman from New Hampshire [Mr. SWETT].

Mr. SWETT. Mr. Chairman, I thank the gentleman from Ohio [Mr. FINGERHUT] for the time to clarify.

Mr. Chairman, I agree with my colleague from Connecticut. This is an important amendment to an important amendment. We have got to keep a wall of separation between this office of compliance and its members and those people who serve on the board, and especially the executive director, and the rest of the congressional activity. I believe that the gentleman from Ohio's amendment does that clearly by keeping former staff, former Members and lobbyists out of that position, and I support his amendment wholeheartedly.

□ 1720

Mr. FINGERHUT. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I would simply reiterate that we support the terms of the Beilenson amendment. But because he has correctly identified for this body the importance of the Office of Compliance, the importance of the executive director to the success of this bill, we urge that we go one step further and make very clear that the executive director is independent of the Congress by guaranteeing it is not a lobbyist, not a former Member of Congress, and not a former staff Member of Congress. I ask for a positive vote on this amendment.

Mr. Chairman, I yield back the balance of my time.

Mr. BEILENSON. Mr. Chairman, I yield 1 minute to the gentleman from Hawaii [Mr. ABERCROMBIE].

Mr. ABERCROMBIE. Mr. Chairman, before this love feast reaches its conclusion, take a good look at what this amendment does. Before all of us rush off into the reform sunset, make sure you understand what it is doing.

We lost whoever the director of, whatever it is that we set up, whenever we did, a year ago. They brought in some general. He did not know anything. That was his primary consideration. Let us make sure we get somebody in here that is as ignorant of the operation of the House of Representatives as possible. Let us make sure we get somebody in here who does not know the first thing about what is going on. Then we will be all right. Then we can go back to our constituents and say, "We finally did the right thing. We were able to bring somebody in who doesn't know anything."

What an insult to the staff. There is nobody on this floor that can scarcely walk from their office over here and know how to get here without their staff. What do you mean, you want to throw out people who had staff work, that had all the years of experience.

I notice none of you are worried about how much money is being spent by the lobbyists to keep us from having an employer mandate or anything else.

Defeat the amendment. I would be proud to have somebody in this position who has been with the staff of this House. Don't vote for this phony-baloney of never having anybody in here who never knew what was going on.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Ohio [Mr. FINGERHUT] to the amendment offered by the gentleman from California [Mr. BEILENSON].

The question was taken; and the Chairman announced that the noes appeared to have it.

RECORDED VOTE

Mr. FINGERHUT. Mr. Chairman, I demand a recorded vote, and pending that, I make the point of order that a quorum is not present.

The CHAIRMAN. The Chair will count for a quorum.

Does the gentleman withdraw his request for a quorum?

Mr. FINGERHUT. I withdraw my point of order, Mr. Chairman.

The CHAIRMAN. The Chair will count for a recorded vote.

A sufficient number having arisen, a recorded vote is ordered.

Mr. ABERCROMBIE. I object. There was no 25 standing. I object. I appeal the ruling of the Chair. Let us get an honest count, or get somebody in the chair that can give us one.

The CHAIRMAN. The committee will come to order. Does the gentleman from Ohio insist on his point of order that a quorum is not present?

Mr. FINGERHUT. I do, Mr. Chairman.

The CHAIRMAN. The Chair will count for a quorum.

Mr. FINGERHUT. Mr. Chairman, I withdraw the point of order.

PARLIAMENTARY INQUIRIES

Mr. FRANK of Massachusetts. Mr. Chairman, I have a parliamentary inquiry.

The CHAIRMAN. The gentleman will state it.

Mr. FRANK of Massachusetts. Mr. Chairman, did the Chair rule that a sufficient number had arisen for a vote?

The CHAIRMAN. Yes; if the Chair may clarify it for the benefit of the Members, the gentleman from Ohio [Mr. FINGERHUT] made the point of order that a quorum was not present. The gentleman from Ohio, the Chair believes, under the recognition of these rules, assumed that a recorded vote would be ordered. The gentleman withdrew his point of order.

Under the rules of the House and general recognition of comity established by this House, the Chair is asking the gentleman from Ohio whether or not he seeks to insist on his point of order.

The gentleman did insist. The Chair was just about to announce that a quorum is not present.

Mr. FRANK of Massachusetts. Mr. Chairman, a further parliamentary inquiry. If the gentleman from Ohio were now to withdraw his point of order, would there be a record vote without a quorum call?

Mr. THOMAS of California. Mr. Chairman, I have a parliamentary inquiry.

The CHAIRMAN. The gentleman will state it.

Mr. THOMAS of California. Mr. Chairman, if I understand the current state of affairs, we are either going to have a quorum call or we are going to have a vote on appealing the decision of the Chair, and I think the quorum call is the preferable vote.

Mr. FRANK of Massachusetts. Mr. Chairman, a point of order. I do not believe there is an appeal pending.

The CHAIRMAN. The Chair does not recognize an appeal from the Chair's count. Having recognized no appeal of the Chair, the decision to order a recorded vote stands. A sufficient number having a recorded vote stands. A sufficient number having arisen, a recorded vote is ordered. Those in favor of the amendment will vote aye, those opposed will vote no. Members will record their vote by electronic device.

Pursuant to rule XXIII, the subsequent recorded vote, if ordered on the Beilenson amendment will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 216, noes 220, not voting 3, as follows:

[Roll No. 389]

AYES—216

Allard
Andrews (NJ)
Andrews (TX)
Archer
Armey
Bacchus (FL)
Bachus (AL)
Baker (CA)
Ballenger
Barca
Barcia
Barlow
Barrett (NE)
Barrett (WI)
Bartlett
Becerra
Bereuter
Bilbray
Bliley
Blute
Browder
Brown (OH)
Bryant
Bunning
Byrne
Calvert
Camp
Canady
Cantwell
Carr
Castle
Clement
Clinger
Coble
Collins (GA)
Combest
Cooper
Coppersmith
Cox
Crapo
Cunningham
Danner
de la Garza
Deal
DeLauro
DeLay
Deutsch
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Edwards (TX)
Ehlers
Eshoo
Everett
Ewing
Farr
Fawell
Fields (TX)
Fingerhut
Fish
Fowler
Franks (CT)
Franks (NJ)
Furse
Gallegly
Gallo
Gekas
Gibbons
Gilchrest
Gilman
Gingrich
Goodlatte
Goodling
Goss
Grams
Grandy
Gunderson
Gutierrez
Hall (TX)
Hamilton
Harman
Hastert
Hayes
Hoekstra
Holden
Houghton
Huffington
Hutchinson
Hutto
Inglis
Inhofe
Istook
Jacobs
Jefferson
Johnson (CT)
Johnson (GA)
Johnson, Sam
Kasich
Kildee
Kim
Kingston
Kleczka
Klein
Klug
Kolbe
Kreidler
Kyl
Lambert
Lancaster
Lantos
Lazio
Leach
Levin
Levy
Lewis (FL)
Lewis (KY)
Lightfoot
Linder
Livingston
Long
Lowey
Lucas
Machtley
Maloney
Manzullo
Margolies-Mezvinsky
McCandless
McCollum
McCurdy
McHale
McHugh
McInnis
McKeon
Meehan
Menendez
Meyers
Mica
Miller (FL)
Minge
Montgomery
Moorhead
Nadler
Norton (DC)
Nussle
Orton
Pallone
Parker
Paxon
Penny
Peterson (MN)
Petri
Pombo
Porter
Portman
Poshard
Price (NC)
Pryce (OH)
Quinn
Ramstad
Ravenel
Richardson
Ridge
Roemer
Rogers
Rohrabacher
Romero-Barcelo (PR)
Ros-Lehtinen
Roth
Roukema
Royce
Santorum
Saxton
Schaefer
Schenk
Schiff
Schroeder
Sensenbrenner
Shaw
Shays
Shepherd
Shuster
Sisisky
Smith (IA)
Smith (MI)
Smith (NJ)
Smith (TX)
Snowe
Solomon
Spence
Spratt
Stearns
Stenholm
Strickland
Stupak
Sundquist
Swett
Talent
Taylor (MS)
Taylor (NC)
Thomas (CA)
Thurman
Torkildsen
Traficant
Tucker
Unsoeld
Upton
Walker
Weldon
Wolf
Wyden
Zeliff
Zimmer

NOES—220

Abercrombie
Ackerman
Andrews (ME)
Applegate
Baesler
Baker (LA)
Barton
Bateman
Beilenson
Bentley
Berman
Bevill
Bilirakis
Bishop
Blackwell
Boehlert
Boehner
Bonilla
Bonior
Borski
Boucher
Brewster
Brooks
Brown (CA)
Brown (FL)
Burton
Buyer
Callahan
Cardin
Chapman
Clay
Clayton
Clyburn
Coleman
Collins (IL)
Collins (MI)
Condit
Conyers
Costello
Coyne
Cramer
Crane
Darden
de Lugo (VI)
DeFazio
Dellums
Derrick
Dicks
Dingell
Dixon
Dooley
Durbin
Edwards (CA)
Emerson
Engel
English
Evans
Faleomavaega (AS)
Fazio
Fields (LA)
Filner
Flake
Foglietta
Ford (MI)
Ford (TN)
Frank (MA)
Frost
Gejdenson
Gephardt
Geren
Gillmor
Glickman
Gonzalez
Gordon
Green
Greenwood
Hall (OH)
Hamburg
Hancock
Hansen
Hastings
Hefley
Hefner
Hilliard
Hinchey
Hoagland
Hobson
Hochbrueckner
Hoke
Horn
Hoyer
Hughes
Hunter
Hyde
Inslee
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy
Kennelly
King
Klink
Knollenberg
Kopetski
LaFalce
LaRocco
Laughlin
Lehman
Lewis (CA)
Lewis (GA)
Lipinski
Lloyd
Mann
Manton
Markey
Martinez
Matsui
Mazzoli
McCloskey
McCrery
McDade
McDermott
McKinney

McMillan
McNulty
Meek
Mfume
Michel
Miller (CA)
Mineta
Mink
Moakley
Mollohan
Moran
Morella
Murphy
Murtha
Myers
Neal (MA)
Neal (NC)
Oberstar
Obey
Olver
Ortiz
Owens
Oxley
Packard
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Pickett
Pickle
Pomeroy
Quillen
Rahall
Rangel
Reed
Regula
Reynolds
Roberts
Rose
Rostenkowski
Rowland
Roybal-Allard
Rush
Sabo
Sanders
Sangmeister
Sarpalius
Sawyer
Schumer
Scott
Serrano
Sharp
Skaggs
Skeen
Skelton
Slattery
Slaughter
Smith (OR)
Stark
Stokes
Studds
Stump
Swift
Synar
Tanner
Tauzin
Tejeda
Thomas (WY)
Thompson
Thornton
Torres
Torricelli
Towns
Underwood (GU)
Valentine
Velazquez
Vento
Visclosky
Volkmer
Vucanovich
Walsh
Waters
Watt
Waxman
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Whitten
Williams
Wilson
Wise
Woolsey
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Yates
Young (AK)
Young (FL)

NOT VOTING—3

Herger
Molinari
Washington

□ 1746

Ms. ROYBAL-ALLARD and Messrs. VOLKMER, GREENWOOD, SCHUMER, and SLATTERY changed their vote from "aye" to "no."

Messrs. LANTOS, NADLER, ARMEY, and UPTON changed their vote from "no" to "aye."

Mr. CRANE changed his vote from "present" to "no."

So the amendment to the amendment was rejected.

The result of the vote was announced as above recorded.

The CHAIRMAN. The question is on the amendment offered by the gentleman from California [Mr. BEILENSON].

The amendment was agreed to.

The CHAIRMAN. It is now in order to consider amendment No. 6 printed in Part 2 of House Report 103–691.

AMENDMENT OFFERED BY MRS. FOWLER

Mrs. FOWLER. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment offered by Mrs. FOWLER: Page 9, insert after the period in line 7 the following: "The term of office of the executive director shall be a single term of 5 years.".

The CHAIRMAN. Pursuant to the rule, the gentlewoman from Florida [Mrs. FOWLER] will be recognized for 5 minutes, and a member opposed will be recognized for 5 minutes.

□ 1750

Mrs. FOWLER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the amendment I offer today on behalf of myself and Representatives FINGERHUT, SHEPHERD, and TORKILDSEN is very simple, yet very significant.

My amendment would stipulate that the Executive Director of the Office of Compliance is appointed for a term of 5 years. The way the bill is currently written, he or she, once appointed, serves until resignation or termination.

The Office of Compliance will be a major office in this institution, and the person who runs it will be on a par with the Clerk, the Doorkeeper and the Sergeant at Arms. If those appointments are reviewed and renewed on a regular basis, so should that of the Executive Director.

My amendment requires the Executive Director be reviewed every 5 years. If he or she is doing a great job, then the board can vote to reappoint.

The CHAIRMAN. The committee will come to order.

PARLIAMENTARY INQUIRY

Mr. McDADE. Mr. Chairman, I have a parliamentary inquiry.

The CHAIRMAN. The gentleman will state it.

Mr. McDADE. Would it be in order to ask the Chair to put a muffler on his gavel?

The CHAIRMAN. That would be out of order. But the Chair would seek order in the committee.

Mr. McDADE. It may not be, Mr. Chairman. I suggest the Chair lighten the gavel.

The CHAIRMAN. The Chair thanks the gentleman for his suggestion. It is always appreciated. The Chair would request Members to give the gentlewoman the respect of the House and allow her to continue.

Mrs. FOWLER. I thank the Chairman.

Mr. Chairman, the integrity of this entire process of congressional accountability hinges on the integrity of the board and Executive Director. That is why this amendment, and all the amendments offered by our bipartisan freshman coalition, seek to strengthen the integrity of the board and Executive Director.

I urge my colleagues to vote "yes" on this amendment.

While I have the time, Mr. Chairman, I would also like to urge my colleagues to vote "yes" on final passage.

The coauthors of my amendment and I serve as cochairs of our respective freshman class reform task forces. Early last year we began a series of meetings to identify areas of reform where there was bipartisan agreement.

First on that list was congressional accountability. One of the reasons our freshman class is the largest in four decades is the fact that the American people have lost confidence in this institution and are desperate for change.

Nothing drives a bigger wedge between this, the "People's House," and the people themselves than the practice of exempting Congress from laws it passes for everyone else.

As freshmen, we made it our top priority to end that practice and begin the process of restoring the confidence of the American people. Ninety-seven of us signed on as cosponsors of the original Shays-Swett Congressional Accountability Act. Our bipartisan freshman group testified before the Joint Committee on the Organization of Congress, the Rules Committee, and the House Administration Committee to show our class' support.

While I would much prefer that we were considering this bill as part of a more comprehensive reform package, I think its passage today will be a major victory for the reform effort.

Passage of this bill will result in much more than just ensuring we run Congress under the same laws as private business. The significant long-term impact of this bill will be that we pass better laws. Knowing that what we pass applies to ourselves will surely make us more vigilant, more pragmatic and maybe more cautious when adding to the statute books.

I urge my colleagues to vote "yes" on H.R. 4822.

Mr. BEILENSON. Mr. Chairman, will the gentlewoman yield?

Mrs. FOWLER. I yield to the gentleman from California.

Mr. BEILENSON. Mr. Chairman, we support the amendment and urge its adoption.

The CHAIRMAN. Does any Member rise in opposition to the amendment?

If not, the question is on the amendment offered by the gentlewoman from Florida [Mrs. FOWLER].

The amendment was agreed to.

The CHAIRMAN. It is now in order to consider amendment number 7 printed in part 2 of House Report 103–691.

AMENDMENT OFFERED BY MS. SHEPHERD

Ms. SHEPHERD. Mr. Chairman, I offer an amendment made in order under the rule.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment offered by Ms. SHEPHERD: Page 11, insert after line 4 the following:

(3) REMOVAL.—Any member of the Board of Directors may be removed from office by a majority decision of the appointing authorities described in subsection (b)(1) and only for—

(A) disability that substantially prevents the member from carrying out the duties of the member,

(B) incompetence,

(C) neglect of duty,

(D) malfeasance, or

(E) a felony or conduct involving moral turpitude.

The CHAIRMAN. Pursuant to the rule, the gentlewoman from Utah [Ms. SHEPHERD] will be recognized for 5 minutes, and a Member opposed will be recognized for 5 minutes.

The Chair recognizes the gentlewoman from Utah [Ms. SHEPHERD].

Ms. SHEPHERD. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the bill we are considering today is silent on conditions under which a member of the Board of Directors can be removed from the Board.

This amendment lays out specific conditions under which a member of the Board can be removed. It simply states that they can only be removed by a majority decision of the joint leadership, and then only for cause.

The intent of the amendment is to ensure members of the Board are not removed simply because they may make politically tough decisions on compliance provisions.

The amendment specifies the following reasons for dismissal: Incompetence; neglect of duty; malfeasance, or a felony or conduct involving moral turpitude.

This "good cause" standard has been used in the executive branch. It is currently applied to the chair of the Merit System Protection Board as well as for the Director of the Office of Government Ethics.

Mr. Chairman, this is, I believe a noncontroversial amendment. I am joined by my fellow freshman colleagues ERIC FINGERHUT, TILLIE FOWLER, and PETER TORKILDSEN in offering this amendment. We have worked together with the bipartisan sponsors of this landmark legislation, Mr. SHAYS and Mr. SWETT, in crafting this amendment and we have their support.

I urge my colleagues to join with us in supporting this noncontroversial but important amendment and in providing strong bipartisan support for passage of this critical legislation.

Mr. ROSE. Mr. Chairman, will the gentlewoman yield?

Ms. SHEPHERD. I yield to the gentleman from North Carolina.

Mr. ROSE. Mr. Chairman, I just want to say I support the gentlewoman's amendment and have no objection to it.

Mr. BEILENSON. Mr. Chairman, will the gentlewoman yield?

Ms. SHEPHERD. I yield to the gentleman from California.

Mr. BEILENSON. Mr. Chairman, we, too, support the amendment, and we urge its adoption.

Ms. SHEPHERD. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I would simply, then, conclude by saying this is an insurance that mirrors what is done in the executive branch. It is exactly the same rule that is used by the Merit System Protection Board, and it would be used by the Office of Compliance.

I urge the adoption of this amendment.

The CHAIRMAN. Does any Member seek recognition to speak in opposition to the amendment?

If not, the question is on the amendment offered by the gentlewoman from Utah [Ms. SHEPHERD].

The amendment was agreed to.

The CHAIRMAN. It is now in order to consider amendment No. 8 printed in part 2 of House Report 103-691.

AMENDMENTS OFFERED BY MR. SHAYS

Mr. ROSE. Mr. Chairman, I ask unanimous consent that amendments 8, 9, and 10, all of which are Shays-Swett amendments, be considered en bloc.

The CHAIRMAN. Is there objection to the request of the gentleman from North Carolina?

There was no objection.

Mr. SHAYS. Mr. Chairman, I offer the amendments made in order under the rule.

The CHAIRMAN. The Clerk will designate the amendments.

The text of the amendments is as follows:

Amendment No. 8 offered by Mr. SHAYS: Page 13, strike "and" at the end of line 23, strike the period at the end of line 25 and insert "; and", and after line 25 insert the following:

(4) may review the regulations in effect under subsection (e)(1) and make such amendments as may be appropriate in accordance with subsection (c).

Amendment No. 9 offered by Mr. SHAYS: Page 14, line 8, strike "that specify the manner in which" and insert "to implement the requirements of" and in line 10 strike "shall apply".

Page 14, line 22, strike "specifying the manner in which" and insert "to implement the requirements of" and beginning in line 23 strike "shall apply to the legislative branch of the Federal Government".

Amendment No. 10 offered by Mr. SHAYS: Page 16, insert after line 24, the following:

(4) ACTION IF DISAPPROVAL.—If a concurrent resolution is considered under subsection (e) and is disapproved, not later than 60 days after the date of the disapproval, the Board of Directors shall propose a new regulation to replace the regulation disapproved with the disapproval of such concurrent resolution. The action of the Board of Directors under this paragraph shall be in accordance with the applicable requirements of this subsection.

The CHAIRMAN. Pursuant to the rule, the gentleman from Connecticut [Mr. SHAYS] will be recognized for 5 minutes, and a Member opposed will be recognized for 5 minutes.

The Chair recognizes the gentleman from Connecticut [Mr. SHAYS].

MODIFICATION TO AMENDMENT NO. 10 OFFERED BY MR. SHAYS

Mr. SHAYS. Mr. Chairman, I ask unanimous consent that amendment No. 10 be modified pursuant to the technical amendment at the desk.

The CHAIRMAN. The Clerk will report the modification.

The Clerk read as follows:

Amendment No. 10, as modified, offered by Mr. SHAYS:

Page 16, insert after line 24, the following:

(4) ACTION IF DISAPPROVAL.—If a regulation is disapproved by a concurrent resolution considered under subsection (e), not later than 60 days after the date of the disapproval, the Board of Directors shall propose a new regulation to replace the regulation disapproved. The action of the Board of Directors under this paragraph shall be in accordance with the applicable requirements of this subsection.

Mr. THOMAS of California (during the reading). Mr. Chairman, I ask unanimous consent that the modification to the amendment be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from California?

Mr. ROSE. Mr. Chairman, reserving the right to object, and I will not object, we have examined the amendment, it is a very technical change, and it is perfectly acceptable to us.

Mr. THOMAS of California. Mr. Chairman, will the gentleman yield?

Mr. ROSE. Further reserving the right to object, I yield to the gentleman from California, the ranking member of the Committee on House Administration.

Mr. THOMAS of California. Mr. Chairman, we have examined the amendment, it is technical in nature, it is perfecting, and we have no objection to the amendment.

Mr. ROSE. Mr. Chairman, I withdraw my reservation of objection.

The CHAIRMAN. Is there objection to the request of the gentleman from California?

There was no objection.

The CHAIRMAN. Is there objection to the request of the gentleman from Connecticut for the modification?

There was no objection.

Mr. SHAYS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, on amendment No. 8, the bill is silent about the ability of the board to review and amend as necessary regulations which it has already promulgated.

Mr. Chairman, the purpose of amendment No. 9, a technical amendment, is to emphasize that the board of directors in fulfilling its responsibilities to write regulations applying to statutes specified in section 3(a) of the bill is to ensure that all the rights and protections of these laws are to apply.

The amendment is meant to make clear that the office may not simply pick and choose which provisions of these laws the regulations will affect but at the same time provide the necessary flexibility for the board of directors to write these regulations in such a way as to accommodate the application of these laws consistent with the separation of powers, to the unique structure, organization, and procedures of the House and Senate.

Mr. Chairman, I would just add the amendment is meant to make clear that this office may not issue regulations that are inconsistent with the statute's language or intent.

Mr. THOMAS of California. Mr. Chairman, will the gentleman yield?

Mr. SHAYS. I yield to the gentleman from California.

Mr. THOMAS of California. Mr. Chairman, we have looked at these amendments. They are not technical in nature, they are substantive, but they do perfect the bill, they are a valuable addition to the bill, and we think they should be adopted.

☐ 1800

Mr. ROSE. Mr. Chairman, will the gentleman yield?

Mr. SHAYS. I yield to the gentleman from North Carolina.

Mr. ROSE. Mr. Chairman, I agree with the conclusion of the gentleman from California [Mr. THOMAS] and have no objection.

Ms. DELAURO. Mr. Chairman, I rise in support of this amendment, and to thank my good friend and colleague the gentleman from Connecticut, and commend him for the tremendous time and effort he has put into this bill.

The idea behind this legislation is simple and straightforward. In fact, many Americans could be forgiven for wondering why this didn't happen a long, long time ago. Making Congress subject to the laws it passes is just common sense.

For years, public trust in this institution has been eroding. People no longer believe we understand them, understand their problems, listen to their concerns. Part of that is because they see us as isolated by the beltway, cut off from the lives they lead.

The fact that we pass laws which apply to them but not to us is compelling evidence of the gulf between us. We struggle daily to close that gap. We could take no greater step to improve our credibility with ordinary Americans than to pass this bill. To live by the standards we set for others.

It is high time. It is long overdue. And it is a matter of our credibility and, in the long term, our ability to govern. Adlai Stevenson said that "Public confidence in the integrity of government is indispensable to faith in democracy." This legislation will do no less than help to restore that faith.

The CHAIRMAN. Does any Member seek recognition to speak in opposition to the amendment?

If not, the question is on the amendments, as modified, offered by the gentleman from Connecticut [Mr. SHAYS].

The amendments, as modified, were agreed to.

The CHAIRMAN. It is now in order to consider amendment No. 11 printed in part 2 of House Report 103-691.

AMENDMENT OFFERED BY MR. ZIMMER

Mr. ZIMMER. Mr. Chairman, I offer an amendment made in order under the rule.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment offered by Mr. ZIMMER: Page 18, insert after the period in line 7 the following: "Any meeting of a committee on a concurrent resolution shall be open to the public.".

Page 19, insert after line 18 the following:

(g) OPEN TO THE PUBLIC.—Any meeting of the Board of Directors held in connection with a study under subsection (a) or (b) shall be open to the public. Any meeting of the Board of Directors in connection with a regulation under subsection (c) shall be open to the public.

The CHAIRMAN. Pursuant to rule, the gentleman from New Jersey [Mr. ZIMMER] will be recognized for 5 minutes, and a Member opposed will be recognized for 5 minutes.

The Chair recognizes the gentleman from New Jersey [Mr. ZIMMER].

Mr. ZIMMER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, this is a straightforward amendment. It would require that any meeting of the Board of Directors of the Office of Compliance be open to the public. It would also require that any meeting of a committee which is considering a concurrent resolution disapproving a recommendation of the Office of Compliance be open to the public.

This legislation is about accountability. This legislation is about restoring credibility to this Congress. One way to accomplish these objectives is to make sure that our deliberations and the deliberations of the Office of Compliance are held in full public view. No back room deals. No smoke-filled rooms. No smokeless rooms. Everything in full view so that the public will have confidence that we are applying to ourselves the laws that apply to them in a straightforward and honest way.

Mr. THOMAS of California. Mr. Chairman, will the gentleman yield?

Mr. ZIMMER. I am glad to yield to the gentleman from California.

Mr. THOMAS of California. Mr. Chairman, I thank the gentleman from New Jersey for yielding. The only concern that anyone might have is the requirement that a meeting of a committee in dealing with this information be open to the public whereas the rules of the House allow under certain circumstances that committee meetings be closed.

That is not a conflict. Very clearly you could have a portion of the meeting dealing with this issue open, and then other portions, if the committee felt it necessary to close it, you could close it. There is no reason that these should ever be held in a closed session, and we support this amendment.

Mr. ZIMMER. I thank the gentleman.

The CHAIRMAN. Does any Member seek recognition in opposition to the amendment?

If not, the question is on the amendment offered by the gentleman from New Jersey [Mr. ZIMMER].

The amendment was agreed to.

The CHAIRMAN. It is now in order to consider amendment No. 12 printed in House Report 103-691.

AMENDMENT OFFERED BY MR. TORKILDSEN

Mr. TORKILDSEN. Mr. Chairman, I offer an amendment made in order under the rule.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment offered by Mr. TORKILDSEN: Page 19, insert at the end of line 21 the following: "subject to the approval of the Board of Directors,".

The CHAIRMAN. Pursuant to the rule, the gentleman from Massachusetts [Mr. TORKILDSEN] will be recognized for 5 minutes, and a Member opposed will be recognized for 5 minutes.

The Chair recognizes the gentleman from Massachusetts [Mr. TORKILDSEN].

Mr. TORKILDSEN. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise today on behalf of an amendment offered by myself, Mrs. FOWLER, Ms. SHEPHERD, and Mr. FINGERHUT. This amendment will strengthen the original form of H.R. 4822, the Congressional Accountability Act.

This amendment would subject the rules of the Office of Compliance to the approval of the Board of Directors and ensure greater accountability of the Executive Director. Because the Board of Directors is, in fact, the heart of the Office of Compliance, it is important that the Executive Director answer to the Board to ensure that no individual have extended control over the functions or rules of the Office. This change is essential to creating a viable, effective Office of Compliance.

Though far from perfect, H.R. 4822 is a strong bill. As cochair of the Freshmen Republican Reform Task Force, I and many of my colleagues have been working hard to make Congress live by the laws it passes for the rest of the country. This bill is a great example of bipartisan cooperation working to restore public confidence in the U.S. Congress. Congressmen SHAYS and SWETT deserve great credit for initiating this bill. The freshmen Democrats and Republicans were instrumental in advancing this legislation to the floor.

I know there is hesitation by some to make all private sector laws apply to Congress. The American people do not have the luxury of determining what laws apply to them; we do. Yes, laws like OSHA and the Fair Labor Standards Act are expensive to implement, but that never stopped Congress from passing them. And if any law is too expensive for Congress to comply with, then shouldn't we ask if it is too expensive for private citizens to comply with?

For over 50 years, Congress has been exempting itself from the very laws that almost every American must follow. This is done in direct contradiction to what the Framers of the Constitution intended. In the 57th Federalist, Madison wrote, the House of Representatives "can make no law which will not have its full operation on themselves and their friends, as well as on the great mass of the society. This has always been one of the strongest bonds by which human policy can connect the rulers and the people together."

What Madison saw as one of the strongest bonds connecting the rulers and the people is missing in the United States today. We can restore some confidence in congressional decisionmaking by simply requiring that Members of Congress obey laws that every other citizen must follow.

I strongly urge my colleagues to support this measure to make Congress comply with many laws that almost every American must comply with every day.

Mr. Chairman, I reserve the balance of my time.

The CHAIRMAN. Does any Member seek recognition in opposition to the amendment?

If not, the question is on the amendment offered by the gentleman from Massachusetts [Mr. TORKILDSEN].

The amendment was agreed to.

The CHAIRMAN. It is now in order to consider amendment No. 13 printed in part 2 of House Report 103-691.

AMENDMENT OFFERED BY MS. NORTON

Ms. NORTON. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment offered by Ms. NORTON: Page 22, strike lines 20 through 24.

Page 28, strike line 18 and all that follows through line 9 on page 32.

Page 28, insert after line 17 the following:

SEC. 11. JUDICIAL REVIEW.

(a) IN GENERAL.—

(1) TYPES OF REVIEW.—Following any hearing under section 10 on a complaint relating to a provision of law described in section 3, any congressional employee aggrieved by a dismissal of a claim under section 10(c), a final decision under section 10(g), a final order under section 10(h), or any Member of the House of Representatives or Senator aggrieved by a final decision under section 10(g) or a final order under section 10(h), may—

(A) bring a civil action in a district court of the United States for a de novo review of such dismissal or of the alleged violation of law with respect to which such decision or order was issued if the law applicable to such dismissal or violation authorizes such a civil action, or

(B) petition for review by the United States Court of Appeals for the Federal Circuit.

If in an action brought under subparagraph (A) a court determines that a dismissal was not authorized or a violation of law occurred, the court may only enter an order described in section 10(h). Bringing a civil action under subparagraph (A) with respect to a matter in which an order was issued under section 10 shall vacate such order.

(2) PROVISIONS APPLICABLE TO REVIEW BY COURT OF APPEALS.—The following provisions apply to a review under paragraph (1)(B):

(A) LAW APPLICABLE.—Chapter 158 of title 28, United States Code, shall apply—

(i) with respect to section 2344 of title 28, United States Code, service of the petition shall be on the House or Senate Legal Counsel, or the appropriate entity of an instrumentality, as the case may be, rather than on the Attorney General;

(ii) the provisions of section 2348 of title 28, United States Code, on the authority of the Attorney General, shall not apply;

(iii) the petition for review shall be filed not later than 90 days after the entry in the Office of a final decision under section 10(g), an order under section 10(h);

(iv) the Office shall be an "agency" as that term is used in chapter 158 of title 28, United States Code;

(v) the Office shall be the respondent in any proceeding under subparagraph (A); and

(vi) the Office of Compliance may provide legal representation to the employee in such appellate proceedings under subparagraph (A) if the employee was a prevailing party in the hearing or if the employee has a nonfrivolous ground of appeal. Rules for providing representation for the employee shall be established by the executive director, subject to the approval of the Board of Directors.

(B) STANDARD OF REVIEW.—To the extent necessary for decision and when presented, the court shall decide all relevant questions of law and interpret constitutional and statutory provisions. The court shall set aside a dismissal under section 10(c), a final decision under section 10(g), or an order under section 10(h) if it is determined that the dismissal, decision, or order was—

(i) arbitrary, capricious, an abuse of discretion, or otherwise not consistent with law;

(ii) not made consistent with required procedures; or

(iii) unsupported by substantial evidence.

(C) RECORD.—In making determinations under subparagraph (B), the court shall review the whole record, or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error. The record on review shall include the record before the hearing board, the decision of the hearing board, and the order of the hearing board.

(b) ATTORNEY'S FEES.—If a congressional employee is the prevailing party in a proceeding under this section, attorney's fees may be allowed by the court in accordance with any standards prescribed under Federal law for the award of such fees.

The CHAIRMAN. Pursuant to the rule, the gentlewoman from the District of Columbia [Ms. NORTON] will be recognized for 5 minutes, and a Member opposed will be recognized for 5 minutes.

The Chair recognizes the gentlewoman from the District of Columbia [Ms. NORTON].

Ms. NORTON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I come to the floor as a former chair of the Equal Employment Opportunity Commission and as a Member who served on the Joint Committee for the Reorganization of Congress. I administered most of the laws that are the subject of H.R. 4822.

I offer an amendment to strengthen the bill by more closely meeting the standard we have set for ourselves to apply the laws we pass to ourselves as they are applied to other Americans.

I have worked closely with the gentleman from Connecticut [Mr. SHAYS], and the gentleman from New Hampshire [Mr. SWETT], and with the staff of the gentleman from California [Mr. THOMAS], as well. My amendment seeks to incorporate their concerns in addition to my own by meeting the goal of equivalent compliance by Congress.

I feel compelled to offer an amendment because without a change, House employees will be deprived of redress and appeal long available to other Americans. My amendment is not inconsistent with the comparable provision currently in the bill. Rather it strengthens the bill's provisions, coming closer to the existing law that now governs other Americans.

The bill, as it now stands, takes away an entire forum that is available to Federal, State, and private sector employees. Under H.R. 4822, House employees would have to make a most difficult choice: To go either to the Federal district court or an administrative hearing board before a three-member board. Other Americans enjoy the right to a cost-free forum to resolve their complaints, and thereafter may still go to Federal district court. Neither Federal, State, nor private sector employees give up their right to make their case before an administrative agency where neither a lawyer nor court costs are necessary.

The bill before us, however, requires House employees to give up their right to cost-free administrative resolution altogether if they desire a de novo district court hearing. Thus the bill goes to the expense of setting up a free administrative forum for everyone else but then denies House employees its use unless they give up the right to a court hearing afterwards. However, private sector, Federal and State employees may go to the EEOC and, if they lose there, may go to district court.

My amendment allows House employees a cost-free hearing before the independent three-member hearing board without depriving the employees of their right to a de novo hearing before a Federal district court, if desired, after a hearing board decision.

Why does my amendment allow both the administrative hearing and the court hearing? To conform to the fact that two forums are provided to other Americans. The members of the hearing board are not selected by the House, but rotate off a list of professionals recommended by the Administrative Conference of the United States and a Federal Mediation and Conciliation Service. In light of the fact that the review board is independent, my amendment offers an incentive to appeal rather than repeat the fact finding process, but to conform to the rules for other Americans, preserves the right of every employee to repeat the fact finding process if she pleases. Thus, the Office of Compliance would defend the hearing board's decision in the court of appeals and thus would in effect provide the employee counsel if the defendant appeals to the court of appeals. Employees who do not prevail before the hearing board but have nonfrivolous appeals would have similar representation if they appeal to the court of appeals.

Every House employee would retain the option of going to the Federal district court de novo, regardless, at her expense, just like other Americans.

Reliance upon a cost-free, independent administrative hearing is the key feature of the Shays-Swett bill, the Schroeder-Snowe Congressional Employees Fairness Act and the Joint Committee on the Organization of Congress's proposal.

My amendment takes away nothing from these bills but uses them as a guide while giving no less to House employees than what other Americans can claim. Do not sell House employees short by taking away their cost-free administrative hearing or their right to a de novo hearing in district court.

Mr. HUGHES. Mr. Chairman, will the gentlewoman yield?

Ms. NORTON. I yield to the gentleman from New Jersey.

Mr. HUGHES. Mr. Chairman, do I understand that what the gentlewoman's amendment does is it requires an employee to exhaust administrative remedies first?

Ms. NORTON. Yes, without depriving that employee of the right to then go to Federal district court as in the private sector.

Mr. HUGHES. But it requires an employee to exhaust all administrative remedies before they can file in the district court?

Ms. NORTON. That is right, where the resolution may well occur.

Mr. HUGHES. If the gentlewoman will yield further, does the gentlewoman envision that then there would be a de novo review, as I understand it, in the Federal district court once they have exhausted those remedies before the Office of Compliance?

Ms. NORTON. I would. That is so, because that is what happens in the private sector.

Mr. HUGHES. Then you envision if, in fact, a district court renders an adverse decision, there would be an appeal to the U.S. Court of Appeals?

Ms. NORTON. As in the private sector, yes. In other words, I have tried to track as closely as possible what happens in the private sector.

Mr. HUGHES. Mr. Chairman, I thank the gentlewoman.

Mr. THOMAS of California. Mr. Chairman, I rise in opposition to the amendment.

The CHAIRMAN. The gentleman from California [Mr. THOMAS] is recognized for 5 minutes.

Mr. THOMAS of California. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I think we have to understand that if this bill is an attempt to place Congress under the laws as the private sector has them, you need to know that the Norton amendment is a step back from that position. The committee, after much discussion, unanimously accepted an amendment which, in fact, puts Congress and its employees closer to what occurs in the private sector. The question that was just asked by the gentleman from New Jersey goes directly to the heart of the question.

In the Fair Labor Standards Act employees have the right to an administrative proceeding or going to the court. In the Civil Rights Act they have that choice. In the Americans With Disabilities Act they have that choice. In the Age Discrimination in Employment Act they have that choice. In the Workers' Adjustment and Retraining Act they have that choice. In the committee version of the bill they have that choice.

They do not have that choice under the Norton amendment. In addition to that, in the private sector there is no inducement to get you to give up your right to go to a trial court and take the administrative proceeding, and then go to the appeals court. In the Norton amendment, if you go to the appeals court, your attorney is provided by the Office of Compliance.

It is an attempt not to have you go to the district court, not to have that right that is available to the private sector in every other of these laws.

We argued this in committee. The amendment accepted by the gentlemen who are the cosponsors of this bill, unanimously supported by the committee, says the employee has the right to take the administrative remedy or, at their choice, go to the district court.

It seems to me that if we are going to place Congress and the Federal employees more under the private sector laws, the committee procedure is closer to that than the Norton amendment, and I would ask that you oppose this amendment.

The CHAIRMAN. The time of the gentlewoman from the District of Columbia [Ms. NORTON] has expired. The gentleman from California [Mr. THOMAS] has 3 minutes remaining.

Mr. THOMAS of California. Mr. Chairman, I yield 1½ minutes to the gentleman from Illinois [Mr. FAWELL].

Mr. FAWELL. Mr. Chairman, I regret I did not have the opportunity of hearing the arguments. I have been in transit to be here.

But it does seem to me that there is no good reason to deprive employees of their right to go directly to court and to bypass the administrative procedures. I know that, for instance, in the civil rights laws, especially in regard to gender discrimination, that the employees made it very clear while we were considering that recent legislation that they felt very definitely that they wanted to have their right to their day in court before a jury so they could set their full case in regard to gender discrimination and, indeed, when you look at the EEOC and the procedures that would be utilized, when you look at civil rights laws, I think one has to recognize that what we have in this statute as it is very much in accord with what the EEOC has in reference to the Civil Rights Act or the ADA. You have conciliation, you have mediation, and then the party has a right to go directly to court.

I think it is good that they have the right to use an administrative procedure hearing here, but it is very, very important that we try to have the law as close to existing law as possible.

Mr. THOMAS of California. Mr. Chairman, I yield 1 minute to the gentleman from Ohio [Mr. BOEHNER].

Mr. BOEHNER. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, I am somewhat sympathetic with the amendment offered by the gentlewoman from the District of Columbia, because that would make the whole process of labor law a lot easier for the private sector and for us, because if the private sector did not have their employees running into court but would, rather, have to go through an administrative procedure first, we could unclog a lot of the problems we have in the courts today.

But that is not what the private sector has to do. And so as sympathetic as I am with what she wants to do, it would make a lot more sense, we need to go back and change the laws that apply to the private sector, and then we could live under that same application.

But in the meantime, I think that we should provide out employees with the same rights and privileges as the private sector employees have, and that means that the committee version is the right version in order to maintain that integrity.

Mr. THOMAS of California. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I believe the gentlewoman from the District of Columbia is well intentioned in her amendment. But, I believe that the committee, in the discussion, in the amendment, and in the committee product, moves us closer to conformance on the model of the Shays-Swett legislation, and I would ask that we oppose the amendment.

The CHAIRMAN. The question is on the amendment offered by the gentlewoman from the District of Columbia [Ms. NORTON].

The question was taken; and the Chairman announced that the noes appeared to have it.

Ms. NORTON. Mr. Chairman, I demand a recorded vote.

A recorded vote was refused.

So the amendment was rejected.

The CHAIRMAN. It is now in order to consider amendment No. 14 printed in part 2 of House Report 103-691.

AMENDMENT OFFERED BY MS. ENGLISH OF ARIZONA

Ms. ENGLISH of Arizona. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment Offered by Ms. ENGLISH of Arizona: Page 37, after line 12, add the following new section:

SEC. 19. LIMITATION ON USE OF TRAVEL AWARDS IN THE HOUSE OF REPRESENTATIVES.

(a) IN GENERAL.—Notwithstanding any other provision of law or any rule, regulation, or other authority, any travel award that accrues by reason of official travel of a Member, officers or employee of the House of Representatives may be used only with respect to official travel.

(b) REGULATIONS.—The Committee on House Administration of the House of Representatives shall have authority to prescribe regulations to carry out this section.

(c) DEFINITIONS.—As used in this section—

(1) the term "travel award" means any frequent flier mileage, free travel, discounted travel, or other travel benefit, whether awarded by coupon, membership, or otherwise; and

(2) the term "official travel" means, with respect to the House of Representatives, travel performed for the conduct of official business of the House of Representatives.

The CHAIRMAN. Pursuant to the rule, the gentlewoman from Arizona [Ms. ENGLISH] will be recognized for 5 minutes, and a Member opposed will be recognized for 5 minutes.

The Chair recognizes the gentlewoman from Arizona [Ms. ENGLISH].

Ms. ENGLISH of Arizona. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the legislation now before the House deals with applying to Congress the laws that we impose on the rest of the Nation.

The amendment I offer today would apply to the House the rule covering the use of frequent-flier tickets that the rest of the entire Federal Government—including the Senate—already lives under.

My amendment would reverse a 1991 House rule change that gave Members and staff the discretion to personally use frequent-flier travel awards earned from official, taxpayer-funded travel. Under the current rules, every four trips I take to my district on the same airline earns me a free airline ticket.

I can either use that ticket to conduct official business, saving a little taxpayer money, or I can use it to fly myself, friends, and family most anywhere in the country for free.

When the taxpayers of my district pay to fly me back and forth between Arizona and Washington so that I can do my job, I just do not think they expect me to get free plane tickets as a result.

I have established a policy in my office—as many of my colleagues have—that says free frequent-flier plane tickets are only to be used for official business.

I think that should be the policy for the House as a whole, and that's what my amendment would accomplish.

This amendment rests on one simple premise. Airline tickets cost money. Taxpayers pay for them. The frequent-flier miles belong to the taxpayers. It is that simple.

In these times of very tight budgetary constraints, when we are trying—legitimately—to cut waste and save money wherever we can, this rule change makes sense. Given the amount of travel that Members of Congress undertake, the value of these awards can be substantial.

For Members lucky enough to represent a Western district, as I do, the value of these free tickets reaches into the thousands of dollars a year. We should not pass by this opportunity to save money and improve the cost-effectiveness of our congressional operations.

In closing, Mr. Chairman, let me restate the premise that my amendment is built on. Airline tickets cost money. Taxpayers pay for them. The frequent-flier miles belong to the taxpayers.

I urge all my colleagues to vote for this amendment and return the House to its original, commonsense treatment of this issue. This is the practice followed by our colleagues in every other part of the Federal Government. It should be our policy as well.

□ 1820

Mr. Chairman, for purposes of debate only, I yield 1 minute to the gentleman from Ohio [Mr. STRICKLAND].

Mr. STRICKLAND. Mr. Chairman, when I first came to Congress, a friend back home asked me, "What's it like in Washington? How does it feel to serve in Congress? What are other Members of Congress really like?"

I told him I was surprised to learn how hard people work in Washington. I said there's a strong, and for the most part, unrecognized work ethic among Members of Congress and their staff.

Yet, despite this work ethic, the approval rating of Congress languishes at around 30 percent. Many of our constituents feel that we are out of touch. Some say we are completely out of touch. Such negative feelings are unwarranted—however, there are steps we can take to move us closer to the people we represent.

Stopping the personal use of frequent flier miles acquired through tax-payer financed official travel is certainly a step in the right direction.

Will this decision to do away with the personal use of frequent flier miles increase the public's approval rating of Congress? Perhaps not, but it is a modest reform which may go a long way in demonstrating to the public that we don't consider ourselves special.

I hope my colleagues will agree with this commonsense reform and support the efforts of the gentlewoman from Arizona [Ms. ENGLISH].

The CHAIRMAN. Does any Member seek recognition to speak in opposition to the amendment offered by the gentlewoman from Arizona [Ms. ENGLISH]?

Mr. ROSE. Yes. Mr. Chairman, I take that time, but not for any other reason than to have the time to enter into a colloquy with the gentlewoman from Arizona, and, if she will allow me to do that, I would like to ask her a few questions about this amendment.

The CHAIRMAN. Does gentleman seek the time in opposition?

Mr. ROSE. Yes, Mr. Chairman, I seek to control the opposition time so that I may have a colloquy.

The CHAIRMAN. The Chair recognizes the gentleman from North Carolina [Mr. ROSE] for 5 minutes.

Mr. ROSE. Mr. Chairman, the amendment that the gentlewoman from Arizona [Ms. ENGLISH] has written says the Committee on House Administration shall have authority to prescribe regulations to carry out this section.

Now, if this comes to the committee, and I would recommend to all my colleagues in the House, I would like to ask my colleagues for a birthday present. This is my birthday today. I am 55 years old; do my colleagues want to vote on that?

I say to my colleagues, "Let's don't have a recorded vote on this. I really wish we could just accept this amendment. I'm willing to work within the committee to do what I believe it is the gentlewoman is after."

The gentlewoman's main concern is that frequent flyer points not be used in any way for personal use. Is that not correct?

Ms. ENGLISH of Arizona. Mr. Chairman, will the gentleman yield?

Mr. ROSE. I yield to the gentlewoman from Arizona.

Ms. ENGLISH of Arizona. Mr. Chairman, the gentleman is correct.

Mr. ROSE. And that they be used for the official things that we do around here that are the official business of the House; is that correct?

Ms. ENGLISH of Arizona. That is correct.

Mr. ROSE. OK.

Mr. Chairman, I have no objection to this amendment.

The CHAIRMAN pro tempore (Mr. MURTHA). The question is on the amendment offered by the gentlewoman from Arizona [Ms. ENGLISH].

The question was taken; and the Chairman pro tempore being in doubt, the Committee divided, and there were—ayes 57, noes 2.

So the amendment was agreed to.

The CHAIRMAN pro tempore. The question is on the amendment in the nature of a substitute, as modified as amended.

The amendment in the nature of a substitute, as modified as amended, was agreed to.

The CHAIRMAN pro tempore. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker having resumed the chair, Mr. MURTHA, Chairman pro tempore of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 4822) to make certain laws applicable to the legislative branch of the Federal Government, pursuant to House Resolution 514, he reported the bill back to the House with an amendment adopted by the Committee of the Whole.

The SPEAKER. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment to the amendment in the nature of a substitute adopted by the Committee of the Whole?

If not, the question is on the amendment.

The amendment was agreed to.

The SPEAKER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER. The question is on the passage of the bill.

The question was taken; and the Speaker announced that the ayes appeared to have it.

Mr. SHAYS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 427, nays 4, not voting 4, as follows:

[Roll No. 390]

YEAS—427

Abercrombie
Ackerman
Allard
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Archer
Armey
Bacchus (FL)
Bachus (AL)
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barca
Barcia
Barlow
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bateman
Becerra
Beilenson
Bentley
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Blackwell
Bliley
Blute
Boehlert
Boehner
Bonilla
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Bunning
Burton
Buyer
Byrne
Callahan
Calvert
Camp
Canady
Cantwell
Cardin
Carr
Castle
Chapman
Clayton
Clement
Clinger
Clyburn
Coble
Coleman
Collins (GA)
Collins (IL)
Combest
Condit
Conyers
Cooper
Coppersmith
Costello
Cox
Coyne
Cramer
Crane
Crapo
Cunningham
Danner
Darden
de la Garza
Deal
DeFazio
DeLauro
DeLay
Dellums
Derrick
Deutsch
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Dooley
Doolittle
Dornan
Dreier
Duncan
Dunn
Durbin
Edwards (CA)
Edwards (TX)
Ehlers
Emerson
Engel
English
Eshoo
Evans
Everett
Ewing
Farr
Fawell
Fazio
Fields (LA)
Fields (TX)
Filner
Fingerhut
Fish
Flake
Foglietta
Foley
Ford (TN)
Fowler
Frank (MA)
Franks (CT)
Franks (NJ)
Frost
Furse
Gallegly
Gejdenson
Gekas
Gephardt
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Glickman
Goodlatte
Goodling
Gordon
Goss
Grams
Grandy
Green
Greenwood
Gunderson
Gutierrez
Hall (OH)
Hall (TX)
Hamburg
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings
Hayes
Hefley
Hefner
Hilliard
Hinchey
Hoagland
Hobson
Hochbrueckner
Hoekstra
Hoke
Holden
Horn
Houghton
Hoyer
Huffington
Hughes
Hunter
Hutchinson
Hutto
Hyde
Inglis
Inhofe
Inslee
Istook
Jacobs
Jefferson
Johnson (CT)
Johnson (GA)
Johnson (SD)
Johnson, E. B.
Johnson, Sam
Johnston
Kanjorski
Kaptur
Kasich
Kennedy
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klein
Klink
Klug
Knollenberg
Kolbe
Kopetski
Kreidler
Kyl
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lazio
Leach
Lehman
Levin
Levy
Lewis (CA)
Lewis (FL)
Lewis (GA)
Lewis (KY)
Lightfoot
Linder
Lipinski
Livingston
Lloyd
Long
Lowey
Lucas
Machtley
Maloney
Mann
Manton
Manzullo
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCandless
McCloskey
McCollum
McCrery
McCurdy
McDade
McDermott
McHale
McHugh
McInnis
McKeon
McKinney
McMillan
McNulty
Meehan
Meek
Menendez
Meyers
Mfume
Mica
Michel
Miller (CA)
Miller (FL)
Mineta
Minge
Mink
Moakley
Mollohan
Montgomery
Moorhead
Moran
Morella
Murphy
Murtha
Myers
Nadler
Neal (MA)
Neal (NC)
Nussle
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Oxley
Packard
Pallone
Parker
Pastor
Paxon
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pickle
Pombo
Pomeroy
Porter
Portman
Poshard
Price (NC)
Pryce (OH)
Quillen
Quinn
Rahall
Ramstad
Rangel
Ravenel
Reed
Regula
Reynolds
Richardson
Ridge
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Rostenkowski
Roth
Roukema
Rowland
Roybal-Allard
Royce
Rush
Sabo
Sanders
Sangmeister
Santorum
Sarpalius
Sawyer
Saxton
Schaefer
Schenk
Schiff
Schroeder
Schumer
Scott
Sensenbrenner
Serrano
Sharp
Shaw
Shays
Shepherd
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slattery
Slaughter
Smith (IA)
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Snowe
Solomon
Spence
Spratt
Stark
Stearns
Stenholm
Stokes
Strickland
Studds
Stump
Stupak
Sundquist
Swett
Swift
Synar
Talent
Tanner
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thomas (CA)
Thomas (WY)
Thompson
Thornton
Thurman
Torkildsen
Torres
Torricelli
Towns
Traficant
Tucker
Unsoeld
Upton
Valentine
Velazquez
Vento
Visclosky
Volkmer
Vucanovich
Walker
Walsh
Waters
Watt
Waxman
Weldon
Wheat
Whitten
Williams
Wilson
Wise
Wolf
Woolsey
Wyden
Wynn
Yates
Young (AK)
Young (FL)
Zeliff
Zimmer

NAYS—4

Clay
Collins (MI)
Ford (MI)
Gonzalez

NOT VOTING—4

Gallo
Herger
Molinari
Washington

☐ 1849

Mr. MOORHEAD, Mr. ARCHER, and Ms. EDDIE BERNICE JOHNSON of Texas changed their vote from "nay" to "yea."

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

KING HOLIDAY AND SERVICE ACT OF 1994

Mr. SAWYER. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the bill (H.R. 1933) to authorize appropriations for the Martin Luther King, Jr. Federal Holiday Commission, to extend such Commission, and to support the planning and performance of national service opportunities in conjunction with the Federal legal holiday honoring the birthday of Martin Luther King, Jr., with Senate amendments thereto, and concur in the Senate amendments.

The Clerk read the title of the bill.

The Clerk read the Senate amendments, as follows:

Senate amendments: Page 2, strike out lines 17 to 21 and insert:

(3) in section 6—

(A) in subsection (a) by striking "maximum rate of pay payable for grade GS–18 of the General Schedule under section 5332" and inserting "rate of pay for level IV of the Executive Schedule under section 5315";

(B) in subsection (b)(1) by adding the following at the end: "A person who has been detailed under the preceding sentence for as many as 365 days (continuously or intermittently) may not subsequently be detailed to the Commission."; and

(C) All Federal employees on loan to the King Commission on the day of enactment of this Act may remain detailed to the Martin Luther King Holiday Commission for not more than 365 days.

Page 3, strike out all after line 3 down to and including "1990" " in line 6 and insert:

(5) by amending section 8 to read as follows:

"SEC. 8. COMMISSION REPORT.

"(a) IN GENERAL.—Not later than April 20 of each year, the Commission shall submit a report to the President and the Congress concerning its activities under this Act or under the National and Community Service Act of 1990.

"(b) ANALYSIS REQUIRED.—The Commission shall include in its annual report—

"(1) a detailed description of all activities undertaken by the Commission;

"(2) an analysis of the spending practices of the Commission indicating how much of the funds of the Commission are dedicated to salaries, travel expenses, and other overhead costs and how much are dedicated to the stated goals of the Commission; and

"(3) a detailed description of any grants made by the Corporation for National and Community Service with the consultation of the Commission.";

Page 3, line 6, strike out "; and"

Page 3, line 8, strike out the period and insert a semicolon

Page 3, after line 8, insert:

(7) by adding at the end the following new section:

"SEC. 10. None of the funds appropriated or donated to the Commission may be used for the purpose of purchasing first class air travel or first class hotel accommodations."; and

Page 3, after line 8, insert:

(8) by adding at the end the following:

"SEC. 11. ACCOUNTING PROCEDURES.

"The Commission shall follow a comprehensive basis of accounting, as defined by the Comptroller General in B-255473. The Commission shall establish an accounting system for review by the Comptroller General under section 3512 of title 31, United States Code. The Comptroller General is authorized to review and audit the Commission, its programs, activities, operations, and financial transactions. The Comptroller General, and his agents, shall have access to all records, files, documents, and papers of the Commission, as necessary, to accomplish such audits.".

Mr. SAWYER (during the reading). Mr. Speaker, I ask unanimous consent that the Senate amendments to the bill be considered as read and printed in the RECORD.

The SPEAKER pro tempore (Mr. CLYBURN). Is there objection to the request of the gentleman from Ohio?

There was no objection.

The SPEAKER pro tempore. Is there objection to the initial request of the gentleman from Ohio?

Mr. GILMAN. Mr. Speaker, reserving the right to object, I yield to my good friend and colleague, the gentleman from Ohio [Mr. SAWYER], chairman of the Subcommittee on Census, Statistics, and Postal Personnel of the Committee on Post Office and Civil Service, for an explanation of the Senate amendments.

Mr. SAWYER. Mr. Speaker, first of all, let me thank my friend and colleague, the gentleman from New York. We have worked closely on this and a number of other pieces of important legislation, and I appreciate his cooperation.

Mr. Speaker, I urge my colleagues to support H.R. 1933, the King Holiday and Service Act, as amended by the Senate.

As passed by the House last March, H.R. 1933 contained three major provisions. First, it would extend the life of the Martin Luther King, Jr. Federal Holiday Commission for 5 years, through fiscal year 1999.

Second, the bill authorizes $300,000 for fiscal year 1995; and increases that amount by a modest $50,000 each year through fiscal year 1999.

Finally, H.R. 1933 authorizes the Corporation for National and Community Service to make grants for planning and carrying out community service opportunities in conjunction with the King holiday.

The Commission sponsors activities throughout the year. However, it is the Federal holiday that casts the necessary light on the continued importance of Martin Luther King, Jr.'s legacy to so many facets of our lives today.

I believe that the Commission is a modest investment for the Federal Government to make in bridging the often wide gap between people of different races and cultures that threatens both social and economic progress in our country.

The Senate considered and passed H.R. 1933 on May 24, with several amendments. The amendments do not make any substantive changes to the bill. They are intended to improve the operation of the Commission and to ensure the most cost-effective use of fiscal and human resources.

Therefore, I urge my colleagues to approve the King Holiday and Service Act, as amended by the Senate.

Mr. GILMAN. Mr. Speaker, further reserving the right to object, I want to thank the gentleman for his explanation of this important commission.

Mr. Speaker, under my reservation of objection, I am pleased to yield to the gentleman from Georgia [Mr. LEWIS].

Mr. LEWIS of Georgia. Mr. Speaker, I wish to thank my good friend and colleague, the gentleman from New York, for yielding. I also thank the gentleman from Ohio [Mr. SAWYER], who has been a strong leader on behalf of this legislation. I want to thank him for his initiative, his vision, his leadership, and his wholehearted support. I would like to also thank the gentleman from New York for his support.

Mr. Speaker, I strongly urge passage of H.R. 1933, as amended by the Senate, to reauthorize the Martin Luther King, Jr. Federal Holiday Commission. The King Commission has done an excellent job of promoting the King holiday. As we know, the King holiday is now celebrated in all 50 States, the District of Columbia, in the military, and in more than 100 nations.

But I believe there is work left to be done. Today, we are witnessing an increase in violence in our schools, in our streets, on our playgrounds. Our children have become victims of violence at the hands of other children. Gang killings have nearly tripled in the last 4 years; 100,000 children bring guns to school each day. Too many of us have had young friends killed by violence. Too many of us have lost our sons. Lost our daughters.

We must stop the violence.

The King Commission is out on the front lines, in our communities, in our cities, fighting violence. It has provided the leadership, guidance, and resources for activities promoting nonviolence throughout the Nation. It is fighting to end the cycle of violence and drug use in our schools, in our communities. It is fighting to make the King holiday a day of reaching out and helping others, a day of interracial cooperation.

Dr. King spoke to the heart and conscience of all of us who believed that nonviolence offered a more excellent way of achieving equality in this country. He was a spokesperson, not only for African-Americans, but for every American. A day in celebration of what he stood for should be a day in celebration of what we all stand for. It should be a celebration of community. It should be a celebration of coming together. It should be a celebration of what America should be, what America could be. It should be a promise of Dr. King's beloved community, a community founded on love, respect, and hope.

We must extend the life of the King Commission, and help make the Martin Luther King, Jr. holiday a holiday for us all.

Mr. GILMAN. Mr. Speaker, further reserving the right to object, I am pleased to yield to the gentleman from Ohio [Mr. SAWYER].

Mr. SAWYER. Mr. Speaker, I thank my friend, the gentleman from New York, for yielding to me.

Mr. Speaker, I appreciate the opportunity simply to associate myself with the remarks of our colleague, the gentleman from Georgia [Mr. LEWIS], and to thank him for his leadership and sponsorship of this measure, and to also thank our colleague, the gentleman from Ohio [Mr. REGULA] for his leadership throughout this, although he could not be with us this afternoon.

Mr. GILMAN. Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER pro tempore. Is there objection to the initial request of the gentleman from Ohio?

There was no objection.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. SAWYER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks, and to include extraneous matter, on the bill, H.R. 1933, and the Senate amendments thereto.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

COMMUNICATION FROM THE HONORABLE BILL McCOLLUM, MEMBER OF CONGRESS

The SPEAKER pro tempore laid before the House the following communication from the Honorable BILL McCOLLUM, Member of Congress:

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, August 9, 1994.

Hon. THOMAS S. FOLEY,
Speaker, U.S. House of Representatives, Washington, DC.

DEAR MR. SPEAKER: This is to formally notify you pursuant to Rule L (50) of the Rules of the House that my office has been served with a subpoena issued by the State of Florida, Division of Administrative Hearings in connection with a civil case involving constituent casework.

After consultation with the General Counsel, I will determine if compliance with the subpoena is consistent with the privileges and precedents of the House.

Sincerely,

BILL MCCOLLUM,
Member of Congress.

□ 1900

CONFERENCE REPORT ON H.R. 3355, VIOLENT CRIME CONTROL AND LAW ENFORCEMENT ACT OF 1993

Mr. BROOKS submitted the following conference report and statement on the bill (H.R. 3355) to amend the Omnibus Crime Control and Safe Streets Act of 1968 to allow grants to increase police presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and otherwise to enhance public safety:

CONFERENCE REPORT (H. REPT. 103-694)

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the amendment of the Senate to the bill (H.R. 3355), to amend the Omnibus Crime Control and Safe Streets Act of 1968 to allow grants to increase police presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and otherwise to enhance public safety, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Violent Crime Control and Law Enforcement Act of 1994".

SEC. 2. TABLE OF CONTENTS.

The following is the table of contents for this Act:

Sec. 1. Short title.
Sec. 2. Table of contents.

TITLE I—PUBLIC SAFETY AND POLICING

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Sec. 330023. Technical corrections relating to section 248 of title 18, United States Code.
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TITLE I—PUBLIC SAFETY AND POLICING

SEC. 10001. SHORT TITLE.

This title may be cited as the "Public Safety Partnership and Community Policing Act of 1994".

SEC. 10002. PURPOSES.

The purposes of this title are to—

(1) substantially increase the number of law enforcement officers interacting directly with members of the community ("cops on the beat");

(2) provide additional and more effective training to law enforcement officers to enhance their problem solving, service, and other skills needed in interacting with members of the community;

(3) encourage the development and implementation of innovative programs to permit members of the community to assist State, Indian tribal government, and local law enforcement agencies in the prevention of crime in the community; and

(4) encourage the development of new technologies to assist State, Indian tribal government, and local law enforcement agencies in reorienting the emphasis of their activities from reacting to crime to preventing crime,

by establishing a program of grants and assistance in furtherance of these objectives, including the authorization for a period of 6 years of grants for the hiring and rehiring of additional career law enforcement officers.

SEC. 10003. COMMUNITY POLICING; "COPS ON THE BEAT".

(a) IN GENERAL.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.) is amended—

(1) by redesignating part Q as part R;

(2) by redesignating section 1701 as section 1801; and

(3) by inserting after part P the following new part:

"PART Q—PUBLIC SAFETY AND COMMUNITY POLICING; 'COPS ON THE BEAT'

"SEC. 1701. AUTHORITY TO MAKE PUBLIC SAFETY AND COMMUNITY POLICING GRANTS.

"(a) GRANT AUTHORIZATION.—The Attorney General may make grants to States, units of local government, Indian tribal governments, other public and private entities, and multi-jurisdictional or regional consortia thereof to increase police presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and otherwise to enhance public safety.

"(b) REHIRING, HIRING, AND INITIAL REDEPLOYMENT GRANT PROJECTS.—

"(1) IN GENERAL.—Grants made under subsection (a) may be used for programs, projects, and other activities to—

"(A) rehire law enforcement officers who have been laid off as a result of State and local budget reductions for deployment in community-oriented policing;

"(B) hire and train new, additional career law enforcement officers for deployment in community-oriented policing across the Nation; and

"(C) procure equipment, technology, or support systems, or pay overtime, if the applicant for such a grant demonstrates to the satisfaction of the Attorney General that expenditures for such purposes would result in an increase in the number of officers deployed in community-oriented policing equal to or greater than the increase in the number of officers that would result from a grant for a like amount for the purposes specified in subparagraph (A) or (B).

"(2) GRANTS FOR EQUIPMENT, TECHNOLOGY, AND SUPPORT SYSTEMS.—Grants pursuant to paragraph (1)(C)—

"(A) may not exceed—

"(i) 20 percent of the funds available for grants pursuant to this subsection in fiscal year 1995;

"(ii) 20 percent of the funds available for grants pursuant to this subsection in fiscal year 1996; or

"(iii) 10 percent of the funds available for grants pursuant to this subsection in fiscal years 1997, 1998, 1999, and 2000; and

"(B) may not be awarded in fiscal years 1998, 1999, or 2000 unless the Attorney General has certified that grants awarded in fiscal years 1995, 1996, and 1997 pursuant to subparagraph (1)(C) have resulted in an increase in the number of officers deployed in community-oriented policing equal to or greater than the increase in the number of officers that have resulted from the grants in like amounts awarded in fiscal years 1995, 1996, and 1997 pursuant to paragraph (1) (A) and (B).

"(c) TROOPS-TO-COPS PROGRAMS.—

"(1) IN GENERAL.—Grants made under subsection (a) may be used to hire former members of the Armed Forces to serve as career law enforcement officers for deployment in community-oriented policing, particularly in communities that are adversely affected by a recent military base closing.

"(2) DEFINITION.—In this subsection, 'former member of the Armed Forces' means a member of the Armed Forces of the United States who is involuntarily separated from the Armed Forces within the meaning of section 1141 of title 10, United States Code.

"(d) ADDITIONAL GRANT PROJECTS.—Grants made under subsection (a) may include programs, projects, and other activities to—

"(1) increase the number of law enforcement officers involved in activities that are focused on interaction with members of the community on proactive crime control and prevention by redeploying officers to such activities;

"(2) provide specialized training to law enforcement officers to enhance their conflict resolution, mediation, problem solving, service, and other skills needed to work in partnership with members of the community;

"(3) increase police participation in multidisciplinary early intervention teams;

"(4) develop new technologies to assist State and local law enforcement agencies in reorienting the emphasis of their activities from reacting to crime to preventing crime;

"(5) develop and implement innovative programs to permit members of the community to assist State and local law enforcement agencies in the prevention of crime in the community, such as a citizens' police academy, including programs designed to increase the level of access to the criminal justice system enjoyed by victims, witnesses, and ordinary citizens by establishing decentralized satellite offices (including video facilities) of principal criminal courts buildings;

"(6) establish innovative programs to reduce, and keep to a minimum, the amount of time that law enforcement officers must be away from the community while awaiting court appearances;

"(7) establish and implement innovative programs to increase and enhance proactive crime control and prevention programs involving law enforcement officers and young persons in the community;

"(8) develop and establish new administrative and managerial systems to facilitate the adoption of community-oriented policing as an organization-wide philosophy;

"(9) establish, implement, and coordinate crime prevention and control programs (involving law enforcement officers working with community members) with other Federal programs that serve the community and community members to better address the comprehensive needs of the community and its members; and

"(10) support the purchase by a law enforcement agency of no more than 1 service weapon per officer, upon hiring for deployment in community-oriented policing or, if necessary, upon existing officers' initial redeployment to community-oriented policing.

"(e) PREFERENTIAL CONSIDERATION OF APPLICATIONS FOR CERTAIN GRANTS.—In awarding grants under this part, the Attorney General may give preferential consideration, where feasible, to applications for hiring and rehiring additional career law enforcement officers that involve a non-Federal contribution exceeding the 25 percent minimum under subsection (i).

"(f) TECHNICAL ASSISTANCE.—

"(1) IN GENERAL.—The Attorney General may provide technical assistance to States, units of local government, Indian tribal governments, and to other public and private entities, in furtherance of the purposes of the Public Safety Partnership and Community Policing Act of 1994.

"(2) MODEL.—The technical assistance provided by the Attorney General may include the development of a flexible model that will define for State and local governments, and other public and private entities, definitions and strategies associated with community or problem-oriented policing and methodologies for its implementation.

"(3) TRAINING CENTERS AND FACILITIES.—The technical assistance provided by the Attorney General may include the establishment and operation of training centers or facilities, either directly or by contracting or cooperative arrangements. The functions of the centers or facilities established under this paragraph may include instruction and seminars for police executives, managers, trainers, supervisors, and such others as the Attorney General considers to be appropriate concerning community or problem-oriented policing and improvements in police-community interaction and cooperation that further the purposes of the Public Safety Partnership and Community Policing Act of 1994.

"(g) UTILIZATION OF COMPONENTS.—The Attorney General may utilize any component or components of the Department of Justice in carrying out this part.

"(h) MINIMUM AMOUNT.—Unless all applications submitted by any State and grantee within the State pursuant to subsection (a) have been funded, each qualifying State, together with grantees within the State, shall receive in each fiscal year pursuant to subsection (a) not less than 0.5 percent of the total amount appropriated in the fiscal year for grants pursuant to that subsection. In this subsection, 'qualifying State' means any State which has submitted an application for a grant, or in which an eligible entity has submitted an application for a grant, which meets the requirements prescribed by the Attorney General and the conditions set out in this part.

"(i) MATCHING FUNDS.—The portion of the costs of a program, project, or activity provided by a grant under subsection (a) may not exceed 75 percent, unless the Attorney General waives, wholly or in part, the requirement under this subsection of a non-Federal contribution to the costs of a program, project, or activity. In relation to a grant for a period exceeding 1 year for hiring or rehiring career law enforcement officers, the Federal share shall decrease from year to year for up to 5 years, looking toward the continuation of the increased hiring level using State or local sources of funding following the conclusion of Federal support, as provided in an approved plan pursuant to section 1702(c)(8).

"(j) ALLOCATION OF FUNDS.—The funds available under this part shall be allocated as provided in section 1001(a)(11)(B).

"(k) TERMINATION OF GRANTS FOR HIRING OFFICERS.—The authority under subsection (a) of this section to make grants for the hiring and rehiring of additional career law enforcement officers shall lapse at the conclusion of 6 years from the date of enactment of this part. Prior to the expiration of this grant authority, the Attorney General shall submit a report to Congress concerning the experience with and effects of such grants. The report may include any recommendations the Attorney General may have for amendments to this part and related provisions of law in light of the termination of the authority to make grants for the hiring and rehiring of additional career law enforcement officers.

"SEC. 1702. APPLICATIONS.

"(a) IN GENERAL.—No grant may be made under this part unless an application has been submitted to, and approved by, the Attorney General.

"(b) APPLICATION.—An application for a grant under this part shall be submitted in such form, and contain such information, as the Attorney General may prescribe by regulation or guidelines.

"(c) CONTENTS.—In accordance with the regulations or guidelines established by the Attorney General, each application for a grant under this part shall—

"(1) include a long-term strategy and detailed implementation plan that reflects consultation with community groups and appropriate private and public agencies and reflects consideration of the statewide strategy under section 503(a)(1);

"(2) demonstrate a specific public safety need;

"(3) explain the applicant's inability to address the need without Federal assistance;

"(4) identify related governmental and community initiatives which complement or will be coordinated with the proposal;

"(5) certify that there has been appropriate coordination with all affected agencies;

"(6) outline the initial and ongoing level of community support for implementing the proposal including financial and in-kind contributions or other tangible commitments;

"(7) specify plans for obtaining necessary support and continuing the proposed program, project, or activity following the conclusion of Federal support;

"(8) if the application is for a grant for hiring or rehiring additional career law enforcement officers, specify plans for the assumption by the applicant of a progressively larger share of the cost in the course of time, looking toward the continuation of the increased hiring level using State or local sources of funding following the conclusion of Federal support;

"(9) assess the impact, if any, of the increase in police resources on other components of the criminal justice system;

"(10) explain how the grant will be utilized to reorient the affected law enforcement agency's mission toward community-oriented policing or enhance its involvement in or commitment to community-oriented policing; and

"(11) provide assurances that the applicant will, to the extent practicable, seek, recruit, and hire members of racial and ethnic minority groups and women in order to increase their ranks within the sworn positions in the law enforcement agency.

"(d) SPECIAL PROVISIONS.—

"(1) SMALL JURISDICTIONS.—Notwithstanding any other provision of this part, in relation to applications under this part of units of local government or law enforcement agencies having jurisdiction over areas with population of less than 50,000, the Attorney General may waive 1 or more of the requirements of subsection (c) and may otherwise make special provisions to facilitate the expedited submission, processing, and approval of such applications.

"(2) SMALL GRANT AMOUNT.—Notwithstanding any other provision of this part, in relation to applications under section 1701(d) for grants of less than $1,000,000, the Attorney General may waive 1 or more of the requirements of subsection (c) and may otherwise make special provisions to facilitate the expedited submission, processing, and approval of such applications.

"SEC. 1703. RENEWAL OF GRANTS.

"(a) IN GENERAL.—Except for grants made for hiring or rehiring additional career law enforcement officers, a grant under this part may be renewed for up to 2 additional years after the first

fiscal year during which a recipient receives its initial grant, if the Attorney General determines that the funds made available to the recipient were used in a manner required under an approved application and if the recipient can demonstrate significant progress in achieving the objectives of the initial application.

"(b) GRANTS FOR HIRING.—Grants made for hiring or rehiring additional career law enforcement officers may be renewed for up to 5 years, subject to the requirements of subsection (a), but notwithstanding the limitation in that subsection concerning the number of years for which grants may be renewed.

"(c) MULTIYEAR GRANTS.—A grant for a period exceeding 1 year may be renewed as provided in this section, except that the total duration of such a grant including any renewals may not exceed 3 years, or 5 years if it is a grant made for hiring or rehiring additional career law enforcement officers.

"SEC. 1704. LIMITATION ON USE OF FUNDS.

"(a) NONSUPPLANTING REQUIREMENT.—Funds made available under this part to States or units of local government shall not be used to supplant State or local funds, or, in the case of Indian tribal governments, funds supplied by the Bureau of Indian Affairs, but shall be used to increase the amount of funds that would, in the absence of Federal funds received under this part, be made available from State or local sources, or in the case of Indian tribal governments, from funds supplied by the Bureau of Indian Affairs.

"(b) NON-FEDERAL COSTS.—

"(1) IN GENERAL.—States and units of local government may use assets received through the Assets Forfeiture equitable sharing program to provide the non-Federal share of the cost of programs, projects, and activities funded under this part.

"(2) INDIAN TRIBAL GOVERNMENTS.—Funds appropriated by the Congress for the activities of any agency of an Indian tribal government or the Bureau of Indian Affairs performing law enforcement functions on any Indian lands may be used to provide the non-Federal share of the cost of programs or projects funded under this part.

"(c) HIRING COSTS.—Funding provided under this part for hiring or rehiring a career law enforcement officer may not exceed $75,000, unless the Attorney General grants a waiver from this limitation.

"SEC. 1705. PERFORMANCE EVALUATION.

"(a) MONITORING COMPONENTS.—Each program, project, or activity funded under this part shall contain a monitoring component, developed pursuant to guidelines established by the Attorney General. The monitoring required by this subsection shall include systematic identification and collection of data about activities, accomplishments, and programs throughout the life of the program, project, or activity and presentation of such data in a usable form.

"(b) EVALUATION COMPONENTS.—Selected grant recipients shall be evaluated on the local level or as part of a national evaluation, pursuant to guidelines established by the Attorney General. Such evaluations may include assessments of individual program implementations. In selected jurisdictions that are able to support outcome evaluations, the effectiveness of funded programs, projects, and activities may be required. Outcome measures may include crime and victimization indicators, quality of life measures, community perceptions, and police perceptions of their own work.

"(c) PERIODIC REVIEW AND REPORTS.—The Attorney General may require a grant recipient to submit to the Attorney General the results of the monitoring and evaluations required under subsections (a) and (b) and such other data and information as the Attorney General deems reasonably necessary.

"SEC. 1706. REVOCATION OR SUSPENSION OF FUNDING.

"If the Attorney General determines, as a result of the reviews required by section 1705, or otherwise, that a grant recipient under this part is not in substantial compliance with the terms and requirements of an approved grant application submitted under section 1702, the Attorney General may revoke or suspend funding of that grant, in whole or in part.

"SEC. 1707. ACCESS TO DOCUMENTS.

"(a) BY THE ATTORNEY GENERAL.—The Attorney General shall have access for the purpose of audit and examination to any pertinent books, documents, papers, or records of a grant recipient under this part and to the pertinent books, documents, papers, or records of State and local governments, persons, businesses, and other entities that are involved in programs, projects, or activities for which assistance is provided under this part.

"(b) BY THE COMPTROLLER GENERAL.—Subsection (a) shall apply with respect to audits and examinations conducted by the Comptroller General of the United States or by an authorized representative of the Comptroller General.

"SEC. 1708. GENERAL REGULATORY AUTHORITY.

"The Attorney General may promulgate regulations and guidelines to carry out this part.

"SEC. 1709. DEFINITIONS.

"In this part—

" 'career law enforcement officer' means a person hired on a permanent basis who is authorized by law or by a State or local public agency to engage in or supervise the prevention, detection, or investigation of violations of criminal laws.

" 'citizens' police academy' means a program by local law enforcement agencies or private non profit organizations in which citizens, especially those who participate in neighborhood watch programs, are trained in ways of facilitating communication between the community and local law enforcement in the prevention of crime.

" 'Indian tribe' means a tribe, band, pueblo, nation, or other organized group or community of Indians, including an Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.)), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.".

(b) TECHNICAL AMENDMENT.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711, et seq.) is amended by striking the item relating to part Q and inserting the following:

"PART Q—PUBLIC SAFETY AND COMMUNITY POLICING; 'COPS ON THE BEAT'

"Sec. 1701. Authority to make public safety and community policing grants.
"Sec. 1702. Applications.
"Sec. 1703. Renewal of grants.
"Sec. 1704. Limitation on use of funds.
"Sec. 1705. Performance evaluation.
"Sec. 1706. Revocation or suspension of funding.
"Sec. 1707. Access to documents.
"Sec. 1708. General regulatory authority.
"Sec. 1709. Definition.

"PART R—TRANSITION; EFFECTIVE DATE; REPEALER

"Sec. 1801. Continuation of rules, authorities, and proceedings.".

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793) is amended—

(1) in paragraph (3) by striking "and O" and inserting "O, P, and Q"; and

(2) by adding at the end the following new paragraph:

"(11)(A) There are authorized to be appropriated to carry out part Q, to remain available until expended—

"(i) $1,332,000,000 for fiscal year 1995;
"(ii) $1,850,000,000 for fiscal year 1996;
"(iii) $1,950,000,000 for fiscal year 1997;
"(iv) $1,700,000,000 for fiscal year 1998;
"(v) $1,700,000,000 for fiscal year 1999; and
"(vi) $268,000,000 for fiscal year 2000.

"(B) Of funds available under part Q in any fiscal year, up to three percent may be used for technical assistance under section 1701(f) or for evaluations or studies carried out or commissioned by the Attorney General in furtherance of the purposes of part Q. Of the remaining funds, 50 percent shall be allocated for grants pursuant to applications submitted by units of local government or law enforcement agencies having jurisdiction over areas with populations exceeding 150,000 or by public and private entities that serve areas with populations exceeding 150,000, and 50 percent shall be allocated for grants pursuant to applications submitted by units of local government or law enforcement agencies having jurisdiction over areas with populations 150,000 or less or by public and private entities that serve areas with populations 150,000 or less. Of the funds available in relation to grants under part Q, at least 85 percent shall be applied to grants for the purposes specified in section 1701(b), and no more than 15 percent may be applied to other grants in furtherance of the purposes of part Q. In view of the extraordinary need for law enforcement assistance in Indian country, an appropriate amount of funds available under part Q shall be made available for grants to Indian tribal governments or tribal law enforcement agencies.".

TITLE II—PRISONS

Subtitle A—Violent Offender Incarceration and Truth in Sentencing Incentive Grants

SEC. 20101. GRANTS FOR CORRECTIONAL FACILITIES.

(a) GRANT AUTHORIZATION.—The Attorney General may make grants to individual States and to States organized as multi-State compacts to develop, expand, modify, operate, or improve correctional facilities and programs, including boot camp facilities and programs and other alternative confinement facilities and programs that can free conventional prison space for the confinement of violent offenders, to ensure that prison cell space is available for the confinement of violent offenders and to implement truth in sentencing laws for sentencing violent offenders.

(b) ELIGIBILITY.—To be eligible to receive a grant under this subtitle, a State or States organized as multi-State compacts shall submit an application to the Attorney General which includes—

(1) assurances that the State or States have implemented, or will implement, correctional policies and programs, including truth in sentencing laws that ensure that violent offenders serve a substantial portion of the sentences imposed, that are designed to provide sufficiently severe punishment for violent offenders, including violent juvenile offenders, and that the prison time served is appropriately related to the determination that the inmate is a violent offender and for a period of time deemed necessary to protect the public;

(2) assurances that the State or States have implemented policies that provide for the recognition of the rights and needs of crime victims;

(3) assurances that funds received under this section will be used to develop, expand, modify, operate, or improve correctional facilities and programs to ensure that prison cell space is available for the confinement of violent offenders;

(4) assurances that the State or States have a comprehensive correctional plan which represents an integrated approach to the management and operation of correctional facilities and programs and which includes diversion programs, particularly drug diversion programs, community corrections programs, a prisoner screening and security classification system, appropriate professional training for corrections officers in dealing with violent offenders, prisoner rehabilitation and treatment programs, prisoner work activities (including, to the extent practicable, activities relating to the development, expansion, modification, or improvement of correctional facilities) and job skills programs, educational programs, a pre-release prisoner assessment to provide risk reduction management, post-release assistance, and an assessment of recidivism rates;

(5) assurances that the State or States have involved counties and other units of local government, when appropriate, in the development, expansion, modification, operation or improvement of correctional facilities and programs designed to ensure the incarceration of violent offenders, and that the State or States will share funds received under this section with counties and other units of local government, taking into account the burden placed on these units of government when they are required to confine sentenced prisoners because of overcrowding in State prison facilities;

(6) assurances that funds received under this section will be used to supplement, not supplant, other Federal, State, and local funds;

(7) assurances that the State or States have implemented, or will implement within 18 months after the date of the enactment of this Act, policies to determine the veteran status of inmates and to ensure that incarcerated veterans receive the veterans benefits to which they are entitled;

(8) if applicable, documentation of the multi-State compact agreement that specifies the development, expansion, modification, operation, or improvement of correctional facilities and programs; and

(9) if applicable, a description of the eligibility criteria for prisoner participation in any boot camp that is to be funded.

(c) CONSIDERATION.—The Attorney General, in making such grants, shall give consideration to the special burden placed on States which incarcerate a substantial number of inmates who are in the United States illegally.

SEC. 20102. TRUTH IN SENTENCING INCENTIVE GRANTS.

(a) TRUTH IN SENTENCING GRANT PROGRAM.—Forty percent of the total amount of funds appropriated to carry out this subtitle for each of fiscal years 1995, 1996, 1997, 1998, 1999, and 2000 shall be made available for Truth in Sentencing Incentive Grants. To be eligible to receive such a grant, a State must meet the requirements of section 20101(b) and shall demonstrate that the State—

(1) has in effect laws which require that persons convicted of violent crimes serve not less than 85 percent of the sentence imposed; or

(2) since 1993—

(A) has increased the percentage of convicted violent offenders sentenced to prison;

(B) has increased the average prison time which will be served in prison by convicted violent offenders sentenced to prison;

(C) has increased the percentage of sentence which will be served in prison by violent offenders sentenced to prison; and

(D) has in effect at the time of application laws requiring that a person who is convicted of a violent crime shall serve not less than 85 percent of the sentence imposed if—

(i) the person has been convicted on 1 or more prior occasions in a court of the United States or of a State of a violent crime or a serious drug offense; and

(ii) each violent crime or serious drug offense was committed after the defendant's conviction of the preceding violent crime or serious drug offense.

(b) ALLOCATION OF TRUTH IN SENTENCING INCENTIVE FUNDS.—

(1) FORMULA ALLOCATION.—The amount available to carry out this section for any fiscal year under subsection (a) shall be allocated to each eligible State in the ratio that the number of part 1 violent crimes reported by such State to the Federal Bureau of Investigation for 1993 bears to the number of part 1 violent crimes reported by all States to the Federal Bureau of Investigation for 1993.

(2) TRANSFER OF UNUSED FUNDS.—On September 30 of each of fiscal years 1996, 1998, 1999, and 2000, the Attorney General shall transfer to the funds to be allocated under section 20103(b)(1) any funds made available to carry out this section that are not allocated to an eligible State under paragraph (1).

SEC. 20103. VIOLENT OFFENDER INCARCERATION GRANTS.

(a) VIOLENT OFFENDER INCARCERATION GRANT PROGRAM.—Sixty percent of the total amount of funds appropriated to carry out this subtitle for each of fiscal years 1995, 1996, 1997, 1998, 1999, and 2000 shall be made available for Violent Offender Incarceration Grants. To be eligible to receive such a grant, a State or States must meet the requirements of section 20101(b).

(b) ALLOCATION OF VIOLENT OFFENDER INCARCERATION FUNDS.—

(1) FORMULA ALLOCATION.—Eighty-five percent of the sum of the amount available for Violent Offender Incarceration Grants for any fiscal year under subsection (a) and any amount transferred under section 20102(b)(2) for that fiscal year shall be allocated as follows:

(A) 0.25 percent shall be allocated to each eligible State except that the United States Virgin Islands, American Samoa, Guam and the Northern Mariana Islands each shall be allocated 0.05 percent.

(B) The amount remaining after application of subparagraph (A) shall be allocated to each eligible State in the ratio that the number of part 1 violent crimes reported by such State to the Federal Bureau of Investigation for 1993 bears to the number of part 1 violent crimes reported by all States to the Federal Bureau of Investigation for 1993.

(2) DISCRETIONARY ALLOCATION.—Fifteen percent of the sum of the amount available for Violent Offender Incarceration Grants for any fiscal year under subsection (a) and any amount transferred under section 20103(b)(3) for that fiscal year shall be allocated at the discretion of the Attorney General to States that have demonstrated the greatest need for such grants and the ability to best utilize the funds to meet the objectives of the grant program and ensure that prison cell space is available for the confinement of violent offenders.

(3) TRANSFER OF UNUSED FORMULA FUNDS.—On September 30 of each of fiscal years 1996, 1997, 1998, 1999, and 2000, the Attorney General shall transfer to the discretionary program under paragraph (2) any funds made available for allocation under paragraph (1) that are not allocated to an eligible State under paragraph (1).

SEC. 20104. MATCHING REQUIREMENT.

The Federal share of a grant received under this subtitle may not exceed 75 percent of the costs of a proposal described in an application approved under this subtitle.

SEC. 20105. RULES AND REGULATIONS.

(a) The Attorney General shall issue rules and regulations regarding the uses of grant funds received under this subtitle not later than 90 days after the date of enactment of this Act.

(b) If data regarding part 1 violent crimes in any State for 1993 is unavailable or substantially inaccurate, the Attorney General shall utilize the best available comparable data regarding the number of violent crimes for 1993 for that State for the purposes of allocation of any funds under this subtitle.

SEC. 20106. TECHNICAL ASSISTANCE AND TRAINING.

The Attorney General may request that the Director of the National Institute of Corrections and the Director of the Federal Bureau of Prisons provide technical assistance and training to a State or States that receive a grant under this subtitle to achieve the purposes of this subtitle.

SEC. 20107. EVALUATION.

The Attorney General may request the Director of the National Institute of Corrections to assist with an evaluation of programs established with funds under this subtitle.

SEC. 20108. DEFINITIONS.

In this subtitle—

"boot camp" means a correctional program of not more than 6 months' incarceration involving—

(A) assignment for participation in the program, in conformity with State law, by prisoners other than prisoners who have been convicted at any time of a violent felony;

(B) adherence by inmates to a highly regimented schedule that involves strict discipline, physical training, and work;

(C) participation by inmates in appropriate education, job training, and substance abuse counseling or treatment; and

(D) post-incarceration aftercare services for participants that are coordinated with the program carried out during the period of imprisonment.

"part 1 violent crimes" means murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault as reported to the Federal Bureau of Investigation for purposes of the Uniform Crime Reports.

"State" or "States" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

SEC. 20109. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle—

(1) $175,000,000 for fiscal year 1995, of which $175,000,000 may be appropriated from the Violent Crime Reduction Trust Fund;

(2) $940,000,000 for fiscal year 1996, of which $500,000,000 may be appropriated from the Violent Crime Reduction Trust Fund;

(3) $1,240,000,000 for fiscal year 1997, of which $800,000,000 may be appropriated from the Violent Crime Reduction Trust Fund;

(4) $1,740,000,000 for fiscal year 1998, of which $1,300,000,000 may be appropriated from the Violent Crime Reduction Trust Fund;

(5) $2,290,000,000 for fiscal year 1999, of which $1,850,000,000 may be appropriated from the Violent Crime Reduction Trust Fund; and

(6) $2,310,000,000 for fiscal year 2000, of which $1,870,000,000 may be appropriated from the Violent Crime Reduction Trust Fund.

Subtitle B—Punishment for Young Offenders

SEC. 20201. CERTAIN PUNISHMENT FOR YOUNG OFFENDERS.

(a) IN GENERAL.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 10003(a), is amended—

(1) by redesignating part R as part S;

(2) by redesignating section 1801 as section 1901; and

(3) by inserting after part Q the following new part:

“PART R—CERTAIN PUNISHMENT FOR YOUNG OFFENDERS

“SEC. 1801. GRANT AUTHORIZATION.

“(a) In General.—The Attorney General may make grants under this part to States, for the use by States and units of local government, for the purpose of developing alternative methods of punishment for young offenders to traditional forms of incarceration and probation.

“(b) Alternative Methods.—The alternative methods of punishment referred to in subsection (a) should ensure certain punishment for young offenders and promote reduced recidivism, crime prevention, and assistance to victims, particularly for young offenders who can be punished more effectively in an environment other than a traditional correctional facility, including—

“(1) alternative sanctions that create accountability and certain punishment for young offenders;

“(2) restitution programs for young offenders;

“(3) innovative projects, such as projects consisting of education and job training activities for incarcerated young offenders, modeled, to the extent practicable, after activities carried out under part B of title IV of the Job Training Partnership Act (relating to Job Corps) (29 U.S.C. 1691 et seq.) and projects that provide family counseling;

“(4) correctional options, such as community-based incarceration, weekend incarceration, and electronic monitoring of offenders;

“(5) community service programs that provide work service placement for young offenders at non-profit, private organizations and community organizations;

“(6) innovative methods that address the problems of young offenders convicted of serious substance abuse (including alcohol abuse) and gang-related offenses; and

“(7) adequate and appropriate after care programs for young offenders, such as substance abuse treatment, education programs, vocational training, job placement counseling, family counseling and other support programs upon release.

“SEC. 1802. STATE APPLICATIONS.

“(a) In General.—

“(1) Submission of Application.—To request a grant under this part, the chief executive of a State shall submit an application to the Attorney General in such form and containing such information as the Attorney General may reasonably require.

“(2) Assurances.—An application under paragraph (1) shall include assurances that Federal funds received under this part shall be used to supplement, not supplant, non-Federal funds that would otherwise be available for activities funded under this part.

“(b) State Office.—The office designated under section 507—

“(1) shall prepare the application as required under subsection (a); and

“(2) shall administer grant funds received under this part, including review of spending, processing, progress, financial reporting, technical assistance, grant adjustments, accounting, auditing, and fund disbursement.

“SEC. 1803. REVIEW OF STATE APPLICATIONS.

“(a) In General.—The Attorney General shall make a grant under section 1801(a) to carry out the projects described in the application submitted by such applicant under section 1802 upon determining that—

“(1) the application is consistent with the requirements of this part; and

“(2) before the approval of the application, the Attorney General has made an affirmative finding in writing that the proposed project has been reviewed in accordance with this part.

“(b) Approval.—Each application submitted under section 1802 shall be considered approved, in whole or in part, by the Attorney General not later than 45 days after first received unless the Attorney General informs the applicant of specific reasons for disapproval.

“(c) Restriction.—Grant funds received under this part shall not be used for land acquisition or construction projects, other than alternative facilities described in section 1801(b).

“(d) Disapproval Notice and Reconsideration.—The Attorney General shall not disapprove any application without first affording the applicant reasonable notice and an opportunity for reconsideration.

“SEC. 1804. LOCAL APPLICATIONS.

“(a) In General.—

“(1) Submission of application.—To request funds under this part from a State, the chief executive of a unit of local government shall submit an application to the office designated under section 1802(b).

“(2) Approval.—An application under paragraph (1) shall be considered to have been approved, in whole or in part, by the State not later than 45 days after such application is first received unless the State informs the applicant in writing of specific reasons for disapproval.

“(3) Disapproval.—The State shall not disapprove any application submitted to the State without first affording the applicant reasonable notice and an opportunity for reconsideration.

“(4) Effect of approval.—If an application under subsection (a) is approved, the unit of local government is eligible to receive funds under this part.

“(b) Distribution to Units of Local Government.—A State that receives funds under section 1801 in a fiscal year shall make such funds available to units of local government with an application that has been submitted and approved by the State within 45 days after the Attorney General has approved the application submitted by the State and has made funds available to the State. The Attorney General may waive the 45-day requirement in this section upon a finding that the State is unable to satisfy such requirement under State statutes.

“SEC. 1805. ALLOCATION AND DISTRIBUTION OF FUNDS.

“(a) State Distribution.—Of the total amount appropriated under this part in any fiscal year—

“(1) 0.4 percent shall be allocated to each of the participating States; and

“(2) of the total funds remaining after the allocation under paragraph (1), there shall be allocated to each of the participating States an amount which bears the same ratio to the amount of remaining funds described in this paragraph as the number of young offenders of such State bears to the number of young offenders in all the participating States.

“(b) Local Distribution.—

“(1) In general.—A State that receives funds under this part in a fiscal year shall distribute to units of local government in such State for the purposes specified under section 1801 that portion of such funds which bears the same ratio to the aggregate amount of such funds as the amount of funds expended by all units of local government for correctional programs in the preceding fiscal year bears to the aggregate amount of funds expended by the State and all units of local government in such State for correctional programs in such preceding fiscal year.

“(2) Undistributed funds.—Any funds not distributed to units of local government under paragraph (1) shall be available for expenditure by such State for purposes specified under section 1801.

“(3) Unused funds.— If the Attorney General determines, on the basis of information available during any fiscal year, that a portion of the funds allocated to a State for such fiscal year will not be used by such State or that a State is not eligible to receive funds under section 1801, the Attorney General shall award such funds to units of local government in such State giving priority to the units of local government that the Attorney General considers to have the greatest need.

“(c) General Requirement.—Notwithstanding subsections (a) and (b), not less than two-thirds of funds received by a State under this part shall be distributed to units of local government unless the State applies for and receives a waiver from the Attorney General.

“(d) Federal Share.—The Federal share of a grant made under this part may not exceed 75 percent of the total costs of the projects described in the application submitted under section 1802(a) for the fiscal year for which the projects receive assistance under this part.

“(e) Consideration.—Notwithstanding subsections (a) and (b), in awarding grants under this part, the Attorney General shall consider as a factor whether a State has in effect throughout such State a law or policy that requires that a juvenile who is in possession of a firearm or other weapon on school property or convicted of a crime involving the use of a firearm or weapon on school property—

“(1) be suspended from school for a reasonable period of time; and

“(2) lose driving license privileges for a reasonable period of time.

“(f) Definition.—For purposes of this part, ‘juvenile’ means a person 18 years of age or younger.

“SEC. 1806. EVALUATION.

“(a) In General.—

“(1) Submission to the director.—Each State and unit of local government that receives a grant under this part shall submit to the Attorney General an evaluation not later than March 1 of each year in accordance with guidelines issued by the Attorney General. Such evaluation shall include an appraisal by representatives of the community of the programs funded by the grant.

“(2) Waiver.—The Attorney General may waive the requirement specified in paragraph (1) if the Attorney General determines that such evaluation is not warranted in the case of the State or unit of local government involved.

“(b) Distribution.—The Attorney General shall make available to the public on a timely basis evaluations received under subsection (a).

“(c) Administrative Costs.—A State or unit of local government may use not more than 5 percent of funds it receives under this part to develop an evaluation program under this section.”.

(b) Technical Amendment.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 10003(a), is amended by striking the matter relating to part R and inserting the following:

“Part R—Certain Punishments for Young Offenders

“Sec. 1801. Grant authorization.
“Sec. 1802. State applications.
“Sec. 1803. Review of State applications.
“Sec. 1804. Local applications.
“Sec. 1805. Allocation and distribution of funds.
“Sec. 1806. Evaluation.

“Part S—Transition—Effective Date—Repealer

“Sec. 1901. Continuation of rules, authorities, and proceedings.”.

(c) Definition.—Section 901(a) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3791(a)), is amended—

(1) by adding a semicolon at the end of paragraph (21);

(2) by striking “and” at the end of paragraph (22);

(3) by striking the period at the end of paragraph (23) and inserting a semicolon; and

(4) by adding after paragraph (23) the following:

"(24) the term 'young offender' means a nonviolent first-time offender or a non-violent offender with a minor criminal record who is 22 years of age or younger (including juveniles); and".

(d) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793), as amended by section 10003(c), is amended—

(1) in paragraph (3) by striking "and Q" and inserting "Q, or R"; and

(2) by adding at the end the following new paragraph:

"(16) There are authorized to be appropriated to carry out projects under part R—

"(A) $20,000,000 for fiscal year 1996;
"(B) $25,000,000 for fiscal year 1997;
"(C) $30,000,000 for fiscal year 1998;
"(D) $35,000,000 for fiscal year 1999; and
"(E) $40,000,000 for fiscal year 2000.".

Subtitle C—Alien Incarceration

SEC. 20301. INCARCERATION OF UNDOCUMENTED CRIMINAL ALIENS.

(a) INCARCERATION.—Section 242 of the Immigration and Nationality Act (8 U.S.C. 1252) is amended by adding at the end the following new subsection:

"(j) INCARCERATION.—

"(1) If the chief executive officer of a State (or, if appropriate, a political subdivision of the State) exercising authority with respect to the incarceration of an undocumented criminal alien submits a written request to the Attorney General, the Attorney General shall, as determined by the Attorney General—

"(A) enter into a contractual arrangement which provides for compensation to the State or a political subdivision of the State, as may be appropriate, with respect to the incarceration of the undocumented criminal alien; or

"(B) take the undocumented criminal alien into the custody of the Federal Government and incarcerate the alien.

"(2) Compensation under paragraph (1)(A) shall be the average cost of incarceration of a prisoner in the relevant State as determined by the Attorney General.

"(3) For purposes of this subsection, the term 'undocumented criminal alien' means an alien who—

"(A) has been convicted of a felony and sentenced to a term of imprisonment; and

"(B)(i) entered the United States without inspection or at any time or place other than as designated by the Attorney General;

"(ii) was the subject of exclusion or deportation proceedings at the time he or she was taken into custody by the State or a political subdivision of the State; or

"(iii) was admitted as a nonimmigrant and at the time he or she was taken into custody by the State or a political subdivision of the State has failed to maintain the nonimmigrant status in which the alien was admitted or to which it was changed under section 248, or to comply with the conditions of any such status.

"(4)(A) In carrying out paragraph (1), the Attorney General shall give priority to the Federal incarceration of undocumented criminal aliens who have committed aggravated felonies.

"(B) The Attorney General shall ensure that undocumented criminal aliens incarcerated in Federal facilities pursuant to this subsection are held in facilities which provide a level of security appropriate to the crimes for which they were convicted.

"(5) There are authorized to be appropriated such sums as may be necessary to carry out this subsection, of which the following amounts may be appropriated from the Violent Crime Reduction Trust Fund:

"(A) $130,000,000 for fiscal year 1995;
"(B) $300,000,000 for fiscal year 1996;
"(C) $330,000,000 for fiscal year 1997;
"(D) $350,000,000 for fiscal year 1998;
"(E) $350,000,000 for fiscal year 1999; and
"(F) $340,000,000 for fiscal year 2000."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 1994.

(c) TERMINATION OF LIMITATION.—Notwithstanding section 242(j)(5) of the Immigration and Nationality Act, as added by subsection (a), the requirements of section 242(j) of the Immigration and Nationality Act, as added by subsection (a), shall not be subject to the availability of appropriations on and after October 1, 2004.

Subtitle D—Miscellaneous Provisions

SEC. 20401. PRISONER'S PLACE OF IMPRISONMENT.

Paragraph (b) of section 3621 of title 18, United States Code, is amended by inserting after subsection (5) the following: "In designating the place of imprisonment or making transfers under this subsection, there shall be no favoritism given to prisoners of high social or economic status.".

SEC. 20402. PRISON IMPACT ASSESSMENTS.

(a) IN GENERAL.—Chapter 303 of title 18, United States Code, is amended by adding at the end the following new section:

"§4047. Prison impact assessments

"(a) Any submission of legislation by the Judicial or Executive branch which could increase or decrease the number of persons incarcerated or in Federal penal institutions shall be accompanied by a prison impact statement (as defined in subsection (b)).

"(b) The Attorney General shall, in consultation with the Sentencing Commission and the Administrative Office of the United States Courts, prepare and furnish prison impact assessments under subsection (c) of this section, and in response to requests from Congress for information relating to a pending measure or matter that might affect the number of defendants processed through the Federal criminal justice system. A prison impact assessment on pending legislation must be supplied within 21 days of any request. A prison impact assessment shall include—

"(1) projections of the impact on prison, probation, and post prison supervision populations;

"(2) an estimate of the fiscal impact of such population changes on Federal expenditures, including those for construction and operation of correctional facilities for the current fiscal year and 5 succeeding fiscal years;

"(3) an analysis of any other significant factor affecting the cost of the measure and its impact on the operations of components of the criminal justice system; and

"(4) a statement of the methodologies and assumptions utilized in preparing the assessment.

"(c) The Attorney General shall prepare and transmit to the Congress, by March 1 of each year, a prison impact assessment reflecting the cumulative effect of all relevant changes in the law taking effect during the preceding calendar year.".

(b) TECHNICAL AMENDMENT.—The chapter analysis for chapter 303 is amended by adding at the end the following new item:

"4047. Prison impact assessments.".

SEC. 20403. SENTENCES TO ACCOUNT FOR COSTS TO THE GOVERNMENT OF IMPRISONMENT, RELEASE, AND PROBATION.

(a) IMPOSITION OF SENTENCE.—Section 3572(a) of title 18, United States Code, is amended—

(1) by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively; and

(2) by inserting after paragraph (5) the following new paragraph:

"(6) the expected costs to the government of any imprisonment, supervised release, or probation component of the sentence;".

(b) DUTIES OF THE SENTENCING COMMISSION.—Section 994 of title 28, United States Code, is amended by adding at the end the following new subsection:

"(y) The Commission, in promulgating guidelines pursuant to subsection (a)(1), may include, as a component of a fine, the expected costs to the Government of any imprisonment, supervised release, or probation sentence that is ordered.".

SEC. 20404. APPLICATION TO PRISONERS TO WHICH PRIOR LAW APPLIES.

In the case of a prisoner convicted of an offense committed prior to November 1, 1987, the reference to supervised release in section 4042(b) of title 18, United States Code, shall be deemed to be a reference to probation or parole.

SEC. 20405. CREDITING OF "GOOD TIME".

Section 3624 of title 18, United States Code, is amended—

(1) by striking "he" each place it appears and inserting "the prisoner";

(2) by striking "his" each place it appears and inserting "the prisoner's";

(3) in subsection (d) by striking "him" and inserting "the prisoner"; and

(4) in subsection (b)—

(A) in the first sentence by inserting "(other than a prisoner serving a sentence for a crime of violence)" after "A prisoner"; and

(B) by inserting after the first sentence the following: "A prisoner who is serving a term of imprisonment of more than 1 year for a crime of violence, other than a term of imprisonment for the duration of the prisoner's life, may receive credit toward the service of the prisoner's sentence, beyond the time served, of up to 54 days at the end of each year of the prisoner's term of imprisonment, beginning at the end of the first year of the term, subject to determination by the Bureau of Prisons that, during that year, the prisoner has displayed exemplary compliance with such institutional disciplinary regulations.".

SEC. 20406. TASK FORCE ON PRISON CONSTRUCTION STANDARDIZATION AND TECHNIQUES.

(a) TASK FORCE.—The Director of the National Institute of Corrections shall, subject to availability of appropriations, establish a task force composed of Federal, State, and local officials expert in prison construction, and of at least an equal number of engineers, architects, and construction experts from the private sector with expertise in prison design and construction, including the use of cost-cutting construction standardization techniques and cost-cutting new building materials and technologies.

(b) COOPERATION.—The task force shall work in close cooperation and communication with other State and local officials responsible for prison construction in their localities.

(c) PERFORMANCE REQUIREMENTS.—The task force shall work to—

(1) establish and recommend standardized construction plans and techniques for prison and prison component construction; and

(2) evaluate and recommend new construction technologies, techniques, and materials,

to reduce prison construction costs at the Federal, State, and local levels and make such construction more efficient.

(d) DISSEMINATION.—The task force shall disseminate information described in subsection (c) to State and local officials involved in prison construction, through written reports and meetings.

(e) PROMOTION AND EVALUATION.—The task force shall—

(1) work to promote the implementation of cost-saving efforts at the Federal, State, and local levels;

(2) evaluate and advise on the results and effectiveness of such cost-saving efforts as adopted, broadly disseminating information on the results; and

(3) to the extent feasible, certify the effectiveness of the cost-savings efforts.

SEC. 20407. EFFICIENCY IN LAW ENFORCEMENT AND CORRECTIONS.

(a) IN GENERAL.—In the administration of each grant program funded by appropriations authorized by this Act or by an amendment made by this Act, the Attorney General shall encourage—

(1) innovative methods for the low-cost construction of facilities to be constructed, converted, or expanded and the low-cost operation of such facilities and the reduction of administrative costs and overhead expenses; and

(2) the use of surplus Federal property.

(b) ASSESSMENT OF CONSTRUCTION COMPONENTS AND DESIGNS.—The Attorney General may make an assessment of the cost efficiency and utility of using modular, prefabricated, precast, and pre-engineered construction components and designs for housing nonviolent criminals.

SEC. 20408. AMENDMENTS TO THE DEPARTMENT OF EDUCATION ORGANIZATION ACT AND THE NATIONAL LITERACY ACT OF 1991.

(a) TECHNICAL AMENDMENT.—The matter preceding paragraph (1) of section 214(d) of the Department of Education Organization Act (20 U.S.C. 3423a(d)) is amended by striking "under subsection (a)" and inserting "under subsection (c)".

(b) ESTABLISHMENT OF A PANEL AND USE OF FUNDS.—Section 601 of the National Literacy Act of 1991 (20 U.S.C. 1211–2) is amended—

(1) by redesignating subsection (g) as subsection (i); and

(2) by inserting after subsection (f) the following new subsections:

"(g) PANEL.—The Secretary is authorized to consult with and convene a panel of experts in correctional education, including program administrators and field-based professionals in adult corrections, juvenile services, jails, and community corrections programs, to—

"(1) develop measures for evaluating the effectiveness of the programs funded under this section; and

"(2) evaluate the effectiveness of such programs.

"(h) USE OF FUNDS.—Notwithstanding any other provision of law, the Secretary may use not more than five percent of funds appropriated under subsection (i) in any fiscal year to carry out grant-related activities such as monitoring, technical assistance, and replication and dissemination.".

SEC. 20409. APPROPRIATE REMEDIES FOR PRISON OVERCROWDING.

(a) AMENDMENT OF TITLE 18, UNITED STATES CODE.—Subchapter C of chapter 229 of part 2 of title 18, United States Code, is amended by adding at the end the following new section:

"§3626. Appropriate remedies with respect to prison crowding

"(a) REQUIREMENT OF SHOWING WITH RESPECT TO THE PLAINTIFF IN PARTICULAR.—

"(1) HOLDING.—A Federal court shall not hold prison or jail crowding unconstitutional under the eighth amendment except to the extent that an individual plaintiff inmate proves that the crowding causes the infliction of cruel and unusual punishment of that inmate.

"(2) RELIEF.—The relief in a case described in paragraph (1) shall extend no further than necessary to remove the conditions that are causing the cruel and unusual punishment of the plaintiff inmate.

"(b) INMATE POPULATION CEILINGS.—

"(1) REQUIREMENT OF SHOWING WITH RESPECT TO PARTICULAR PRISONERS.—A Federal court shall not place a ceiling on the inmate population of any Federal, State, or local detention facility as an equitable remedial measure for conditions that violate the eighth amendment unless crowding is inflicting cruel and unusual punishment on particular identified prisoners.

"(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to have any effect on Federal judicial power to issue equitable relief other than that described in paragraph (1), including the requirement of improved medical or health care and the imposition of civil contempt fines or damages, where such relief is appropriate.

"(c) PERIODIC REOPENING.—Each Federal court order or consent decree seeking to remedy an eighth amendment violation shall be reopened at the behest of a defendant for recommended modification at a minimum of 2-year intervals.".

(b) APPLICATION OF AMENDMENT.—Section 3626 of title 18, United States Code, as added by paragraph (1), shall apply to all outstanding court orders on the date of enactment of this Act. Any State or municipality shall be entitled to seek modification of any outstanding eighth amendment decree pursuant to that section.

(c) TECHNICAL AMENDMENT.—The subchapter analysis for subchapter C of chapter 229 of title 18, United States Code, is amended by adding at the end the following new item:

"3626. Appropriate remedies with respect to prison crowding.".

(d) SUNSET PROVISION.—This section and the amendments made by this section are repealed effective as of the date that is 5 years after the date of enactment of this Act.

SEC. 20410. CONGRESSIONAL APPROVAL OF ANY EXPANSION AT LORTON AND CONGRESSIONAL HEARINGS ON FUTURE NEEDS.

(a) CONGRESSIONAL APPROVAL.—Notwithstanding any other provision of law, the existing prison facilities and complex at the District of Columbia Corrections Facility at Lorton, Virginia, shall not be expanded unless such expansion has been approved by the Congress under the authority provided to Congress in section 446 of the District of Columbia Self-Government and Governmental Reorganization Act.

(b) SENATE HEARINGS.—The Senate directs the Subcommittee on the District of Columbia of the Committee on Appropriations of the Senate to conduct hearings regarding expansion of the prison complex in Lorton, Virginia, prior to any approval granted pursuant to subsection (a). The subcommittee shall permit interested parties, including appropriate officials from the County of Fairfax, Virginia, to testify at such hearings.

(c) DEFINITION.—For purposes of this section, the terms "expanded" and "expansion" mean any alteration of the physical structure of the prison complex that is made to increase the number of inmates incarcerated at the prison.

SEC. 20411. AWARDS OF PELL GRANTS TO PRISONERS PROHIBITED.

(a) IN GENERAL.—Section 401(b)(8) of the Higher Education Act of 1965 (20 U.S.C. 1070a(b)(8)) is amended to read as follows:

"(8) No basic grant shall be awarded under this subpart to any individual who is incarcerated in any Federal or State penal institution.".

(b) APPLICATION OF AMENDMENT.—The amendment made by this section shall apply with respect to periods of enrollment beginning on or after the date of enactment of this Act.

SEC. 20412. EDUCATION REQUIREMENT FOR EARLY RELEASE.

Section 3624(b) of title 18, United States Code, is amended—

(1) by inserting "(1)" after "behavior.—";

(2) by striking "Such credit toward service of sentence vests at the time that it is received. Credit that has vested may not later be withdrawn, and credit that has not been earned may not later be granted." and inserting "Credit that has not been earned may not later be granted."; and

(3) by adding at the end the following:

"(2) Credit toward a prisoner's service of sentence shall not be vested unless the prisoner has earned or is making satisfactory progress toward a high school diploma or an equivalent degree.

"(3) The Attorney General shall ensure that the Bureau of Prisons has in effect an optional General Educational Development program for inmates who have not earned a high school diploma or its equivalent.

"(4) Exemptions to the General Educational Development requirement may be made as deemed appropriate by the Director of the Federal Bureau of Prisons.".

SEC. 20413. CONVERSION OF CLOSED MILITARY INSTALLATIONS INTO FEDERAL PRISON FACILITIES.

(a) STUDY OF SUITABLE BASES.—The Secretary of Defense and the Attorney General shall jointly conduct a study of all military installations selected before the date of enactment of this Act to be closed pursuant to a base closure law for the purpose of evaluating the suitability of any of these installations, or portions of these installations, for conversion into Federal prison facilities. As part of the study, the Secretary and the Attorney General shall identify the military installations so evaluated that are most suitable for conversion into Federal prison facilities.

(b) SUITABILITY FOR CONVERSION.—In evaluating the suitability of a military installation for conversion into a Federal prison facility, the Secretary of Defense and the Attorney General shall consider the estimated cost to convert the installation into a prison facility and such other factors as the Secretary and the Attorney General consider to be appropriate.

(c) TIME FOR STUDY.—The study required by subsection (a) shall be completed not later than the date that is 180 days after the date of enactment of this Act.

(d) CONSTRUCTION OF FEDERAL PRISONS.—

(1) IN GENERAL.—In determining where to locate any new Federal prison facility, and in accordance with the Department of Justice's duty to review and identify a use for any portion of an installation closed pursuant to title II of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100–526) and the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101–510), the Attorney General shall—

(A) consider whether using any portion of a military installation closed or scheduled to be closed in the region pursuant to a base closure law provides a cost-effective alternative to the purchase of real property or construction of new prison facilities;

(B) consider whether such use is consistent with a reutilization and redevelopment plan; and

(C) give consideration to any installation located in a rural area the closure of which will have a substantial adverse impact on the economy of the local communities and on the ability of the communities to sustain an economic recovery from such closure.

(2) CONSENT.—With regard to paragraph (1)(B), consent must be obtained from the local re-use authority for the military installation, recognized and funded by the Secretary of Defense, before the Attorney General may proceed with plans for the design or construction of a prison at the installation.

(3) REPORT ON BASIS OF DECISION.—Before proceeding with plans for the design or construction of a Federal prison, the Attorney General shall submit to Congress a report explaining the basis of the decision on where to locate the new prison facility.

(4) REPORT ON COST-EFFECTIVENESS.—If the Attorney General decides not to utilize any portion of a closed military installation or an installation scheduled to be closed for locating a prison, the report shall include an analysis of why installations in the region, the use of which as a prison would be consistent with a reutilization and redevelopment plan, does not provide a cost-effective alternative to the purchase of real property or construction of new prison facilities.

(e) DEFINITION.—In this section, "base closure law" means—

(1) the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101–510; 10 U.S.C. 2687 note); and

(2) title II of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100–526; 10 U.S.C. 2687 note).

SEC. 20414. POST-CONVICTION RELEASE DRUG TESTING—FEDERAL OFFENDERS.

(a) DRUG TESTING PROGRAM.—

(1) IN GENERAL.—Subchapter A of chapter 229 of title 18, United States Code, is amended by adding at the end the following new section:

"§3608. Drug testing of Federal offenders on post-conviction release

"The Director of the Administrative Office of the United States Courts, in consultation with the Attorney General and the Secretary of Health and Human Services, shall, subject to the availability of appropriations, establish a program of drug testing of Federal offenders on post-conviction release. The program shall include such standards and guidelines as the Director may determine necessary to ensure the reliability and accuracy of the drug testing programs. In each judicial district the chief probation officer shall arrange for the drug testing of defendants on post-conviction release pursuant to a conviction for a felony or other offense described in section 3563(a)(4).".

(2) TECHNICAL AMENDMENT.—The subchapter analysis for subchapter A of chapter 229 of title 18, United States Code, is amended by adding at the end the following new item:

"3608. Drug testing of Federal offenders on post-conviction release.".

(b) CONDITIONS OF PROBATION.—Section 3563(a) of title 18, United States Code, is amended—

(1) in paragraph (2) by striking "and" after the semicolon;

(2) in paragraph (3) by striking the period and inserting "; and";

(3) by adding at the end the following new paragraph:

"(4) for a felony, a misdemeanor, or an infraction, that the defendant refrain from any unlawful use of a controlled substance and submit to one drug test within 15 days of release on probation and at least 2 periodic drug tests thereafter (as determined by the court) for use of a controlled substance, but the condition stated in this paragraph may be ameliorated or suspended by the court for any individual defendant if the defendant's presentence report or other reliable sentencing information indicates a low risk of future substance abuse by the defendant."; and

(4) by adding at the end the following: "The results of a drug test administered in accordance with paragraph (4) shall be subject to confirmation only if the results are positive, the defendant is subject to possible imprisonment for such failure, and either the defendant denies the accuracy of such test or there is some other reason to question the results of the test. A defendant who tests positive may be detained pending verification of a positive drug test result. A drug test confirmation shall be a urine drug test confirmed using gas chromatography/mass spectrometry techniques or such test as the Director of the Administrative Office of the United States Courts after consultation with the Secretary of Health and Human Services may determine to be of equivalent accuracy. The court shall consider whether the availability of appropriate substance abuse treatment programs, or an individual's current or past participation in such programs, warrants an exception in accordance with United States Sentencing Commission guidelines from the rule of section 3565(b), when considering any action against a defendant who fails a drug test administered in accordance with paragraph (4).".

(c) CONDITIONS OF SUPERVISED RELEASE.—Section 3583(d) of title 18, United States Code, is amended by inserting after the first sentence the following: "The court shall also order, as an explicit condition of supervised release, that the defendant refrain from any unlawful use of a controlled substance and submit to a drug test within 15 days of release on supervised release and at least 2 periodic drug tests thereafter (as determined by the court) for use of a controlled substance. The condition stated in the preceding sentence may be ameliorated or suspended by the court as provided in section 3563(a)(4). The results of a drug test administered in accordance with the preceding subsection shall be subject to confirmation only if the results are positive, the defendant is subject to possible imprisonment for such failure, and either the defendant denies the accuracy of such test or there is some other reason to question the results of the test. A drug test confirmation shall be a urine drug test confirmed using gas chromatography/mass spectrometry techniques or such test as the Director of the Administrative Office of the United States Courts after consultation with the Secretary of Health and Human Services may determine to be of equivalent accuracy. The court shall consider whether the availability of appropriate substance abuse treatment programs, or an individual's current or past participation in such programs, warrants an exception in accordance with United States Sentencing Commission guidelines from the rule of section 3583(g) when considering any action against a defendant who fails a drug test.".

(d) CONDITIONS OF PAROLE.—Section 4209(a) of title 18, United States Code, is amended by inserting after the first sentence the following: "In every case, the Commission shall also impose as a condition of parole that the parolee pass a drug test prior to release and refrain from any unlawful use of a controlled substance and submit to at least 2 periodic drug tests (as determined by the Commission) for use of a controlled substance. The condition stated in the preceding sentence may be ameliorated or suspended by the Commission for any individual parolee if it determines that there is good cause for doing so. The results of a drug test administered in accordance with the provisions of the preceding sentence shall be subject to confirmation only if the results are positive, the defendant is subject to possible imprisonment for such failure, and either the defendant denies the accuracy of such test or there is some other reason to question the results of the test. A drug test confirmation shall be a urine drug test confirmed using gas chromatography/mass spectrometry techniques or such test as the Director of the Administrative Office of the United States Courts after consultation with the Secretary of Health and Human Services may determine to be of equivalent accuracy. The Commission shall consider whether the availability of appropriate substance abuse treatment programs, or an individual's current or past participation in such programs, warrants an exception in accordance with United States Sentencing Commission guidelines from the rule of section 4214(f) when considering any action against a defendant who fails a drug test.".

SEC. 20415. REPORTING OF CASH RECEIVED BY CRIMINAL COURT CLERKS.

(a) IN GENERAL.—Section 6050I of the Internal Revenue Code of 1986 (relating to returns relating to cash received in trade or business) is amended by adding at the end the following new subsection:

"(g) CASH RECEIVED BY CRIMINAL COURT CLERKS.—

"(1) IN GENERAL.—Every clerk of a Federal or State criminal court who receives more than $10,000 in cash as bail for any individual charged with a specified criminal offense shall make a return described in paragraph (2) (at such time as the Secretary may by regulations prescribe) with respect to the receipt of such bail.

"(2) RETURN.—A return is described in this paragraph if such return—

"(A) is in such form as the Secretary may prescribe, and

"(B) contains—

"(i) the name, address, and TIN of—

"(I) the individual charged with the specified criminal offense, and

"(II) each person posting the bail (other than a person licensed as a bail bondsman),

"(ii) the amount of cash received,

"(iii) the date the cash was received, and

"(iv) such other information as the Secretary may prescribe.

"(3) SPECIFIED CRIMINAL OFFENSE.—For purposes of this subsection, the term 'specified criminal offense' means—

"(A) any Federal criminal offense involving a controlled substance,

"(B) racketeering (as defined in section 1951, 1952, or 1955 of title 18, United States Code),

"(C) money laundering (as defined in section 1956 or 1957 of such title), and

"(D) any State criminal offense substantially similar to an offense described in subparagraph (A), (B), or (C).

"(4) INFORMATION TO FEDERAL PROSECUTORS.—Each clerk required to include on a return under paragraph (1) the information described in paragraph (2)(B) with respect to an individual described in paragraph (2)(B)(i)(I) shall furnish (at such time as the Secretary may by regulations prescribe) a written statement showing such information to the United States Attorney for the jurisdiction in which such individual resides and the jurisdiction in which the specified criminal offense occurred.

"(5) INFORMATION TO PAYORS OF BAIL.—Each clerk required to make a return under paragraph (1) shall furnish (at such time as the Secretary may by regulations prescribe) to each person whose name is required to be set forth in such return by reason of paragraph (2)(B)(i)(II) a written statement showing—

"(A) the name and address of the clerk's office required to make the return, and

"(B) the aggregate amount of cash described in paragraph (1) received by such clerk.".

(b) CONFORMING AMENDMENTS.—

(1) Clause (iv) of section 6724(d)(1)(B) of the Internal Revenue Code of 1986 is amended to read as follows:

"(iv) section 6050I (a) or (g)(1) (relating to cash received in trade or business, etc.),".

(2) Subparagraph (K) of section 6724(d)(2) of the Internal Revenue Code of 1986 is amended to read as follows:

"(K) section 6050I(e) or paragraph (4) or (5) of section 6050I(g) (relating to cash received in trade or business, etc.),".

(3) The heading for section 6050I of the Internal Revenue Code of 1986 is amended by striking "**BUSINESS**" and inserting "**BUSINESS, ETC.**".

(4) The table of sections for subpart B of part III of subchapter A of chapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by striking "business" and inserting "business, etc" in the item relating to section 6050I.

(c) Regulations.—The Secretary of the Treasury or the Secretary's delegate shall prescribe temporary regulations under the amendments made by this section within 90 days after the date of enactment of this Act.

(d) Effective Date.—The amendments made by this section shall take effect on the 60th day after the date on which the temporary regulations are prescribed under subsection (c).

SEC. 20416. CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS.

(a) Exhaustion of Administrative Remedies.—Section 7 of the Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997e) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking "ninety days" and inserting "180 days"; and

(B) in paragraph (2), by inserting before the period at the end the following: "or are otherwise fair and effective"; and

(2) in subsection (c)—

(A) in paragraph (1) by inserting before the period at the end the following: "or are otherwise fair and effective"; and

(B) in paragraph (2) by inserting before the period at the end the following: "or is no longer fair and effective".

(b) Effective Date.—The amendments made by subsection (a) shall take effect on the date of enactment of this Act.

SEC. 20417. NOTIFICATION OF RELEASE OF PRISONERS.

Section 4042 of title 18, United States Code, is amended—

(1) by striking "The Bureau" and inserting "(a) In General.—The Bureau";

(2) by striking "This section" and inserting "(c) Application of Section.—This section";

(3) in paragraph (4) of subsection (a), as designated by paragraph (1)—

(A) by striking "Provide" and inserting "provide"; and

(B) by striking the period at the end and inserting "; and";

(4) by inserting after paragraph (4) of subsection (a), as designated by paragraph (1), the following new paragraph:

"(5) provide notice of release of prisoners in accordance with subsection (b)."; and

(5) by inserting after subsection (a), as designated by paragraph (1), the following new subsection:

"(b) Notice of Release of Prisoners.—(1) At least 5 days prior to the date on which a prisoner described in paragraph (3) is to be released on supervised release, or, in the case of a prisoner on supervised release, at least 5 days prior to the date on which the prisoner changes residence to a new jurisdiction, written notice of the release or change of residence shall be provided to the chief law enforcement officer of the State and of the local jurisdiction in which the prisoner will reside. Notice prior to release shall be provided by the Director of the Bureau of Prisons. Notice concerning a change of residence following release shall be provided by the probation officer responsible for the supervision of the released prisoner, or in a manner specified by the Director of the Administrative Office of the United States Courts. The notice requirements under this subsection do not apply in relation to a prisoner being protected under chapter 224.

"(2) A notice under paragraph (1) shall disclose—

"(A) the prisoner's name;

"(B) the prisoner's criminal history, including a description of the offense of which the prisoner was convicted; and

"(C) any restrictions on conduct or other conditions to the release of the prisoner that are imposed by law, the sentencing court, or the Bureau of Prisons or any other Federal agency.

"(3) A prisoner is described in this paragraph if the prisoner was convicted of—

"(A) a drug trafficking crime, as that term is defined in section 924(c)(2); or

"(B) a crime of violence (as defined in section 924(c)(3)).

"(4) The notice provided under this section shall be used solely for law enforcement purposes.".

SEC. 20418. CORRECTIONAL JOB TRAINING AND PLACEMENT.

(a) Purpose.—It is the purpose of this section to encourage and support job training programs, and job placement programs, that provide services to incarcerated persons or ex-offenders.

(b) Definitions.—As used in this section:

(1) Correctional Institution.—The term "correctional institution" means any prison, jail, reformatory, work farm, detention center, or halfway house, or any other similar institution designed for the confinement or rehabilitation of criminal offenders.

(2) Correctional Job Training or Placement Program.—The term "correctional job training or placement program" means an activity that provides job training or job placement services to incarcerated persons or ex-offenders, or that assists incarcerated persons or ex-offenders in obtaining such services.

(3) Ex-offender.—The term "ex-offender" means any individual who has been sentenced to a term of probation by a Federal or State court, or who has been released from a Federal, State, or local correctional institution.

(4) Incarcerated Person.—The term "incarcerated person" means any individual incarcerated in a Federal or State correctional institution who is charged with or convicted of any criminal offense.

(c) Establishment of Office.—

(1) In General.—The Attorney General shall establish within the Department of Justice an Office of Correctional Job Training and Placement. The Office shall be headed by a Director, who shall be appointed by the Attorney General.

(2) Timing.—The Attorney General shall carry out this subsection not later than 6 months after the date of enactment of this section.

(d) Functions of Office.—The Attorney General, acting through the Director of the Office of Correctional Job Training and Placement, in consultation with the Secretary of Labor, shall—

(1) assist in coordinating the activities of the Federal Bonding Program of the Department of Labor, the activities of the Department of Labor related to the certification of eligibility for targeted jobs credits under section 51 of the Internal Revenue Code of 1986 with respect to ex-offenders, and any other correctional job training or placement program of the Department of Justice or Department of Labor;

(2) provide technical assistance to State and local employment and training agencies that—

(A) receive financial assistance under this Act; or

(B) receive financial assistance through other programs carried out by the Department of Justice or Department of Labor, for activities related to the development of employability;

(3) prepare and implement the use of special staff training materials, and methods, for developing the staff competencies needed by State and local agencies to assist incarcerated persons and ex-offenders in gaining marketable occupational skills and job placement;

(4) prepare and submit to Congress an annual report on the activities of the Office of Correctional Job Training and Placement, and the status of correctional job training or placement programs in the United States;

(5) cooperate with other Federal agencies carrying out correctional job training or placement programs to ensure coordination of such programs throughout the United States;

(6) consult with, and provide outreach to—

(A) State job training coordinating councils, administrative entities, and private industry councils, with respect to programs carried out under this Act; and

(B) other State and local officials, with respect to other employment or training programs carried out by the Department of Justice or Department of Labor;

(7) collect from States information on the training accomplishments and employment outcomes of a sample of incarcerated persons and ex-offenders who were served by employment or training programs carried out, or that receive financial assistance through programs carried out, by the Department of Justice or Department of Labor; and

(8)(A) collect from States and local governments information on the development and implementation of correctional job training or placement programs; and

(B) disseminate such information, as appropriate.

TITLE III—CRIME PREVENTION

Subtitle A—Ounce of Prevention Council

SEC. 30101. OUNCE OF PREVENTION COUNCIL.

(a) Establishment.—

(1) In General.—There is established an Ounce of Prevention Council (referred to in this title as the "Council"), the members of which—

(A) shall include the Attorney General, the Secretary of Education, the Secretary of Health and Human Services, the Secretary of Housing and Urban Development, the Secretary of Labor, the Secretary of Agriculture, the Secretary of the Treasury, the Secretary of the Interior, and the Director of the Office of National Drug Control Policy; and

(B) may include other officials of the executive branch as directed by the President.

(2) Chair.—The President shall designate the Chair of the Council from among its members (referred to in this title as the "Chair").

(3) Staff.—The Council may employ any necessary staff to carry out its functions, and may delegate any of its functions or powers to a member or members of the Council.

(b) Program Coordination.—For any program authorized under the Violent Crime Control and Law Enforcement Act of 1994, the Ounce of Prevention Council Chair, only at the request of the Council member with jurisdiction over that program, may coordinate that program, in whole or in part, through the Council.

(c) Administrative Responsibilities and Powers.—In addition to the program coordination provided in subsection (b), the Council shall be responsible for such functions as coordinated planning, development of a comprehensive crime prevention program catalogue, provision of assistance to communities and community-based organizations seeking information regarding crime prevention programs and integrated program service delivery, and development of strategies for program integration and grant simplification. The Council shall have the authority to audit the expenditure of funds received by grantees under programs administered by or coordinated through the Council. In consultation with the Council, the Chair may issue regulations and guidelines to carry out this subtitle and programs administered by or coordinated through the Council.

SEC. 30102. OUNCE OF PREVENTION GRANT PROGRAM.

(a) In General.—The Council may make grants for—

(1) summer and after-school (including weekend and holiday) education and recreation programs;

(2) mentoring, tutoring, and other programs involving participation by adult role models (such as D.A.R.E. America);

(3) programs assisting and promoting employability and job placement; and

(4) prevention and treatment programs to reduce substance abuse, child abuse, and adolescent pregnancy, including outreach programs for at-risk families.

(b) APPLICANTS.—Applicants may be Indian tribal governments, cities, counties, or other municipalities, school boards, colleges and universities, private nonprofit entities, or consortia of eligible applicants. Applicants must show that a planning process has occurred that has involved organizations, institutions, and residents of target areas, including young people, and that there has been cooperation between neighborhood-based entities, municipality-wide bodies, and local private-sector representatives. Applicants must demonstrate the substantial involvement of neighborhood-based entities in the carrying out of the proposed activities. Proposals must demonstrate that a broad base of collaboration and coordination will occur in the implementation of the proposed activities, involving cooperation among youth-serving organizations, schools, health and social service providers, employers, law enforcement professionals, local government, and residents of target areas, including young people. Applications shall be geographically based in particular neighborhood or sections of municipalities or particular segments of rural areas, and applications shall demonstrate how programs will serve substantial proportions of children and youth resident in the target area with activities designed to have substantial impact on their lives.

(c) PRIORITY.—In making such grants, the Council shall give preference to coalitions consisting of a broad spectrum of community-based and social service organizations that have a coordinated team approach to reducing gang membership and the effects of substance abuse, and providing alternatives to at-risk youth.

(d) FEDERAL SHARE.—

(1) IN GENERAL.—The Federal share of a grant made under this part may not exceed 75 percent of the total costs of the projects described in the applications submitted under subsection (b) for the fiscal year for which the projects receive assistance under this title.

(2) WAIVER.—The Council may waive the 25 percent matching requirement under paragraph (1) upon making a determination that a waiver is equitable in view of the financial circumstances affecting the ability of the applicant to meet that requirement.

(3) NON-FEDERAL SHARE.—The non-Federal share of such costs may be in cash or in kind, fairly evaluated, including plant, equipment, and services.

(4) NONSUPPLANTING REQUIREMENT.—Funds made available under this title to a governmental entity shall not be used to supplant State or local funds, or in the case of Indian tribal governments, funds supplied by the Bureau of Indian Affairs, but shall be used to increase the amount of funds that would, in the absence of Federal funds received under this title, be made available from State or local sources, or in the case of Indian tribal governments, from funds supplied by the Bureau of Indian Affairs.

(5) EVALUATION.—The Council shall conduct a thorough evaluation of the programs assisted under this title.

SEC. 30103. DEFINITION.

In this subtitle, "Indian tribe" means a tribe, band, pueblo, nation, or other organized group or community of Indians, including an Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

SEC. 30104. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle—

(1) $3,000,000 for fiscal year 1995;

(2) $15,000,000 for fiscal year 1996;

(3) $20,000,000 for fiscal year 1997;

(4) $20,000,000 for fiscal year 1998;

(5) $21,000,000 for fiscal year 1999; and

(6) $21,000,000 for fiscal year 2000.

Subtitle B—Youth Employment and Skills Crime Prevention

SEC. 30201. YOUTH EMPLOYMENT AND SKILLS CRIME PREVENTION GRANTS.

(a) IN GENERAL.—Part H of title IV of the Job Training Partnership Act (29 U.S.C. 1782 et seq.) is amended—

(1) by striking section 495;

(2) by redesignating sections 496, 497, 498, and 498A as sections 495, 496, 497, and 497A, respectively;

(3) by striking "this part" each place it appears and inserting "the provisions of this part other than section 498"; and

(4) by adding at the end the following new section:

"SEC. 498. YOUTH EMPLOYMENT AND SKILLS CRIME PREVENTION GRANTS.

"(a) STATEMENT OF PURPOSE.—The purpose of this section is to test the proposition that crime can be reduced in neighborhoods with high incidences of crime and poverty through a saturation jobs program, offered either separately or in conjunction with the services provided for under other sections of the Youth Fair Chance Program, that provides employment opportunities leading to permanent unsubsidized employment for disadvantaged young adults in those neighborhoods.

"(b) PROGRAM AUTHORIZATION.—The Secretary, in conjunction with the Attorney General, Secretary of Health and Human Services, and Secretary of Housing and Urban Development and in consultation with other appropriate Federal officials, including the Ounce of Prevention Council and the Community Empowerment Board, may make Youth Employment and Skills Crime Prevention grants authorized under this section to eligible entities for the purpose of providing a job saturation program for youth in target areas, as determined under subsection (c), to reduce crime.

"(c) PROGRAM TARGET AREA.—The target area of each grant shall be a neighborhood that—

"(1) is an area with severe crime problems, including a high incidence of violent crime or drug trafficking, or a history of street gang activity;

"(2) is a high poverty area (as defined in section 497A(2)) or set of contiguous high poverty areas;

"(3) is an area with a population consistent with the requirements of section 494(b)(1)(B), except that in appropriate circumstances, the Secretary, in conjunction with the Attorney General and the Secretary of Housing and Urban Development, may waive this limitation; and

"(4) is located in an area that meets the requirements of a participating community under section 497A(1).

"(d) PARTICIPANTS.—

"(1) ELIGIBLE POPULATION.—Young adults residing or attending school in a target area shall be eligible to participate in programs under this section if such individuals are 16 through 25 years of age. In certain circumstances, as determined by the Secretary in conjunction with the Attorney General and Secretary of Housing and Urban Development, youths aged 14 or 15 may also be eligible to participate.

"(2) RESPONSIBLE BEHAVIOR BY PARTICIPANTS.—Continued participation in a program under this section shall be conditioned, during participation in the program, on—

"(A) avoiding crime, including illegal drug use;

"(B) regular attendance and satisfactory performance at work;

"(C) paying child support when paternity has been established and the participant has an income;

"(D) in-school participants, who are under the age of 18, remaining in school until graduation; and

"(E) encouraging eligible participants who have dropped out of high school and who have not obtained a General Equivalency Diploma (GED) to return to school or an alternative education program.

"(e) APPLICATION FOR GRANTS.—

"(1) IN GENERAL.—To be eligible to receive a grant under this section, a chief elected official (as described in section 493(c)), on behalf of a target area meeting the criteria set forth in subsection (c), shall apply to the Secretary of Labor for a Youth Employment and Skills Crime Prevention grant by submitting an application that contains a plan for reducing crime by substantially increasing employment levels of young adults in the area.

"(2) CONTENTS.—A plan under paragraph (1) shall—

"(A) describe the private sector, nonprofit, and public sector components of the target area's job saturation strategy to reduce crime by substantially increasing the employment levels of young adults in that area, and describe, to the extent practicable, the nature of the employment opportunities that will be generated for young adults residing or attending school in the target areas;

"(B) describe the outcomes that will be used to evaluate the local success of the program, including reducing crime and substance abuse and increasing employment for young adults in the target area;

"(C) specify the organization that shall administer the program;

"(D) describe the public/private partnership that will promote collaboration between the State and local governments; local job training, education, and employment; public housing agencies and authorities; local residents, community-based organizations, and nonprofit organizations; and local community policing, gang prevention activities, substance abuse treatment and prevention programs, and juvenile justice or delinquency prevention initiatives;

"(E) describe how the public and private sectors will work together to assist young adults to make the transition from subsidized to unsubsidized jobs;

"(F) describe the extent of the local commitment of resources to the program, including the commitment of substantial resources by the last year of the program; and

"(G) provide such other information as the Secretary, in conjunction with the Attorney General and the Secretary of Housing and Urban Development, may require.

"(f) AWARD PRIORITIES.—In evaluating the applications submitted for Youth Employment and Skills Crime Prevention grants, the Secretary and the Attorney General and Secretary of Housing and Urban Development shall give priority to applications that—

"(1) demonstrate extensive community support, linkages among the local education authority, the service delivery area, and local and Federal law enforcement agencies, and linkages to crime prevention and substance abuse programs;

"(2) target areas that include public and assisted housing projects and their residents;

"(3) demonstrate that the target area has developed a comprehensive strategy to integrate programs funded under this section with other federally funded youth employment and training programs, as well as education programs, operating in the same area;

"(4) demonstrate that the target area has developed a comprehensive strategy to integrate activities funded under this section with community policing and gang violence prevention programs operating in the same area;

"(5) demonstrate a sufficient commitment on the part of employers to provide jobs for youth as specified in subsection (g) to qualify that area as a site that will test the proposition that a saturation jobs program, provided either separately or in conjunction with the education and training services provided for under other sections of the Youth Fair Chance Program, would have a significant effect on decreasing crime in the target area; and

"(6) target areas with the highest crime, unemployment, and poverty rates.

"(g) JOB SATURATION AGREEMENTS.—A grant recipient receiving funds under the Youth Employment and Skills Crime Prevention Program shall enter into a job saturation agreement with the Secretary, which agreement shall—

"(1) require the grant recipient to saturate the targeted areas with employment opportunities with for-profit, nonprofit, and public employers that are likely to lead to permanent, unsubsidized employment for youths who agree to condition their participation on the criteria established in subsection (d)(2);

"(2) specify the conditions under which funds provided under this section will be used to provide wage subsidies to employers, which conditions shall—

"(A) encourage private sector employers to employ participants, with an emphasis on opportunities that provide advanced or specialized training;

"(B) require private employers, under conditions specified by the Secretary, during the course of a participant's subsidized employment, to gradually increase such employer's share of the funding of that participant's wages;

"(C) encourage, if practicable, the provision of a structured and integrated work and learning experience, which may include components of the School-to-Work Opportunities Act of 1994;

"(D) encourage assistance to nonprofit employers and public agencies to employ participants in projects designed to address community needs, such as projects to enhance neighborhood infrastructure, to modernize public housing, and to provide other community services;

"(E) limit the duration of all subsidized employment provided pursuant to this section for a participant to not more than 2,080 hours;

"(F) require that the subsidized employment provided to any such youth who is still enrolled in high school shall not exceed 20 hours per week during the school year; and

"(G) contain such other terms and conditions as the Secretary in conjunction with the Attorney General and the Secretary of Housing and Urban Development require; and

"(3) provide that the grant recipient will make additional services available, including counseling, job development and placement, followup, and supportive services, to facilitate the transition of participating youth and young adults to permanent unsubsidized employment.

"(h) GRANT RECIPIENT, DURATION AND NUMBER.—

"(1) GRANT RECIPIENT.—Grants under this section may be awarded only to the service delivery area in which the target area is located.

"(2) DURATION OF GRANTS.—Grants under this section shall be awarded for 1 year, and be renewable for each of the 4 succeeding years based on conditions established by the Secretary in conjunction with the Attorney General and the Secretary of Housing and Urban Development.

"(3) NUMBER OF GRANTS.—There shall be no more than 20 grants awarded under this section. At least 2 of, and not less than 20 percent of the number of, the grants awarded under the Youth Employment and Skills Crime Prevention Program shall be in target areas that are also receiving funding under other provisions of this part.

"(i) FEDERAL RESPONSIBILITIES.—

"(1) PERFORMANCE MEASURES.—The Secretary, in conjunction with the Attorney General and the Secretary of Housing and Urban Development, shall establish a system of performance measures for assessing programs established pursuant to this section.

"(2) EVALUATION.—

"(A) IN GENERAL.—The Secretary, in conjunction with the Attorney General and the Secretary of Housing and Urban Development, shall conduct a rigorous national evaluation of Youth Employment and Skills Crime Prevention grants funded under this section that will track and assess the effectiveness of those programs and include an evaluation of the extent to which such grants reduced crime and substance abuse and increased employment and earnings.

"(B) OUTCOME COMPARISON.—The evaluation under subparagraph (A) shall compare outcomes for participating youth in areas receiving grants under the Youth Employment and Skills Crime Prevention program with—

"(i) outcomes for participating youth in areas receiving grants under both the Youth Employment Skills Crime Prevention Program and the Youth Fair Chance program; and

"(ii) outcomes for participating youth in areas receiving grants under the Youth Fair Chance Program only,

in order to determine which programs and which activities under those programs were most effective in reducing crime and substance abuse and increasing employment and earnings.

"(C) COST-BENEFIT ANALYSES; STATISTICAL METHODS AND TECHNIQUES.—The evaluation under subparagraph (A) may include cost-benefit analyses and shall utilize sound statistical methods and techniques.

"(D) TRANSMITTAL.—The evaluation under subparagraph (A) and any interim reports that may be prepared shall be transmitted to the President and to the Congress, the evaluation to be transmitted not later than December 31, 1999.

"(3) TECHNICAL ASSISTANCE.—The Secretary, in conjunction with the Attorney General and the Secretary of Housing and Urban Development, may provide appropriate technical assistance to carry out Youth Employment and Skills Crime Prevention grants under this section.

"(4) ADMINISTRATION.—The technical assistance, administration, and evaluations authorized by this section may be carried out directly by the Secretary or through grants, contracts, or other cooperative arrangements with the Attorney General, the Secretary of Housing and Urban Development, or other entities or agencies.".

(b) TECHNICAL AMENDMENTS.—

(1) EXCEPTION FROM LIMITATION ON SUBSIDIZED EMPLOYMENT.—Section 141(k) of the Job Training Partnership Act (29 U.S.C. 1551(a)) is amended by inserting ", or the individual employed is a participant in a program under part H of title IV" before the period.

(2) CLARIFICATION OF AUTHORIZATION OF APPROPRIATIONS.—Section 3(c)(3) of the Job Training Partnership Act (29 U.S.C. 1502(c)(3)) is amended to read as follows:

"(3) There are authorized to be appropriated to carry out part H of title IV (other than section 498) such sums as may be necessary for each of the fiscal years 1994 through 1997.

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out section 498 of the Job Training Partnership Act, as added by subsection (a)—

(A) $150,000,000 for fiscal year 1996, of which $55,000,000 is authorized to be appropriated from the Violent Crime Reduction Trust Fund established by this Act, and $95,000,000 is authorized from the General Fund of the Treasury;

(B) $155,000,000 for fiscal year 1996, of which $55,000,000 is authorized to be appropriated from the Violent Crime Reduction Trust Fund established by this Act, and $90,000,000 is authorized from the General Fund of the Treasury;

(C) $190,000,000 for fiscal year 1998, of which $100,000,000 is authorized to be appropriated from the Violent Crime Reduction Trust Fund established by this Act, and $90,000,000 is authorized from the General Fund of the Treasury;

(D) $200,000,000 for fiscal year 1999, of which $145,000,000 is authorized to be appropriated from the Violent Crime Reduction Trust Fund established by this Act, and $55,000,000 is authorized from the General Fund of the Treasury; and

(E) $205,000,000 for fiscal year 2000, of which $185,000,000 is authorized to be appropriated from the Violent Crime Reduction Trust Fund established by this Act, and $20,000,000 is authorized from the General Fund of the Treasury.

(2) AVAILABILITY OF FUNDS.—Funds appropriated pursuant to this subsection shall remain available for obligation until expended.

(3) EVALUATIONS AND TECHNICAL ASSISTANCE.—Of the amounts appropriated under paragraph (1) for a fiscal year, the Secretary of Labor, in conjunction with the Attorney General and the Secretary of Housing and Urban Development, may reserve not more than 5 percent of such amounts for the fiscal year to carry out section 498(i) of the Job Training Partnership Act as added by subsection (a).

Subtitle C—Model Intensive Grant Programs

SEC. 30301. GRANT AUTHORIZATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Attorney General may award grants to not more than 15 chronic high intensive crime areas to develop comprehensive model crime prevention programs that—

(A) involve and utilize a broad spectrum of community resources, including nonprofit community organizations, law enforcement organizations, and appropriate State and Federal agencies, including the State educational agencies;

(B) attempt to relieve conditions that encourage crime; and

(C) provide meaningful and lasting alternatives to involvement in crime.

(2) CONSULTATION WITH THE OUNCE OF PREVENTION COUNCIL.—The Attorney General may consult with the Ounce of Prevention Council in awarding grants under paragraph (1).

(b) PRIORITY.—In awarding grants under subsection (a), the Attorney General shall give priority to proposals that—

(1) are innovative in approach to the prevention of crime in a specific area;

(2) vary in approach to ensure that comparisons of different models may be made; and

(3) coordinate crime prevention programs funded under this program with other existing Federal programs to address the overall needs of communities that benefit from grants received under this title.

SEC. 30302. USES OF FUNDS.

(a) IN GENERAL.—Funds awarded under this subtitle may be used only for purposes described in an approved application. The intent of grants under this subtitle is to fund intensively comprehensive crime prevention programs in chronic high intensive crime areas.

(b) GUIDELINES.—The Attorney General shall issue and publish in the Federal Register guidelines that describe suggested purposes for which funds under approved programs may be used.

(c) EQUITABLE DISTRIBUTION OF FUNDS.—In disbursing funds under this subtitle, the Attorney General shall ensure the distribution of awards equitably on a geographic basis, including urban and rural areas of varying population and geographic size.

SEC. 30303. PROGRAM REQUIREMENTS.

(a) DESCRIPTION.—An applicant shall include a description of the distinctive factors that contribute to chronic violent crime within the area proposed to be served by the grant. Such factors may include lack of alternative activities and programs for youth, deterioration or lack of public facilities, inadequate public services such as public transportation, street lighting, community-based substance abuse treatment facilities, or employment services offices, and inadequate police or public safety services, equipment, or facilities.

(b) COMPREHENSIVE PLAN.—An applicant shall include a comprehensive, community-based plan to attack intensively the principal factors identified in subsection (a). Such plans shall describe the specific purposes for which funds are proposed to be used and how each purpose will address specific factors. The plan also shall specify how local nonprofit organizations, government agencies, private businesses, citizens groups, volunteer organizations, and interested citizens will cooperate in carrying out the purposes of the grant.

(c) EVALUATION.—An applicant shall include an evaluation plan by which the success of the plan will be measured, including the articulation of specific, objective indicia of performance, how the indicia will be evaluated, and a projected timetable for carrying out the evaluation.

SEC. 30304. APPLICATIONS.

To request a grant under this subtitle the chief local elected official of an area shall—

(1) prepare and submit to the Attorney General an application in such form, at such time, and in accordance with such procedures, as the Attorney General shall establish; and

(2) provide an assurance that funds received under this subtitle shall be used to supplement, not supplant, non-Federal funds that would otherwise be available for programs funded under this subtitle.

SEC. 30305. REPORTS.

Not later than December 31, 1998, the Attorney General shall prepare and submit to the Committees on the Judiciary of the House and Senate an evaluation of the model programs developed under this subtitle and make recommendations regarding the implementation of a national crime prevention program.

SEC. 30306. DEFINITIONS.

In this subtitle—

"chief local elected official" means an official designated under regulations issued by the Attorney General. The criteria used by the Attorney General in promulgating such regulations shall ensure administrative efficiency and accountability in the expenditure of funds and execution of funded projects under this subtitle.

"chronic high intensity crime area" means an area meeting criteria adopted by the Attorney General by regulation that, at a minimum, define areas with—

(A) consistently high rates of violent crime as reported in the Federal Bureau of Investigation's "Uniform Crime Reports", and

(B) chronically high rates of poverty as determined by the Bureau of the Census.

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

SEC. 30307. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle—

(1) $115,000,000 for fiscal year 1996;

(2) $150,000,000 for fiscal year 1997;

(3) $175,000,000 for fiscal year 1998;

(4) $200,000,000 for fiscal year 1999; and

(5) $255,000,000 for fiscal year 2000.

Subtitle D—Family and Community Endeavor Schools Grant Program

SEC. 30401. COMMUNITY SCHOOLS YOUTH SERVICES AND SUPERVISION GRANT PROGRAM.

(a) SHORT TITLE.—This section may be cited as the "Community Schools Youth Services and Supervision Grant Program Act of 1994".

(b) DEFINITIONS.—In this section—

"child" means a person who is not younger than 5 and not older than 18 years old.

"community-based organization" means a private, locally initiated, community-based organization that—

(A) is a nonprofit organization, as defined in section 103(23) of the Juvenile Justice and Delinquency Prevention Act of 1974 (42 U.S.C. 5603(23)); and

(B) is operated by a consortium of service providers, consisting of representatives of 5 or more of the following categories of persons:

(i) Residents of the community.

(ii) Business and civic leaders actively involved in providing employment and business development opportunities in the community.

(iii) Educators.

(iv) Religious organizations (which shall not provide any sectarian instruction or sectarian worship in connection with an activity funded under this title).

(v) Law enforcement agencies.

(vi) Public housing agencies.

(vii) Other public agencies.

(viii) Other interested parties.

"eligible community" means an area identified pursuant to subsection (e).

"Indian tribe" means a tribe, band, pueblo, nation, or other organized group or community of Indians, including an Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"poverty line" means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)) applicable to a family of the size involved.

"public school" means a public elementary school, as defined in section 1201(i) of the Higher Education Act of 1965 (20 U.S.C. 1141(i)), and a public secondary school, as defined in section 1201(d) of that Act.

"Secretary" means the Secretary of Health and Human Services, in consultation and coordination with the Attorney General.

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, and the United States Virgin Islands.

(c) PROGRAM AUTHORITY.—

(1) IN GENERAL.—

(A) ALLOCATIONS FOR STATES AND INDIAN COUNTRY.—For any fiscal year in which the sums appropriated to carry out this section equal or exceed $20,000,000, from the sums appropriated to carry out this subsection, the Secretary shall allocate, for grants under subparagraph (B) to community-based organizations in each State, an amount bearing the same ratio to such sums as the number of children in the State who are from families with incomes below the poverty line bears to the number of children in all States who are from families with incomes below the poverty line. In view of the extraordinary need for assistance in Indian country, an appropriate amount of funds available under this subtitle shall be made available for such grants in Indian country.

(B) GRANTS TO COMMUNITY-BASED ORGANIZATIONS FROM ALLOCATIONS.—For such a fiscal year, the Secretary may award grants from the appropriate State or Indian country allocation determined under subparagraph (A) on a competitive basis to eligible community-based organizations to pay for the Federal share of assisting eligible communities to develop and carry out programs in accordance with this section.

(C) REALLOCATION.—If, at the end of such a fiscal year, the Secretary determines that funds allocated for community-based organizations in a State or Indian country under subparagraph (B) remain unobligated, the Secretary may use such funds to award grants to eligible community-based organizations in another State or Indian country to pay for such Federal share. In awarding such grants, the Secretary shall consider the need to maintain geographic diversity among the recipients of such grants. Amounts made available through such grants shall remain available until expended.

(2) OTHER FISCAL YEARS.—For any fiscal year in which the sums appropriated to carry out this section are less than $20,000,000, the Secretary may award grants on a competitive basis to eligible community-based organizations to pay for the Federal share of assisting eligible communities to develop and carry out programs in accordance with this section.

(3) ADMINISTRATIVE COSTS.—The Secretary may use not more than 3 percent of the funds appropriated to carry out this section in any fiscal year for administrative costs.

(d) PROGRAM REQUIREMENTS.—

(1) LOCATION.—A community-based organization that receives a grant under this section to assist in carrying out such a program shall ensure that the program is carried out—

(A) when appropriate, in the facilities of a public school during nonschool hours; or

(B) in another appropriate local facility in a State or Indian country, such as a college or university, a local or State park or recreation center, church, or military base, that is—

(i) in a location that is easily accessible to children in the community; and

(ii) in compliance with all applicable local ordinances.

(2) USE OF FUNDS.—Such community-based organization—

(A) shall use funds made available through the grant to provide, to children in the eligible community, services and activities that—

(i) shall include supervised sports programs, and extracurricular and academic programs, that are offered—

(I) after school and on weekends and holidays, during the school year; and

(II) as daily full-day programs (to the extent available resources permit) or as part-day programs, during the summer months;

(B) in providing such extracurricular and academic programs, shall provide programs such as curriculum-based supervised educational, work force preparation, entrepreneurship, cultural, health programs, social activities, arts and crafts programs, dance programs, tutorial and mentoring programs, and other related activities;

(C) may use—

(i) such funds for minor renovation of facilities that are in existence prior to the operation of the program and that are necessary for the operation of the program for which the organization receives the grant, purchase of sporting and recreational equipment and supplies, reasonable costs for the transportation of participants in the program, hiring of staff, provision of meals for such participants, provision of health services consisting of an initial basic physical examination, provision of first aid and nutrition guidance, family counselling, parental training, and substance abuse treatment where appropriate; and

(ii) not more than 5 percent of such funds to pay for the administrative costs of the program; and

(D) may not use such funds to provide sectarian worship or sectarian instruction.

(e) ELIGIBLE COMMUNITY IDENTIFICATION.—

(1) IDENTIFICATION.—To be eligible to receive a grant under this section, a community-based organization shall identify an eligible community to be assisted under this section.

(2) CRITERIA.—Such eligible community shall be an area that meets such criteria with respect to significant poverty and significant juvenile delinquency, and such additional criteria, as the Secretary may by regulation require.

(f) APPLICATIONS.—

(1) APPLICATION REQUIRED.—To be eligible to receive a grant under this section, a community-based organization shall submit an application to the Secretary at such time, in such manner, and accompanied by such information, as the Secretary may reasonably require, and obtain approval of such application.

(2) CONTENTS OF APPLICATION.—Each application submitted pursuant to paragraph (1) shall—

(A) describe the activities and services to be provided through the program for which the grant is sought;

(B) contain an assurance that the community-based organization will spend grant funds received under this section in a manner that the community-based organization determines will best accomplish the objectives of this section;

(C) contain a comprehensive plan for the program that is designed to achieve identifiable goals for children in the eligible community;

(D) set forth measurable goals and outcomes for the program that—

(i) will—

(I) where appropriate, make a public school the focal point of the eligible community; or

(II) make a local facility described in subsection (d)(1)(B) such a focal point; and

(ii) may include reducing the percentage of children in the eligible community that enter the juvenile justice system, increasing the graduation rates, school attendance, and academic success of children in the eligible community, and improving the skills of program participants;

(E) provide evidence of support for accomplishing such goals and outcomes from—

(i) community leaders;

(ii) businesses;

(iii) local educational agencies;

(iv) local officials;

(v) State officials;

(vi) Indian tribal government officials; and

(vii) other organizations that the community-based organization determines to be appropriate;

(F) contain an assurance that the community-based organization will use grant funds received under this section to provide children in the eligible community with activities and services that shall include supervised sports programs, and extracurricular and academic programs, in accordance with subparagraphs (A) and (B) of subsection (d)(2);

(G) contain a list of the activities and services that will be offered through the program for which the grant is sought and sponsored by private nonprofit organizations, individuals, and groups serving the eligible community, including—

(i) extracurricular and academic programs, such as programs described in subsection (d)(2)(B); and

(ii) activities that address specific needs in the community;

(H) demonstrate the manner in which the community-based organization will make use of the resources, expertise, and commitment of private entities in carrying out the program for which the grant is sought;

(I) include an estimate of the number of children in the eligible community expected to be served pursuant to the program;

(J) include a description of charitable private resources, and all other resources, that will be made available to achieve the goals of the program;

(K) contain an assurance that the community-based organization will use competitive procedures when purchasing, contracting, or otherwise providing for goods, activities, or services to carry out programs under this section;

(L) contain an assurance that the program will maintain a staff-to-participant ratio (including volunteers) that is appropriate to the activity or services provided by the program;

(M) contain an assurance that the program will maintain an average attendance rate of not less than 75 percent of the participants enrolled in the program, or will enroll additional participants in the program;

(N) contain an assurance that the community-based organization will comply with any evaluation under subsection (m), any research effort authorized under Federal law, and any investigation by the Secretary;

(O) contain an assurance that the community-based organization shall prepare and submit to the Secretary an annual report regarding any program conducted under this section;

(P) contain an assurance that the program for which the grant is sought will, to the maximum extent possible, incorporate services that are provided solely through non-Federal private or nonprofit sources; and

(Q) contain an assurance that the community-based organization will maintain separate accounting records for the program.

(3) PRIORITY.—In awarding grants to carry out programs under this section, the Secretary shall give priority to community-based organizations who submit applications that demonstrate the greatest effort in generating local support for the programs.

(g) ELIGIBILITY OF PARTICIPANTS.—

(1) IN GENERAL.—To the extent possible, each child who resides in an eligible community shall be eligible to participate in a program carried out in such community that receives assistance under this section.

(2) ELIGIBILITY.—To be eligible to participate in a program that receives assistance under this section, a child shall provide the express written approval of a parent or guardian, and shall submit an official application and agree to the terms and conditions of participation in the program.

(3) NONDISCRIMINATION.—(A) In selecting children to participate in a program that receives assistance under this section, a community-based organization shall not discriminate on the basis of race, color, religion, sex, national origin, or disability.

(B) In selecting children to participate in a program that receives assistance under this section, a community-based organization may find a child ineligible to participate in such a program if the organization determines that the child has behavior problems that pose an unacceptable risk of injury or illness to other participants or has a physical or mental disability so serious that the child would be unable to participate in the program.

(h) PEER REVIEW PANEL.—

(1) ESTABLISHMENT.—The Secretary may establish a peer review panel that shall be comprised of individuals with demonstrated experience in designing and implementing community-based programs.

(2) COMPOSITION.—A peer review panel shall include at least 1 representative from each of the following:

(A) A community-based organization.

(B) A local government.

(C) A school district.

(D) The private sector.

(E) A charitable organization.

(F) A representative of the United States Olympic Committee, at the option of the Secretary.

(3) FUNCTIONS.—A peer review panel shall conduct the initial review of all grant applications received by the Secretary under subsection (f), make recommendations to the Secretary regarding—

(A) grant funding under this section; and

(B) a design for the evaluation of programs assisted under this section.

(i) INVESTIGATIONS AND INSPECTIONS.—The Secretary may conduct such investigations and inspections as may be necessary to ensure compliance with the provisions of this section.

(j) PAYMENTS; FEDERAL SHARE; NON-FEDERAL SHARE.—

(1) PAYMENTS.—The Secretary shall, subject to the availability of appropriations, pay to each community-based organization having an application approved under subsection (f) the Federal share of the costs of developing and carrying out programs described in subsection (c).

(2) FEDERAL SHARE.—The Federal share of such costs shall be no more than—

(A) 75 percent for each of fiscal years 1995 and 1996;

(B) 70 percent for fiscal year 1997; and

(C) 60 percent for fiscal year 1998 and thereafter.

(3) NON-FEDERAL SHARE.—

(A) IN GENERAL.—The non-Federal share of such costs may be in cash or in kind, fairly evaluated, including plant, equipment, and services (including the services described in subsection (f)(2)(P)), and funds appropriated by the Congress for the activity of any agency of an Indian tribal government or the Bureau of Indian Affairs on any Indian lands may be used to provide the non-Federal share of the costs of programs or projects funded under this subtitle.

(B) SPECIAL RULE.—At least 15 percent of the non-Federal share of such costs shall be provided from private or nonprofit sources.

(k) EVALUATION.—The Secretary shall conduct a thorough evaluation of the programs assisted under this section, which shall include an assessment of—

(1) the number of children participating in each program assisted under this section;

(2) the academic achievement of such children;

(3) school attendance and graduation rates of such children; and

(4) the number of such children being processed by the juvenile justice system.

SEC. 30402. FAMILY AND COMMUNITY ENDEAVOR SCHOOLS GRANT PROGRAM.

(a) SHORT TITLE.—This section may be cited as the "Family and Community Endeavor Schools Act".

(b) PURPOSE.—It is the purpose of this section to improve the overall development of at-risk children who reside in eligible communities as defined in subsection (l)(3).

(c) PROGRAM AUTHORITY.—The Secretary may award grants on a competitive basis to eligible local entities to pay for the Federal share of assisting eligible communities to develop and carry out programs in accordance with this section. No local entity shall receive a grant of less than $250,000 in a fiscal year. Amounts made available through such grants shall remain available until expended.

(d) PROGRAM REQUIREMENTS.—

(1) IMPROVEMENT PROGRAMS.—A local entity that receives funds under this section shall develop or expand programs that are designed to improve academic and social development by instituting a collaborative structure that trains and coordinates the efforts of teachers, administrators, social workers, guidance counselors, parents, and school volunteers to provide concurrent social services for at-risk students at selected public schools in eligible communities.

(2) OPTIONAL ACTIVITIES.—A local entity that receives funds under this section may develop a variety of programs to serve the comprehensive needs of students, including—

(A) homework assistance and after-school programs, including educational, social, and athletic activities;

(B) nutrition services;

(C) mentoring programs;

(D) family counseling; and

(E) parental training programs.

(e) ELIGIBLE COMMUNITY IDENTIFICATION.—The Secretary through regulation shall define the criteria necessary to qualify as an eligible community as defined in subsection (l)(3).

(f) GRANT ELIGIBILITY.—To be eligible to receive a grant under this section, a local entity shall—

(1) identify an eligible community to be assisted;

(2) develop a community planning process that includes—

(A) parents and family members;

(B) local school officials;

(C) teachers employed at schools within the eligible community;

(D) public housing resident organization members, where applicable; and

(E) public and private nonprofit organizations that provide education, child protective services, or other human services to low-income, at-risk children and their families; and

(3) develop a concentrated strategy for implementation of the community planning process developed under paragraph (2) that targets clusters of at-risk children in the eligible community.

(g) APPLICATIONS.—

(1) APPLICATION REQUIRED.—To be eligible to receive a grant under this section, a local entity shall submit an application to the Secretary at such time, in such manner, and accompanied by such information, as the Secretary may reasonably require, and obtain approval of such application.

(2) CONTENTS OF APPLICATION.—Each application submitted under paragraph (1) shall—

(A) contain a comprehensive plan for the program that is designed to improve the academic and social development of at-risk children in schools in the eligible community;

(B) provide evidence of support for accomplishing the objectives of such plan from—

(i) community leaders;

(ii) a school district;

(iii) local officials; and

(iv) other organizations that the local entity determines to be appropriate;

(C) provide an assurance that the local entity will use grant funds received under this subsection to implement the program requirements listed in subsection (d);

(D) include an estimate of the number of children in the eligible community expected to be served under the program;

(E) provide an assurance that the local entity will comply with any evaluation requested under subsection (k), any research effort authorized under Federal law, and any investigation by the Secretary;

(F) provide an assurance that the local entity shall prepare and submit to the Secretary an annual report regarding any program conducted under this section;

(G) provide an assurance that funds made available under this section shall be used to supplement, not supplant, other Federal funds that would otherwise be available for activities funded under this section; and

(H) provide an assurance that the local entity will maintain separate accounting records for the program.

(3) PRIORITY.—In awarding grants to carry out programs under this section, the Secretary shall give priority to local entities which submit applications that demonstrate the greatest effort in generating local support for the programs.

(h) PEER REVIEW PANEL.—

(1) ESTABLISHMENT.—The Secretary shall establish a peer review panel not to exceed 8 members that shall be comprised of individuals with demonstrated experience in designing and implementing programs to improve the academic and social development of at-risk children.

(2) FUNCTIONS.—Such panel shall make recommendations to the Secretary regarding—

(A) an illustrative model that effectively achieves the program requirements indicated in subsection (d) and a process whereby local entities can request such model; and

(B) a design for the evaluation of programs assisted under this section.

(i) INVESTIGATIONS AND INSPECTIONS.—The Secretary may conduct such investigations and inspections as may be necessary to ensure compliance with the provisions of this section.

(j) FEDERAL SHARE.—

(1) PAYMENTS.—The Secretary shall, subject to the availability of appropriations, pay to each local entity having an application approved under subsection (g) the Federal share of the costs of developing and carrying out programs referred to in subsection (d).

(2) FEDERAL SHARE.—The Federal share of such costs shall be 70 percent.

(3) NON-FEDERAL SHARE.—

(A) IN GENERAL.—The non-Federal share of such costs may be in cash or in kind, fairly evaluated, including personnel, plant, equipment, and services.

(B) SPECIAL RULE.—Not less than 15 percent of the non-Federal share of such costs shall be provided from private or nonprofit sources.

(k) EVALUATION.—The Secretary shall require a thorough evaluation of the programs assisted under this section, which shall include an assessment of the academic and social achievement of children assisted with funds provided under this section.

(l) DEFINITIONS.—For purposes of this section—

(1) the term "Secretary" means to the Secretary of the Department of Education;

(2) the term "local entity" means—

(A) a local educational agency, or

(B) a community-based organization as defined in section 1471(3) of the Elementary and Secondary Education Act of 1965;

(3) the term "eligible community" means an area which meets criteria with respect to significant poverty and significant violent crime, and such additional criteria, as the Secretary may by regulation require; and

(4) the term "public school" means an elementary school (as defined in section 1471(8) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 2891(8))) and a secondary school (as defined in section 1471(21) of that Act).

SEC. 30403. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to carry out this subtitle—

(1) $37,000,000 for fiscal year 1995;

(2) $115,000,000 for fiscal year 1996;

(3) $135,000,000 for fiscal year 1997;

(4) $170,000,000 for fiscal year 1998;

(5) $215,000,000 for fiscal year 1999; and

(6) $228,000,000 for fiscal year 2000.

(b) PROGRAMS.—Of the amounts appropriated under subsection (a) for any fiscal year—

(1) 70 percent shall be made available to carry out section 30401; and

(2) 30 percent shall be made available to carry out section 30402.

Subtitle E—Police Partnerships for Children

SEC. 30501. DEFINITIONS.

In this subtitle—

"Indian tribe" means a tribe, band, pueblo, nation, or other organized group or community of Indians, including an Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.)), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"partnership" means a cooperative arrangement or association involving one or more law enforcement agencies, and one or more public or private agencies that provide child or family services; and

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

SEC. 30502. GRANT AUTHORITY.

(a) PARTNERSHIP GRANTS.—

(1) IN GENERAL.—The Attorney General, in consultation with the Secretary of Health and Human Services, may make grants to partnerships for—

(A) teams or units involving both specially trained law enforcement professionals and child or family services professionals of the partnership that on a 24-hour basis respond to or deal with violent incidents in which a child is involved as a perpetrator, witness, or victim;

(B) training for law enforcement officers regarding behavior, psychology, family systems, and community culture and attitudes that is relevant to dealing with children who are involved in violent incidents or at risk of involvement in such incidents, or with families of such children;

(C) programs for children and families that are designed jointly by the law enforcement and child or family services components of the partnership, including programs providing 24-hour response to crisis situations affecting children, in-school programs (including D.A.R.E America), after-school activity and neighborhood recreation programs, parent support groups that are led jointly by child or family services and law enforcement personnel, mentoring programs, and programs that provide training in nonviolent conflict resolution; and

(D) regularly scheduled case conferences by the team of child or family services professionals and law enforcement officers described in subparagraph (A).

(2) CONSULTATION WITH OUNCE OF PREVENTION COUNCIL.—The Attorney General may consult with the Ounce of Prevention Council in awarding grants under paragraph (1).

(b) GRANTS FOR POLICE RESIDENCE IN HIGH CRIME AREAS.—The Secretary of Housing and Urban Development, in consultation with the Attorney General, may make grants to States, Indian tribal governments, units of local government, public housing authorities, owners of federally assisted housing, and owners of housing in high crime areas in order to provide dwelling units to law enforcement officers without charge or at a substantially reduced rent for the purpose of providing greater security for residents of high crime areas.

SEC. 30503. ADMINISTRATION.

(a) USE OF COMPONENTS.—The Attorney General may utilize any component or components of the Department of Justice in carrying out this subtitle.

(b) REGULATORY AUTHORITY.—The Attorney General, for the purposes of section 30502(a), and the Secretary of Housing and Urban Development, for purposes of section 30502(b), may issue regulations and guidelines to carry out this subtitle, including specifications concerning application requirements, selection criteria, duration and renewal of grants, evaluation requirements, matching funds, limitation of administrative expenses, submission of reports by grantees, recordkeeping by grantees, and access to books, records, and documents maintained by

grantees or other persons for purposes of audit or examination.

(c) Applications.—In addition to any other requirements that may be specified by the Attorney General—

(1) an application for a grant under section 30502(a) shall—

(A) certify that the applicant is a partnership as defined in section 30501, or a law enforcement agency or public or private child or family services agency that is participating in a partnership and seeking support on behalf of the partnership;

(B) ensure that the head of the law enforcement agency and the head of the child and family services organization agree to the establishment of the partnership and that the law enforcement agency and the child and family services organization in the partnership will cooperate in carrying out the program;

(C) include a long-term strategy and detailed implementation plan;

(D) certify that the Federal support provided under this subtitle will be used to supplement, and not supplant, State and local sources of funding that would otherwise be available, and in the case of Indian tribal governments, funds supplied by the Bureau of Indian Affairs;

(E) identify any related governmental or community initiatives which complement or will be coordinated with the proposal; and

(F) specify plans for obtaining necessary support and continuing the proposed program following the conclusion of Federal support; and

(2) in addition to any other requirements that may be specified by the Secretary of Housing and Urban Development, an application for a grant under section 30502(b) shall—

(A) certify that there has been appropriate consultation with the employing agency of any law enforcement officer who is to be provided with a dwelling unit;

(B) identify any related governmental or community initiatives which complement or will be coordinated with the proposal;

(C) certify that the Federal support provided will be used to supplement, and not supplant, State, Indian tribal government, and local sources of funding that would otherwise be available; and

(D) provide assurances that local police officers will not be required to reside in residences funded under this subtitle.

(d) Matching Funds.—The portion of the costs of a program provided by a grant under this subtitle may not exceed 75 percent, unless the Attorney General, for purposes of section 30502(a), or the Secretary of Housing and Urban Development, for purposes of section 30502(b), waives, wholly or in part, the requirement under this subsection of a non-Federal contribution to the costs of a program. Funds appropriated by the Congress for the activity of any agency of an Indian tribal government or of the Bureau of Indian Affairs on any Indian lands may be used to provide the non-Federal share of the programs funded under this subtitle.

(e) In-Kind Contributions.—The Attorney General shall accept the value of in-kind contributions made by the grant recipient as a part or all of the non-Federal share of grants.

(f) Funding Priority.—In making grants under section 30502(a), the Attorney General shall give priority to applications by partnerships involving law enforcement agencies that engage in community-oriented policing for programs assisting distressed communities or populations with a high incidence of violence affecting children.

SEC. 30504. TECHNICAL ASSISTANCE, TRAINING, AND EVALUATION.

(a) Technical Assistance and Training.—The Attorney General may provide technical assistance and training to further the purposes of this subtitle.

(b) Evaluations.—In addition to any evaluation requirements that may be prescribed for grantees, the Attorney General may carry out or make arrangements for evaluations of programs that receive support under this subtitle.

(c) Administration.—The technical assistance, training, and evaluations authorized by this section may be carried out directly by the Attorney General, or through grants, contracts, or other cooperative arrangements with other entities.

SEC. 30505. AUTHORIZATION OF APPROPRIATIONS.

(a) In General.—There are authorized to be appropriated to carry out this subtitle—

(1) $4,000,000 for fiscal year 1996;

(2) $5,000,000 for fiscal year 1997;

(3) $6,000,000 for fiscal year 1998;

(4) $7,000,000 for fiscal year 1999; and

(5) $8,000,000 for fiscal year 2000.

(b) Limitation.—Not more than 35 percent of the funds made available in a fiscal year for this subtitle may be expended for grants under section 30502(b).

Subtitle F—Midnight Sports

SEC. 30601. GRANTS FOR MIDNIGHT SPORTS LEAGUE ANTICRIME PROGRAMS.

(a) Authority.—

(1) In general.—The Secretary of Housing and Urban Development, in consultation with the Attorney General of the United States, the Secretary of Labor, and the Secretary of Education, shall make grants, to the extent that amounts are approved in appropriations under subsection (k), to eligible entities to assist such entities in carrying out midnight sports league programs meeting the requirements of subsection (d).

(2) Consultation with ounce of prevention council.—The Attorney General may consult with the Ounce of Prevention Council in awarding grants under paragraph (1).

(b) Eligible Entities.—

(1) In general.—Grants under subsection (a) may be made only to the following eligible entities:

(A) Entities eligible under section 520(b) of the Cranston-Gonzalez National Affordable Housing Act (42 U.S.C. 11903a(b)) for a grant under section 520(a) of that Act.

(B) Nonprofit organizations providing crime prevention, employment counseling, job training, or other educational services.

(C) Nonprofit organizations providing federally assisted low-income housing.

(2) Prohibition on second grants.—A grant under subsection (a) may not be made to an eligible entity if the entity previously received a grant under such subsection.

(c) Use of Grant Amounts.—Any eligible entity that receives a grant under subsection (a) may use the grant only—

(1) to establish or carry out a midnight sports league program under subsection (d);

(2) for salaries for administrators and staff of the program;

(3) for other administrative costs of the program, except that not more than 5 percent of the grant may be used for such administrative costs; and

(4) for costs of training and assistance provided under subsection (d).

(d) Program Requirements.—Each eligible entity receiving a grant under subsection (a) shall establish a midnight sports league program as follows:

(1) The program shall establish a sports league of not less than 80 players.

(2) Not less than 50 percent of the players in the sports league shall be residents of federally assisted low-income housing.

(3) The program shall be designed to serve primarily youths and young adults from a neighborhood or community whose population has not less than 2 of the following characteristics (in comparison with national averages):

(A) A substantial problem regarding use or sale of illegal drugs.

(B) A high incidence of crimes committed by youths or young adults.

(C) A high incidence of persons infected with the human immunodeficiency virus or sexually transmitted diseases.

(D) A high incidence of pregnancy, or a high birth rate, among adolescents.

(E) A high unemployment rate for youths and young adults.

(F) A high rate of high school dropouts.

(4) The program shall require each player in the league to attend employment counseling, job training, and other educational classes provided under the program, which shall be held in conjunction with league sports games at or near the site of the games.

(5) The program shall serve only youths and young adults who demonstrate a need for such counseling, training, and education provided by the program, in accordance with criteria for demonstrating need, which shall be established by the Secretary of Housing and Urban Development, in consultation with the Attorney General, the Secretary of Labor, and the Secretary of Education.

(6) The program shall obtain sponsors for each team in the sports league. Sponsors shall be private individuals or businesses in the neighborhood or community served by the program who make financial contributions to the program and participate in or supplement the employment, job training, and educational services provided to the players under the program with additional training or educational opportunities.

(7) The program shall comply with any criteria established by the Secretary of Housing and Urban Development in consultation with the Attorney General, the Secretary of Labor, and the Secretary of Education.

(e) Grant Amount Limitations.—

(1) Private contributions.—The Secretary of Housing and Urban Development, in consultation with the Attorney General, the Secretary of Labor, and the Secretary of Education, may not make a grant under subsection (a) to an eligible entity that applies for a grant under subsection (f) unless the applicant entity certifies to the Secretary of Housing and Urban Development, or the Attorney General, that the entity will supplement the grant amounts with amounts of funds from non-Federal sources, as follows:

(A) In each of the first 2 years that amounts from the grant are disbursed (under paragraph (5)), an amount sufficient to provide not less than 35 percent of the cost of carrying out the midnight sports league program.

(B) In each of the last 3 years that amounts from the grant are disbursed, an amount sufficient to provide not less than 50 percent of the cost of carrying out the midnight sports league program.

(2) Non-federal funds.—For purposes of this subsection, the term "funds from non-Federal sources" includes amounts from nonprofit organizations, public housing agencies, States, units of local government, and Indian housing authorities, private contributions, any salary paid to staff (other than from grant amounts under subsection (a)) to carry out the program of the eligible entity, in-kind contributions to carry out the program (as determined by the Secretary of Housing and Urban Development, in consultation with the Attorney General, the Secretary of Labor, and the Secretary of Education), the value of any donated material, equipment, or building, the value of any lease on a building, the value of any utilities provided, and the value of any time and services contributed by volunteers to carry out the program of the eligible entity. Funds appropriated

by the Congress for the activity of any agency of an Indian tribal government or of the Bureau of Indian Affairs on any Indian lands may be used to provide the non-Federal share of the costs of programs funded under this subtitle.

(3) PROHIBITION ON SUBSTITUTION OF FUNDS.—Grants made under subsection (a), and amounts provided by States and units of local government to supplement the grants, may not be used to replace other public funds previously used, or designated for use, under this section.

(4) MAXIMUM AND MINIMUM GRANT AMOUNTS.—The Secretary of Housing and Urban Development, in consultation with the Attorney General, the Secretary of Labor, and the Secretary of Education, may not make a grant under subsection (a) to any single eligible entity in an amount less than $50,000 or exceeding $250,000.

(5) DISBURSEMENT.—Each grant made under subsection (a)(1) shall be disbursed to the eligible entity receiving the grant over the 5-year period beginning on the date that the entity is selected to receive the grant, as follows:

(A) In each of the first 2 years of such 5-year period, 23 percent of the total grant amount shall be disbursed to the entity.

(B) In each of the last 3 years of such 5-year period, 18 percent of the total grant amount shall be disbursed to the entity.

(f) APPLICATIONS.—To be eligible to receive a grant under subsection (a), an eligible entity shall submit to the Secretary of Housing and Urban Development an application in the form and manner required by the Secretary of Housing and Urban Development, in consultation with the Attorney General, the Secretary of Labor, and the Secretary of Education, which shall include—

(1) a description of the midnight sports league program to be carried out by the entity, including a description of the employment counseling, job training, and other educational services to be provided;

(2) letters of agreement from service providers to provide training and counseling services required under subsection (d) and a description of such service providers;

(3) letters of agreement providing for facilities for sports games and counseling, training, and educational services required under subsection (d) and a description of the facilities;

(4) a list of persons and businesses from the community served by the program who have expressed interest in sponsoring, or have made commitments to sponsor, a team in the midnight sports league; and

(5) evidence that the neighborhood or community served by the program meets the requirements of subsection (d)(3).

(g) SELECTION.—The Secretary of Housing and Urban Development, in consultation with the Attorney General, the Secretary of Labor, and the Secretary of Education, shall select eligible entities that submit applications under subsection (f) to receive grants under subsection (a). The Secretary of Housing and Urban Development, in consultation with the Attorney General, the Secretary of Labor, and the Secretary of Education, shall establish criteria for selection of applicants to receive such grants. The criteria shall include a preference for selection of eligible entities carrying out midnight sports league programs in suburban and rural areas.

(h) REPORTS.—The Secretary of Housing and Urban Development, in consultation with the Attorney General, the Secretary of Labor, and the Secretary of Education, shall require each eligible entity receiving a grant under subsection (a) to submit for each year in which grant amounts are received by the entity, a report describing the activities carried out with such amounts.

(i) DEFINITIONS.—In this section—

"eligible entity" means an entity described under subsection (b)(1).

"federally assisted low-income housing" has the meaning given the term in section 5126 of the Public and Assisted Housing Drug Elimination Act of 1990.

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for grants under subsection (a)—

(A) $5,000,000 for fiscal year 1996;

(B) $8,000,000 for fiscal year 1997;

(C) $8,000,000 for fiscal year 1998;

(D) $9,000,000 for fiscal year 1999; and

(E) $10,000,000 for fiscal year 2000.

Subtitle G—Assistance for Delinquent and At-Risk Youth

SEC. 30701. GRANT AUTHORITY.

(a) GRANTS.—

(1) IN GENERAL.—In order to prevent the commission of crimes or delinquent acts by juveniles, the Attorney General may make grants to public or private nonprofit organizations to support the development and operation of projects to provide residential services to youth, aged 11 to 19, who—

(A) have dropped out of school;

(B) have come into contact with the juvenile justice system; or

(C) are at risk of dropping out of school or coming into contact with the juvenile justice system.

(2) CONSULTATION WITH THE OUNCE OF PREVENTION COUNCIL.—The Attorney General may consult with the Ounce of Prevention Council in making grants under paragraph (1).

(3) SERVICES.—Such services shall include activities designed to—

(A) increase the self-esteem of such youth;

(B) assist such youth in making healthy and responsible choices;

(C) improve the academic performance of such youth pursuant to a plan jointly developed by the applicant and the school which each such youth attends or should attend; and

(D) provide such youth with vocational and life skills.

(b) APPLICATIONS.—

(1) IN GENERAL.—A public agency or private nonprofit organization which desires a grant under this section shall submit an application at such time and in such manner as the Attorney General may prescribe.

(2) CONTENTS.—An application under paragraph (1) shall include—

(A) a description of the program developed by the applicant, including the activities to be offered;

(B) a detailed discussion of how such program will prevent youth from committing crimes or delinquent acts;

(C) evidence that such program—

(i) will be carried out in facilities which meet applicable State and local laws with regard to safety;

(ii) will include academic instruction, approved by the State, Indian tribal government, or local educational agency, which meets or exceeds State, Indian tribal government, and local standards and curricular requirements; and

(iii) will include instructors and other personnel who possess such qualifications as may be required by applicable State or local laws; and

(D) specific, measurable outcomes for youth served by the program.

(c) CONSIDERATION OF APPLICATIONS.—Not later than 60 days following the submission of applications, the Attorney General shall—

(1) approve each application and disburse the funding for each such application; or

(2) disapprove the application and inform the applicant of such disapproval and the reasons therefor.

(d) REPORTS.—A grantee under this section shall annually submit a report to the Attorney General that describes the activities and accomplishments of such program, including the degree to which the specific youth outcomes are met.

(e) DEFINITIONS.—In this subtitle—

"Indian tribe" means a tribe, band, pueblo, nation, or other organized group or community of Indians, including Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.)), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

SEC. 30702. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under section 30701—

(1) $6,000,000 for fiscal year 1996;

(2) $7,000,000 for fiscal year 1997;

(3) $8,000,000 for fiscal year 1998;

(4) $9,000,000 for fiscal year 1999; and

(5) $10,000,000 for fiscal year 2000.

Subtitle H—Police Recruitment

SEC. 30801. GRANT AUTHORITY.

(a) GRANTS.—

(1) IN GENERAL.—The Attorney General may make grants to qualified community organizations to assist in meeting the costs of qualified programs which are designed to recruit and retain applicants to police departments.

(2) CONSULTATION WITH THE OUNCE OF PREVENTION COUNCIL.—The Attorney General may consult with the Ounce of Prevention Council in making grants under paragraph (1).

(b) QUALIFIED COMMUNITY ORGANIZATIONS.—An organization is a qualified community organization which is eligible to receive a grant under subsection (a) if the organization—

(1) is a nonprofit organization; and

(2) has training and experience in—

(A) working with a police department and with teachers, counselors, and similar personnel,

(B) providing services to the community in which the organization is located,

(C) developing and managing services and techniques to recruit individuals to become members of a police department and to assist such individuals in meeting the membership requirements of police departments,

(D) developing and managing services and techniques to assist in the retention of applicants to police departments, and

(E) developing other programs that contribute to the community.

(c) QUALIFIED PROGRAMS.—A program is a qualified program for which a grant may be made under subsection (a) if the program is designed to recruit and train individuals from underrepresented neighborhoods and localities and if—

(1) the overall design of the program is to recruit and retain applicants to a police department;

(2) the program provides recruiting services which include tutorial programs to enable individuals to meet police force academic requirements and to pass entrance examinations;

(3) the program provides counseling to applicants to police departments who may encounter problems throughout the application process; and

(4) the program provides retention services to assist in retaining individuals to stay in the application process of a police department.

(d) APPLICATIONS.—To qualify for a grant under subsection (a), a qualified organization

shall submit an application to the Attorney General in such form as the Attorney General may prescribe. Such application shall—

(1) include documentation from the applicant showing—

(A) the need for the grant;

(B) the intended use of grant funds;

(C) expected results from the use of grant funds; and

(D) demographic characteristics of the population to be served, including age, disability, race, ethnicity, and languages used; and

(2) contain assurances satisfactory to the Attorney General that the program for which a grant is made will meet the applicable requirements of the program guidelines prescribed by the Attorney General under subsection (i).

(e) ACTION BY THE ATTORNEY GENERAL.—Not later than 60 days after the date that an application for a grant under subsection (a) is received, the Attorney General shall consult with the police department which will be involved with the applicant and shall—

(1) approve the application and disburse the grant funds applied for; or

(2) disapprove the application and inform the applicant that the application is not approved and provide the applicant with the reasons for the disapproval.

(f) GRANT DISBURSEMENT.—The Attorney General shall disburse funds under a grant under subsection (a) in accordance with regulations of the Attorney General which shall ensure—

(1) priority is given to applications for areas and organizations with the greatest showing of need;

(2) that grant funds are equitably distributed on a geographic basis; and

(3) the needs of underserved populations are recognized and addressed.

(g) GRANT PERIOD.—A grant under subsection (a) shall be made for a period not longer than 3 years.

(h) GRANTEE REPORTING.—(1) For each year of a grant period for a grant under subsection (a), the recipient of the grant shall file a performance report with the Attorney General explaining the activities carried out with the funds received and assessing the effectiveness of such activities in meeting the purpose of the recipient's qualified program.

(2) If there was more than one recipient of a grant, each recipient shall file such report.

(3) The Attorney General shall suspend the funding of a grant, pending compliance, if the recipient of the grant does not file the report required by this subsection or uses the grant for a purpose not authorized by this section.

(i) GUIDELINES.—The Attorney General shall, by regulation, prescribe guidelines on content and results for programs receiving a grant under subsection (a). Such guidelines shall be designed to establish programs which will be effective in training individuals to enter instructional programs for police departments and shall include requirements for—

(1) individuals providing recruiting services;

(2) individuals providing tutorials and other academic assistance programs;

(3) individuals providing retention services; and

(4) the content and duration of recruitment, retention, and counseling programs and the means and devices used to publicize such programs.

SEC. 30802. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for grants under section 30801—

(1) $2,000,000 for fiscal year 1996;

(2) $4,000,000 for fiscal year 1997;

(3) $5,000,000 for fiscal year 1998;

(4) $6,000,000 for fiscal year 1999; and

(5) $7,000,000 for fiscal year 2000.

Subtitle I—National Triad Program

SEC. 30901. PURPOSES.

The purposes of this subtitle are—

(1) to support a coordinated effort among law enforcement, older Americans organizations, and social service agencies to stem the tide of violence against older Americans and support media and nonmedia strategies aimed at increasing both public understanding of the problem and the older Americans' skills in preventing crime against themselves and their property; and

(2) to address the problem of crime against older Americans in a systematic and effective manner by promoting and expanding collaborative crime prevention programs, such as the Triad model, that assist law enforcement agencies and older Americans in implementing specific strategies for crime prevention, victim assistance, citizen involvement, and public education.

SEC. 30902. NATIONAL ASSESSMENT AND DISSEMINATION.

(a) IN GENERAL.—The Attorney General, in consultation with the Assistant Secretary for Aging, shall conduct a qualitative and quantitative national assessment of—

(1) the nature and extent of crimes committed against older Americans and the effect of such crimes on the victims;

(2) the numbers, extent, and impact of violent crimes and nonviolent crimes (such as frauds and "scams") against older Americans and the extent of unreported crimes;

(3) the collaborative needs of law enforcement, health, and social service organizations, focusing on prevention of crimes against older Americans, to identify, investigate, and provide assistance to victims of those crimes; and

(4) the development and growth of strategies to respond effectively to the matters described in paragraphs (1), (2), and (3).

(b) MATTERS TO BE ADDRESSED.—The national assessment made pursuant to subsection (a) shall address—

(1) the analysis and synthesis of data from a broad range of sources in order to develop accurate information on the nature and extent of crimes against older Americans, including identifying and conducting such surveys and other data collection efforts as are needed and designing a strategy to keep such information current over time;

(2) institutional and community responses to elderly victims of crime, focusing on the problems associated with fear of victimization, abuse of older Americans, and hard-to-reach older Americans who are in poor health, are living alone or without family nearby, or living in high crime areas;

(3) special services and responses required by elderly victims;

(4) whether the experience of older Americans with some service organizations differs markedly from that of younger populations;

(5) the kinds of programs that have proven useful in reducing victimization of older Americans through crime prevention activities and programs;

(6) the kinds of programs that contribute to successful coordination among public sector agencies and community organizations in reducing victimization of older Americans; and

(7) the research agenda needed to develop a comprehensive understanding of the problems of crimes against older Americans, including the changes that can be anticipated in the crimes themselves and appropriate responses as the society increasingly ages.

(c) AVOIDANCE OF DUPLICATION.—In conducting the assessment under subsection (a), the Attorney General, in consultation with the Assistant Secretary of Aging, shall draw upon the findings of existing studies and avoid duplication of efforts that have previously been made.

(d) DISSEMINATION.—Based on the results of the national assessment and analysis of successful or promising strategies in dealing with the problems described in subsection (b) and other problems, including coalition efforts such as the Triad programs described in section 1066, the Attorney General, in consultation with the Assistant Secretary of Aging, shall disseminate the results through reports, publications, clearinghouse services, public service announcements, and programs of evaluation, demonstration, training, and technical assistance.

SEC. 30903. PILOT PROGRAMS.

(a) AWARDS.—The Attorney General, in consultation with the Assistant Secretary of Aging, shall make grants to coalitions of local law enforcement agencies and older Americans to assist in the development of programs and execute field tests of particularly promising strategies for crime prevention services and related services based on the concepts of the Triad model, which can then be evaluated and serve as the basis for further demonstration and education programs.

(b) TRIAD COOPERATIVE MODEL.—(1) Subject to paragraph (2), a pilot program funded under this section shall consist of a cooperative model, which calls for the participation of the sheriff, at least 1 police chief, and a representative of at least 1 older Americans' organization within a county and may include participation by general service coalitions of law enforcement, victim service, and senior citizen advocate service organizations. If there exists within the applicant county an area agency on aging as defined in section 102(17) of the Older Americans Act of 1965, the applicant county must include the agency as an organizational component in its program.

(2) If there is not both a sheriff and a police chief in a county or if the sheriff or a police chief do not participate, a pilot program funded under this section shall include in the place of the sheriff or police chief another key law enforcement official in the county such as a local prosecutor.

(c) APPLICATION.—A coalition that desires to establish a pilot program under this section shall submit to the Attorney General an application that includes—

(1) a description of the community and its senior citizen population;

(2) assurances that Federal funds received under this title shall be used to provide additional and appropriate education and services to the community's older Americans;

(3) a description of the extent of involvement of each organizational component (chief, sheriff (or other law enforcement official), and senior organization representative) and focus of the program;

(4) a comprehensive plan including—

(A) a description of the crime problems facing older Americans and need for expanded law enforcement and victim assistance services;

(B) a description of the types of projects to be developed or expanded;

(C) a plan for an evaluation of the results of the program;

(D) a description of the resources (including matching funds, in-kind services, and other resources) available in the community to implement the program's development or expansion;

(E) a description of the gaps that cannot be filled with existing resources;

(F) an explanation of how the requested grant will be used to fill those gaps; and

(G) a description of the means and methods the applicant will use to reduce criminal victimization of older persons; and

(5) funding requirements for implementing a comprehensive plan.

(d) DISTRIBUTION OF GRANT AWARDS.—The Attorney General, in consultation with the Assistant Secretary for Aging, shall attempt, to the

extent practicable, to achieve an equitable geographic distribution of grant awards for pilot programs authorized under this subtitle.

(e) POST-GRANT PERIOD REPORT.—A grant recipient under this section shall, not later than 6 months after the conclusion of the grant period, submit to the Attorney General a report that—

(1) describes the composition of organizations that participated in the pilot program;

(2) identifies problem areas encountered during the course of the pilot program;

(3) provides data comparing the types and frequency of criminal activity before and after the grant period and the effect of such criminal activity on older Americans in the community; and

(4) describes the grant recipient's plans and goals for continuance of the program after the grant period.

SEC. 30904. TRAINING ASSISTANCE, EVALUATION, AND DISSEMINATION AWARDS.

In conjunction with the national assessment under section 30902—

(1) the Attorney General, in consultation with the Assistant Secretary for Aging, shall make awards to organizations with demonstrated ability to provide training and technical assistance in establishing crime prevention programs based on the Triad model, for purposes of aiding in the establishment and expansion of pilot programs under this section;

(2) the Attorney General, in consultation with the Assistant Secretary of Aging, shall make awards to research organizations, for the purposes of—

(A) evaluating the effectiveness of selected pilot programs; and

(B) conducting the research and development identified through the national assessment as being critical; and

(3) the Attorney General, in consultation with the Assistant Secretary for Aging, shall make awards to public service advertising coalitions, for the purposes of mounting a program of public service advertisements to increase public awareness and understanding of the issues surrounding crimes against older Americans and promoting ideas or programs to prevent them.

SEC. 30905. REPORT.

The Attorney General, in consultation with the Assistant Secretary for Aging, and the Director of the National Institute of Justice shall submit to Congress an annual report (which may be included with the report submitted under section 102(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3712(b))) describing the results of the pilot programs conducted under section 30903.

SEC. 30906. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated—

(1) to the Attorney General for the purpose of making pilot program awards in that amount under section 30903—

(A) $1,000,000 for fiscal year 1996;

(B) $1,000,000 for fiscal year 1997; and

(C) $1,000,000 for fiscal year 1998;

(2) to the Attorney General for the purpose of funding the national training and technical assistance effort under sections 30902 and 30903—

(A) $250,000 for fiscal year 1996;

(B) $250,000 for fiscal year 1997; and

(C) $250,000 for fiscal year 1998;

(3) to the Attorney General and to the Administration on Aging, for the purpose of developing public service announcements under sections 30902 and 30904—

(A) $250,000 for fiscal year 1996;

(B) $250,000 for fiscal year 1997; and

(C) $250,000 for fiscal year 1998;

(4) to the Attorney General for the purposes of conducting the national assessment, evaluating pilot programs, and carrying out the research agenda under sections 30902 and 30904—

(A) $500,000 for fiscal year 1996;

(B) $500,000 for fiscal year 1997; and

(C) $500,000 for fiscal year 1998;

(5) to the extent that funds are not otherwise available for the purpose, such sums as are necessary to pay the administrative costs of carrying out this subtitle.

Subtitle J—Local Partnership Act

SEC. 31001. ESTABLISHMENT OF PAYMENT PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title 31, United States Code, is amended by inserting after chapter 65 the following new chapter:

"CHAPTER 67—FEDERAL PAYMENTS

"Sec.
"6701. Payments to local governments.
"6702. Local Government Fiscal Assistance Fund.
"6703. Qualification for payment.
"6704. State area allocations; allocations and payments to territorial governments.
"6705. Local government allocations.
"6706. Income gap multiplier.
"6707. State variation of local government allocations.
"6708. Adjustments of local government allocations.
"6709. Information used in allocation formulas.
"6710. Public participation.
"6711. Prohibited discrimination.
"6712. Discrimination proceedings.
"6713. Suspension and termination of payments in discrimination proceedings.
"6714. Compliance agreements.
"6715. Enforcement by the Attorney General of prohibitions on discrimination.
"6716. Civil action by a person adversely affected.
"6717. Judicial review.
"6718. Investigations and reviews.
"6719. Reports.
"6720. Definitions, application, and administration.

"§6701. Payments to local governments

"(a) PAYMENT AND USE.—

"(1) PAYMENT.—The Secretary shall pay to each unit of general local government which qualifies for a payment under this chapter an amount equal to the sum of any amounts allocated to the government under this chapter for each payment period. The Secretary shall pay such amount out of the Local Government Fiscal Assistance Fund under section 6702.

"(2) USE.—Amounts paid to a unit of general local government under this section shall be used by that unit for carrying out one or more programs of the unit related to—

"(A) education to prevent crime;

"(B) substance abuse treatment to prevent crime; or

"(C) job programs to prevent crime.

"(3) COORDINATION.—Programs funded under this title shall be coordinated with other existing Federal programs to meet the overall needs of communities that benefit from funds received under this section.

"(b) TIMING OF PAYMENTS.—The Secretary shall pay each amount allocated under this chapter to a unit of general local government for a payment period by the later of 90 days after the date the amount is available or the first day of the payment period provided that the unit of general local government has provided the Secretary with the assurances required by section 6703(d).

"(c) ADJUSTMENTS.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall adjust a payment under this chapter to a unit of general local government to the extent that a prior payment to the government was more or less than the amount required to be paid.

"(2) CONSIDERATIONS.—The Secretary may increase or decrease under this subsection a payment to a unit of local government only if the Secretary determines the need for the increase or decrease, or the unit requests the increase or decrease, within one year after the end of the payment period for which the payment was made.

"(d) RESERVATION FOR ADJUSTMENTS.—The Secretary may reserve a percentage of not more than 2 percent of the amount under this section for a payment period for all units of general local government in a State if the Secretary considers the reserve is necessary to ensure the availability of sufficient amounts to pay adjustments after the final allocation of amounts among the units of general local government in the State.

"(e) REPAYMENT OF UNEXPENDED AMOUNTS.—

"(1) REPAYMENT REQUIRED.—A unit of general local government shall repay to the Secretary, by not later than 15 months after receipt from the Secretary, any amount that is—

"(A) paid to the unit from amounts appropriated under the authority of this section; and

"(B) not expended by the unit within one year after receipt from the Secretary.

"(2) PENALTY FOR FAILURE TO REPAY.—If the amount required to be repaid is not repaid, the Secretary shall reduce payments in future payment periods accordingly.

"(3) DEPOSIT OF AMOUNTS REPAID.—Amounts received by the Secretary as repayments under this subsection shall be deposited in the Local Government Fiscal Assistance Fund for future payments to units of general local government.

"(f) EXPENDITURE WITH DISADVANTAGED BUSINESS ENTERPRISES.—

"(1) GENERAL RULE.—Of amounts paid to a unit of general local government under this chapter for a payment period, not less than 10 percent of the total combined amounts obligated by the unit for contracts and subcontracts shall be expended with—

"(A) small business concerns controlled by socially and economically disadvantaged individuals and women; and

"(B) historically Black colleges and universities and colleges and universities having a student body in which more than 20 percent of the students are Hispanic Americans or Native Americans.

"(2) EXCEPTION.—Paragraph (1) shall not apply to amounts paid to a unit of general local government to the extent the unit determines that the paragraph does not apply through a process that provides for public participation.

"(3) DEFINITIONS.—For purposes of this subsection—

"(A) the term 'small business concern' has the meaning such term has under section 3 of the Small Business Act; and

"(B) the term 'socially and economically disadvantaged individuals' has the meaning such term has under section 8(d) of the Small Business Act and relevant subcontracting regulations promulgated pursuant to that section.

"(g) NONSUPPLANTING REQUIREMENT.—

"(1) IN GENERAL.—Funds made available under this chapter to units of local government shall not be used to supplant State or local funds, but will be used to increase the amount of funds that would, in the absence of funds under this chapter, be made available from State or local sources.

"(2) BASE LEVEL AMOUNT.—The total level of funding available to a unit of local government for accounts serving eligible purposes under this chapter in the fiscal year immediately preceding receipt of a grant under this chapter shall be designated the 'base level account' for the fiscal year in which grant is received. Grants under this chapter in a given fiscal year shall be reduced on a dollar for dollar basis to the extent that a unit of local government reduces its base level account in that fiscal year.

"§6702. Local Government Fiscal Assistance Fund

"(a) ADMINISTRATION OF FUND.—The Department of the Treasury has a Local Government Fiscal Assistance Fund, which consists of amounts appropriated to the Fund.

"(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Fund—

"(1) $300,000,000 for fiscal year 1996;

"(2) $315,000,000 for fiscal year 1997;

"(3) $395,000,000 for fiscal year 1998;

"(4) $395,000,000 for fiscal year 1999; and

"(5) $395,000,000 for fiscal year 2000.

Such sums are to remain available until expended.

"(c) ADMINISTRATIVE COSTS.—Up to 2.5 percent of the amount authorized to be appropriated under subsection (b) is authorized to be appropriated for the period fiscal year 1995 through fiscal year 2000 to be available for administrative costs by the Secretary in furtherance of the purposes of the program. Such sums are to remain available until expended.

"§6703. Qualification for payment

"(a) IN GENERAL.—The Secretary shall issue regulations establishing procedures under which eligible units of general local government are required to provide notice to the Secretary of the units' proposed use of assistance under this chapter. Subject to subsection (c), the assistance provided shall be used, in amounts determined by the unit, for activities under, or for activities that are substantially similar to an activity under, 1 or more of the following programs and the notice shall identify 1 or more of the following programs for each such use:

"(1) The Drug Abuse Resistance Education Program under section 5122 of the Elementary and Secondary Education Act of 1965.

"(2) The National Youth Sports Program under section 682 of the Community Services Block Grant Act (Public Law 97–35) as amended by section 205, Public Law 103–252.

"(3) The Gang Resistance Education and Training Program under the Act entitled 'An Act making appropriations for the Treasury Department, the United States Postal Service, the Executive Office of the President, and certain Independent Agencies, for the fiscal year ending September 30, 1991, and for other purposes', approved November 5, 1990 (Public Law 101–509).

"(4) Programs under title II or IV of the Job Training Partnership Act (29 U.S.C. 1601 et seq.).

"(5) Programs under subtitle C of title I of the National and Community Service Act of 1990 (42 U.S.C. 12571 et seq.) as amended.

"(6) Programs under the School to Work Opportunities Act (Public Law 103–239).

"(7) Substance Abuse Treatment and Prevention programs authorized under title V or XIX of the Public Health Services Act (43 U.S.C. 201 et seq.).

"(8) Programs under the Head Start Act (42 U.S.C. 9831 et seq.).

"(9) Programs under part A or B of chapter 1 of title I of the Elementary and Secondary Education Act of 1965.

"(10) The TRIO programs under part A of title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.).

"(11) Programs under the National Literacy Act of 1991.

"(12) Programs under the Carl Perkins Vocational Educational and Applied Technology Education Act (20 U.S.C. 2301 et seq.).

"(13) The demonstration partnership programs including the community initiative targeted to minority youth under section 203 of the Human Services Reauthorization of 1994 (Public Law 103–232).

"(14) The runaway and homeless youth program and the transitional living program for homeless youth under title III of the Juvenile Justice and Delinquency Prevention Act (Public Law 102–586).

"(15) The family support program under subtitle F of title VII of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 1148 et seq.).

"(16) After-school activities for school aged children under the Child Care and Development Block Grant Act (42 U.S.C. 9858 et seq.).

"(17) The community-based family resource programs under section 401 of the Human Services Reauthorization Act of 1994 (Public Law 103–232).

"(18) The family violence programs under the Child Abuse Prevention and Treatment Act Amendments of 1984.

"(19) Job training programs administered by the Department of Agriculture, the Department of Defense, or the Department of Housing and Urban Development.

"(b) NOTICE TO AGENCY.—Upon receipt of notice under subsection (a) from an eligible unit of general local government, the Secretary shall notify the head of the appropriate Federal agency for each program listed in subsection (a) that is identified in the notice as a program under which an activity will be conducted with assistance under this chapter. The notification shall state that the unit has elected to use some or all of its assistance under this chapter for activities under that program. The head of a Federal agency that receives such a notification shall ensure that such use is in compliance with the laws and regulations applicable to that program, except that any requirement to provide matching funds shall not apply to that use.

"(c) ALTERNATIVE USES OF FUNDS.—

"(1) ALTERNATIVE USES AUTHORIZED.—In lieu of, or in addition to, use for an activity described in subsection (a) and notice for that use under subsection (a), an eligible unit of general local government may use assistance under this chapter, and shall provide notice of that use to the Secretary under subsection (a), for any other activity that is consistent with 1 or more of the purposes described in section 6701(a)(2).

"(2) NOTICE DEEMED TO DESCRIBE CONSISTENT USE.—Notice by a unit of general local government that it intends to use assistance under this chapter for an activity other than an activity described in subsection (a) is deemed to describe an activity that is consistent with 1 or more of the purposes described in section 6701(a)(2) unless the Secretary provides to the unit, within 30 days after receipt of that notice of intent from the unit, written notice (including an explanation) that the use is not consistent with those purposes.

"(d) GENERAL REQUIREMENTS FOR QUALIFICATION.—A unit of general local government qualifies for a payment under this chapter for a payment period only after establishing to the satisfaction of the Secretary that—

"(1) the government will establish a trust fund in which the government will deposit all payments received under this chapter;

"(2) the government will use amounts in the trust fund (including interest) during a reasonable period;

"(3) the government will expend the payments so received, in accordance with the laws and procedures that are applicable to the expenditure of revenues of the government;

"(4) if at least 25 percent of the pay of individuals employed by the government in a public employee occupation is paid out of the trust fund, individuals in the occupation any part of whose pay is paid out of the trust fund will receive pay at least equal to the prevailing rate of pay for individuals employed in similar public employee occupations by the government;

"(5) All laborers and mechanics employed by contractors or subcontractors in the performance of any contract and subcontract for the repair, renovation, alteration, or construction, including painting and decorating, of any building or work that is financed in whole or in part by a grant under this title, shall be paid wages not less than those determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (commonly known as the Davis-Bacon Act); as amended (40 U.S.C. 276a–276a–5). The Secretary of Labor shall have the authority and functions set forth in reorganization plan of No. 14 of 1950 (15 FR 3176; 64 Stat. 1267) and section 2 of the Act of June 1, 1934 (commonly known as the Copeland Anti-Kickback Act) as amended (40 U.S.C. 276c, 48 Stat. 948).

"(6) the government will use accounting, audit, and fiscal procedures that conform to guidelines which shall be prescribed by the Secretary after consultation with the Comptroller General of the United States. As applicable, amounts received under this chapter shall be audited in compliance with the Single Audit Act of 1984;

"(7) after reasonable notice to the government, the government will make available to the Secretary and the Comptroller General of the United States, with the right to inspect, records the Secretary reasonably requires to review compliance with this chapter or the Comptroller General of the United States reasonably requires to review compliance and operations under section 6718(b);

"(8) the government will make reports the Secretary reasonably requires, in addition to the annual reports required under section 6719(b); and

"(9) the government will spend the funds only for the purposes set forth in section 6701(a)(2).

"(e) REVIEW BY GOVERNORS.—A unit of general local government shall give the chief executive officer of the State in which the government is located an opportunity for review and comment before establishing compliance with subsection (d).

"(f) SANCTIONS FOR NONCOMPLIANCE.—

"(1) IN GENERAL.—If the Secretary decides that a unit of general local government has not complied substantially with subsection (d) or regulations prescribed under subsection (d), the Secretary shall notify the government. The notice shall state that if the government does not take corrective action by the 60th day after the date the government receives the notice, the Secretary will withhold additional payments to the government for the current payment period and later payment periods until the Secretary is satisfied that the government—

"(A) has taken the appropriate corrective action; and

"(B) will comply with subsection (d) and regulations prescribed under subsection (d).

"(2) NOTICE.—Before giving notice under paragraph (1), the Secretary shall give the chief executive officer of the unit of general local government reasonable notice and an opportunity for comment.

"(3) PAYMENT CONDITIONS.—The Secretary may make a payment to a unit of general local government notified under paragraph (1) only if the Secretary is satisfied that the government—

"(A) has taken the appropriate corrective action; and

"(B) will comply with subsection (d) and regulations prescribed under subsection (d).

"§6704. State area allocations; allocations and payments to territorial governments

"(a) FORMULA ALLOCATION BY STATE.—For each payment period, the Secretary shall allocate to each State out of the amount appropriated for the period under the authority of section 6702(b) (minus the amounts allocated to territorial governments under subsection (e) for the payment period) an amount bearing the same ratio to the amount appropriated (minus such amounts allocated under subsection (e)) as

the amount allocated to the State under this section bears to the total amount allocated to all States under this section. The Secretary shall—

''(1) determine the amount allocated to the State under subsection (b) or (c) of this section and allocate the larger amount to the State; and

''(2) allocate the amount allocated to the State to units of general local government in the State under sections 6705 and 6706.

''(b) GENERAL FORMULA.—

''(1) IN GENERAL.—For the payment period beginning October 1, 1994, the amount allocated to a State under this subsection for a payment period is the amount bearing the same ratio to $5,300,000,000 as—

''(A) the population of the State, multiplied by the general tax effort factor of the State (determined under paragraph (2)), multiplied by the relative income factor of the State (determined under paragraph (3)), multiplied by the relative rate of the labor force unemployed in the State (determined under paragraph (4)); bears to

''(B) the sum of the products determined under subparagraph (A) of this paragraph for all States.

''(2) GENERAL TAX EFFORT FACTOR.—The general tax effort factor of a State for a payment period is—

''(A) the net amount of State and local taxes of the State collected during the year 1991 as reported by the Bureau of the Census in the publication Government Finances 1990–1991; divided by

''(B) the total income of individuals, as determined by the Secretary of Commerce for national accounts purposes for 1992 as reported in the publication Survey of Current Business (August 1993), attributed to the State for the same year.

''(3) RELATIVE INCOME FACTOR.—The relative income factor of a State is a fraction in which—

''(A) the numerator is the per capita income of the United States; and

''(B) the denominator is the per capita income of the State.

''(4) RELATIVE RATE OF LABOR FORCE.—The relative rate of the labor force unemployed in a State is a fraction in which—

''(A) the numerator is the percentage of the labor force of the State that is unemployed in the calendar year preceding the payment period (as determined by the Secretary of Labor for general statistical purposes); and

''(B) the denominator is the percentage of the labor force of the United States that is unemployed in the calendar year preceding the payment period (as determined by the Secretary of Labor for general statistical purposes).

''(c) ALTERNATIVE FORMULA.—For the payment period beginning October 1, 1994, the amount allocated to a State under this subsection for a payment period is the total amount the State would receive if—

''(1) $1,166,666,667 were allocated among the States on the basis of population by allocating to each State an amount bearing the same ratio to the total amount to be allocated under this paragraph as the population of the State bears to the population of all States;

''(2) $1,166,666,667 were allocated among the States on the basis of population inversely weighted for per capita income, by allocating to each State an amount bearing the same ratio to the total amount to be allocated under this paragraph as—

''(A) the population of the State, multiplied by a fraction in which—

''(i) the numerator is the per capita income of all States; and

''(ii) the denominator is the per capita income of the State; bears to

''(B) the sum of the products determined under subparagraph (A) for all States;

''(3) $600,000,000 were allocated among the States on the basis of income tax collections by allocating to each State an amount bearing the same ratio to the total amount to be allocated under this paragraph as the income tax amount of the State (determined under subsection (d)(1)) bears to the sum of the income tax amounts of all States;

''(4) $600,000,000 were allocated among the States on the basis of general tax effort by allocating to each State an amount bearing the same ratio to the total amount to be allocated under this paragraph as the general tax effort amount of the State (determined under subsection (d)(2)) bears to the sum of the general tax effort amounts of all States;

''(5) $600,000,000 were allocated among the States on the basis of unemployment by allocating to each State an amount bearing the same ratio to the total amount to be allocated under this paragraph as—

''(A) the labor force of the State, multiplied by a fraction in which—

''(i) the numerator is the percentage of the labor force of the State that is unemployed in the calendar year preceding the payment period (as determined by the Secretary of Labor for general statistical purposes); and

''(ii) the denominator is the percentage of the labor force of the United States that is unemployed in the calendar year preceding the payment period (as determined by the Secretary of Labor for general statistical purposes), bears to

''(B) the sum of the products determined under subparagraph (A) for all States; and

''(6) $1,166,666,667 were allocated among the States on the basis of urbanized population by allocating to each State an amount bearing the same ratio to the total amount to be allocated under this paragraph as the urbanized population of the State bears to the urbanized population of all States. In this paragraph, the term 'urbanized population' means the population of an area consisting of a central city or cities of at least 50,000 inhabitants and the surrounding closely settled area for the city or cities considered as an urbanized area as published by the Bureau of the Census for 1990 in the publication General Population Characteristics for Urbanized Areas.

''(d) INCOME TAX AMOUNT AND TAX EFFORT AMOUNT.—

''(1) INCOME TAX AMOUNT.—The income tax amount of a State for a payment period is 15 percent of the net amount collected during the calendar year ending before the beginning of the payment period from the tax imposed on the income of individuals by the State and described as a State income tax under section 164(a)(3) of the Internal Revenue Code of 1986 (26 U.S.C. 164(a)(3)). The income tax amount for a payment period shall be at least 1 percent but not more than 6 percent of the United States Government individual income tax liability attributed to the State for the taxable year ending during the last calendar year ending before the beginning of the payment period. The Secretary shall determine the Government income tax liability attributed to the State by using the data published by the Secretary for 1991 in the publication Statistics of Income Bulletin (Winter 1993–1994).

''(2) GENERAL TAX EFFORT AMOUNT.—The general tax effort amount of a State for a payment period is the amount determined by multiplying—

''(A) the net amount of State and local taxes of the State collected during the year 1991 as reported in the Bureau of Census in the publication Government Finances 1990–1991; and

''(B) the general tax effort factor of the State determined under subsection (b)(2).

''(e) ALLOCATION FOR PUERTO RICO, GUAM, AMERICAN SAMOA, AND THE VIRGIN ISLANDS.—

''(1) IN GENERAL.—(A) For each payment period for which funds are available for allocation under this chapter, the Secretary shall allocate to each territorial government an amount equal to the product of 1 percent of the amount of funds available for allocation multiplied by the applicable territorial percentage.

''(B) For the purposes of this paragraph, the applicable territorial percentage of a territory is equal to the quotient resulting from the division of the territorial population of such territory by the sum of the territorial population for all territories.

''(2) PAYMENTS TO LOCAL GOVERNMENTS.—The governments of the territories shall make payments to local governments within their jurisdiction from sums received under this subsection as they consider appropriate.

''(3) DEFINITIONS.—For purposes of this subsection—

''(A) the term 'territorial government' means the government of a territory;

''(B) the term 'territory' means Puerto Rico, Guam, American Samoa, and the Virgin Islands; and

''(C) the term 'territorial population' means the most recent population for each territory as determined by the Bureau of Census.

''§6705. Local government allocations

''(a) INDIAN TRIBES AND ALASKAN NATIVES VILLAGES.—If there is in a State an Indian tribe or Alaskan native village having a recognized governing body carrying out substantial governmental duties and powers, the Secretary shall allocate to the tribe or village, out of the amount allocated to the State under section 6704, an amount bearing the same ratio to the amount allocated to the State as the population of the tribe or village bears to the population of the State. The Secretary shall allocate amounts under this subsection to Indian tribes and Alaskan native villages in a State before allocating amounts to units of general local government in the State under subsection (c). For the payment period beginning October 1, 1994, the Secretary shall use as the population of each Indian tribe or Alaskan native village the population for 1991 as reported by the Bureau of Indian Affairs in the publication Indian Service Population and Labor Force Estimates (January 1991). In addition to uses authorized under section 6701(a)(2), amounts allocated under this subsection and paid to an Indian tribe or Alaskan native village under this chapter may be used for renovating or building prisons or other correctional facilities.

''(b) NEWLY INCORPORATED LOCAL GOVERNMENTS AND ANNEXED GOVERNMENTS.—If there is in a State a unit of general local government that has been incorporated since the date of the collection of the data used by the Secretary in making allocations pursuant to sections 6704 through 6706 and 6708, the Secretary shall allocate to this newly incorporated local government, out of the amount allocated to the State under section 6704, an amount bearing the same ratio to the amount allocated to the State as the population of the newly incorporated local government bears to the population of the State. If there is in the State a unit of general local government that has been annexed since the date of the collection of the data used by the Secretary in making allocations pursuant to sections 6704 through 6706 and 6708, the Secretary shall pay the amount that would have been allocated to this local government to the unit of general local government that annexed it.

''(c) OTHER LOCAL GOVERNMENT ALLOCATIONS.—

''(1) IN GENERAL.—The Secretary shall allocate among the units of general local government in a State (other than units receiving allocations under subsection (a)) the amount allocated to the State under section 6704 (as that amount is reduced by allocations under subsection (a)). Of the amount to be allocated, the

Secretary shall allocate a portion equal to ½ of such amount in accordance with section 6706(1), and shall allocate a portion equal to ½ of such amount in accordance with section 6706(2). A unit of general local government shall receive an amount equal to the sum of amounts allocated to the unit from each portion.

"(2) RATIO.—From each portion to be allocated to units of local government in a State under paragraph (1), the Secretary shall allocate to a unit an amount bearing the same ratio to the funds to be allocated as—

"(A) the population of the unit, multiplied by the general tax effort factor of the unit (determined under paragraph (3)), multiplied by the income gap of the unit (determined under paragraph (4)), bears to

"(B) the sum of the products determined under subparagraph (A) for all units in the State for which the income gap for that portion under paragraph (4) is greater than zero.

"(3) GENERAL TAX EFFORT FACTOR.—(A) Except as provided in subparagraph (C), the general tax effort factor of a unit of general local government for a payment period is—

"(i) the adjusted taxes of the unit; divided by

"(ii) the total income attributed to the unit.

"(B) If the amount determined under subparagraphs (A) (i) and (ii) for a unit of general local government is less than zero, the general tax effort factor of the unit is deemed to be zero.

"(C)(i) Except as otherwise provided in this subparagraph, for the payment period beginning October 1, 1994, the adjusted taxes of a unit of general local government are the taxes imposed by the unit for public purposes (except employee and employer assessments and contributions to finance retirement and social insurance systems and other special assessments for capital outlay), as determined by the Bureau of the Census for the 1987 Census of Governments and adjusted as follows:

"(I) Adjusted taxes equals total taxes times a fraction in which the numerator is the sum of unrestricted revenues and revenues dedicated for spending on education minus total education spending and the denominator is total unrestricted revenues.

"(II) Total taxes is the sum of property tax; general sales tax; alcoholic beverage tax; amusement tax; insurance premium tax; motor fuels tax; parimutuels tax; public utilities tax; tobacco tax; other selective sales tax; alcoholic beverage licenses, amusement licenses; corporation licenses, hunting and fishing licenses; motor vehicle licenses; motor vehicle operator licenses; public utility licenses; occupation and business licenses, not elsewhere classified; other licenses, individual income tax; corporation net income tax; death and gift tax; documentary and stock transfer tax; severance tax; and taxes not elsewhere classified.

"(III) Unrestricted revenues is the sum of total taxes and intergovernmental revenue from Federal Government, general revenue sharing; intergovernmental revenue from Federal Government, other general support; intergovernmental revenue from Federal Government, other; intergovernmental revenue from State government, other general support; intergovernmental revenue from State government, other; intergovernmental revenue from local governments, other general support; intergovernmental revenue from local governments, other; miscellaneous general revenue, property sale-housing and community development; miscellaneous general revenue, property sale-other property; miscellaneous general revenue, interest earnings on investments; miscellaneous general revenue, fines and forfeits; miscellaneous general revenue, rents; miscellaneous general revenues, royalties; miscellaneous general revenue, donations from private sources; miscellaneous general revenue, net lottery revenue (after prizes and administrative expenses); miscellaneous general revenue, other miscellaneous general revenue; and all other general charges, not elsewhere classified.

"(IV) Revenues dedicated for spending on education is the sum of elementary and secondary education, school lunch; elementary and secondary education, tuition; elementary and secondary education, other; higher education, auxiliary enterprises; higher education, other; other education, not elsewhere classified; intergovernmental revenue from Federal Government, education; intergovernmental revenue from State government, education; intergovernmental revenue from local governments, interschool system revenue; intergovernmental revenue from local governments, education; interest earnings, higher education; interest earnings, elementary and secondary education; miscellaneous revenues, higher education; and miscellaneous revenues, elementary and secondary education.

"(V) Total education spending is the sum of elementary and secondary education, current operations; elementary and secondary education, construction; elementary and secondary education, other capital outlays; elementary and secondary education, to State governments; elementary and secondary education, to local governments, not elsewhere classified; elementary and secondary education, to counties; elementary and secondary education, to municipalities; elementary and secondary education, to townships; elementary and secondary education, to school districts; elementary and secondary education, to special districts; higher education-auxiliary enterprises, current operations; higher education-auxiliary enterprises, construction; higher education, auxiliary enterprises, other capital outlays; other higher education, current operations; other higher education, construction; other higher education, other capital outlays; other higher education, to State government; other higher education, to local governments, not elsewhere classified; other higher education, to counties; other higher education, to municipalities; other higher education, to townships; other higher education, to school districts; other higher education, to special districts; education assistance and subsidies; education, not elsewhere classified, current operations; education, not elsewhere classified, construction education, not elsewhere classified, other capital outlays; education, not elsewhere classified, to State government; education, not elsewhere classified, to local governments, not elsewhere classified; education, not elsewhere classified, to counties; education, not elsewhere classified, to municipalities; education, not elsewhere classified, to townships; education, not elsewhere classified, to school districts; education, not elsewhere classified, to special districts; and education, not elsewhere classified, to Federal Government.

"(VI) If the amount of adjusted taxes is less than zero, the amount of adjusted tax shall be deemed to be zero.

"(VII) If the amount of adjusted taxes exceeds the amount of total taxes, the amount of adjusted taxes is deemed to equal the amount of total taxes.

"(ii) The Secretary shall, for purposes of clause (i), include that part of sales taxes transferred to a unit of general local government that are imposed by a county government in the geographic area of which is located the unit of general local government as taxes imposed by the unit for public purposes if—

"(I) the county government transfers any part of the revenue from the taxes to the unit of general local government without specifying the purpose for which the unit of general local government may expend the revenue; and

"(II) the chief executive officer of the State notifies the Secretary that the taxes satisfy the requirements of this clause.

"(iii) The adjusted taxes of a unit of general local government shall not exceed the maximum allowable adjusted taxes for that unit.

"(iv) The maximum allowable adjusted taxes for a unit of general local government is the allowable adjusted taxes of the unit minus the excess adjusted taxes of the unit.

"(v) The allowable adjusted taxes of a unit of general government is the greater of—

"(I) the amount equal to 2.5, multiplied by the per capita adjusted taxes of all units of general local government of the same type in the State, multiplied by the population of the unit; or

"(II) the amount equal to the population of the unit, multiplied by the sum of the adjusted taxes of all units of municipal local government in the State, divided by the sum of the populations of all the units of municipal local government in the State.

"(vi) The excess adjusted taxes of a unit of general local government is the amount equal to—

"(I) the adjusted taxes of the unit, minus

"(II) 1.5 multiplied by the allowable adjusted taxes of the unit;

except that if this amount is less than zero then the excess adjusted taxes of the unit is deemed to be zero.

"(vii) For purposes of this subparagraph—

"(I) the term 'per capita adjusted taxes of all units of general local government of the same type' means the sum of the adjusted taxes of all units of general local government of the same type divided by the sum of the populations of all units of general local government of the same type; and

"(II) the term 'units of general local government of the same type' means all townships if the unit of general local government is a township, all municipalities if the unit of general local government is a municipality, all counties if the unit of general local government is a county, or all unified city/county governments if the unit of general local government is a unified city/county government.

"(4) INCOME GAP.—(A) Except as provided in subparagraph (B), the income gap of a unit of general local government is—

"(i) the number which applies under section 6706, multiplied by the per capita income of the State in which the unit is located; minus

"(ii) the per capita income of the geographic area of the unit.

"(B) If the amount determined under subparagraph (A) for a unit of general local government is less than zero, then the relative income factor of the unit is deemed to be zero.

"(d) SMALL GOVERNMENT ALLOCATIONS.—If the Secretary decides that information available for a unit of general local government with a population below a number (of not more than 500) prescribed by the Secretary is inadequate, the Secretary may allocate to the unit, in lieu of any allocation under subsection (b) for a payment period, an amount bearing the same ratio to the total amount to be allocated under subsection (b) for the period for all units of general local government in the State as the population of the unit bears to the population of all units in the State.

"§6706. Income gap multiplier

"For purposes of determining the income gap of a unit of general local government under section 6705(b)(4)(A), the number which applies is—

"(1) 1.6, with respect to ½ of any amount allocated under section 6704 to the State in which the unit is located; and

"(2) 1.2, with respect to the remainder of such amount.

"§6707. State variation of local government allocations

"(a) STATE FORMULA.—A State government may provide by law for the allocation of

amounts among units of general local government in the State on the basis of population multiplied by the general tax effort factors or income gaps of the units of general local government determined under sections 6705 (a) and (b) or a combination of those factors. A State government providing for a variation of an allocation formula provided under sections 6705 (a) and (b) shall notify the Secretary of the variation by the 30th day before the beginning of the first payment period in which the variation applies. A variation shall—

"(1) provide for allocating the total amount allocated under sections 6705 (a) and (b); and

"(2) apply uniformly in the State.

"(b) Certification.—A variation by a State government under this section may apply only if the Secretary certifies that the variation complies with this section. The Secretary may certify a variation only if the Secretary is notified of the variation at least 30 days before the first payment period in which the variation applies.

"§6708. Adjustments of local government allocations

"(a) Maximum Amount.—The amount allocated to a unit of general local government for a payment period may not exceed the adjusted taxes imposed by the unit of general local government as determined under section 6705(b)(3). Amounts in excess of adjusted taxes shall be paid to the Governor of the State in which the unit of local government is located.

"(b) De Minimis Allocations to Units of General Local Government.—If the amount allocated to a unit of general local government (except an Indian tribe or an Alaskan native village) for a payment period would be less than $5,000 but for this subsection or is waived by the governing authority of the unit of general local government, the Secretary shall pay the amount to the Governor of the State in which the unit is located.

"(c) Use of Payments to States.—The Governor of a State shall use all amounts paid to the Governor under subsections (a) and (b) for programs described in section 6701(a)(2) in areas of the State where are located the units of general local government with respect to which amounts are paid under subsection (b).

"(d) De Minimis Allocations to Indian Tribes and Alaskan Native Villages.—

"(1) Aggregation of de minimis allocations.—If the amount allocated to an Indian tribe or an Alaskan native village for a payment period would be less than $5,000 but for this subsection or is waived by the chief elected official of the tribe or village, the amount—

"(A) shall not be paid to the tribe or village (except under paragraph (2)); and

"(B) shall be aggregated with other such amounts and available for use by the Attorney General under paragraph (2).

"(2) Use of aggregated amounts.—Amounts aggregated under paragraph (1) for a payment period shall be available for use by the Attorney General to make grants in the payment period on a competitive basis to Indian Tribes and Alaskan native village for—

"(A) programs described in section 6701(a)(2); or

"(B) renovating or building prisons or other correctional facilities.

"§6709. Information used in allocation formulas

"(a) Population Data for Payment Period Beginning October 1, 1994.—For the payment period beginning October 1, 1994, the Secretary, in making allocations pursuant to sections 6704 through 6706 and 6708, shall use for the population of the States the population for 1992 as reported by the Bureau of the Census in the publication Current Population Reports, Series P–25, No. 1045 (July 1992) and for the population of units of general local government the Secretary shall use the population for 1990 as reported by the Bureau of the Census in the publication Summary Social, Economic, and Housing Characteristics.

"(b) Data for Payment Periods Beginning After September 30, 1995.—For any payment period beginning after September 30, 1995, the Secretary, in making allocations pursuant to sections 6704 through 6706 and 6708, shall use information more recent than the information used for the payment period beginning October 1, 1994, provided the Secretary notifies the Committee on Government Operations of the House of Representatives at least 90 days prior to the beginning of the payment period that the Secretary has determined that the more recent information is more reliable than the information used for the payment period beginning October 1, 1994.

"§6710. Public participation

"(a) Hearings.—

"(1) In general.—A unit of general local government expending payments under this chapter shall hold at least one public hearing on the proposed use of the payment in relation to its entire budget. At the hearing, persons shall be given an opportunity to provide written and oral views to the governmental authority responsible for enacting the budget and to ask questions about the entire budget and the relation of the payment to the entire budget. The government shall hold the hearing at a time and a place that allows and encourages public attendance and participation.

"(2) Senior citizens.—A unit of general local government holding a hearing required under this subsection or by the budget process of the government shall try to provide senior citizens and senior citizen organizations with an opportunity to present views at the hearing before the government makes a final decision on the use of the payment.

"(b) Disclosure of Information.—

"(1) In general.—By the 10th day before a hearing required under subsection (a)(1) is held, a unit of general local government shall—

"(A) make available for inspection by the public at the principal office of the government a statement of the proposed use of the payment and a summary of the proposed budget of the government; and

"(B) publish in at least one newspaper of general circulation the proposed use of the payment with the summary of the proposed budget and a notice of the time and place of the hearing.

"(2) Availability.—By the 30th day after adoption of the budget under State or local law, the government shall—

"(A) make available for inspection by the public at the principal office of the government a summary of the adopted budget, including the proposed use of the payment; and

"(B) publish in at least one newspaper of general circulation a notice that the information referred to in subparagraph (A) is available for inspection.

"(c) Waivers of Requirements.—A requirement—

"(1) under subsection (a)(1) may be waived if the budget process required under the applicable State or local law or charter provisions—

"(A) ensures the opportunity for public attendance and participation contemplated by subsection (a); and

"(B) includes a hearing on the proposed use of a payment received under this chapter in relation to the entire budget of the government; and

"(2) under subsection (b)(1)(B) and paragraph (2)(B) may be waived if the cost of publishing the information would be unreasonably burdensome in relation to the amount allocated to the government from amounts available for payment under this chapter, or if publication is otherwise impracticable.

"(d) Exception to 10-Day Limitation.—If the Secretary is satisfied that a unit of general local government will provide adequate notice of the proposed use of a payment received under this chapter, the 10-day period under subsection (b)(1) may be changed to the extent necessary to comply with applicable State or local law.

"§6711. Prohibited discrimination

"(a) General Prohibition.—No person in the United States shall be excluded from participating in, be denied the benefits of, or be subject to discrimination under, a program or activity of a unit of general local government because of race, color, national origin, or sex if the government receives a payment under this chapter.

"(b) Additional Prohibitions.—The following prohibitions and exemptions also apply to a program or activity of a unit of general local government if the government receives a payment under this chapter:

"(1) A prohibition against discrimination because of age under the Age Discrimination Act of 1975.

"(2) A prohibition against discrimination against an otherwise qualified handicapped individual under section 504 of the Rehabilitation Act of 1973.

"(3) A prohibition against discrimination because of religion, or an exemption from that prohibition, under the Civil Rights Act of 1964 or title VIII of the Act of April 11, 1968 (popularly known as the Civil Rights Act of 1968).

"(c) Limitations on Applicability of Prohibitions.—Subsections (a) and (b) do not apply if the government shows, by clear and convincing evidence, that a payment received under this chapter is not used to pay for any part of the program or activity with respect to which the allegation of discrimination is made.

"(d) Investigation Agreements.—The Secretary shall try to make agreements with heads of agencies of the United States Government and State agencies to investigate noncompliance with this section. An agreement shall—

"(1) describe the cooperative efforts to be taken (including sharing civil rights enforcement personnel and resources) to obtain compliance with this section; and

"(2) provide for notifying immediately the Secretary of actions brought by the United States Government or State agencies against a unit of general local government alleging a violation of a civil rights law or a regulation prescribed under a civil rights law.

"§6712. Discrimination proceedings

"(a) Notice of Noncompliance.—By the 10th day after the Secretary makes a finding of discrimination or receives a holding of discrimination about a unit of general local government, the Secretary shall submit a notice of noncompliance to the government. The notice shall state the basis of the finding or holding.

"(b) Informal Presentation of Evidence.—A unit of general local government may present evidence informally to the Secretary within 30 days after the government receives a notice of noncompliance from the Secretary. Except as provided in subsection (e), the government may present evidence on whether—

"(1) a person in the United States has been excluded or denied benefits of, or discriminated against under, the program or activity of the government, in violation of section 6711(a);

"(2) the program or activity of the government violated a prohibition described in section 6711(b); and

"(3) any part of that program or activity has been paid for with a payment received under this chapter.

"(c) Temporary Suspension of Payments.—By the end of the 30-day period under subsection (b), the Secretary shall decide whether

the unit of general local government has not complied with section 6711 (a) or (b), unless the government has entered into a compliance agreement under section 6714. If the Secretary decides that the government has not complied, the Secretary shall notify the government of the decision and shall suspend payments to the government under this chapter unless, within 10 days after the government receives notice of the decision, the government—

"(1) enters into a compliance agreement under section 6714; or

"(2) requests a proceeding under subsection (d)(1).

"(d) ADMINISTRATIVE REVIEW OF SUSPENSIONS.—

"(1) PROCEEDING.—A proceeding requested under subsection (c)(2) shall begin by the 30th day after the Secretary receives a request for the proceeding. The proceeding shall be before an administrative law judge appointed under section 3105 of title 5, United States Code. By the 30th day after the beginning of the proceeding, the judge shall issue a preliminary decision based on the record at the time on whether the unit of general local government is likely to prevail in showing compliance with section 6711 (a) or (b).

"(2) DECISION.—If the administrative law judge decides at the end of a proceeding under paragraph (1) that the unit of general local government has—

"(A) not complied with section 6711 (a) or (b), the judge may order payments to the government under this chapter terminated; or

"(B) complied with section 6711 (a) or (b), a suspension under section 6713(a)(1)(A) shall be discontinued promptly.

"(3) LIKELIHOOD OF PREVAILING.—An administrative law judge may not issue a preliminary decision that the government is not likely to prevail if the judge has issued a decision described in paragraph (2)(A).

"(e) BASIS FOR REVIEW.—In a proceeding under subsections (b) through (d) on a program or activity of a unit of general local government about which a holding of discrimination has been made, the Secretary or administrative law judge may consider only whether a payment under this chapter was used to pay for any part of the program or activity. The holding of discrimination is conclusive. If the holding is reversed by an appellate court, the Secretary or judge shall end the proceeding.

"§6713. Suspension and termination of payments in discrimination proceedings

"(a) IMPOSITION AND CONTINUATION OF SUSPENSIONS.—

"(1) IN GENERAL.—The Secretary shall suspend payment under this chapter to a unit of general local government—

"(A) if an administrative law judge appointed under section 3105 of title 5, United States Code, issues a preliminary decision in a proceeding under section 6712(d)(1) that the government is not likely to prevail in showing compliance with section 6711 (a) and (b);

"(B) if the administrative law judge decides at the end of the proceeding that the government has not complied with section 6711 (a) or (b), unless the government makes a compliance agreement under section 6714 by the 30th day after the decision; or

"(C) if required under section 6712(c).

"(2) EFFECTIVENESS.—A suspension already ordered under paragraph (1)(A) continues in effect if the administrative law judge makes a decision under paragraph (1)(B).

"(b) LIFTING OF SUSPENSIONS AND TERMINATIONS.—If a holding of discrimination is reversed by an appellate court, a suspension or termination of payments in a proceeding based on the holding shall be discontinued.

"(c) RESUMPTION OF PAYMENTS UPON ATTAINING COMPLIANCE.—The Secretary may resume payment to a unit of general local government of payments suspended by the Secretary only—

"(1) as of the time of, and under the conditions stated in—

"(A) the approval by the Secretary of a compliance agreement under section 6714(a)(1); or

"(B) a compliance agreement entered into by the Secretary under section 6714(a)(2);

"(2) if the government complies completely with an order of a United States court, a State court, or administrative law judge that covers all matters raised in a notice of noncompliance submitted by the Secretary under section 6712(a);

"(3) if a United States court, a State court, or an administrative law judge decides (including a judge in a proceeding under section 6712(d)(1)), that the government has complied with sections 6711 (a) and (b); or

"(4) if a suspension is discontinued under subsection (b).

"(d) PAYMENT OF DAMAGES AS COMPLIANCE.—For purposes of subsection (c)(2), compliance by a government may consist of the payment of restitution to a person injured because the government did not comply with section 6711 (a) or (b).

"(e) RESUMPTION OF PAYMENTS UPON REVERSAL BY COURT.—The Secretary may resume payment to a unit of general local government of payments terminated under section 6712(d)(2)(A) only if the decision resulting in the termination is reversed by an appellate court.

"§6714. Compliance agreements

"(a) TYPES OF COMPLIANCE AGREEMENTS.—A compliance agreement is an agreement—

"(1) approved by the Secretary, between the governmental authority responsible for prosecuting a claim or complaint that is the basis of a holding of discrimination and the chief executive officer of the unit of general local government that has not complied with section 6711 (a) or (b); or

"(2) between the Secretary and the chief executive officer.

"(b) CONTENTS OF AGREEMENTS.—A compliance agreement—

"(1) shall state the conditions the unit of general local government has agreed to comply with that would satisfy the obligations of the government under sections 6711 (a) and (b);

"(2) shall cover each matter that has been found not to comply, or would not comply, with section 6711 (a) or (b); and

"(3) may be a series of agreements that dispose of those matters.

"(c) AVAILABILITY OF AGREEMENTS TO PARTIES.—The Secretary shall submit a copy of a compliance agreement to each person who filed a complaint referred to in section 6716(b), or, if an agreement under subsection (a)(1), each person who filed a complaint with a governmental authority, about a failure to comply with section 6711 (a) or (b). The Secretary shall submit the copy by the 15th day after an agreement is made. However, if the Secretary approves an agreement under subsection (a)(1) after the agreement is made, the Secretary may submit the copy by the 15th day after approval of the agreement.

"§6715. Enforcement by the Attorney General of prohibitions on discrimination

"The Attorney General may bring a civil action in an appropriate district court of the United States against a unit of general local government that the Attorney General has reason to believe has engaged or is engaging in a pattern or practice in violation of section 6711 (a) or (b). The court may grant—

"(1) a temporary restraining order;

"(2) an injunction; or

"(3) an appropriate order to ensure enjoyment of rights under section 6711 (a) or (b), including an order suspending, terminating, or requiring repayment of, payments under this chapter or placing additional payments under this chapter in escrow pending the outcome of the action.

"§6716. Civil action by a person adversely affected

"(a) AUTHORITY FOR PRIVATE SUITS IN FEDERAL OR STATE COURT.—If a unit of general local government, or an officer or employee of a unit of general local government acting in an official capacity, engages in a practice prohibited by this chapter, a person adversely affected by the practice may bring a civil action in an appropriate district court of the United States or a State court of general jurisdiction. Before bringing an action under this section, the person must exhaust administrative remedies under subsection (b).

"(b) ADMINISTRATIVE REMEDIES REQUIRED TO BE EXHAUSTED.—A person adversely affected shall file an administrative complaint with the Secretary or the head of another agency of the United States Government or the State agency with which the Secretary has an agreement under section 6711(d). Administrative remedies are deemed to be exhausted by the person after the 90th day after the complaint was filed if the Secretary, the head of the Government agency, or the State agency—

"(1) issues a decision that the government has not failed to comply with this chapter; or

"(2) does not issue a decision on the complaint.

"(c) AUTHORITY OF COURT.—In an action under this section, the court—

"(1) may grant—

"(A) a temporary restraining order;

"(B) an injunction; or

"(C) another order, including suspension, termination, or repayment of, payments under this chapter or placement of additional payments under this chapter in escrow pending the outcome of the action; and

"(2) to enforce compliance with section 6711 (a) or (b), may allow a prevailing party (except the United States Government) a reasonable attorney's fee.

"(d) INTERVENTION BY ATTORNEY GENERAL.—In an action under this section to enforce compliance with section 6711 (a) or (b), the Attorney General may intervene in the action if the Attorney General certifies that the action is of general public importance. The United States Government is entitled to the same relief as if the Government had brought the action and is liable for the same fees and costs as a private person.

"§6717. Judicial review

"(a) APPEALS IN FEDERAL COURT OF APPEALS.—A unit of general local government which receives notice from the Secretary about withholding payments under section 6703(f), suspending payments under section 6713(a)(1)(B), or terminating payments under section 6712(d)(2)(A), may apply for review of the action of the Secretary by filing a petition for review with the court of appeals of the United States for the circuit in which the government is located. The petition shall be filed by the 60th day after the date the notice is received. The clerk of the court shall immediately send a copy of the petition to the Secretary.

"(b) FILING OF RECORD OF ADMINISTRATIVE PROCEEDING.—The Secretary shall file with the court a record of the proceeding on which the Secretary based the action. The court may consider only objections to the action of the Secretary that were presented before the Secretary.

"(c) COURT ACTION.—The court may affirm, change, or set aside any part of the action of the Secretary. The findings of fact by the Secretary are conclusive if supported by substantial evidence in the record. If a finding is not supported by substantial evidence in the record, the

court may remand the case to the Secretary to take additional evidence. Upon such a remand, the Secretary may make new or modified findings and shall certify additional proceedings to the court.

"(d) REVIEW ONLY BY SUPREME COURT.—A judgment of a court under this section may be reviewed only by the Supreme Court under section 1254 of title 28, United States Code.

"§6718. Investigations and reviews

"(a) INVESTIGATIONS BY SECRETARY.—

"(1) IN GENERAL.—The Secretary shall within a reasonable time limit—

"(A) carry out an investigation and make a finding after receiving a complaint referred to in section 6716(b), a determination by a State or local administrative agency, or other information about a possible violation of this chapter;

"(B) carry out audits and reviews (including investigations of allegations) about possible violations of this chapter; and

"(C) advise a complainant of the status of an audit, investigation, or review of an allegation by the complainant of a violation of section 6711 (a) or (b) or other provision of this chapter.

"(2) TIME LIMIT.—The maximum time limit under paragraph (1)(A) is 120 days.

"(b) REVIEWS BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall carry out reviews of the activities of the Secretary, State governments, and units of general local government necessary for the Congress to evaluate compliance and operations under this chapter. These reviews shall include a comparison of the waste and inefficiency of local governments using funds under this chapter compared to waste and inefficiency with other comparable Federal programs.

"§6719. Reports

"(a) REPORTS BY SECRETARY TO CONGRESS.—Before June 2 of each year prior to 2002, the Secretary personally shall report to the Congress on—

"(1) the status and operation of the Local Government Fiscal Assistance Fund during the prior fiscal year; and

"(2) the administration of this chapter, including a complete and detailed analysis of—

"(A) actions taken to comply with sections 6711 through 6715, including a description of the kind and extent of noncompliance and the status of pending complaints;

"(B) the extent to which units of general local government receiving payments under this chapter have complied with the requirements of this chapter;

"(C) the way in which payments under this chapter have been distributed in the jurisdictions receiving payments; and

"(D) significant problems in carrying out this chapter and recommendations for legislation to remedy the problems.

"(b) REPORTS BY UNITS OF GENERAL LOCAL GOVERNMENT TO SECRETARY.—

"(1) IN GENERAL.—At the end of each fiscal year, each unit of general local government which received a payment under this chapter for the fiscal year shall submit a report to the Secretary. The report shall be submitted in the form and at a time prescribed by the Secretary and shall be available to the public for inspection. The report shall state—

"(A) the amounts and purposes for which the payment has been appropriated, expended, or obligated in the fiscal year;

"(B) the relationship of the payment to the relevant functional items in the budget of the government; and

"(C) the differences between the actual and proposed use of the payment.

"(2) AVAILABILITY OF REPORT.—The Secretary shall provide a copy of a report submitted under paragraph (1) by a unit of general local government to the chief executive officer of the State in which the government is located. The Secretary shall provide the report in the manner and form prescribed by the Secretary.

"§6720. Definitions, application, and administration

"(a) DEFINITIONS.—In this chapter—

"(1) 'unit of general local government' means—

"(A) a county, township, city, or political subdivision of a county, township, or city, that is a unit of general local government as determined by the Secretary of Commerce for general statistical purposes; and

"(B) the District of Columbia and the recognized governing body of an Indian tribe or Alaskan Native village that carries out substantial governmental duties and powers;

"(2) 'payment period' means each 1-year period beginning on October 1 of the years 1994 through 2000;

"(3) 'State and local taxes' means taxes imposed by a State government or unit of general local government or other political subdivision of a State government for public purposes (except employee and employer assessments and contributions to finance retirement and social insurance systems and other special assessments for capital outlay) as determined by the Secretary of Commerce for general statistical purposes;

"(4) 'State' means any of the several States and the District of Columbia;

"(5) 'income' means the total money income received from all sources as determined by the Secretary of Commerce for general statistical purposes, which for units of general local government is reported by the Bureau of the Census for 1990 in the publication Summary Social, Economic, and Housing Characteristics;

"(6) 'per capita income' means—

"(A) in the case of the United States, the income of the United States divided by the population of the United States;

"(B) in the case of a State, the income of that State, divided by the population of that State; and

"(C) in the case of a unit of general local government, the income of that unit of general local government divided by the population of the unit of general local government;

"(7) 'finding of discrimination' means a decision by the Secretary about a complaint described in section 6716(b), a decision by a State or local administrative agency, or other information (under regulations prescribed by the Secretary) that it is more likely than not that a unit of general local government has not complied with section 6711 (a) or (b);

"(8) 'holding of discrimination' means a holding by a United States court, a State court, or an administrative law judge appointed under section 3105 of title 5, United States Code, that a unit of general local government expending amounts received under this chapter has—

"(A) excluded a person in the United States from participating in, denied the person the benefits of, or subjected the person to discrimination under, a program or activity because of race, color, national origin, or sex; or

"(B) violated a prohibition against discrimination described in section 6711(b); and

"(9) 'Secretary' means the Secretary of Housing and Urban Development.

"(b) DELEGATION OF ADMINISTRATION.—The Secretary may enter into agreements with other executive branch departments and agencies to delegate to that department or agency all or part of the Secretary's responsibility for administering this chapter.

"(c) TREATMENT OF SUBSUMED AREAS.—If the entire geographic area of a unit of general local government is located in a larger entity, the unit of general local government is deemed to be located in the larger entity. If only part of the geographic area of a unit is located in a larger entity, each part is deemed to be located in the larger entity and to be a separate unit of general local government in determining allocations under this chapter. Except as provided in regulations prescribed by the Secretary, the Secretary shall make all data computations based on the ratio of the estimated population of the part to the population of the entire unit of general local government.

"(d) BOUNDARY AND OTHER CHANGES.—If a boundary line change, a State statutory or constitutional change, annexation, a governmental reorganization, or other circumstance results in the application of sections 6704 through 6708 in a way that does not carry out the purposes of sections 6701 through 6708, the Secretary shall apply sections 6701 through 6708 under regulations of the Secretary in a way that is consistent with those purposes.".

(b) ISSUANCE OF REGULATIONS.—Within 90 days of the date of enactment of this Act the Secretary shall issue regulations, which may be interim regulations, to implement subsection (a), modifying the regulations for carrying into effect the Revenue Sharing Act that were in effect as of July 1, 1987, and that were published in 31 C.F.R. part 51. The Secretary need not hold a public hearing before issuing these regulations.

(c) DEFICIT NEUTRALITY.—Any appropriation to carry out the amendment made by this subtitle to title 31, United States Code, for fiscal year 1995 or 1996 shall be offset by cuts elsewhere in appropriations for that fiscal year.

SEC. 31002. TECHNICAL AMENDMENT.

The table of chapters at the beginning of subtitle V of title 31, United States Code, is amended by adding after the item relating to chapter 65 the following:

"67. Federal payments .... 6701".

Subtitle K—National Community Economic Partnership

SEC. 31101. SHORT TITLE.

This subtitle may be cited as the "National Community Economic Partnership Act of 1994".

CHAPTER 1—COMMUNITY ECONOMIC PARTNERSHIP INVESTMENT FUNDS

SEC. 31111. PURPOSE.

It is the purpose of this chapter to increase private investment in distressed local communities and to build and expand the capacity of local institutions to better serve the economic needs of local residents through the provision of financial and technical assistance to community development corporations.

SEC. 31112. PROVISION OF ASSISTANCE.

(a) AUTHORITY.—The Secretary of Health and Human Services (referred to in this subtitle as the "Secretary") may, in accordance with this chapter, provide nonrefundable lines of credit to community development corporations for the establishment, maintenance or expansion of revolving loan funds to be utilized to finance projects intended to provide business and employment opportunities for low-income, unemployed, or underemployed individuals and to improve the quality of life in urban and rural areas.

(b) REVOLVING LOAN FUNDS.—

(1) COMPETITIVE ASSESSMENT OF APPLICATIONS.—In providing assistance under subsection (a), the Secretary shall establish and implement a competitive process for the solicitation and consideration of applications from eligible entities for lines of credit for the capitalization of revolving funds.

(2) ELIGIBLE ENTITIES.—To be eligible to receive a line of credit under this chapter an applicant shall—

(A) be a community development corporation;

(B) prepare and submit an application to the Secretary that shall include a strategic investment plan that identifies and describes the economic characteristics of the target area to be served, the types of business to be assisted and the impact of such assistance on low-income, underemployed, and unemployed individuals in the target area;

(C) demonstrate previous experience in the development of low-income housing or community or business development projects in a low-income community and provide a record of achievement with respect to such projects; and

(D) have secured one or more commitments from local sources for contributions (either in cash or in kind, letters of credit or letters of commitment) in an amount that is at least equal to the amount requested in the application submitted under subparagraph (B).

(3) EXCEPTION.—Notwithstanding the provisions of paragraph (2)(D), the Secretary may reduce local contributions to not less than 25 percent of the amount of the line of credit requested by the community development corporation if the Secretary determines such to be appropriate in accordance with section 31116.

SEC. 31113. APPROVAL OF APPLICATIONS.

(a) IN GENERAL.—In evaluating applications submitted under section 31112(b)(2)(B), the Secretary shall ensure that—

(1) the residents of the target area to be served (as identified under the strategic development plan) would have an income that is less than the median income for the area (as determined by the Secretary);

(2) the applicant community development corporation possesses the technical and managerial capability necessary to administer a revolving loan fund and has past experience in the development and management of housing, community and economic development programs;

(3) the applicant community development corporation has provided sufficient evidence of the existence of good working relationships with—

(A) local businesses and financial institutions, as well as with the community the corporation proposes to serve; and

(B) local and regional job training programs;

(4) the applicant community development corporation will target job opportunities that arise from revolving loan fund investments under this chapter so that 75 percent of the jobs retained or created under such investments are provided to—

(A) individuals with—

(i) incomes that do not exceed the Federal poverty line; or

(ii) incomes that do not exceed 80 percent of the median income of the area;

(B) individuals who are unemployed or underemployed;

(C) individuals who are participating or have participated in job training programs authorized under the Job Training Partnership Act (29 U.S.C. 1501 et seq.) or the Family Support Act of 1988 (Public Law 100–485);

(D) individuals whose jobs may be retained as a result of the provision of financing available under this chapter; or

(E) individuals who have historically been underrepresented in the local economy; and

(5) a representative cross section of applicants are approved, including large and small community development corporations, urban and rural community development corporations and community development corporations representing diverse populations.

(b) PRIORITY.—In determining which application to approve under this chapter the Secretary shall give priority to those applicants proposing to serve a target area—

(1) with a median income that does not exceed 80 percent of the median for the area (as determined by the Secretary); and

(2) with a high rate of unemployment, as determined by the Secretary or in which the population loss is at least 7 percent from April 1, 1980, to April 1, 1990, as reported by the Bureau of the Census.

SEC. 31114. AVAILABILITY OF LINES OF CREDIT AND USE.

(a) APPROVAL OF APPLICATION.—The Secretary shall provide a community development corporation that has an application approved under section 31113 with a line of credit in an amount determined appropriate by the Secretary, subject to the limitations contained in subsection (b).

(b) LIMITATIONS ON AVAILABILITY OF AMOUNTS.—

(1) MAXIMUM AMOUNT.—The Secretary shall not provide in excess of $2,000,000 in lines of credit under this chapter to a single applicant.

(2) PERIOD OF AVAILABILITY.—A line of credit provided under this chapter shall remain available over a period of time established by the Secretary, but in no event shall any such period of time be in excess of 3 years from the date on which such line of credit is made available.

(3) EXCEPTION.—Notwithstanding paragraphs (1) and (2), if a recipient of a line of credit under this chapter has made full and productive use of such line of credit, can demonstrate the need and demand for additional assistance, and can meet the requirements of section 31112(b)(2), the amount of such line of credit may be increased by not more than $1,500,000.

(c) AMOUNTS DRAWN FROM LINE OF CREDIT.—Amounts drawn from each line of credit under this chapter shall be used solely for the purposes described in section 31111 and shall only be drawn down as needed to provide loans, investments, or to defray administrative costs related to the establishment of a revolving loan fund.

(d) USE OF REVOLVING LOAN FUNDS.—Revolving loan funds established with lines of credit provided under this chapter may be used to provide technical assistance to private business enterprises and to provide financial assistance in the form of loans, loan guarantees, interest reduction assistance, equity shares, and other such forms of assistance to business enterprises in target areas and who are in compliance with section 31113(a)(4).

SEC. 31115. LIMITATIONS ON USE OF FUNDS.

(a) MATCHING REQUIREMENT.—Not to exceed 50 percent of the total amount to be invested by an entity under this chapter may be derived from funds made available from a line of credit under this chapter.

(b) TECHNICAL ASSISTANCE AND ADMINISTRATION.—Not to exceed 10 percent of the amounts available from a line of credit under this chapter shall be used for the provision of training or technical assistance and for the planning, development, and management of economic development projects. Community development corporations shall be encouraged by the Secretary to seek technical assistance from other community development corporations, with expertise in the planning, development and management of economic development projects. The Secretary shall assist in the identification and facilitation of such technical assistance.

(c) LOCAL AND PRIVATE SECTOR CONTRIBUTIONS.—To receive funds available under a line of credit provided under this chapter, an entity, using procedures established by the Secretary, shall demonstrate to the community development corporation that such entity agrees to provide local and private sector contributions in accordance with section 31112(b)(2)(D), will participate with such community development corporation in a loan, guarantee or investment program for a designated business enterprise, and that the total financial commitment to be provided by such entity is at least equal to the amount to be drawn from the line of credit.

(d) USE OF PROCEEDS FROM INVESTMENTS.—Proceeds derived from investments made using funds made available under this chapter may be used only for the purposes described in section 31111 and shall be reinvested in the community in which they were generated.

SEC. 31116. PROGRAM PRIORITY FOR SPECIAL EMPHASIS PROGRAMS.

(a) IN GENERAL.—The Secretary shall give priority in providing lines of credit under this chapter to community development corporations that propose to undertake economic development activities in distressed communities that target women, Native Americans, at risk youth, farmworkers, population-losing communities, very low-income communities, single mothers, veterans, and refugees; or that expand employee ownership of private enterprises and small businesses, and to programs providing loans of not more than $35,000 to very small business enterprises.

(b) RESERVATION OF FUNDS.—Not less than 5 percent of the amounts made available under section 31112(a)(2)(A) may be reserved to carry out the activities described in subsection (a).

CHAPTER 2—EMERGING COMMUNITY DEVELOPMENT CORPORATIONS

SEC. 31121. COMMUNITY DEVELOPMENT CORPORATION IMPROVEMENT GRANTS.

(a) PURPOSE.—It is the purpose of this section to provide assistance to community development corporations to upgrade the management and operating capacity of such corporations and to enhance the resources available to enable such corporations to increase their community economic development activities.

(b) SKILL ENHANCEMENT GRANTS.—

(1) IN GENERAL.—The Secretary shall award grants to community development corporations to enable such corporations to attain or enhance the business management and development skills of the individuals that manage such corporations to enable such corporations to seek the public and private resources necessary to develop community economic development projects.

(2) USE OF FUNDS.—A recipient of a grant under paragraph (1) may use amounts received under such grant—

(A) to acquire training and technical assistance from agencies or institutions that have extensive experience in the development and management of low-income community economic development projects; or

(B) to acquire such assistance from other highly successful community development corporations.

(c) OPERATING GRANTS.—

(1) IN GENERAL.—The Secretary shall award grants to community development corporations to enable such corporations to support an administrative capacity for the planning, development, and management of low-income community economic development projects.

(2) USE OF FUNDS.—A recipient of a grant under paragraph (1) may use amounts received under such grant—

(A) to conduct evaluations of the feasibility of potential low-income community economic development projects that address identified needs in the low-income community and that conform to those projects and activities permitted under subtitle A;

(B) to develop a business plan related to such a potential project; or

(C) to mobilize resources to be contributed to a planned low-income community economic development project or strategy.

(d) APPLICATIONS.—A community development corporation that desires to receive a grant under this section shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(e) AMOUNT AVAILABLE FOR A COMMUNITY DEVELOPMENT CORPORATION.—Amounts provided

under this section to a community development corporation shall not exceed $75,000 per year. Such corporations may apply for grants under this section for up to 3 consecutive years, except that such corporations shall be required to submit a new application for each grant for which such corporation desires to receive and compete on the basis of such applications in the selection process.

SEC. 31122. EMERGING COMMUNITY DEVELOPMENT CORPORATION REVOLVING LOAN FUNDS.

(a) AUTHORITY.—The Secretary may award grants to emerging community development corporations to enable such corporations to establish, maintain or expand revolving loan funds, to make or guarantee loans, or to make capital investments in new or expanding local businesses.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be a community development corporation;

(2) have completed not less than one nor more than two community economic development projects or related projects that improve or provide job and employment opportunities to low-income individuals;

(3) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a strategic investment plan that identifies and describes the economic characteristics of the target area to be served, the types of business to be assisted using amounts received under the grant and the impact of such assistance on low-income individuals; and

(4) have secured one or more commitments from local sources for contributions (either in cash or in kind, letters of credit, or letters of commitment) in an amount that is equal to at least 10 percent of the amounts requested in the application submitted under paragraph (2).

(c) USE OF THE REVOLVING LOAN FUND.—

(1) IN GENERAL.—A revolving loan fund established or maintained with amounts received under this section may be utilized to provide financial and technical assistance, loans, loan guarantees or investments to private business enterprises to—

(A) finance projects intended to provide business and employment opportunities for low-income individuals and to improve the quality of life in urban and rural areas; and

(B) build and expand the capacity of emerging community development corporations and serve the economic needs of local residents.

(2) TECHNICAL ASSISTANCE.—The Secretary shall encourage emerging community development corporations that receive grants under this section to seek technical assistance from established community development corporations, with expertise in the planning, development and management of economic development projects and shall facilitate the receipt of such assistance.

(3) LIMITATION.—Not to exceed 10 percent of the amounts received under this section by a grantee shall be used for training, technical assistance and administrative purposes.

(d) USE OF PROCEEDS FROM INVESTMENTS.—Proceeds derived from investments made with amounts provided under this section may be utilized only for the purposes described in this subtitle and shall be reinvested in the community in which they were generated.

(e) AMOUNTS AVAILABLE.—Amounts provided under this section to a community development corporation shall not exceed $500,000 per year.

CHAPTER 3—MISCELLANEOUS PROVISIONS

SEC. 31131. DEFINITIONS.

As used in this subtitle:

(1) COMMUNITY DEVELOPMENT CORPORATION.—The term "community development corporation" means a private, nonprofit corporation whose board of directors is comprised of business, civic and community leaders, and whose principal purpose includes the provision of low-income housing or community economic development projects that primarily benefit low-income individuals and communities.

(2) LOCAL AND PRIVATE SECTOR CONTRIBUTION.—The term "local and private sector contribution" means the funds available at the local level (by private financial institutions, State and local governments) or by any private philanthropic organization and private, nonprofit organizations that will be committed and used solely for the purpose of financing private business enterprises in conjunction with amounts provided under this subtitle.

(3) POPULATION-LOSING COMMUNITY.—The term "population-losing community" means any county in which the net population loss is at least 7 percent from April 1, 1980 to April 1, 1990, as reported by the Bureau of the Census.

(4) PRIVATE BUSINESS ENTERPRISE.—The term "private business enterprise" means any business enterprise that is engaged in the manufacture of a product, provision of a service, construction or development of a facility, or that is involved in some other commercial, manufacturing or industrial activity, and that agrees to target job opportunities stemming from investments authorized under this subtitle to certain individuals.

(5) TARGET AREA.—The term "target area" means any area defined in an application for assistance under this subtitle that has a population whose income does not exceed the median for the area within which the target area is located.

(6) VERY LOW-INCOME COMMUNITY.—The term "very low-income community" means a community in which the median income of the residents of such community does not exceed 50 percent of the median income of the area.

SEC. 31132. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to carry out chapters 1 and 2—

(1) $50,000,000 for fiscal year 1996;

(2) $80,000,000 for fiscal year 1997;

(3) $85,000,000 for fiscal year 1998; and

(4) $85,000,000 for fiscal year 1999.

(b) EARMARKS.—Of the aggregate amount appropriated under subsection (a) for each fiscal year—

(1) 60 percent shall be available to carry out chapter 1; and

(2) 40 percent shall be available to carry out chapter 2.

(c) AMOUNTS.—Amounts appropriated under subsection (a) shall remain available for expenditure without fiscal year limitation.

SEC. 31133. PROHIBITION.

None of the funds authorized under this subtitle shall be used to finance the construction of housing.

Subtitle L—Gang Prevention Services for Boys and Girls

SEC. 31201. PROGRAM AUTHORITY.

(a) IN GENERAL.—The Attorney General, in consultation with the Secretary of Education and Secretary of Health and Human Services, may make grants to eligible service providers to carry out programs that prevent young children from becoming gang involved. In making such grants, the Attorney General shall give priority to eligible service providers that have a proven track record of serving young children and have an overall budget of not more than $750,000 per program per fiscal year, prior to receiving a grant under this section.

(b) CONSULTATION WITH OUNCE OF PREVENTION COUNCIL.—The Attorney General may consult with the Ounce of Prevention Council in making grants under subsection (a).

SEC. 31202. PROGRAM REQUIREMENTS.

The eligible service providers receiving a grant under section 31201 shall—

(1) provide a comprehensive array of support services to assist the participants to reach their full potential as contributing law-abiding citizens (which support services may include education and health services; career development training; music, art, and drama activities; physical fitness training; life skills training; mental health counseling; and job placement counseling);

(2) to the extent practicable, involve the parents and other family members of participating children, and the members of local organizations that support the educational and law enforcement institutions of the community, as is appropriate, in the administration and operation of the gang prevention program;

(3) utilize community resources and related support services as needed in the operation of the program;

(4) accept referrals from public institutions, as is appropriate, such as law enforcement, mental health, local school systems, and other entities of local government; and

(5) utilize volunteer staff, including participants in programs funded under the National and Community Service Program, Public Law 103–62, to the maximum extent practicable in the operation of the program.

SEC. 31203. ELIGIBLE PROVIDERS.

Community-based service providers, as defined in the Juvenile Justice and Delinquency Prevention Act of 1974, that have a proven track record of providing services to children ages 5 to 18 shall be eligible to apply for funds under this subtitle. A priority shall be given to service providers that have a history of providing services uniquely designed to meet the needs of young children such as the Boys and Girls Clubs of America or service providers that display the potential for providing such targeted services.

SEC. 31204. ELIGIBLE PARTICIPANTS.

Children that have the potential, because of community composition and other factors, to come into contact with gangs, or who have a family member that has come into contact with a gang, and are not more than 18 years old at the time of entry into the program, shall be eligible to receive services provided by programs receiving assistance under this subtitle.

SEC. 31205. APPLICATIONS PROCESS.

Eligible service providers may submit to the Attorney General, for approval, an application in such form at such time as the Attorney General deems appropriate.

SEC. 31206. EVALUATION.

The Attorney General shall conduct an evaluation of the effectiveness of the program model grants authorized under this subtitle, and the extent to which it can be replicated by other local communities. The Attorney General shall report to the Congress no later than January 1, 1999, on the details of such evaluations.

SEC. 31207. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle—

(1) $3,000,000 for fiscal year 1996;

(2) $3,000,000 for fiscal year 1997;

(3) $4,000,000 for fiscal year 1998;

(4) $5,000,000 for fiscal year 1999; and

(5) $5,000,000 for fiscal year 2000.

Subtitle M—Olympic Youth Development Centers

SEC. 31301. OLYMPIC YOUTH DEVELOPMENT CENTERS.

(a) DEFINITIONS.—In this section—

"child" means an individual who is not younger than 8 and not older than 18.

"Committee" means the United States Olympic Committee.

"Council" means the Ounce of Prevention Council.

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

(b) GRANT.—The Council may make a grant to United States Olympic Committee for the purpose of establishing Olympic Youth Development Centers and carrying out programs through such centers.

(c) PROGRAM REQUIREMENTS.—

(1) LOCATION.—The Committee, on receiving a grant under this section to establish such a center shall ensure that the center is established in an appropriate facility in a State, such as a college or university, a local or State park or recreation center, church, or military base, that is—

(A) in a location that is easily accessible to children in the community; and

(B) in compliance with all applicable local ordinances.

(2) CENTERS.—The Committee shall, subject to the availability of appropriations, not later than 1 year after the date of enactment of this Act, establish not fewer than 6 such centers, and shall, subject to the availability of appropriations, to the extent possible, establish not less than 1 such center in each State by fiscal year 1997. In selecting locations for such centers, the Committee shall consider the need to maintain geographic diversity, and to maintain a balance of urban and rural locations for such centers.

(3) USE OF FUNDS.—The Committee—

(A) may use funds made available through the grant to provide supervised sports and recreation programs that are offered—

(i) after school and on weekends and holidays, during the school year; and

(ii) as daily (or weeklong) full-day programs (to the extent available resources permit) or as part-day programs, during the summer months;

(B) may use—

(i) such funds for the minor renovation of facilities that are in existence prior to the operation of the program and necessary for the operation of the program for which the Committee receives the grant, purchase of sporting and recreational equipment and supplies, reasonable cost for transportation of participants in the program, hiring of staff, provision of meals for such participants, provision of health services consisting of an initial basic physical examination, and provision of first aid and nutrition guidance; and

(ii) not more than 5 percent of such funds to pay for the administrative costs of the program; and

(C) may not use such funds to provide sectarian worship or sectarian instruction.

(4) EXECUTIVE DIRECTOR.—The Committee shall appoint an Executive Director to coordinate the centers and programs described in subsection (b), and shall appoint a Director for each such center to carry out such programs at the center.

(d) APPLICATION.—

(1) IN GENERAL.—To be eligible to receive a grant under this section, the Committee shall submit an application to the Council at such time, in such manner, and accompanied by such information, as the Council may reasonably require, and obtain approval of such application.

(2) CONTENTS OF APPLICATION.—The application submitted pursuant to paragraph (1) shall—

(A) contain an assurance that the program to be carried out through the center for which the grant is sought will maintain an average attendance rate of not less than 75 percent of the participants enrolled in the program, or will enroll additional participants in the program;

(B) contain an assurance that the Committee will comply with any evaluation under subsection (i), any research effort authorized under Federal law, and any investigation by the Administrator;

(C) contain an assurance that the Committee shall prepare and submit to the Administrator an annual report regarding any program conducted under this section;

(D) contain an assurance that the program for which the grant is sought will, to the maximum extent possible, incorporate services that are provided solely through non-Federal private or nonprofit sources;

(E) contain an assurance that the Committee will maintain separate accounting records for the program; and

(F) contain an assurance that the program will include outreach efforts in order to encourage participation in the program.

(e) ELIGIBILITY OF PARTICIPANTS.—

(1) IN GENERAL.—The Committee shall select children to participate in programs that receive assistance under this section without regard to the athletic ability of the children. In selecting children to participate in programs that receive assistance under this section, the Committee shall give priority to children from low-income communities and high-crime areas with demonstrated gang activity as determined by the Council.

(2) PARENTAL APPROVAL.—To be eligible to participate in a program that receives assistance under this section, a child shall provide the express written approval of a parent or guardian, and shall submit an official application and agree to the terms and conditions of participation in the program.

(3) NONDISCRIMINATION.—In selecting children to participate in a program that receives assistance under this section, the Committee shall not discriminate on the basis of race, color, religion, sex, national origin, or disability.

(4) BEHAVIOR PROBLEMS.—The Committee may find a child ineligible to participate in such a program if the Committee determines that the child has behavior problems that pose an unacceptable risk of injury or illness to other participants or has a physical or mental disability so serious that the child would be unable to participate in the program with reasonable accommodation.

(f) INVESTIGATIONS AND INSPECTIONS.—The Council may conduct such investigations and inspections as may be necessary to ensure compliance with the provisions of this section.

(g) FEDERAL SHARE.—

(1) PAYMENTS; FEDERAL SHARE; NON-FEDERAL SHARE.—

(A) PAYMENTS.—On approval of an application under subsection (d), the Council shall, subject to the availability of appropriations pay to the Committee the Federal share of the costs of establishing the centers and carrying out the programs described in subsection (b).

(B) FEDERAL SHARE.—The Federal share of such costs shall be not more than—

(i) 75 percent for fiscal years 1995 and 1996;

(ii) 70 percent for fiscal year 1997; and

(iii) 60 percent for fiscal year 1998.

(2) NON-FEDERAL SHARE.—

(A) IN GENERAL.—The non-Federal share of such costs may be in cash or in kind, fairly evaluated, including plant, equipment, and services (including the services described in subsection (d)(2)(D)).

(B) SPECIAL RULE.—The Committee may not charge fees for the participation of children in programs carried out under this section.

(h) REPORTS.—At the end of each fiscal year, the Council shall submit to Congress a report on the activities conducted under this section, including a summary of the information in the report submitted under subsection (d)(2)(C).

(i) EVALUATION.—The Council shall conduct a thorough evaluation of the programs assisted under this section, which shall include an assessment of—

(1) the number of children participating in each program assisted under this section;

(2) the academic achievement of such children;

(3) school attendance and graduation rates of such children; and

(4) the number of such children being processed by the juvenile justice system.

(j) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

(A) $7,000,000 for fiscal year 1996;

(B) $8,000,000 for fiscal year 1997;

(C) $10,000,000 for fiscal year 1998;

(D) $11,000,000 for fiscal year 1999; and

(E) $13,000,000 for fiscal year 2000.

(2) AVAILABILITY.—Amounts appropriated to carry out this section shall remain available until expended.

Subtitle N—Anticrime Youth Councils

SEC. 31401. PURPOSE.

The purpose of this subtitle is to provide for the establishment of youth anticrime councils to give intermediate and secondary school students a structured forum through which to work with community organizations, law enforcement officials, government and media representatives, and school administrators and faculty to address issues regarding youth and violence. The purpose of such councils is to empower local youth and ensure that their recommendations for preventing youth involvement in crime and violence will be heard and possibly incorporated into community anticrime strategies.

SEC. 31402. AUTHORITY TO MAKE GRANTS.

(a) IN GENERAL.—The Attorney General may make grants to public and nonprofit community-based organizations to establish regional anticrime youth councils each of which is composed of intermediate and secondary school students who represent all the schools in a separate congressional district.

(b) CONSULTATION.—The Attorney General may consult with the Ounce of Prevention Council in making grants under subsection (a).

SEC. 31403. APPLICATIONS FOR GRANTS.

To request a grant under section 31402, a public and nonprofit community-based organization shall submit to the Attorney General an application in such form and containing such information as the Attorney General may require by rule, including assurances that—

(1) the anticrime youth council with respect to which such grant is requested will be—

(A) selected by a teacher or administrator of an intermediate or secondary school in the congressional district involved, in consultation with teachers and administrators of other intermediate and secondary schools in such district,

(B) composed of not more than 5 students from each of the intermediate and secondary schools in such district, selected as described in subparagraph (A) from among individuals who have first-hand knowledge of issues and problems relating to students who attend schools in such district,

(C) supervised by an individual who—

(i) is familiar with issues regarding youth violence,

(ii) has strong ties to the communities in such district and to the organizations with which such council will interact, and

(iii) will be responsible for coordinating the dissemination of information to such council, supervising council meetings, and acting as a liaison between such council and communities in such district, and

(D) meet not less frequently than monthly—

(i) to discuss issues of concern, including youth crime, school violence, job creation, and recreation, and

(ii) to develop creative solutions for assisting community organizations, law enforcement officials, school officials, government officials, and others to address such issues, and

(2) the applicant will submit to the Attorney General a report, not later than 180 days after the first year for which such applicant receives a grant under section 31402, that—

(A) specifies the number of students and schools involved and represented on such council,

(B) specifies the number of organizations and individuals that council and its subcommittees met with,

(C) specifies the number of grants, policies, and programs submitted to the youth council for review and recommendation,

(D) contains evidence that—

(i) the community has consulted such council and adopted its recommendations, and

(ii) a grant review process has been established within a school system or police department that includes an evaluation by the youth council,

(E) describes the effect that participation on such council has had on the student representatives, (such as improved school attendance and academic performance, and decreased criminal involvement),

(F) describes the effect that participation on such council has had on the participating schools (such as decrease in incidence of school violence),

(G) describes the extent to which other students attended council and subcommittee meetings, and participated as members of the audience in such council's activities,

(H) describes the extent to which family service, youth service, and the education, police, health, and judicial departments within such district coordinate anticrime efforts as a result of the recommendations and programs of such council, and

(I) describes the extent to which such council raises public awareness and knowledge, via the media, about youth violence and such council's efforts to help prevent it.

SEC. 31404. SELECTION OF GRANT RECIPIENTS.

For the purpose of selecting eligible applicants to receive grants under section 31402, the Attorney General shall take into consideration—

(1) the extent to which all schools in a congressional district are represented on the proposed youth anticrime council,

(2) the extent to which youth crime and violence are an issue of concern in such district,

(3) the extent to which the community is committed to coordinating and meeting with the youth councils, and

(4) the extent to which the students selected to serve on such council are representative of the geographical area and knowledgeable about the issues that such council will consider.

SEC. 31405. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle—

(1) $500,000 for fiscal year 1996;

(2) $800,000 for fiscal year 1997;

(3) $1,000,000 for fiscal year 1998;

(4) $1,300,000 for fiscal year 1999; and

(5) $1,400,000 for fiscal year 2000.

Subtitle O—Urban Recreation and At-Risk Youth

SEC. 31501. PURPOSE OF ASSISTANCE.

Section 1003 of the Urban Park and Recreation Recovery Act of 1978 is amended by adding the following at the end: "It is further the purpose of this title to improve recreation facilities and expand recreation services in urban areas with a high incidence of crime and to help deter crime through the expansion of recreation opportunities for at-risk youth. It is the further purpose of this section to increase the security of urban parks and to promote collaboration between local agencies involved in parks and recreation, law enforcement, youth social services, and juvenile justice system.".

SEC. 31502. DEFINITIONS.

Section 1004 of the Urban Park and Recreation Recovery Act of 1978 is amended by inserting the following new subsection after subsection (c) and by redesignating subsections (d) through (j) as (e) through (k), respectively:

"(d) 'at-risk youth recreation grants' means—

"(1) rehabilitation grants,

"(2) innovation grants, or

"(3) matching grants for continuing program support for programs of demonstrated value or success in providing constructive alternatives to youth at risk for engaging in criminal behavior, including grants for operating, or coordinating recreation programs and services;

in neighborhoods and communities with a high prevalence of crime, particularly violent crime or crime committed by youthful offenders; in addition to the purposes specified in subsection (b), rehabilitation grants referred to in paragraph (1) of this subsection may be used for the provision of lighting, emergency phones or other capital improvements which will improve the security of urban parks;".

SEC. 31503. CRITERIA FOR SELECTION.

Section 1005 of the Urban Park and Recreation Recovery Act of 1978 is amended by striking "and" at the end of paragraph (6), by striking the period at the end of paragraph (7) and inserting "; and" and by adding the following at the end:

"(8) in the case of at-risk youth recreation grants, the Secretary shall give a priority to each of the following criteria:

"(A) Programs which are targeted to youth who are at the greatest risk of becoming involved in violence and crime.

"(B) Programs which teach important values and life skills, including teamwork, respect, leadership, and self-esteem.

"(C) Programs which offer tutoring, remedial education, mentoring, and counseling in addition to recreation opportunities.

"(D) Programs which offer services during late night or other nonschool hours.

"(E) Programs which demonstrate collaboration between local park and recreation, juvenile justice, law enforcement, and youth social service agencies and nongovernmental entities, including the private sector and community and nonprofit organizations.

"(F) Programs which leverage public or private recreation investments in the form of services, materials, or cash.

"(G) Programs which show the greatest potential of being continued with non-Federal funds or which can serve as models for other communities.".

SEC. 31504. PARK AND RECREATION ACTION RECOVERY PROGRAMS.

Section 1007(b) of the Urban Park and Recreation Recovery Act of 1978 is amended by adding the following at the end: "In order to be eligible to receive 'at-risk youth recreation grants' a local government shall amend its 5-year action program to incorporate the goal of reducing crime and juvenile delinquency and to provide a description of the implementation strategies to achieve this goal. The plan shall also address how the local government is coordinating its recreation programs with crime prevention efforts of law enforcement, juvenile corrections, and youth social service agencies.".

SEC. 31505. MISCELLANEOUS AND TECHNICAL AMENDMENTS.

(a) PROGRAM SUPPORT.—Section 1013 of the Urban Park and Recreation Recovery Act of 1978 is amended by inserting "(a) IN GENERAL.—" after "1013" and by adding the following new subsection at the end:

"(b) PROGRAM SUPPORT.—Not more than 25 percent of the amounts made available under this title to any local government may be used for program support.".

(b) EXTENSION.—Section 1003 of the Urban Park and Recreation Recovery Act of 1978 is amended by striking "for a period of five years" and by striking "short-term".

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subtitle—

(2) $3,000,000 for fiscal year 1996;

(3) $500,000 for fiscal year 1997;

(4) $500,000 for fiscal year 1998;

(5) $500,000 for fiscal year 1999; and

(6) $500,000 for fiscal year 2000.

Subtitle P—Boys and Girls Clubs in Public Housing

SEC. 31601. ESTABLISHMENT.

(a) IN GENERAL.—The Secretary of Housing and Urban Development, in consultation with the Attorney General, shall enter into contracts with the Boys and Girls Clubs of America, a national nonprofit youth organization to establish Boys and Girls Clubs in public housing.

(b) CONSULTATION.—The Secretary of Housing and Urban Development may consult with the Ounce of Prevention Council in making grants under subsection (a).

SEC. 31602. REPORT.

By May 1 of each fiscal year for which funds for this section are provided, the Secretary of Housing and Urban Development shall submit a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Banking, Finance and Urban Affairs of the House of Representatives that details the progress of establishing boys and girls clubs in public housing and the effectiveness of the programs in reducing drug abuse and gang violence.

SEC. 31603. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle—

(1) $4,000,000 for fiscal year 1996;

(2) $5,000,000 for fiscal year 1997;

(3) $6,000,000 for fiscal year 1998;

(4) $7,000,000 for fiscal year 1999; and

(5) $8,000,000 for fiscal year 2000.

Subtitle Q—Community-Based Justice Grants for Prosecutors

SEC. 31701. GRANT AUTHORIZATION.

(a) IN GENERAL.—The Attorney General may make grants to State, Indian tribal, or local prosecutors for the purpose of supporting the creation or expansion of community-based justice programs.

(b) CONSULTATION.—The Attorney General may consult with the Ounce of Prevention Council in making grants under subsection (a).

SEC. 31702. USE OF FUNDS.

Grants made by the Attorney General under this section shall be used—

(1) to fund programs that require the cooperation and coordination of prosecutors, school officials, police, probation officers, youth and social service professionals, and community members in the effort to reduce the incidence of, and increase the successful identification and speed of prosecution of, young violent offenders;

(2) to fund programs in which prosecutors focus on the offender, not simply the specific offense, and impose individualized sanctions, designed to deter that offender from further antisocial conduct, and impose increasingly serious sanctions on a young offender who continues to commit offenses;

(3) to fund programs that coordinate criminal justice resources with educational, social service, and community resources to develop and deliver violence prevention programs, including mediation and other conflict resolution methods,

treatment, counselling, educational, and recreational programs that create alternatives to criminal activity; and

(4) in rural States (as defined in section 1501(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796bb(B)), to fund cooperative efforts between State and local prosecutors, victim advocacy and assistance groups, social and community service providers, and law enforcement agencies to investigate and prosecute child abuse cases, treat youthful victims of child abuse, and work in cooperation with the community to develop education and prevention strategies directed toward the issues with which such entities are concerned.

SEC. 31703. APPLICATIONS.

(a) ELIGIBILITY.—In order to be eligible to receive a grant under this part for any fiscal year, a State, Indian tribal, or local prosecutor, in conjunction with the chief executive officer of the jurisdiction in which the program will be placed, shall submit an application to the Attorney General in such form and containing such information as the Attorney General may reasonably require.

(b) REQUIREMENTS.—Each applicant shall include—

(1) a request for funds for the purposes described in section 31702;

(2) a description of the communities to be served by the grant, including the nature of the youth crime, youth violence, and child abuse problems within such communities;

(3) assurances that Federal funds received under this part shall be used to supplement, not supplant, non-Federal funds that would otherwise be available for activities funded under this section; and

(4) statistical information in such form and containing such information that the Attorney General may require.

(c) COMPREHENSIVE PLAN.—Each applicant shall include a comprehensive plan that shall contain—

(1) a description of the youth violence or child abuse crime problem;

(2) an action plan outlining how the applicant will achieve the purposes as described in section 31702;

(3) a description of the resources available in the community to implement the plan together with a description of the gaps in the plan that cannot be filled with existing resources; and

(4) a description of how the requested grant will be used to fill gaps.

SEC. 31704. ALLOCATION OF FUNDS; LIMITATIONS ON GRANTS.

(a) ADMINISTRATIVE COST LIMITATION.—The Attorney General shall use not more than 5 percent of the funds available under this program for the purposes of administration and technical assistance.

(b) RENEWAL OF GRANTS.—A grant under this part may be renewed for up to 2 additional years after the first fiscal year during which the recipient receives its initial grant under this part, subject to the availability of funds, if—

(1) the Attorney General determines that the funds made available to the recipient during the previous years were used in a manner required under the approved application; and

(2) the Attorney General determines that an additional grant is necessary to implement the community prosecution program described in the comprehensive plan required by section 31703.

SEC. 31705. AWARD OF GRANTS.

The Attorney General shall consider the following facts in awarding grants:

(1) Demonstrated need and evidence of the ability to provide the services described in the plan required under section 31703.

(2) The Attorney General shall attempt, to the extent practicable, to achieve an equitable geographic distribution of grant awards.

SEC. 31706. REPORTS.

(a) REPORT TO ATTORNEY GENERAL.—State and local prosecutors that receive funds under this subtitle shall submit to the Attorney General a report not later than March 1 of each year that describes progress achieved in carrying out the plan described under section 31703(c).

(b) REPORT TO CONGRESS.—The Attorney General shall submit to the Congress a report by October 1 of each year in which grants are made available under this subtitle which shall contain a detailed statement regarding grant awards, activities of grant recipients, a compilation of statistical information submitted by applicants, and an evaluation of programs established under this subtitle.

SEC. 31707. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle—

(1) $7,000,000 for fiscal year 1996;

(2) $10,000,000 for fiscal year 1997;

(3) $10,000,000 for fiscal year 1998;

(4) $11,000,000 for fiscal year 1999; and

(5) $12,000,000 for fiscal year 2000.

SEC. 31708. DEFINITIONS.

In this subtitle—

"Indian tribe" means a tribe, band, pueblo, nation, or other organized group or community of Indians, including an Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, and the United States Virgin Islands.

"young violent offender" means individuals, ages 7 through 22, who have committed crimes of violence, weapons offenses, drug distribution, hate crimes and civil rights violations, and offenses against personal property of another.

Subtitle R—Child Safety

SEC. 31801. SHORT TITLE.

This subtitle may be cited as the "Child Safety Act".

SEC. 31802. PURPOSE.

The purpose of this subtitle is to authorize funding to enable supervised visitation centers and programs to provide the following:

(1) Supervised visitation for children whose parents are separated or divorced and the children are at risk because—

(A) there is documented sexual, physical, or emotional abuse as determined by the a court of competent jurisdiction;

(B) there is suspected or elevated risk of sexual, physical, or emotional abuse, or there have been threats of parental abduction of the child;

(C) due to domestic violence, there is an ongoing risk of harm to a parent or child;

(D) a parent is impaired because of substance abuse or mental illness;

(E) there are allegations that a child is at risk for any of the reasons stated in subparagraphs (A), (B), (C), and (D), pending an investigation of the allegations; or

(F) other circumstances, as determined by a court of competent jurisdiction, point to the existence of such a risk.

(2) Supervised visitation for children who have been removed from their parents and placed outside the home as a result of abuse or neglect or other risk of harm to them.

(3) An evaluation of visitation within the center or program, or contracted out to appropriately trained professionals, to assist in making determinations of future placement of children or access to the parents.

(4) A safe location for custodial parents to temporarily transfer custody of their children to noncustodial parents, or where a parent or child is at risk for any of the reasons stated in paragraph (1).

(5) An additional safeguard against the child witnessing abuse or a safeguard against the injury or death of a child or parent.

(6) An environment for families to have positive interaction activities, quality time, non-violent memory building experiences during visitation to help build the parent/child relationship.

(7) Parent and child education and support groups to help parents heal and learn new skills, and to help children heal from past abuse or family conflict.

(8) Documentation of visitation for use by child protective services, court-ordered evaluators, individuals or entities treating a family member, or a court of competent jurisdiction.

SEC. 31803. DEMONSTRATION GRANTS FOR SUPERVISED VISITATION CENTERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to in this subtitle as the "Secretary") is authorized to award grants to and enter into contracts and cooperative agreements with new or existing public or nonprofit private entities to assist such entities in the establishment or operation of supervised visitation centers.

(b) CONSIDERATIONS.—In awarding grants, contracts and agreements under subsection (a), the Secretary shall take into account—

(1) the number of families to be served by the existing or proposed visitation center to be funded under the grant, contract, or agreement;

(2) the extent to which supervised visitation centers are needed locally;

(3) the relative need of the applicant; and

(4) the capacity of the applicant to make rapid and effective use of assistance provided under the grant, contract, or agreement.

(c) USE OF FUNDS.—

(1) IN GENERAL.—Amounts provided under a grant, contract or cooperative agreement awarded under this section shall be used to support existing programs or establish new supervised visitation centers and for the purposes described in section 31802. In using such amounts, grantees shall target the economically disadvantaged and those individuals who could not otherwise afford such visitation services. Other individuals may be permitted to utilize the services provided by the center on a fee basis.

(2) PROHIBITION.—No visitation center funded under this title shall permit participation of any person denied visitation rights by a court of law.

SEC. 31804. DEMONSTRATION GRANT APPLICATION.

(a) IN GENERAL.—A grant, contract, or cooperative agreement may not be made or entered into under this Act unless an application for such grant, contract or cooperative agreement has been submitted to and approved by the Secretary.

(b) APPROVAL.—Grants, contracts, and cooperative agreements under this Act shall be awarded in accordance with such regulations as the Secretary may promulgate. At a minimum, to be approved by the Secretary under this section an application shall—

(1) demonstrate that the applicant has recognized expertise in the area of family violence, and a record of high-quality service to victims of family violence; and

(2) include specific procedures to minimize risk of harm to any client during services at the center or program.

SEC. 31805. EVALUATION OF DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Not later than 30 days after the end of each fiscal year, a recipient of a grant, contract or cooperative agreement under

this Act shall prepare and submit to the Secretary a report that contains information concerning—

(1) the number of families served per year;

(2) the number of families and the number of visits per family served per year categorized by—

(A) origin of referral, if any;

(B) all reasons for use of center or program, including—

(i) child abuse or neglect;

(ii) child sexual abuse;

(iii) domestic violence;

(iv) substance abuse;

(v) mental illness;

(vi) risk of parental abduction;

(vii) interference with visitation;

(viii) foster care arrangement; and

(ix) order of protection; and

(C) length of visits in hours;

(3) the number of supervised visitation arrangements terminated because of violations of visitation terms, including violence;

(4) the number of protective temporary transfers of custody during the report year;

(5) the number of parental abduction cases in a judicial district using supervised visitation services, both as identified in criminal prosecution and custody violations;

(6) the number of safety and security problems that occur during the report year;

(7) the number of families who are turned away because the center cannot accommodate the demand for services;

(8) the process by which children or abused partners will be protected during visitations, temporary custody transfers and other activities for which the supervised visitation centers are created;

(9) the type of service provided, including—

(A) supervision of exchange only;

(B) supervision of visits occurring on site; and

(C) supervision of visits occurring off site;

(10) other services provided, such as parent and child education and support groups; and

(11) any other information determined appropriate in regulations promulgated by the Secretary.

(b) EVALUATION.—The Secretary shall designate an appropriate agency to conduct or coordinate an evaluation of the supervised visitation center or program operated under the grant, contract, or agreement. The selected agency shall make agreements with the court and the child protection social servicers division of the State to participate in the evaluation of the center or program, and shall ensure that local domestic violence agencies or State and local domestic violence coalitions are solicited and their evaluations and opinions are included in the evaluation. The entities conducting such evaluations, separately or in combination, shall submit a narrative evaluation of the center or program to the center or program, the coordinating State agency, and the Secretary.

(c) DEMONSTRATION OF NEED.—The recipient of a grant, contract or cooperative agreement under this Act shall demonstrate, during the first 3 years of the project operated under the grant, contract or agreement, the need for continued funding.

SEC. 31806. SPECIAL GRANTS TO STUDY THE EFFECT OF SUPERVISED VISITATION ON SEXUALLY ABUSED OR SEVERELY PHYSICALLY ABUSED CHILDREN.

(a) AUTHORIZATION.—The Secretary may award special grants to public or nonprofit private entities to assist such entities in designing and implementing research on supervised visitation centers or programs established under this Act to determine—

(1) the performances of the supervised visitation centers and programs receiving grants, making use of the data reported under section 31805 where possible;

(2) the effect of supervised visitation on children, including in particular—

(A) the effect on children who have been sexually abused or severely physically abused by a parent;

(B) whether the effect on such children is different if contact is allowed only when the abusive parent has completed a certified course for such abusers; or

(C) whether the effect on such children is different if contact is allowed only where the child expresses a positive wish for contact;

(3) the effect of the families' use of supervised visitation services on their use of the court system, including in particular, the number and nature of subsequent returns to court;

(4) the relationship between the type of abuse or neglect experienced by the child and the use of supervised visitation centers by the maltreating parent;

(5) in cases of spouse or partner abuse only, the extent to which supervised visitation should be predicated on participation by the abusive spouse in a specialized treatment program; and

(6) such other issues as determined by the Secretary.

(b) APPLICATION.—To be eligible to receive a grant under this section an entity shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require, including documentary evidence to demonstrate that the entity possesses significant experience in social science research with particular experience in research concerning clinical issues involving children, abuse, and visitation. The level of clinical expertise and experience required will be determined by the Secretary.

(c) REPORT.—For the duration of the grant, the grantee shall prepare and submit to the Secretary a report of the research and data collected, at such times as the Secretary may require.

SEC. 31807. REPORTING.

Not later than 18 months after the date of enactment of this Act, and annually thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report containing the information collected under the reports received under sections 31805 and 31806, including recommendations made by the Secretary concerning whether or not the supervised visitation center demonstration and research programs should be reauthorized.

SEC. 31808. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated for the purpose of awarding grants, contracts, and cooperative agreements under this subtitle

(1) $4,000,000 for fiscal year 1996;

(2) $5,000,000 for fiscal year 1997;

(3) $6,000,000 for fiscal year 1998;

(4) $7,000,000 for fiscal year 1999; and

(5) $8,000,000 for fiscal year 2000.

(b) DISTRIBUTION.—Of the amounts appropriated under subsection (a) for each fiscal year—

(1) not less than 90 percent shall be used to award grants, contracts, or cooperative agreements under section 31804; and

(2) not more than 10 percent shall be used to award grants under section 31806.

Subtitle S—Family Unity Demonstration Project

SEC. 31901. SHORT TITLE.

This subtitle may be cited as the "Family Unity Demonstration Project Act".

SEC. 31902. PURPOSE.

The purpose of this subtitle is to evaluate the effectiveness of certain demonstration projects in helping to—

(1) alleviate the harm to children and primary caretaker parents caused by separation due to the incarceration of the parents;

(2) reduce recidivism rates of prisoners by encouraging strong and supportive family relationships; and

(3) explore the cost effectiveness of community correctional facilities.

SEC. 31903. DEFINITIONS.

In this subtitle—

"child" means a person who is less than 7 years of age.

"community correctional facility" means a residential facility that—

(A) is used only for eligible offenders and their children under 7 years of age;

(B) is not within the confines of a jail or prison;

(C) houses no more than 50 prisoners in addition to their children; and

(D) provides to inmates and their children—

(i) a safe, stable, environment for children;

(ii) pediatric and adult medical care consistent with medical standards for correctional facilities;

(iii) programs to improve the stability of the parent-child relationship, including educating parents regarding—

(I) child development; and

(II) household management;

(iv) alcoholism and drug addiction treatment for prisoners; and

(v) programs and support services to help inmates—

(I) to improve and maintain mental and physical health, including access to counseling;

(II) to obtain adequate housing upon release from State incarceration;

(III) to obtain suitable education, employment, or training for employment; and

(IV) to obtain suitable child care.

"eligible offender" means a primary caretaker parent who—

(A) has been sentenced to a term of imprisonment of not more than 7 years or is awaiting sentencing for a conviction punishable by such a term of imprisonment; and

(B) has not engaged in conduct that—

(i) knowingly resulted in death or serious bodily injury;

(ii) is a felony for a crime of violence against a person; or

(iii) constitutes child neglect or mental, physical, or sexual abuse of a child.

"primary caretaker parent" means—

(A) a parent who has consistently assumed responsibility for the housing, health, and safety of a child prior to incarceration; or

(B) a woman who has given birth to a child after or while awaiting her sentencing hearing and who expresses a willingness to assume responsibility for the housing, health, and safety of that child,

a parent who, in the best interest of a child, has arranged for the temporary care of the child in the home of a relative or other responsible adult shall not for that reason be excluded from the category "primary caretaker".

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

SEC. 31904. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION.—There are authorized to be appropriated to carry out this subtitle—

(1) $4,000,000 for fiscal year 1996;

(2) $4,000,000 for fiscal year 1997;

(3) $4,000,000 for fiscal year 1998;

(4) $4,000,000 for fiscal year 1999; and

(5) $6,000,000 for fiscal year 2000.

(b) AVAILABILITY OF APPROPRIATIONS.—Of the amount appropriated under subsection (a) for any fiscal year—

(1) 90 percent shall be available to carry out chapter 1; and

(2) 10 percent shall be available to carry out chapter 2.

CHAPTER 1—GRANTS TO STATES

SEC. 31911. AUTHORITY TO MAKE GRANTS.

(a) GENERAL AUTHORITY.—The Attorney General may make grants, on a competitive basis, to States to carry out in accordance with this subtitle family unity demonstration projects that enable eligible offenders to live in community correctional facilities with their children.

(b) PREFERENCES.—For the purpose of making grants under subsection (a), the Attorney General shall give preference to a State that includes in the application required by section 31912 assurances that if the State receives a grant—

(1) both the State corrections agency and the State health and human services agency will participate substantially in, and cooperate closely in all aspects of, the development and operation of the family unity demonstration project for which such a grant is requested;

(2) boards made up of community members, including residents, local businesses, corrections officials, former prisoners, child development professionals, educators, and maternal and child health professionals will be established to advise the State regarding the operation of such project;

(3) the State has in effect a policy that provides for the placement of all prisoners, whenever possible, in correctional facilities for which they qualify that are located closest to their respective family homes;

(4) unless the Attorney General determines that a longer timeline is appropriate in a particular case, the State will implement the project not later than 180 days after receiving a grant under subsection (a) and will expend all of the grant during a 1-year period;

(5) the State has the capacity to continue implementing a community correctional facility beyond the funding period to ensure the continuity of the work;

(6) unless the Attorney General determines that a different process for selecting participants in a project is desirable, the State will—

(A) give written notice to a prisoner, not later than 30 days after the State first receives a grant under subsection (a) or 30 days after the prisoner is sentenced to a term of imprisonment of not more than 7 years (whichever is later), of the proposed or current operation of the project;

(B) accept at any time at which the project is in operation an application by a prisoner to participate in the project if, at the time of application, the remainder of the prisoner's sentence exceeds 180 days;

(C) review applications by prisoners in the sequence in which the State receives such applications; and

(D) not more than 50 days after reviewing such applications approve or disapprove the application; and

(7) for the purposes of selecting eligible offenders to participate in such project, the State has authorized State courts to sentence an eligible offender directly to a community correctional facility, provided that the court gives assurances that the offender would have otherwise served a term of imprisonment.

(c) SELECTION OF GRANTEES.—The Attorney General shall make grants under subsection (a) on a competitive basis, based on such criteria as the Attorney General shall issue by rule and taking into account the preferences described in subsection (b).

SEC. 31912. ELIGIBILITY TO RECEIVE GRANTS.

To be eligible to receive a grant under section 31911, a State shall submit to the Attorney General an application at such time, in such form, and containing such information as the Attorney General reasonably may require by rule.

SEC. 31913. REPORT.

(a) IN GENERAL.—A State that receives a grant under this title shall, not later than 90 days after the 1-year period in which the grant is required to be expended, submit a report to the Attorney General regarding the family unity demonstration project for which the grant was expended.

(b) CONTENTS.—A report under subsection (a) shall—

(1) state the number of prisoners who submitted applications to participate in the project and the number of prisoners who were placed in community correctional facilities;

(2) state, with respect to prisoners placed in the project, the number of prisoners who are returned to that jurisdiction and custody and the reasons for such return;

(3) describe the nature and scope of educational and training activities provided to prisoners participating in the project;

(4) state the number, and describe the scope of, contracts made with public and nonprofit private community-based organizations to carry out such project; and

(5) evaluate the effectiveness of the project in accomplishing the purposes described in section 31902.

CHAPTER 2—FAMILY UNITY DEMONSTRATION PROJECT FOR FEDERAL PRISONERS

SEC. 31921. AUTHORITY OF THE ATTORNEY GENERAL.

(a) IN GENERAL.—With the funds available to carry out this subtitle for the benefit of Federal prisoners, the Attorney General, acting through the Director of the Bureau of Prisons, shall select eligible prisoners to live in community correctional facilities with their children.

(b) GENERAL CONTRACTING AUTHORITY.—In implementing this title, the Attorney General may enter into contracts with appropriate public or private agencies to provide housing, sustenance, services, and supervision of inmates eligible for placement in community correctional facilities under this title.

(c) USE OF STATE FACILITIES.—At the discretion of the Attorney General, Federal participants may be placed in State projects as defined in chapter 1. For such participants, the Attorney General shall, with funds available under section 31904(b)(2), reimburse the State for all project costs related to the Federal participant's placement, including administrative costs.

SEC. 31922. REQUIREMENTS.

For the purpose of placing Federal participants in a family unity demonstration project under section 31921, the Attorney General shall consult with the Secretary of Health and Human Services regarding the development and operation of the project.

Subtitle T—Substance Abuse Treatment in Federal Prisons

SEC. 32001. SUBSTANCE ABUSE TREATMENT IN FEDERAL PRISONS.

Section 3621 of title 18, United States Code, is amended—

(1) in the last sentence of subsection (b), by striking ", to the extent practicable,"; and

(2) by adding at the end the following new subsection:

"(e) SUBSTANCE ABUSE TREATMENT.—

"(1) PHASE-IN.—In order to carry out the requirement of the last sentence of subsection (b) of this section, that every prisoner with a substance abuse problem have the opportunity to participate in appropriate substance abuse treatment, the Bureau of Prisons shall, subject to the availability of appropriations, provide residential substance abuse treatment (and make arrangements for appropriate aftercare)—

"(A) for not less than 50 percent of eligible prisoners by the end of fiscal year 1995, with priority for such treatment accorded based on an eligible prisoner's proximity to release date;

"(B) for not less than 75 percent of eligible prisoners by the end of fiscal year 1996, with priority for such treatment accorded based on an eligible prisoner's proximity to release date; and

"(C) for all eligible prisoners by the end of fiscal year 1997 and thereafter, with priority for such treatment accorded based on an eligible prisoner's proximity to release date.

"(2) INCENTIVE FOR PRISONERS' SUCCESSFUL COMPLETION OF TREATMENT PROGRAM.—

"(A) GENERALLY.—Any prisoner who, in the judgment of the Director of the Bureau of Prisons, has successfully completed a program of residential substance abuse treatment provided under paragraph (1) of this subsection, shall remain in the custody of the Bureau under such conditions as the Bureau deems appropriate. If the conditions of confinement are different from those the prisoner would have experienced absent the successful completion of the treatment, the Bureau shall periodically test the prisoner for substance abuse and discontinue such conditions on determining that substance abuse has recurred.

"(B) PERIOD OF CUSTODY.—The period a prisoner convicted of a nonviolent offense remains in custody after successfully completing a treatment program may be reduced by the Bureau of Prisons, but such reduction may not be more than one year from the term the prisoner must otherwise serve.

"(3) REPORT.—The Bureau of Prisons shall transmit to the Committees on the Judiciary of the Senate and the House of Representatives on January 1, 1995, and on January 1 of each year thereafter, a report. Such report shall contain—

"(A) a detailed quantitative and qualitative description of each substance abuse treatment program, residential or not, operated by the Bureau;

"(B) a full explanation of how eligibility for such programs is determined, with complete information on what proportion of prisoners with substance abuse problems are eligible; and

"(C) a complete statement of to what extent the Bureau has achieved compliance with the requirements of this title.

"(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection—

"(A) $15,000,000 for fiscal year 1996;

"(B) $21,000,000 for fiscal year 1997;

"(C) $28,000,000 for fiscal year 1998;

"(D) $30,000,000 for fiscal year 1999; and

"(E) $31,000,000 for fiscal year 2000.

"(5) DEFINITIONS.—As used in this subsection—

"(A) the term 'residential substance abuse treatment' means a course of individual and group activities, lasting between 6 and 12 months, in residential treatment facilities set apart from the general prison population—

"(i) directed at the substance abuse problems of the prisoner; and

"(ii) intended to develop the prisoner's cognitive, behavioral, social, vocational, and other skills so as to solve the prisoner's substance abuse and related problems;

"(B) the term 'eligible prisoner' means a prisoner who is—

"(i) determined by the Bureau of Prisons to have a substance abuse problem; and

"(ii) willing to participate in a residential substance abuse treatment program; and

"(C) the term 'aftercare' means placement, case management and monitoring of the participant in a community-based substance abuse treatment program when the participant leaves the custody of the Bureau of Prisons.

"(6) COORDINATION OF FEDERAL ASSISTANCE.—The Bureau of Prisons shall consult with the Department of Health and Human Services concerning substance abuse treatment and related services and the incorporation of applicable components of existing comprehensive approaches including relapse prevention and aftercare services.".

Subtitle U—Residential Substance Abuse Treatment for State Prisoners

SEC. 32101. RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR STATE PRISONERS.

(a) RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR PRISONERS.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 20201(a), is amended—

(1) by redesignating part S as part T;

(2) by redesignating section 1901 as section 2001; and

(3) by inserting after part R the following new part:

"PART S—RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR STATE PRISONERS

"SEC. 1901. GRANT AUTHORIZATION.

"(a) The Attorney General may make grants under this part to States, for use by States and units of local government for the purpose of developing and implementing residential substance abuse treatment programs within State correctional facilities, as well as within local correctional and detention facilities in which inmates are incarcerated for a period of time sufficient to permit substance abuse treatment.

"(b) CONSULTATION.—The Attorney General shall consult with the Secretary of Health and Human Services to ensure that projects of substance abuse treatment and related services for State prisoners incorporate applicable components of existing comprehensive approaches including relapse prevention and after care services.

"SEC. 1902. STATE APPLICATIONS.

"(a) IN GENERAL.—(1) To request a grant under this part the chief executive of a State shall submit an application to the Attorney General in such form and containing such information as the Attorney General may reasonably require.

"(2) Such application shall include assurances that Federal funds received under this part shall be used to supplement, not supplant, non-Federal funds that would otherwise be available for activities funded under this part.

"(3) Such application shall coordinate the design and implementation of treatment programs between State correctional representatives and the State Alcohol and Drug Abuse agency (and, if appropriate, between representatives of local correctional agencies and representatives of either the State alcohol and drug abuse agency or any appropriate local alcohol and drug abuse agency).

"(b) SUBSTANCE ABUSE TESTING REQUIREMENT.—To be eligible to receive funds under this part, a State must agree to implement or continue to require urinalysis or other proven reliable forms of testing of individuals in correctional residential substance abuse treatment programs. Such testing shall include individuals released from residential substance abuse treatment programs who remain in the custody of the State.

"(c) ELIGIBILITY FOR PREFERENCE WITH AFTER CARE COMPONENT.—

"(1) To be eligible for a preference under this part, a State must ensure that individuals who participate in the substance abuse treatment program established or implemented with assistance provided under this part will be provided with aftercare services.

"(2) State aftercare services must involve the coordination of the correctional facility treatment program with other human service and rehabilitation programs, such as educational and job training programs, parole supervision programs, half-way house programs, and participation in self-help and peer group programs, that may aid in the rehabilitation of individuals in the substance abuse treatment program.

"(3) To qualify as an aftercare program, the head of the substance abuse treatment program, in conjunction with State and local authorities and organizations involved in substance abuse treatment, shall assist in placement of substance abuse treatment program participants with appropriate community substance abuse treatment facilities when such individuals leave the correctional facility at the end of a sentence or on parole.

"(d) COORDINATION OF FEDERAL ASSISTANCE.—Each application submitted for a grant under this section shall include a description of how the funds made available under this section will be coordinated with Federal assistance for substance abuse treatment and aftercare services currently provided by the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration.

"(e) STATE OFFICE.—The Office designated under section 507—

"(1) shall prepare the application as required under this section; and

"(2) shall administer grant funds received under this part, including review of spending, processing, progress, financial reporting, technical assistance, grant adjustments, accounting, auditing, and fund disbursement.

"SEC. 1903. REVIEW OF STATE APPLICATIONS.

"(a) IN GENERAL.—The Attorney General shall make a grant under section 1901 to carry out the projects described in the application submitted under section 1902 upon determining that—

"(1) the application is consistent with the requirements of this part; and

"(2) before the approval of the application the Attorney General has made an affirmative finding in writing that the proposed project has been reviewed in accordance with this part.

"(b) APPROVAL.—Each application submitted under section 1902 shall be considered approved, in whole or in part, by the Attorney General not later than 90 days after first received unless the Attorney General informs the applicant of specific reasons for disapproval.

"(c) RESTRICTION.—Grant funds received under this part shall not be used for land acquisition or construction projects.

"(d) DISAPPROVAL NOTICE AND RECONSIDERATION.—The Attorney General shall not disapprove any application without first affording the applicant reasonable notice and an opportunity for reconsideration.

"SEC. 1904. ALLOCATION AND DISTRIBUTION OF FUNDS.

"(a) ALLOCATION.—Of the total amount appropriated under this part in any fiscal year—

"(1) 0.4 percent shall be allocated to each of the participating States; and

"(2) of the total funds remaining after the allocation under paragraph (1), there shall be allocated to each of the participating States an amount which bears the same ratio to the amount of remaining funds described in this paragraph as the State prison population of such State bears to the total prison population of all the participating States.

"(b) FEDERAL SHARE.—The Federal share of a grant made under this part may not exceed 75 percent of the total costs of the projects described in the application submitted under section 1902 for the fiscal year for which the projects receive assistance under this part.

"SEC. 1905. EVALUATION.

"Each State that receives a grant under this part shall submit to the Attorney General an evaluation not later than March 1 of each year in such form and containing such information as the Attorney General may reasonably require.".

(b) TECHNICAL AMENDMENT.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 20201(b), is amended by inserting after the matter relating to part R the following new part:

"PART S—RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR STATE PRISONERS

"Sec. 1901. Grant authorization.
"Sec. 1902. State applications.
"Sec. 1903. Review of State applications.
"Sec. 1904. Allocation and distribution of funds.
"Sec. 1905. Evaluation.

"PART T—TRANSITION-EFFECTIVE DATE-REPEALER

"Sec. 2001. Confirmation of rules, authorities, and proceedings.".

(c) DEFINITIONS.—Section 901(a) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3791(a)), (as amended by section 20201(c), is amended—

(1) by striking "and" at the end of paragraph (23);

(2) by striking the period at the end of paragraph (24) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(25) the term 'residential substance abuse treatment program' means a course of individual and group activities, lasting between 6 and 12 months, in residential treatment facilities set apart from the general prison population—

"(A) directed at the substance abuse problems of the prisoner; and

"(B) intended to develop the prisoner's cognitive, behavioral, social, vocational, and other skills so as to solve the prisoner's substance abuse and related problems.".

(d) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793), as amended by section 20201(d), is amended—

(1) in paragraph (3) by striking "and R" and inserting "R, or S"; and

(2) by adding at the end the following new paragraph:

"(17) There are authorized to be appropriated to carry out the projects under part S—

"(A) $30,000,000 for fiscal year 1996;

"(B) $40,000,000 for fiscal year 1997;

"(C) $70,000,000 for fiscal year 1998;

"(D) $80,000,000 for fiscal year 1999; and

"(E) $80,000,000 for fiscal year 2000.".

Subtitle V—Prevention, Diagnosis, and Treatment of Tuberculosis in Correctional Institutions

SEC. 32201. PREVENTION, DIAGNOSIS, AND TREATMENT OF TUBERCULOSIS IN CORRECTIONAL INSTITUTIONS.

(a) GUIDELINES.—The Attorney General, in consultation with the Secretary of Health and Human Services and the Director of the National Institute of Corrections, shall develop and disseminate to appropriate entities, including State, Indian tribal, and local correctional institutions and the Immigration and Naturalization Service, guidelines for the prevention, diagnosis, treatment, and followup care of tuberculosis among inmates of correctional institutions and persons held in holding facilities operated by or under contract with the Immigration and Naturalization Service.

(b) COMPLIANCE.—The Attorney General shall ensure that prisons in the Federal prison system and holding facilities operated by or under contract with the Immigration and Naturalization Service comply with the guidelines described in subsection (a).

(c) GRANTS.—

(1) IN GENERAL.—The Attorney General shall make grants to State, Indian tribal, and local correction authorities and public health authorities to assist in establishing and operating programs for the prevention, diagnosis, treatment, and followup care of tuberculosis among inmates of correctional institutions.

(2) FEDERAL SHARE.—The Federal share of funding of a program funded with a grant under paragraph (1) shall not exceed 50 percent.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(A) $700,000 for fiscal year 1996;

(B) $1,000,000 for fiscal year 1997;

(C) $1,000,000 for fiscal year 1998;

(D) $1,100,000 for fiscal year 1999; and

(E) $1,200,000 for fiscal year 2000.

(d) DEFINITIONS.—In this section—

"Indian tribe" means a tribe, band, pueblo, nation, or other organized group or community of Indians, including an Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, and the United States Virgin Islands.

Subtitle W—Hope in Youth Program

SEC. 32301. PROGRAM AUTHORITY.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subtitle as the "Secretary") may make grants to eligible service providers in one or more political subdivisions of a State containing an area designated as an empowerment zone or enterprise community, as authorized under the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), that have submitted an approved plan to establish advisory organizations in low-income communities within the political subdivision containing an empowerment zone which will serve as umbrella agencies for strategic planning and evaluation of service programs serving the low-income communities in which the advisory organization operates.

(b) COORDINATION WITH THE OUNCE OF PREVENTION COUNCIL.—The Secretary may coordinate with the Ounce of Prevention Council in making grants under subsection (a).

SEC. 32302. PROGRAM REQUIREMENTS.

Each advisory organization established as described in section 32301 shall—

(1) provide a permanent multi-issue forum for public policy discussion which will serve as part of a stable infrastructure of community outreach and support,

(2) develop a mechanism by which local support service providers may be evaluated and assessed in the level of service they provide to the community, and which establishes a method for advisory organization participants to review and participate in efforts to maintain or increase the quality of services provided by such providers,

(3) create a Family Outreach Team approach which provides a youth worker, a parent worker, and a school-parent organizer to provide training in outreach, mentoring, community organizing and peer counseling and mentoring to locally recruited volunteers in a particular area. The Family Outreach Team assists such volunteers in outreach, development and coordination of service delivery from among the service providers in the area, including the schools,

(4) establish processes by which local public agencies can effectively involve the private sector in the provision of services that meet the needs of local communities,

(5) establish processes of coalition building in which diverse groups within low-income communities attempt to work cooperatively to meet the collective needs of low-income communities, and

(6) create a training program to foster community-based leadership in low-income communities.

SEC. 32303. ELIGIBLE PROVIDERS.

Consortia of public and private nonprofit local social service organizations that have a proven ability to involve disparate populations of low-income citizens and competing service providers are eligible to receive grants under section 32301.

SEC. 32304. APPLICATIONS.

Applications may be submitted, for approval by the Secretary, by eligible service providers at such time and in such manner as the Secretary may reasonably require. Such applications shall contain—

(1) assurances that selection of participants, organizations, and citizens will not be on the basis of religious preference or affiliation,

(2) assurances that participating organizations and citizens will not offer services based on any religious preference or affiliation, and

(3) assurances that such service providers will, to the extent practicable, involve participation by citizens not traditionally involved in such activities, including homeless individuals, alcohol- and drug-addicted individuals, and gang involved or violent youth.

SEC. 32305. EVALUATION.

The Secretary shall commence a program to evaluate the success and effectiveness of this program 2 years after the program has received an appropriation, and such evaluation shall be completed no later than 1 year after the second program year has been completed. A report thereon shall be submitted to the Congress within 60 days of the completion of the evaluation.

SEC. 32306. DEFINITION.

As used in this subtitle, the term "State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

SEC. 32307. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle—

(1) $3,000,000 for fiscal year 1996;

(2) $3,500,000 for fiscal year 1997;

(3) $4,000,000 for fiscal year 1998;

(4) $4,500,000 for fiscal year 1999;

(5) $5,000,000 for fiscal year 2000;

Subtitle X—Gang Resistance Education and Training

SEC. 32401. GANG RESISTANCE EDUCATION AND TRAINING PROJECTS.

(a) ESTABLISHMENT OF PROJECTS.—

(1) IN GENERAL.—The Secretary of the Treasury shall establish not less than 50 Gang Resistance Education and Training (GREAT) projects, to be located in communities across the country, in addition to the number of projects currently funded.

(2) SELECTION OF COMMUNITIES.—Communities identified for such GREAT projects shall be selected by the Secretary of the Treasury on the basis of gang-related activity in that particular community.

(3) AMOUNT OF ASSISTANCE PER PROJECT; ALLOCATION.—The Secretary of the Treasury shall make available not less than $800,000 per project, subject to the availability of appropriations, and such funds shall be allocated—

(A) 50 percent to the affected State and local law enforcement and prevention organizations participating in such projects; and

(B) 50 percent to the Bureau of Alcohol, Tobacco and Firearms for salaries, expenses, and associated administrative costs for operating and overseeing such projects.

(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

(1) $10,000,000 for fiscal year 1995;

(2) $8,000,000 for fiscal year 1996;

(3) $8,000,000 for fiscal year 1997;

(4) $8,000,000 for fiscal year 1998;

(5) $8,000,000 for fiscal year 1999; and

(6) $8,000,000 for fiscal year 2000.

TITLE IV—VIOLENCE AGAINST WOMEN

SEC. 40001. SHORT TITLE.

This title may be cited as the "Violence Against Women Act of 1994".

Subtitle A—Safe Streets for Women

SEC. 40101. SHORT TITLE.

This subtitle may be cited as the "Safe Streets for Women Act of 1994".

CHAPTER 1—FEDERAL PENALTIES FOR SEX CRIMES

SEC. 40111. REPEAT OFFENDERS.

(a) IN GENERAL.—Chapter 109A of title 18, United States Code, is amended by adding at the end the following new section:

"§2247. Repeat offenders

"Any person who violates a provision of this chapter, after one or more prior convictions for an offense punishable under this chapter, or after one or more prior convictions under the laws of any State relating to aggravated sexual abuse, sexual abuse, or abusive sexual contact have become final, is punishable by a term of imprisonment up to twice that otherwise authorized.".

(b) AMENDMENT OF SENTENCING GUIDELINES.—The Sentencing Commission shall implement the amendment made by subsection (a) by promulgating amendments, if appropriate, in the sentencing guidelines applicable to chapter 109A offenses.

(c) CHAPTER ANALYSIS.—The chapter analysis for chapter 109A of title 18, United States Code, is amended by adding at the end the following new item:

"2247. Repeat offenders.".

SEC. 40112. FEDERAL PENALTIES.

(a) AMENDMENT OF SENTENCING GUIDELINES.—Pursuant to its authority under section 994(p) of title 28, United States Code, the United States Sentencing Commission shall review and amend, where necessary, its sentencing guidelines on aggravated sexual abuse under section 2241 of title 18, United States Code, or sexual abuse under section 2242 of title 18, United States Code, as follows:

(1) The Commission shall review and promulgate amendments to the guidelines, if appropriate, to enhance penalties if more than 1 offender is involved in the offense.

(2) The Commission shall review and promulgate amendments to the guidelines, if appropriate, to reduce unwarranted disparities between the sentences for sex offenders who are known to the victim and sentences for sex offenders who are not known to the victim.

(3) The Commission shall review and promulgate amendments to the guidelines to enhance penalties, if appropriate, to render Federal penalties on Federal territory commensurate with penalties for similar offenses in the States.

(4) The Commission shall review and promulgate amendments to the guidelines, if appropriate, to account for the general problem of recidivism in cases of sex offenses, the severity of the offense, and its devastating effects on survivors.

(b) REPORT.—Not later than 180 days after the date of enactment of this Act, the United States Sentencing Commission shall review and submit to Congress a report containing an analysis of Federal rape sentencing, accompanied by comment from independent experts in the field, describing—

(1) comparative Federal sentences for cases in which the rape victim is known to the defendant and cases in which the rape victim is not known to the defendant;

(2) comparative Federal sentences for cases on Federal territory and sentences in surrounding States; and

(3) an analysis of the effect of rape sentences on populations residing primarily on Federal territory relative to the impact of other Federal offenses in which the existence of Federal jurisdiction depends upon the offense's being committed on Federal territory.

SEC. 40113. MANDATORY RESTITUTION FOR SEX CRIMES.

(a) Sexual Abuse.—

(1) In general.—Chapter 109A of title 18, United States Code, is amended by adding at the end the following new section:

"§2248. Mandatory restitution

"(a) In General.—Notwithstanding section 3663, and in addition to any other civil or criminal penalty authorized by law, the court shall order restitution for any offense under this chapter.

"(b) Scope and Nature of Order.—

"(1) Directions.—The order of restitution under this section shall direct that—

"(A) the defendant pay to the victim (through the appropriate court mechanism) the full amount of the victim's losses as determined by the court, pursuant to paragraph (3); and

"(B) the United States Attorney enforce the restitution order by all available and reasonable means.

"(2) Enforcement by victim.—An order of restitution also may be enforced by a victim named in the order to receive the restitution in the same manner as a judgment in a civil action.

"(3) Definition.—For purposes of this subsection, the term 'full amount of the victim's losses' includes any costs incurred by the victim for—

"(A) medical services relating to physical, psychiatric, or psychological care;

"(B) physical and occupational therapy or rehabilitation;

"(C) necessary transportation, temporary housing, and child care expenses;

"(D) lost income;

"(E) attorneys' fees, plus any costs incurred in obtaining a civil protection order; and

"(F) any other losses suffered by the victim as a proximate result of the offense.

"(4) Order mandatory.—(A) The issuance of a restitution order under this section is mandatory.

"(B) A court may not decline to issue an order under this section because of—

"(i) the economic circumstances of the defendant; or

"(ii) the fact that a victim has, or is entitled to, receive compensation for his or her injuries from the proceeds of insurance or any other source.

"(C)(i) Notwithstanding subparagraph (A), the court may take into account the economic circumstances of the defendant in determining the manner in which and the schedule according to which the restitution is to be paid.

"(ii) For purposes of this subparagraph, the term 'economic circumstances' includes—

"(I) the financial resources and other assets of the defendant;

"(II) projected earnings, earning capacity, and other income of the defendant; and

"(III) any financial obligations of the defendant, including obligations to dependents.

"(D) Subparagraph (A) does not apply if—

"(i) the court finds on the record that the economic circumstances of the defendant do not allow for the payment of any amount of a restitution order, and do not allow for the payment of any or some portion of the amount of a restitution order in the foreseeable future (under any reasonable schedule of payments); and

"(ii) the court enters in its order the amount of the victim's losses, and provides a nominal restitution award.

"(5) More than 1 offender.—When the court finds that more than 1 offender has contributed to the loss of a victim, the court may make each offender liable for payment of the full amount of restitution or may apportion liability among the offenders to reflect the level of contribution and economic circumstances of each offender.

"(6) More than 1 victim.—When the court finds that more than 1 victim has sustained a loss requiring restitution by an offender, the court shall order full restitution of each victim but may provide for different payment schedules to reflect the economic circumstances of each victim.

"(7) Payment schedule.—An order under this section may direct the defendant to make a single lump-sum payment or partial payments at specified intervals.

"(8) Setoff.—Any amount paid to a victim under this section shall be set off against any amount later recovered as compensatory damages by the victim from the defendant in—

"(A) any Federal civil proceeding; and

"(B) any State civil proceeding, to the extent provided by the law of the State.

"(9) Effect on other sources of compensation.—The issuance of a restitution order shall not affect the entitlement of a victim to receive compensation with respect to a loss from insurance or any other source until the payments actually received by the victim under the restitution order fully compensate the victim for the loss.

"(10) Condition of probation or supervised release.—Compliance with a restitution order issued under this section shall be a condition of any probation or supervised release of a defendant. If an offender fails to comply with a restitution order, the court may, after a hearing, revoke probation or a term of supervised release, modify the terms or conditions of probation or a term of supervised release, or hold the defendant in contempt pursuant to section 3583(e). In determining whether to revoke probation or a term of supervised release, modify the terms or conditions of probation or supervised release or hold a defendant serving a term of supervised release in contempt, the court shall consider the defendant's employment status, earning ability and financial resources, the willfulness of the defendant's failure to comply, and any other circumstances that may have a bearing on the defendant's ability to comply.

"(c) Proof of Claim.—

"(1) Affidavit.—Within 60 days after conviction and, in any event, not later than 10 days prior to sentencing, the United States Attorney (or the United States Attorney's delegee), after consulting with the victim, shall prepare and file an affidavit with the court listing the amounts subject to restitution under this section. The affidavit shall be signed by the United States Attorney (or the United States Attorney's delegee) and the victim. Should the victim object to any of the information included in the affidavit, the United States Attorney (or the United States Attorney's delegee) shall advise the victim that the victim may file a separate affidavit and shall provide the victim with an affidavit form which may be used to do so.

"(2) Objection.—If, after the defendant has been notified of the affidavit, no objection is raised by the defendant, the amounts attested to in the affidavit filed pursuant to paragraph (1) shall be entered in the court's restitution order. If objection is raised, the court may require the victim or the United States Attorney (or the United States Attorney's delegee) to submit further affidavits or other supporting documents, demonstrating the victim's losses.

"(3) Additional documentation and testimony.—If the court concludes, after reviewing the supporting documentation and considering the defendant's objections, that there is a substantial reason for doubting the authenticity or veracity of the records submitted, the court may require additional documentation or hear testimony on those questions. The privacy of any records filed, or testimony heard, pursuant to this section shall be maintained to the greatest extent possible, and such records may be filed or testimony heard in camera.

"(4) Final determination of losses.—If the victim's losses are not ascertainable by the date that is 10 days prior to sentencing as provided in paragraph (1), the United States Attorney (or the United States Attorney's delegee) shall so inform the court, and the court shall set a date for the final determination of the victim's losses, not to exceed 90 days after sentencing. If the victim subsequently discovers further losses, the victim shall have 60 days after discovery of those losses in which to petition the court for an amended restitution order. Such order may be granted only upon a showing of good cause for the failure to include such losses in the initial claim for restitutionary relief.

"(d) Modification of Order.—A victim or the offender may petition the court at any time to modify a restitution order as appropriate in view of a change in the economic circumstances of the offender.

"(e) Reference to Magistrate or Special Master.—The court may refer any issue arising in connection with a proposed order of restitution to a magistrate or special master for proposed findings of fact and recommendations as to disposition, subject to a de novo determination of the issue by the court.

"(f) Definition.—For purposes of this section, the term 'victim' means the individual harmed as a result of a commission of a crime under this chapter, including, in the case of a victim who is under 18 years of age, incompetent, incapacitated, or deceased, the legal guardian of the victim or representative of the victim's estate, another family member, or any other person appointed as suitable by the court, but in no event shall the defendant be named as such representative or guardian.".

(2) Technical amendment.—The chapter analysis for chapter 109A of title 18, United States Code, is amended by adding at the end the following new item:

"2248. Mandatory restitution.".

(b) Sexual Exploitation and Other Abuse of Children.—

(1) In general.—Chapter 110 of title 18, United States Code, is amended by adding at the end the following new section:

"§2259. Mandatory restitution

"(a) In General.—Notwithstanding section 3663, and in addition to any other civil or criminal penalty authorized by law, the court shall order restitution for any offense under this chapter.

"(b) Scope and Nature of Order.—

"(1) Directions.—The order of restitution under this section shall direct that—

"(A) the defendant pay to the victim (through the appropriate court mechanism) the full amount of the victim's losses as determined by the court, pursuant to paragraph (3); and

"(B) the United States Attorney enforce the restitution order by all available and reasonable means.

"(2) Enforcement by victim.—An order of restitution may also be enforced by a victim named in the order to receive the restitution in the same manner as a judgment in a civil action.

"(3) Definition.—For purposes of this subsection, the term 'full amount of the victim's losses' includes any costs incurred by the victim for—

"(A) medical services relating to physical, psychiatric, or psychological care;

"(B) physical and occupational therapy or rehabilitation;

"(C) necessary transportation, temporary housing, and child care expenses;

"(D) lost income;

"(E) attorneys' fees, as well as other costs incurred; and

"(F) any other losses suffered by the victim as a proximate result of the offense.

"(4) ORDER MANDATORY.—(A) The issuance of a restitution order under this section is mandatory.

"(B) A court may not decline to issue an order under this section because of—

"(i) the economic circumstances of the defendant; or

"(ii) the fact that a victim has, or is entitled to, receive compensation for his or her injuries from the proceeds of insurance or any other source.

"(C)(i) Notwithstanding subparagraph (A), the court may take into account the economic circumstances of the defendant in determining the manner in which and the schedule according to which the restitution is to be paid.

"(ii) For purposes of this subparagraph, the term 'economic circumstances' includes—

"(I) the financial resources and other assets of the defendant;

"(II) projected earnings, earning capacity, and other income of the defendant; and

"(III) any financial obligations of the defendant, including obligations to dependents.

"(D) Subparagraph (A) does not apply if—

"(i) the court finds on the record that the economic circumstances of the defendant do not allow for the payment of any amount of a restitution order, and do not allow for the payment of any or some portion of the amount of a restitution order in the foreseeable future (under any reasonable schedule of payments); and

"(ii) the court enters in its order the amount of the victim's losses, and provides a nominal restitution award.

"(5) MORE THAN 1 OFFENDER.—When the court finds that more than 1 offender has contributed to the loss of a victim, the court may make each offender liable for payment of the full amount of restitution or may apportion liability among the offenders to reflect the level of contribution and economic circumstances of each offender.

"(6) MORE THAN 1 VICTIM.—When the court finds that more than 1 victim has sustained a loss requiring restitution by an offender, the court shall order full restitution of each victim but may provide for different payment schedules to reflect the economic circumstances of each victim.

"(7) PAYMENT SCHEDULE.—An order under this section may direct the defendant to make a single lump-sum payment or partial payments at specified intervals.

"(8) SETOFF.—Any amount paid to a victim under this section shall be set off against any amount later recovered as compensatory damages by the victim from the defendant in—

"(A) any Federal civil proceeding; and

"(B) any State civil proceeding, to the extent provided by the law of the State.

"(9) EFFECT ON OTHER SOURCES OF COMPENSATION.—The issuance of a restitution order shall not affect the entitlement of a victim to receive compensation with respect to a loss from insurance or any other source until the payments actually received by the victim under the restitution order fully compensate the victim for the loss.

"(10) CONDITION OF PROBATION OR SUPERVISED RELEASE.—Compliance with a restitution order issued under this section shall be a condition of any probation or supervised release of a defendant. If an offender fails to comply with a restitution order, the court may, after a hearing, revoke probation or a term of supervised release, modify the terms or conditions of probation or a term of supervised release, or hold the defendant in contempt pursuant to section 3583(e). In determining whether to revoke probation or a term of supervised release, modify the terms or conditions of probation or supervised release or hold a defendant serving a term of supervised release in contempt, the court shall consider the defendant's employment status, earning ability and financial resources, the willfulness of the defendant's failure to comply, and any other circumstances that may have a bearing on the defendant's ability to comply.

"(c) PROOF OF CLAIM.—

"(1) AFFIDAVIT.—Within 60 days after conviction and, in any event, not later than 10 days prior to sentencing, the United States Attorney (or the United States Attorney's delegee), after consulting with the victim, shall prepare and file an affidavit with the court listing the amounts subject to restitution under this section. The affidavit shall be signed by the United States Attorney (or the United States Attorney's delegee) and the victim. Should the victim object to any of the information included in the affidavit, the United States Attorney (or the United States Attorney's delegee) shall advise the victim that the victim may file a separate affidavit and shall provide the victim with an affidavit form which may be used to do so.

"(2) OBJECTION.—If, after the defendant has been notified of the affidavit, no objection is raised by the defendant, the amounts attested to in the affidavit filed pursuant to paragraph (1) shall be entered in the court's restitution order. If objection is raised, the court may require the victim or the United States Attorney (or the United States Attorney's delegee) to submit further affidavits or other supporting documents, demonstrating the victim's losses.

"(3) ADDITIONAL DOCUMENTATION AND TESTIMONY.—If the court concludes, after reviewing the supporting documentation and considering the defendant's objections, that there is a substantial reason for doubting the authenticity or veracity of the records submitted, the court may require additional documentation or hear testimony on those questions. The privacy of any records filed, or testimony heard, pursuant to this section shall be maintained to the greatest extent possible, and such records may be filed or testimony heard in camera.

"(4) FINAL DETERMINATION OF LOSSES.—If the victim's losses are not ascertainable by the date that is 10 days prior to sentencing as provided in paragraph (1), the United States Attorney (or the United States Attorney's delegee) shall so inform the court, and the court shall set a date for the final determination of the victim's losses, not to exceed 90 days after sentencing. If the victim subsequently discovers further losses, the victim shall have 60 days after discovery of those losses in which to petition the court for an amended restitution order. Such order may be granted only upon a showing of good cause for the failure to include such losses in the initial claim for restitutionary relief.

"(d) MODIFICATION OF ORDER.—A victim or the offender may petition the court at any time to modify a restitution order as appropriate in view of a change in the economic circumstances of the offender.

"(e) REFERENCE TO MAGISTRATE OR SPECIAL MASTER.—The court may refer any issue arising in connection with a proposed order of restitution to a magistrate or special master for proposed findings of fact and recommendations as to disposition, subject to a de novo determination of the issue by the court.

"(f) DEFINITION.—For purposes of this section, the term 'victim' means the individual harmed as a result of a commission of a crime under this chapter, including, in the case of a victim who is under 18 years of age, incompetent, incapacitated, or deceased, the legal guardian of the victim or representative of the victim's estate, another family member, or any other person appointed as suitable by the court, but in no event shall the defendant be named as such representative or guardian.".

(2) TECHNICAL AMENDMENT.—The chapter analysis for chapter 110 of title 18, United States Code, is amended by adding at the end the following new item:

"2259. Mandatory restitution.".

SEC. 40114. AUTHORIZATION FOR FEDERAL VICTIM'S COUNSELORS.

There are authorized to be appropriated for the United States Attorneys for the purpose of appointing Victim/Witness Counselors for the prosecution of sex crimes and domestic violence crimes where applicable (such as the District of Columbia)—

(1) $500,000 for fiscal year 1996;

(2) $500,000 for fiscal year 1997; and

(3) $500,000 for fiscal year 1998.

CHAPTER 2—LAW ENFORCEMENT AND PROSECUTION GRANTS TO REDUCE VIOLENT CRIMES AGAINST WOMEN

SEC. 40121. GRANTS TO COMBAT VIOLENT CRIMES AGAINST WOMEN.

(a) IN GENERAL.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 32101(a), is amended—

(1) by redesignating part T as part U;

(2) by redesignating section 2001 as section 2101; and

(3) by inserting after part S the following new part:

"PART T—GRANTS TO COMBAT VIOLENT CRIMES AGAINST WOMEN

"SEC. 2001. PURPOSE OF THE PROGRAM AND GRANTS.

"(a) GENERAL PROGRAM PURPOSE.—The purpose of this part is to assist States, Indian tribal governments, and units of local government to develop and strengthen effective law enforcement and prosecution strategies to combat violent crimes against women, and to develop and strengthen victim services in cases involving violent crimes against women.

"(b) PURPOSES FOR WHICH GRANTS MAY BE USED.—Grants under this part shall provide personnel, training, technical assistance, data collection and other equipment for the more widespread apprehension, prosecution, and adjudication of persons committing violent crimes against women, and specifically, for the purposes of—

"(1) training law enforcement officers and prosecutors to more effectively identify and respond to violent crimes against women, including the crimes of sexual assault and domestic violence;

"(2) developing, training, or expanding units of law enforcement officers and prosecutors specifically targeting violent crimes against women, including the crimes of sexual assault and domestic violence;

"(3) developing and implementing more effective police and prosecution policies, protocols, orders, and services specifically devoted to preventing, identifying, and responding to violent crimes against women, including the crimes of sexual assault and domestic violence;

"(4) developing, installing, or expanding data collection and communication systems, including computerized systems, linking police, prosecutors, and courts or for the purpose of identifying and tracking arrests, protection orders, violations of protection orders, prosecutions, and convictions for violent crimes against women, including the crimes of sexual assault and domestic violence;

"(5) developing, enlarging, or strengthening victim services programs, including sexual assault and domestic violence programs, developing or improving delivery of victim services to racial, cultural, ethnic, and language minorities, providing specialized domestic violence *court advocates in courts where a significant number of protection orders are granted, and increasing reporting and reducing attrition rates for cases involving violent crimes against women, including crimes of sexual assault and domestic violence;*

''(6) developing, enlarging, or strengthening programs addressing stalking; and

''(7) developing, enlarging, or strengthening programs addressing the needs and circumstances of Indian tribes in dealing with violent crimes against women, including the crimes of sexual assault and domestic violence.

"SEC. 2002. STATE GRANTS.

''(a) GENERAL GRANTS.—The Attorney General may make grants to States, for use by States, units of local government, nonprofit nongovernmental victim services programs, and Indian tribal governments for the purposes described in section 2001(b).

''(b) AMOUNTS.—Of the amounts appropriated for the purposes of this part—

''(1) 4 percent shall be available for grants to Indian tribal governments;

''(2) $500,000 shall be available for grants to applicants in each State; and

''(3) the remaining funds shall be available for grants to applicants in each State in an amount that bears the same ratio to the amount of remaining funds as the population of the State bears to the population of all of the States that results from a distribution among the States on the basis of each State's population in relation to the population of all States (not including populations of Indian tribes).

''(c) QUALIFICATION.—Upon satisfying the terms of subsection (d), any State shall be qualified for funds provided under this part upon certification that—

''(1) the funds shall be used for any of the purposes described in section 2001(b);

''(2) grantees and subgrantees shall develop a plan for implementation and shall consult and coordinate with nonprofit, nongovernmental victim services programs, including sexual assault and domestic violence victim services programs;

''(3) at least 25 percent of the amount granted shall be allocated, without duplication, to each of the following 3 areas: prosecution, law enforcement, and victim services; and

''(4) any Federal funds received under this part shall be used to supplement, not supplant, non-Federal funds that would otherwise be available for activities funded under this subtitle.

''(d) APPLICATION REQUIREMENTS.—The application requirements provided in section 513 shall apply to grants made under this part. In addition, each application shall include the certifications of qualification required by subsection (c), including documentation from nonprofit, nongovernmental victim services programs, describing their participation in developing the plan required by subsection (c)(2). An application shall include—

''(1) documentation from the prosecution, law enforcement, and victim services programs to be assisted, demonstrating—

''(A) need for the grant funds;

''(B) intended use of the grant funds;

''(C) expected results from the use of grant funds; and

''(D) demographic characteristics of the populations to be served, including age, marital status, disability, race, ethnicity and language background;

''(2) proof of compliance with the requirements for the payment of forensic medical exams provided in section 2005; and

''(3) proof of compliance with the requirements for paying filing and service fees for domestic violence cases provided in section 2006.

''(e) DISBURSEMENT.—

''(1) IN GENERAL.—Not later than 60 days after the receipt of an application under this part, the Attorney General shall—

''(A) disburse the appropriate sums provided for under this part; or

''(B) inform the applicant why the application does not conform to the terms of section 513 or to the requirements of this section.

''(2) REGULATIONS.—In disbursing monies under this part, the Attorney General shall issue regulations to ensure that States will—

''(A) give priority to areas of varying geographic size with the greatest showing of need based on the availability of existing domestic violence and sexual assault programs in the population and geographic area to be served in relation to the availability of such programs in other such populations and geographic areas;

''(B) determine the amount of subgrants based on the population and geographic area to be served;

''(C) equitably distribute monies on a geographic basis including nonurban and rural areas of various geographic sizes; and

''(D) recognize and address the needs of underserved populations.

''(f) FEDERAL SHARE.—The Federal share of a grant made under this subtitle may not exceed 75 percent of the total costs of the projects described in the application submitted.

''(g) INDIAN TRIBES.—Funds appropriated by the Congress for the activities of any agency of an Indian tribal government or of the Bureau of Indian Affairs performing law enforcement functions on any Indian lands may be used to provide the non-Federal share of the cost of programs or projects funded under this part.

''(h) GRANTEE REPORTING.—

''(1) IN GENERAL.—Upon completion of the grant period under this part, a State or Indian tribal grantee shall file a performance report with the Attorney General explaining the activities carried out, which report shall include an assessment of the effectiveness of those activities in achieving the purposes of this part.

''(2) CERTIFICATION BY GRANTEE AND SUBGRANTEES.—A section of the performance report shall be completed by each grantee and subgrantee that performed the direct services contemplated in the application, certifying performance of direct services under the grant.

''(3) SUSPENSION OF FUNDING.—The Attorney General shall suspend funding for an approved application if—

''(A) an applicant fails to submit an annual performance report;

''(B) funds are expended for purposes other than those described in this part; or

''(C) a report under paragraph (1) or accompanying assessments demonstrate to the Attorney General that the program is ineffective or financially unsound.

"SEC. 2003. DEFINITIONS.

''In this part—

''(1) the term 'domestic violence' includes felony or misdemeanor crimes of violence committed by a current or former spouse of the victim, by a person with whom the victim shares a child in common, by a person who is cohabitating with or has cohabitated with the victim as a spouse, by a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction receiving grant monies, or by any other adult person against a victim who is protected from that person's acts under the domestic or family violence laws of the jurisdiction receiving grant monies;

''(2) the term 'Indian country' has the meaning stated in section 1151 of title 18, United States Code;

''(3) the term 'Indian tribe' means a tribe, band, pueblo, nation, or other organized group or community of Indians, including any Alaska Native village or regional or village corporation (as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.)), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians;

''(4) the term 'law enforcement' means a public agency charged with policing functions, including any of its component bureaus (such as governmental victim services programs);

''(5) the term 'prosecution' means any public agency charged with direct responsibility for prosecuting criminal offenders, including such agency's component bureaus (such as governmental victim services programs);

''(6) the term 'sexual assault' means any conduct proscribed by chapter 109A of title 18, United States Code, whether or not the conduct occurs in the special maritime and territorial jurisdiction of the United States or in a Federal prison and includes both assaults committed by offenders who are strangers to the victim and assaults committed by offenders who are known or related by blood or marriage to the victim;

''(7) the term 'underserved populations' includes populations underserved because of geographic location (such as rural isolation), underserved racial or ethnic populations, and populations underserved because of special needs, such as language barriers or physical disabilities; and

''(8) the term 'victim services' means a nonprofit, nongovernmental organization that assists domestic violence or sexual assault victims, including rape crisis centers, battered women's shelters, and other sexual assault or domestic violence programs, including nonprofit, nongovernmental organizations assisting domestic violence or sexual assault victims through the legal process.

"SEC. 2004. GENERAL TERMS AND CONDITIONS.

''(a) NONMONETARY ASSISTANCE.—In addition to the assistance provided under this part, the Attorney General may request any Federal agency to use its authorities and the resources granted to it under Federal law (including personnel, equipment, supplies, facilities, and managerial, technical, and advisory services) in support of State, tribal, and local assistance efforts.

''(b) REPORTING.—Not later than 180 days after the end of each fiscal year for which grants are made under this part, the Attorney General shall submit to the Committee on the Judiciary of the House of Representatives and the Committee on the Judiciary of the Senate a report that includes, for each State and for each grantee Indian tribe—

''(1) the number of grants made and funds distributed under this part;

''(2) a summary of the purposes for which those grants were provided and an evaluation of their progress;

''(3) a statistical summary of persons served, detailing the nature of victimization, and providing data on age, sex, relationship of victim to offender, geographic distribution, race, ethnicity, language, and disability; and

''(4) an evaluation of the effectiveness of programs funded under this part.

''(c) REGULATIONS OR GUIDELINES.—Not later than 120 days after the date of enactment of this part, the Attorney General shall publish proposed regulations or guidelines implementing this part. Not later than 180 days after the date of enactment, the Attorney General shall publish final regulations or guidelines implementing this part.

"SEC. 2005. RAPE EXAM PAYMENTS.

''(a) RESTRICTION OF FUNDS.—

''(1) IN GENERAL.—A State, Indian tribal government, or unit of local government, shall not be entitled to funds under this part unless the State, Indian tribal government, unit of local

government, or another governmental entity incurs the full out-of-pocket cost of forensic medical exams described in subsection (b) for victims of sexual assault.

"(2) REDISTRIBUTION.—Funds withheld from a State or unit of local government under paragraph (1) shall be distributed to other States or units of local government pro rata. Funds withheld from an Indian tribal government under paragraph (1) shall be distributed to other Indian tribal governments pro rata.

"(b) MEDICAL COSTS.—A State, Indian tribal government, or unit of local government shall be deemed to incur the full out of pocket cost of forensic medical exams for victims of sexual assault if any government entity—

"(1) provides such exams to victims free of charge to the victim;

"(2) arranges for victims to obtain such exams free of charge to the victims; or

"(3) reimburses victims for the cost of such exams if—

"(A) the reimbursement covers the full cost of such exams, without any deductible requirement or limit on the amount of a reimbursement;

"(B) the reimbursing governmental entity permits victims to apply for reimbursement for not less than one year from the date of the exam;

"(C) the reimbursing governmental entity provides reimbursement not later than 90 days after written notification of the victim's expense; and

"(D) the State, Indian tribal government, unit of local government, or reimbursing governmental entity provides information at the time of the exam to all victims, including victims with limited or no English proficiency, regarding how to obtain reimbursement.

"SEC. 2006. FILING COSTS FOR CRIMINAL CHARGES.

"(a) IN GENERAL.—A State, Indian tribal government, or unit of local government, shall not be entitled to funds under this part unless the State, Indian tribal government, or unit of local government—

"(1) certifies that its laws, policies, and practices do not require, in connection with the prosecution of any misdemeanor or felony domestic violence offense, that the abused bear the costs associated with the filing of criminal charges against the domestic violence offender, or the costs associated with the issuance or service of a warrant, protection order, or witness subpoena; or

"(2) gives the Attorney General assurances that its laws, policies and practices will be in compliance with the requirements of paragraph (1) within the later of—

"(A) the period ending on the date on which the next session of the State legislature ends; or

"(B) 2 years.

"(b) REDISTRIBUTION.—Funds withheld from a State, unit of local government, or Indian tribal government under subsection (a) shall be distributed to other States, units of local government, and Indian tribal government, respectively, pro rata.".

(b) TECHNICAL AMENDMENT.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 32101(b), is amended by striking the matter relating to part T and inserting the following:

"PART T—GRANTS TO COMBAT VIOLENT CRIMES AGAINST WOMEN

"Sec. 2001. Purpose of the program and grants.
"Sec. 2002. State grants.
"Sec. 2003. General definitions.
"Sec. 2004. General terms and conditions.
"Sec. 2005. Rape exam payments.
"Sec. 2006. Filing costs for criminal charges.

"PART U—TRANSITION—EFFECTIVE DATE—REPEALER

"Sec. 2101. Continuation of rules, authorities, and proceedings.".

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793), as amended by section 32101(d), is amended—

(1) in paragraph (3) by striking "and S" and inserting "S, and T"; and

(2) by adding at the end the following new paragraph:

"(18) There are authorized to be appropriated to carry out part T—

"(A) $85,000,000 for fiscal year 1995;
"(B) $150,000,000 for fiscal year 1996;
"(C) $175,000,000 for fiscal year 1997;
"(D) $190,000,000 for fiscal year 1998;
"(E) $195,000,000 for fiscal year 1999; and
"(F) $205,000,000 for fiscal year 2000.".

CHAPTER 3—SAFETY FOR WOMEN IN PUBLIC TRANSIT AND PUBLIC PARKS

SEC. 40131. GRANTS FOR CAPITAL IMPROVEMENTS TO PREVENT CRIME IN PUBLIC TRANSPORTATION.

(a) GENERAL PURPOSE.—There is authorized to be appropriated out of the general fund of the Treasury not to exceed $10,000,000, for the Secretary of Transportation (referred to in this section as the "Secretary") to make capital grants for the prevention of crime and to increase security in existing and future public transportation systems. None of the provisions of this Act may be construed to prohibit the financing of projects under this section where law enforcement responsibilities are vested in a local public body other than the grant applicant.

(b) GRANTS FOR LIGHTING, CAMERA SURVEILLANCE, AND SECURITY PHONES.—

(1) From the sums authorized for expenditure under this section for crime prevention, the Secretary is authorized to make grants and loans to States and local public bodies or agencies for the purpose of increasing the safety of public transportation by—

(A) increasing lighting within or adjacent to public transportation systems, including bus stops, subway stations, parking lots, or garages;

(B) increasing camera surveillance of areas within and adjacent to public transportation systems, including bus stops, subway stations, parking lots, or garages;

(C) providing emergency phone lines to contact law enforcement or security personnel in areas within or adjacent to public transportation systems, including bus stops, subway stations, parking lots, or garages; or

(D) any other project intended to increase the security and safety of existing or planned public transportation systems.

(2) From the sums authorized under this section, at least 75 percent shall be expended on projects of the type described in subsection (b)(1) (A) and (B).

(c) REPORTING.—All grants under this section are contingent upon the filing of a report with the Secretary and the Department of Justice, Office of Victims of Crime, showing crime rates in or adjacent to public transportation before, and for a 1-year period after, the capital improvement. Statistics shall be compiled on the basis of the type of crime, sex, race, ethnicity, language, and relationship of victim to the offender.

(d) INCREASED FEDERAL SHARE.—Notwithstanding any other provision of law, the Federal share under this section for each capital improvement project that enhances the safety and security of public transportation systems and that is not required by law (including any other provision of this Act) shall be 90 percent of the net project cost of the project.

(e) SPECIAL GRANTS FOR PROJECTS TO STUDY INCREASING SECURITY FOR WOMEN.—From the sums authorized under this section, the Secretary shall provide grants and loans for the purpose of studying ways to reduce violent crimes against women in public transit through better design or operation of public transit systems.

(f) GENERAL REQUIREMENTS.—All grants or loans provided under this section shall be subject to the same terms, conditions, requirements, and provisions applicable to grants and loans as specified in section 5321 of title 49, United States Code.

SEC. 40132. GRANTS FOR CAPITAL IMPROVEMENTS TO PREVENT CRIME IN NATIONAL PARKS.

Public Law 91-383 (16 U.S.C. 1a-1 et seq.) is amended by adding at the end the following new section:

"SEC. 13. NATIONAL PARK SYSTEM CRIME PREVENTION ASSISTANCE.

"(a) AVAILABILITY OF FUNDS.—From sums appropriated out of the general fund of the Treasury, not to exceed $10,000,000, the Secretary of the Interior shall take all necessary actions to seek to reduce the incidence of violent crime in the National Park System.

"(b) RECOMMENDATIONS FOR IMPROVEMENT.—The Secretary shall direct the chief official responsible for law enforcement within the National Park Service to—

"(1) compile a list of areas within the National Park System with the highest rates of violent crime;

"(2) make recommendations concerning capital improvements, and other measures, needed within the National Park System to reduce the rates of violent crime, including the rate of sexual assault; and

"(3) publish the information required by paragraphs (1) and (2) in the Federal Register.

"(c) DISTRIBUTION OF FUNDS.—Based on the recommendations and list issued pursuant to subsection (b), the Secretary shall distribute the funds authorized by subsection (a) throughout the National Park System. Priority shall be given to those areas with the highest rates of sexual assault.

"(d) USE OF FUNDS.—Funds provided under this section may be used—

"(1) to increase lighting within or adjacent to National Park System units;

"(2) to provide emergency phone lines to contact law enforcement or security personnel in areas within or adjacent to National Park System units;

"(3) to increase security or law enforcement personnel within or adjacent to National Park System units; or

"(4) for any other project intended to increase the security and safety of National Park System units.".

SEC. 40133. GRANTS FOR CAPITAL IMPROVEMENTS TO PREVENT CRIME IN PUBLIC PARKS.

Section 6 of the Land and Water Conservation Fund Act of 1965 (16 U.S.C. 460l-8) is amended by adding at the end the following new subsection:

"(h) CAPITAL IMPROVEMENT AND OTHER PROJECTS TO REDUCE CRIME.—

"(1) AVAILABILITY OF FUNDS.—In addition to assistance for planning projects, and in addition to the projects identified in subsection (e), and from amounts appropriated out of the general fund of the Treasury, the Secretary may provide financial assistance to the States, not to exceed $15,000,000, for projects or combinations thereof for the purpose of making capital improvements and other measures to increase safety in urban parks and recreation areas, including funds to—

"(A) increase lighting within or adjacent to public parks and recreation areas;

"(B) provide emergency phone lines to contact law enforcement or security personnel in areas within or adjacent to public parks and recreation areas;

"(C) increase security personnel within or adjacent to public parks and recreation areas; and

"(D) fund any other project intended to increase the security and safety of public parks and recreation areas.

"(2) ELIGIBILITY.—In addition to the requirements for project approval imposed by this section, eligibility for assistance under this subsection shall be dependent upon a showing of need. In providing funds under this subsection, the Secretary shall give priority to projects proposed for urban parks and recreation areas with the highest rates of crime and, in particular, to urban parks and recreation areas with the highest rates of sexual assault.

"(3) FEDERAL SHARE.—Notwithstanding subsection (c), the Secretary may provide 70 percent improvement grants for projects undertaken by any State for the purposes described in this subsection, and the remaining share of the cost shall be borne by the State.".

CHAPTER 4—NEW EVIDENTIARY RULES

SEC. 40141. SEXUAL HISTORY IN CRIMINAL AND CIVIL CASES.

(a) MODIFICATION OF PROPOSED AMENDMENT.—The proposed amendments to the Federal Rules of Evidence that are embraced by an order entered by the Supreme Court of the United States on April 29, 1994, shall take effect on December 1, 1994, as otherwise provided by law, but with the amendment made by subsection (b).

(b) RULE.—Rule 412 of the Federal Rules of Evidence is amended to read as follows:

"Rule 412. Sex Offense Cases; Relevance of Alleged Victim's Past Sexual Behavior or Alleged Sexual Predisposition

"(a) EVIDENCE GENERALLY INADMISSIBLE.—The following evidence is not admissible in any civil or criminal proceeding involving alleged sexual misconduct except as provided in subdivisions (b) and (c):

"(1) Evidence offered to prove that any alleged victim engaged in other sexual behavior.

"(2) Evidence offered to prove any alleged victim's sexual predisposition.

"(b) EXCEPTIONS.—

"(1) In a criminal case, the following evidence is admissible, if otherwise admissible under these rules:

"(A) evidence of specific instances of sexual behavior by the alleged victim offered to prove that a person other than the accused was the source of semen, injury or other physical evidence;

"(B) evidence of specific instances of sexual behavior by the alleged victim with respect to the person accused of the sexual misconduct offered by the accused to prove consent or by the prosecution; and

"(C) evidence the exclusion of which would violate the constitutional rights of the defendant.

"(2) In a civil case, evidence offered to prove the sexual behavior or sexual predisposition of any alleged victim is admissible if it is otherwise admissible under these rules and its probative value substantially outweighs the danger of harm to any victim and of unfair prejudice to any party. Evidence of an alleged victim's reputation is admissible only if it has been placed in controversy by the alleged victim.

"(c) PROCEDURE TO DETERMINE ADMISSIBILITY.—

"(1) A party intending to offer evidence under subdivision (b) must—

"(A) file a written motion at least 14 days before trial specifically describing the evidence and stating the purpose for which it is offered unless the court, for good cause requires a different time for filing or permits filing during trial; and

"(B) serve the motion on all parties and notify the alleged victim or, when appropriate, the alleged victim's guardian or representative.

"(2) Before admitting evidence under this rule the court must conduct a hearing in camera and afford the victim and parties a right to attend and be heard. The motion, related papers, and the record of the hearing must be sealed and remain under seal unless the court orders otherwise.".

(c) TECHNICAL AMENDMENT.—The table of contents for the Federal Rules of Evidence is amended by amending the item relating to rule 412 to read as follows:

"412. Sex Offense Cases; Relevance of Alleged Victim's Past Sexual Behavior or Alleged Sexual Predisposition:
"(a) Evidence generally inadmissible.
"(b) Exceptions.
"(c) Procedure to determine admissibility.".

CHAPTER 5—ASSISTANCE TO VICTIMS OF SEXUAL ASSAULT

SEC. 40151. EDUCATION AND PREVENTION GRANTS TO REDUCE SEXUAL ASSAULTS AGAINST WOMEN.

Part A of title XIX of the Public Health and Human Services Act (42 U.S.C. 300w et seq.) is amended by adding at the end the following new section:

"SEC. 1910A. USE OF ALLOTMENTS FOR RAPE PREVENTION EDUCATION.

"(a) PERMITTED USE.—Notwithstanding section 1904(a)(1), amounts transferred by the State for use under this part may be used for rape prevention and education programs conducted by rape crisis centers or similar nongovernmental nonprofit entities for—

"(1) educational seminars;

"(2) the operation of hotlines;

"(3) training programs for professionals;

"(4) the preparation of informational materials; and

"(5) other efforts to increase awareness of the facts about, or to help prevent, sexual assault, including efforts to increase awareness in underserved racial, ethnic, and language minority communities.

"(b) TARGETING OF EDUCATION PROGRAMS.—States providing grant monies must ensure that at least 25 percent of the monies are devoted to education programs targeted for middle school, junior high school, and high school students.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

"(1) $35,000,000 for fiscal year 1996;

"(2) $40,000,000 for fiscal year 1997;

"(3) $45,000,000 for fiscal year 1998;

"(4) $50,000,000 for fiscal year 1999; and

"(5) $50,000,000 for fiscal year 2000.

"(d) LIMITATION.—Funds authorized under this section may only be used for providing rape prevention and education programs.

"(e) DEFINITION.—For purposes of this section, the term 'rape prevention and education' includes education and prevention efforts directed at offenses committed by offenders who are not known to the victim as well as offenders who are known to the victim.

"(f) TERMS.—The Secretary shall make allotments to each State on the basis of the population of the State, and subject to the conditions provided in this section and sections 1904 through 1909.".

SEC. 40152. TRAINING PROGRAMS.

(a) IN GENERAL.—The Attorney General, after consultation with victim advocates and individuals who have expertise in treating sex offenders, shall establish criteria and develop training programs to assist probation and parole officers and other personnel who work with released sex offenders in the areas of—

(1) case management;

(2) supervision; and

(3) relapse prevention.

(b) TRAINING PROGRAMS.—The Attorney General shall ensure, to the extent practicable, that training programs developed under subsection (a) are available in geographically diverse locations throughout the country.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $1,000,000 for fiscal year 1996; and

(2) $1,000,000 for fiscal year 1997.

SEC. 40153. CONFIDENTIALITY OF COMMUNICATIONS BETWEEN SEXUAL ASSAULT OR DOMESTIC VIOLENCE VICTIMS AND THEIR COUNSELORS.

(a) STUDY AND DEVELOPMENT OF MODEL LEGISLATION.—The Attorney General shall—

(1) study and evaluate the manner in which the States have taken measures to protect the confidentiality of communications between sexual assault or domestic violence victims and their therapists or trained counselors;

(2) develop model legislation that will provide the maximum protection possible for the confidentiality of such communications, within any applicable constitutional limits, taking into account the following factors:

(A) the danger that counseling programs for victims of sexual assault and domestic violence will be unable to achieve their goal of helping victims recover from the trauma associated with these crimes if there is no assurance that the records of the counseling sessions will be kept confidential;

(B) consideration of the appropriateness of an absolute privilege for communications between victims of sexual assault or domestic violence and their therapists or trained counselors, in light of the likelihood that such an absolute privilege will provide the maximum guarantee of confidentiality but also in light of the possibility that such an absolute privilege may be held to violate the rights of criminal defendants under the Federal or State constitutions by denying them the opportunity to obtain exculpatory evidence and present it at trial; and

(C) consideration of what limitations on the disclosure of confidential communications between victims of these crimes and their counselors, short of an absolute privilege, are most likely to ensure that the counseling programs will not be undermined, and specifically whether no such disclosure should be allowed unless, at a minimum, there has been a particularized showing by a criminal defendant of a compelling need for records of such communications, and adequate procedural safeguards are in place to prevent unnecessary or damaging disclosures; and

(3) prepare and disseminate to State authorities the findings made and model legislation developed as a result of the study and evaluation.

(b) REPORT AND RECOMMENDATIONS.—Not later than the date that is 1 year after the date of enactment of this Act, the Attorney General shall report to the Congress—

(1) the findings of the study and the model legislation required by this section; and

(2) recommendations based on the findings on the need for and appropriateness of further action by the Federal Government.

(c) REVIEW OF FEDERAL EVIDENTIARY RULES.—The Judicial Conference of the United States shall evaluate and report to Congress its views on whether the Federal Rules of Evidence should be amended, and if so, how they should be amended, to guarantee that the confidentiality of communications between sexual assault victims and their therapists or trained counselors will be adequately protected in Federal court proceedings.

SEC. 40154. INFORMATION PROGRAMS.

The Attorney General shall compile information regarding sex offender treatment programs and ensure that information regarding community treatment programs in the community into which a convicted sex offender is released is *made available to each person serving a sentence of imprisonment in a Federal penal or correctional institution for a commission of an offense under chapter 109A of title 18, United States Code, or for the commission of a similar offense, including halfway houses and psychiatric institutions.*

SEC. 40155. EDUCATION AND PREVENTION GRANTS TO REDUCE SEXUAL ABUSE OF RUNAWAY, HOMELESS, AND STREET YOUTH.

Part A of the Runaway and Homeless Youth Act (42 U.S.C. 5711 et seq.) is amended—

(1) by redesignating sections 316 and 317 as sections 317 and 318, respectively; and

(2) by inserting after section 315 the following new section:

"GRANTS FOR PREVENTION OF SEXUAL ABUSE AND EXPLOITATION

"SEC. 316. (a) IN GENERAL.—The Secretary shall make grants under this section to private, nonprofit agencies for street-based outreach and education, including treatment, counseling, provision of information, and referral for runaway, homeless, and street youth who have been subjected to or are at risk of being subjected to sexual abuse.

"(b) PRIORITY.—In selecting among applicants for grants under subsection (a), the Secretary shall give priority to agencies that have experience in providing services to runaway, homeless, and street youth.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

"(1) $7,000,000 for fiscal year 1996;

"(2) $8,000,000 for fiscal year 1997; and

"(3) $15,000,000 for fiscal year 1998.

"(d) DEFINITIONS.—For the purposes of this section—

"(1) the term 'street-based outreach and education' includes education and prevention efforts directed at offenses committed by offenders who are not known to the victim as well as offenders who are known to the victim; and

"(2) the term 'street youth' means a juvenile who spends a significant amount of time on the street or in other areas of exposure to encounters that may lead to sexual abuse.".

SEC. 40156. VICTIMS OF CHILD ABUSE PROGRAMS.

(a) COURT-APPOINTED SPECIAL ADVOCATE PROGRAM.—

(1) REAUTHORIZATION.—Section 218(a) of the Victims of Child Abuse Act of 1990 (42 U.S.C. 13014(a)) is amended to read as follows:

"(a) AUTHORIZATION.—There are authorized to be appropriated to carry out this subtitle—

"(1) $6,000,000 for fiscal year 1996;

"(2) $6,000,000 for fiscal year 1997;

"(3) $7,000,000 for fiscal year 1998;

"(4) $9,000,000 for fiscal year 1999; and

"(5) $10,000,000 for fiscal year 2000.".

(2) TECHNICAL AMENDMENT.—Section 216 of the Victims of Child Abuse Act of 1990 (42 U.S.C. 13012) is amended by striking "this chapter" and inserting "this subtitle".

(b) CHILD ABUSE TRAINING PROGRAMS FOR JUDICIAL PERSONNEL AND PRACTITIONERS.—

(1) REAUTHORIZATION.—Section 224(a) of the Victims of Child Abuse Act of 1990 (42 U.S.C. 13024(a)) is amended to read as follows:

"(a) AUTHORIZATION.—There are authorized to be appropriated to carry out this subtitle—

"(1) $750,000 for fiscal year 1996;

"(2) $1,000,000 for fiscal year 1997;

"(3) $2,000,000 for fiscal year 1998;

"(4) $2,000,000 for fiscal year 1999; and

"(5) $2,300,000 for fiscal year 2000.".

(2) TECHNICAL AMENDMENT.—Section 221(b) of the Victims of Child Abuse Act of 1990 (42 U.S.C. 13021(b)) is amended by striking "this chapter" and inserting "this subtitle".

(c) GRANTS FOR TELEVISED TESTIMONY.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 is amended—

(1) by amending section 1001(a)(7) (42 U.S.C. 3793(a)(7)) to read as follows:

"(7) There are authorized to be appropriated to carry out part N—

"(A) $250,000 for fiscal year 1996;

"(B) $1,000,000 for fiscal year 1997;

"(C) $1,000,000 for fiscal year 1998;

"(D) $1,000,000 for fiscal year 1999; and

"(E) $1,000,000 for fiscal year 2000.";

(2) in section 1402 (42 U.S.C. 3796aa-1) by striking "to States, for the use of States and units of local government in the States";

(3) in section 1403 (42 U.S.C. 3796aa-2)—

(A) by inserting "or unit of local government" after "of a State";

(B) by inserting "and" after paragraph (1);

(C) in paragraph (2) by striking the semicolon at the end and inserting a period; and

(D) by striking paragraphs (3) and (4);

(4) in section 1404 (42 U.S.C. 3796aa-3)—

(A) in subsection (a)—

(i) by striking "The Bureau" and all that follows through "determining that" and inserting "An applicant is eligible to receive a grant under this part if—";

(ii) in paragraph (1) by striking "there is in effect in such State" and inserting "the applicant certifies and the Director determines that there is in effect in the State";

(iii) in paragraph (2) by striking "such State law shall meet" and inserting "the applicant certifies and the Director determines that State law meets";

(iv) by inserting "and" after subparagraph (E);

(v) in paragraph (3)—

(I) by inserting "the Director determines that" before "the application"; and

(II) by striking "; and" and inserting a period;

(vi) by striking paragraph (4);

(vii) by striking "Each application" and inserting the following:

"(b) Each application"; and

(viii) by striking "the Bureau" each place it appears and inserting "the Director"; and

(B) by redesignating subsection (b) as subsection (c) and by striking "The Bureau" and inserting "The Director";

(5) by striking section 1405 (42 U.S.C. 3796aa-4);

(6) in section 1406 (42 U.S.C. 3796aa-5)—

(A) in subsection (a)—

(i) by striking "State which" and inserting "State or unit of local government that";

(ii) by striking "title" and inserting "part"; and

(iii) in paragraph (1) by striking "State"; and

(B) in subsection (b)(1) by striking "such State" and inserting "the State and units of local government in the State";

(7) in section 1407 (42 U.S.C. 3796aa-6)—

(A) in subsection (c)—

(i) by striking "Each State" and all that follows through "effective audit" and inserting "Grant recipients (or private organizations with which grant recipients have contracted to provide equipment or training using grant funds) shall keep such records as the Director may require by rule to facilitate such an audit."; and

(ii) in paragraph (2) by striking "States which receive grants, and of units of local government which receive any part of a grant made under this part" and inserting "grant recipients (or private organizations with which grant recipients have contracted to provide equipment or training using grant funds)"; and

(B) by adding at the end the following new subsection:

"(d) UTILIZATION OF PRIVATE SECTOR.—Nothing in this part shall prohibit the utilization of any grant funds to contract with a private organization to provide equipment or training for the televising of testimony as contemplated by the application submitted by an applicant.";

(8) by striking section 1408 (42 U.S.C. 3796aa-7); and

(9) in the table of contents—

(A) in the item relating to section 1405 by striking "Allocation and distribution of funds under formula grants" and inserting "(Repealed)"; and

(B) in the item relating to section 1408 by striking "State office" and inserting "(Repealed)".

Subtitle B—Safe Homes for Women

SEC. 40201. SHORT TITLE.

This title may be cited as the "Safe Homes for Women Act of 1994".

CHAPTER 1—NATIONAL DOMESTIC VIOLENCE HOTLINE

SEC. 40211. GRANT FOR A NATIONAL DOMESTIC VIOLENCE HOTLINE.

The Family Violence Prevention and Services Act (42 U.S.C. 10401 et seq.) is amended by adding at the end the following new section:

"SEC. 316. NATIONAL DOMESTIC VIOLENCE HOTLINE GRANT.

"(a) IN GENERAL.—The Secretary may award a grant to a private, nonprofit entity to provide for the operation of a national, toll-free telephone hotline to provide information and assistance to victims of domestic violence.

"(b) DURATION.—A grant under this section may extend over a period of not more than 5 years.

"(c) ANNUAL APPROVAL.—The provision of payments under a grant under this section shall be subject to annual approval by the Secretary and subject to the availability of appropriations for each fiscal year to make the payments.

"(d) ACTIVITIES.—Funds received by an entity under this section shall be used to establish and operate a national, toll-free telephone hotline to provide information and assistance to victims of domestic violence. In establishing and operating the hotline, a private, nonprofit entity shall—

"(1) contract with a carrier for the use of a toll-free telephone line;

"(2) employ, train, and supervise personnel to answer incoming calls and provide counseling and referral services to callers on a 24-hour-a-day basis;

"(3) assemble and maintain a current database of information relating to services for victims of domestic violence to which callers may be referred throughout the United States, including information on the availability of shelters that serve battered women; and

"(4) publicize the hotline to potential users throughout the United States.

"(e) APPLICATION.—A grant may not be made under this section unless an application for such grant has been approved by the Secretary. To be approved by the Secretary under this subsection an application shall—

"(1) contain such agreements, assurances, and information, be in such form and be submitted in such manner as the Secretary shall prescribe through notice in the Federal Register;

"(2) include a complete description of the applicant's plan for the operation of a national domestic violence hotline, including descriptions of—

"(A) the training program for hotline personnel;

"(B) the hiring criteria for hotline personnel;

"(C) the methods for the creation, maintenance and updating of a resource database;

"(D) a plan for publicizing the availability of the hotline;

"(E) a plan for providing service to non-English speaking callers, including hotline personnel who speak Spanish; and

"(F) a plan for facilitating access to the hotline by persons with hearing impairments;

"(3) demonstrate that the applicant has nationally recognized expertise in the area of domestic violence and a record of high quality

service to victims of domestic violence, including a demonstration of support from advocacy groups, such as domestic violence State coalitions or recognized national domestic violence groups;

"(4) demonstrates that the applicant has a commitment to diversity, and to the provision of services to ethnic, racial, and non-English speaking minorities, in addition to older individuals and individuals with disabilities; and

"(5) contain such other information as the Secretary may require.

"(f) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

"(A) $1,000,000 for fiscal year 1995;

"(B) $400,000 for fiscal year 1996;

"(C) $400,000 for fiscal year 1997;

"(D) $400,000 for fiscal year 1998;

"(E) $400,000 for fiscal year 1999; and

"(F) $400,000 for fiscal year 2000.

"(2) AVAILABILITY.—Funds authorized to be appropriated under paragraph (1) shall remain available until expended.".

CHAPTER 2—INTERSTATE ENFORCEMENT

SEC. 40221. INTERSTATE ENFORCEMENT.

(a) IN GENERAL.—Part 1 of title 18, United States Code, is amended by inserting after chapter 110 the following new chapter:

"CHAPTER 110A—DOMESTIC VIOLENCE

"Sec. 2261. Interstate domestic violence.
"Sec. 2262. Interstate violation of protection order.
"Sec. 2263. Pretrial release of defendant.
"Sec. 2264. Restitution.
"Sec. 2265. Full faith and credit given to protection orders.
"Sec. 2266. Definitions.

"§2261. Interstate domestic violence

"(a) OFFENSES.—

"(1) CROSSING A STATE LINE.—A person who travels across a State line or enters or leaves Indian country with the intent to injure, harass, or intimidate that person's spouse or intimate partner, and who, in the course of or as a result of such travel, intentionally commits a crime of violence and thereby causes bodily injury to such spouse or intimate partner, shall be punished as provided in subsection (b).

"(2) CAUSING THE CROSSING OF A STATE LINE.—A person who causes a spouse or intimate partner to cross a State line or to enter or leave Indian country by force, coercion, duress, or fraud and, in the course or as a result of that conduct, intentionally commits a crime of violence and thereby causes bodily injury to the person's spouse or intimate partner, shall be punished as provided in subsection (b).

"(b) PENALTIES.—A person who violates this section shall be fined under this title, imprisoned—

"(1) for life or any term of years, if death of the offender's spouse or intimate partner results;

"(2) for not more than 20 years if permanent disfigurement or life threatening bodily injury to the offender's spouse or intimate partner results;

"(3) for not more than 10 years, if serious bodily injury to the offender's spouse or intimate partner results or if the offender uses a dangerous weapon during the offense;

"(4) as provided for the applicable conduct under chapter 109A if the offense would constitute an offense under chapter 109A (without regard to whether the offense was committed in the special maritime and territorial jurisdiction of the United States or in a Federal prison); and

"(5) for not more than 5 years, in any other case,

or both fined and imprisoned.

"§2262. Interstate violation of protection order

"(a) OFFENSES.—

"(1) CROSSING A STATE LINE.—A person who travels across a State line or enters or leaves Indian country with the intent to engage in conduct that—

"(A)(i) violates the portion of a protection order that involves protection against credible threats of violence, repeated harassment, or bodily injury to the person or persons for whom the protection order was issued; or

"(ii) would violate subparagraph (A) if the conduct occurred in the jurisdiction in which the order was issued; and

"(B) subsequently engages in such conduct,

shall be punished as provided in subsection (b).

"(2) CAUSING THE CROSSING OF A STATE LINE.—A person who causes a spouse or intimate partner to cross a State line or to enter or leave Indian country by force, coercion, duress, or fraud, and, in the course or as a result of that conduct, intentionally commits an act that injures the person's spouse or intimate partner in violation of a valid protection order issued by a State shall be punished as provided in subsection (b).

"(b) PENALTIES.—A person who violates this section shall be fined under this title, imprisoned—

"(1) for life or any term of years, if death of the offender's spouse or intimate partner results;

"(2) for not more than 20 years if permanent disfigurement or life threatening bodily injury to the offender's spouse or intimate partner results;

"(3) for not more than 10 years, if serious bodily injury to the offender's spouse or intimate partner results or if the offender uses a dangerous weapon during the offense;

"(4) as provided for the applicable conduct under chapter 109A if the offense would constitute an offense under chapter 109A (without regard to whether the offense was committed in the special maritime and territorial jurisdiction of the United States or in a Federal prison); and

"(5) for not more than 5 years, in any other case,

or both fined and imprisoned.

"§2263. Pretrial release of defendant

"In any proceeding pursuant to section 3142 for the purpose of determining whether a defendant charged under this chapter shall be released pending trial, or for the purpose of determining conditions of such release, the alleged victim shall be given an opportunity to be heard regarding the danger posed by the defendant.

"§2264. Restitution

"(a) IN GENERAL.—Notwithstanding section 3663, and in addition to any other civil or criminal penalty authorized by law, the court shall order restitution for any offense under this chapter.

"(b) SCOPE AND NATURE OF ORDER.—

"(1) DIRECTIONS.—The order of restitution under this section shall direct that—

"(A) the defendant pay to the victim (through the appropriate court mechanism) the full amount of the victim's losses as determined by the court, pursuant to paragraph (3); and

"(B) the United States Attorney enforce the restitution order by all available and reasonable means.

"(2) ENFORCEMENT BY VICTIM.—An order of restitution also may be enforced by a victim named in the order to receive the restitution in the same manner as a judgment in a civil action.

"(3) DEFINITION.—For purposes of this subsection, the term 'full amount of the victim's losses' includes any costs incurred by the victim for—

"(A) medical services relating to physical, psychiatric, or psychological care;

"(B) physical and occupational therapy or rehabilitation;

"(C) necessary transportation, temporary housing, and child care expenses;

"(D) lost income;

"(E) attorneys' fees, plus any costs incurred in obtaining a civil protection order; and

"(F) any other losses suffered by the victim as a proximate result of the offense.

"(4) ORDER MANDATORY.—(A) The issuance of a restitution order under this section is mandatory.

"(B) A court may not decline to issue an order under this section because of—

"(i) the economic circumstances of the defendant; or

"(ii) the fact that a victim has, or is entitled to, receive compensation for his or her injuries from the proceeds of insurance or any other source.

"(C)(i) Notwithstanding subparagraph (A), the court may take into account the economic circumstances of the defendant in determining the manner in which and the schedule according to which the restitution is to be paid.

"(ii) For purposes of this subparagraph, the term 'economic circumstances' includes—

"(I) the financial resources and other assets of the defendant;

"(II) projected earnings, earning capacity, and other income of the defendant; and

"(III) any financial obligations of the defendant, including obligations to dependents.

"(D) Subparagraph (A) does not apply if—

"(i) the court finds on the record that the economic circumstances of the defendant do not allow for the payment of any amount of a restitution order, and do not allow for the payment of any or some portion of the amount of a restitution order in the foreseeable future (under any reasonable schedule of payments); and

"(ii) the court enters in its order the amount of the victim's losses, and provides a nominal restitution award.

"(5) MORE THAN 1 OFFENDER.—When the court finds that more than 1 offender has contributed to the loss of a victim, the court may make each offender liable for payment of the full amount of restitution or may apportion liability among the offenders to reflect the level of contribution and economic circumstances of each offender.

"(6) MORE THAN 1 VICTIM.—When the court finds that more than 1 victim has sustained a loss requiring restitution by an offender, the court shall order full restitution of each victim but may provide for different payment schedules to reflect the economic circumstances of each victim.

"(7) PAYMENT SCHEDULE.—An order under this section may direct the defendant to make a single lump-sum payment or partial payments at specified intervals.

"(8) SETOFF.—Any amount paid to a victim under this section shall be set off against any amount later recovered as compensatory damages by the victim from the defendant in—

"(A) any Federal civil proceeding; and

"(B) any State civil proceeding, to the extent provided by the law of the State.

"(9) EFFECT ON OTHER SOURCES OF COMPENSATION.—The issuance of a restitution order shall not affect the entitlement of a victim to receive compensation with respect to a loss from insurance or any other source until the payments actually received by the victim under the restitution order fully compensate the victim for the loss.

"(10) CONDITION OF PROBATION OR SUPERVISED RELEASE.—Compliance with a restitution order issued under this section shall be a condition of any probation or supervised release of a defendant. If an offender fails to comply with a restitution order, the court may, after a hearing, revoke probation or a term of supervised release, modify the terms or conditions of probation or a term of supervised release, or hold the defendant in contempt pursuant to section 3583(e). In determining whether to revoke probation or a term *of supervised release, modify the terms or conditions of probation or supervised release or hold a defendant serving a term of supervised release in contempt, the court shall consider the defendant's employment status, earning ability and financial resources, the willfulness of the defendant's failure to comply, and any other circumstances that may have a bearing on the defendant's ability to comply.*

"(c) AFFIDAVIT.—Within 60 days after conviction and, in any event, not later than 10 days before sentencing, the United States Attorney (or such Attorney's delegate), after consulting with the victim, shall prepare and file an affidavit with the court listing the amounts subject to restitution under this section. The affidavit shall be signed by the United States Attorney (or the delegate) and the victim. Should the victim object to any of the information included in the affidavit, the United States Attorney (or the delegate) shall advise the victim that the victim may file a separate affidavit and assist the victim in the preparation of the affidavit.

"(d) OBJECTION.—If, after the defendant has been notified of the affidavit, no objection is raised by the defendant, the amounts attested to in the affidavit filed pursuant to subsection (a) shall be entered in the court's restitution order. If objection is raised, the court may require the victim or the United States Attorney (or the United States Attorney's delegate) to submit further affidavits or other supporting documents, demonstrating the victim's losses.

"(e) ADDITIONAL DOCUMENTATION AND TESTIMONY.—If the court concludes, after reviewing the supporting documentation and considering the defendant's objections, that there is a substantial reason for doubting the authenticity or veracity of the records submitted, the court may require additional documentation or hear testimony on those questions. The privacy of any records filed, or testimony heard, pursuant to this section, shall be maintained to the greatest extent possible, and such records may be filed or testimony heard in camera.

"(f) FINAL DETERMINATION OF LOSSES.—If the victim's losses are not ascertainable 10 days before sentencing as provided in subsection (c), the United States Attorney (or the United States Attorney's delegate) shall so inform the court, and the court shall set a date for the final determination of the victim's losses, not to exceed 90 days after sentencing. If the victim subsequently discovers further losses, the victim shall have 90 days after discovery of those losses in which to petition the court for an amended restitution order. Such order may be granted only upon a showing of good cause for the failure to include such losses in the initial claim for restitutionary relief.

"(g) RESTITUTION IN ADDITION TO PUNISHMENT.—An award of restitution to the victim of an offense under this chapter is not a substitute for imposition of punishment under this chapter.

"§2265. Full faith and credit given to protection orders

"(a) FULL FAITH AND CREDIT.—Any protection order issued that is consistent with subsection (b) of this section by the court of one State or Indian tribe (the issuing State or Indian tribe) shall be accorded full faith and credit by the court of another State or Indian tribe (the enforcing State or Indian tribe) and enforced as if it were the order of the enforcing State or tribe.

"(b) PROTECTION ORDER.—A protection order issued by a State or tribal court is consistent with this subsection if—

"(1) such court has jurisdiction over the parties and matter under the law of such State or Indian tribe; and

"(2) reasonable notice and opportunity to be heard is given to the person against whom the order is sought sufficient to protect that person's right to due process. In the case of ex parte orders, notice and opportunity to be heard must be provided within the time required by State or tribal law, and in any event within a reasonable time after the order is issued, sufficient to protect the respondent's due process rights.

"(c) CROSS OR COUNTER PETITION.—A protection order issued by a State or tribal court against one who has petitioned, filed a complaint, or otherwise filed a written pleading for protection against abuse by a spouse or intimate partner is not entitled to full faith and credit if—

"(1) no cross or counter petition, complaint, or other written pleading was filed seeking such a protection order; or

"(2) a cross or counter petition has been filed and the court did not make specific findings that each party was entitled to such an order.

"§2266. Definitions

"In this chapter—

"'bodily injury' means any act, except one done in self-defense, that results in physical injury or sexual abuse.

"'Indian country' has the meaning stated in section 1151.

"'protection order' includes any injunction or other order issued for the purpose of preventing violent or threatening acts or harassment against, or contact or communication with or physical proximity to, another person, including temporary and final orders issued by civil and criminal courts (other than support or child custody orders) whether obtained by filing an independent action or as a pendente lite order in another proceeding so long as any civil order was issued in response to a complaint, petition or motion filed by or on behalf of a person seeking protection.

"'spouse or intimate partner' includes—

"(A) a spouse, a former spouse, a person who shares a child in common with the abuser, and a person who cohabits or has cohabited with the abuser as a spouse; and

"(B) any other person similarly situated to a spouse who is protected by the domestic or family violence laws of the State in which the injury occurred or where the victim resides.

"'State' includes a State of the United States, the District of Columbia, a commonwealth, territory, or possession of the United States.

"'travel across State lines' does not include travel across State lines by an individual who is a member of an Indian tribe when such individual remains at all times in the territory of the Indian tribe of which the individual is a member.".

(b) TECHNICAL AMENDMENT.—The part analysis for part I of title 18, United States Code, is amended by inserting after the item for chapter 110 the following new item:

"110A. Domestic violence .... 2261.".

CHAPTER 3—ARREST POLICIES IN DOMESTIC VIOLENCE CASES

SEC. 40231. ENCOURAGING ARREST POLICIES.

(a) IN GENERAL.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 40121(a), is amended—

(1) by redesignating part U as part V;

(2) by redesignating section 2101 as section 2201; and

(3) by inserting after part T the following new part:

"PART U—GRANTS TO ENCOURAGE ARREST POLICIES

"SEC. 2101. GRANTS.

"(a) PURPOSE.—The purpose of this part is to encourage States, Indian tribal governments, and units of local government to treat domestic violence as a serious violation of criminal law.

"(b) GRANT AUTHORITY.—The Attorney General may make grants to eligible States, Indian tribal governments, or units of local government for the following purposes:

"(1) To implement mandatory arrest or proarrest programs and policies in police departments, including mandatory arrest programs and policies for protection order violations.

"(2) To develop policies and training in police departments to improve tracking of cases involving domestic violence.

"(3) To centralize and coordinate police enforcement, prosecution, or judicial responsibility for domestic violence cases in groups or units of police officers, prosecutors, or judges.

"(4) To coordinate computer tracking systems to ensure communication between police, prosecutors, and both criminal and family courts.

"(5) To strengthen legal advocacy service programs for victims of domestic violence.

"(6) To educate judges in criminal and other courts about domestic violence and to improve judicial handling of such cases.

"(c) ELIGIBILITY.—Eligible grantees are States, Indian tribal governments, or units of local government that—

"(1) certify that their laws or official policies—

"(A) encourage or mandate arrests of domestic violence offenders based on probable cause that an offense has been committed; and

"(B) encourage or mandate arrest of domestic violence offenders who violate the terms of a valid and outstanding protection order;

"(2) demonstrate that their laws, policies, or practices and their training programs discourage dual arrests of offender and victim;

"(3) certify that their laws, policies, or practices prohibit issuance of mutual restraining orders of protection except in cases where both spouses file a claim and the court makes detailed findings of fact indicating that both spouses acted primarily as aggressors and that neither spouse acted primarily in self-defense; and

"(4) certify that their laws, policies, or practices do not require, in connection with the prosecution of any misdemeanor or felony domestic violence offense, that the abused bear the costs associated with the filing of criminal charges or the service of such charges on an abuser, or that the abused bear the costs associated with the issuance or service of a warrant, protection order, or witness subpoena.

"SEC. 2102. APPLICATIONS.

"(a) APPLICATION.—An eligible grantee shall submit an application to the Attorney General that—

"(1) contains a certification by the chief executive officer of the State, Indian tribal government, or local government entity that the conditions of section 2101(c) are met or will be met within the later of—

"(A) the period ending on the date on which the next session of the State or Indian tribal legislature ends; or

"(B) 2 years of the date of enactment of this part;

"(2) describes plans to further the purposes stated in section 2101(a);

"(3) identifies the agency or office or groups of agencies or offices responsible for carrying out the program; and

"(4) includes documentation from nonprofit, private sexual assault and domestic violence programs demonstrating their participation in developing the application, and identifying such programs in which such groups will be consulted for development and implementation.

"(b) PRIORITY.—In awarding grants under this part, the Attorney General shall give priority to applicants that—

"(1) do not currently provide for centralized handling of cases involving domestic violence by police, prosecutors, and courts; and

"(2) demonstrate a commitment to strong enforcement of laws, and prosecution of cases, involving domestic violence.

"SEC. 2103. REPORTS.

"Each grantee receiving funds under this part shall submit a report to the Attorney General evaluating the effectiveness of projects developed with funds provided under this part and containing such additional information as the Attorney General may prescribe.

"SEC. 2104. REGULATIONS OR GUIDELINES.

"Not later than 120 days after the date of enactment of this part, the Attorney General shall publish proposed regulations or guidelines implementing this part. Not later than 180 days after the date of enactment of this part, the Attorney General shall publish final regulations or guidelines implementing this part.

"SEC. 2105. DEFINITIONS.

"For purposes of this part—

"(1) the term 'domestic violence' includes felony or misdemeanor crimes of violence committed by a current or former spouse of the victim, by a person with whom the victim shares a child in common, by a person who is cohabitating with or has cohabitated with the victim as a spouse, by a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction receiving grant monies, or by any other adult person against a victim who is protected from that person's acts under the domestic or family violence laws of the eligible State, Indian tribal government, or unit of local government that receives a grant under this part; and

"(2) the term 'protection order' includes any injunction issued for the purpose of preventing violent or threatening acts of domestic violence, including temporary and final orders issued by civil or criminal courts (other than support or child custody orders or provisions) whether obtained by filing an independent action or as a pendente lite order in another proceeding.".

(b) TECHNICAL AMENDMENT.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 40121(b), is amended by striking the matter relating to part U and inserting the following:

"PART U—GRANTS TO ENCOURAGE ARREST POLICIES

"Sec. 2101. Grants.
"Sec. 2102. Applications.
"Sec. 2103. Reports.
"Sec. 2104. Regulations or guidelines.
"Sec. 2105. Definitions.

"PART V—TRANSITION—EFFECTIVE DATE—REPEALER

"Sec. 2201. Continuation of rules, authorities, and proceedings.".

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793), as amended by section 40121(c), is amended—

(1) in paragraph (3) by striking "and T" and inserting "T, and U"; and

(2) by adding at the end the following new paragraph:

"(19) There are authorized to be appropriated to carry out part U—

"(A) $28,000,000 for fiscal year 1996;

"(B) $33,000,000 for fiscal year 1997; and

"(C) $59,000,000 for fiscal year 1998.

(d) ADMINISTRATIVE PROVISIONS.—

(1) REGULATIONS.—Section 801(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3782(b)), is amended by striking "and O" and inserting "O, and U".

(2) DENIAL OF APPLICATION.—Section 802(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3783 (b)) is amended in the first sentence by striking "or O" and inserting "O, or U".

CHAPTER 4—SHELTER GRANTS

SEC. 40241. GRANTS FOR BATTERED WOMEN'S SHELTERS.

Section 310(a) of the Family Violence Prevention and Services Act (42 U.S.C. 10409(a)) is amended to read as follows:

"(a) IN GENERAL.—There are authorized to be appropriated to carry out this title—

"(1) $50,000,000 for fiscal year 1996;

"(2) $60,000,000 for fiscal year 1997;

"(3) $70,000,000 for fiscal year 1998;

"(4) $72,500,000 for fiscal year 1999; and

"(5) $72,500,000 for fiscal year 2000.".

CHAPTER 5—YOUTH EDUCATION

SEC. 40251. YOUTH EDUCATION AND DOMESTIC VIOLENCE.

The Family Violence Prevention and Services Act (42 U.S.C. 10401 et seq.), as amended by section 40211, is amended by adding at the end the following new section:

"SEC. 317. YOUTH EDUCATION AND DOMESTIC VIOLENCE.

"(a) GENERAL PURPOSE.—For purposes of this section, the Secretary may, in consultation with the Secretary of Education, select, implement and evaluate 4 model programs for education of young people about domestic violence and violence among intimate partners.

"(b) NATURE OF PROGRAM.—The Secretary shall select, implement and evaluate separate model programs for 4 different audiences: primary schools, middle schools, secondary schools, and institutions of higher education. The model programs shall be selected, implemented, and evaluated in consultation with educational experts, legal and psychological experts on battering, and victim advocate organizations such as battered women's shelters, State coalitions and resource centers.

"(c) REVIEW AND DISSEMINATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall transmit the design and evaluation of the model programs, along with a plan and cost estimate for nationwide distribution, to the relevant committees of Congress for review.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

"400,000 for fiscal year 1996.

CHAPTER 6—COMMUNITY PROGRAMS ON DOMESTIC VIOLENCE

SEC. 40261. ESTABLISHMENT OF COMMUNITY PROGRAMS ON DOMESTIC VIOLENCE.

The Family Violence Prevention and Services Act (42 U.S.C. 10401 et seq.), as amended by section 40251, is amended by adding at the end the following new section:

"SEC. 318. DEMONSTRATION GRANTS FOR COMMUNITY INITIATIVES.

"(a) IN GENERAL.—The Secretary shall provide grants to nonprofit private organizations to establish projects in local communities involving many sectors of each community to coordinate intervention and prevention of domestic violence.

"(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity—

"(1) shall be a nonprofit organization organized for the purpose of coordinating community projects for the intervention in and prevention of domestic violence; and

"(2) shall include representatives of pertinent sectors of the local community, which may include—

"(A) health care providers;

"(B) the education community;

"(C) the religious community;

"(D) the justice system;

"(E) domestic violence program advocates;

"(F) human service entities such as State child services divisions;

"(G) business and civic leaders; and

"(H) other pertinent sectors.

"(c) APPLICATIONS.—An organization that desires to receive a grant under this section shall submit to the Secretary an application, in such form and in such manner as the Secretary shall prescribe through notice in the Federal Register, that—

"(1) demonstrates that the applicant will serve a community leadership function, bringing together opinion leaders from each sector of the community to develop a coordinated community consensus opposing domestic violence;

"(2) demonstrates a community action component to improve and expand current intervention and prevention strategies through increased communication and coordination among all affected sectors;

"(3) includes a complete description of the applicant's plan for the establishment and operation of the community project, including a description of—

"(A) the method for identification and selection of an administrative committee made up of persons knowledgeable in domestic violence to oversee the project, hire staff, assure compliance with the project outline, and secure annual evaluation of the project;

"(B) the method for identification and selection of project staff and a project evaluator;

"(C) the method for identification and selection of a project council consisting of representatives of the community sectors listed in subsection (b)(2);

"(D) the method for identification and selection of a steering committee consisting of representatives of the various community sectors who will chair subcommittees of the project council focusing on each of the sectors; and

"(E) a plan for developing outreach and public education campaigns regarding domestic violence; and

"(4) contains such other information, agreements, and assurances as the Secretary may require.

"(d) TERM.—A grant provided under this section may extend over a period of not more than 3 fiscal years.

"(e) CONDITIONS ON PAYMENT.—Payments under a grant under this section shall be subject to—

"(1) annual approval by the Secretary; and

"(2) availability of appropriations.

"(f) GEOGRAPHICAL DISPERSION.—The Secretary shall award grants under this section to organizations in communities geographically dispersed throughout the country.

"(g) USE OF GRANT MONIES.—

"(1) IN GENERAL.—A grant made under subsection (a) shall be used to establish and operate a community project to coordinate intervention and prevention of domestic violence.

"(2) REQUIREMENTS.—In establishing and operating a project, a nonprofit private organization shall—

"(A) establish protocols to improve and expand domestic violence intervention and prevention strategies among all affected sectors;

"(B) develop action plans to direct responses within each community sector that are in conjunction with development in all other sectors; and

"(C) provide for periodic evaluation of the project with a written report and analysis to assist application of this concept in other communities.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

"(1) $4,000,000 for fiscal year 1996; and

"(2) $6,000,000 for fiscal year 1997.

"(i) REGULATIONS.—Not later than 60 days after the date of enactment of this section, the Secretary shall publish proposed regulations implementing this section. Not later than 120 days

after the date of enactment, the Secretary shall publish final regulations implementing this section.".

CHAPTER 7—FAMILY VIOLENCE PREVENTION AND SERVICES ACT AMENDMENTS

SEC. 40271. GRANTEE REPORTING.

(a) SUBMISSION OF APPLICATION.—Section 303(a)(2)(C) of the Family Violence Prevention and Services Act (42 U.S.C. 10402(a)(2)(C)) is amended by inserting "and a plan to address the needs of underserved populations, including populations underserved because of ethnic, racial, cultural, language diversity or geographic isolation" after "such State".

(b) APPROVAL OF APPLICATION.—Section 303(a) of the Family Violence Prevention and Services Act (42 U.S.C. 10402(a)) is amended by adding at the end the following new paragraph:

"(4) Upon completion of the activities funded by a grant under this subpart, the State grantee shall file a performance report with the Director explaining the activities carried out together with an assessment of the effectiveness of those activities in achieving the purposes of this subpart. A section of this performance report shall be completed by each grantee or subgrantee that performed the direct services contemplated in the application certifying performance of direct services under the grant. The Director shall suspend funding for an approved application if an applicant fails to submit an annual performance report or if the funds are expended for purposes other than those set forth under this subpart, after following the procedures set forth in paragraph (3). Federal funds may be used only to supplement, not supplant, State funds.".

SEC. 40272. TECHNICAL AMENDMENTS.

(a) DEFINITIONS.—Section 309(5)(B) of the Family Violence Prevention and Services Act (42 U.S.C. 10408(5)(B)) is amended by inserting "or other supportive services" before "by peers individually or in groups,".

(b) SPECIAL ISSUE RESOURCE CENTERS.—

(1) GRANTS.—Section 308(a)(2) of the Family Violence Prevention and Services Act (42 U.S.C. 10407(a)(2)) is amended by striking "six" and inserting "seven".

(2) FUNCTIONS.—Section 308(c) of the Family Violence Prevention and Services Act (42 U.S.C. 10407(c)) is amended—

(A) by striking the period at the end of paragraph (6) and inserting ", including the issuance and enforcement of protection orders."; and

(B) by adding at the end the following new paragraph:

"(7) Providing technical assistance and training to State domestic violence coalitions.".

(c) STATE DOMESTIC VIOLENCE COALITIONS.—Section 311(a) of the Family Violence Prevention and Services Act (42 U.S.C. 10410(a)) is amended—

(1) by redesignating paragraphs (1), (2), (3), and (4) as paragraphs (2), (3), (4), and (5);

(2) by inserting before paragraph (2), as redesignated by paragraph (1), the following new paragraph:

"(1) working with local domestic violence programs and providers of direct services to encourage appropriate responses to domestic violence within the State, including—

"(A) training and technical assistance for local programs and professionals working with victims of domestic violence;

"(B) planning and conducting State needs assessments and planning for comprehensive services;

"(C) serving as an information clearinghouse and resource center for the State; and

"(D) collaborating with other governmental systems which affect battered women;";

(3) in paragraph (2)(K), as redesignated by paragraph (1), by striking "and court officials and other professionals" and inserting ", judges, court officers and other criminal justice professionals,";

(4) in paragraph (3), as redesignated by paragraph (1)—

(A) by inserting ", criminal court judges," after "family law judges," each place it appears;

(B) in subparagraph (F), by inserting "custody" after "temporary"; and

(C) in subparagraph (H), by striking "supervised visitations that do not endanger victims and their children," and inserting "supervised visitations or denial of visitation to protect against danger to victims or their children"; and

(5) in paragraph (4), as redesignated by paragraph (1), by inserting ", including information aimed at underserved racial, ethnic or language-minority populations" before the semicolon.

CHAPTER 8—CONFIDENTIALITY FOR ABUSED PERSONS

SEC. 40281. CONFIDENTIALITY OF ABUSED PERSON'S ADDRESS.

(a) REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the United States Postal Service shall promulgate regulations to secure the confidentiality of domestic violence shelters and abused persons' addresses.

(b) REQUIREMENTS.—The regulations under subsection (a) shall require—

(1) in the case of an individual, the presentation to an appropriate postal official of a valid, outstanding protection order; and

(2) in the case of a domestic violence shelter, the presentation to an appropriate postal authority of proof from a State domestic violence coalition that meets the requirements of section 311 of the Family Violence Prevention and Services Act (42 U.S.C. 10410)) verifying that the organization is a domestic violence shelter.

(c) DISCLOSURE FOR CERTAIN PURPOSES.—The regulations under subsection (a) shall not prohibit the disclosure of addresses to State or Federal agencies for legitimate law enforcement or other governmental purposes.

(d) EXISTING COMPILATIONS.—Compilations of addresses existing at the time at which order is presented to an appropriate postal official shall be excluded from the scope of the regulations under subsection (a).

CHAPTER 9—DATA AND RESEARCH

SEC. 40291. RESEARCH AGENDA.

(a) REQUEST FOR CONTRACT.—The Attorney General shall request the National Academy of Sciences, through its National Research Council, to enter into a contract to develop a research agenda to increase the understanding and control of violence against women, including rape and domestic violence. In furtherance of the contract, the National Academy shall convene a panel of nationally recognized experts on violence against women, in the fields of law, medicine, criminal justice, and direct services to victims and experts on domestic violence in diverse, ethnic, social, and language minority communities and the social sciences. In setting the agenda, the Academy shall focus primarily on preventive, educative, social, and legal strategies, including addressing the needs of underserved populations.

(b) DECLINATION OF REQUEST.—If the National Academy of Sciences declines to conduct the study and develop a research agenda, it shall recommend a nonprofit private entity that is qualified to conduct such a study. In that case, the Attorney General shall carry out subsection (a) through the nonprofit private entity recommended by the Academy. In either case, whether the study is conducted by the National Academy of Sciences or by the nonprofit group it recommends, the funds for the contract shall be made available from sums appropriated for the conduct of research by the National Institute of Justice.

(c) REPORT.—The Attorney General shall ensure that no later than 1 year after the date of enactment of this Act, the study required under subsection (a) is completed and a report describing the findings made is submitted to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives.

SEC. 40292. STATE DATABASES.

(a) IN GENERAL.—The Attorney General shall study and report to the States and to Congress on how the States may collect centralized databases on the incidence of sexual and domestic violence offenses within a State.

(b) CONSULTATION.—In conducting its study, the Attorney General shall consult persons expert in the collection of criminal justice data, State statistical administrators, law enforcement personnel, and nonprofit nongovernmental agencies that provide direct services to victims of domestic violence. The final report shall set forth the views of the persons consulted on the recommendations.

(c) REPORT.—The Attorney General shall ensure that no later than 1 year after the date of enactment of this Act, the study required under subsection (a) is completed and a report describing the findings made is submitted to the Committees on the Judiciary of the Senate and the House of Representatives.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

$200,000 for fiscal year 1996.

SEC. 40293. NUMBER AND COST OF INJURIES.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Centers for Disease Control Injury Control Division, shall conduct a study to obtain a national projection of the incidence of injuries resulting from domestic violence, the cost of injuries to health care facilities, and recommend health care strategies for reducing the incidence and cost of such injuries.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

$100,000 for fiscal year 1996.

CHAPTER 10—RURAL DOMESTIC VIOLENCE AND CHILD ABUSE ENFORCEMENT

SEC. 40295. RURAL DOMESTIC VIOLENCE AND CHILD ABUSE ENFORCEMENT ASSISTANCE.

(a) GRANTS.—The Attorney General may make grants to States, Indian tribal governments, and local governments of rural States, and to other public or private entities of rural States—

(1) to implement, expand, and establish cooperative efforts and projects between law enforcement officers, prosecutors, victim advocacy groups, and other related parties to investigate and prosecute incidents of domestic violence and child abuse;

(2) to provide treatment and counseling to victims of domestic violence and child abuse; and

(3) to work in cooperation with the community to develop education and prevention strategies directed toward such issues.

(b) DEFINITIONS.—In this section—

"Indian tribe" means a tribe, band, pueblo, nation, or other organized group or community of Indians, including an Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"rural State" has the meaning stated in section 1501(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796bb(B)).

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

(A) $7,000,000 for fiscal year 1996;

(B) $8,000,000 for fiscal year 1997;

(C) $15,000,000 for fiscal year 1998;

(2) ADDITIONAL FUNDING.—In addition to funds received under a grant under subsection (a), a law enforcement agency may use funds received under a grant under section 103 to accomplish the objectives of this section.

Subtitle C—Civil Rights for Women

SEC. 40301. SHORT TITLE.

This subtitle may be cited as the "Civil Rights Remedies for Gender-Motivated Violence Act".

SEC. 40302. CIVIL RIGHTS.

(a) PURPOSE.—Pursuant to the affirmative power of Congress to enact this subtitle under section 5 of the Fourteenth Amendment to the Constitution, as well as under section 8 of Article I of the Constitution, it is the purpose of this subtitle to protect the civil rights of victims of gender motivated violence and to promote public safety, health, and activities affecting interstate commerce by establishing a Federal civil rights cause of action for victims of crimes of violence motivated by gender.

(b) RIGHT TO BE FREE FROM CRIMES OF VIOLENCE.—All persons within the United States shall have the right to be free from crimes of violence motivated by gender (as defined in subsection (d)).

(c) CAUSE OF ACTION.—A person (including a person who acts under color of any statute, ordinance, regulation, custom, or usage of any State) who commits a crime of violence motivated by gender and thus deprives another of the right declared in subsection (b) shall be liable to the party injured, in an action for the recovery of compensatory and punitive damages, injunctive and declaratory relief, and such other relief as a court may deem appropriate.

(d) DEFINITIONS.—For purposes of this section—

(1) the term "crime of violence motivated by gender" means a crime of violence committed because of gender or on the basis of gender, and due, at least in part, to an animus based on the victim's gender; and

(2) the term "crime of violence" means—

(A) an act or series of acts that would constitute a felony against the person or that would constitute a felony against property if the conduct presents a serious risk of physical injury to another, and that would come within the meaning of State or Federal offenses described in section 16 of title 18, United States Code, whether or not those acts have actually resulted in criminal charges, prosecution, or conviction and whether or not those acts were committed in the special maritime, territorial, or prison jurisdiction of the United States; and

(B) includes an act or series of acts that would constitute a felony described in subparagraph (A) but for the relationship between the person who takes such action and the individual against whom such action is taken.

(e) LIMITATION AND PROCEDURES.—

(1) LIMITATION.—Nothing in this section entitles a person to a cause of action under subsection (c) for random acts of violence unrelated to gender or for acts that cannot be demonstrated, by a preponderance of the evidence, to be motivated by gender (within the meaning of subsection (d)).

(2) NO PRIOR CRIMINAL ACTION.—Nothing in this section requires a prior criminal complaint, prosecution, or conviction to establish the elements of a cause of action under subsection (c).

(3) CONCURRENT JURISDICTION.—The Federal and State courts shall have concurrent jurisdiction over actions brought pursuant to this subtitle.

(4) SUPPLEMENTAL JURISDICTION.—Neither section 1367 of title 28, United States Code, nor subsection (c) of this section shall be construed, by reason of a claim arising under such subsection, to confer on the courts of the United States jurisdiction over any State law claim seeking the establishment of a divorce, alimony, equitable distribution of marital property, or child custody decree.

(5) LIMITATION ON REMOVAL.—Section 1445 of title 28, United States Code, is amended by adding at the end the following new subsection:

"(d) A civil action in any State court arising under section 40302 of the Violence Against Women Act of 1994 may not be removed to any district court of the United States.".

SEC. 40303. ATTORNEY'S FEES.

Section 722 of the Revised Statutes (42 U.S.C. 1988) is amended in the last sentence—

(1) by striking "or" after "Public Law 92–318,"; and

(2) by inserting ", or section 40302 of the Violence Against Women Act of 1994," after "1964".

SEC. 40304. SENSE OF THE SENATE CONCERNING PROTECTION OF THE PRIVACY OF RAPE VICTIMS.

It is the sense of the Senate that news media, law enforcement officers, and other persons should exercise restraint and respect a rape victim's privacy by not disclosing the victim's identity to the general public or facilitating such disclosure without the consent of the victim.

Subtitle D—Equal Justice for Women in the Courts Act

SEC. 40401. SHORT TITLE.

This subtitle may be cited as the "Equal Justice for Women in the Courts Act of 1994".

CHAPTER 1—EDUCATION AND TRAINING FOR JUDGES AND COURT PERSONNEL IN STATE COURTS

SEC. 40411. GRANTS AUTHORIZED.

The State Justice Institute may award grants for the purpose of developing, testing, presenting, and disseminating model programs to be used by States (as defined in section 202 of the State Justice Institute Act of 1984 (42 U.S.C. 10701)) in training judges and court personnel in the laws of the States and by Indian tribes in training tribal judges and court personnel in the laws of the tribes on rape, sexual assault, domestic violence, and other crimes of violence motivated by the victim's gender.

SEC. 40412. TRAINING PROVIDED BY GRANTS.

Training provided pursuant to grants made under this subtitle may include current information, existing studies, or current data on—

(1) the nature and incidence of rape and sexual assault by strangers and nonstrangers, marital rape, and incest;

(2) the underreporting of rape, sexual assault, and child sexual abuse;

(3) the physical, psychological, and economic impact of rape and sexual assault on the victim, the costs to society, and the implications for sentencing;

(4) the psychology of sex offenders, their high rate of recidivism, and the implications for sentencing;

(5) the historical evolution of laws and attitudes on rape and sexual assault;

(6) sex stereotyping of female and male victims of rape and sexual assault, racial stereotyping of rape victims and defendants, and the impact of such stereotypes on credibility of witnesses, sentencing, and other aspects of the administration of justice;

(7) application of rape shield laws and other limits on introduction of evidence that may subject victims to improper sex stereotyping and harassment in both rape and nonrape cases, including the need for sua sponte judicial intervention in inappropriate cross-examination;

(8) the use of expert witness testimony on rape trauma syndrome, child sexual abuse accommodation syndrome, post-traumatic stress syndrome, and similar issues;

(9) the legitimate reasons why victims of rape, sexual assault, and incest may refuse to testify against a defendant;

(10) the nature and incidence of domestic violence;

(11) the physical, psychological, and economic impact of domestic violence on the victim, the costs to society, and the implications for court procedures and sentencing;

(12) the psychology and self-presentation of batterers and victims and the implications for court proceedings and credibility of witnesses;

(13) sex stereotyping of female and male victims of domestic violence, myths about presence or absence of domestic violence in certain racial, ethnic, religious, or socioeconomic groups, and their impact on the administration of justice;

(14) historical evolution of laws and attitudes on domestic violence;

(15) proper and improper interpretations of the defenses of self-defense and provocation, and the use of expert witness testimony on battered woman syndrome;

(16) the likelihood of retaliation, recidivism, and escalation of violence by batterers, and the potential impact of incarceration and other meaningful sanctions for acts of domestic violence including violations of orders of protection;

(17) economic, psychological, social and institutional reasons for victims' inability to leave the batterer, to report domestic violence or to follow through on complaints, including the influence of lack of support from police, judges, and court personnel, and the legitimate reasons why victims of domestic violence may refuse to testify against a defendant;

(18) the need for orders of protection, and the implications of mutual orders of protection, dual arrest policies, and mediation in domestic violence cases; and

(19) recognition of and response to gender-motivated crimes of violence other than rape, sexual assault and domestic violence, such as mass or serial murder motivated by the gender of the victims.

SEC. 40413. COOPERATION IN DEVELOPING PROGRAMS IN MAKING GRANTS UNDER THIS TITLE.

The State Justice Institute shall ensure that model programs carried out pursuant to grants made under this subtitle are developed with the participation of law enforcement officials, public and private nonprofit victim advocates, legal experts, prosecutors, defense attorneys, and recognized experts on gender bias in the courts.

SEC. 40414. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to carry out this chapter—

$600,000 for fiscal year 1996.

(b) MODEL PROGRAMS.—Of amounts appropriated under this section, the State Justice Institute shall expend not less than 40 percent on model programs regarding domestic violence and not less than 40 percent on model programs regarding rape and sexual assault.

CHAPTER 2—EDUCATION AND TRAINING FOR JUDGES AND COURT PERSONNEL IN FEDERAL COURTS

SEC. 40421. AUTHORIZATIONS OF CIRCUIT STUDIES; EDUCATION AND TRAINING GRANTS.

(a) STUDIES.—In order to gain a better understanding of the nature and the extent of gender bias in the Federal courts, the circuit judicial councils are encouraged to conduct studies of the instances, if any, of gender bias in their respective circuits and to implement recommended reforms.

(b) MATTERS FOR EXAMINATION.—The studies under subsection (a) may include an examination of the effects of gender on—

(1) the treatment of litigants, witnesses, attorneys, jurors, and judges in the courts, including before magistrate and bankruptcy judges;

(2) the interpretation and application of the law, both civil and criminal;

(3) treatment of defendants in criminal cases;

(4) treatment of victims of violent crimes in judicial proceedings;

(5) sentencing;

(6) sentencing alternatives and the nature of supervision of probation and parole;

(7) appointments to committees of the Judicial Conference and the courts;

(8) case management and court sponsored alternative dispute resolution programs;

(9) the selection, retention, promotion, and treatment of employees;

(10) appointment of arbitrators, experts, and special masters;

(11) the admissibility of the victim's past sexual history in civil and criminal cases; and

(12) the aspects of the topics listed in section 40412 that pertain to issues within the jurisdiction of the Federal courts.

(c) CLEARINGHOUSE.—The Administrative Office of the United States Courts shall act as a clearinghouse to disseminate any reports and materials issued by the gender bias task forces under subsection (a) and to respond to requests for such reports and materials. The gender bias task forces shall provide the Administrative Office of the Courts of the United States with their reports and related material.

(d) MODEL PROGRAMS.—The Federal Judicial Center, in carrying out section 620(b)(3) of title 28, United States Code, may—

(1) include in the educational programs it presents and prepares, including the training programs for newly appointed judges, information on issues related to gender bias in the courts including such areas as are listed in subsection (a) along with such other topics as the Federal Judicial Center deems appropriate;

(2) prepare materials necessary to implement this subsection; and

(3) take into consideration the findings and recommendations of the studies conducted pursuant to subsection (a), and to consult with individuals and groups with relevant expertise in gender bias issues as it prepares or revises such materials.

SEC. 40422. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated—

(1) to the Salaries and Expenses Account of the Courts of Appeals, District Courts, and other Judicial Services to carry out section 40421(a)—

$500,000 for fiscal year 1996.

(2) to the Federal Judicial Center to carry out section 40421(d)—

$100,000 for fiscal year 1996.

(3) to the Administrative Office of the United States Courts to carry out section 40421(c)—

$100,000 for fiscal year 1996.

Subtitle E—Violence Against Women Act Improvements

SEC. 40501. PRE-TRIAL DETENTION IN SEX OFFENSE CASES.

Section 3156(a)(4) of title 18, United States Code, is amended—

(1) by striking "or" at the end of subparagraph (A);

(2) by striking the period at the end of subparagraph (B) and inserting "; or"; and

(3) by adding after subparagraph (B) the following new subparagraph:

"(C) any felony under chapter 109A or chapter 110.".

SEC. 40502. INCREASED PENALTIES FOR SEX OFFENSES AGAINST VICTIMS BELOW THE AGE OF 16.

Section 2245(2) of title 18, United States Code, is amended—

(1) by striking "or" at the end of subparagraph (B);

(2) by striking "; and" at the end of subparagraph (C) and inserting "; or"; and

(3) by inserting after subparagraph (C) the following new subparagraph:

"(D) the intentional touching, not through the clothing, of the genitalia of another person who has not attained the age of 16 years with an intent to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person;".

SEC. 40503. PAYMENT OF COST OF TESTING FOR SEXUALLY TRANSMITTED DISEASES.

(a) FOR VICTIMS IN SEX OFFENSE CASES.—Section 503(c)(7) of the Victims' Rights and Restitution Act of 1990 (42 U.S.C. 10607(c)(7)) is amended by adding at the end the following: "The Attorney General shall provide for the payment of the cost of up to 2 anonymous and confidential tests of the victim for sexually transmitted diseases, including HIV, gonorrhea, herpes, chlamydia, and syphilis, during the 12 months following sexual assaults that pose a risk of transmission, and the cost of a counseling session by a medically trained professional on the accuracy of such tests and the risk of transmission of sexually transmitted diseases to the victim as the result of the assault. A victim may waive anonymity and confidentiality of any tests paid for under this section.".

(b) PENALTIES FOR INTENTIONAL TRANSMISSION OF HIV.—Not later than 6 months after the date of enactment of this Act, the United States Sentencing Commission shall conduct a study and prepare and submit to the committees on the Judiciary of the Senate and the House of Representatives a report concerning recommendations for the revision of sentencing guidelines that relate to offenses in which an HIV infected individual engages in sexual activity if the individual knows that he or she is infected with HIV and intends, through such sexual activity, to expose another to HIV.

SEC. 40504. EXTENSION AND STRENGTHENING OF RESTITUTION.

Section 3663(b) of title 18, United States Code, is amended—

(1) in paragraph (2) by inserting "including an offense under chapter 109A or chapter 110" after "an offense resulting in bodily injury to a victim";

(2) by striking "and" at the end of paragraph (3);

(3) by redesignating paragraph (4) as paragraph (5); and

(4) by inserting after paragraph (3) the following new paragraph:

"(4) in any case, reimburse the victim for lost income and necessary child care, transportation, and other expenses related to participation in the investigation or prosecution of the offense or attendance at proceedings related to the offense; and".

SEC. 40505. ENFORCEMENT OF RESTITUTION ORDERS THROUGH SUSPENSION OF FEDERAL BENEFITS.

Section 3663 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(i)(1) A Federal agency shall immediately suspend all Federal benefits provided by the agency to the defendant, and shall terminate the defendant's eligibility for Federal benefits administered by that agency, upon receipt of a certified copy of a written judicial finding that the defendant is delinquent in making restitution in accordance with any schedule of payments or any requirement of immediate payment imposed under this section.

"(2) Any written finding of delinquency described in paragraph (1) shall be made by a court, after a hearing, upon motion of the victim named in the order to receive the restitution or upon motion of the United States.

"(3) A defendant found to be delinquent may subsequently seek a written finding from the court that the defendant has rectified the delinquency or that the defendant has made and will make good faith efforts to rectify the delinquency. The defendant's eligibility for Federal benefits shall be reinstated upon receipt by the agency of a certified copy of such a finding.

"(4) In this subsection, "Federal benefit" means a grant, contract, loan, professional license, or commercial license provided by an agency of the United States.".

SEC. 40506. NATIONAL BASELINE STUDY ON CAMPUS SEXUAL ASSAULT.

(a) STUDY.—The Attorney General, in consultation with the Secretary of Education, shall provide for a national baseline study to examine the scope of the problem of campus sexual assaults and the effectiveness of institutional and legal policies in addressing such crimes and protecting victims. The Attorney General may utilize the Bureau of Justice Statistics, the National Institute of Justice, and the Office for Victims of Crime in carrying out this section.

(b) REPORT.—Based on the study required by subsection (a) and data collected under the Student Right-To-Know and Campus Security Act (20 U.S.C. 1001 note; Public Law 101-542) and amendments made by that Act, the Attorney General shall prepare a report including an analysis of—

(1) the number of reported allegations and estimated number of unreported allegations of campus sexual assaults, and to whom the allegations are reported (including authorities of the educational institution, sexual assault victim service entities, and local criminal authorities);

(2) the number of campus sexual assault allegations reported to authorities of educational institutions which are reported to criminal authorities;

(3) the number of campus sexual assault allegations that result in criminal prosecution in comparison with the number of non-campus sexual assault allegations that result in criminal prosecution;

(4) Federal and State laws or regulations pertaining specifically to campus sexual assaults;

(5) the adequacy of policies and practices of educational institutions in addressing campus sexual assaults and protecting victims, including consideration of—

(A) the security measures in effect at educational institutions, such as utilization of campus police and security guards, control over access to grounds and buildings, supervision of student activities and student living arrangements, control over the consumption of alcohol by students, lighting, and the availability of escort services;

(B) the articulation and communication to students of the institution's policies concerning sexual assaults;

(C) policies and practices that may prevent or discourage the reporting of campus sexual assaults to local criminal authorities, or that may otherwise obstruct justice or interfere with the prosecution of perpetrators of campus sexual assaults;

(D) the nature and availability of victim services for victims of campus sexual assaults;

(E) the ability of educational institutions' disciplinary processes to address allegations of sexual assault adequately and fairly;

(F) measures that are taken to ensure that victims are free of unwanted contact with alleged assailants, and disciplinary sanctions that are imposed when a sexual assault is determined to have occurred; and

(G) the grounds on which educational institutions are subject to lawsuits based on campus sexual assaults, the resolution of these cases, and measures that can be taken to avoid the likelihood of lawsuits and civil liability;

(6) in conjunction with the report produced by the Department of Education in coordination with institutions of education under the Student Right-To-Know and Campus Security Act (20 U.S.C. 1001 note; Public Law 101–542) and amendments made by that Act, an assessment of the policies and practices of educational institutions that are of greatest effectiveness in addressing campus sexual assaults and protecting victims, including policies and practices relating to the particular issues described in paragraph (5); and

(7) any recommendations the Attorney General may have for reforms to address campus sexual assaults and protect victims more effectively, and any other matters that the Attorney General deems relevant to the subject of the study and report required by this section.

(c) SUBMISSION OF REPORT.—The report required by subsection (b) shall be submitted to the Congress no later than September 1, 1996.

(d) DEFINITION.—For purposes of this section, "campus sexual assaults" includes sexual assaults occurring at institutions of postsecondary education and sexual assaults committed against or by students or employees of such institutions.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out the study required by this section—$200,000 for fiscal year 1996.

SEC. 40507. REPORT ON BATTERED WOMEN'S SYNDROME.

(a) REPORT.—Not less than 1 year after the date of enactment of this Act, the Attorney General and the Secretary of Health and Human Services shall transmit to the House Committee on Energy and Commerce, the Senate Committee on Labor and Human Resources, and the Committees on the Judiciary of the Senate and the House of Representatives a report on the medical and psychological basis of "battered women's syndrome" and on the extent to which evidence of the syndrome has been considered in criminal trials.

(b) COMPONENTS.—The report under subsection (a) shall include—

(1) medical and psychological testimony on the validity of battered women's syndrome as a psychological condition;

(2) a compilation of State, tribal, and Federal court cases in which evidence of battered women's syndrome was offered in criminal trials; and

(3) an assessment by State, tribal, and Federal judges, prosecutors, and defense attorneys of the effects that evidence of battered women's syndrome may have in criminal trials.

SEC. 40508. REPORT ON CONFIDENTIALITY OF ADDRESSES FOR VICTIMS OF DOMESTIC VIOLENCE.

(a) REPORT.—The Attorney General shall conduct a study of the means by which abusive spouses may obtain information concerning the addresses or locations of estranged or former spouses, notwithstanding the desire of the victims to have such information withheld to avoid further exposure to abuse. Based on the study, the Attorney General shall transmit a report to Congress including—

(1) the findings of the study concerning the means by which information concerning the addresses or locations of abused spouses may be obtained by abusers; and

(2) analysis of the feasibility of creating effective means of protecting the confidentiality of information concerning the addresses and locations of abused spouses to protect such persons from exposure to further abuse while preserving access to such information for legitimate purposes.

(b) USE OF COMPONENTS.—The Attorney General may use the National Institute of Justice and the Office for Victims of Crime in carrying out this section.

SEC. 40509. REPORT ON RECORDKEEPING RELATING TO DOMESTIC VIOLENCE.

Not later than 1 year after the date of enactment of this Act, the Attorney General shall complete a study of, and shall submit to Congress a report and recommendations on, problems of recordkeeping of criminal complaints involving domestic violence. The study and report shall examine—

(1) the efforts that have been made by the Department of Justice, including the Federal Bureau of Investigation, to collect statistics on domestic violence; and

(2) the feasibility of requiring that the relationship between an offender and victim be reported in Federal records of crimes of aggravated assault, rape, and other violent crimes.

Subtitle F—National Stalker and Domestic Violence Reduction

SEC. 40601. AUTHORIZING ACCESS TO FEDERAL CRIMINAL INFORMATION DATABASES.

(a) ACCESS AND ENTRY.—Section 534 of title 28, United States Code, is amended by adding at the end the following:

"(e)(1) Information from national crime information databases consisting of identification records, criminal history records, protection orders, and wanted person records may be disseminated to civil or criminal courts for use in domestic violence or stalking cases. Nothing in this subsection shall be construed to permit access to such records for any other purpose.

"(2) Federal and State criminal justice agencies authorized to enter information into criminal information databases may include—

"(A) arrests, convictions, and arrest warrants for stalking or domestic violence or for violations of protection orders for the protection of parties from stalking or domestic violence; and

"(B) protection orders for the protection of persons from stalking or domestic violence, provided such orders are subject to periodic verification.

"(3) As used in this subsection—

"(A) the term 'national crime information databases' means the National Crime Information Center and its incorporated criminal history databases, including the Interstate Identification Index; and

"(B) the term 'protection order' includes an injunction or any other order issued for the purpose of preventing violent or threatening acts or harassment against, or contact or communication with or physical proximity to, another person, including temporary and final orders issued by civil or criminal courts (other than support or child custody orders) whether obtained by filing an independent action or as a pendente lite order in another proceeding so long as any civil order was issued in response to a complaint, petition, or motion filed by or on behalf of a person seeking protection.".

(b) RULEMAKING.—The Attorney General may make rules to carry out the subsection added to section 534 of title 28, United States Code, by subsection (a), after consultation with the officials charged with managing the National Crime Information Center and the Criminal Justice Information Services Advisory Policy Board.

SEC. 40602. GRANT PROGRAM.

(a) IN GENERAL.—The Attorney General is authorized to provide grants to States and units of local government to improve processes for entering data regarding stalking and domestic violence into local, State, and national crime information databases.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State or unit of local government shall certify that it has or intends to establish a program that enters into the National Crime Information Center records of—

(1) warrants for the arrest of persons violating protection orders intended to protect victims from stalking or domestic violence;

(2) arrests or convictions of persons violating protection or domestic violence; and

(3) protection orders for the protection of persons from stalking or domestic violence.

SEC. 40603. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle—

(1) $1,500,000 for fiscal year 1996;

(2) $1,750,000 for fiscal year 1997; and

(3) $2,750,000 for fiscal year 1998.

SEC. 40604. APPLICATION REQUIREMENTS.

An application for a grant under this subtitle shall be submitted in such form and manner, and contain such information, as the Attorney General may prescribe. In addition, applications shall include documentation showing—

(1) the need for grant funds and that State or local funding, as the case may be, does not already cover these operations;

(2) intended use of the grant funds, including a plan of action to increase record input; and

(3) an estimate of expected results from the use of the grant funds.

SEC. 40605. DISBURSEMENT.

Not later than 90 days after the receipt of an application under this subtitle, the Attorney General shall either provide grant funds or shall inform the applicant why grant funds are not being provided.

SEC. 40606. TECHNICAL ASSISTANCE, TRAINING, AND EVALUATIONS.

The Attorney General may provide technical assistance and training in furtherance of the purposes of this subtitle, and may provide for the evaluation of programs that receive funds under this subtitle, in addition to any evaluation requirements that the Attorney General may prescribe for grantees. The technical assistance, training, and evaluations authorized by this section may be carried out directly by the Attorney General, or through contracts or other arrangements with other entities.

SEC. 40607. TRAINING PROGRAMS FOR JUDGES.

The State Justice Institute, after consultation with nationally recognized nonprofit organizations with expertise in stalking and domestic violence cases, shall conduct training programs for State (as defined in section 202 of the State Justice Institute Authorization Act of 1984 (42 U.S.C. 10701)) and Indian tribal judges to ensure that a judge issuing an order in a stalking or domestic violence case has all available criminal history and other information, whether from State or Federal sources.

SEC. 40608. RECOMMENDATIONS ON INTRASTATE COMMUNICATION.

The State Justice Institute, after consultation with nationally recognized nonprofit associations with expertise in data sharing among criminal justice agencies and familiarity with the issues raised in stalking and domestic violence cases, shall recommend proposals regarding how State courts may increase intrastate communication between civil and criminal courts.

SEC. 40609. INCLUSION IN NATIONAL INCIDENT-BASED REPORTING SYSTEM.

Not later than 2 years after the date of enactment of this Act, the Attorney General, in accordance with the States, shall compile data regarding domestic violence and intimidation (including stalking) as part of the National Incident-Based Reporting System (NIBRS).

SEC. 40610. REPORT TO CONGRESS.

The Attorney General shall submit to the Congress an annual report, beginning one year after the date of the enactment of this Act, that provides information concerning the incidence of stalking and domestic violence, and evaluates the effectiveness of State antistalking efforts and legislation.

SEC. 40611. DEFINITIONS.

As used in this subtitle—

(1) the term "national crime information databases" refers to the National Crime Information Center and its incorporated criminal history databases, including the Interstate Identification Index; and

(2) the term "protection order" includes an injunction or any other order issued for the purpose of preventing violent or threatening acts or harassment against, or contact or communication with or physical proximity to, another person, including temporary and final orders issued by civil or criminal courts (other than support or child custody orders) whether obtained by filing an independent action or as a pendente lite order in another proceeding so long as any civil order was issued in response to a complaint, petition, or motion filed by or on behalf of a person seeking protection.

Subtitle G—Protections for Battered Immigrant Women and Children

SEC. 40701. ALIEN PETITIONING RIGHTS FOR IMMEDIATE RELATIVE OR SECOND PREFERENCE STATUS.

(a) IN GENERAL.—Section 204(a)(1) of the Immigration and Nationality Act (8 U.S.C. 1154(a)(1)) is amended—

(1) in subparagraph (A)—

(A) by inserting "(i)" after "(A)",

(B) by redesignating the second sentence as clause (ii), and

(C) by adding at the end the following new clauses:

"(iii) An alien who is the spouse of a citizen of the United States, who is a person of good moral character, who is eligible to be classified as an immediate relative under section 201(b)(2)(A)(i), and who has resided in the United States with the alien's spouse may file a petition with the Attorney General under this subparagraph for classification of the alien (and any child of the alien if such a child has not been classified under clause (iv)) under such section if the alien demonstrates to the Attorney General that—

"(I) the alien is residing in the United States, the marriage between the alien and the spouse was entered into in good faith by the alien, and during the marriage the alien or a child of the alien has been battered by or has been the subject of extreme cruelty perpetrated by the alien's spouse; and

"(II) the alien is a person whose deportation, in the opinion of the Attorney General, would result in extreme hardship to the alien or a child of the alien.

"(iv) An alien who is the child of a citizen of the United States, who is a person of good moral character, who is eligible to be classified as an immediate relative under section 201(b)(2)(A)(i), and who has resided in the United States with the citizen parent may file a petition with the Attorney General under this subparagraph for classification of the alien under such section if the alien demonstrates to the Attorney General that—

"(I) the alien is residing in the United States and during the period of residence with the citizen parent the alien has been battered by or has been the subject of extreme cruelty perpetrated by the alien's citizen parent; and

"(II) the alien is a person whose deportation, in the opinion of the Attorney General, would result in extreme hardship to the alien.";

(2) in subparagraph (B)—

(A) by inserting "(i)" after "(B)"; and

(B) by adding at the end the following new clauses:

"(ii) An alien who is the spouse of an alien lawfully admitted for permanent residence, who is a person of good moral character, who is eligible for classification under section 203(a)(2)(A), and who has resided in the United States with the alien's legal permanent resident spouse may file a petition with the Attorney General under this subparagraph for classification of the alien (and any child of the alien if such a child has not been classified under clause (iii)) under such section if the alien demonstrates to the Attorney General that the conditions described in subclauses (I) and (II) of subparagraph (A)(iii) are met with respect to the alien.

"(iii) An alien who is the child of an alien lawfully admitted for permanent residence, who is a person of good moral character, who is eligible for classification under section 203(a)(2)(A), and who has resided in the United States with the alien's permanent resident alien parent may file a petition with the Attorney General under this subparagraph for classification of the alien under such section if the alien demonstrates to the Attorney General that—

"(I) the alien is residing in the United States and during the period of residence with the permanent resident parent the alien has been battered by or has been the subject of extreme cruelty perpetrated by the alien's permanent resident parent; and

"(II) the alien is a person whose deportation, in the opinion of the Attorney General, would result in extreme hardship to the alien."; and

(3) by adding at the end the following new subparagraph:

"(H) In acting on petitions filed under clause (iii) or (iv) of subparagraph (A) or clause (ii) or (iii) of subparagraph (B), the Attorney General shall consider any credible evidence relevant to the petition. The determination of what evidence is credible and the weight to be given that evidence shall be within the sole discretion of the Attorney General.".

(b) CONFORMING AMENDMENTS.—(1) Section 204(a)(2) of the Immigration and Nationality Act (8 U.S.C. 1154(a)(2)) is amended—

(A) in subparagraph (A) by striking "filed by an alien who," and inserting "for the classification of the spouse of an alien if the alien,"; and

(B) in subparagraph (B) by striking "by an alien whose prior marriage" and inserting "for the classification of the spouse of an alien if the prior marriage of the alien".

(2) Section 201(b)(2)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1151(b)(2)(A)(i)) is amended by striking "204(a)(1)(A)" and inserting "204(a)(1)(A)(ii)".

(c) SURVIVAL RIGHTS TO PETITION.—Section 204 of the Immigration and Nationality Act (8 U.S.C. 1154) is amended by adding at the end the following new subsection:

"(h) The legal termination of a marriage may not be the sole basis for revocation under section 205 of a petition filed under subsection (a)(1)(A)(iii) or a petition filed under subsection (a)(1)(B)(ii) pursuant to conditions described in subsection (a)(1)(A)(iii)(I).".

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1995.

SEC. 40702. USE OF CREDIBLE EVIDENCE IN SPOUSAL WAIVER APPLICATIONS.

(a) IN GENERAL.—Section 216(c)(4) of the Immigration and nationality Act (8 U.S.c. 1186a(c)(4)) is amended by inserting after the second sentence the following: "In acting on applications under this paragraph, the Attorney General shall consider any credible evidence relevant to the application. The determination of what evidence is credible and the weight to be given that evidence shall be within the sole discretion of the Attorney General.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to applications made before, on, or after such date.

SEC. 40703. SUSPENSION OF DEPORTATION.

(a) BATTERED SPOUSE OR CHILD.—Section 244(a) of the Immigration and Nationality Act (8 U.S.C. 1254(a)) is amended—

(1) by striking "or" at the end of paragraph (1);

(2) by striking the period at the end of paragraph (2) and inserting "; or"; and

(3) by inserting after paragraph (2) the following:

"(3) is deportable under any law of the United States except section 241(a)(1)(G) and the provisions specified in paragraph (2); has been physically present in the United States for a continuous period of not less than 3 years immediately preceding the date of such application; has been battered or subjected to extreme cruelty in the United States by a spouse or parent who is a United States citizen or lawful permanent resident (or is the parent of a child of a United States citizen or lawful permanent resident and the child has been battered or subjected to extreme cruelty in the United States by such citizen or permanent resident parent); and proves that during all of such time in the United States the alien was and is a person of good moral character; and is a person whose deportation would, in the opinion of the Attorney General, result in extreme hardship to the alien or the alien's parent or child.".

(b) CONSIDERATION OF EVIDENCE.—Section 244 of the Immigration and Nationality Act (8 U.S.C. 1254) is amended by adding at the end the following new subsection:

"(g) In acting on applications under subsection (a)(3), the Attorney General shall consider any credible evidence relevant to the application. The determination of what evidence is credible and the weight to be given that evidence shall be within the sole discretion of the Attorney General.".

TITLE V—DRUG COURTS

SEC. 50001. DRUG COURTS.

(a) IN GENERAL.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 40231(a), is amended—

(1) by redesignating part V as part W;

(2) by redesignating section 2201 as section 2301; and

(3) by inserting after part U the following new part:

"PART V—DRUG COURTS

"SEC. 2201. GRANT AUTHORITY.

"The Attorney General may make grants to States, State courts, local courts, units of local government, and Indian tribal governments, acting directly or through agreements with other public or private entities, for programs that involve—

"(1) continuing judicial supervision over offenders with substance abuse problems who are not violent offenders; and

"(2) the integrated administration of other sanctions and services, which shall include—

"(A) mandatory periodic testing for the use of controlled substances or other addictive substances during any period of supervised release or probation for each participant;

"(B) substance abuse treatment for each participant;

"(C) diversion, probation, or other supervised release involving the possibility of prosecution, confinement, or incarceration based on noncompliance with program requirements or failure to show satisfactory progress; and

"(D) programmatic, offender management, and aftercare services such as relapse prevention, health care, education, vocational training, job placement, housing placement, and child care or other family support services for each participant who requires such services.

"SEC. 2202. PROHIBITION OF PARTICIPATION BY VIOLENT OFFENDERS.

"The Attorney General shall—

"(1) issue regulations and guidelines to ensure that the programs authorized in this part do not permit participation by violent offenders; and

"(2) immediately suspend funding for any grant under this part, pending compliance, if *the Attorney General finds that violent offenders are participating in any program funded under this part.*

"SEC. 2203. DEFINITION.

"In this part, 'violent offender' means a person who—

"(1) is charged with or convicted of an offense, during the course of which offense or conduct—

"(A) the person carried, possessed, or used a firearm or dangerous weapon;

"(B) there occurred the death of or serious bodily injury to any person; or

"(C) there occurred the use of force against the person of another,

without regard to whether any of the circumstances described in subparagraph (A), (B), or (C) is an element of the offense or conduct of which or for which the person is charged or convicted; or

"(2) has one or more prior convictions for a felony crime of violence involving the use or attempted use of force against a person with the intent to cause death or serious bodily harm.

"SEC. 2204. ADMINISTRATION.

"(a) CONSULTATION.—The Attorney General shall consult with the Secretary of Health and Human Services and any other appropriate officials in carrying out this part.

"(b) USE OF COMPONENTS.—The Attorney General may utilize any component or components of the Department of Justice in carrying out this part.

"(c) REGULATORY AUTHORITY.—The Attorney General may issue regulations and guidelines necessary to carry out this part.

"(d) APPLICATIONS.—In addition to any other requirements that may be specified by the Attorney General, an application for a grant under this part shall—

"(1) include a long-term strategy and detailed implementation plan;

"(2) explain the applicant's inability to fund the program adequately without Federal assistance;

"(3) certify that the Federal support provided will be used to supplement, and not supplant, State, Indian tribal, and local sources of funding that would otherwise be available;

"(4) identify related governmental or community initiatives which complement or will be coordinated with the proposal;

"(5) certify that there has been appropriate consultation with all affected agencies and that there will be appropriate coordination with all affected agencies in the implementation of the program;

"(6) certify that participating offenders will be supervised by one or more designated judges with responsibility for the drug court program;

"(7) specify plans for obtaining necessary support and continuing the proposed program following the conclusion of Federal support; and

"(8) describe the methodology that will be used in evaluating the program.

"SEC. 2205. APPLICATIONS.

"To request funds under this part, the chief executive or the chief justice of a State or the chief executive or chief judge of a unit of local government or Indian tribal government shall submit an application to the Attorney General in such form and containing such information as the Attorney General may reasonably require.

"SEC. 2206. FEDERAL SHARE.

"The Federal share of a grant made under this part may not exceed 75 percent of the total costs of the program described in the application submitted under section 2205 for the fiscal year for which the program receives assistance under this part, unless the Attorney General waives, wholly or in part, the requirement of a matching contribution under this section. In-kind contributions may constitute a portion of the non-Federal share of a grant.

"SEC. 2207. GEOGRAPHIC DISTRIBUTION.

"The Attorney General shall ensure that, to the extent practicable, an equitable geographic distribution of grant awards is made.

"SEC. 2208. REPORT.

"A State, Indian tribal government, or unit of local government that receives funds under this part during a fiscal year shall submit to the Attorney General a report in March of the following year regarding the effectiveness of this part.

"SEC. 2209. TECHNICAL ASSISTANCE, TRAINING, AND EVALUATION.

"(a) TECHNICAL ASSISTANCE AND TRAINING.—The Attorney General may provide technical assistance and training in furtherance of the purposes of this part.

"(b) EVALUATIONS.—In addition to any evaluation requirements that may be prescribed for grantees, the Attorney General may carry out or make arrangements for evaluations of programs that receive support under this part.

"(c) ADMINISTRATION.—The technical assistance, training, and evaluations authorized by this section may be carried out directly by the Attorney General, in collaboration with the Secretary of Health and Human Services, or through grants, contracts, or other cooperative arrangements with other entities.".

(b) TECHNICAL AMENDMENT.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 40231(b), is amended by striking the matter relating to part V and inserting the following:

"PART V—DRUG COURTS

"Sec. 2201. Grant authority.
"Sec. 2202. Prohibition of participation by violent offenders.
"Sec. 2203. Definition.
"Sec. 2204. Administration.
"Sec. 2205. Applications.
"Sec. 2206. Federal share.
"Sec. 2207. Geographic distribution.
"Sec. 2208. Report.
"Sec. 2209. Technical assistance, training, and evaluation.

"PART W—TRANSITION-EFFECTIVE DATE-REPEALER

"Sec. 2301. Continuation of rules, authorities, and proceedings.".

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793), as amended by section 40231(c), is amended—

(1) in paragraph (3) by striking "and U" and inserting "U, and V"; and

(2) by adding at the end the following new paragraph:

"(20) There are authorized to be appropriated to carry out part V—

"(1) $100,000,000 for fiscal year 1995;
"(2) $150,000,000 for fiscal year 1996;
"(3) $200,000,000 for fiscal year 1997;
"(4) $250,000,000 for fiscal year 1998;
"(5) $300,000,000 for fiscal year 1999; and
"(6) $300,000,000 for fiscal year 2000.".

SEC. 50002. STUDY BY THE GENERAL ACCOUNTING OFFICE.

(a) IN GENERAL.—The Comptroller General of the United States shall study and assess the effectiveness and impact of grants authorized by part V of title I of the Omnibus Crime Control and Safe Streets Act of 1968 as added by section 50001(a), and report to Congress the results of the study on or before January 1, 1997.

(b) DOCUMENTS AND INFORMATION.—The Attorney General and grant recipients shall provide the Comptroller General with all relevant documents and information that the Comptroller General deems necessary to conduct the study under subsection (a), including the identities and criminal records of program participants.

(c) CRITERIA.—In assessing the effectiveness of the grants made under programs authorized by part V of the Omnibus Crime Control and Safe Streets Act of 1968, the Comptroller General shall consider, among other things—

(1) recidivism rates of program participants;

(2) completion rates among program participants;

(3) drug use by program participants; and

(4) the costs of the program to the criminal justice system.

TITLE VI—DEATH PENALTY

SEC. 60001. SHORT TITLE.

This title may be cited as the "Federal Death Penalty Act of 1994".

SEC. 60002. CONSTITUTIONAL PROCEDURES FOR THE IMPOSITION OF THE SENTENCE OF DEATH.

(a) IN GENERAL.—Part II of title 18, United States Code, is amended by inserting after chapter 227 the following new chapter:

"CHAPTER 228—DEATH SENTENCE

"Sec.
"3591. Sentence of death.
"3592. Mitigating and aggravating factors to be considered in determining whether a sentence of death is justified.
"3593. Special hearing to determine whether a sentence of death is justified.
"3594. Imposition of a sentence of death.
"3595. Review of a sentence of death.
"3596. Implementation of a sentence of death.
"3597. Use of State facilities.
"3598. Special provisions for Indian country.

"§3591. Sentence of death

"(a) A defendant who has been found guilty of—

"(1) an offense described in section 794 or section 2381; or

"(2) any other offense for which a sentence of death is provided, if the defendant, as determined beyond a reasonable doubt at the hearing under section 3593—

"(A) intentionally killed the victim;

"(B) intentionally inflicted serious bodily injury that resulted in the death of the victim;

"(C) intentionally participated in an act, contemplating that the life of a person would be taken or intending that lethal force would be used in connection with a person, other than one of the participants in the offense, and the victim died as a direct result of the act; or

"(D) intentionally and specifically engaged in an act of violence, knowing that the act created a grave risk of death to a person, other than one of the participants in the offense, such that participation in the act constituted a reckless disregard for human life and the victim died as a direct result of the act,

shall be sentenced to death if, after consideration of the factors set forth in section 3592 in the course of a hearing held pursuant to section 3593, it is determined that imposition of a sentence of death is justified, except that no person may be sentenced to death who was less than 18 years of age at the time of the offense.

"(b) A defendant who has been found guilty of—

"(1) an offense referred to in section 408(c)(1) of the Controlled Substances Act (21 U.S.C. 848(c)(1)), committed as part of a continuing criminal enterprise offense under the conditions described in subsection (b) of that section which involved not less than twice the quantity of controlled substance described in subsection (b)(2)(A) or twice the gross receipts described in subsection (b)(2)(B); or

"(2) an offense referred to in section 408(c)(1) of the Controlled Substances Act (21 U.S.C. 848(c)(1)), committed as part of a continuing criminal enterprise offense under that section,

where the defendant is a principal administrator, organizer, or leader of such an enterprise, and the defendant, in order to obstruct the investigation or prosecution of the enterprise or an offense involved in the enterprise, attempts to kill or knowingly directs, advises, authorizes, or assists another to attempt to kill any public officer, juror, witness, or members of the family or household of such a person,

shall be sentenced to death if, after consideration of the factors set forth in section 3592 in the course of a hearing held pursuant to section 3593, it is determined that imposition of a sentence of death is justified, except that no person may be sentenced to death who was less than 18 years of age at the time of the offense.

"§3592. Mitigating and aggravating factors to be considered in determining whether a sentence of death is justified

"(a) MITIGATING FACTORS.—In determining whether a sentence of death is to be imposed on a defendant, the finder of fact shall consider any mitigating factor, including the following:

"(1) IMPAIRED CAPACITY.—The defendant's capacity to appreciate the wrongfulness of the defendant's conduct or to conform conduct to the requirements of law was significantly impaired, regardless of whether the capacity was so impaired as to constitute a defense to the charge.

"(2) DURESS.—The defendant was under unusual and substantial duress, regardless of whether the duress was of such a degree as to constitute a defense to the charge.

"(3) MINOR PARTICIPATION.—The defendant is punishable as a principal in the offense, which was committed by another, but the defendant's participation was relatively minor, regardless of whether the participation was so minor as to constitute a defense to the charge.

"(4) EQUALLY CULPABLE DEFENDANTS.—Another defendant or defendants, equally culpable in the crime, will not be punished by death.

"(5) NO PRIOR CRIMINAL RECORD.—The defendant did not have a significant prior history of other criminal conduct.

"(6) DISTURBANCE.—The defendant committed the offense under severe mental or emotional disturbance.

"(7) VICTIM'S CONSENT.—The victim consented to the criminal conduct that resulted in the victim's death.

"(8) OTHER FACTORS.—Other factors in the defendant's background, record, or character or any other circumstance of the offense that mitigate against imposition of the death sentence.

"(b) AGGRAVATING FACTORS FOR ESPIONAGE AND TREASON.—In determining whether a sentence of death is justified for an offense described in section 3591(a)(1), the jury, or if there is no jury, the court, shall consider each of the following aggravating factors for which notice has been given and determine which, if any, exist:

"(1) PRIOR ESPIONAGE OR TREASON OFFENSE.—The defendant has previously been convicted of another offense involving espionage or treason for which a sentence of either life imprisonment or death was authorized by law.

"(2) GRAVE RISK TO NATIONAL SECURITY.—In the commission of the offense the defendant knowingly created a grave risk of substantial danger to the national security.

"(3) GRAVE RISK OF DEATH.—In the commission of the offense the defendant knowingly created a grave risk of death to another person.

The jury, or if there is no jury, the court, may consider whether any other aggravating factor for which notice has been given exists.

"(c) AGGRAVATING FACTORS FOR HOMICIDE.—In determining whether a sentence of death is justified for an offense described in section 3591(a)(2), the jury, or if there is no jury, the court, shall consider each of the following aggravating factors for which notice has been given and determine which, if any, exist:

"(1) DEATH DURING COMMISSION OF ANOTHER CRIME.—The death, or injury resulting in death, occurred during the commission or attempted commission of, or during the immediate flight from the commission of, an offense under section 32 (destruction of aircraft or aircraft facilities), section 33 (destruction of motor vehicles or motor vehicle facilities), section 36 (violence at international airports), section 351 (violence against Members of Congress, Cabinet officers, or Supreme Court Justices), an offense under section 751 (prisoners in custody of institution or officer), section 794 (gathering or delivering defense information to aid foreign government), section 844(d) (transportation of explosives in interstate commerce for certain purposes), section 844(f) (destruction of Government property by explosives), section 1118 (prisoners serving life term), section 1201 (kidnaping), section 844(i) (destruction of property affecting interstate commerce by explosives), section 1116 (killing or attempted killing of diplomats), section 1203 (hostage taking), section 1992 (wrecking trains), section 2280 (maritime violence), section 2281 (maritime platform violence), section 2332 (terrorist acts abroad against United States nationals), section 2339 (use of weapons of mass destruction), or section 2381 (treason) of this title, or section 46502 of title 49, United States Code (aircraft piracy).

"(2) PREVIOUS CONVICTION OF VIOLENT FELONY INVOLVING FIREARM.—For any offense, other than an offense for which a sentence of death is sought on the basis of section 924(c), the defendant has previously been convicted of a Federal or State offense punishable by a term of imprisonment of more than 1 year, involving the use or attempted or threatened use of a firearm (as defined in section 921) against another person.

"(3) PREVIOUS CONVICTION OF OFFENSE FOR WHICH A SENTENCE OF DEATH OR LIFE IMPRISONMENT WAS AUTHORIZED.—The defendant has previously been convicted of another Federal or State offense resulting in the death of a person, for which a sentence of life imprisonment or a sentence of death was authorized by statute.

"(4) PREVIOUS CONVICTION OF OTHER SERIOUS OFFENSES.—The defendant has previously been convicted of 2 or more Federal or State offenses, punishable by a term of imprisonment of more than 1 year, committed on different occasions, involving the infliction of, or attempted infliction of, serious bodily injury or death upon another person.

"(5) GRAVE RISK OF DEATH TO ADDITIONAL PERSONS.—The defendant, in the commission of the offense, or in escaping apprehension for the violation of the offense, knowingly created a grave risk of death to 1 or more persons in addition to the victim of the offense.

"(6) HEINOUS, CRUEL, OR DEPRAVED MANNER OF COMMITTING OFFENSE.—The defendant committed the offense in an especially heinous, cruel, or depraved manner in that it involved torture or serious physical abuse to the victim.

"(7) PROCUREMENT OF OFFENSE BY PAYMENT.—The defendant procured the commission of the offense by payment, or promise of payment, of anything of pecuniary value.

"(8) PECUNIARY GAIN.—The defendant committed the offense as consideration for the receipt, or in the expectation of the receipt, of anything of pecuniary value.

"(9) SUBSTANTIAL PLANNING AND PREMEDITATION.—The defendant committed the offense after substantial planning and premeditation to cause the death of a person or commit an act of terrorism.

"(10) CONVICTION FOR TWO FELONY DRUG OFFENSES.—The defendant has previously been convicted of 2 or more State or Federal offenses punishable by a term of imprisonment of more than one year, committed on different occasions, involving the distribution of a controlled substance.

"(11) VULNERABILITY OF VICTIM.—The victim was particularly vulnerable due to old age, youth, or infirmity.

"(12) CONVICTION FOR SERIOUS FEDERAL DRUG OFFENSES.—The defendant had previously been convicted of violating title II or III of the Controlled Substances Act for which a sentence of 5 or more years may be imposed or had previously been convicted of engaging in a continuing criminal enterprise.

"(13) CONTINUING CRIMINAL ENTERPRISE INVOLVING DRUG SALES TO MINORS.—The defendant committed the offense in the course of engaging in a continuing criminal enterprise in violation of section 408(c) of the Controlled Substances Act (21 U.S.C. 848(c)), and that violation involved the distribution of drugs to persons under the age of 21 in violation of section 418 of that Act (21 U.S.C. 859).

"(14) HIGH PUBLIC OFFICIALS.—The defendant committed the offense against—

"(A) the President of the United States, the President-elect, the Vice President, the Vice President-elect, the Vice President-designate, or, if there is no Vice President, the officer next in order of succession to the office of the President of the United States, or any person who is acting as President under the Constitution and laws of the United States;

"(B) a chief of state, head of government, or the political equivalent, of a foreign nation;

"(C) a foreign official listed in section 1116(b)(3)(A), if the official is in the United States on official business; or

"(D) a Federal public servant who is a judge, a law enforcement officer, or an employee of a United States penal or correctional institution—

"(i) while he or she is engaged in the performance of his or her official duties;

"(ii) because of the performance of his or her official duties; or

"(iii) because of his or her status as a public servant.

For purposes of this subparagraph, a 'law enforcement officer' is a public servant authorized by law or by a Government agency or Congress to conduct or engage in the prevention, investigation, or prosecution or adjudication of an offense, and includes those engaged in corrections, parole, or probation functions.

"(15) PRIOR CONVICTION OF SEXUAL ASSAULT OR CHILD MOLESTATION.—In the case of an offense under chapter 109A (sexual abuse) or chapter 110 (sexual abuse of children), the defendant has previously been convicted of a crime of sexual assault or crime of child molestation.

The jury, or if there is no jury, the court, may consider whether any other aggravating factor for which notice has been given exists.

"(d) AGGRAVATING FACTORS FOR DRUG OFFENSE DEATH PENALTY.—In determining whether a sentence of death is justified for an offense described in section 3591(b), the jury, or if there is no jury, the court, shall consider each of the following aggravating factors for which notice has been given and determine which, if any, exist:

"(1) PREVIOUS CONVICTION OF OFFENSE FOR WHICH A SENTENCE OF DEATH OR LIFE IMPRISONMENT WAS AUTHORIZED.—The defendant has previously been convicted of another Federal or State offense resulting in the death of a person, for which a sentence of life imprisonment or death was authorized by statute.

"(2) PREVIOUS CONVICTION OF OTHER SERIOUS OFFENSES.—The defendant has previously been convicted of two or more Federal or State offenses, each punishable by a term of imprisonment of more than one year, committed on different occasions, involving the importation,

manufacture, or distribution of a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) or the infliction of, or attempted infliction of, serious bodily injury or death upon another person.

"(3) PREVIOUS SERIOUS DRUG FELONY CONVICTION.—The defendant has previously been convicted of another Federal or State offense involving the manufacture, distribution, importation, or possession of a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) for which a sentence of five or more years of imprisonment was authorized by statute.

"(4) USE OF FIREARM.—In committing the offense, or in furtherance of a continuing criminal enterprise of which the offense was a part, the defendant used a firearm or knowingly directed, advised, authorized, or assisted another to use a firearm to threaten, intimidate, assault, or injure a person.

"(5) DISTRIBUTION TO PERSONS UNDER 21.—The offense, or a continuing criminal enterprise of which the offense was a part, involved conduct proscribed by section 418 of the Controlled Substances Act (21 U.S.C. 859) which was committed directly by the defendant.

"(6) DISTRIBUTION NEAR SCHOOLS.—The offense, or a continuing criminal enterprise of which the offense was a part, involved conduct proscribed by section 419 of the Controlled Substances Act (21 U.S.C. 860) which was committed directly by the defendant.

"(7) USING MINORS IN TRAFFICKING.—The offense, or a continuing criminal enterprise of which the offense was a part, involved conduct proscribed by section 420 of the Controlled Substances Act (21 U.S.C. 861) which was committed directly by the defendant.

"(8) LETHAL ADULTERANT.—The offense involved the importation, manufacture, or distribution of a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)), mixed with a potentially lethal adulterant, and the defendant was aware of the presence of the adulterant.

The jury, or if there is no jury, the court, may consider whether any other aggravating factor for which notice has been given exists.

"§3593. Special hearing to determine whether a sentence of death is justified

"(a) NOTICE BY THE GOVERNMENT.—If, in a case involving an offense described in section 3591, the attorney for the government believes that the circumstances of the offense are such that a sentence of death is justified under this chapter, the attorney shall, a reasonable time before the trial or before acceptance by the court of a plea of guilty, sign and file with the court, and serve on the defendant, a notice—

"(1) stating that the government believes that the circumstances of the offense are such that, if the defendant is convicted, a sentence of death is justified under this chapter and that the government will seek the sentence of death; and

"(2) setting forth the aggravating factor or factors that the government, if the defendant is convicted, proposes to prove as justifying a sentence of death.

The factors for which notice is provided under this subsection may include factors concerning the effect of the offense on the victim and the victim's family, and may include oral testimony, a victim impact statement that identifies the victim of the offense and the extent and scope of the injury and loss suffered by the victim and the victim's family, and any other relevant information. The court may permit the attorney for the government to amend the notice upon a showing of good cause.

"(b) HEARING BEFORE A COURT OR JURY.—If the attorney for the government has filed a notice as required under subsection (a) and the defendant is found guilty of or pleads guilty to an offense described in section 3591, the judge who presided at the trial or before whom the guilty plea was entered, or another judge if that judge is unavailable, shall conduct a separate sentencing hearing to determine the punishment to be imposed. The hearing shall be conducted—

"(1) before the jury that determined the defendant's guilt;

"(2) before a jury impaneled for the purpose of the hearing if—

"(A) the defendant was convicted upon a plea of guilty;

"(B) the defendant was convicted after a trial before the court sitting without a jury;

"(C) the jury that determined the defendant's guilt was discharged for good cause; or

"(D) after initial imposition of a sentence under this section, reconsideration of the sentence under this section is necessary; or

"(3) before the court alone, upon the motion of the defendant and with the approval of the attorney for the government.

A jury impaneled pursuant to paragraph (2) shall consist of 12 members, unless, at any time before the conclusion of the hearing, the parties stipulate, with the approval of the court, that it shall consist of a lesser number.

"(c) PROOF OF MITIGATING AND AGGRAVATING FACTORS.—Notwithstanding rule 32(c) of the Federal Rules of Criminal Procedure, when a defendant is found guilty or pleads guilty to an offense under section 3591, no presentence report shall be prepared. At the sentencing hearing, information may be presented as to any matter relevant to the sentence, including any mitigating or aggravating factor permitted or required to be considered under section 3592. Information presented may include the trial transcript and exhibits if the hearing is held before a jury or judge not present during the trial, or at the trial judge's discretion. The defendant may present any information relevant to a mitigating factor. The government may present any information relevant to an aggravating factor for which notice has been provided under subsection (a). Information is admissible regardless of its admissibility under the rules governing admission of evidence at criminal trials except that information may be excluded if its probative value is outweighed by the danger of creating unfair prejudice, confusing the issues, or misleading the jury. The government and the defendant shall be permitted to rebut any information received at the hearing, and shall be given fair opportunity to present argument as to the adequacy of the information to establish the existence of any aggravating or mitigating factor, and as to the appropriateness in the case of imposing a sentence of death. The government shall open the argument. The defendant shall be permitted to reply. The government shall then be permitted to reply in rebuttal. The burden of establishing the existence of any aggravating factor is on the government, and is not satisfied unless the existence of such a factor is established beyond a reasonable doubt. The burden of establishing the existence of any mitigating factor is on the defendant, and is not satisfied unless the existence of such a factor is established by a preponderance of the information.

"(d) RETURN OF SPECIAL FINDINGS.—The jury, or if there is no jury, the court, shall consider all the information received during the hearing. It shall return special findings identifying any aggravating factor or factors set forth in section 3592 found to exist and any other aggravating factor for which notice has been provided under subsection (a) found to exist. A finding with respect to a mitigating factor may be made by 1 or more members of the jury, and any member of the jury who finds the existence of a mitigating factor may consider such factor established for purposes of this section regardless of the number of jurors who concur that the factor has been established. A finding with respect to any aggravating factor must be unanimous. If no aggravating factor set forth in section 3592 is found to exist, the court shall impose a sentence other than death authorized by law.

"(e) RETURN OF A FINDING CONCERNING A SENTENCE OF DEATH.—If, in the case of—

"(1) an offense described in section 3591(a)(1), an aggravating factor required to be considered under section 3592(b) is found to exist;

"(2) an offense described in section 3591(a)(2), an aggravating factor required to be considered under section 3592(c) is found to exist; or

"(3) an offense described in section 3591(b), an aggravating factor required to be considered under section 3592(d) is found to exist,

the jury, or if there is no jury, the court, shall consider whether all the aggravating factor or factors found to exist sufficiently outweigh all the mitigating factor or factors found to exist to justify a sentence of death, or, in the absence of a mitigating factor, whether the aggravating factor or factors alone are sufficient to justify a sentence of death. Based upon this consideration, the jury by unanimous vote, or if there is no jury, the court, shall recommend whether the defendant should be sentenced to death, to life imprisonment without possibility of release or some other lesser sentence.

"(f) SPECIAL PRECAUTION TO ENSURE AGAINST DISCRIMINATION.—In a hearing held before a jury, the court, prior to the return of a finding under subsection (e), shall instruct the jury that, in considering whether a sentence of death is justified, it shall not consider the race, color, religious beliefs, national origin, or sex of the defendant or of any victim and that the jury is not to recommend a sentence of death unless it has concluded that it would recommend a sentence of death for the crime in question no matter what the race, color, religious beliefs, national origin, or sex of the defendant or of any victim may be. The jury, upon return of a finding under subsection (e), shall also return to the court a certificate, signed by each juror, that consideration of the race, color, religious beliefs, national origin, or sex of the defendant or any victim was not involved in reaching his or her individual decision and that the individual juror would have made the same recommendation regarding a sentence for the crime in question no matter what the race, color, religious beliefs, national origin, or sex of the defendant or any victim may be.

"§3594. Imposition of a sentence of death

"Upon a recommendation under section 3593(e) that the defendant should be sentenced to death or life imprisonment without possibility of release, the court shall sentence the defendant accordingly. Otherwise, the court shall impose any lesser sentence that is authorized by law. Notwithstanding any other law, if the maximum term of imprisonment for the offense is life imprisonment, the court may impose a sentence of life imprisonment without possibility of release.

"§3595. Review of a sentence of death

"(a) APPEAL.—In a case in which a sentence of death is imposed, the sentence shall be subject to review by the court of appeals upon appeal by the defendant. Notice of appeal must be filed within the time specified for the filing of a notice of appeal. An appeal under this section may be consolidated with an appeal of the judgment of conviction and shall have priority over all other cases.

"(b) REVIEW.—The court of appeals shall review the entire record in the case, including—

"(1) the evidence submitted during the trial;

"(2) the information submitted during the sentencing hearing;

"(3) the procedures employed in the sentencing hearing; and

"(4) the special findings returned under section 3593(d).

"(c) DECISION AND DISPOSITION.—

"(1) The court of appeals shall address all substantive and procedural issues raised on the appeal of a sentence of death, and shall consider whether the sentence of death was imposed under the influence of passion, prejudice, or any other arbitrary factor and whether the evidence supports the special finding of the existence of an aggravating factor required to be considered under section 3592.

"(2) Whenever the court of appeals finds that—

"(A) the sentence of death was imposed under the influence of passion, prejudice, or any other arbitrary factor;

"(B) the admissible evidence and information adduced does not support the special finding of the existence of the required aggravating factor; or

"(C) the proceedings involved any other legal error requiring reversal of the sentence that was properly preserved for appeal under the rules of criminal procedure,

the court shall remand the case for reconsideration under section 3593 or imposition of a sentence other than death. The court of appeals shall not reverse or vacate a sentence of death on account of any error which can be harmless, including any erroneous special finding of an aggravating factor, where the Government establishes beyond a reasonable doubt that the error was harmless.

"(3) The court of appeals shall state in writing the reasons for its disposition of an appeal of a sentence of death under this section.

"§3596. Implementation of a sentence of death

"(a) IN GENERAL.—A person who has been sentenced to death pursuant to this chapter shall be committed to the custody of the Attorney General until exhaustion of the procedures for appeal of the judgment of conviction and for review of the sentence. When the sentence is to be implemented, the Attorney General shall release the person sentenced to death to the custody of a United States marshal, who shall supervise implementation of the sentence in the manner prescribed by the law of the State in which the sentence is imposed. If the law of the State does not provide for implementation of a sentence of death, the court shall designate another State, the law of which does provide for the implementation of a sentence of death, and the sentence shall be implemented in the latter State in the manner prescribed by such law.

"(b) PREGNANT WOMAN.—A sentence of death shall not be carried out upon a woman while she is pregnant.

"(c) MENTAL CAPACITY.—A sentence of death shall not be carried out upon a person who is mentally retarded. A sentence of death shall not be carried out upon a person who, as a result of mental disability, lacks the mental capacity to understand the death penalty and why it was imposed on that person.

"§3597. Use of State facilities

"(a) IN GENERAL.—A United States marshal charged with supervising the implementation of a sentence of death may use appropriate State or local facilities for the purpose, may use the services of an appropriate State or local official or of a person such an official employs for the purpose, and shall pay the costs thereof in an amount approved by the Attorney General.

"(b) EXCUSE OF AN EMPLOYEE ON MORAL OR RELIGIOUS GROUNDS.—No employee of any State department of corrections, the United States Department of Justice, the Federal Bureau of Prisons, or the United States Marshals Service, and no employee providing services to that department, bureau, or service under contract shall be required, as a condition of that employment or contractual obligation, to be in attendance at or to participate in any prosecution or execution under this section if such participation is contrary to the moral or religious convictions of the employee. In this subsection, 'participation in executions' includes personal preparation of the condemned individual and the apparatus used for execution and supervision of the activities of other personnel in carrying out such activities.

"§3598. Special provisions for Indian country

"Notwithstanding sections 1152 and 1153, no person subject to the criminal jurisdiction of an Indian tribal government shall be subject to a capital sentence under this chapter for any offense the Federal jurisdiction for which is predicated solely on Indian country (as defined in section 1151 of this title) and which has occurred within the boundaries of Indian country, unless the governing body of the tribe has elected that this chapter have effect over land and persons subject to its criminal jurisdiction.".

(b) TECHNICAL AMENDMENT.—The part analysis for part II of title 18, United States Code, is amended by inserting after the item relating to chapter 227 the following new item:

"228. Death sentence .... 3591".

SEC. 60003. SPECIFIC OFFENSES FOR WHICH DEATH PENALTY IS AUTHORIZED.

(a) CONFORMING CHANGES IN TITLE 18.—Title 18, United States Code, is amended as follows:

(1) AIRCRAFT AND MOTOR VEHICLES.—Section 34 of title 18, United States Code, is amended by striking the comma after "imprisonment for life", inserting a period, and striking the remainder of the section.

(2) ESPIONAGE.—Section 794(a) of title 18, United States Code, is amended by striking the period at the end of the section and inserting ", except that the sentence of death shall not be imposed unless the jury or, if there is no jury, the court, further finds that the offense resulted in the identification by a foreign power (as defined in section 101(a) of the Foreign Intelligence Surveillance Act of 1978) of an individual acting as an agent of the United States and consequently in the death of that individual, or directly concerned nuclear weaponry, military spacecraft or satellites, early warning systems, or other means of defense or retaliation against large-scale attack; war plans; communications intelligence or cryptographic information; or any other major weapons system or major element of defense strategy.".

(3) EXPLOSIVE MATERIALS.—(A) Section 844(d) of title 18, United States Code, is amended by striking "as provided in section 34 of this title".

(B) Section 844(f) of title 18, United States Code, is amended by striking "as provided in section 34 of this title".

(C) Section 844(i) of title 18, United States Code, is amended by striking "as provided in section 34 of this title".

(4) MURDER.—The second undesignated paragraph of section 1111(b) of title 18, United States Code, is amended to read as follows:

"Whoever is guilty of murder in the first degree shall be punished by death or by imprisonment for life;".

(5) KILLING OF FOREIGN OFFICIAL.—Section 1116(a) of title 18, United States Code, is amended by striking "any such person who is found guilty of murder in the first degree shall be sentenced to imprisonment for life, and".

(6) KIDNAPPING.—Section 1201(a) of title 18, United States Code, is amended by inserting after "or for life" the following: "and, if the death of any person results, shall be punished by death or life imprisonment".

(7) NONMAILABLE INJURIOUS ARTICLES.—The last paragraph of section 1716 of title 18, United States Code, is amended by striking the comma after "imprisonment for life" and inserting a period and striking the remainder of the paragraph.

(8) WRECKING TRAINS.—The second to the last undesignated paragraph of section 1992 of title 18, United States Code, is amended by striking the comma after "imprisonment for life", inserting a period, and striking the remainder of the section.

(9) BANK ROBBERY.—Section 2113(e) of title 18, United States Code, is amended by striking "or punished by death if the verdict of the jury shall so direct" and inserting "or if death results shall be punished by death or life imprisonment".

(10) HOSTAGE TAKING.—Section 1203(a) of title 18, United States Code, is amended by inserting after "or for life" the following: "and, if the death of any person results, shall be punished by death or life imprisonment".

(11) MURDER FOR HIRE.—Section 1958 of title 18, United States Code, is amended by striking "and if death results, shall be subject to imprisonment for any term of years or for life, or shall be fined not more than $50,000, or both" and inserting "and if death results, shall be punished by death or life imprisonment, or shall be fined not more than $250,000, or both".

(12) RACKETEERING.—Section 1959(a)(1) of title 18, United States Code, is amended to read as follows:

"(1) for murder, by death or life imprisonment, or a fine of not more than $250,000, or both; and for kidnapping, by imprisonment for any term of years or for life, or a fine of not more than $250,000, or both;".

(13) GENOCIDE.—Section 1091(b)(1) of title 18, United States Code, is amended by striking "a fine of not more than $1,000,000 or imprisonment for life," and inserting ", where death results, by death or imprisonment for life and a fine of not more than $1,000,000, or both;".

(14) CARJACKING.—Section 2119(3) of title 18, United States Code, is amended by striking the period after "both" and inserting ", or sentenced to death." and by striking ", possessing a firearm as defined in section 921 of this title," and inserting ", with the intent to cause death or serious bodily harm".

(b) CONFORMING AMENDMENT TO FEDERAL AVIATION ACT OF 1954.—Chapter 465 of title 49, United States Code, is amended—

(1) in the chapter analysis by striking "Death penalty sentencing procedure for aircraft piracy" and inserting "Repealed"; and

(2) by striking section 46503.

SEC. 60004. APPLICABILITY TO UNIFORM CODE OF MILITARY JUSTICE.

Chapter 228 of title 18, United States Code, as added by this title, shall not apply to prosecutions under the Uniform Code of Military Justice (10 U.S.C. 801).

SEC. 60005. DEATH PENALTY FOR MURDER BY A FEDERAL PRISONER.

(a) IN GENERAL.—Chapter 51 of title 18, United States Code, is amended by adding at the end the following new section:

"§1118. Murder by a Federal prisoner

"(a) OFFENSE.—A person who, while confined in a Federal correctional institution under a sentence for a term of life imprisonment, commits the murder of another shall be punished by death or by life imprisonment.

"(b) DEFINITIONS.—In this section—

"'Federal correctional institution' means any Federal prison, Federal correctional facility, Federal community program center, or Federal halfway house.

"'murder' means a first degree or second degree murder (as defined in section 1111).

"'term of life imprisonment' means a sentence for the term of natural life, a sentence commuted to natural life, an indeterminate term of a minimum of at least fifteen years and a maximum of life, or an unexecuted sentence of death.".

(b) TECHNICAL AMENDMENT.—The chapter analysis for chapter 51 of title 18, United States

Code, is amended by adding at the end the following new item:

"1118. Murder by a Federal prisoner.".

SEC. 60006. DEATH PENALTY FOR CIVIL RIGHTS MURDERS.

(a) Conspiracy Against Rights.—Section 241 of title 18, United States Code, is amended by striking the period at the end of the last sentence and inserting ", or may be sentenced to death.".

(b) Deprivation of Rights Under Color of Law.—Section 242 of title 18, United States Code, is amended by striking the period at the end of the last sentence and inserting ", or may be sentenced to death.".

(c) Federally Protected Activities.—Section 245(b) of title 18, United States Code, is amended in the matter following paragraph (5) by inserting ", or may be sentenced to death" after "or for life".

(d) Damage to Religious Property; Obstruction of the Free Exercise of Religious Rights.—Section 247(c)(1) of title 18, United States Code, is amended by inserting ", or may be sentenced to death" after "or both".

SEC. 60007. DEATH PENALTY FOR THE MURDER OF FEDERAL LAW ENFORCEMENT OFFICIALS.

Section 1114 of title 18, United States Code, is amended by striking "punished as provided under sections 1111 and 1112 of this title," and inserting "punished, in the case of murder, as provided under section 1111, or, in the case of manslaughter, as provided under section 1112.".

SEC. 60008. NEW OFFENSE FOR THE INDISCRIMINATE USE OF WEAPONS TO FURTHER DRUG CONSPIRACIES.

(a) Short Title.—This section may be cited as the "Drive-By Shooting Prevention Act of 1994".

(b) In General.—Chapter 2 of title 18, United States Code, is amended by adding at the end the following new section:

"§36. Drive-by shooting

"(a) Definition.—In this section, 'major drug offense' means—

"(1) a continuing criminal enterprise punishable under section 403(c) of the Controlled Substances Act (21 U.S.C. 848(c));

"(2) a conspiracy to distribute controlled substances punishable under section 406 of the Controlled Substances Act (21 U.S.C. 846) section 1013 of the Controlled Substances Import and Export Control Act (21 U.S.C. 963); or

"(3) an offense involving major quantities of drugs and punishable under section 401(b)(1)(A) of the Controlled Substances Act (21 U.S.C. 841(b)(1)(A)) or section 1010(b)(1) of the Controlled Substances Import and Export Act (21 U.S.C. 960(b)(1)).

"(b) Offense and Penalties.—(1) A person who, in furtherance or to escape detection of a major drug offense and with the intent to intimidate, harass, injure, or maim, fires a weapon into a group of two or more persons and who, in the course of such conduct, causes grave risk to any human life shall be punished by a term of no more than 25 years, by fine under this title, or both.

"(2) A person who, in furtherance or to escape detection of a major drug offense and with the intent to intimidate, harass, injure, or maim, fires a weapon into a group of 2 or more persons and who, in the course of such conduct, kills any person shall, if the killing—

"(A) is a first degree murder (as defined in section 1111(a)), be punished by death or imprisonment for any term of years or for life, fined under this title, or both; or

"(B) is a murder other than a first degree murder (as defined in section 1111(a)), be fined under this title, imprisoned for any term of years or for life, or both.".

(c) Technical Amendment.—The chapter analysis for chapter 2 of title 18, United States Code, is amended by adding at the end the following new item:

"36. Drive-by shooting.".

SEC. 60009. FOREIGN MURDER OF UNITED STATES NATIONALS.

(a) In General.—Chapter 51 of title 18, United States Code, as amended by section 60005(a), is amended by adding at the end the following new section:

"§1119. Foreign murder of United States nationals

"(a) Definition.—In this section, 'national of the United States' has the meaning stated in section 101(a)(22) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(22)).

"(b) Offense.—A person who, being a national of the United States, kills or attempts to kill a national of the United States while such national is outside the United States but within the jurisdiction of another country shall be punished as provided under sections 1111, 1112, and 1113.

"(c) Limitations on Prosecution.—(1) No prosecution may be instituted against any person under this section except upon the written approval of the Attorney General, the Deputy Attorney General, or an Assistant Attorney General, which function of approving prosecutions may not be delegated. No prosecution shall be approved if prosecution has been previously undertaken by a foreign country for the same conduct.

"(2) No prosecution shall be approved under this section unless the Attorney General, in consultation with the Secretary of State; determines that the conduct took place in a country in which the person is no longer present, and the country lacks the ability to lawfully secure the person's return. A determination by the Attorney General under this paragraph is not subject to judicial review.".

(b) Technical Amendments.—(1) Section 1117 of title 18, United States Code, is amended by striking "or 1116" and inserting "1116, or 1119".

(2) The chapter analysis for chapter 51 of title 18, United States Code, as amended by section 60005(a), is amended by adding at the end the following new item:

"1119. Foreign murder of United States nationals.".

SEC. 60010. DEATH PENALTY FOR RAPE AND CHILD MOLESTATION MURDERS.

(a) Offense.—Chapter 109A of title 18, United States Code, is amended—

(1) by redesignating section 2245 as section 2246; and

(2) by inserting after section 2244 the following new section:

"§2245. Sexual abuse resulting in death

"A person who, in the course of an offense under this chapter, engages in conduct that results in the death of a person, shall be punished by death or imprisoned for any term of years or for life.".

(b) Technical Amendments.—The chapter analysis for chapter 109A of title 18, United States Code, is amended by striking the item for section 2245 and inserting the following:

"2245. Sexual abuse resulting in death.
"2246. Definitions for chapter.".

SEC. 60011. DEATH PENALTY FOR SEXUAL EXPLOITATION OF CHILDREN.

Section 2251(d) of title 18, United States Code, is amended by adding at the end the following: "Whoever, in the course of an offense under this section, engages in conduct that results in the death of a person, shall be punished by death or imprisoned for any term of years or for life.".

SEC. 60012. MURDER BY ESCAPED PRISONERS.

(a) In General.—Chapter 51 of title 18, United States Code, as amended by section 60009(a), is amended by adding at the end the following new section:

"§1120. Murder by escaped prisoners

"(a) Definition.—In this section, 'Federal prison' and 'term of life imprisonment' have the meanings stated in section 1118.

"(b) Offense and Penalty.—A person, having escaped from a Federal prison where the person was confined under a sentence for a term of life imprisonment, kills another shall be punished as provided in sections 1111 and 1112.".

(b) Technical Amendment.—The chapter analysis for chapter 51 of title 18, United States Code, as amended by section 60009(b)(2), is amended by adding at the end the following new item:

"1120. Murder by escaped prisoners.".

SEC. 60013. DEATH PENALTY FOR GUN MURDERS DURING FEDERAL CRIMES OF VIOLENCE AND DRUG TRAFFICKING CRIMES.

Section 924 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(i) A person who, in the course of a violation of subsection (c), causes the death of a person through the use of a firearm, shall—

"(1) if the killing is a murder (as defined in section 1111), be punished by death or by imprisonment for any term of years or for life; and

"(2) if the killing is manslaughter (as defined in section 1112), be punished as provided in that section.".

SEC. 60014. HOMICIDES AND ATTEMPTED HOMICIDES INVOLVING FIREARMS IN FEDERAL FACILITIES.

Section 930 of title 18, United States Code, is amended—

(1) by redesignating subsections (c), (d), (e), and (f) as subsections (d), (e), (f), and (g), respectively;

(2) in subsection (a) by striking "(c)" and inserting "(d)"; and

(3) by inserting after subsection (b) the following new subsection:

"(c) A person who kills or attempts to kill any person in the course of a violation of subsection (a) or (b), or in the course of an attack on a Federal facility involving the use of a firearm or other dangerous weapon, shall be punished as provided in sections 1111, 1112, and 1113.".

SEC. 60015. DEATH PENALTY FOR THE MURDER OF STATE OR LOCAL OFFICIALS ASSISTING FEDERAL LAW ENFORCEMENT OFFICIALS AND STATE CORRECTIONAL OFFICERS.

(a) In General.—Chapter 51 of title 18, United States Code, as amended by section 60012(a), is amended by adding at the end the following new section:

"§ 1121. Killing persons aiding Federal investigations or State correctional officers

"(a) Whoever intentionally kills—

"(1) a State or local official, law enforcement officer, or other officer or employee while working with Federal law enforcement officials in furtherance of a Federal criminal investigation—

"(A) while the victim is engaged in the performance of official duties;

"(B) because of the performance of the victim's official duties; or

"(C) because of the victim's status as a public servant; or

"(2) any person assisting a Federal criminal investigation, while that assistance is being rendered and because of it,

shall be sentenced according to the terms of section 1111, including by sentence of death or by imprisonment for life.

"(b)(1) Whoever, in a circumstance described in paragraph (3) of this subsection, while incarcerated, intentionally kills any State correctional officer engaged in, or on account of the

performance of such officer's official duties, shall be sentenced to a term of imprisonment which shall not be less than 20 years, and may be sentenced to life imprisonment or death.

"(2) As used in this section, the term, 'State correctional officer' includes any officer or employee of any prison, jail, or other detention facility, operated by, or under contract to, either a State or local governmental agency, whose job responsibilities include providing for the custody of incarcerated individuals.

"(3) The circumstance referred to in paragraph (1) is that—

"(A) the correctional officer is engaged in transporting the incarcerated person interstate; or

"(B) the incarcerated person is incarcerated pursuant to a conviction for an offense against the United States.".

(b) Technical Amendment.—The chapter analysis for chapter 51 of title 18, United States Code, as amended by section 60012(b), is amended by adding at the end the following new item:

"1121. Killing persons aiding Federal investigations or State correctional officers.".

SEC. 60016. PROTECTION OF COURT OFFICERS AND JURORS.

Section 1503 of title 18, United States Code, is amended—

(1) by inserting "(a)" before "Whoever";

(2) by striking "fined not more than $5,000 or imprisoned not more than five years, or both." and inserting "punished as provided in subsection (b).";

(3) by adding at the end the following new subsection:

"(b) The punishment for an offense under this section is—

"(1) in the case of a killing, the punishment provided in sections 1111 and 1112;

"(2) in the case of an attempted killing, or a case in which the offense was committed against a petit juror and in which a class A or B felony was charged, imprisonment for not more than 20 years, a fine under this title, or both; and

"(3) in any other case, imprisonment for not more than 10 years, a fine under this title, or both."; and

(4) in subsection (a), as designated by paragraph (1), by striking "commissioner" each place it appears and inserting "magistrate judge".

SEC. 60017. PROHIBITION OF RETALIATORY KILLINGS OF WITNESSES, VICTIMS, AND INFORMANTS.

Section 1513 of title 18, United States Code, is amended—

(1) by redesignating subsections (a) and (b) as subsections (b) and (c), respectively; and

(2) by inserting after the section heading the following new subsection:

"(a)(1) Whoever kills or attempts to kill another person with intent to retaliate against any person for—

"(A) the attendance of a witness or party at an official proceeding, or any testimony given or any record, document, or other object produced by a witness in an official proceeding; or

"(B) providing to a law enforcement officer any information relating to the commission or possible commission of a Federal offense or a violation of conditions of probation, parole, or release pending judicial proceedings,

shall be punished as provided in paragraph (2).

"(2) The punishment for an offense under this subsection is—

"(A) in the case of a killing, the punishment provided in sections 1111 and 1112; and

"(B) in the case of an attempt, imprisonment for not more than 20 years.".

SEC. 60018. DEATH PENALTY FOR MURDER OF FEDERAL WITNESSES.

Section 1512(a)(2)(A) of title 18, United States Code, is amended to read as follows:

"(A) in the case of murder (as defined in section 1111), the death penalty or imprisonment for life, and in the case of any other killing, the punishment provided in section 1112;".

SEC. 60019. OFFENSES OF VIOLENCE AGAINST MARITIME NAVIGATION OR FIXED PLATFORMS.

(a) In General.—Chapter 111 of title 18, United States Code, is amended by adding at the end the following new sections:

"§2280. Violence against maritime navigation

"(a) Offenses.—

"(1) In general.—A person who unlawfully and intentionally—

"(A) seizes or exercises control over a ship by force or threat thereof or any other form of intimidation;

"(B) performs an act of violence against a person on board a ship if that act is likely to endanger the safe navigation of that ship;

"(C) destroys a ship or causes damage to a ship or to its cargo which is likely to endanger the safe navigation of that ship;

"(D) places or causes to be placed on a ship, by any means whatsoever, a device or substance which is likely to destroy that ship, or cause damage to that ship or its cargo which endangers or is likely to endanger the safe navigation of that ship;

"(E) destroys or seriously damages maritime navigational facilities or seriously interferes with their operation, if such act is likely to endanger the safe navigation of a ship;

"(F) communicates information, knowing the information to be false and under circumstances in which such information may reasonably be believed, thereby endangering the safe navigation of a ship;

"(G) injures or kills any person in connection with the commission or the attempted commission of any of the offenses set forth in subparagraphs (A) through (F); or

"(H) attempts to do any act prohibited under subparagraphs (A) through (G),

shall be fined under this title, imprisoned not more than 20 years, or both; and if the death of any person results from conduct prohibited by this paragraph, shall be punished by death or imprisoned for any term of years or for life.

"(2) Threat to navigation.—A person who threatens to do any act prohibited under paragraph (1) (B), (C) or (E), with apparent determination and will to carry the threat into execution, if the threatened act is likely to endanger the safe navigation of the ship in question, shall be fined under this title, imprisoned not more than 5 years, or both.

"(b) Jurisdiction.—There is jurisdiction over the activity prohibited in subsection (a)—

"(1) in the case of a covered ship, if—

"(A) such activity is committed—

"(i) against or on board a ship flying the flag of the United States at the time the prohibited activity is committed;

"(ii) in the United States and the activity is not prohibited as a crime by the State in which the activity takes place; or

"(iii) the activity takes place on a ship flying the flag of a foreign country or outside the United States, by a national of the United States or by a stateless person whose habitual residence is in the United States;

"(B) during the commission of such activity, a national of the United States is seized, threatened, injured or killed; or

"(C) the offender is later found in the United States after such activity is committed;

"(2) in the case of a ship navigating or scheduled to navigate solely within the territorial sea or internal waters of a country other than the United States, if the offender is later found in the United States after such activity is committed; and

"(3) in the case of any vessel, if such activity is committed in an attempt to compel the United States to do or abstain from doing any act.

"(c) Bar To Prosecution.—It is a bar to Federal prosecution under subsection (a) for conduct that occurred within the United States that the conduct involved was during or in relation to a labor dispute, and such conduct is prohibited as a felony under the law of the State in which it was committed. For purposes of this section, the term 'labor dispute' has the meaning set forth in section 2(c) of the Norris-LaGuardia Act, as amended (29 U.S.C. 113(c)).

"(d) Delivery of Suspected Offender.—The master of a covered ship flying the flag of the United States who has reasonable grounds to believe that there is on board that ship any person who has committed an offense under Article 3 of the Convention for the Suppression of Unlawful Acts Against the Safety of Maritime Navigation may deliver such person to the authorities of a State Party to that Convention. Before delivering such person to the authorities of another country, the master shall notify in an appropriate manner the Attorney General of the United States of the alleged offense and await instructions from the Attorney General as to what action to take. When delivering the person to a country which is a State Party to the Convention, the master shall, whenever practicable, and if possible before entering the territorial sea of such country, notify the authorities of such country of the master's intention to deliver such person and the reasons therefor. If the master delivers such person, the master shall furnish to the authorities of such country the evidence in the master's possession that pertains to the alleged offense.

"(e) Definitions.—In this section—

"'covered ship' means a ship that is navigating or is scheduled to navigate into, through or from waters beyond the outer limit of the territorial sea of a single country or a lateral limit of that country's territorial sea with an adjacent country.

"'national of the United States' has the meaning stated in section 101(a)(22) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(22)).

"'territorial sea of the United States' means all waters extending seaward to 12 nautical miles from the baselines of the United States determined in accordance with international law.

"'ship' means a vessel of any type whatsoever not permanently attached to the sea-bed, including dynamically supported craft, submersibles or any other floating craft, but does not include a warship, a ship owned or operated by a government when being used as a naval auxiliary or for customs or police purposes, or a ship which has been withdrawn from navigation or laid up.

"'United States', when used in a geographical sense, includes the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands and all territories and possessions of the United States.

"§2281. Violence against maritime fixed platforms

"(a) Offenses.—

"(1) In general.—A person who unlawfully and intentionally—

"(A) seizes or exercises control over a fixed platform by force or threat thereof or any other form of intimidation;

"(B) performs an act of violence against a person on board a fixed platform if that act is likely to endanger its safety;

"(C) destroys a fixed platform or causes damage to it which is likely to endanger its safety;

"(D) places or causes to be placed on a fixed platform, by any means whatsoever, a device or substance which is likely to destroy that fixed platform or likely to endanger its safety;

"(E) injures or kills any person in connection with the commission or the attempted commission of any of the offenses set forth in subparagraphs (A) through (D); or

"(F) attempts to do anything prohibited under subparagraphs (A) through (E),

shall be fined under this title, imprisoned not more than 20 years, or both; and if death results to any person from conduct prohibited by this paragraph, shall be punished by death or imprisoned for any term of years or for life.

"(2) THREAT TO SAFETY.—A person who threatens to do anything prohibited under paragraph (1) (B) or (C), with apparent determination and will to carry the threat into execution, if the threatened act is likely to endanger the safety of the fixed platform, shall be fined under this title, imprisoned not more than 5 years, or both.

"(b) JURISDICTION.—There is jurisdiction over the activity prohibited in subsection (a) if—

"(1) such activity is committed against or on board a fixed platform—

"(A) that is located on the continental shelf of the United States;

"(B) that is located on the continental shelf of another country, by a national of the United States or by a stateless person whose habitual residence is in the United States; or

"(C) in an attempt to compel the United States to do or abstain from doing any act;

"(2) during the commission of such activity against or on board a fixed platform located on a continental shelf, a national of the United States is seized, threatened, injured or killed; or

"(3) such activity is committed against or on board a fixed platform located outside the United States and beyond the continental shelf of the United States and the offender is later found in the United States.

"(c) BAR TO PROSECUTION.—It is a bar to Federal prosecution under subsection (a) for conduct that occurred within the United States that the conduct involved was during or in relation to a labor dispute, and such conduct is prohibited as a felony under the law of the State in which it was committed. For purposes of this section, the term 'labor dispute' has the meaning set forth in section 2(c) of the Norris-LaGuardia Act, as amended (29 U.S.C. 113(c)).

"(d) DEFINITIONS.—In this section—

"'continental shelf' means the sea-bed and subsoil of the submarine areas that extend beyond a country's territorial sea to the limits provided by customary international law as reflected in Article 76 of the 1982 Convention on the Law of the Sea.

"'fixed platform' means an artificial island, installation or structure permanently attached to the sea-bed for the purpose of exploration or exploitation of resources or for other economic purposes.

"'national of the United States' has the meaning stated in section 101(a)(22) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(22)).

"'territorial sea of the United States' means all waters extending seaward to 12 nautical miles from the baselines of the United States determined in accordance with international law.

"'United States', when used in a geographical sense, includes the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands and all territories and possessions of the United States.".

(b) TECHNICAL AMENDMENT.—The chapter analysis for chapter 111 of title 18, United States Code, is amended by adding at the end the following new items:

"2280. Violence against maritime navigation.
"2281. Violence against maritime fixed platforms.".

(c) EFFECTIVE DATES.—This section and the amendments made by this section shall take effect on the later of—

(1) the date of the enactment of this Act; or

(2)(A) in the case of section 2280 of title 18, United States Code, the date the Convention for the Suppression of Unlawful Acts Against the Safety of Maritime Navigation has come into force and the United States has become a party to that Convention; and

(B) in the case of section 2281 of title 18, United States Code, the date the Protocol for the Suppression of Unlawful Acts Against the Safety of Fixed Platforms Located on the Continental Shelf has come into force and the United States has become a party to that Protocol.

SEC. 60020. TORTURE.

Section 2340A(a) of title 18, United States Code, is amended by inserting "punished by death or" before "imprisoned for any term of years or for life.".

SEC. 60021. VIOLENCE AT AIRPORTS SERVING INTERNATIONAL CIVIL AVIATION.

(a) OFFENSE.—Chapter 2 of title 18, United States Code, as amended by section 60008(b), is amended by adding at the end the following new section:

"§37. Violence at international airports

"(a) OFFENSE.—A person who unlawfully and intentionally, using any device, substance, or weapon—

"(1) performs an act of violence against a person at an airport serving international civil aviation that causes or is likely to cause serious bodily injury (as defined in section 1365 of this title) or death; or

"(2) destroys or seriously damages the facilities of an airport serving international civil aviation or a civil aircraft not in service located thereon or disrupts the services of the airport,

if such an act endangers or is likely to endanger safety at that airport, or attempts to do such an act, shall be fined under this title, imprisoned not more than 20 years, or both; and if the death of any person results from conduct prohibited by this subsection, shall be punished by death or imprisoned for any term of years or for life.

"(b) JURISDICTION.—There is jurisdiction over the prohibited activity in subsection (a) if—

"(1) the prohibited activity takes place in the United States; or

"(2) the prohibited activity takes place outside the United States and the offender is later found in the United States.

"(c) It is a bar to Federal persecution under subsection (a) for conduct that occurred within the United States that the conduct involved was during or in relation to a labor dispute, and such conduct is prohibited as a felony under the law of the State in which it was committed. For purposes of this section, the term 'labor dispute' has the meaning set forth in section 2(c) of the Norris-LaGuardia Act, as amended (29 U.S.C. 113(c)).

(b) TECHNICAL AMENDMENT.—The chapter analysis for chapter 2 of title 18, United States Code, as amended by section 60008(c), is amended by adding at the end the following new item:

"37. Violence at international airports.".

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the later of—

(1) the date of enactment of this Act; or

(2) the date on which the Protocol for the Suppression of Unlawful Acts of Violence at Airports Serving International Civil Aviation, Supplementary to the Convention for the Suppression of Unlawful Acts Against the Safety of Civil Aviation, done at Montreal on 23 September 1971, has come into force and the United States has become a party to the Protocol.

SEC. 60022. TERRORIST DEATH PENALTY ACT.

Section 2332(a)(1) of title 18, United States Code is amended to read as follows:

"(1) if the killing is murder (as defined in section 1111(a)), be fined under this title, punished by death or imprisonment for any term of years or for life, or both;".

SEC. 60023. WEAPONS OF MASS DESTRUCTION.

(a) OFFENSE.—Chapter 113A of title 18, United States Code, is amended by inserting after section 2332 the following new section:

"§2332a. Use of weapons of mass destruction

"(a) OFFENSE.—A person who uses, or attempts or conspires to use, a weapon of mass destruction—

"(1) against a national of the United States while such national is outside of the United States;

"(2) against any person within the United States; or

"(3) against any property that is owned, leased or used by the United States or by any department or agency of the United States, whether the property is within or outside of the United States,

shall be imprisoned for any term of years or for life, and if death results, shall be punished by death or imprisoned for any term of years or for life.

"(b) DEFINITIONS.—For purposes of this section—

"(1) the term 'national of the United States' has the meaning given in section 101(a)(22) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(22)); and

"(2) the term 'weapon of mass destruction' means—

"(A) any destructive device as defined in section 921 of this title;

"(B) poison gas;

"(C) any weapon involving a disease organism; or

"(D) any weapon that is designed to release radiation or radioactivity at a level dangerous to human life.".

(b) TECHNICAL AMENDMENT.—The chapter analysis for chapter 113A of title 18, United States Code, is amended by inserting after the item relating to section 2332 the following:

"2332a. Use of weapons of mass destruction.".

SEC. 60024. ENHANCED PENALTIES FOR ALIEN SMUGGLING.

Section 274(a) of the Immigration and Nationality Act (8 U.S.C. 1324(a)) is amended—

(1) in paragraph (1)—

(A) by striking "(1) Any person" and inserting "(1)(A) Any person";

(B) by striking "(A) knowing" and inserting "(i) knowing";

(C) by striking "(B) knowing" and inserting "(ii) knowing";

(D) by striking "(C) knowing" and inserting "(iii) knowing";

(E) by striking "(D) encourages" and inserting "(iv) encourages";

(F) by striking "shall be fined in accordance with title 18, or imprisoned not more than five years, or both, for each alien in respect to whom any violation of this paragraph occurs" and inserting "shall be punished as provided in subparagraph (B)"; and

(G) by adding at the end the following new subparagraph:

"(B) A person who violates subparagraph (A) shall, for each alien in respect to whom such a violation occurs—

"(i) in the case of a violation of subparagraph (A)(i), be fined under title 18, United States Code, imprisoned not more than 10 years, or both;

"(ii) in the case of a violation of subparagraph (A) (ii), (iii), or (iv), be fined under title 18, United States Code, imprisoned not more than 5 years, or both;

"(iii) in the case of a violation of subparagraph (A) (i), (ii), (iii), or (iv) during and in relation to which the person causes serious bodily injury (as defined in section 1365 of title 18, United States Code) to, or places in jeopardy the life of, any person, be fined under title 18, United States Code, imprisoned not more than 20 years, or both; and

"(iv) in the case of a violation of subparagraph (A) (i), (ii), (iii), or (iv) resulting in the death of any person, be punished by death or imprisoned for any term of years or for life, fined under title 18, United States Code, or both."; and

(2) in paragraph (2) by striking "or imprisoned not more than five years, or both" and inserting "or in the case of a violation of subparagraph (B)(ii), imprisoned not more than 10 years, or both; or in the case of a violation of subparagraph (B)(i) or (B)(iii), imprisoned not more than 5 years, or both.".

SEC. 60025. PROTECTION OF JURORS AND WITNESSES IN CAPITAL CASES.

Section 3432 of title 18, United States Code, is amended by inserting before the period the following: ", except that such list of the veniremen and witnesses need not be furnished if the court finds by a preponderance of the evidence that providing the list may jeopardize the life or safety of any person".

SEC. 60026. APPOINTMENT OF COUNSEL.

Section 3005 of title 18, United States Code, is amended by striking "learned in the law" and all that follows through "He shall" and inserting "; and the court before which the defendant is to be tried, or a judge thereof, shall promptly, upon the defendant's request, assign 2 such counsel, of whom at least 1 shall be learned in the law applicable to capital cases, and who shall have free access to the accused at all reasonable hours. In assigning counsel under this section, the court shall consider the recommendation of the Federal Public Defender organization, or, if no such organization exists in the district, of the Administrative Office of the United States Courts. The defendant shall".

TITLE VII—MANDATORY LIFE IMPRISONMENT FOR PERSONS CONVICTED OF CERTAIN FELONIES

SEC. 70001. MANDATORY LIFE IMPRISONMENT FOR PERSONS CONVICTED OF CERTAIN FELONIES.

Section 3559 of title 18, United States Code, is amended—

(1) in subsection (b), by striking "An" and inserting "Except as provided in subsection (c), an" in lieu thereof; and

(2) by adding the following new subsection at the end:

"(c) IMPRISONMENT OF CERTAIN VIOLENT FELONS.—

"(1) MANDATORY LIFE IMPRISONMENT.—Notwithstanding any other provision of law, a person who is convicted in a court of the United States of a serious violent felony shall be sentenced to life imprisonment if—

"(A) the person has been convicted (and those convictions have become final) on separate prior occasions in a court of the United States or of a State of—

"(i) 2 or more serious violent felonies; or

"(ii) one or more serious violent felonies and one or more serious drug offenses; and

"(B) each serious violent felony or serious drug offense used as a basis for sentencing under this subsection, other than the first, was committed after the defendant's conviction of the preceding serious violent felony or serious drug offense.

"(2) DEFINITIONS.—For purposes of this subsection—

"(A) the term 'assault with intent to commit rape' means an offense that has as its elements engaging in physical contact by which a person intentionally places another person in fear of aggravated sexual abuse or sexual abuse (as described in sections 2241 and 2242);

"(B) the term 'arson' means an offense that has as its elements maliciously damaging or destroying any building, inhabited structure, vehicle, vessel, or real property by means of fire or an explosive;

"(C) the term 'extortion' means an offense that has as its elements the extraction of anything of value from another person by threatening or placing that person in fear of injury to any person or kidnapping of any person;

"(D) the term 'firearms use' means an offense that has as its elements those described in section 924(c) or 929(a), if the firearm was brandished, discharged, or otherwise used as a weapon and the crime of violence or drug trafficking crime during and relation to which the firearm was used was subject to prosecution in a court of the United States or a court of a State, or both;

"(E) the term 'kidnapping' means an offense that has as its elements the abduction, restraining, confining, or carrying away of another person by force or threat of force;

"(F) the term 'serious violent felony' means—

"(i) a Federal or State offense, by whatever designation and wherever committed, consisting of murder (as described in section 1111); manslaughter other than involuntary manslaughter (as described in section 1112); assault with intent to commit murder (as described in section 113(a)); assault with intent to commit rape; aggravated sexual abuse and sexual abuse (as described in sections 2241 and 2242); abusive sexual contact (as described in sections 2244 (a)(1) and (a)(2)); kidnapping; aircraft piracy (as described in section 46502 of Title 49); robbery (as described in section 2111, 2113, or 2118); carjacking (as described in section 2119); extortion; arson; firearms use; or attempt, conspiracy, or solicitation to commit any of the above offenses; and

"(ii) any other offense punishable by a maximum term of imprisonment of 10 years or more that has as an element the use, attempted use, or threatened use of physical force against the person of another or that, by its nature, involves a substantial risk that physical force against the person of another may be used in the course of committing the offense;

"(G) the term 'State' means a State of the United States, the District of Columbia, and a commonwealth, territory, or possession of the United States; and

"(H) the term 'serious drug offense' means—

"(i) an offense that is punishable under section 401(b)(1)(A) or 408 of the Controlled Substances Act (21 U.S.C. 841(b)(1)(A), 848) or section 1010(b)(1)(A) of the Controlled Substances Import and Export Act (21 U.S.C. 960(b)(1)(A)); or

"(ii) an offense under State law that, had the offense been prosecuted in a court of the United States, would have been punishable under section 401(b)(1)(A) or 408 of the Controlled Substances Act (21 U.S.C. 841(b)(1)(A), 848) or section 1010(b)(1)(A) of the Controlled Substances Import and Export Act (21 U.S.C. 960(b)(1)(A)).

"(3) NONQUALIFYING FELONIES.—

"(A) ROBBERY IN CERTAIN CASES.—Robbery, an attempt, conspiracy, or solicitation to commit robbery; or an offense described in paragraph (2)(F)(ii) shall not serve as a basis for sentencing under this subsection if the defendant establishes by clear and convincing evidence that—

"(i) no firearm or other dangerous weapon was used in the offense and no threat of use of a firearm or other dangerous weapon was involved in the offense; and

"(ii) the offense did not result in death or serious bodily injury (as defined in section 1365) to any person.

"(B) ARSON IN CERTAIN CASES.—Arson shall not serve as a basis for sentencing under this subsection if the defendant establishes by clear and convincing evidence that—

"(i) the offense posed no threat to human life; and

"(ii) the defendant reasonably believed the offense posed no threat to human life.

"(4) INFORMATION FILED BY UNITED STATES ATTORNEY.—The provisions of section 411(a) of the Controlled Substances Act (21 U.S.C. 851(a)) shall apply to the imposition of sentence under this subsection.

"(5) RULE OF CONSTRUCTION.—This subsection shall not be construed to preclude imposition of the death penalty.

"(6) SPECIAL PROVISION FOR INDIAN COUNTRY.—No person subject to the criminal jurisdiction of an Indian tribal government shall be subject to this subsection for any offense for which Federal jurisdiction is solely predicated on Indian country (as defined in section 1151) and which occurs within the boundaries of such Indian country unless the governing body of the tribe has elected that this subsection have effect over land and persons subject to the criminal jurisdiction of the tribe.

"(7) RESENTENCING UPON OVERTURNING OF PRIOR CONVICTION.—If the conviction for a serious violent felony or serious drug offense that was a basis for sentencing under this subsection is found, pursuant to any appropriate State or Federal procedure, to be unconstitutional or is vitiated on the explicit basis of innocence, or if the convicted person is pardoned on the explicit basis of innocence, the person serving a sentence imposed under this subsection shall be resentenced to any sentence that was available at the time of the original sentencing.".

SEC. 70002. LIMITED GRANT OF AUTHORITY TO BUREAU OF PRISONS.

Section 3582(c)(1)(A) of title 18, United States Code, is amended—

(1) so that the margin of the matter starting with "extraordinary" and ending with "reduction" the first place it appears is indented an additional two ems;

(2) by inserting a one-em dash after "that" the second place it appears;

(3) by inserting a semicolon after "reduction" the first place it appears;

(4) by indenting the first line of the matter referred to in paragraph (1) and designating that matter as clause (i); and

(5) by inserting after such matter the following:

"(ii) the defendant is at least 70 years of age, has served at least 30 years in prison, pursuant to a sentence imposed under section 3559(c), for the offense or offenses for which the defendant is currently imprisoned, and a determination has been made by the Director of the Bureau of Prisons that the defendant is not a danger to the safety of any other person or the community, as provided under section 3142(g);".

TITLE VIII—APPLICABILITY OF MANDATORY MINIMUM PENALTIES IN CERTAIN CASES

SEC. 80001. LIMITATION ON APPLICABILITY OF MANDATORY MINIMUM PENALTIES IN CERTAIN CASES.

(a) IN GENERAL.—Section 3553 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(f) LIMITATION ON APPLICABILITY OF STATUTORY MINIMUMS IN CERTAIN CASES.—Notwithstanding any other provision of law, in the case of an offense under section 401, 404, or 406 of the Controlled Substances Act (21 U.S.C. 841, 844, 846) or section 1010 or 1013 of the Controlled Substances Import and Export Act (21 U.S.C. 961, 963), the court shall impose a sentence pursuant to guidelines promulgated by the United States Sentencing Commission under section 994 of title 28 without regard to any statutory minimum sentence, if the court finds at sentencing that—

"(1) the defendant does not have more than 1 criminal history point, as determined under the sentencing guidelines;

"(2) the defendant did not use violence or credible threats of violence or possess a firearm or other dangerous weapon (or induce another participant to do so) in connection with the offense;

"(3) the offense did not result in death or serious bodily injury to any person;

"(4) the defendant was not an organizer, leader, manager, or supervisor of others in the offense, as determined under the sentencing guidelines; and

"(5) not later than the time of the sentencing hearing, the defendant has provided to the Government all information the defendant has concerning the offense or offenses that were part of the same course of conduct or of a common scheme or plan, but the fact that the defendant has no relevant or useful other information to provide or that the Government is already aware of the information shall not preclude a determination by the court that the defendant has complied with this requirement, and a defendant sentenced before this subsection takes effect shall be deemed to have satisfied the requirement of this paragraph if such defendant—

"(A) received an adjustment under the sentencing guidelines for acceptance of responsibility;

"(B) received a sentence below the applicable guideline range for having provided substantial assistance in the investigation or prosecution of another person who has committed an offense; or

"(C) provides to the Government, after moving for resentencing and before determination of that motion, all information that the defendant has concerning the offense or offenses that were part of the same course of conduct or of a common scheme or plan.

(b) SENTENCING COMMISSION AUTHORITY.—

(1) IN GENERAL.—(A) The United States Sentencing Commission (referred to in this subsection as the "Commission"), under section 994(a)(1) and (p) of title 28—

(i) shall promulgate guidelines, or amendments to guidelines, to carry out the purposes of this section and the amendment made by this section; and

(ii) may promulgate policy statements, or amendments to policy statements, to assist in the application of this section and that amendment.

(B) In the case of a defendant for whom the statutorily required minimum sentence is 5 years, such guidelines and amendments to guidelines issued under subparagraph (A) shall call for a guideline range in which the lowest term of imprisonment is at least 24 months.

(2) PROCEDURES.—If the Commission determines that it is necessary to do so in order that the amendments made under paragraph (1) may take effect on the effective date of the amendment made by subsection (a), the Commission may promulgate the amendments made under paragraph (1) in accordance with the procedures set forth in section 21(a) of the Sentencing Act of 1987, as though the authority under that section had not expired.

(c) EFFECTIVE DATE AND APPLICATION.—The amendment made by subsection (a) shall apply to all sentences imposed on or after the 10th day beginning after the date of enactment of this Act.

SEC. 80002. SPECIAL RULE.

(a) OFFENSES SUBJECT TO SENTENCING GUIDELINES.—For the purpose of section 3582(c)(2) of title 18, United States Code, with respect to a prisoner who, as determined by the court, has demonstrated good behavior while in prison, the changes in sentencing made as a result of this title shall be deemed to be changes in the sentencing ranges by the United States Sentencing Commission pursuant to section 994(o) of title 28, United States Code.

(b) OFFENSES NOT SUBJECT TO SENTENCING GUIDELINES.—Notwithstanding any other provision of law, a defendant serving a term of imprisonment who—

(1) was convicted of an offense that occurred prior to November 1, 1987, or was sentenced as if the offense had occurred before such date;

(2) meets the criteria set forth in section 3553(f) of title 18, United States Code; and

(3) has demonstrated good behavior while in prison; shall be eligible for release consideration under the provisions of chapter 311 of title 18, United States Code (as such provisions remain applicable to an individual who committed an offense prior to November 1, 1987). Such a release determination shall be made pursuant to the guidelines and policy statements issued by the United States Sentencing Commission.

TITLE IX—DRUG CONTROL

Subtitle A—Enhanced Penalties and General Provisions

SEC. 90101. ENHANCEMENT OF PENALTIES FOR DRUG TRAFFICKING IN PRISONS.

Section 1791 of title 18, United States Code, is amended—

(1) in subsection (c), by inserting before "Any" the following new sentence: "Any punishment imposed under subsection (b) for a violation of this section involving a controlled substance shall be consecutive to any other sentence imposed by any court for an offense involving such a controlled substance.";

(2) in subsection (d)(1)(A), by inserting after "a firearm or destructive device" the following: "or a controlled substance in schedule I or II, other than marijuana or a controlled substance referred to in subparagraph (C) of this subsection";

(3) in subsection (d)(1)(B), by inserting before "ammunition," the following: "marijuana or a controlled substance in schedule III, other than a controlled substance referred to in subparagraph (C) of this subsection,";

(4) in subsection (d)(1)(C), by inserting "methamphetamine, its salts, isomers, and salts of its isomers," after "a narcotic drug,";

(5) in subsection (d)(1)(D), by inserting "(A), (B), or" before "(C)"; and

(6) in subsection (b), by striking "(c)" each place it appears and inserting "(d)".

SEC. 90102. INCREASED PENALTIES FOR DRUG-DEALING IN "DRUG-FREE" ZONES.

Pursuant to its authority under section 994 of title 28, United States Code, the United States Sentencing Commission shall amend its sentencing guidelines to provide an appropriate enhancement for a defendant convicted of violating section 419 of the Controlled Substances Act (21 U.S.C. 860).

SEC. 90103. ENHANCED PENALTIES FOR ILLEGAL DRUG USE IN FEDERAL PRISONS AND FOR SMUGGLING DRUGS INTO FEDERAL PRISONS.

(a) DECLARATION OF POLICY.—It is the policy of the Federal Government that the use or distribution of illegal drugs in the Nation's Federal prisons will not be tolerated and that such crimes shall be prosecuted to the fullest extent of the law.

(b) SENTENCING GUIDELINES.—Pursuant to its authority under section 994 of title 28, United States Code, the United States Sentencing Commission shall amend its sentencing guidelines to appropriately enhance the penalty for a person convicted of an offense—

(1) under section 404 of the Controlled Substances Act involving simple possession of a controlled substance within a Federal prison or other Federal detention facility; or

(2) under section 401(b) of the Controlled Substances Act involving the smuggling of a controlled substance into a Federal prison or other Federal detention facility or the distribution or intended distribution of a controlled substance within a Federal prison or other Federal detention facility.

(c) NO PROBATION.—Notwithstanding any other law, the court shall not sentence a person convicted of an offense described in subsection (b) to probation.

SEC. 90104. CLARIFICATION OF NARCOTIC OR OTHER DANGEROUS DRUGS UNDER RICO.

Section 1961(1) of title 18, United States Code, is amended by striking "narcotic or other dangerous drugs" each place it appears and inserting "a controlled substance or listed chemical (as defined in section 102 of the Controlled Substances Act)".

SEC. 90105. CONFORMING AMENDMENTS TO RECIDIVIST PENALTY PROVISIONS OF THE CONTROLLED SUBSTANCES ACT AND THE CONTROLLED SUBSTANCES IMPORT AND EXPORT ACT.

(a) Sections 401(b)(1) (B), (C), and (D) of the Controlled Substances Act (21 U.S.C. 841(b)(1) (B), (C), and (D)) and sections 1010(b) (1), (2), and (3) of the Controlled Substances Import and Export Act (21 U.S.C. 960(b) (1), (2), and (3)) are each amended in the sentence or sentences beginning "If any person commits" by striking "one or more prior convictions" through "have become final" and inserting "a prior conviction for a felony drug offense has become final".

(b) Section 1012(b) of the Controlled Substances Import and Export Act (21 U.S.C. 962(b)) is amended by striking "one or more prior convictions of him for a felony under any provision of this title or title II or other law of a State, the United States, or a foreign country relating to narcotic drugs, marihuana, or depressant or stimulant drugs, have become final" and inserting "one or more prior convictions of such person for a felony drug offense have become final".

(c) Section 401(b)(1)(A) of the Controlled Substances Act (21 U.S.C. 841(b)(1)(A)) is amended by striking the sentence beginning "For purposes of this subparagraph, the term 'felony drug offense' means".

(d) Section 102 of the Controlled Substances Act (21 U.S.C. 802) is amended by adding at the end the following new paragraph:

"(43) The term 'felony drug offense' means an offense that is punishable by imprisonment for more than one year under any law of the United States or of a State or foreign country that prohibits or restricts conduct relating to narcotic drugs, marihuana, or depressant or stimulant substances.".

SEC. 90106. ADVERTISING.

Section 403 of the Controlled Substances Act (21 U.S.C. 843) is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following new subsection:

"(c) It shall be unlawful for any person to place in any newspaper, magazine, handbill, or other publications, any written advertisement knowing that it has the purpose of seeking or offering illegally to receive, buy, or distribute a Schedule I controlled substance. As used in this section the term 'advertisement' includes, in addition to its ordinary meaning, such advertisements as those for a catalog of Schedule I controlled substances and any similar written advertisement that has the purpose of seeking or offering illegally to receive, buy, or distribute a Schedule I controlled substance. The term 'advertisement' does not include material which merely advocates the use of a similar material, which advocates a position or practice, and does not attempt to propose or facilitate an actual transaction in a Schedule I controlled substance.".

SEC. 90107. VIOLENT CRIME AND DRUG EMERGENCY AREAS.

(a) DEFINITIONS.—In this section—

"major violent crime or drug-related emergency" means an occasion or instance in which violent crime, drug smuggling, drug trafficking, or drug abuse violence reaches such levels, as *determined by the President, that Federal assistance is needed to supplement State and local efforts and capabilities to save lives, and to protect property and public health and safety.*

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

(b) DECLARATION OF VIOLENT CRIME AND DRUG EMERGENCY AREAS.—If a major violent crime or drug-related emergency exists throughout a State or a part of a State, the President may declare the State or part of a State to be a violent crime or drug emergency area and may take appropriate actions authorized by this section.

(c) PROCEDURE.—

(1) IN GENERAL.—A request for a declaration designating an area to be a violent crime or drug emergency area shall be made, in writing, by the chief executive officer of a State or local government, respectively (or in the case of the District of Columbia, the mayor), and shall be forwarded to the Attorney General in such form as the Attorney General may by regulation require. One or more cities, counties, States, or the District of Columbia may submit a joint request for designation as a major violent crime or drug emergency area under this subsection.

(2) FINDING.—A request made under paragraph (1) shall be based on a written finding that the major violent crime or drug-related emergency is of such severity and magnitude that Federal assistance is necessary to ensure an effective response to save lives and to protect property and public health and safety.

(d) IRRELEVANCY OF POPULATION DENSITY.—The President shall not limit declarations made under this section to highly populated centers of violent crime or drug trafficking, drug smuggling, or drug use, but shall also consider applications from governments of less populated areas where the magnitude and severity of such activities is beyond the capability of the State or local government to respond.

(e) REQUIREMENTS.—As part of a request for a declaration under this section, and as a prerequisite to Federal violent crime or drug emergency assistance under this section, the chief executive officer of a State or local government shall—

(1) take appropriate action under State or local law and furnish information on the nature and amount of State and local resources that have been or will be committed to alleviating the major violent crime- or drug-related emergency;

(2) submit a detailed plan outlining that government's short- and long-term plans to respond to the violent crime or drug emergency, specifying the types and levels of Federal assistance requested and including explicit goals (including quantitative goals) and timetables; and

(3) specify how Federal assistance provided under this section is intended to achieve those goals.

(f) REVIEW PERIOD.—The Attorney General shall review a request submitted pursuant to this section, and the President shall decide whether to declare a violent crime or drug emergency area, within 30 days after receiving the request.

(g) FEDERAL ASSISTANCE.—The President may—

(1) direct any Federal agency, with or without reimbursement, to utilize its authorities and the resources granted to it under Federal law (including personnel, equipment, supplies, facilities, financial assistance, and managerial, technical, and advisory services) in support of State and local assistance efforts; and

(2) provide technical and advisory assistance, including communications support and law enforcement-related intelligence information.

(h) DURATION OF FEDERAL ASSISTANCE.—

(1) IN GENERAL.—Federal assistance under this section shall not be provided to a violent crime or drug emergency area for more than 1 year.

(2) EXTENSION.—The chief executive officer of a jurisdiction may apply to the President for an extension of assistance beyond 1 year. The President may extend the provision of Federal assistance for not more than an additional 180 days.

(i) REGULATIONS.—Not later than 120 days after the date of enactment of this Act, the Attorney General shall issue regulations to implement this section.

(j) NO EFFECT ON EXISTING AUTHORITY.—Nothing in this section shall diminish or detract from existing authority possessed by the President or Attorney General.

Subtitle B—NATIONAL NARCOTICS LEADERSHIP ACT AMENDMENTS

SEC. 90201. IMPLEMENTATION OF NATIONAL DRUG CONTROL STRATEGY.

(a) PROGRAM BUDGET.—Section 1003(c) of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1502(c)) is amended—

(1) by redesignating paragraphs (5), (6), and (7), as paragraphs (6), (7), and (8), respectively; and

(2) by inserting after paragraph (4) the following new paragraph:

"(5) The Director shall request the head of a department or agency to include in the department's or agency's budget submission to the Office of Management and Budget funding requests for specific initiatives that are consistent with the President's priorities for the National Drug Control Strategy and certifications made pursuant to paragraph (3), and the head of the department or agency shall comply with such a request.".

(b) BUDGET RECOMMENDATION.—Section 1003(b) of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1502(b)) is amended—

(1) by striking "and" at the end of paragraph (6);

(2) by striking the period at the end of paragraph (7) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(8) provide, by July 1 of each year, budget recommendations to the heads of departments and agencies with responsibilities under the National Drug Control Program, which recommendations shall apply to the second following fiscal year and address funding priorities developed in the annual National Drug Control Strategy.".

(c) CONTROL OF DRUG-RELATED RESOURCES.—Section 1003 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1502) is amended—

(1) in subsection (d)—

(A) by amending paragraph (2) to read as follows:

"(2) request the head of a department or agency or program to place department, agency, or program personnel who are engaged in drug control activities on temporary detail to another department or agency in order to implement the National Drug Control Strategy, and the head of the department or agency shall comply with such a request;

(B) by striking "and" at the end of paragraph (6);

(C) by striking the period at the end of paragraph (7) and inserting a semicolon; and

(D) by adding after paragraph (7) the following new paragraphs:

"(8) except to the extent that the Director's authority under this paragraph is limited in an annual appropriations Act, transfer funds appropriated to a National Drug Control Program agency account to a different National Drug Control Program agency account in an amount that does not exceed 2 percent of the amount appropriated to either account, upon advance approval of the Committees on Appropriations of each House of Congress; and

"(9) in order to ensure compliance with the National Drug Control Program, issue to the head of a National Drug Control Program agency a funds control notice described in subsection (f)."; and

(2) by adding at the end the following new subsections:

"(f) FUNDS CONTROL NOTICES.—(1) A funds control notice may direct that all or part of an amount appropriated to the National Drug Control Program agency account be obligated by—

"(A) months, fiscal year quarters, or other time periods; and

"(B) activities, functions, projects, or object classes.

"(2) An officer or employee of a National Drug Control Program agency shall not make or authorize an expenditure or obligation contrary to a funds control notice issued by the Director.

"(3) In the case of a violation of paragraph (2) by an officer or employee of a National Drug Control Program agency, the head of the agency, upon the request of and in consultation with the Director, may subject the officer or employee to appropriate administrative discipline, including, when circumstances warrant, suspension from duty without pay or removal from office.".

(d) CERTIFICATION OF ADEQUACY OF BUDGET REQUEST.—Section 1003(c)(3)(B) of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1502(c)(3)(B)) is amended—

(1) by inserting "in whole or in part" after "adequacy of such request"; and

(2) by striking the semicolon at the end and inserting "and, with respect to a request that is not certified as adequate to implement the objectives of the National Drug Control Strategy, include in the certification an initiative or funding level that would make the request adequate;".

SEC. 90202. OFFICE PERSONNEL RESTRICTION.

Section 1003 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1502) is amended by adding at the end the following new subsection:

"(f) PROHIBITION ON POLITICAL CAMPAIGNING.—A Federal officer in the Office of National Drug Control Policy who is appointed by the President, by and with the advice and consent of the Senate, may not participate in Federal election campaign activities, except that such an official is not prohibited by this subsection from making contributions to individual candidates.".

SEC. 90203. NATIONAL DRUG CONTROL STRATEGY OUTCOME MEASURES.

Section 1005(a) of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1504(a)) is amended—

(1) in paragraph (2)(A) by inserting "and the consequences of drug abuse" after "drug abuse"; and

(2) by amending paragraph (4) to read as follows:

"(4) The Director shall include with each National Drug Control Strategy an evaluation of the effectiveness of Federal drug control during the preceding year. The evaluation shall include an assessment of Federal drug control efforts, including—

"(A) assessment of the reduction of drug use, including estimates of drug prevalence and frequency of use as measured by national, State, and local surveys of illicit drug use and by other special studies of—

"(i) high-risk populations, including school dropouts, the homeless and transient, arrestees, parolees, and probationers, and juvenile delinquents; and

"(ii) drug use in the workplace and the productivity lost by such use;

"(B) assessment of the reduction of drug availability, as measured by—

"(i) the quantities of cocaine, heroin, and marijuana available for consumption in the United States;

"(ii) the amount of cocaine and heroin entering the United States;

"(iii) the number of hectares of poppy and coca cultivated and destroyed;

"(iv) the number of metric tons of heroin and cocaine seized;

"(v) the number of cocaine processing labs destroyed;

"(vi) changes in the price and purity of heroin and cocaine;

"(vii) the amount and type of controlled substances diverted from legitimate retail and wholesale sources; and

"(viii) the effectiveness of Federal technology programs at improving drug detection capabilities at United States ports of entry;

"(C) assessment of the reduction of the consequences of drug use and availability, which shall include estimation of—

"(i) burdens drug users placed on hospital emergency rooms in the United States, such as the quantity of drug-related services provided;

"(ii) the annual national health care costs of drug use, including costs associated with people becoming infected with the human immunodeficiency virus and other communicable diseases as a result of drug use;

"(iii) the extent of drug-related crime and criminal activity; and

"(iv) the contribution of drugs to the underground economy, as measured by the retail value of drugs sold in the United States; and

"(D) determination of the status of drug treatment in the United States, by assessing—

"(i) public and private treatment capacity within each State, including information on the number of treatment slots available in relation to the number actually used, including data on intravenous drug users and pregnant women;

"(ii) the extent, within each State, to which treatment is available, on demand, to intravenous drug users and pregnant women;

"(iii) the number of drug users the Director estimates could benefit from treatment; and

"(iv) the success of drug treatment programs, including an assessment of the effectiveness of the mechanisms in place federally, and within each State, to determine the relative quality of substance abuse treatment programs, the qualifications of treatment personnel, and the mechanism by which patients are admitted to the most appropriate and cost effective treatment setting.

"(5) The Director shall include with the National Drug Control Strategy required to be submitted not later than February 1, 1995, and with every second such strategy submitted thereafter—

"(A) an assessment of the quality of current drug use measurement instruments and techniques to measure supply reduction and demand reduction activities;

"(B) an assessment of the adequacy of the coverage of existing national drug use measurement instruments and techniques to measure the casual drug user population and groups at-risk for drug use;

"(C) an assessment of the actions the Director shall take to correct any deficiencies and limitations identified pursuant to subparagraphs (A) and (B); and

"(D) identification of the specific factors that restrict the availability of treatment services to those seeking it and proposed administrative or legislative remedies to make treatment available to those individuals.

"(6) Federal agencies responsible for the collection or estimation of drug-related information required by the Director shall cooperate with the Director, to the fullest extent possible, to enable the Director to satisfy the requirements of sections 4 and 5.

"(7) With each National Drug Control Strategy, the Director shall report to the President and the Congress on the Director's assessment of drug use and availability in the United States, including an estimate of the effectiveness of interdiction, treatment, prevention, law enforcement, and international programs under the National Drug Control Strategy in effect in the preceding year in reducing drug use and availability.".

SEC. 90204. COUNTER-DRUG TECHNOLOGY ASSESSMENT CENTER.

(a) DRUG ABUSE ADDICTION AND REHABILITATION CENTER.—Section 1003A of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1502a(c)(1)) is amended—

(1) by redesignating subparagraphs (B), (C), and (D) as subparagraphs (C), (D), and (E), respectively; and

(2) by inserting after subparagraph (A) the following:

"(B) in consultation with the National Institute on Drug Abuse, and through interagency agreements or grants, examine addiction and rehabilitation research and the application of technology to expanding the effectiveness or availability of drug treatment;".

(b) ASSISTANCE FROM THE ADVANCED RESEARCH PROJECT AGENCY.—Section 1003A of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1502a) is amended by adding at the end the following:

"(f) ASSISTANCE AND SUPPORT TO OFFICE OF NATIONAL DRUG CONTROL POLICY.—The Director of the Advanced Research Project Agency shall, to the fullest extent possible, render assistance and support to the Office of National Drug Control Policy and its Director.".

(c) REPEAL AND REDESIGNATION.—The National Narcotics Leadership Act of 1988 is amended by—

(1) repealing section 1008 (21 U.S.C. 1505), as in effect on the date of the enactment of this Act;

(2) redesignating section 1003A, as amended by subsection (b) of this section, as section 1008; and

(3) moving such section, as redesignated, so as to follow section 1007.

SEC. 90205. SPECIAL FORFEITURE FUND AMENDMENTS.

(a) DEPOSITS INTO SPECIAL FORFEITURE FUND.—Section 6073 of the Asset Forfeiture Amendments Act of 1988 (21 U.S.C. 1509) is amended to read as follows:

"(b) DEPOSITS.—There shall be deposited into the Fund the amounts specified by section 524(c)(9) of title 28, United States Code, and section 9307(g) of title 31, United States Code, and any earnings on the investments authorized by subsection (d).".

(b) TRANSFERS FROM DEPARTMENT OF JUSTICE ASSETS FORFEITURE FUND.—Section 524(c)(9) of title 28, United States Code, is amended by amending subparagraphs (B), (C), and (D) to read as follows:

"(B) Subject to subparagraphs (C) and (D), at the end of each of fiscal years 1994, 1995, 1996, and 1997, the Attorney General shall transfer from the Fund not more than $100,000,000 to the Special Forfeiture Fund established by section 6073 of the Anti-Drug Abuse Act of 1988.

"(C) Transfers under subparagraph (B) may be made only from the excess unobligated balance and may not exceed one-half of the excess unobligated balance for any year. In addition, transfers under subparagraph (B) may be made only to the extent that the sum of the transfers in a fiscal year and one-half of the unobligated balance at the beginning of that fiscal year for the Special Forfeiture Fund does not exceed $100,000,000.

"(D) For the purpose of determining amounts available for distribution at year end for any fiscal year, 'excess unobligated balance' means the unobligated balance of the Fund generated by that fiscal year's operations, less any amounts that are required to be retained in the Fund to ensure the availability of amounts in the subsequent fiscal year for purposes authorized under paragraph (1).".

(c) TRANSFERS FROM DEPARTMENT OF THE TREASURY FORFEITURE FUND.— Section 9703(g) of title 31, United States Code, is amended—

(1) in paragraph (3)—

(A) by amending subparagraph (A) to read as follows:

"(A) Subject to subparagraphs (B) and (C), at the end of each of fiscal years 1994, 1995, 1996, and 1997, the Secretary shall transfer from the Fund not more than $100,000,000 to the Special Forfeiture Fund established by section 6073 of the Anti-Drug Abuse Act of 1988."; and

(B) in subparagraph (B) by adding the following at the end: "Further, transfers under subparagraph (A) may not exceed one-half of the excess unobligated balance for a year. In addition, transfers under subparagraph (A) may be made only to the extent that the sum of the transfers in a fiscal year and one-half of the unobligated balance at the beginning of that fiscal year for the Special Forfeiture Fund does not exceed $100,000,000."; and

(2) in subparagraph (4)(A)—

(A) in clause (i) by striking "(i)"; and

(B) by striking clause (ii).

(d) SURPLUS FUNDS.—Section 6073 of the Asset Forfeiture Amendments Act of 1988 (21 U.S.C. 1509) is amended—

(1) by redesignating subsections (c), (d), (e), and (f), as subsections (d), (e), (f), and (g), respectively; and

(2) by inserting after subsection (b) the following new subsection:

"(c) SUPER SURPLUS.—(1) Any unobligated balance up to $20,000,000 remaining in the Fund on September 30 of a fiscal year shall be available to the Director, subject to paragraph (2), to transfer to, and for obligation and expenditure in connection with drug control activities of, any Federal agency or State or local entity with responsibilities under the National Drug Control Strategy.

"(2) A transfer may be made under paragraph (1) only with the advance written approval of the Committees on Appropriations of each House of Congress.".

SEC. 90206. AUTHORIZATION OF APPROPRIATIONS.

Section 1011 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1508) is amended by striking "4" and inserting "8".

SEC. 90207. ADEQUATE STAFFING OF THE OFFICE OF NATIONAL DRUG CONTROL POLICY.

Section 1008(d)(1) of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1502(d)(1)) is amended by striking "such" and inserting "up to 75 and such additional".

SEC. 90208. TERMINATION OF OFFICE OF NATIONAL DRUG CONTROL POLICY.

(a) REAUTHORIZATION.—Section 1009 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1506) is amended by striking "the date which is 5 years after the date of the enactment of this subtitle" and inserting "September 30, 1997".

(b) CONTINUED EFFECTIVENESS.—The National Narcotics Leadership Act of 1988 (21 U.S.C. 1501 et seq.) shall be considered not to have been repealed by operation of section 1009 of that Act, but shall remain in effect as if the amendment made by subsection (a) had been included in that Act on the date of its enactment.

TITLE X—DRUNK DRIVING PROVISIONS

SEC. 100001. SHORT TITLE.

This title may be cited as the "Drunk Driving Child Protection Act of 1994".

SEC. 100002. STATE LAWS APPLIED IN AREAS OF FEDERAL JURISDICTION.

Section 13(b) of title 18, United States Code, is amended—

(1) by striking ''For purposes'' and inserting ''(1) Subject to paragraph (2) and for purposes''; and

(2) by adding at the end the following new paragraph:

''(2)(A) In addition to any term of imprisonment provided for operating a motor vehicle under the influence of a drug or alcohol imposed under the law of a State, territory, possession, or district, the punishment for such an offense under this section shall include an additional term of imprisonment of not more than 1 year, or if serious bodily injury of a minor is caused, not more than 5 years, or if death of a minor is caused, not more than 10 years, and an additional fine of not more than $1,000, or both, if—

''(i) a minor (other than the offender) was present in the motor vehicle when the offense was committed; and

''(ii) the law of the State, territory, possession, or district in which the offense occurred does not provide an additional term of imprisonment under the circumstances described in clause (i).

''(B) For the purposes of subparagraph (A), the term 'minor' means a person less than 18 years of age.''.

SEC. 100003. DRIVING WHILE INTOXICATED PROSECUTION PROGRAM.

Section 501(b) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3751) is amended—

(1) by striking ''and'' at the end of paragraph (20);

(2) by striking the period at the end of paragraph (21) and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(22) programs for the prosecution of driving while intoxicated charges and the enforcement of other laws relating to alcohol use and the operation of motor vehicles.''.

TITLE XI—FIREARMS

Subtitle A—Assault Weapons

SEC. 110101. SHORT TITLE.

This subtitle may be cited as the ''Public Safety and Recreational Firearms Use Protection Act''.

SEC. 110102. RESTRICTION ON MANUFACTURE, TRANSFER, AND POSSESSION OF CERTAIN SEMIAUTOMATIC ASSAULT WEAPONS.

(a) RESTRICTION.—Section 922 of title 18, United States Code, is amended by adding at the end the following new subsection:

''(v)(1) It shall be unlawful for a person to manufacture, transfer, or possess a semiautomatic assault weapon.

''(2) Paragraph (1) shall not apply to the possession or transfer of any semiautomatic assault weapon otherwise lawfully possessed under Federal law on the date of the enactment of this subsection.

''(3) Paragraph (1) shall not apply to—

''(A) any of the firearms, or replicas or duplicates of the firearms, specified in Appendix A to this section, as such firearms were manufactured on October 1, 1993;

''(B) any firearm that—

''(i) is manually operated by bolt, pump, lever, or slide action;

''(ii) has been rendered permanently inoperable; or

''(iii) is an antique firearm;

''(C) any semiautomatic rifle that cannot accept a detachable magazine that holds more than 5 rounds of ammunition; or

''(D) any semiautomatic shotgun that cannot hold more than 5 rounds of ammunition in a fixed or detachable magazine.

The fact that a firearm is not listed in Appendix A shall not be construed to mean that paragraph (1) applies to such firearm. No firearm exempted by this subsection may be deleted from Appendix A so long as this subsection is in effect.

''(4) Paragraph (1) shall not apply to—

''(A) the manufacture for, transfer to, or possession by the United States or a department or agency of the United States or a State or a department, agency, or political subdivision of a State, or a transfer to or possession by a law enforcement officer employed by such an entity for purposes of law enforcement (whether on or off duty);

''(B) the transfer to a licensee under title I of the Atomic Energy Act of 1954 for purposes of establishing and maintaining an on-site physical protection system and security organization required by Federal law, or possession by an employee or contractor of such licensee on-site for such purposes or off-site for purposes of licensee-authorized training or transportation of nuclear materials;

''(C) the possession, by an individual who is retired from service with a law enforcement agency and is not otherwise prohibited from receiving a firearm, of a semiautomatic assault weapon transferred to the individual by the agency upon such retirement; or

''(D) the manufacture, transfer, or possession of a semiautomatic assault weapon by a licensed manufacturer or licensed importer for the purposes of testing or experimentation authorized by the Secretary.''.

(b) DEFINITION OF SEMIAUTOMATIC ASSAULT WEAPON.—Section 921(a) of title 18, United States Code, is amended by adding at the end the following new paragraph:

''(30) The term 'semiautomatic assault weapon' means—

''(A) any of the firearms, or copies or duplicates of the firearms in any caliber, known as—

''(i) Norinco, Mitchell, and Poly Technologies Avtomat Kalashnikovs (all models);

''(ii) Action Arms Israeli Military Industries UZI and Galil;

''(iii) Beretta Ar70 (SC–70);

''(iv) Colt AR–15;

''(v) Fabrique National FN/FAL, FN/LAR, and FNC;

''(vi) SWD M–10, M–11, M–11/9, and M–12;

''(vii) Steyr AUG;

''(viii) INTRATEC TEC–9, TEC–DC9 and TEC–22; and

''(ix) revolving cylinder shotguns, such as (or similar to) the Street Sweeper and Striker 12;

''(B) a semiautomatic rifle that has an ability to accept a detachable magazine and has at least 2 of—

''(i) a folding or telescoping stock;

''(ii) a pistol grip that protrudes conspicuously beneath the action of the weapon;

''(iii) a bayonet mount;

''(iv) a flash suppressor or threaded barrel designed to accommodate a flash suppressor; and

''(v) a grenade launcher;

''(C) a semiautomatic pistol that has an ability to accept a detachable magazine and has at least 2 of—

''(i) an ammunition magazine that attaches to the pistol outside of the pistol grip;

''(ii) a threaded barrel capable of accepting a barrel extender, flash suppressor, forward handgrip, or silencer;

''(iii) a shroud that is attached to, or partially or completely encircles, the barrel and that permits the shooter to hold the firearm with the nontrigger hand without being burned;

''(iv) a manufactured weight of 50 ounces or more when the pistol is unloaded; and

''(v) a semiautomatic version of an automatic firearm; and

''(D) a semiautomatic shotgun that has at least 2 of—

''(i) a folding or telescoping stock;

''(ii) a pistol grip that protrudes conspicuously beneath the action of the weapon;

''(iii) a fixed magazine capacity in excess of 5 rounds; and

''(iv) an ability to accept a detachable magazine.''.

(c) PENALTIES.—

(1) VIOLATION OF SECTION 922(v).—Section 924(a)(1)(B) of such title is amended by striking ''or (q) of section 922'' and inserting ''(r), or (v) of section 922''.

(2) USE OR POSSESSION DURING CRIME OF VIOLENCE OR DRUG TRAFFICKING CRIME.—Section 924(c)(1) of such title is amended in the first sentence by inserting '', or semiautomatic assault weapon,'' after ''short-barreled shotgun,''.

(d) IDENTIFICATION MARKINGS FOR SEMIAUTOMATIC ASSAULT WEAPONS.—Section 923(i) of such title is amended by adding at the end the following: ''The serial number of any semiautomatic assault weapon manufactured after the date of the enactment of this sentence shall clearly show the date on which the weapon was manufactured.''.

SEC. 110103. BAN OF LARGE CAPACITY AMMUNITION FEEDING DEVICES.

(a) PROHIBITION.—Section 922 of title 18, United States Code, as amended by section 110102(a), is amended by adding at the end the following new subsection:

''(w)(1) Except as provided in paragraph (2), it shall be unlawful for a person to transfer or possess a large capacity ammunition feeding device.

''(2) Paragraph (1) shall not apply to the possession or transfer of any large capacity ammunition feeding device otherwise lawfully possessed on the date of the enactment of this subsection.

''(3) This subsection shall not apply to—

''(A) the manufacture for, transfer to, or possession by the United States or a department or agency of the United States or a State or a department, agency, or political subdivision of a State, or a transfer to or possession by a law enforcement officer employed by such an entity for purposes of law enforcement (whether on or off duty);

''(B) the transfer to a licensee under title I of the Atomic Energy Act of 1954 for purposes of establishing and maintaining an on-site physical protection system and security organization required by Federal law, or possession by an employee or contractor of such licensee on-site for such purposes or off-site for purposes of licensee-authorized training or transportation of nuclear materials;

''(C) the possession, by an individual who is retired from service with a law enforcement agency and is not otherwise prohibited from receiving ammunition, of a large capacity ammunition feeding device transferred to the individual by the agency upon such retirement; or

''(D) the manufacture, transfer, or possession of any large capacity ammunition feeding device by a licensed manufacturer or licensed importer for the purposes of testing or experimentation authorized by the Secretary.''

(b) DEFINITION OF LARGE CAPACITY AMMUNITION FEEDING DEVICE.—Section 921(a) of title 18, United States Code, as amended by section 110102(b), is amended by adding at the end the following new paragraph:

''(31) The term 'large capacity ammunition feeding device'—

''(A) means—

''(i) a magazine, belt, drum, feed strip, or similar device that has a capacity of, or that can be readily restored or converted to accept, more than 10 rounds of ammunition; and

''(ii) any combination of parts from which a device described in clause (i) can be assembled; but

''(B) does not include an attached tubular device designed to accept, and capable of operating only with, .22 caliber rimfire ammunition.''.

(c) Large Capacity Ammunition Feeding Devices Treated as Firearms.—Section 921(a)(3) of title 18, United States Code, is amended in the first sentence by striking "or (D) any destructive device." and inserting "(D) any destructive device; or (E) any large capacity ammunition feeding device.".

(d) Penalty.—Section 924(a)(1)(B) of title 18, United States Code, as amended by section 110102(c)(1), is amended by striking "or (v)" and inserting "(v), or (w)".

(e) Identification Markings for Large Capacity Ammunition Feeding Devices.—Section 923(i) of title 18, United States Code, as amended by section 110102(d) of this Act, is amended by adding at the end the following: "A large capacity ammunition feeding device manufactured after the date of the enactment of this sentence shall be identified by a serial number that clearly shows that the device was manufactured or imported after the effective date of this subsection, and such other identification as the Secretary may by regulation prescribe.".

SEC. 110104. STUDY BY ATTORNEY GENERAL.

(a) Study.—The Attorney General shall investigate and study the effect of this subtitle and the amendments made by this subtitle, and in particular shall determine their impact, if any, on violent and drug trafficking crime. The study shall be conducted over a period of 18 months, commencing 12 months after the date of enactment of this Act.

(b) Report.—Not later than 30 months after the date of enactment of this Act, the Attorney General shall prepare and submit to the Congress a report setting forth in detail the findings and determinations made in the study under subsection (a).

SEC. 110105. EFFECTIVE DATE.

This subtitle and the amendments made by this subtitle—

(1) shall take effect on the date of the enactment of this Act; and

(2) are repealed effective as of the date that is 10 years after that date.

SEC. 110106. APPENDIX A TO SECTION 922 OF TITLE 18.

Section 922 of title 18, United States Code, is amended by adding at the end the following appendix:

"APPENDIX A

Centerfire Rifles—Autoloaders

Browning BAR Mark II Safari Semi-Auto Rifle
Browning BAR Mark II Safari Magnum Rifle
Browning High-Power Rifle
Heckler & Koch Model 300 Rifle
Iver Johnson M–1 Carbine
Iver Johnson 50th Anniversary M–1 Carbine
Marlin Model 9 Camp Carbine
Marlin Model 45 Carbine
Remington Nylon 66 Auto-Loading Rifle
Remington Model 7400 Auto Rifle
Remington Model 7400 Rifle
Remington Model 7400 Special Purpose Auto Rifle
Ruger Mini-14 Autoloading Rifle (w/o folding stock)
Ruger Mini Thirty Rifle

Centerfire Rifles—Lever & Slide

Browning Model 81 BLR Lever-Action Rifle
Browning Model 81 Long Action BLR
Browning Model 1886 Lever-Action Carbine
Browning Model 1886 High Grade Carbine
Cimarron 1860 Henry Replica
Cimarron 1866 Winchester Replicas
Cimarron 1873 Short Rifle
Cimarron 1873 Sporting Rifle
Cimarron 1873 30" Express Rifle
Dixie Engraved 1873 Rifle
E.M.F. 1866 Yellowboy Lever Actions
E.M.F. 1860 Henry Rifle
E.M.F. Model 73 Lever-Action Rifle
Marlin Model 336CS Lever-Action Carbine
Marlin Model 30AS Lever-Action Carbine
Marlin Model 444SS Lever-Action Sporter
Marlin Model 1894S Lever-Action Carbine
Marlin Model 1894CS Carbine
Marlin Model 1894CL Classic
Marlin Model 1895SS Lever-Action Rifle
Mitchell 1858 Henry Replica
Mitchell 1866 Winchester Replica
Mitchell 1873 Winchester Replica
Navy Arms Military Henry Rifle
Navy Arms Henry Trapper
Navy Arms Iron Frame Henry
Navy Arms Henry Carbine
Navy Arms 1866 Yellowboy Rifle
Navy Arms 1873 Winchester-Style Rifle
Navy Arms 1873 Sporting Rifle
Remington 7600 Slide Action
Remington Model 7600 Special Purpose Slide Action
Rossi M92 SRC Saddle-Ring Carbine
Rossi M92 SRS Short Carbine
Savage 99C Lever-Action Rifle
Uberti Henry Rifle
Uberti 1866 Sporting Rilfe
Uberti 1873 Sporting Rifle
Winchester Model 94 Side Eject Lever-Action Rifle
Winchester Model 94 Trapper Side Eject
Winchester Model 94 Big Bore Side Eject
Winchester Model 94 Ranger Side Eject Lever-Action Rifle
Winchester Model 94 Wrangler Side Eject

Centerfire Rifles—Bolt Action

Alpine Bolt-Action Rifle
A-Square Caesar Bolt-Action Rifle
A-Square Hannibal Bolt-Action Rifle
Anschutz 1700D Classic Rifles
Anschutz 1700D Custom Rifles
Anschutz 1700D Bavarian Bolt-Action Rifle
Anschutz 1733D Mannlicher Rifle
Barret Model 90 Bolt-Action Rifle
Beeman/HW 60J Bolt-Action Rifle
Blaser R84 Bolt-Action Rifle
BRNO 537 Sporter Bolt-Action Rifle
BRNO ZKB 527 Fox Bolt-Action Rifle
BRNO ZKK 600, 601, 602 Bolt-Action Rifles
Browning A-Bolt Rifle
Browning A-Bolt Stainless Stalker
Browning A-Bolt Left Hand
Browning A-Bolt Short Action
Browning Euro-Bolt Rifle
Browning A-Bolt Gold Medallion
Browning A-Bolt Micro Medallion
Century Centurion 14 Sporter
Century Enfield Sporter #4
Century Swedish Sporter #38
Century Mauser 98 Sporter
Cooper Model 38 Centerfire Sporter
Dakota 22 Sporter Bolt-Action Rifle
Dakota 76 Classic Bolt-Action Rifle
Dakota 76 Short Action Rifles
Dakota 76 Safari Bolt-Action Rifle
Dakota 416 Rigby African
E.A.A./Sabatti Rover 870 Bolt-Action Rifle
Auguste Francotte Bolt-Action Rifles
Carl Gustaf 2000 Bolt-Action Rifle
Heym Magnum Express Series Rifle
Howa Lightning Bolt-Action Rifle
Howa Realtree Camo Rifle
Interarms Mark X Viscount Bolt-Action Rifle
Interarms Mini-Mark X Rifle
Interarms Mark X Whitworth Bolt-Action Rifle
Interarms Whitworth Express Rifle
Iver Johnson Model 5100A1 Long-Range Rifle
KDF K15 American Bolt-Action Rifle
Krico Model 600 Bolt-Action Rifle
Krico Model 700 Bolt-Action Rifles
Mauser Model 66 Bolt-Action Rifle
Mauser Model 99 Bolt-Action Rifle
McMillan Signature Classic Sporter
McMillan Signature Super Varminter
McMillan Signature Alaskan
McMillan Signature Titanium Mountain Rifle
McMillan Classic Stainless Sporter
McMillan Talon Safari Rifle
McMillan Talon Sporter Rifle
Midland 1500S Survivor Rifle
Navy Arms TU–33/40 Carbine
Parker-Hale Model 81 Classic Rifle
Parker-Hale Model 81 Classic African Rifle
Parker-Hale Model 1000 Rifle
Parker-Hale Model 1100M African Magnum
Parker-Hale Model 1100 Lightweight Rifle
Parker-Hale Model 1200 Super Rifle
Parker-Hale Model 1200 Super Clip Rifle
Parker-Hale Model 1300C Scout Rifle
Parker-Hale Model 2100 Midland Rifle
Parker-Hale Model 2700 Lightweight Rifle
Parker-Hale Model 2800 Midland Rifle
Remington Model Seven Bolt-Action Rifle
Remington Model Seven Youth Rifle
Remington Model Seven Custom KS
Remington Model Seven Custom MS Rifle
Remington 700 ADL Bolt-Action Rifle
Remington 700 BDL Bolt-Action Rifle
Remington 700 BDL Varmint Special
Remington 700 BDL European Bolt-Action Rifle
Remington 700 Varmint Synthetic Rifle
Remington 700 BDL SS Rifle
Remington 700 Stainless Synthetic Rifle
Remington 700 MTRSS Rifle
Remington 700 BDL Left Hand
Remington 700 Camo Synthetic Rifle
Remington 700 Safari
Remington 700 Mountain Rifle
Remington 700 Custom KS Mountain Rifle
Remington 700 Classic Rifle
Ruger M77 Mark II Rifle
Ruger M77 Mark II Magnum Rifle
Ruger M77RL Ultra Light
Ruger M77 Mark II All-Weather Stainless Rifle
Ruger M77 RSI International Carbine
Ruger M77 Mark II Express Rifle
Ruger M77VT Target Rifle
Sako Hunter Rifle
Sako Fiberclass Sporter
Sako Safari Grade Bolt Action
Sako Hunter Left-Hand Rifle
Sako Classic Bolt Action
Sako Hunter LS Rifle
Sako Deluxe Lightweight
Sako Super Deluxe Sporter
Sako Mannlicher-Style Carbine
Sako Varmint Heavy Barrel
Sako TRG–S Bolt-Action Rifle
Sauer 90 Bolt-Action Rifle
Savage 110G Bolt-Action Rifle
Savage 110CY Youth/Ladies Rifle
Savage 110WLE One of One Thousand Limited Edition Rifle
Savage 110GXP3 Bolt-Action Rifle
Savage 110F Bolt-Action Rifle

Savage 110FXP3 Bolt-Action Rifle
Savage 110GV Varmint Rifle
Savage 112FV Varmint Rifle
Savage Model 112FVS Varmint Rifle
Savage Model 112BV Heavy Barrel Varmint Rifle
Savage 116FSS Bolt-Action Rifle
Savage Model 116FSK Kodiak Rifle
Savage 110FP Police Rifle
Steyr-Mannlicher Sporter Models SL, L, M, S, S/T
Steyr-Mannlicher Luxus Model L, M, S
Steyr-Mannlicher Model M Professional Rifle
Tikka Bolt-Action Rifle
Tikka Premium Grade Rifles
Tikka Varmint/Continental Rifle
Tikka Whitetail/Battue Rifle
Ultra Light Arms Model 20 Rifle
Ultra Light Arms Model 28, Model 40 Rifles
Voere VEC 91 Lightning Bolt-Action Rifle
Voere Model 2165 Bolt-Action Rifle
Voere Model 2155, 2150 Bolt-Action Rifles
Weatherby Mark V Deluxe Bolt-Action Rifle
Weatherby Lasermark V Rifle
Weatherby Mark V Crown Custom Rifles
Weatherby Mark V Sporter Rifle
Weatherby Mark V Safari Grade Custom Rifles
Weatherby Weathermark Rifle
Weatherby Weathermark Alaskan Rifle
Weatherby Classicmark No. 1 Rifle
Weatherby Weatherguard Alaskan Rifle
Weatherby Vanguard VGX Deluxe Rifle
Weatherby Vanguard Classic Rifle
Weatherby Vanguard Classic No. 1 Rifle
Weatherby Vanguard Weatherguard Rifle
Wichita Classic Rifle
Wichita Varmint Rifle
Winchester Model 70 Sporter
Winchester Model 70 Sporter WinTuff
Winchester Model 70 SM Sporter
Winchester Model 70 Stainless Rifle
Winchester Model 70 Varmint
Winchester Model 70 Synthetic Heavy Varmint Rifle
Winchester Model 70 DBM Rifle
Winchester Model 70 DBM-S Rifle
Winchester Model 70 Featherweight
Winchester Model 70 Featherweight WinTuff
Winchester Model 70 Featherweight Classic
Winchester Model 70 Lightweight Rifle
Winchester Ranger Rifle
Winchester Model 70 Super Express Magnum
Winchester Model 70 Super Grade
Winchester Model 70 Custom Sharpshooter
Winchester Model 70 Custom Sporting Sharpshooter Rifle

Centerfire Rifles—Single Shot

Armsport 1866 Sharps Rifle, Carbine
Brown Model One Single Shot Rifle
Browning Model 1885 Single Shot Rifle
Dakota Single Shot Rifle
Desert Industries G-90 Single Shot Rifle
Harrington & Richardson Ultra Varmint Rifle
Model 1885 High Wall Rifle
Navy Arms Rolling Block Buffalo Rifle
Navy Arms #2 Creedmoor Rifle
Navy Arms Sharps Cavalry Carbine
Navy Arms Sharps Plains Rifle
New England Firearms Handi-Rifle
Red Willow Armory Ballard No. 5 Pacific
Red Willow Armory Ballard No. 1.5 Hunting Rifle
Red Willow Armory Ballard No. 8 Union Hill Rifle
Red Willow Armory Ballard No. 4.5 Target Rifle
Remington-Style Rolling Block Carbine
Ruger No. 1B Single Shot
Ruger No. 1A Light Sporter
Ruger No. 1H Tropical Rifle
Ruger No. 1S Medium Sporter
Ruger No. 1 RSI International
Ruger No. 1V Special Varminter
C. Sharps Arms New Model 1874 Old Reliable
C. Sharps Arms New Model 1875 Rifle
C. Sharps Arms 1875 Classic Sharps
C. Sharps Arms New Model 1875 Target & Long Range
Shiloh Sharps 1874 Long Range Express
Shiloh Sharps 1874 Montana Roughrider
Shiloh Sharps 1874 Military Carbine
Shiloh Sharps 1874 Business Rifle
Shiloh Sharps 1874 Military Rifle
Sharps 1874 Old Reliable
Thompson/Center Contender Carbine
Thompson/Center Stainless Contender Carbine
Thompson/Center Contender Carbine Survival System
Thompson/Center Contender Carbine Youth Model
Thompson/Center TCR '87 Single Shot Rifle
Uberti Rolling Block Baby Carbine

Drillings, Combination Guns, Double Rifles

Beretta Express SSO O/U Double Rifles
Beretta Model 455 SxS Express Rifle
Chapuis RGExpress Double Rifle
Auguste Francotte Sidelock Double Rifles
Auguste Francotte Boxlock Double Rifle
Heym Model 55B O/U Double Rifle
Heym Model 55FW O/U Combo Gun
Heym Model 88b Side-by-Side Double Rifle
Kodiak Mk. IV Double Rifle
Kreighoff Teck O/U Combination Gun
Kreighoff Trumpf Drilling
Merkel Over/Under Combination Guns
Merkel Drillings
Merkel Model 160 Side-by-Side Double Rifles
Merkel Over/Under Double Rifles
Savage 24F O/U Combination Gun
Savage 24F-12T Turkey Gun
Springfield Inc. M6 Scout Rifle/Shotgun
Tikka Model 412s Combination Gun
Tikka Model 412S Double Fire
A. Zoli Rifle-Shotgun O/U Combo

Rimfire Rifles—Autoloaders

AMT Lightning 25/22 Rifle
AMT Lightning Small-Game Hunting Rifle II
AMT Magnum Hunter Auto Rifle
Anschutz 525 Deluxe Auto
Armscor Model 20P Auto Rifle
Browning Auto-22 Rifle
Browning Auto-22 Grade VI
Krico Model 260 Auto Rifle
Lakefield Arms Model 64B Auto Rifle
Marlin Model 60 Self-Loading Rifle
Marlin Model 60ss Self-Loading Rifle
Marlin Model 70 HC Auto
Marlin Model 990l Self-Loading Rifle
Marlin Model 70P Papoose
Marlin Model 922 Magnum Self-Loading Rifle
Marlin Model 995 Self-Loading Rifle
Norinco Model 22 ATD Rifle
Remington Model 522 Viper Autoloading Rifle
Remington 552BDL Speedmaster Rifle
Ruger 10/22 Autoloading Carbine (w/o folding stock)
Survival Arms AR-7 Explorer Rifle
Texas Remington Revolving Carbine
Voere Model 2115 Auto Rifle

Rimfire Rifles—Lever & Slide Action

Browning BL-22 Lever-Action Rifle
Marlin 39TDS Carbine
Marlin Model 39AS Golden Lever-Action Rifle
Remington 572BDL Fieldmaster Pump Rifle
Norinco EM-321 Pump Rifle
Rossi Model 62 SA Pump Rifle
Rossi Model 62 SAC Carbine
Winchester Model 9422 Lever-Action Rifle
Winchester Model 9422 Magnum Lever-Action Rifle

Rimfire Rifles—Bolt Actions & Single Shots

Anschutz Achiever Bolt-Action Rifle
Anschutz 1416D/1516D Classic Rifles
Anschutz 1418D/1518D Mannlicher Rifles
Anschutz 1700D Classic Rifles
Anschutz 1700D Custom Rifles
Anschutz 1700 FWT Bolt-Action Rifle
Anschutz 1700D Graphite Custom Rifle
Anschutz 1700D Bavarian Bolt-Action Rifle
Armscor Model 14P Bolt-Action Rifle
Armscor Model 1500 Rifle
BRNO ZKM-452 Deluxe Bolt-Action Rifle
BRNO ZKM 452 Deluxe
Beeman/HW 60-J-ST Bolt-Action Rifle
Browning A-Bolt 22 Bolt-Action Rifle
Browning A-Bolt Gold Medallion
Cabanas Phaser Rifle
Cabanas Master Bolt-Action Rifle
Cabanas Espronceda IV Bolt-Action Rifle
Cabanas Leyre Bolt-Action Rifle
Chipmunk Single Shot Rifle
Cooper Arms Model 36S Sporter Rifle
Dakota 22 Sporter Bolt-Action Rifle
Krico Model 300 Bolt-Action Rifles
Lakefield Arms Mark II Bolt-Action Rifle
Lakefield Arms Mark I Bolt-Action Rifle
Magtech Model MT-22C Bolt-Action Rifle
Marlin Model 880 Bolt-Action Rifle
Marlin Model 881 Bolt-Action Rifle
Marlin Model 882 Bolt-Action Rifle
Marlin Model 883 Bolt-Action Rifle
Marlin Model 883SS Bolt-Action Rifle
Marlin Model 25MN Bolt-Action Rifle
Marlin Model 25N Bolt-Action Repeater
Marlin Model 15YN "Little Buckaroo"
Mauser Model 107 Bolt-Action Rifle
Mauser Model 201 Bolt-Action Rifle
Navy Arms TU-KKW Training Rifle
Navy Arms TU-33/40 Carbine
Navy Arms TU-KKW Sniper Trainer
Norinco JW-27 Bolt-Action Rifle
Norinco JW-15 Bolt-Action Rifle
Remington 541-T
Remington 40-XR Rimfire Custom sporter
Remington 541-T HB Bolt-Action Rifle
Remington 581-S Sportsman Rifle
Ruger 77/22 Rimfire Bolt-Action Rifle
Ruger K77/22 Varmint Rifle
Ultra Light Arms Model 20 RF Bolt-Action Rifle
Winchester Model 52B Sporting Rifle

Competition Rifles—Centerfire & Rimfire

Anschutz 64-MS Left Silhouette
Anschutz 1808D RT Super Match 54 Target
Anschutz 1827B Biathlon Rifle

Anschutz 1903D Match Rifle
Anschutz 1803D Intermediate Match
Anschutz 1911 Match Rifle
Anschutz 54.18MS REP Deluxe Silhouette Rifle
Anschutz 1913 Super Match Rifle
Anschutz 1907 Match Rifle
Anschutz 1910 Super Match II
Anschutz 54.18MS Silhouette Rifle
Anschutz Super Match 54 Target Model 2013
Anschutz Super Match 54 Target Model 2007
Beeman/Feinwerkbau 2600 Target Rifle
Cooper Arms Model TRP–1 ISU Standard Rifle
E.A.A./Weihrauch HW 60 Target Rifle
E.A.A./HW 660 Match Rifle
Finnish Lion Standard Target Rifle
Krico Model 360 S2 Biathlon Rifle
Krico Model 400 Match Rifle
Krico Model 360S Biathlon Rifle
Krico Model 500 Kricotronic Match Rifle
Krico Model 600 Sniper Rifle
Krico Model 600 Match Rifle
Lakefield Arms Model 90B Target Rifle
Lakefield Arms Model 91T Target Rifle
Lakefield Arms Model 92S Silhouette Rifle
Marlin Model 2000 Target Rifle
Mauser Model 86–SR Specialty Rifle
McMillan M–86 Sniper Rifle
McMillan Combo M–87/M–88 50-Caliber Rifle
McMillan 300 Phoenix Long Range Rifle
McMillan M–89 Sniper Rifle
McMillan National Match Rifle
McMillan Long Range Rifle
Parker-Hale M–87 Target Rifle
Parker-Hale M–85 Sniper Rifle
Remington 40–XB Rangemaster Target Centerfire
Remington 40–XR KS Rimfire Position Rifle
Remington 40–XBBR KS
Remington 40–XC KS National Match Course Rifle
Sako TRG–21 Bolt-Action Rifle
Steyr-Mannlicher Match SPG–UIT Rifle
Steyr-Mannlicher SSG P–I Rifle
Steyr-Mannlicher SSG P–III Rifle
Steyr-Mannlicher SSG P–IV Rifle
Tanner Standard UIT Rifle
Tanner 50 Meter Free Rifle
Tanner 300 Meter Free Rifle
Wichita Silhouette Rifle

Shotguns—Autoloaders

American Arms/Franchi Black Magic 48/AL
Benelli Super Black Eagle Shotgun
Benelli Super Black Eagle Slug Gun
Benelli M1 Super 90 Field Auto Shotgun
Benelli Montefeltro Super 90 20-Gauge Shotgun
Benelli Montefeltro Super 90 Shotgun
Benelli M1 Sporting Special Auto Shotgun
Benelli Black Eagle Competition Auto Shotgun
Beretta A–303 Auto Shotgun
Beretta 390 Field Auto Shotgun
Beretta 390 Super Trap, Super Skeet Shotguns
Beretta Vittoria Auto Shotgun
Beretta Model 1201F Auto Shotgun
Browning BSA 10 Auto Shotgun
Browning BSA 10 Stalker Auto Shotgun
Browning A–500R Auto Shotgun
Browning A–500G Auto Shotgun
Browning A–500G Sporting Clays
Browning Auto-5 Light 12 and 20
Browning Auto-5 Stalker
Browning Auto-5 Magnum 20
Browning Auto-5 Magnum 12
Churchill Turkey Automatic Shotgun
Cosmi Automatic Shotgun
Maverick Model 60 Auto Shotgun
Mossberg Model 5500 Shotgun
Mossberg Model 9200 Regal Semi-Auto Shotgun
Mossberg Model 9200 USST Auto Shotgun
Mossberg Model 9200 Camo Shotgun
Mossberg Model 6000 Auto Shotgun
Remington Model 1100 Shotgun
Remington 11–87 Premier shotgun
Remington 11–87 Sporting Clays
Remington 11–87 Premier Skeet
Remington 11–87 Premier Trap
Remington 11–87 Special Purpose Magnum
Remington 11–87 SPS–T Camo Auto Shotgun
Remington 11–87 Special Purpose Deer Gun
Remington 11–87 SPS–BG-Camo Deer/Turkey Shotgun
Remington 11–87 SPS-Deer Shotgun
Remington 11–87 Special Purpose Synthetic Camo
Remington SP–10 Magnum-Camo Auto Shotgun
Remington SP–10 Magnum Auto Shotgun
Remington SP–10 Magnum Turkey Combo
Remington 1100 LT–20 Auto
Remington 1100 Special Field
Remington 1100 20-Gauge Deer Gun
Remington 1100 LT–20 Tournament Skeet
Winchester Model 1400 Semi-Auto Shotgun

Shotguns—Slide Actions

Browning Model 42 Pump Shotgun
Browning BPS Pump Shotgun
Browning BPS Stalker Pump Shotgun
Browning BPS Pigeon Grade Pump Shotgun
Browning BPS pump Shotgun (Ladies and Youth Model)
Browning BPS Game Gun Turkey Special
Browning BPS Game Gun Deer Special
Ithaca Model 87 Supreme Pump Shotgun
Ithaca Model 87 Deerslayer Shotgun
Ithaca Deerslayer II Rifled Shotgun
Ithaca Model 87 Turkey Gun
Ithaca Model 87 Deluxe Pump Shotgun
Magtech Model 586–VR Pump Shotgun
Maverick Models 88, 91 Pump Shotguns
Mossberg Model 500 Sporting Pump
Mossberg Model 500 Camo Pump
Mossberg Model 500 Muzzleloader Combo
Mossberg Model 500 Trophy Slugster
Mossberg Turkey Model 500 Pump
Mossberg Model 500 Bantam Pump
Mossberg Field Grade Model 835 Pump Shotgun
Mossberg Model 835 Regal Ulti-Mag Pump
Remington 870 Wingmaster
Remington 870 Special Purpose Deer Gun
Remington 870 SPS–BG-Camo Deer/Turkey Shotgun
Remington 870 SPS-Deer Shotgun
Remington 870 Marine Magnum
Remington 870 TC Trap
Remington 870 Special Purpose Synthetic Camo
Remington 870 Wingmaster Small Gauges
Remington 870 Express Rifle Sighted Deer Gun
Remington 879 SPS Special Purpose Magnum
Remington 870 SPS–T Camo Pump Shotgun
Remington 870 Special Field
Remington 870 Express Turkey
Remington 870 High Grades
Remington 870 Express
Remington Model 870 Express Youth Gun
Winchester Model 12 Pump Shotgun
Winchester Model 42 High Grade Shotgun
Winchester Model 1300 Walnut Pump
Winchester Model 1300 Slug Hunter Deer Gun
Winchester Model 1300 Ranger Pump Gun Combo & Deer Gun
Winchester Model 1300 Turkey Gun
Winchester Model 1300 Ranger Pump Gun

Shotguns—Over/Unders

American Arms/Franchi Falconet 2000 O/U
American Arms Silver I O/U
American Arms Silver II Shotgun
American Arms Silver Skeet O/U
American Arms/Franchi Sporting 2000 O/U
American Arms Silver Sporting O/U
American Arms Silver Trap O/U
American Arms WS/OU 12, TS/OU 12 Shotguns
American Arms WT/OU 10 Shotgun
Armsport 2700 O/U Goose Gun
Armsport 2700 Series O/U
Armsport 2900 Tri-Barrel Shotgun
Baby Bretton Over/Under Shotgun
Beretta Model 686 Ultralight O/U
Beretta ASE 90 Competition O/U Shotgun
Beretta Over/Under Field Shotguns
Beretta Onyx Hunter Sport O/U Shotgun
Beretta Model SO5, SO6, SO9 Shotguns
Beretta Sporting Clay Shotguns
Beretta 687EL Sporting O/U
Beretta 682 Super Sporting O/U
Beretta Series 682 Competition Over/Unders
Browning Citori O/U Shotgun
Browning Superlight Citori Over/Under
Browning Lightning Sporting Clays
Browning Micro Citori Lightning
Browning Citori Plus Trap Combo
Browning Citori Plus Trap Gun
Browning Citori O/U Skeet Models
Browning Citori O/U Trap Models
Browning Special Sporting Clays
Browning Citori GTI Sporting Clays
Browning 325 Sporting Clays
Centurion Over/Under Shotgun
Chapuis Over/Under Shotgun
Connecticut Valley Classics Classic Sporter O/U
Connecticut Valley Classics Classic Field Waterfowler
Charles Daly Field Grade O/U
Charles Daly Lux Over/Under
E.A.A./Sabatti Sporting Clays Pro-Gold O/U
E.A.A/Sabatti Falcon-Mon Over/Under
Kassnar Grade I O/U Shotgun
Krieghoff K–80 Sporting Clays O/U
Krieghoff K–80 Skeet Shotgun
Krieghoff K–80 International Skeet
Krieghoff K–80 Four-Barrel Skeet Set
Krieghoff K–80/RT Shotguns
Krieghoff K–80 O/U Trap Shotgun
Laurona Silhouette 300 Sporting Clays
Laurona Silhouette 300 Trap
Laurona Super Model Over/Unders
Ljutic LM–6 Deluxe O/U Shotgun
Marocchi Conquista Over/Under Shotgun
Marocchi Avanza O/U Shotgun

Merkel Model 200E O/U Shotgun
Merkel Model 200E Skeet, Trap Over/Unders
Merkel Model 203E, 303E Over/Under Shotguns
Perazzi Mirage Special Sporting O/U
Perazzi Mirage Special Four-Gauge Skeet
Perazzi Sporting Classic O/U
Perazzi MX7 Over/Under Shotguns
Perazzi Mirage Special Skeet Over/Under
Perazzi MX8/MX8 Special Trap, Skeet
Perazzi MX8/20 Over/Under Shotgun
Perazzi MX9 Single Over/Under Shotguns
Perazzi MX12 Hunting Over/Under
Perazzi MX28, MX410 Game O/U Shotguns
Perazzi MX20 Hunting Over/Under
Piotti Boss Over/Under Shotgun
Remington Peerless Over/Under Shotgun
Ruger Red Label O/U Shotgun
Ruger Sporting Clays O/U Shotgun
San Marco 12-Ga. Wildflower Shotgun
San Marco Field Special O/U Shotgun
San Marco 10-Ga. O/U Shotgun
SKB Model 505 Deluxe Over/Under Shotgun
SKB Model 685 Over/Under Shotgun
SKB Model 885 Over/Under Trap, Skeet, Sporting Clays
Stoeger/IGA Condor I O/U Shotgun
Stoeger/IGA ERA 2000 Over/Under Shotgun
Techni-Mec Model 610 Over/Under
Tikka Model 412S Field Grade Over/Under
Weatherby Athena Grade IV O/U Shotguns
Weatherby Athena Grade V Classic Field O/U
Weatherby Orion O/U Shotguns
Weatherby II, III Classic Field O/Us
Weatherby Orion II Classic Sporting Clays O/U
Weatherby Orion II Sporting Clays O/U
Winchester Model 1001 O/U Shotgun
Winchester Model 1001 Sporting Clays O/U
Pietro Zanoletti Model 2000 Field O/U

Shotguns—Side by Sides

American Arms Brittany Shotgun
American Arms Gentry Double Shotgun
American Arms Derby Side-by-Side
American Arms Grulla #2 Double Shotgun
American Arms WS/SS 10
American Arms TS/SS 10 Double Shotgun
American Arms TS/SS 12 Side-by-Side
Arrieta Sidelock Double Shotguns
Armsport 1050 Series Double Shotguns
Arizaga Model 31 Double Shotgun
AYA Boxlock Shotguns
AYA Sidelock Double Shotguns
Beretta Model 452 Sidelock Shotgun
Beretta Side-by-Side Field Shotguns
Crucelegui Hermanos Model 150 Double
Chapuis Side-by-Side Shotgun
E.A.A./Sabatti Saba-Mon Double Shotgun
Charles Daly Model Dss Double
Ferlib Model F VII Double Shotgun
Auguste Francotte Boxlock Shotgun
Auguste Francotte Sidelock Shotgun
Garbi Model 100 Double
Garbi Model 101 Side-by-Side
Garbi Model 103A, B Side-by-Side
Garbi Model 200 Side-by-Side
Bill Hanus Birdgun Doubles
Hatfield Uplander Shotgun
Merkel Model 8, 47E Side-by-Side Shotguns
Merkel Model 47LSC Sporting Clays Double
Merkel Model 47S, 147S Side-by-Sides
Parker Reproductions Side-by-Side
Piotti King No. 1 Side-by-Side
Piotti Lunik Side-by-Side
Piotti King Extra Side-by-Side
Piotti Piuma Side-by-Side
Precision Sports Model 600 Series Doubles
Rizzini Boxlock Side-by-Side
Rizzini Sidelock Side-by-Side
Stoeger/IGA Uplander Side-by-Side Shotgun
Ugartechea 10-Ga. Magnum Shotgun

Shotguns—Bolt Actions & Single Shots

Armsport Single Barrel Shotgun
Browning BT-99 Competition Trap Special
Browning BT-99 Plus Trap Gun
Browning BT-99 Plus Micro
Browning Recoilless Trap Shotgun
Browning Micro Recoilless Trap Shotgun
Desert Industries Big Twenty Shotgun
Harrington & Richardson Topper Model 098
Harrington & Richardson Topper Classic Youth Shotgun
Harrington & Richardson N.W.T.F. Turkey Mag
Harrington & Richardson Topper Deluxe Model 098
Krieghoff KS-5 Trap Gun
Krieghoff KS-5 Special
Krieghoff K-80 Single Barrel Trap Gun
Ljutic Mono Gun Single Barrel
Ljutic LTX Super Deluxe Mono Gun
Ljutic Recoilless Space Gun Shotgun
Marlin Model 55 Goose Gun Bolt Action
New England Firearms Turkey and Goose Gun
New England Firearms N.W.T.F. Shotgun
New England Firearms Tracker Slug Gun
New England Firearms Standard Pardner
New England Firearms Survival Gun
Perazzi TM1 Special Single Trap
Remington 90-T Super Single Shotgun
Snake Charmer II Shotgun
Stoeger/IGA Reuna Single Barrel Shotgun
Thompson/Center TCR '87 Hunter Shotgun.".

Subtitle B—Youth Handgun Safety

SEC. 110201. PROHIBITION OF THE POSSESSION OF A HANDGUN OR AMMUNITION BY, OR THE PRIVATE TRANSFER OF A HANDGUN OR AMMUNITION TO, A JUVENILE.

(a) OFFENSE.—Section 922 of title 18, United States Code, as amended by section 110103(a), is amended by adding at the end the following new subsection:

"(x)(1) It shall be unlawful for a person to sell, deliver, or otherwise transfer to a person who the transferor knows or has reasonable cause to believe is a juvenile—

"(A) a handgun; or

"(B) ammunition that is suitable for use only in a handgun.

"(2) It shall be unlawful for any person who is a juvenile to knowingly possess—

"(A) a handgun; or

"(B) ammunition that is suitable for use only in a handgun.

"(3) This subsection does not apply to—

"(A) a temporary transfer of a handgun or ammunition to a juvenile or to the possession or use of a handgun or ammunition by a juvenile if the handgun and ammunition are possessed and used by the juvenile—

"(i) in the course of employment, in the course of ranching or farming related to activities at the residence of the juvenile (or on property used for ranching or farming at which the juvenile, with the permission of the property owner or lessee, is performing activities related to the operation of the farm or ranch), target practice, hunting, or a course of instruction in the safe and lawful use of a handgun;

"(ii) with the prior written consent of the juvenile's parent or guardian who is not prohibited by Federal, State, or local law from possessing a firearm, except—

"(I) during transportation by the juvenile of an unloaded handgun in a locked container directly from the place of transfer to a place at which an activity described in clause (i) is to take place and transportation by the juvenile of that handgun, unloaded and in a locked container, directly from the place at which such an activity took place to the transferor; or

"(II) with respect to ranching or farming activities as described in clause (i), a juvenile may possess and use a handgun or ammunition with the prior written approval of the juvenile's parent or legal guardian and at the direction of an adult who is not prohibited by Federal, State or local law from possessing a firearm;

"(iii) the juvenile has the prior written consent in the juvenile's possession at all times when a handgun is in the possession of the juvenile; and

"(iv) in accordance with State and local law;

"(B) a juvenile who is a member of the Armed Forces of the United States or the National Guard who possesses or is armed with a handgun in the line of duty;

"(C) a transfer by inheritance of title (but not possession) of a handgun or ammunition to a juvenile; or

"(D) the possession of a handgun or ammunition by a juvenile taken in defense of the juvenile or other persons against an intruder into the residence of the juvenile or a residence in which the juvenile is an invited guest.

"(4) A handgun or ammunition, the possession of which is transferred to a juvenile in circumstances in which the transferor is not in violation of this subsection shall not be subject to permanent confiscation by the Government if its possession by the juvenile subsequently becomes unlawful because of the conduct of the juvenile, but shall be returned to the lawful owner when such handgun or ammunition is no longer required by the Government for the purposes of investigation or prosecution.

"(5) For purposes of this subsection, the term 'juvenile' means a person who is less than 18 years of age.

"(6)(A) In a prosecution of a violation of this subsection, the court shall require the presence of a juvenile defendant's parent or legal guardian at all proceedings.

"(B) The court may use the contempt power to enforce subparagraph (A).

"(C) The court may excuse attendance of a parent or legal guardian of a juvenile defendant at a proceeding in a prosecution of a violation of this subsection for good cause shown.".

(b) PENALTIES.—Section 924(a) of title 18, United States Code, is amended—

(1) in paragraph (1) by striking "paragraph (2) or (3) of"; and

(2) by adding at the end the following new paragraph:

"(5)(A)(i) A juvenile who violates section 922(x) shall be fined under this title, imprisoned not more than 1 year, or both, except that a juvenile described in clause (ii) shall be sentenced to probation on appropriate conditions and shall not be incarcerated unless the juvenile fails to comply with a condition of probation.

"(ii) A juvenile is described in this clause if—

"(I) the offense of which the juvenile is charged is possession of a handgun or ammunition in violation of section 922(x)(2); and

"(II) the juvenile has not been convicted in any court of an offense (including an offense under section 922(x) or a similar State law, but not including any other offense consisting of conduct that if engaged in by an adult would not constitute an offense) or adjudicated as a juvenile delinquent for conduct that if engaged in by an adult would constitute an offense.

"(B) A person other than a juvenile who knowingly violates section 922(x)—

"(i) shall be fined under this title, imprisoned not more than 1 year, or both; and

"(ii) if the person sold, delivered, or otherwise transferred a handgun or ammunition to a juvenile knowing or having reasonable cause to know that the juvenile intended to carry or otherwise possess or discharge or otherwise use the handgun or ammunition in the commission of a crime of violence, shall be fined under this title, imprisoned not more than 10 years, or both.".

(c) Technical Amendment of Juvenile Delinquency Provisions in Title 18, United States Code.—

(1) Section 5031.—Section 5031 of title 18, United States Code, is amended by inserting "or a violation by such a person of section 922(x)" before the period at the end.

(2) Section 5032.—Section 5032 of title 18, United States Code, is amended—

(A) in the first undesignated paragraph by inserting "or (x)" after "922(p)"; and

(B) in the fourth undesignated paragraph by inserting "or section 922(x) of this title," before "criminal prosecution on the basis".

(d) Technical Amendment of the Juvenile Justice and Delinquency Prevention Act of 1974.—Section 223(a)(12)(A) of the Juvenile Justice and Delinquency Prevention Act of 1974 (42 U.S.C. 5633(a)(12)(A)) is amended by striking "which do not constitute violations of valid court orders" and inserting "(other than an offense that constitutes a violation of a valid court order or a violation of section 922(x) of title 18, United States Code, or a similar State law)."

(e) Model Law.—The Attorney General, acting through the Director of the National Institute for Juvenile Justice and Delinquency Prevention, shall—

(1) evaluate existing and proposed juvenile handgun legislation in each State;

(2) develop model juvenile handgun legislation that is constitutional and enforceable;

(3) prepare and disseminate to State authorities the findings made as the result of the evaluation; and

(4) report to Congress by December 31, 1995, findings and recommendations concerning the need or appropriateness of further action by the Federal Government.

Subtitle C—Licensure

SEC. 110301. FIREARMS LICENSURE AND REGISTRATION TO REQUIRE A PHOTOGRAPH AND FINGERPRINTS.

(a) Firearms Licensure.—Section 923(a) of title 18, United States Code, is amended in the second sentence by inserting "and shall include a photograph and fingerprints of the applicant" before the period.

(b) Registration.—Section 5802 of the Internal Revenue Code of 1986 is amended by inserting after the first sentence the following: "An individual required to register under this section shall include a photograph and fingerprints of the individual with the initial application.".

SEC. 110302. COMPLIANCE WITH STATE AND LOCAL LAW AS A CONDITION TO LICENSE.

Section 923(d)(1) of title 18, United States Code, is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(F) the applicant certifies that—

"(i) the business to be conducted under the license is not prohibited by State or local law in the place where the licensed premise is located;

"(ii)(I) within 30 days after the application is approved the business will comply with the requirements of State and local law applicable to the conduct of the business; and

"(II) the business will not be conducted under the license until the requirements of State and local law applicable to the business have been met; and

"(iii) that the applicant has sent or delivered a form to be prescribed by the Secretary, to the chief law enforcement officer of the locality in which the premises are located, which indicates that the applicant intends to apply for a Federal firearms license.".

SEC. 110303. ACTION ON FIREARMS LICENSE APPLICATION.

Section 923(d)(2) of title 18, United States Code, is amended by striking "forty-five-day" and inserting "60-day".

SEC. 110304. INSPECTION OF FIREARMS LICENSEES' INVENTORY AND RECORDS.

Section 923(g)(1)(B)(ii) of title 18, United States Code, is amended to read as follows:

"(ii) for ensuring compliance with the record keeping requirements of this chapter—

"(I) not more than once during any 12-month period; or

"(II) at any time with respect to records relating to a firearm involved in a criminal investigation that is traced to the licensee.".

SEC. 110305. REPORTS OF THEFT OR LOSS OF FIREARMS.

Section 923(g) of title 18, United States Code, is amended by adding at the end the following new paragraph:

"(6) Each licensee shall report the theft or loss of a firearm from the licensee's inventory or collection, within 48 hours after the theft or loss is discovered, to the Secretary and to the appropriate local authorities.".

SEC. 110306. RESPONSES TO REQUESTS FOR INFORMATION.

Section 923(g) of title 18, United States Code, as amended by section 110405, is amended by adding at the end the following new paragraph:

"(7) Each licensee shall respond immediately to, and in no event later than 24 hours after the receipt of, a request by the Secretary for information contained in the records required to be kept by this chapter as may be required for determining the disposition of 1 or more firearms in the course of a bona fide criminal investigation. The requested information shall be provided orally or in writing, as the Secretary may require. The Secretary shall implement a system whereby the licensee can positively identify and establish that an individual requesting information via telephone is employed by and authorized by the agency to request such information.".

SEC. 110307. NOTIFICATION OF NAMES AND ADDRESSES OF FIREARMS LICENSEES.

Section 923 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(1) The Secretary of the Treasury shall notify the chief law enforcement officer in the appropriate State and local jurisdictions of the names and addresses of all persons in the State to whom a firearms license is issued.".

Subtitle D—Domestic Violence

SEC. 110401. PROHIBITION AGAINST DISPOSAL OF FIREARMS TO, OR RECEIPT OF FIREARMS BY, PERSONS WHO HAVE COMMITTED DOMESTIC ABUSE.

(a) Intimate Partner Defined.—Section 921(a) of title 18, United States Code, as amended by section 110103(b), is amended by inserting at the end the following new paragraph:

"(32) The term 'intimate partner' means, with respect to a person, the spouse of the person, a former spouse of the person, an individual who is a parent of a child of the person, and an individual who cohabitates or has cohabited with the person.".

(b) Prohibition Against Disposal of Firearms.—Section 922(d) of title 18, United States Code, is amended—

(1) by striking "or" at the end of paragraph (6);

(2) by striking the period at the end of paragraph (7) and inserting "; or"; and

(3) by inserting after paragraph (7) the following new paragraph:

"(8) is subject to a court order that restrains such person from harassing, stalking, or threatening an intimate partner of such person or child of such intimate partner or person, or engaging in other conduct that would place an intimate partner in reasonable fear of bodily injury to the partner or child, except that this paragraph shall only apply to a court order that—

"(A) was issued after a hearing of which such person received actual notice, and at which such person had the opportunity to participate; and

"(B)(i) includes a finding that such person represents a credible threat to the physical safety of such intimate partner or child; or

"(ii) by its terms explicitly prohibits the use, attempted use, or threatened use of physical force against such intimate partner or child that would reasonably be expected to cause bodily injury.".

(c) Prohibition Against Receipt of Firearms.—Section 922(g) of title 18, United States Code, is amended—

(1) by striking "or" at the end of paragraph (6);

(2) by inserting "or" at the end of paragraph (7); and

(3) by inserting after paragraph (7) the following:

"(8) who is subject to a court order that—

"(A) was issued after a hearing of which such person received actual notice, and at which such person had an opportunity to participate;

"(B) restrains such person from harassing, stalking, or threatening an intimate partner of such person or child of such intimate partner or person, or engaging in other conduct that would place an intimate partner in reasonable fear of bodily injury to the partner or child; and

"(C)(i) includes a finding that such person represents a credible threat to the physical safety of such intimate partner or child; or

"(ii) by its terms explicitly prohibits the use, attempted use, or threatened use of physical force against such intimate partner or child that would reasonably be expected to cause bodily injury,".

(d) Storage of Firearms.—Section 926(a) of title 18, United States Code, is amended—

(1) by striking "and" at the end of paragraph (1);

(2) by striking the period at the end of paragraph (2) and inserting "; and"; and

(3) by inserting after paragraph (2) the following:

"(3) regulations providing for effective receipt and secure storage of firearms relinquished by or seized from persons described in subsection (d)(8) or (g)(8) of section 922.".

(e) Return of Firearms.—Section 924(d)(1) of title 18, United States Code, is amended by striking "the seized" and inserting "or lapse of or court termination of the restraining order to which he is subject, the seized or relinquished".

Subtitle E—Gun Crime Penalties

SEC. 110501. ENHANCED PENALTY FOR USE OF A SEMIAUTOMATIC FIREARM DURING A CRIME OF VIOLENCE OR A DRUG TRAFFICKING CRIME.

(a) Amendment to Sentencing Guidelines.—Pursuant to its authority under section 994 of

title 28, United States Code, the United States Sentencing Commission shall amend its sentencing guidelines to provide an appropriate enhancement of the punishment for a crime of violence (as defined in section 924(c)(3) of title 18, United States Code) or a drug trafficking crime (as defined in section 924(c)(2) of title 18, United States Code) if a semiautomatic firearm is involved.

(b) SEMIAUTOMATIC FIREARM.—In subsection (a), "semiautomatic firearm" means any repeating firearm that utilizes a portion of the energy of a firing cartridge to extract the fired cartridge case and chamber the next round and that requires a separate pull of the trigger to fire each cartridge.

SEC. 110502. ENHANCED PENALTY FOR SECOND OFFENSE OF USING AN EXPLOSIVE TO COMMIT A FELONY.

Pursuant to its authority under section 994 of title 28, United States Code, the United States Sentencing Commission shall promulgate amendments to the sentencing guidelines to appropriately enhance penalties in a case in which a defendant convicted under section 844(h) of title 18, United States Code, has previously been convicted under that section.

SEC. 110503. SMUGGLING FIREARMS IN AID OF DRUG TRAFFICKING.

Section 924 of title 18, United States Code, as amended by section 60013, is amended by adding at the end the following new subsection:

"(j) A person who, with intent to engage in or to promote conduct that—

"(1) is punishable under the Controlled Substances Act (21 U.S.C. 801 et seq.), the Controlled Substances Import and Export Act (21 U.S.C. 951 et seq.), or the Maritime Drug Law Enforcement Act (46 U.S.C. App. 1901 et seq.);

"(2) violates any law of a State relating to any controlled substance (as defined in section 102 of the Controlled Substances Act, 21 U.S.C. 802); or

"(3) constitutes a crime of violence (as defined in subsection (c)(3),

smuggles or knowingly brings into the United States a firearm, or attempts to do so, shall be imprisoned not more than 10 years, fined under this title, or both.".

SEC. 110504. THEFT OF FIREARMS AND EXPLOSIVES.

(a) FIREARMS.—Section 924 of title 18, United States Code, as amended by section 110203(a), is amended by adding at the end the following new subsection:

"(k) A person who steals any firearm which is moving as, or is a part of, or which has moved in, interstate or foreign commerce shall be imprisoned for not more than 10 years, fined under this title, or both.".

(b) EXPLOSIVES.—Section 844 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(k) A person who steals any explosives materials which are moving as, or are a part of, or which have moved in, interstate or foreign commerce shall be imprisoned for not more than 10 years, fined under this title, or both.".

SEC. 110505. REVOCATION OF SUPERVISED RELEASE AFTER IMPRISONMENT.

Section 3583 of title 18, United States Code, is amended—

(1) in subsection (d) by striking "possess illegal controlled substances" and inserting "unlawfully possess a controlled substance";

(2) in subsection (e)—

(A) by striking "person" each place such term appears in such subsection and inserting "defendant"; and

(B) by amending paragraph (3) to read as follows:

"(3) revoke a term of supervised release, and require the defendant to serve in prison all or part of the term of supervised release authorized by statute for the offense that resulted in such term of supervised release without credit for time previously served on postrelease supervision, if the court, pursuant to the Federal Rules of Criminal Procedure applicable to revocation of probation or supervised release, finds by a preponderance of the evidence that the defendant violated a condition of supervised release, except that a defendant whose term is revoked under this paragraph may not be required to serve more than 5 years in prison if the offense that resulted in the term of supervised release is a class A felony, more than 3 years in prison if such offense is a class B felony, more than 2 years in prison if such offense is a class C or D felony, or more than one year in any other case; or"; and

(3) by striking subsection (g) and inserting the following:

"(g) MANDATORY REVOCATION FOR POSSESSION OF CONTROLLED SUBSTANCE OR FIREARM OR FOR REFUSAL TO COMPLY WITH DRUG TESTING.—If the defendant—

"(1) possesses a controlled substance in violation of the condition set forth in subsection (d);

"(2) possesses a firearm, as such term is defined in section 921 of this title, in violation of Federal law, or otherwise violates a condition of supervised release prohibiting the defendant from possessing a firearm; or

"(3) refuses to comply with drug testing imposed as a condition of supervised release;

the court shall revoke the term of supervised release and require the defendant to serve a term of imprisonment not to exceed the maximum term of imprisonment authorized under subsection (e)(3).

"(h) SUPERVISED RELEASE FOLLOWING REVOCATION.—When a term of supervised release is revoked and the defendant is required to serve a term of imprisonment that is less than the maximum term of imprisonment authorized under subsection (e)(3), the court may include a requirement that the defendant be placed on a term of supervised release after imprisonment. The length of such a term of supervised release shall not exceed the term of supervised release authorized by statute for the offense that resulted in the original term of supervised release, less any term of imprisonment that was imposed upon revocation of supervised release.

"(i) DELAYED REVOCATION.—The power of the court to revoke a term of supervised release for violation of a condition of supervised release, and to order the defendant to serve a term of imprisonment and, subject to the limitations in subsection (h), a further term of supervised release, extends beyond the expiration of the term of supervised release for any period reasonably necessary for the adjudication of matters arising before its expiration if, before its expiration, a warrant or summons has been issued on the basis of an allegation of such a violation.".

SEC. 110506. REVOCATION OF PROBATION.

(a) IN GENERAL.—Section 3565(a) of title 18, United States Code, is amended—

(1) in paragraph (2) by striking "impose any other sentence that was available under subchapter A at the time of the initial sentencing" and inserting "resentence the defendant under subchapter A"; and

(2) by striking the last sentence.

(b) MANDATORY REVOCATION.—Section 3565(b) of title 18, United States Code, is amended to read as follows:

"(b) MANDATORY REVOCATION FOR POSSESSION OF CONTROLLED SUBSTANCE OR FIREARM OR REFUSAL TO COMPLY WITH DRUG TESTING.—If the defendant—

"(1) possesses a controlled substance in violation of the condition set forth in section 3563(a)(3);

"(2) possesses a firearm, as such term is defined in section 921 of this title, in violation of Federal law, or otherwise violates a condition of probation prohibiting the defendant from possessing a firearm; or

"(3) refuses to comply with drug testing, thereby violating the condition imposed by section 3563(a)(4),

the court shall revoke the sentence of probation and resentence the defendant under subchapter A to a sentence that includes a term of imprisonment.".

SEC. 110507. INCREASED PENALTY FOR KNOWINGLY MAKING FALSE, MATERIAL STATEMENT IN CONNECTION WITH THE ACQUISITION OF A FIREARM FROM A LICENSED DEALER.

Section 924(a) of title 18, United States Code, is amended—

(1) in subsection (a)(1)(B) by striking "(a)(6),"; and

(2) in subsection (a)(2) by inserting "(a)(6)," after "subsections".

SEC. 110508. POSSESSION OF EXPLOSIVES BY FELONS AND OTHERS.

Section 842(i) of title 18, United States Code, is amended by inserting "or possess" after "to receive".

SEC. 110509. SUMMARY DESTRUCTION OF EXPLOSIVES SUBJECT TO FORFEITURE.

Section 844(c) of title 18, United States Code, is amended—

(1) by inserting "(1)" after "(c)"; and

(2) by adding at the end the following new paragraphs:

"(2) Notwithstanding paragraph (1), in the case of the seizure of any explosive materials for any offense for which the materials would be subject to forfeiture in which it would be impracticable or unsafe to remove the materials to a place of storage or would be unsafe to store them, the seizing officer may destroy the explosive materials forthwith. Any destruction under this paragraph shall be in the presence of at least 1 credible witness. The seizing officer shall make a report of the seizure and take samples as the Secretary may by regulation prescribe.

"(3) Within 60 days after any destruction made pursuant to paragraph (2), the owner of (including any person having an interest in) the property so destroyed may make application to the Secretary for reimbursement of the value of the property. If the claimant establishes to the satisfaction of the Secretary that—

"(A) the property has not been used or involved in a violation of law; or

"(B) any unlawful involvement or use of the property was without the claimant's knowledge, consent, or willful blindness,

the Secretary shall make an allowance to the claimant not exceeding the value of the property destroyed.".

SEC. 110510. ELIMINATION OF OUTMODED LANGUAGE RELATING TO PAROLE.

(a) SECTION 924(e)(1) OF TITLE 18.—Section 924(e)(1) of title 18, United States Code, is amended by striking ", and such person shall not be eligible for parole with respect to the sentence imposed under this subsection".

(b) SECTION 924(c)(1) OF TITLE 18.—Section 924(c)(1) of title 18, United States Code, is amended by striking "No person sentenced under this subsection shall be eligible for parole during the term of imprisonment imposed under this subsection.".

SEC. 10511. PROHIBITION AGAINST TRANSACTIONS INVOLVING STOLEN FIREARMS WHICH HAVE MOVED IN INTERSTATE OR FOREIGN COMMERCE.

Section 922(j) of title 18, United States Code, is amended to read as follows:

"(j) It shall be unlawful for any person to receive, possess, conceal, store, barter, sell, or dispose of any stolen firearm or stolen ammunition, or pledge or accept as security for a loan any

stolen firearm or stolen ammunition, which is moving as, which is a part of, which constitutes, or which has been shipped or transported in, interstate or foreign commerce, either before or after it was stolen, knowing or having reasonable cause to believe that the firearm or ammunition was stolen.".

SEC. 110512. USING A FIREARM IN THE COMMISSION OF COUNTERFEITING OR FORGERY.

Pursuant to its authority under section 994 of title 28, United States Code, the United States Sentencing Commission shall amend its sentencing guidelines to provide an appropriate enhancement of the punishment for a defendant convicted of a felony under chapter 25 of title 18, United States Code, if the defendant used or carried a firearm (as defined in section 921(a)(3) of title 18, United States Code) during and in relation to the felony.

SEC. 110513. ENHANCED PENALTIES FOR FIREARMS POSSESSION BY VIOLENT FELONS AND SERIOUS DRUG OFFENDERS.

Pursuant to its authority under section 994 of title 28, United States Code, the United States Sentencing Commission shall amend its sentencing guidelines to—

(1) appropriately enhance penalties in cases in which a defendant convicted under section 922(g) of title 18, United States Code, has 1 prior conviction by any court referred to in section 922(g)(1) of title 18 for a violent felony (as defined in section 924(e)(2)(B) of that title) or a serious drug offense (as defined in section 924(e)(2)(A) of that title); and

(2) appropriately enhance penalties in cases in which such a defendant has 2 prior convictions for a violent felony (as so defined) or a serious drug offense (as so defined).

SEC. 110514. RECEIPT OF FIREARMS BY NONRESIDENT.

Section 922(a) of title 18, United States Code, is amended—

(1) by striking "and" at the end of paragraph (7);

(2) by striking the period at the end of paragraph (8) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(9) for any person, other than a licensed importer, licensed manufacturer, licensed dealer, or licensed collector, who does not reside in any State to receive any firearms unless such receipt is for lawful sporting purposes.".

SEC. 110515. THEFT OF FIREARMS OR EXPLOSIVES FROM LICENSEE.

(a) FIREARMS.—Section 924 of title 18, United States Code, as amended by section 110504(a), is amended by adding at the end the following new subsection:

"(l) A person who steals any firearm from a licensed importer, licensed manufacturer, licensed dealer, or licensed collector shall be fined under this title, imprisoned not more than 10 years, or both.".

(b) EXPLOSIVES.—Section 844 of title 18, United States Code, as amended by section 110204(b), is amended by adding at the end the following new subsection:

"(l) A person who steals any explosive material from a licensed importer, licensed manufacturer, or licensed dealer, or from any permittee shall be fined under this title, imprisoned not more than 10 years, or both.".

SEC. 110516. DISPOSING OF EXPLOSIVES TO PROHIBITED PERSONS.

Section 842(d) of title 18, United States Code, is amended by striking "licensee" and inserting "person".

SEC. 110517. INCREASED PENALTY FOR INTERSTATE GUN TRAFFICKING.

Section 924 of title 18, United States Code, as amended by section 110515(a), is amended by adding at the end the following new subsection:

"(m) A person who, with the intent to engage in conduct that constitutes a violation of section 922(a)(1)(A), travels from any State or foreign country into any other State and acquires, or attempts to acquire, a firearm in such other State in furtherance of such purpose shall be imprisoned for not more than 10 years.".

SEC. 110518. FIREARMS AND EXPLOSIVES CONSPIRACY.

(a) FIREARMS.—Section 924 of title 18, United States Code, as amended by section 110517(a), is amended by adding at the end the following new subsection:

"(n) A person who conspires to commit an offense under subsection (c) shall be imprisoned for not more than 20 years, fined under this title, or both; and if the firearm is a machinegun or destructive device, or is equipped with a firearm silencer or muffler, shall be imprisoned for any term of years or life.".

(b) EXPLOSIVES.—Section 844 of title 18, United States Code, as amended by section 110515(b), is amended by adding at the end the following new subsection:

"(m) A person who conspires to commit an offense under subsection (h) shall be imprisoned for any term of years not exceeding 20, fined under this title, or both.

SEC. 110519. DEFINITION OF ARMOR PIERCING AMMUNITION.

Section 921(a)(17) of title 18, United States Code, is amended by revising subparagraph (B) and adding a new subparagraph (C) to read as follows:

"(B) The term 'armor piercing ammunition' means—

"(i) a projectile or projectile core which may be used in a handgun and which is constructed entirely (excluding the presence of traces of other substances) from one or a combination of tungsten alloys, steel, iron, brass, bronze, beryllium copper, or depleted uranium; or

"(ii) a full jacketed projectile larger than .22 caliber designed and intended for use in a handgun and whose jacket has a weight of more than 25 percent of the total weight of the projectile.

"(C) The term 'armor piercing ammunition' does not include shotgun shot required by Federal or State environmental or game regulations for hunting purposes, a frangible projectile designed for target shooting, a projectile which the Secretary finds is primarily intended to be used for sporting purposes, or any other projectile or projectile core which the Secretary finds is intended to be used for industrial purposes, including a charge used in an oil and gas well perforating device.".

TITLE XII—TERRORISM

SEC. 120001. EXTENSION OF THE STATUTE OF LIMITATION FOR CERTAIN TERRORISM OFFENSES.

(a) IN GENERAL.—Chapter 213 of title 18, United States Code, is amended by inserting after section 3285 the following new section:

"§3286. Extension of statute of limitation for certain terrorism offenses

"Notwithstanding section 3282, no person shall be prosecuted, tried, or punished for any offense involving a violation of section 32 (aircraft destruction), section 36 (airport violence), section 112 (assaults upon diplomats), section 351 (crimes against Congressmen or Cabinet officers), section 1116 (crimes against diplomats), section 1203 (hostage taking), section 1361 (willful injury to government property), section 1751 (crimes against the President), section 2280 (maritime violence), section 2281 (maritime platform violence), section 2331 (terrorist acts abroad against United States nationals), section 2339 (use of weapons of mass destruction), or section 2340A (torture) of this title or section 46502, 46504, 46505, or 46506 of title 49, unless the indictment is found or the information is instituted within 8 years after the offense was committed.".

(b) APPLICATION OF AMENDMENT.—The amendment made by subsection (a) shall not apply to any offense committed more than 5 years prior to the date of enactment of this Act.

(c) TECHNICAL AMENDMENT.—The chapter analysis for chapter 213 of title 18, United States Code, is amended by inserting after the item relating to section 3285 the following new item:

"3286. Extension of statute of limitation for certain terrorism offenses.".

SEC. 120002. JURISDICTION OVER CRIMES AGAINST UNITED STATES NATIONALS ON CERTAIN FOREIGN SHIPS.

Section 7 of title 18, United States Code (relating to the special maritime and territorial jurisdiction of the United States), is amended by inserting at the end thereof the following new paragraph:

"(8) To the extent permitted by international law, any foreign vessel during a voyage having a scheduled departure from or arrival in the United States with respect to an offense committed by or against a national of the United States.".

SEC. 120003. COUNTERFEITING UNITED STATES CURRENCY ABROAD.

(a) IN GENERAL.—Chapter 25 of title 18, United States Code, is amended by adding before section 471 the following new section:

"§ 470. Counterfeit acts committed outside the United States

"A person who, outside the United States, engages in the act of—

"(1) making, dealing, or possessing any counterfeit obligation or other security of the United States; or

"(2) making, dealing, or possessing any plate, stone, or other thing, or any part thereof, used to counterfeit such obligation or security,

if such act would constitute a violation of section 471, 473, or 474 if committed within the United States, shall be fined under this title, imprisoned not more than 20 years, or both.".

(b) TECHNICAL AMENDMENTS.—

(1) CHAPTER ANALYSIS.—The chapter analysis for chapter 25 of title 18, United States Code, is amended by adding before section 471 the following new item:

"470. Counterfeit acts committed outside the United States.".

(2) PART ANALYSIS.—The part analysis for part I of title 18, United States Code, is amended by amending the item for chapter 25 to read as follows:

"25. Counterfeiting and forgery .... 470".

SEC. 120004. SENTENCING GUIDELINES INCREASE FOR TERRORIST CRIMES.

The United States Sentencing Commission is directed to amend its sentencing guidelines to provide an appropriate enhancement for any felony, whether committed within or outside the United States, that involves or is intended to promote international terrorism, unless such involvement or intent is itself an element of the crime.

SEC. 120005. PROVIDING MATERIAL SUPPORT TO TERRORISTS.

(a) OFFENSE.—Chapter 113A of title 18, United States Code, is amended by adding the following new section:

"§ 2339A. Providing material support to terrorists

"(a) DEFINITION.—In this section, 'material support or resources' means currency or other financial securities, financial services, lodging, training, safehouses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, *personnel, transportation, and other physical assets, but does not include humanitarian assistance to persons not directly involved in such violations.*

"(b) OFFENSE.—A person who, within the United States, provides material support or resources or conceals or disguises the nature, location, source, or ownership of material support or resources, knowing or intending that they are to be used in preparation for, or in carrying out, a violation of section 32, 36, 351, 844 (f) or (i), 1114, 1116, 1203, 1361, 1363, 1751, 2280, 2281, 2331, or 2339 of this title or section 46502 of title 49, or in preparation for or carrying out the concealment of an escape from the commission of any such violation, shall be fined under this title, imprisoned not more than 10 years, or both.

"(c) INVESTIGATIONS.—

"(1) IN GENERAL.—Within the United States, an investigation may be initiated or continued under this section only when facts reasonably indicate that—

"(A) in the case of an individual, the individual knowingly or intentionally engages, has engaged, or is about to engage in the violation of this or any other Federal criminal law; and

"(B) in the case of a group of individuals, the group knowingly or intentionally engages, has engaged, or is about to engage in the violation of this or any other Federal criminal law.

"(2) ACTIVITIES PROTECTED BY THE FIRST AMENDMENT.—An investigation may not be initiated or continued under this section based on activities protected by the First Amendment to the Constitution, including expressions of support or the provision of financial support for the nonviolent political, religious, philosophical, or ideological goals or beliefs of any person or group.".

(b) TECHNICAL AMENDMENT.—The chapter analysis for chapter 113A of title 18, United States Code, is amended by adding the following new item:

"2339A. Providing material support to terrorists.".

TITLE XIII—CRIMINAL ALIENS AND IMMIGRATION ENFORCEMENT

SEC. 130001. ENHANCEMENT OF PENALTIES FOR FAILING TO DEPART, OR REENTERING, AFTER FINAL ORDER OF DEPORTATION.

(a) FAILURE TO DEPART.—Section 242(e) of the Immigration and Nationality Act (8 U.S.C. 1252(e)) is amended—

(1) by striking "paragraph (2), (3), or (4) of" the first time it appears; and

(2) by striking "shall be imprisoned not more than ten years" and inserting "shall be imprisoned not more than four years, or shall be imprisoned not more than ten years if the alien is a member of any of the classes described in paragraph (1)(E), (2), (3), or (4) of section 241(a).".

(b) REENTRY.—Section 276(b) of the Immigration and Nationality Act (8 U.S.C. 1326(b)) is amended—

(1) in paragraph (1)—

(A) by inserting after "commission of" the following: "three or more misdemeanors involving drugs, crimes against the person, or both, or"; and

(B) by striking "5" and inserting "10";

(2) in paragraph (2), by striking "15" and inserting "20"; and

(3) by adding at the end the following sentence:

"For the purposes of this subsection, the term 'deportation' includes any agreement in which an alien stipulates to deportation during a criminal trial under either Federal or State law.".

SEC. 130002. CRIMINAL ALIEN TRACKING CENTER.

(a) OPERATION.—The Attorney General shall, under the authority of section 242(a)(3)(A) of the Immigration and Nationality Act (8 U.S.C. 1252(a)(3)(A)), operate a criminal alien tracking center.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $3,400,000 for fiscal year 1996;

(2) $3,600,000 for fiscal year 1997;

(3) $3,700,000 for fiscal year 1998;

(4) $3,800,000 for fiscal year 1999; and

(5) $3,900,000 for fiscal year 2000.

SEC. 130003. ALIEN WITNESS COOPERATION AND COUNTERTERRORISM INFORMATION.

(a) ESTABLISHMENT OF NEW NONIMMIGRANT CLASSIFICATION.—Section 101(a)(15) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)) is amended—

(1) by striking "or" at the end of subparagraph (Q),

(2) by striking the period at the end of subparagraph (R) and inserting "; or", and

(3) by adding at the end the following new subparagraph:

"(S) subject to section 214(j), an alien—

"(i) who the Attorney General determines—

"(I) is in possession of critical reliable information concerning a criminal organization or enterprise;

"(II) is willing to supply or has supplied such information to Federal or State law enforcement authorities or a Federal or State court; and

"(III) whose presence in the United States the Attorney General determines is essential to the success of an authorized criminal investigation or the successful prosecution of an individual involved in the criminal organization or enterprise; or

"(ii) who the Secretary of State and the Attorney General jointly determine—

"(I) is in possession of critical reliable information concerning a terrorist organization, enterprise, or operation;

"(II) is willing to supply or has supplied such information to Federal law enforcement authorities or a Federal court;

"(III) will be or has been placed in danger as a result of providing such information; and

"(IV) is eligible to receive a reward under section 36(a) of the State Department Basic Authorities Act of 1956,

and, if the Attorney General (or with respect to clause (ii), the Secretary of State and the Attorney General jointly) considers it to be appropriate, the spouse, married and unmarried sons and daughters, and parents of an alien described in clause (i) or (ii) if accompanying, or following to join, the alien.".

(b) CONDITIONS OF ENTRY.—

(1) WAIVER OF GROUNDS FOR EXCLUSION.—Section 212(d) of the Immigration and Nationality Act (8 U.S.C. 1182(d)) is amended by inserting at the beginning the following new paragraph:

"(1) The Attorney General shall determine whether a ground for exclusion exists with respect to a nonimmigrant described in section 101(a)(15)(S). The Attorney General, in the Attorney General's discretion, may waive the application of subsection (a) (other than paragraph (3)(E)) in the case of a nonimmigrant described in section 101(a)(15)(S), if the Attorney General considers it to be in the national interest to do so. Nothing in this section shall be regarded as prohibiting the Immigration and Naturalization Service from instituting deportation proceedings against an alien admitted as a nonimmigrant under section 101(a)(15)(S) for conduct committed after the alien's admission into the United States, or for conduct or a condition that was not disclosed to the Attorney General prior to the alien's admission as a nonimmigrant under section 101(a)(15)(S).".

(2) NUMERICAL LIMITATIONS; PERIOD OF ADMISSION; ETC.—Section 214 of the Immigration and Nationality Act (8 U.S.C. 1184) is amended by adding at the end the following new subsection:

"(j)(1) The number of aliens who may be provided a visa as nonimmigrants under section 101(a)(15)(S)(i) in any fiscal year may not exceed 100. The number of aliens who may be provided a visa as nonimmigrants under section 101(a)(15)(S)(ii) in any fiscal year may not exceed 25.

"(2) No alien may be admitted into the United States as such a nonimmigrant more than 5 years after the date of the enactment of this subsection.

"(3) The period of admission of an alien as such a nonimmigrant may not exceed 3 years. Such period may not be extended by the Attorney General.

"(4) As a condition for the admission, and continued stay in lawful status, of such a nonimmigrant, the nonimmigrant—

"(A) shall report not less often than quarterly to the Attorney General such information concerning the alien's whereabouts and activities as the Attorney General may require;

"(B) may not be convicted of any criminal offense punishable by a term of imprisonment of 1 year or more after the date of such admission;

"(C) must have executed a form that waives the nonimmigrant's right to contest, other than on the basis of an application for withholding of deportation, any action for deportation of the alien instituted before the alien obtains lawful permanent resident status; and

"(D) shall abide by any other condition, limitation, or restriction imposed by the Attorney General.

"(5) The Attorney General shall submit a report annually to the Committee on the Judiciary of the House of Representatives and the Committee on the Judiciary of the Senate concerning—

"(A) the number of such nonimmigrants admitted;

"(B) the number of successful criminal prosecutions or investigations resulting from cooperation of such aliens;

"(C) the number of terrorist acts prevented or frustrated resulting from cooperation of such aliens;

"(D) the number of such nonimmigrants whose admission or cooperation has not resulted in successful criminal prosecution or investigation or the prevention or frustration of a terrorist act; and

"(E) the number of such nonimmigrants who have failed to report quarterly (as required under paragraph (4)) or who have been convicted of crimes in the United States after the date of their admission as such a nonimmigrant.".

(3) PROHIBITION OF CHANGE OF STATUS.—Section 248(1) of the Immigration and Naturalization Act (8 U.S.C. 1258(1)) is amended by striking "or (K)" and inserting "(K), or (S)".

(c) ADJUSTMENT TO PERMANENT RESIDENT STATUS.—

(1) IN GENERAL.—Section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) is amended by adding at the end the following new subsection:

"(i)(1) If, in the opinion of the Attorney General—

"(A) a nonimmigrant admitted into the United States under section 101(a)(15)(S)(i) has supplied information described in subclause (I) of such section; and

"(B) the provision of such information has substantially contributed to the success of an authorized criminal investigation or the prosecution of an individual described in subclause (III) of that section,

the Attorney General may adjust the status of the alien (and the spouse, married and unmarried sons and daughters, and parents of the *alien if admitted under that section) to that of an alien lawfully admitted for permanent residence if the alien is not described in section 212(a)(3)(E).*

"(2) If, in the sole discretion of the Attorney General—

"(A) a nonimmigrant admitted into the United States under section 101(a)(15)(S)(ii) has supplied information described in subclause (I) of such section, and

"(B) the provision of such information has substantially contributed to—

"(i) the prevention or frustration of an act of terrorism against a United States person or United States property, or

"(ii) the success of an authorized criminal investigation of, or the prosecution of, an individual involved in such an act of terrorism, and

"(C) the nonimmigrant has received a reward under section 36(a) of the State Department Basic Authorities Act of 1956,

the Attorney General may adjust the status of the alien (and the spouse, married and unmarried sons and daughters, and parents of the alien if admitted under such section) to that of an alien lawfully admitted for permanent residence if the alien is not described in section 212(a)(3)(E).

"(3) Upon the approval of adjustment of status under paragraphs (1) or (2), the Attorney General shall record the alien's lawful admission for permanent residence as of the date of such approval and the Secretary of State shall reduce by one the number of visas authorized to be issued under sections 201(d) and 203(b)(4) for the fiscal year then current.".

(2) EXCLUSIVE MEANS OF ADJUSTMENT.—Section 245(c) of the Immigration and Nationality Act (8 U.S.C. 1255(c)) is amended by striking "or" before "(4)" and by inserting before the period at the end the following: "; or (5) an alien who was admitted as a nonimmigrant described in section 101(a)(15)(S)".

(d) EXTENSION OF PERIOD OF DEPORTATION FOR CONVICTION OF A CRIME.—Section 241(a)(2)(A)(i)(I) of the Immigration and Nationality Act (8 U.S.C. 1251(a)(2)(A)(i)(I)) is amended by inserting "(or 10 years in the case of an alien provided lawful permanent resident status under section 245(i))" after "five years".

SEC. 130004. DEPORTATION PROCEDURES FOR CERTAIN CRIMINAL ALIENS WHO ARE NOT PERMANENT RESIDENTS.

(a) ELIMINATION OF ADMINISTRATIVE HEARING FOR CERTAIN CRIMINAL ALIENS.—Section 242A of the Immigration and Nationality Act (8 U.S.C. 1252a) is amended by adding at the end the following new subsection:

"(b) DEPORTATION OF ALIENS WHO ARE NOT PERMANENT RESIDENTS.—

"(1) The Attorney General may, in the case of an alien described in paragraph (2), determine the deportability of such alien under section 241(a)(2)(A)(iii) (relating to conviction of an aggravated felony) and issue an order of deportation pursuant to the procedures set forth in this subsection or section 242(b).

"(2) An alien is described in this paragraph if the alien—

"(A) was not lawfully admitted for permanent residence at the time at which proceedings under this section commenced; and

"(B) is not eligible for any relief from deportation under this Act.

"(3) The Attorney General may not execute any order described in paragraph (1) until 30 calendar days have passed from the date that such order was issued, unless waived by the alien, in order that the alien has an opportunity to apply for judicial review under section 106.

"(4) Proceedings before the Attorney General under this subsection shall be in accordance with such regulations as the Attorney General shall prescribe. The Attorney General shall provide that—

"(A) the alien is given reasonable notice of the charges and of the opportunity described in subparagraph (C);

"(B) the alien shall have the privilege of being represented (at no expense to the government) by such counsel, authorized to practice in such proccedings, as the alien shall choose;

"(C) the alien has a reasonable opportunity to inspect the evidence and rebut the charges;

"(D) the determination of deportability is supported by clear, convincing, and unequivocal evidence and a record is maintained for judicial review; and

"(E) the final order of deportation is not entered by the same person who issues the charges.".

(b) LIMITED JUDICIAL REVIEW.—Section 106 of the Immigration and Nationality Act (8 U.S.C. 1105a) is amended—

(1) in the first sentence of subsection (a), by inserting "or pursuant to section 242A" after "under section 242(b)";

(2) in subsection (a)(1) and subsection (a)(3), by inserting "(including an alien described in section 242A)" after "aggravated felony"; and

(3) by adding at the end the following new subsection:

"(d)(1) A petition for review or for habeas corpus on behalf of an alien against whom a final order of deportation has been issued pursuant to section 242A(b) may challenge only—

"(A) whether the alien is in fact the alien described in the order;

"(B) whether the alien is in fact an alien described in section 242A(b)(2);

"(C) whether the alien has been convicted of an aggravated felony and such conviction has become final; and

"(D) whether the alien was afforded the procedures required by section 242A(b)(5).

"(2) No court shall have jurisdiction to review any issue other than an issue described in paragraph (1).".

(c) TECHNICAL AMENDMENTS.—Section 242A of the Immigration and Nationality Act (8 U.S.C. 1252a) is amended—

(1) by amending the heading to read as follows:

"EXPEDITED DEPORTATION OF ALIENS CONVICTED OF COMMITTING AGGRAVATED FELONIES";

(2) in subsection (a), as designated prior to enactment of this Act, by striking "(a) IN GENERAL.—" and inserting the following:

"(a) DEPORTATION OF CRIMINAL ALIENS.—

"(1) IN GENERAL.—";

(3) in subsection (b), as designated prior to enactment of this Act, by striking "(b) IMPLEMENTATION.—" and inserting "(2) IMPLEMENTATION.—";

(4) by striking subsection (c);

(5) in subsection (d)—

(A) by striking "(d) EXPEDITED PROCEEDINGS.—(1)" and inserting "(3) EXPEDITED PROCEEDINGS.—(A)"; and

(B) by striking "(2)" and inserting "(B)"; and

(6) in subsection (e)—

(A) by striking "(e) REVIEW.—(1)" and inserting "(4) REVIEW.—(A)";

(B) by striking the second sentence; and

(C) by striking "(2)" and inserting "(B)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to all aliens against whom deportation proceedings are initiated after the date of enactment of this Act.

SEC. 130005. EXPEDITIOUS DEPORTATION FOR DENIED ASYLUM APPLICANTS.

(a) IN GENERAL.—The Attorney General may provide for the expeditious adjudication of asylum claims and the expeditious deportation of asylum applicants whose applications have been finally denied, unless the applicant remains in an otherwise valid nonimmigrant status.

(b) EMPLOYMENT AUTHORIZATION.—Section 208 of the Immigration and Nationality Act (8 U.S.C. 1158) is amended by adding at the end the following new subsection:

"(e) An applicant for asylum is not entitled to employment authorization except as may be provided by regulation in the discretion of the Attorney General.".

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $64,000,000 for fiscal year 1995;

(2) $90,000,000 for fiscal year 1996;

(3) $93,000,000 for fiscal year 1997; and

(4) $91,000,000 for fiscal year 1998.

SEC. 130006. IMPROVING BORDER CONTROLS.

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the Immigration and Naturalization Service to increase the resources for the Border Patrol, the Inspections Program, and the Deportation Branch to apprehend illegal aliens who attempt clandestine entry into the United States or entry into the United States with fraudulent documents or who remain in the country after their nonimmigrant visas expire—

(1) $228,000,000 for fiscal year 1995, of which $181,000,000 is authorized to be appropriated from the Violent Crime Reduction Trust Fund established by this Act, and $47,000,000 is authorized from the General Fund of the Treasury;

(2) $185,000,000 for fiscal year 1996, of which $137,000,000 is authorized to be appropriated from the Violent Crime Reduction Trust Fund established by this Act, and $48,000,000 is authorized from the General Fund of the Treasury;

(3) $204,000,000 for fiscal year 1997, of which $156,000,000 is authorized to be appropriated from the Violent Crime Reduction Trust Fund established by this Act, and $48,000,000 is authorized from the General Fund of the Treasury;

(4) $58,000,000 for fiscal year 1998, of which $10,000,000 is authorized to be appropriated from the Violent Crime Reduction Trust Fund established by this Act, and $48,000,000 is authorized from the General Fund of the Treasury;

Of the sums authorized in this section, all necessary funds shall, subject to the availability of appropriations, be allocated to increase the number of agent positions (and necessary support personnel positions) in the Border Patrol by not less than 1,000 full-time equivalent positions in each of fiscal years 1995, 1996, 1997, and 1998 beyond the number funded as of October 1, 1994.

(b) REPORT.—By September 30, 1996 and September 30, 1998, the Attorney General shall report to the Congress on the programs described in this section. The report shall include an evaluation of the programs, an outcome-based measurement of performance, and an analysis of the cost effectiveness of the additional resources provided under this Act.

SEC. 130007. EXPANDED SPECIAL DEPORTATION PROCEEDINGS.

(a) IN GENERAL.—Subject to the availability of appropriations, the Attorney General may expand the program authorized by section 242A(d) and 242(i) of the Immigration and Nationality Act to ensure that such aliens are immediately deportable upon their release from incarceration.

(b) DETENTION AND REMOVAL OF CRIMINAL ALIENS.—Subject to the availability of appropriations, the Attorney General may—

(1) construct or contract for the construction of 2 Immigration and Naturalization Service Processing Centers to detain criminal aliens; and

(2) provide for the detention and removal of such aliens.

(c) REPORT.—By September 30, 1996, and September 30, 1998 the Attorney General shall report to the Congress on the programs referred to in subsections (a) and (b). The report shall include an evaluation of the programs, an outcome-based measurement of performance, and

an analysis of the cost effectiveness of the additional resources provided under this Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $55,000,000 for fiscal year 1995;

(2) $54,000,000 for fiscal year 1996;

(3) $49,000,000 for fiscal year 1997; and

(4) $2,000,000 for fiscal year 1998.

SEC. 130008. AUTHORITY TO ACCEPT CERTAIN ASSISTANCE.

(a) IN GENERAL.—Subject to subsection (b) and notwithstanding any other provision of law, the Attorney General, in the discretion of the Attorney General, may accept, hold, administer, and utilize gifts of property and services (which may not include cash assistance) from State and local governments for the purpose of assisting the Immigration and Naturalization Service in the transportation of deportable aliens who are arrested for misdemeanor or felony crimes under State or Federal law and who are either unlawfully within the United States or willing to submit to voluntary departure under safeguards. Any property acquired pursuant to this section shall be acquired in the name of the United States.

(b) LIMITATION.—The Attorney General shall terminate or rescind the exercise of the authority under subsection (a) if the Attorney General determines that the exercise of such authority has resulted in discrimination by law enforcement officials on the basis of race, color, or national origin.

SEC. 130009. PASSPORT AND VISA OFFENSES PENALTIES IMPROVEMENT.

(a) IN GENERAL.—Chapter 75 of title 18, United States Code, is amended—

(1) in section 1541 by striking "not more than $500 or imprisoned not more than one year" and inserting "under this title, imprisoned not more than 10 years";

(2) in each of sections 1542, 1543, and 1544 by striking "not more than $2,000 or imprisoned not more than five years" and inserting "under this title, imprisoned not more than 10 years";

(3) in section 1545 by striking "not more than $2,000 or imprisoned not more than three years" and inserting "under this title, imprisoned not more than 10 years";

(4) in section 1546(a) by striking "five years" and inserting "10 years";

(5) in section 1546(b) by striking "in accordance with this title, or imprisoned not more than two years" and inserting "under this title, imprisoned not more than 5 years"; and

(6) by adding at the end the following new section:

"§1547. Alternative imprisonment maximum for certain offenses

"Notwithstanding any other provision of this title, the maximum term of imprisonment that may be imposed for an offense under this chapter (other than an offense under section 1545)—

"(1) if committed to facilitate a drug trafficking crime (as defined in 929(a)) is 15 years; and

"(2) if committed to facilitate an act of international terrorism (as defined in section 2331) is 20 years.".

(b) TECHNICAL AMENDMENT.—The chapter analysis for chapter 75 of title 18, United States Code, is amended by adding at the end the following new item:

"1547. Alternative imprisonment maximum for certain offenses.".

SEC. 130010. ASYLUM.

(a) FINDINGS.—The Senate finds that—

(1) in the last decade applications for asylum have greatly exceeded the original 5,000 annual limit provided in the Refugee Act of 1980, with more than 150,000 asylum applications filed in fiscal year 1993, and the backlog of cases growing to 340,000;

(2) this flood of asylum claims has swamped the system, creating delays in the processing of applications of up to several years;

(3) the delay in processing asylum claims due to the overwhelming numbers has contributed to numerous problems, including—

(A) an abuse of the asylum laws by fraudulent applicants whose primary interest is obtaining work authority in the United States while their claim languishes in the backlogged asylum processing system;

(B) the growth of alien smuggling operations, often involving organized crime;

(C) a drain on limited resources resulting from the high cost of processing frivolous asylum claims through our multilayered system; and

(D) an erosion of public support for asylum, which is a treaty obligation.

(4) asylum, a safe haven protection for aliens abroad who cannot return home, has been perverted by some aliens who use asylum claims to circumvent our immigration and refugee laws and procedures; and

(5) a comprehensive revision of our asylum law and procedures is required to address these problems.

(b) POLICY.—It is the sense of the Senate that—

(1) asylum is a process intended to protect aliens in the United States who cannot safely return home;

(2) persons outside their country of nationality who have a well-founded fear of persecution if they return should apply for refugee status at one of our refugee processing offices abroad; and

(3) the immigration, refugee and asylum laws of the United States should be reformed to provide—

(A) a procedure for the expeditious exclusion of any asylum applicant who arrives at a port-of-entry with fraudulent documents, or no documents, and makes a noncredible claim of asylum; and

(B) the immigration, refugee and asylum laws of the United States should be reformed to provide for a streamlined affirmative asylum processing system for asylum applicants who make their application after they have entered the United States.

TITLE XIV—YOUTH VIOLENCE

SEC. 140001. PROSECUTION AS ADULTS OF CERTAIN JUVENILES FOR CRIMES OF VIOLENCE.

The 4th undesignated paragraph of section 5032 of title 18, United States Code, is amended by striking "; however" and inserting ". In the application of the preceding sentence, if the crime of violence is an offense under section 113(a), 113(b), 113(c), 1111, 1113, or, if the juvenile possessed a firearm during the offense, section 2111, 2113, 2241(a), or 2241(c), 'thirteen' shall be substituted for 'fifteen' and 'thirteenth' shall be substituted for 'fifteenth'. Notwithstanding sections 1152 and 1153, no person subject to the criminal jurisdiction of an Indian tribal government shall be subject to the preceding sentence for any offense the Federal jurisdiction for which is predicated solely on Indian country (as defined in section 1151), and which has occurred within the boundaries of such Indian country, unless the governing body of the tribe has elected that the preceding sentence have effect over land and persons subject to its criminal jurisdiction. However".

SEC. 140002. COMMENCEMENT OF JUVENILE PROCEEDING.

Section 5032 of title 18, United States Code, is amended by striking "Any proceedings against a juvenile under this chapter or as an adult shall not be commenced until" and inserting "A juvenile shall not be transferred to adult prosecution nor shall a hearing be held under section 5037 (disposition after a finding of juvenile delinquency) until".

SEC. 140003. SEPARATION OF JUVENILE FROM ADULT OFFENDERS.

Section 5039 of title 18, United States Code, is amended by inserting ", whether pursuant to an adjudication of delinquency or conviction for an offense," after "committed" the first place it appears.

SEC. 140004. BINDOVER SYSTEM FOR CERTAIN VIOLENT JUVENILES.

Section 501(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3751), as amended by section 100003, is amended—

(1) by striking "and" at the end of paragraph (21);

(2) by striking the period at the end of paragraph (22) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(23) programs that address the need for effective bindover systems for the prosecution of violent 16- and 17-year-old juveniles in courts with jurisdiction over adults for the crimes of—

"(A) murder in the first degree;

"(B) murder in the second degree;

"(C) attempted murder;

"(D) armed robbery when armed with a firearm;

"(E) aggravated battery or assault when armed with a firearm;

"(F) criminal sexual penetration when armed with a firearm; and

"(G) drive-by shootings as described in section 36 of title 18, United States Code.".

SEC. 140005. AMENDMENT CONCERNING RECORDS OF CRIMES COMMITTED BY JUVENILES.

Section 5038 of title 18, United States Code, is amended in subsection (f) by adding "or whenever a juvenile has been found guilty of committing an act after his 13th birthday which if committed by an adult would be an offense described in the second sentence of the fourth paragraph of section 5032 of this title," after "title 21,".

SEC. 140006. INCREASED PENALTIES FOR EMPLOYING CHILDREN TO DISTRIBUTE DRUGS NEAR SCHOOLS AND PLAYGROUNDS.

Section 419 of the Controlled Substances Act (21 U.S.C. 860) is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following new subsection:

"(c) Notwithstanding any other law, any person at least 21 years of age who knowingly and intentionally—

"(1) employs, hires, uses, persuades, induces, entices, or coerces a person under 18 years of age to violate this section; or

"(2) employs, hires, uses, persuades, induces, entices, or coerces a person under 18 years of age to assist in avoiding detection or apprehension for any offense under this section by any Federal, State, or local law enforcement official, is punishable by a term of imprisonment, a fine, or both, up to triple those authorized by section 401.".

SEC. 140007. INCREASED PENALTIES FOR TRAVEL ACT CRIMES INVOLVING VIOLENCE AND CONSPIRACY TO COMMIT CONTRACT KILLINGS.

(a) TRAVEL ACT PENALTIES.—Section 1952(a) of title 18, United States Code, is amended by striking "and thereafter performs or attempts to perform any of the acts specified in subparagraphs (1), (2), and (3), shall be fined not more than $10,000 or imprisoned for not more than five years, or both." and inserting "and thereafter performs or attempts to perform—

"(A) an act described in paragraph (1) or (3) shall be fined under this title, imprisoned not more than 5 years, or both; or

"(B) an act described in paragraph (2) shall be fined under this title, imprisoned for not more than 20 years, or both, and if death results shall be imprisoned for any term of years or for life.".

(b) MURDER CONSPIRACY PENALTIES.—Section 1958(a) of title 18, United States Code, is amended by inserting "or who conspires to do so" before "shall be fined" the first place it appears.

SEC. 140008. SOLICITATION OF MINOR TO COMMIT CRIME.

(a) DIRECTIVE TO SENTENCING COMMISSION.—(1) The United States Sentencing Commission shall promulgate guidelines or amend existing guidelines to provide that a defendant 21 years of age or older who has been convicted of an offense shall receive an appropriate sentence enhancement if the defendant involved a minor in the commission of the offense.

(2) The Commission shall provide that the guideline enhancement promulgate pursuant to paragraph (1) shall apply for any offense in relation to which the defendant has solicited, procured, recruited, counseled, encouraged, trained, directed, commanded, intimidated, or otherwise used or attempted to use any person less than 18 years of age with the intent that the minor would commit a Federal offense.

(b) RELEVANT CONSIDERATIONS.—In implementing the directive in subsection (a), the Sentencing Commission shall consider—

(1) the severity of the crime that the defendant intended the minor to commit;

(2) the number of minors that the defendant used or attempted to use in relation to the offense;

(3) the fact that involving a minor in a crime of violence is frequently of even greater seriousness than involving a minor in a drug trafficking offense, for which the guidelines already provide a two-level enhancement; and

(4) the possible relevance of the proximity in age between the offender and the minor(s) involved in the offense.

TITLE XV—CRIMINAL STREET GANGS

SEC. 150001. CRIMINAL STREET GANGS.

(a) IN GENERAL.—Part I of title 18, United States Code, is amended by inserting after chapter 25 the following new chapter:

"CHAPTER 26—CRIMINAL STREET GANGS

"§521. Criminal street gangs

"(a) DEFINITIONS.—

" 'conviction' includes a finding, under State or Federal law, that a person has committed an act of juvenile delinquency involving a violent or controlled substances felony.

" 'criminal street gang' means an ongoing group, club, organization, or association of 5 or more persons—

"(A) that has as 1 of its primary purposes the commission of 1 or more of the criminal offenses described in subsection (c);

"(B) the members of which engage, or have engaged within the past 5 years, in a continuing series of offenses described in subsection (c); and

"(C) the activities of which affect interstate or foreign commerce.

"(b) PENALTY.—The sentence of a person convicted of an offense described in subsection (c) shall be increased by up to 10 years if the offense is committed under the circumstances described in subsection (d).

"(c) OFFENSES.—The offenses described in this section are—

"(1) a Federal felony involving a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) for which the maximum penalty is not less than 5 years;

"(2) a Federal felony crime of violence that has as an element the use or attempted use of physical force against the person of another; and

"(3) a conspiracy to commit an offense described in paragraph (1) or (2).

"(d) CIRCUMSTANCES.—The circumstances described in this section are that the offense described in subsection (c) was committed by a person who—

"(1) participates in a criminal street gang with knowledge that its members engage in or have engaged in a continuing series of offenses described in subsection (c);

"(2) intends to promote or further the felonious activities of the criminal street gang or maintain or increase his or her position in the gang; and

"(3) has been convicted within the past 5 years for—

"(A) an offense described in subsection (c);

"(B) a State offense—

"(i) involving a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) for which the maximum penalty is not less than 5 years' imprisonment; or

"(ii) that is a felony crime of violence that has as an element the use or attempted use of physical force against the person of another;

"(C) any Federal or State felony offense that by its nature involves a substantial risk that physical force against the person of another may be used in the course of committing the offense; or

"(D) a conspiracy to commit an offense described in subparagraph (A), (B), or (C).".

(b) TECHNICAL AMENDMENT.—The part analysis for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 25 the following new item:

"26. Criminal street gangs .... 521".

SEC. 150002. ADULT PROSECUTION OF SERIOUS JUVENILE OFFENDERS.

Section 5032 of title 18, United States Code, is amended—

(1) in the first undesignated paragraph by striking "922(p)" and inserting "924(b), (g), or (h)";

(2) in the fourth undesignated paragraph by inserting "or in section 924(b), (g), or (h) of this title," before "criminal prosecution" the first place it appears; and

(3) in the fifth undesignated paragraph by adding at the end the following: "In considering the nature of the offense, as required by this paragraph, the court shall consider the extent to which the juvenile played a leadership role in an organization, or otherwise influenced other persons to take part in criminal activities, involving the use or distribution of controlled substances or firearms. Such a factor, if found to exist, shall weigh in favor of a transfer to adult status, but the absence of this factor shall not preclude such a transfer.".

SEC. 150003. ADDITION OF ANTI-GANG BYRNE GRANT FUNDING OBJECTIVE.

Section 501(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3751(4)), as amended by section 140004, is amended—

(1) by striking "and" at the end of paragraph (22);

(2) by striking the period at the end of paragraph (23) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(24) law enforcement and prevention programs relating to gangs, or to youth who are involved or at risk of involvement in gangs.".

SEC. 150004. JUVENILE DRUG TRAFFICKING AND GANG PREVENTION GRANTS.

Part D of title II of the Juvenile Justice and Delinquency Prevention Act of 1974 (42 U.S.C. 5631 et seq.) is amended—

(1) by redesignating subpart III as subpart IV;

(2) by redesignating section 283 as section 284; and

(3) by inserting after subpart II the following new subpart:

"Subpart III—Juvenile Drug Trafficking and Gang Prevention Grants

"FORMULA GRANTS

"SEC. 283. (a) AUTHORIZATION.—The Administrator may make grants to States, units of general local government, private not-for-profit anticrime organizations, or combinations thereof to assist them in planning, establishing, operating, coordinating, and evaluating projects, directly or through grants and contracts with public and private agencies, for the development of more effective programs including prevention and enforcement programs to reduce—

"(1) the formation or continuation of juvenile gangs; and

"(2) the use and sale of illegal drugs by juveniles.

"(b) PARTICULAR PURPOSES.—The grants made under this section can be used for any of the following specific purposes:

"(1) To reduce the participation of juveniles in drug-related crimes (including drug trafficking and drug use), particularly in and around elementary and secondary schools.

"(2) To reduce juvenile involvement in organized crime, drug and gang-related activity, particularly activities that involve the distribution of drugs by or to juveniles.

"(3) To develop within the juvenile justice system, including the juvenile corrections system, innovative means to address the problems of juveniles convicted of serious drug-related and gang-related offenses.

"(4) To reduce juvenile drug and gang-related activity in public housing projects.

"(5) To develop and provide parenting classes to parents of at-risk youth, giving parents the skills they need to provide adequate care and supervision of such youth and to counteract the influences leading youth to a life of gangs, crime, and drugs.

"(6) To develop and provide training in methods of nonviolent dispute resolution to youth of junior high school and high school age.

"(7) To reduce and prevent juvenile drug and gang-related activity in rural areas.

"(8) To provide technical assistance and training to personnel and agencies responsible for the adjudicatory and corrections components of the juvenile justice system to—

"(A) identify drug-dependent or gang-involved juvenile offenders; and

"(B) provide appropriate counseling and treatment to such offenders.

"(9) To promote the involvement of all juveniles in lawful activities, including in-school and after-school programs for academic, athletic, or artistic enrichment that also teach that drug and gang involvement are wrong.

"(10) To facilitate Federal and State cooperation with local school officials to develop education, prevention, and treatment programs for juveniles who are likely to participate in drug trafficking, drug use, or gang-related activities.

"(11) To prevent juvenile drug and gang involvement in public housing projects through programs establishing youth sports and other activities, including girls' and boys' clubs, scout troops, and little leagues.

"(12) To provide pre- and post-trial drug abuse treatment to juveniles in the juvenile justice system with the highest possible priority to providing drug abuse treatment to drug-dependent pregnant juveniles and drug-dependent juvenile mothers.

"(13) To provide education and treatment programs for juveniles exposed to severe violence in their homes, schools, or neighborhoods.

"(14) To establish sports mentoring and coaching programs in which athletes serve as role models for juveniles to teach that athletics provides a positive alternative to drug and gang involvement.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 283A. There is authorized to be appropriated to carry out this subpart—

"(1) $15,000,000 for fiscal year 1996;

"(2) $21,000,000 for fiscal year 1997;

"(3) $25,000,000 for fiscal year 1998;

"(4) $30,000,000 for fiscal year 1999; and

"(5) $34,000,000 for fiscal year 2000.

"APPLICATION

"SEC. 283B. (a) IN GENERAL.—Each State or entity applying for a grant under section 283 shall submit an application to the Administrator in such form and containing such information as the Administrator shall prescribe.

"(b) REGULATIONS.—To the extent practicable, the Administrator shall prescribe regulations governing applications for this subpart that are substantially similar to the regulations governing applications required under part D, including the regulations relating to competition.

"MENTAL HEALTH SCREENING

"SEC. 283C. (a) SENSE OF THE CONGRESS.—It is the sense of the Congress that no child should have to be incarcerated in a State youth center or detention facility solely in order to receive mental health treatment.

"(b) IN GENERAL.—Not later than 2 years after the date of enactment of this subpart, the Attorney General, acting through the Administrator of the Office of Juvenile Justice and Delinquency Prevention, in collaboration with the Secretary of Health and Human Services, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, shall, subject to the availability of appropriations—

"(1) study the nature and prevalence of mental illness among youth in the juvenile justice system at several different points in the system, including the arrest stage, the adjudication, and dispositional stage, and the commitment stage, such study to be based on the best available data and include reviews of existing studies by the Government Accounting Office, the Inspector General's office, and such other interested parties as are appropriate;

"(2) develop a model system that the States can use to assess, diagnose, and treat the mental health needs of youth who come in contact with the juvenile justice system; and

"(3) disseminate the results of the study and the model to each State's Juvenile Justice Advisory Group.

"(c) STUDY.—The study should include analysis of—

"(1) national prevalence of rates of the different clinical categories of mental illness for youth who come in contact with the juvenile justice system;

"(2) the prevalence of multiple mental disorders among youth who have come in contact with the juvenile justice system;

"(3) recommendations to the Committee on the Judiciary of the Senate and the Committee on Education and Labor of the House of Representatives on the appropriateness and need for further Federal action; and

"(4) such other analysis as is appropriate.

"(d) MODEL.—The model should provide—

"(1) guidelines for accurate and timely assessment, diagnosis, and treatment at several different points in the juvenile justice system including the arrest stage, the adjudication and dispositional stage, and the commitment stage;

"(2) a method for fostering collaboration between the mental health agencies, juvenile justice agencies, educational agencies, social services agencies, substance abuse treatment agencies, police, and families;

"(3) a funding mechanism for implementing the model; and

"(4) such other guidelines as are appropriate.".

SEC. 150005. GRANTS FOR YOUTH DEVELOPMENT CENTERS.

Part B of title II of the Juvenile Justice and Delinquency Prevention Act of 1974 (42 U.S.C. 5631 et seq.), is amended—

(1) by inserting before section 221 the following heading:

"Subpart I—Juvenile Justice and Delinquency Prevention Formula Grant Program";

and

(2) by adding at the end the following new subpart:

"Subpart II—Youth Violence Prevention Block Grants

"SEC. 232. (a) IN GENERAL.—The Administrator of the Office of Juvenile Justice and Delinquency Prevention shall subject to availability of appropriations make grants to States to assist the States in planning, establishing, operating, coordinating, and evaluating programs directly or through grants and contracts with public and private agencies for the development of more effective education, training, research, prevention, diversion, treatment, and rehabilitation programs in the area of juvenile violence.

"(b) ISSUES TO BE ADDRESSED.—A program funded under subsection (a) shall address issues identified as contributing to youth violence, which may include—

"(1) conflict resolution programs in schools;

"(2) alternatives to school suspension;

"(3) juvenile court diversion programs; and

"(4) other innovative projects.

"(c) ALLOCATION OF FUNDS.—The amount appropriated under this section for a fiscal year shall be allocated among the States by allocating to each State an amount that bears the same proportion to the amount appropriated as the number of residents of the State under the age of 18 years bears to the number of residents of all of the States under the age of 18 years.

"(d) ADMINISTRATION.—Grants made under this section shall be administered by the State office designated under section 507 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3757).

"(e) APPLICATIONS BY PUBLIC AND PRIVATE AGENCIES.—

"(1) IN GENERAL.—A public or private agency desiring to receive a grant or enter into a contract under this subpart shall submit an application at such time, in such manner, and containing such information as the office described in subsection (d) may prescribe.

"(2) CONTENTS.—In accordance with guidelines established by the office described in subsection (d), an application under paragraph (1) shall—

"(A) set forth a program or activity for carrying out 1 or more of the purposes described in subsections (a) and (b) and specifically identify each such purpose that the program or activity is designed to carry out;

"(B) provide that the program or activity will be administered by or under the supervision of the applicant;

"(C) provide for the proper and efficient administration of the program or activity;

"(D) provide for regular evaluation of the program or activity;

"(E) provide an assurance that the proposed program or activity will supplement, not supplant, similar programs and activities already available in the community;

"(F) describe how the program or activity will be coordinated with programs, activities, and services available locally;

"(G) provide that regular reports on such program or activity shall be sent to the administering office named in subsection (d); and

"(H) provide for such fiscal control and fund accounting procedures as may be necessary to ensure prudent use, proper disbursement, and accurate accounting of funds received under this subpart.

"(f) MATCHING FUNDS REQUIREMENTS.—

"(1) FUNDS RECEIVED UNDER THIS SUBPART.—Funds received through a grant under this section may not be expended for more than 75 percent of the cost of any program that is so funded.

"(2) FUNDS FROM OTHER SOURCES.—In providing for the 25 percent share of the cost of a program from other sources, a State—

"(A) shall provide for such share through a payment in cash or in kind, fairly evaluated, including facilities, equipment, or services; and

"(B) may provide for such share through State sources, local sources, private sources, nonprofit sources, other Federal sources, or any combination of these sources.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

"(1) $5,000,000 for fiscal year 1996;

"(2) $8,000,000 for fiscal year 1997;

"(3) $10,000,000 for fiscal year 1998;

"(4) $12,000,000 for fiscal year 1999; and

"(5) $15,000,000 for fiscal year 2000.".

SEC. 150006. MENTORING PROGRAM.

Section 288C of part G of title II of the Juvenile Justice and Delinquency Prevention Act of 1974 is amended to read as follows:

"REGULATIONS AND GUIDELINES

"SEC. 288C. (a) PROGRAM GUIDELINES.—The Administrator shall issue program guidelines to implement this part. The program guidelines shall be effective only after a period for public notice and comment.

"(b) MODEL SCREENING GUIDELINES.—The Administrator shall develop and distribute to program participants specific model guidelines for the screening of prospective program mentors.".

SEC. 150007. JUVENILE ANTI-DRUG AND ANTI-GANG GRANTS IN FEDERALLY ASSISTED LOW-INCOME HOUSING.

Grants authorized in this Act to reduce or prevent juvenile drug and gang-related activity in "public housing" may be used for such purposes in federally assisted, low-income housing.

SEC. 150008. GANG INVESTIGATION COORDINATION AND INFORMATION COLLECTION.

(a) COORDINATION.—The Attorney General (or the Attorney General's designee), in consultation with the Secretary of the Treasury (or the Secretary's designee), shall develop a national strategy to coordinate gang-related investigations by Federal law enforcement agencies.

(b) DATA COLLECTION.—The Director of the Federal Bureau of Investigation shall acquire and collect information on incidents of gang violence for inclusion in an annual uniform crime report.

(c) REPORT.—The Attorney General shall prepare a report on national gang violence outlining the strategy developed under subsection (a) to be submitted to the President and Congress by January 1, 1996.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $1,000,000 for fiscal year 1996.

SEC. 150009. MULTIJURISDICTIONAL GANG TASK FORCES.

Section 504(f) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 is amended by inserting "victims assistance programs, or multijurisdictional gang task forces" after "drug task forces".

TITLE XVI—CHILD PORNOGRAPHY

SEC. 160001. PENALTIES FOR INTERNATIONAL TRAFFICKING IN CHILD PORNOGRAPHY.

(a) IMPORT RELATED OFFENSE.—Chapter 110 of title 18, United States Code, is amended by adding at the end the following new section:

"§2258. Production of sexually explicit depictions of a minor for importation into the United States

"(a) USE OF MINOR.—A person who, outside the United States, employs, uses, persuades, induces, entices, or coerces any minor to engage in, or who has a minor assist any other person *to engage in, or who transports any minor with the intent that the minor engage in any sexually explicit conduct for the purpose of producing any visual depiction of such conduct, intending that the visual depiction will be imported into the United States or into waters within 12 miles of the coast of the United States, shall be punished as provided in subsection (c).*

"(b) USE OF VISUAL DEPICTION.—A person who, outside the United States, knowingly receives, transports, ships, distributes, sells, or possesses with intent to transport, ship, sell, or distribute any visual depiction of a minor engaging in sexually explicit conduct (if the production of the visual depiction involved the use of a minor engaging in sexually explicit conduct), intending that the visual depiction will be imported into the United States or into waters within a distance of 12 miles of the coast of the United States, shall be punished as provided in subsection (c).

"(c) PENALTIES.—A person who violates subsection (a) or (b), or conspires or attempts to do so—

"(1) shall be fined under this title, imprisoned not more than 10 years, or both; and

"(2) if the person has a prior conviction under this chapter or chapter 109A, shall be fined under this title, imprisoned not more than 20 years, or both.".

(b) TECHNICAL AMENDMENT.—

(1) CHAPTER ANALYSIS.—The chapter analysis for chapter 110 of title 18, United States Code, is amended by adding at the end the following new item:

"2258. Production of sexually explicit depictions of a minor for importation into the United States.".

(2) FINE PROVISIONS.—Section 2251(d) of title 18, United States Code, is amended—

(A) by striking "not more than $100,000, or" and inserting "under this title,";

(B) by striking "not more than $200,000, or" and inserting "under this title,"; and

(C) by striking "not more than $250,000" and inserting "under this title".

(c) SECTION 2251 PENALTY ENHANCEMENT.—Section 2251(d) of title 18, United States Code, is amended by striking "this section" the second place it appears and inserting "this chapter or chapter 109A".

(d) SECTION 2252 PENALTY ENHANCEMENT.—Section 2252(b)(1) of title 18, United States Code, is amended by striking "this section" and inserting "this chapter or chapter 109A".

(e) CONSPIRACY AND ATTEMPT.—Sections 2251(d) and 2252(b) of title 18, United States Code, are each amended by inserting ", or attempts or conspires to violate," after "violates" each place it appears.

(f) RICO AMENDMENT.—Section 1961(l) of title 18, United States Code, is amended by striking "2251–2252" and inserting "2251, 2251A, 2252, and 2258".

(g) TRANSPORTATION OF MINORS.—Section 2423 of title 18, United States Code, is amended—

(1) by striking "(a) Whoever" and inserting "(a) TRANSPORTATION WITH INTENT TO ENGAGE IN CRIMINAL SEXUAL ACTIVITY.—A person who"; and

(2) by adding at the end the following new subsection:

"(b) TRAVEL WITH INTENT TO ENGAGE IN SEXUAL ACT WITH A JUVENILE.—A person who travels in interstate commerce, or conspires to do so, or a United States citizen or an alien admitted for permanent residence in the United States who travels in foreign commerce, or conspires to do so, for the purpose of engaging in any sexual act (as defined in section 2245) with a person under 18 years of age that would be in violation of chapter 109A if the sexual act occurred in the special maritime and territorial jurisdiction of the United States shall be fined under this title, imprisoned not more than 10 years, or both.".

SEC. 160002. SENSE OF CONGRESS CONCERNING STATE LEGISLATION REGARDING CHILD PORNOGRAPHY.

It is the sense of the Congress that each State that has not yet done so should enact legislation prohibiting the production, distribution, receipt, or simple possession of materials depicting a person under 18 years of age engaging in sexually explicit conduct (as defined in section 2256 of title 18, United States Code) and providing for a maximum imprisonment of at least 1 year and for the forfeiture of assets used in the commission or support of, or gained from, such offenses.

SEC. 160003. CONFIRMATION OF INTENT OF CONGRESS IN ENACTING SECTIONS 2252 AND 2256 OF TITLE 18, UNITED STATES CODE.

(a) DECLARATION.—The Congress declares that in enacting sections 2252 and 2256 of title 18, United States Code, it was and is the intent of Congress that—

(1) the scope of "exhibition of the genitals or pubic area" in section 2256(2)(E), in the definition of "sexually explicit conduct", is not limited to nude exhibitions or exhibitions in which the outlines of those areas were discernible through clothing; and

(2) the requirements in section 2252(a) (1)(A), (2)(A), (3)(B)(i), and (4)(B)(i) that the production of a visual depiction involve the use of a minor engaging in "sexually explicit conduct" of the kind described in section 2256(2)(E) are satisfied if a person photographs a minor in such a way as to exhibit the child in a lascivious manner.

(b) SENSE OF THE CONGRESS.—It is the sense of the Congress that in filing its brief in United States v. Knox, No. 92–1183, and thereby depriving the United States Supreme Court of the adverseness necessary for full and fair presentation of the issues arising in the case, the Department of Justice did not accurately reflect the intent of Congress in arguing that "the videotapes in [the Knox case] constitute 'lascivious exhibition[s] of the genitals or pubic area' only if those body parts are visible in the tapes and the minors posed or acted lasciviously.".

TITLE XVII—CRIMES AGAINST CHILDREN

Subtitle A—Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act

SEC. 170101. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—

(1) STATE GUIDELINES.—The Attorney General shall establish guidelines for State programs requiring any person who is convicted of a criminal offense against a victim who is a minor, or of any other sexually violent offense to register a current address with a designated State law enforcement agency for 10 years after release from prison, or being placed on parole, supervised release, or probation.

(2) DEFINITION.—For purposes of this subsection—

(A) the term "criminal offense against a victim who is a minor" means any criminal offense that consists of—

(i) kidnapping of a minor, except by a parent;

(ii) false imprisonment of a minor, except by a parent;

(iii) criminal sexual conduct toward a minor;

(iv) solicitation of a minor to engage in sexual conduct;

(v) use of a minor in a sexual performance;

(vi) solicitation of a minor to practice prostitution;

(vii) any conduct that by its nature is a sexual offense against a minor; or

(viii) an attempt to commit an offense described in any of clauses (i) through (vii), if the State—

(I) makes such an attempt a criminal offense; and

(II) chooses to include such an offense in those which are criminal offenses against a victim who is a minor for the purposes of this section; and

(B) the term "sexually violent offense" means any criminal offense that consists of aggravated sexual abuse or sexual abuse (as described in sections 2241 and 2242 of title 18, United States Code) or an offense that has as its elements engaging in physical contact with another person or using or brandishing a weapon against another person with intent to commit aggravated sexual abuse or sexual abuse (as described in sections 2241 and 2242 of title 18, United States Code).

(b) REGISTRATION REQUIREMENT UPON RELEASE, PAROLE, SUPERVISED RELEASE, OR PROBATION.—An approved State registration program established under this section shall contain the following requirements:

(1) DUTY OF STATE PRISON OFFICIAL OR COURT.—If a person who is required to register under this section is released from prison, or placed on parole, supervised release, or probation, a State prison officer, or in the case of probation, the court, shall—

(A) inform the person of the duty to register and obtain the information required for such registration;

(B) inform the person that if the person changes residence address, the person shall give the new address to a designated State law enforcement agency in writing within 10 days;

(C) inform the person that if the person changes residence to another State, the person shall register the new address with the law enforcement agency with whom the person last registered, and the person is also required to register with a designated law enforcement agency in the new State not later than 10 days after establishing residence in the new State, if the new State has a registration requirement;

(D) obtain fingerprints and a photograph of the person if these have not already been obtained in connection with the offense that triggers registration; and

(E) require the person to read and sign a form stating that the duty of the person to register under this section has been explained.

(2) TRANSFER OF INFORMATION TO STATE AND THE FBI.—The officer, or in the case of a person placed on probation, the court, shall, within 3 days after receipt of information described in paragraph (1), forward it to a designated State law enforcement agency. The State law enforcement agency shall immediately enter the information into the appropriate State law enforcement record system and notify the appropriate law enforcement agency having jurisdiction where the person expects to reside. The State law enforcement agency shall also immediately transmit the conviction data and fingerprints to the Federal Bureau of Investigation.

(3) ANNUAL VERIFICATION.—On each anniversary of a person's initial registration date during the period in which the person is required to register under this section, the designated State law enforcement agency shall mail a nonforwardable verification form to the last reported address of the person. The person shall mail the verification form to the designated State law enforcement agency within 10 days after receipt of the form. The verification form shall be signed by the person, and state that the person still resides at the address last reported to the designated State law enforcement agency. If the person fails to mail the verification form to the designated State law enforcement agency within 10 days after receipt of the form, the person shall be in violation of this section unless the person proves that the person has not changed his or her residence address.

(4) NOTIFICATION OF LOCAL LAW ENFORCEMENT AGENCIES OF CHANGES IN ADDRESS.—Any change of address by a person required to register under this section reported to the designated State law enforcement agency shall immediately be reported to the appropriate law enforcement agency having jurisdiction where the person is residing. The designated law enforcement agency shall, if the person changes residence to another State, notify the law enforcement agency with which the person must register in the new State, if the new State has a registration requirement.

(5) PRIVACY OF DATA.—The information collected under a State registration program shall be treated as private data on individuals and may be disclosed only to law enforcement agencies for law enforcement purposes or to government agencies conducting confidential background checks with fingerprints. A law enforcement agency may release relevant information concerning a sex offender required to register under this section when such release of information is necessary to carry out law enforcement purposes or to notify the victims of the offender.

(c) REGISTRATION FOR CHANGE OF ADDRESS TO ANOTHER STATE.—A person who has been convicted of an offense which triggered registration in a State shall register the new address with a designated law enforcement agency in another State to which the person moves not later than 10 days after such person establishes residence in the new State, if the new State has a registration requirement.

(d) REGISTRATION FOR 10 YEARS.—A person required to register under this section shall continue to comply with this section until 10 years have elapsed since the person was released from prison, or placed on parole, supervised release, or probation.

(e) PENALTY.—A person required to register under a State program established pursuant to this section who knowingly fails to so register and keep such registration current shall be subject to criminal penalties in any State in which the person has so failed.

(f) IMMUNITY.—The State program shall provide appropriate legal immunity to law enforcement agencies, employees of law enforcement agencies, and State officials for good faith and reasonably diligent conduct in carrying out the State program.

(g) COMPLIANCE.—

(1) COMPLIANCE DATE.—Each State shall have 3 years from the date of the enactment of this Act in which to implement this section.

(2) INELIGIBILITY FOR FUNDS.—The allocation of funds under section 506 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3756) received by a State not complying with the guidelines issued under this section 3 years after the date of enactment of this Act may be reduced by the Attorney General by up to 10 percent and the unallocated funds shall be reallocated to the States in compliance with this section.

Subtitle B—Assaults Against Children

SEC. 170201. ASSAULTS AGAINST CHILDREN.

(a) SIMPLE ASSAULT.—Section 113(e) of title 18, United States Code, is amended by inserting ", or if the victim of the assault is an individual who has not attained the age of 16 years, by fine under this title or imprisonment for not more than 1 year, or both" before the period.

(b) ASSAULTS RESULTING IN SUBSTANTIAL BODILY INJURY.—Section 113 of title 18, United States Code, is amended by adding at the end the following:

"(7) Assault resulting in substantial bodily injury to an individual who has not attained the age of 16 years, by fine under this title or imprisonment for not more than 5 years, or both.".

(c) TECHNICAL AND STYLISTIC CHANGES TO SECTION 113.—Section 113 of title 18, United States Code, is amended—

(1) in paragraph (b), by striking "of not more than $3,000" and inserting "under this title";

(2) in paragraph (c), by striking "of not more than $1,000" and inserting "under this title";

(3) in paragraph (d), by striking "of not more than $500" and inserting "under this title";

(4) by modifying the left margin of each of paragraphs (a) through (f) so that they are indented 2 ems;

(5) by redesignating paragraphs (a) through (f) as paragraphs (1) through (6); and

(6) by inserting "(a)" before "Whoever".

(d) DEFINITIONS.—Section 113 of title 18, United States Code, is amended by adding at the end the following:

"(b) As used in this subsection—

"(1) the term 'substantial bodily injury' means bodily injury which involves—

"(A) a temporary but substantial disfigurement; or

"(B) a temporary but substantial loss or impairment of the function of any bodily member, organ, or mental faculty; and

"(2) the term 'serious bodily injury' has the meaning given that term in section 1365 of this title.".

(e) ASSAULTS IN INDIAN COUNTRY.—Section 1153(a) of title 18, United States Code, is amended by inserting "(as defined in section 1365 of this title), an assault against an individual who has not attained the age of 16 years" after "serious bodily injury".

Subtitle C—Missing and Exploited Children

SEC. 170301. SHORT TITLE.

This subtitle may be cited as the "Morgan P. Hardiman Task Force on Missing and Exploited Children Act".

SEC. 170302. PURPOSE.

The purpose of this subtitle is to establish a task force comprised of law enforcement officers from pertinent Federal agencies to work with the National Center for Missing and Exploited Children (referred to as the "Center") and coordinate the provision of Federal law enforcement resources to assist State and local authorities in investigating the most difficult cases of missing and exploited children.

SEC. 170303. ESTABLISHMENT OF TASK FORCE.

Title IV of the Juvenile Justice and Delinquency Prevention Act of 1974 (42 U.S.C. 5771 et seq.) is amended—

(1) by redesignating sections 407 and 408 as sections 408 and 409, respectively; and

(2) by inserting after section 406 the following new section:

"TASK FORCE

"SEC. 407. (a) ESTABLISHMENT.—There is established a Missing and Exploited Children's Task Force (referred to as the "Task Force").

"(b) MEMBERSHIP.—

"(1) IN GENERAL.—The Task Force shall include at least 2 members from each of—

"(A) the Federal Bureau of Investigation;

"(B) the Secret Service;

"(C) the Bureau of Alcohol, Tobacco and Firearms;

"(D) the United States Customs Service;

"(E) the Postal Inspection Service;

"(F) the United States Marshals Service; and

"(G) the Drug Enforcement Administration.

"(2) CHIEF.—A representative of the Federal Bureau of Investigation (in addition to the members of the Task Force selected under paragraph (1)(A)) shall act as chief of the Task Force.

"(3) SELECTION.—(A) The Director of the Federal Bureau of Investigation shall select the chief of the Task Force.

"(B) The heads of the agencies described in paragraph (1) shall submit to the chief of the Task Force a list of at least 5 prospective Task Force members, and the chief shall select 2, or such greater number as may be agreeable to an agency head, as Task Force members.

"(4) PROFESSIONAL QUALIFICATIONS.—The members of the Task Force shall be law enforcement personnel selected for their expertise that would enable them to assist in the investigation of cases of missing and exploited children.

"(5) STATUS.—A member of the Task Force shall remain an employee of his or her respective agency for all purposes (including the purpose of performance review), and his or her service on the Task Force shall be without interruption or loss of civil service privilege or status and shall be on a nonreimbursable basis.

"(6) PERIOD OF SERVICE.—(A) Subject to subparagraph (B), 1 member from each agency shall initially serve a 1-year term, and the other member from the same agency shall serve a 1-year term, and may be selected to a renewal of service for 1 additional year; thereafter, each new member to serve on the Task Force shall serve for a 2-year period with the member's term of service beginning and ending in alternate years with the other member from the same agency; the period of service for the chief of the Task Force shall be 3 years.

"(B) The chief of the Task Force may at any time request the head of an agency described in paragraph (1) to submit a list of 5 prospective Task Force members to replace a member of the Task Force, for the purpose of maintaining a Task Force membership that will be able to meet the demands of its caseload.

"(c) SUPPORT.—

"(1) IN GENERAL.—The Administrator of the General Services Administration, in coordination with the heads of the agencies described in subsection (b)(1), shall provide the Task Force office space and administrative and support services, such office space to be in close proximity to the office of the Center, so as to enable the Task Force to coordinate its activities with that of the Center on a day-to-day basis.

"(2) LEGAL GUIDANCE.—The Attorney General shall assign an attorney to provide legal guidance, as needed, to members of the Task Force.

"(d) PURPOSE.—

"(1) IN GENERAL.—The purpose of the Task Force shall be to make available the combined resources and expertise of the agencies described in paragraph (1) to assist State and local governments in the most difficult missing and exploited child cases nationwide, as identified by the chief of the Task Force from time to time, in consultation with the Center, and as many additional cases as resources permit, including the provision of assistance to State and local investigators on location in the field.

"(2) TECHNICAL ASSISTANCE.—The role of the Task Force in any investigation shall be to provide advice and technical assistance and to make available the resources of the agencies described in subsection (b)(1); the Task Force shall not take a leadership role in any such investigation.

"(e) CROSS-DESIGNATION OF TASK FORCE MEMBERS.—The Attorney General may cross-designate the members of the Task Force with jurisdiction to enforce Federal law related to child abduction to the extent necessary to accomplish the purposes of this section.".

TITLE XVIII—RURAL CRIME

Subtitle A—Drug Trafficking in Rural Areas

SEC. 180101. AUTHORIZATIONS FOR RURAL LAW ENFORCEMENT AGENCIES.

(a) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a)(9) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 is amended to read as follows:

"(9) There are authorized to be appropriated to carry out part O—

"(A) $24,000,000 for fiscal year 1996;

"(B) $40,000,000 for fiscal year 1997;

"(C) $50,000,000 for fiscal year 1998;

"(D) $60,000,000 for fiscal year 1999; and

"(E) $66,000,000 for fiscal year 2000.".

(b) AMENDMENT TO BASE ALLOCATION.—Section 1501(a)(2)(A) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 is amended by striking "$100,000" and inserting "$250,000".

(c) CLARIFICATION.—Section 1501(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. §3796bb(b)) is amended by inserting ", based on the decennial census of 1990 through fiscal year 1997" before the period.

SEC. 180102. RURAL CRIME AND DRUG ENFORCEMENT TASK FORCES.

(a) ESTABLISHMENT.—The Attorney General, in consultation with the Governors, mayors, and chief executive officers of State and local law enforcement agencies, may establish a Rural Crime and Drug Enforcement Task Force in judicial districts that encompass significant rural lands. Assets seized as a result of investigations initiated by a Rural Crime and Drug Enforcement Task Force and forfeited under Federal law shall be used, consistent with the guidelines on equitable sharing established by the Attorney General and of the Secretary of the Treasury, primarily to enhance the operations of the task force and its participating State and local law enforcement agencies.

(b) TASK FORCE MEMBERSHIP.—The Task Forces established under subsection (a) shall be carried out under policies and procedures established by the Attorney General. The Attorney General may deputize State and local law enforcement officers and may cross-designate up to 100 Federal law enforcement officers, when necessary to undertake investigations pursuant to section 503(a) of the Controlled Substances Act (21 U.S.C. 873(a)) or offenses punishable by a term of imprisonment of 10 years or more under title 18, United States Code. The task forces—

(1) shall include representatives from—

(A) State and local law enforcement agencies;

(B) the office of the United States Attorney for the judicial district; and

(C) the Federal Bureau of Investigation, the Drug Enforcement Administration, the Immigration and Naturalization Service, and the United States Marshals Service; and

(2) may include representatives of other Federal law enforcement agencies, such as the United States Customs Service, United States Park Police, United States Forest Service, Bureau of Alcohol, Tobacco, and Firearms, and Bureau of Land Management.

SEC. 180103. RURAL DRUG ENFORCEMENT TRAINING.

(a) SPECIALIZED TRAINING FOR RURAL OFFICERS.—The Director of the Federal Law Enforcement Training Center shall develop a specialized course of instruction devoted to training law enforcement officers from rural agencies in the investigation of drug trafficking and related crimes.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out subsection (a)—

(1) $1,000,000 for fiscal year 1996;
(2) $1,000,000 for fiscal year 1997;
(3) $1,000,000 for fiscal year 1998;
(4) $1,000,000 for fiscal year 1999; and
(5) $1,000,000 for fiscal year 2000.

SEC. 180104. MORE AGENTS FOR THE DRUG ENFORCEMENT ADMINISTRATION.

There are authorized to be appropriated for the hiring of additional Drug Enforcement Administration agents—

(1) $12,000,000 for fiscal year 1996;
(2) $20,000,000 for fiscal year 1997;
(3) $30,000,000 for fiscal year 1998;
(4) $40,000,000 for fiscal year 1999; and
(5) $48,000,000 for fiscal year 2000.

Subtitle B—Drug Free Truck Stops and Safety Rest Areas

SEC. 180201. DRUG FREE TRUCK STOPS AND SAFETY REST AREAS.

(a) SHORT TITLE.—This section may be cited as the "Drug Free Truck Stop Act".

(b) AMENDMENT TO CONTROLLED SUBSTANCES ACT.—

(1) IN GENERAL.—Part D of the Controlled Substances Act (21 U.S.C. 801 et seq.) is amended by inserting after section 408 the following new section:

"TRANSPORTATION SAFETY OFFENSES

"SEC. 409. (a) DEFINITIONS.—In this section—

"'safety rest area' means a roadside facility with parking facilities for the rest or other needs of motorists.

"'truck stop' means a facility (including any parking lot appurtenant thereto) that—

"(A) has the capacity to provide fuel or service, or both, to any commercial motor vehicle (as defined in section 31301 of title 49, United States Code), operating in commerce (as defined in that section); and

"(B) is located within 2,500 feet of the National System of Interstate and Defense Highways or the Federal-Aid Primary System.

"(b) FIRST OFFENSE.—A person who violates section 401(a)(1) or section 416 by distributing or possessing with intent to distribute a controlled substance in or on, or within 1,000 feet of, a truck stop or safety rest area is (except as provided in subsection (b)) subject to—

"(1) twice the maximum punishment authorized by section 401(b); and

"(2) twice any term of supervised release authorized by section 401(b) for a first offense.

"(c) SUBSEQUENT OFFENSE.—A person who violates section 401(a)(1) or section 416 by distributing or possessing with intent to distribute a controlled substance in or on, or within 1,000 feet of, a truck stop or a safety rest area after a prior conviction or convictions under subsection (a) have become final is subject to—

"(1) 3 times the maximum punishment authorized by section 401(b); and

"(2) 3 times any term of supervised release authorized by section 401(b) for a first offense.".

(2) TECHNICAL AMENDMENTS.—

(A) CROSS REFERENCE.—Section 401(b) of the Controlled Substances Act (21 U.S.C. 841(b)) is amended by inserting "409," before "418," each place it appears.

(B) TABLE OF CONTENTS.—The table of contents of the Comprehensive Drug Abuse Prevention and Control Act of 1970 is amended by striking the item relating to section 409 and inserting the following new item:

"Sec. 409. Transportation safety offenses.".

(c) SENTENCING GUIDELINES.—Pursuant to its authority under section 994 of title 28, United States Code, and section 21 of the Sentencing Act of 1987 (28 U.S.C. 994 note), the United States Sentencing Commission shall promulgate guidelines, or shall amend existing guidelines, to provide an appropriate enhancement of punishment for a defendant convicted of violating section 409 of the Controlled Substances Act, as added by subsection (b).

Subtitle C—Sense of Congress Regarding Funding for Rural Areas

SEC. 180301. FUNDING FOR RURAL AREAS.

It is the sense of Congress that—

(1) the Attorney General should ensure that funding for programs authorized by the provisions of this Act and amendments made by this Act is distributed in such a manner that rural areas continue to receive comparable support for their broad-based crime fighting initiatives;

(2) rural communities should not receive less funding than they received in fiscal year 1994 for anti-crime initiatives as a result of any legislative or administrative actions; and

(3) to the maximum extent possible, funding for the Edward Byrne Memorial State and Local Law Enforcement Assistance Program should be maintained at its fiscal year 1994 level.

TITLE XIX—FEDERAL LAW ENFORCEMENT

SEC. 190001. FEDERAL JUDICIARY AND FEDERAL LAW ENFORCEMENT.

(a) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE FEDERAL JUDICIARY.—

FEDERAL JUDICIARY.—There are authorized to be appropriated for the activities of the Federal Judiciary to help meet the increased demands for judicial activities, including supervised release, pre-trial and probation services, that will result from enactment into law of this Act—

(A) $30,000,000 for fiscal year 1996;
(B) $35,000,000 for fiscal year 1997;
(C) $40,000,000 for fiscal year 1998;
(D) $40,000,000 for fiscal year 1999; and
(E) $55,000,000 for fiscal year 2000.

(b) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE DEPARTMENT OF JUSTICE.—There is authorized to be appropriated for the activities and agencies of the Department of Justice, in addition to sums authorized elsewhere in this section, to help meet the increased demands for Department of Justice activities that will result from enactment into law of this Act—

(A) $45,000,000 for fiscal year 1996;
(B) $55,000,000 for fiscal year 1997;
(C) $60,000,000 for fiscal year 1998;
(D) $60,000,000 for fiscal year 1999; and

(c) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE FEDERAL BUREAU OF INVESTIGATION.—There is authorized to be appropriated for the activities of the Federal Bureau of Investigation, to help meet the increased demands for Federal Bureau of Investigation activities that will result from enactment into law of this Act—

(A) $35,000,000 for fiscal year 1996;
(B) $40,000,000 for fiscal year 1997;
(C) $50,000,000 for fiscal year 1998;
(D) $60,000,000 for fiscal year 1999; and
(E) $60,000,000 for fiscal year 2000.

(d) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR UNITED STATES ATTORNEYS.—There is authorized to be appropriated for the account Department of Justice, Legal Activities, "Salaries and expenses, United States Attorneys", to help meet the increased demands for litigation and related activities which will result from enactment into law of this Act—

(A) $5,000,000 for fiscal year 1996;
(B) $8,000,000 for fiscal year 1997;
(C) $10,000,000 for fiscal year 1998;
(D) $12,000,000 for fiscal year 1999; and
(E) $15,000,000 for fiscal year 2000.

(e) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE DEPARTMENT OF THE TREASURY.—There is authorized to be appropriated for the activities of the Bureau of Alcohol, Tobacco, and Firearms, the United States Customs Service, the Financial Crimes Enforcement Network, the Federal Law Enforcement Training Center, the Criminal Investigation Division of the Internal Revenue Service, and the United States Secret Service to help meet the increased demands for Department of Treasury activities that will result from enactment into law of this Act—

(1) $30,000,000 for fiscal year 1995;
(2) $70,000,000 for fiscal year 1996;
(3) $90,000,000 for fiscal year 1997;
(4) $110,000,000 for fiscal year 1998;
(5) $125,000,000 for fiscal year 1999; and
(6) $125,000,000 for fiscal year 2000.

TITLE XX—POLICE CORPS AND LAW ENFORCEMENT OFFICERS TRAINING AND EDUCATION

Subtitle A—Police Corps

SEC. 200101. SHORT TITLE.

This subtitle may be cited as the "Police Corps Act".

SEC. 200102. PURPOSES.

The purposes of this subtitle are to—

(1) address violent crime by increasing the number of police with advanced education and training on community patrol; and

(2) provide educational assistance to law enforcement personnel and to students who possess a sincere interest in public service in the form of law enforcement.

SEC. 200103. DEFINITIONS.

In this subtitle—

"academic year" means a traditional academic year beginning in August or September and ending in the following May or June.

"dependent child" means a natural or adopted child or stepchild of a law enforcement officer who at the time of the officer's death—

(A) was no more than 21 years old; or

(B) if older than 21 years, was in fact dependent on the child's parents for at least one-half of the child's support (excluding educational expenses), as determined by the Director.

"Director" means the Director of the Office of the Police Corps and Law Enforcement Education appointed under section 200104.

"educational expenses" means expenses that are directly attributable to—

(A) a course of education leading to the award of the baccalaureate degree in legal- or criminal justice-related studies; or

(B) a course of graduate study legal or criminal justice studies following award of a baccalaureate degree,

including the cost of tuition, fees, books, supplies, transportation, room and board and miscellaneous expenses.

"institution of higher education" has the meaning stated in the first sentence of section 1201(a) of the Higher Education Act of 1965 (20 U.S.C. 1141(a)).

"participant" means a participant in the Police Corps program selected pursuant to section 200106.

"State" means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands.

"State Police Corps program" means a State police corps program that meets the requirements of section 200110.

SEC. 200104. ESTABLISHMENT OF OFFICE OF THE POLICE CORPS AND LAW ENFORCEMENT EDUCATION.

There is established in the Department of Justice, under the general authority of the Attorney General, an Office of the Police Corps and Law Enforcement Education.

SEC. 200105. DESIGNATION OF LEAD AGENCY AND SUBMISSION OF STATE PLAN.

(a) LEAD AGENCY.—A State that desires to participate in the Police Corps program under this subtitle shall designate a lead agency that will be responsible for—

(1) submitting to the Director a State plan described in subsection (b); and

(2) administering the program in the State.

(b) STATE PLANS.—A State plan shall—

(1) contain assurances that the lead agency shall work in cooperation with the local law enforcement liaisons, representatives of police labor organizations and police management organizations, and other appropriate State and local agencies to develop and implement interagency agreements designed to carry out the program;

(2) contain assurances that the State shall advertise the assistance available under this subtitle;

(3) contain assurances that the State shall screen and select law enforcement personnel for participation in the program; and

(4) meet the requirements of section 200110.

SEC. 200106. SCHOLARSHIP ASSISTANCE.

(a) SCHOLARSHIPS AUTHORIZED.—(1) The Director may award scholarships to participants who agree to work in a State or local police force in accordance with agreements entered into pursuant to subsection (d).

(2)(A) Except as provided in subparagraph (B), each scholarship payment made under this section for each academic year shall not exceed—

(i) $7,500; or

(ii) the cost of the educational expenses related to attending an institution of higher education.

(B) In the case of a participant who is pursuing a course of educational study during substantially an entire calendar year, the amount of scholarship payments made during such year shall not exceed $10,000.

(C) The total amount of scholarship assistance received by any one student under this section shall not exceed $30,000.

(3) Recipients of scholarship assistance under this section shall continue to receive such scholarship payments only during such periods as the Director finds that the recipient is maintaining satisfactory progress as determined by the institution of higher education the recipient is attending.

(4)(A) The Director shall make scholarship payments under this section directly to the institution of higher education that the student is attending.

(B) Each institution of higher education receiving a payment on behalf of a participant pursuant to subparagraph (A) shall remit to such student any funds in excess of the costs of tuition, fees, and room and board payable to the institution.

(b) REIMBURSEMENT AUTHORIZED.—(1) The Director may make payments to a participant to reimburse such participant for the costs of educational expenses if the student agrees to work in a State or local police force in accordance with the agreement entered into pursuant to subsection (d).

(2)(A) Each payment made pursuant to paragraph (1) for each academic year of study shall not exceed—

(i) $7,500; or

(ii) the cost of educational expenses related to attending an institution of higher education.

(B) In the case of a participant who is pursuing a course of educational study during substantially an entire calendar year, the amount of scholarship payments made during such year shall not exceed $10,000.

(C) The total amount of payments made pursuant to subparagraph (A) to any 1 student shall not exceed $30,000.

(c) USE OF SCHOLARSHIP.—Scholarships awarded under this subsection shall only be used to attend a 4-year institution of higher education, except that—

(1) scholarships may be used for graduate and professional study; and

(2) if a participant has enrolled in the program upon or after transfer to a 4-year institution of higher education, the Director may reimburse the participant for the participant's prior educational expenses.

(d) AGREEMENT.—(1)(A) Each participant receiving a scholarship or a payment under this section shall enter into an agreement with the Director.

(B) An agreement under subparagraph (A) shall contain assurances that the participant shall—

(i) after successful completion of a baccalaureate program and training as prescribed in section 200108, work for 4 years in a State or local police force without there having arisen sufficient cause for the participant's dismissal under the rules applicable to members of the police force of which the participant is a member;

(ii) complete satisfactorily—

(I) an educational course of study and receipt of a baccalaureate degree (in the case of undergraduate study) or the reward of credit to the participant for having completed one or more graduate courses (in the case of graduate study); and

(II) Police Corps training and certification by the Director that the participant has met such performance standards as may be established pursuant to section 200108; and

(iii) repay all of the scholarship or payment received plus interest at the rate of 10 percent if the conditions of clauses (i) and (ii) are not complied with.

(2)(A) A recipient of a scholarship or payment under this section shall not be considered to be in violation of the agreement entered into pursuant to paragraph (1) if the recipient—

(i) dies; or

(ii) becomes permanently and totally disabled as established by the sworn affidavit of a qualified physician.

(B) If a scholarship recipient is unable to comply with the repayment provision set forth in paragraph (1)(B)(ii) because of a physical or emotional disability or for good cause as determined by the Director, the Director may substitute community service in a form prescribed by the Director for the required repayment.

(C) The Director shall expeditiously seek repayment from a participant who violates an agreement described in paragraph (1).

(e) DEPENDENT CHILD.—A dependent child of a law enforcement officer—

(1) who is a member of a State or local police force or is a Federal criminal investigator or uniformed police officer,

(2) who is not a participant in the Police Corps program, but

(3) who serves in a State for which the Director has approved a Police Corps plan, and

(4) who is killed in the course of performing police duties,

shall be entitled to the scholarship assistance authorized in this section for any course of study in any accredited institution of higher education. Such dependent child shall not incur any repayment obligation in exchange for the scholarship assistance provided in this section.

(f) APPLICATION.—Each participant desiring a scholarship or payment under this section shall submit an application as prescribed by the Director in such manner and accompanied by such information as the Director may reasonably require.

SEC. 200107. SELECTION OF PARTICIPANTS.

(a) IN GENERAL.—Participants in State Police Corps programs shall be selected on a competitive basis by each State under regulations prescribed by the Director.

(b) SELECTION CRITERIA AND QUALIFICATIONS.—(1) In order to participate in a State Police Corps program, a participant shall—

(A) be a citizen of the United States or an alien lawfully admitted for permanent residence in the United States;

(B) meet the requirements for admission as a trainee of the State or local police force to which the participant will be assigned pursuant to section 200110(5), including achievement of satisfactory scores on any applicable examination, except that failure to meet the age requirement for a trainee of the State or local police shall not disqualify the applicant if the applicant will be of sufficient age upon completing an undergraduate course of study;

(C) possess the necessary mental and physical capabilities and emotional characteristics to discharge effectively the duties of a law enforcement officer;

(D) be of good character and demonstrate sincere motivation and dedication to law enforcement and public service;

(E) in the case of an undergraduate, agree in writing that the participant will complete an educational course of study leading to the award of a baccalaureate degree and will then accept an appointment and complete 4 years of

service as an officer in the State police or in a local police department within the State;

(F) in the case of a participant desiring to undertake or continue graduate study, agree in writing that the participant will accept an appointment and complete 4 years of service as an officer in the State police or in a local police department within the State before undertaking or continuing graduate study;

(G) contract, with the consent of the participant's parent or guardian if the participant is a minor, to serve for 4 years as an officer in the State police or in a local police department, if an appointment is offered; and

(H) except as provided in paragraph (2), be without previous law enforcement experience.

(2)(A) Until the date that is 5 years after the date of enactment of this Act, up to 10 percent of the applicants accepted into the Police Corps program may be persons who—

(i) have had some law enforcement experience; and

(ii) have demonstrated special leadership potential and dedication to law enforcement.

(B)(i) The prior period of law enforcement of a participant selected pursuant to subparagraph (A) shall not be counted toward satisfaction of the participant's 4-year service obligation under section 200109, and such a participant shall be subject to the same benefits and obligations under this subtitle as other participants, including those stated in section (b)(1) (E) and (F).

(ii) Clause (i) shall not be construed to preclude counting a participant's previous period of law enforcement experience for purposes other than satisfaction of the requirements of section 200109, such as for purposes of determining such a participant's pay and other benefits, rank, and tenure.

(3) It is the intent of this subtitle that there shall be no more than 20,000 participants in each graduating class. The Director shall approve State plans providing in the aggregate for such enrollment of applicants as shall assure, as nearly as possible, annual graduating classes of 20,000. In a year in which applications are received in a number greater than that which will produce, in the judgment of the Director, a graduating class of more than 20,000, the Director shall, in deciding which applications to grant, give preference to those who will be participating in State plans that provide law enforcement personnel to areas of greatest need.

(c) RECRUITMENT OF MINORITIES.—Each State participating in the Police Corps program shall make special efforts to seek and recruit applicants from among members of all racial, ethnic or gender groups. This subsection does not authorize an exception from the competitive standards for admission established pursuant to subsections (a) and (b).

(d) ENROLLMENT OF APPLICANT.—(1) An applicant shall be accepted into a State Police Corps program on the condition that the applicant will be matriculated in, or accepted for admission at, a 4-year institution of higher education—

(A) as a full-time student in an undergraduate program; or

(B) for purposes of taking a graduate course.

(2) If the applicant is not matriculated or accepted as set forth in paragraph (1), the applicant's acceptance in the program shall be revoked.

(e) LEAVE OF ABSENCE.—(1) A participant in a State Police Corps program who requests a leave of absence from educational study, training or service for a period not to exceed 1 year (or 18 months in the aggregate in the event of multiple requests) due to temporary physical or emotional disability shall be granted such leave of absence by the State.

(2) A participant who requests a leave of absence from educational study, training or service for a period not to exceed 1 year (or 18 months in the aggregate in the event of multiple requests) for any reason other than those listed in paragraph (1) may be granted such leave of absence by the State.

(3) A participant who requests a leave of absence from educational study or training for a period not to exceed 30 months to serve on an official church mission may be granted such leave of absence.

(f) ADMISSION OF APPLICANTS.—An applicant may be admitted into a State Police Corps program either before commencement of or during the applicant's course of educational study.

SEC. 200108. POLICE CORPS TRAINING.

(a) IN GENERAL.—(1) The Director shall establish programs of training for Police Corps participants. Such programs may be carried out at up to 3 training centers established for this purpose and administered by the Director, or by contracting with existing State training facilities. The Director shall contract with a State training facility upon request of such facility if the Director determines that such facility offers a course of training substantially equivalent to the Police Corps training program described in this subtitle.

(2) The Director may enter into contracts with individuals, institutions of learning, and government agencies (including State and local police forces) to obtain the services of persons qualified to participate in and contribute to the training process.

(3) The Director may enter into agreements with agencies of the Federal Government to utilize on a reimbursable basis space in Federal buildings and other resources.

(4) The Director may authorize such expenditures as are necessary for the effective maintenance of the training centers, including purchases of supplies, uniforms, and educational materials, and the provision of subsistence, quarters, and medical care to participants.

(b) TRAINING SESSIONS.—A participant in a State Police Corps program shall attend two 8-week training sessions at a training center, one during the summer following completion of sophomore year and one during the summer following completion of junior year. If a participant enters the program after sophomore year, the participant shall complete 16 weeks of training at times determined by the Director.

(c) FURTHER TRAINING.—The 16 weeks of Police Corps training authorized in this section is intended to serve as basic law enforcement training but not to exclude further training of participants by the State and local authorities to which they will be assigned. Each State plan approved by the Director under section 10 shall include assurances that following completion of a participant's course of education each participant shall receive appropriate additional training by the State or local authority to which the participant is assigned. The time spent by a participant in such additional training, but not the time spent in Police Corps training, shall be counted toward fulfillment of the participant's 4-year service obligation.

(d) COURSE OF TRAINING.—The training sessions at training centers established under this section shall be designed to provide basic law enforcement training, including vigorous physical and mental training to teach participants self-discipline and organizational loyalty and to impart knowledge and understanding of legal processes and law enforcement.

(e) EVALUATION OF PARTICIPANTS.—A participant shall be evaluated during training for mental, physical, and emotional fitness, and shall be required to meet performance standards prescribed by the Director at the conclusion of each training session in order to remain in the Police Corps program.

(f) STIPEND.—The Director shall pay participants in training sessions a stipend of $250 a week during training.

SEC. 200109. SERVICE OBLIGATION.

(a) SWEARING IN.—Upon satisfactory completion of the participant's course of education and training program established in section 200108 and meeting the requirements of the police force to which the participant is assigned, a participant shall be sworn in as a member of the police force to which the participant is assigned pursuant to the State Police Corps plan, and shall serve for 4 years as a member of that police force.

(b) RIGHTS AND RESPONSIBILITIES.—A participant shall have all of the rights and responsibilities of and shall be subject to all rules and regulations applicable to other members of the police force of which the participant is a member, including those contained in applicable agreements with labor organizations and those provided by State and local law.

(c) DISCIPLINE.—If the police force of which the participant is a member subjects the participant to discipline such as would preclude the participant's completing 4 years of service, and result in denial of educational assistance under section 200106, the Director may, upon a showing of good cause, permit the participant to complete the service obligation in an equivalent alternative law enforcement service and, if such service is satisfactorily completed, section 200106(d)(1)(B)(iii) shall not apply.

(d) LAYOFFS.—If the police force of which the participant is a member lays off the participant such as would preclude the participant's completing 4 years of service, and result in denial of educational assistance under section 200106, the Director may permit the participant to complete the service obligation in an equivalent alternative law enforcement service and, if such service is satisfactorily completed, section 200106(d)(1)(B)(iii) shall not apply.

SEC. 200110. STATE PLAN REQUIREMENTS.

A State Police Corps plan shall—

(1) provide for the screening and selection of participants in accordance with the criteria set out in section 200107;

(2) state procedures governing the assignment of participants in the Police Corps program to State and local police forces (no more than 10 percent of all the participants assigned in each year by each State to be assigned to a statewide police force or forces);

(3) provide that participants shall be assigned to those geographic areas in which—

(A) there is the greatest need for additional law enforcement personnel; and

(B) the participants will be used most effectively;

(4) provide that to the extent consistent with paragraph (3), a participant shall be assigned to an area near the participant's home or such other place as the participant may request;

(5) provide that to the extent feasible, a participant's assignment shall be made at the time the participant is accepted into the program, subject to change—

(A) prior to commencement of a participant's fourth year of undergraduate study, under such circumstances as the plan may specify; and

(B) from commencement of a participant's fourth year of undergraduate study until completion of 4 years of police service by participant, only for compelling reasons or to meet the needs of the State Police Corps program and only with the consent of the participant;

(6) provide that no participant shall be assigned to serve with a local police force—

(A) whose size has declined by more than 5 percent since June 21, 1989; or

(B) which has members who have been laid off but not retired;

(7) provide that participants shall be placed and to the extent feasible kept on community and preventive patrol;

(8) ensure that participants will receive effective training and leadership;

(9) provide that the State may decline to offer a participant an appointment following completion of Federal training, or may remove a participant from the Police Corps program at any time, only for good cause (including failure to make satisfactory progress in a course of educational study) and after following reasonable review procedures stated in the plan; and

(10) provide that a participant shall, while serving as a member of a police force, be compensated at the same rate of pay and benefits and enjoy the same rights under applicable agreements with labor organizations and under State and local law as other police officers of the same rank and tenure in the police force of which the participant is a member.

SEC. 200111. ASSISTANCE TO STATES AND LOCALITIES EMPLOYING POLICE CORPS OFFICERS.

Each jurisdiction directly employing Police Corps participants during the 4-year term of service prescribed by section 200109 shall receive $10,000 on account of each such participant at the completion of each such year of service, but—

(1) no such payment shall be made on account of service in any State or local police force—

(A) whose average size, in the year for which payment is to be made, not counting Police Corps participants assigned under section 106, has declined more than 2 percent since January 1, 1993; or

(B) which has members who have been laid off but not retired; and

(2) no such payment shall be made on account of any Police Corps participant for years of service after the completion of the term of service prescribed in section 200109.

SEC. 200112. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated from the General Fund of the Treasury to carry out this subtitle—

(1) $100,000,000 for fiscal year 1995;

(2) $300,000,000 for fiscal year 1996; and

(3) such sums as may be necessary for each of the fiscal years 1997, through 2000.

SEC. 200113. REPORTS TO CONGRESS.

(a) In General.—Not later than April 1 of each year, the Director shall submit a report to the Attorney General, the President, the Speaker of the House of Representatives, and the President of the Senate.

(b) Contents.—A report under subsection (a) shall—

(1) state the number of current and past participants in the Police Corps program, broken down according to the levels of educational study in which they are engaged and years of service they have served on police forces (including service following completion of the 4-year service obligation);

(2) describe the geographic, racial, and gender dispersion of participants in the Police Corps program; and

(3) describe the progress of the Police Corps program and make recommendations for changes in the program.

Subtitle B—Law Enforcement Scholarship Program

SEC. 200201. SHORT TITLE.

This subtitle may be cited as the "Law Enforcement Scholarships and Recruitment Act".

SEC. 200202. DEFINITIONS.

In this subtitle—

"Director" means the Director of the Office of the Police Corps and Law Enforcement Education appointed under section 200104.

"educational expenses" means expenses that are directly attributable to—

(A) a course of education leading to the award of an associate degree;

(B) a course of education leading to the award of a baccalaureate degree; or

(C) a course of graduate study following award of a baccalaureate degree,

including the cost of tuition, fees, books, supplies, and related expenses.

"institution of higher education" has the meaning stated in the first sentence of section 1201(a) of the Higher Education Act of 1965 (20 U.S.C. 1141(a)).

"law enforcement position" means employment as an officer in a State or local police force, or correctional institution.

"State" means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands of the United States, American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands.

SEC. 200203. ALLOTMENT.

From amounts appropriated under section 200210, the Director shall allot—

(1) 80 percent of such amounts to States on the basis of the number of law enforcement officers in each State compared to the number of law enforcement officers in all States; and

(2) 20 percent of such amounts to States on the basis of the shortage of law enforcement personnel and the need for assistance under this subtitle in the State compared to the shortage of law enforcement personnel and the need for assistance under this subtitle in all States.

SEC. 200204. ESTABLISHMENT OF PROGRAM.

(a) Use of Allotment.—

(1) In General.—A State that receives an allotment pursuant to section 200203 shall use the allotment to pay the Federal share of the costs of—

(A) awarding scholarships to in-service law enforcement personnel to enable such personnel to seek further education; and

(B) providing—

(i) full-time employment in summer; or

(ii) part-time (not to exceed 20 hours per week) employment for a period not to exceed 1 year.

(2) Employment.—The employment described in paragraph (1)(B)—

(A) shall be provided by State and local law enforcement agencies for students who are juniors or seniors in high school or are enrolled in an institution of higher education and who demonstrate an interest in undertaking a career in law enforcement;

(B) shall not be in a law enforcement position; and

(C) shall consist of performing meaningful tasks that inform students of the nature of the tasks performed by law enforcement agencies.

(b) Payments; Federal Share; Non-Federal Share.—

(1) Payments.—Subject to the availability of appropriations, the Director shall pay to each State that receives an allotment under section 200203 the Federal share of the cost of the activities described in the application submitted pursuant to section 200203.

(2) Federal Share.—The Federal share shall not exceed 60 percent.

(3) Non-Federal Share.—The non-Federal share of the cost of scholarships and student employment provided under this subtitle shall be supplied from sources other than the Federal Government.

(c) Responsibilities of Director.—The Director shall be responsible for the administration of the programs conducted pursuant to this subtitle and shall, in consultation with the Assistant Secretary for Postsecondary Education, issue rules to implement this subtitle.

(d) Administrative Expenses.—A State that receives an allotment under section 200203 may reserve not more than 8 percent of the allotment for administrative expenses.

(e) Special Rule.—A State that receives an allotment under section 200203 shall ensure that each scholarship recipient under this subtitle be compensated at the same rate of pay and benefits and enjoy the same rights under applicable agreements with labor organizations and under State and local law as other law enforcement personnel of the same rank and tenure in the office of which the scholarship recipient is a member.

(f) Supplementation of Funding.—Funds received under this subtitle shall only be used to supplement, and not to supplant, Federal, State, or local efforts for recruitment and education of law enforcement personnel.

SEC. 200205. SCHOLARSHIPS.

(a) Period of Award.—Scholarships awarded under this subtitle shall be for a period of 1 academic year.

(b) Use of Scholarships.—Each individual awarded a scholarship under this subtitle may use the scholarship for educational expenses at an institution of higher education.

SEC. 200206. ELIGIBILITY.

(a) Scholarships.—A person shall be eligible to receive a scholarship under this subtitle if the person has been employed in law enforcement for the 2-year period immediately preceding the date on which assistance is sought.

(b) Ineligibility for Student Employment.—A person who has been employed as a law enforcement officer is ineligible to participate in a student employment program carried out under this subtitle.

SEC. 200207. STATE APPLICATION.

(a) In General.—Each State desiring an allotment under section 200203 shall submit an application to the Director at such time, in such manner, and accompanied by such information as the Director may reasonably require.

(b) Contents.—An application under subsection (a) shall—

(1) describe the scholarship program and the student employment program for which assistance under this subtitle is sought;

(2) contain assurances that the lead agency will work in cooperation with the local law enforcement liaisons, representatives of police labor organizations and police management organizations, and other appropriate State and local agencies to develop and implement interagency agreements designed to carry out this subtitle;

(3) contain assurances that the State will advertise the scholarship assistance and student employment it will provide under this subtitle and that the State will use such programs to enhance recruitment efforts;

(4) contain assurances that the State will screen and select law enforcement personnel for participation in the scholarship program under this subtitle;

(5) contain assurances that under such student employment program the State will screen and select, for participation in such program, students who have an interest in undertaking a career in law enforcement;

(6) contain assurances that under such scholarship program the State will make scholarship payments to institutions of higher education on behalf of persons who receive scholarships under this subtitle;

(7) with respect to such student employment program, identify—

(A) the employment tasks that students will be assigned to perform;

(B) the compensation that students will be paid to perform such tasks; and

(C) the training that students will receive as part of their participation in the program;

(8) identify model curriculum and existing programs designed to meet the educational and professional needs of law enforcement personnel; and

(9) contain assurances that the State will promote cooperative agreements with educational and law enforcement agencies to enhance law enforcement personnel recruitment efforts in institutions of higher education.

SEC. 200208. LOCAL APPLICATION.

(a) IN GENERAL.—A person who desires a scholarship or employment under this subtitle shall submit an application to the State at such time, in such manner, and accompanied by such information as the State may reasonably require.

(b) CONTENTS.—An application under subsection (a) shall describe—

(1) the academic courses for which a scholarship is sought; or

(2) the location and duration of employment that is sought.

(c) PRIORITY.—In awarding scholarships and providing student employment under this subtitle, each State shall give priority to applications from persons who are—

(1) members of racial, ethnic, or gender groups whose representation in the law enforcement agencies within the State is substantially less than in the population eligible for employment in law enforcement in the State;

(2) pursuing an undergraduate degree; and

(3) not receiving financial assistance under the Higher Education Act of 1965.

SEC. 200209. SCHOLARSHIP AGREEMENT.

(a) IN GENERAL.—A person who receives a scholarship under this subtitle shall enter into an agreement with the Director.

(b) CONTENTS.—An agreement described in subsection (a) shall—

(1) provide assurances that the scholarship recipient will work in a law enforcement position in the State that awarded the scholarship in accordance with the service obligation described in subsection (c) after completion of the scholarship recipient's academic courses leading to an associate, bachelor, or graduate degree;

(2) provide assurances that the scholarship recipient will repay the entire scholarship in accordance with such terms and conditions as the Director shall prescribe if the requirements of the agreement are not complied with, unless the scholarship recipient—

(A) dies;

(B) becomes physically or emotionally disabled, as established by the sworn affidavit of a qualified physician; or

(C) has been discharged in bankruptcy; and

(3) set forth the terms and conditions under which the scholarship recipient may seek employment in the field of law enforcement in a State other than the State that awarded the scholarship.

(c) SERVICE OBLIGATION.—

(1) IN GENERAL.— Except as provided in paragraph (2), a person who receives a scholarship under this subtitle shall work in a law enforcement position in the State that awarded the scholarship for a period of 1 month for each credit hour for which funds are received under the scholarship.

(2) SPECIAL RULE.—For purposes of satisfying the requirement of paragraph (1), a scholarship recipient shall work in a law enforcement position in the State that awarded the scholarship for not less than 6 months but shall not be required to work in such a position for more than 2 years.

SEC. 200210. AUTHORIZATION OF APPROPRIATIONS.

(a) GENERAL AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the General Fund of the Treasury to carry out this subtitle—

(1) $30,000,000 for fiscal year 1996;

(2) $30,000,000 for fiscal year 1997;

(3) $30,000,000 for fiscal year 1998;

(4) $30,000,000 for fiscal year 1999; and

(5) $30,000,000 for fiscal year 2000.

(b) USES OF FUNDS.—Of the funds appropriated under subsection (a) for a fiscal year—

(1) 80 percent shall be available to provide scholarships described in section 200204(a)(1)(A); and

(2) 20 percent shall be available to provide employment described in sections 200204(a)(1)(B) and 200204(a)(2).

TITLE XXI—STATE AND LOCAL LAW ENFORCEMENT

Subtitle A—Byrne Program

SEC. 210101. EXTENSION OF BYRNE GRANT FUNDING.

There is authorized to be appropriated for fiscal years 1995 through 2000 such sums as may be necessary to carry out the programs under parts D and E of title I of the Omnibus Crime Control and Safe Streets Act of 1968, of which the following amounts may be appropriated from the Violent Crime Reduction Trust Fund:

(1) $580,000,000 for fiscal year 1995;

(2) $130,000,000 for fiscal year 1996;

(3) $100,000,000 for fiscal year 1997;

(4) $75,000,000 for fiscal year 1998;

(5) $70,000,000 for fiscal year 1999; and

(6) $45,000,000 for fiscal year 2000.

Subtitle B—Law Enforcement Family Support

SEC. 210201. LAW ENFORCEMENT FAMILY SUPPORT.

(a) IN GENERAL.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 50001(a), is amended—

(1) by redesignating part W as part X;

(2) by redesignating section 2301 as 2401; and

(3) by inserting after part V the following new part:

"PART W—FAMILY SUPPORT

"SEC. 2301. DUTIES.

"The Attorney General shall—

"(1) establish guidelines and oversee the implementation of family-friendly policies within law enforcement-related offices and divisions in the Department of Justice;

"(2) study the effects of stress on law enforcement personnel and family well-being and disseminate the findings of such studies to Federal, State, and local law enforcement agencies, related organizations, and other interested parties;

"(3) identify and evaluate model programs that provide support services to law enforcement personnel and families;

"(4) provide technical assistance and training programs to develop stress reduction and family support to State and local law enforcement agencies;

"(5) collect and disseminate information regarding family support, stress reduction, and psychological services to Federal, State, and local law enforcement agencies, law enforcement-related organizations, and other interested entities; and

"(6) determine issues to be researched by the Department of Justice and by grant recipients.

"SEC. 2302. GENERAL AUTHORIZATION.

"The Attorney General may make grants to States and local law enforcement agencies and to organizations representing State or local law enforcement personnel to provide family support services to law enforcement personnel.

"SEC. 2303. USES OF FUNDS.

"(a) IN GENERAL.—A State or local law enforcement agency or organization that receives a grant under this Act shall use amounts provided under the grant to establish or improve training and support programs for law enforcement personnel.

"(b) REQUIRED ACTIVITIES.—A law enforcement agency or organization that receives funds under this part shall provide at least one of the following services:

"(1) Counseling for law enforcement family members.

"(2) Child care on a 24-hour basis.

"(3) Marital and adolescent support groups.

"(4) Stress reduction programs.

"(5) Stress education for law enforcement recruits and families.

"(6) Technical assistance and training programs to support any or all of the services described in paragraphs (1), (2), (3), (4), and (5).

"(c) OPTIONAL ACTIVITIES.—A law enforcement agency or organization that receives funds under this part may provide the following services:

"(1) Post-shooting debriefing for officers and their spouses.

"(2) Group therapy.

"(3) Hypertension clinics.

"(4) Critical incident response on a 24-hour basis.

"(5) Law enforcement family crisis telephone services on a 24-hour basis.

"(6) Counseling for law enforcement personnel exposed to the human immunodeficiency virus.

"(7) Counseling for peers.

"(8) Counseling for families of personnel killed in the line of duty.

"(9) Seminars regarding alcohol, drug use, gambling, and overeating.

"(10) Technical assistance and training to support any or all of the services described in paragraphs (1), (2), (3), (4), (5), (6), (7), (8), and (9).

"SEC. 2304. APPLICATIONS.

"A law enforcement agency or organization desiring to receive a grant under this part shall submit to the Attorney General an application at such time, in such manner, and containing or accompanied by such information as the Attorney General may reasonably require. Such application shall—

"(1) certify that the law enforcement agency shall match all Federal funds with an equal amount of cash or in-kind goods or services from other non-Federal sources;

"(2) include a statement from the highest ranking law enforcement official from the State or locality or from the highest ranking official from the organization applying for the grant that attests to the need and intended use of services to be provided with grant funds; and

"(3) assure that the Attorney General or the Comptroller General of the United States shall have access to all records related to the receipt and use of grant funds received under this part.

"SEC. 2305. AWARD OF GRANTS; LIMITATION.

"(a) GRANT DISTRIBUTION.—In approving grants under this part, the Attorney General shall assure an equitable distribution of assistance among the States, among urban and rural areas of the United States, and among urban and rural areas of a State.

"(b) DURATION.—The Attorney General may award a grant each fiscal year, not to exceed $100,000 to a State or local law enforcement agency or $250,000 to a law enforcement organization for a period not to exceed 5 years. In any application from a State or local law enforcement agency or organization for a grant to continue a program for the second, third, fourth, or fifth fiscal year following the first fiscal year in which a grant was awarded to such agency, the Attorney General shall review the progress made toward meeting the objectives of the program. The Attorney General may refuse to award a grant if the Attorney General finds sufficient progress has not been made toward meeting such objectives, but only after affording the applicant notice and an opportunity for reconsideration.

"(c) LIMITATION.—Not more than 5 percent of grant funds received by a State or a local law enforcement agency or organization may be used for administrative purposes.

"SEC. 2306. DISCRETIONARY RESEARCH GRANTS.

"The Attorney General may reserve 10 percent of funds to award research grants to a State or local law enforcement agency or organization to study issues of importance in the law enforcement field as determined by the Attorney General.

"SEC. 2307. REPORTS.

"A State or local law enforcement agency or organization that receives a grant under this part shall submit to the Attorney General an annual report that includes—

"(1) program descriptions;

"(2) the number of staff employed to administer programs;

"(3) the number of individuals who participated in programs; and

"(4) an evaluation of the effectiveness of grant programs.

"SEC. 2308. DEFINITIONS.

"For purposes of this part—

"(1) the term 'family-friendly policy' means a policy to promote or improve the morale and well being of law enforcement personnel and their families; and

"(2) the term 'law enforcement personnel' means individuals employed by Federal, State, and local law enforcement agencies.".

(b) TECHNICAL AMENDMENT.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 50001(b), is amended by striking the matter relating to part V and inserting the following:

"PART W—FAMILY SUPPORT

"Sec. 2301. Duties.
"Sec. 2302. General authorization.
"Sec. 2303. Uses of funds.
"Sec. 2304. Applications.
"Sec. 2305. Award of grants; limitation.
"Sec. 2306. Discretionary research grants.
"Sec. 2307. Reports.
"Sec. 2308. Definitions.

"PART V—TRANSITION-EFFECTIVE DATE-REPEALS

"Sec. 2301. Continuation of rules, authorities, and privileges.".

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 50001(c), is amended—

(1) in paragraph (3) by striking "and V" and inserting "V, and W"; and

(2) by adding at the end the following new paragraph:

"(21) There are authorized to be appropriated to carry out part W—

"(1) $2,500,000 for fiscal year 1996;

"(2) $4,000,000 for fiscal year 1997;

"(3) $5,000,000 for fiscal year 1998;

"(4) $6,000,000 for fiscal year 1999; and

"(5) $7,500,000 for fiscal year 2000.".

Subtitle C—DNA Identification

SEC. 210301. SHORT TITLE.

This subtitle may be cited as the "DNA Identification Act of 1994".

SEC. 210302. FUNDING TO IMPROVE THE QUALITY AND AVAILABILITY OF DNA ANALYSES FOR LAW ENFORCEMENT IDENTIFICATION PURPOSES.

(a) DRUG CONTROL AND SYSTEM IMPROVEMENT GRANT PROGRAM.—Section 501(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3751(b)) as amended by section 150003, is amended—

(1) by striking "and" at the end of paragraph (23);

(2) by striking the period at the end of paragraph (24) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(25) developing or improving in a forensic laboratory a capability to analyze deoxyribonucleic acid (hereinafter in this title referred to as 'DNA') for identification purposes.".

(b) STATE APPLICATIONS.—Section 503(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3753(a)) is amended by adding at the end the following new paragraph:

"(12) If any part of funds received from a grant made under this part is to be used to develop or improve a DNA analysis capability in a forensic laboratory, a certification that—

"(A) DNA analyses performed at such laboratory will satisfy or exceed then current standards for a quality assurance program for DNA analysis, issued by the Director of the Federal Bureau of Investigation under section 210303 of the DNA Identification Act of 1994;

"(B) DNA samples obtained by, and DNA analyses performed at, such laboratory will be accessible only—

"(i) to criminal justice agencies for law enforcement identification purposes;

"(ii) in judicial proceedings, if otherwise admissible pursuant to applicable statutes or rules;

"(iii) for criminal defense purposes, to a defendant, who shall have access to samples and analyses performed in connection with the case in which such defendant is charged; or

"(iv) if personally identifiable information is removed, for a population statistics database, for identification research and protocol development purposes, or for quality control purposes; and

"(C) such laboratory, and each analyst performing DNA analyses at such laboratory, will undergo, at regular intervals of not to exceed 180 days, external proficiency testing by a DNA proficiency testing program meeting the standards issued under section 210303 of the DNA Identification Act of 1994.".

(c) DNA IDENTIFICATION GRANTS.—

(1) IN GENERAL.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as amended by section 210201(a), is amended—

(A) by redesignating part X as part Y;

(B) by redesignating section 2401 as section 2501; and

(C) by inserting after part W the following new part:

"PART X—DNA IDENTIFICATION GRANTS

"SEC. 2401. GRANT AUTHORIZATION.

"The Attorney General may make funds available under this part to States and units of local government, or combinations thereof, to carry out all or a substantial part of a program or project intended to develop or improve the capability to analyze deoxyribonucleic acid (referred to in this part as 'DNA') in a forensic laboratory.

"SEC. 2402. APPLICATIONS.

"To request a grant under this part, the chief executive officer of a State or unit of local government shall submit an application in such form as the Attorney General may require.

"SEC. 2403. APPLICATION REQUIREMENTS.

"No grant may be made under this part unless an application has been submitted to the Attorney General in which the applicant certifies that—

"(1) DNA analyses performed at the laboratory will satisfy or exceed then current standards for a quality assurance program for DNA analysis issued by the Director of the Federal Bureau of Investigation under section 210303 of the DNA Identification Act of 1994.

"(2) DNA samples obtained by and DNA analyses performed at the laboratory shall be made available only—

"(A) to criminal justice agencies for law enforcement identification purposes;

"(B) in judicial proceedings, if otherwise admissible pursuant to applicable statutes or rules;

"(C) for criminal defense purposes, to a defendant, who shall have access to samples and analyses performed in connection with the case in which the defendant is charged; or

"(D) if personally identifiable information is removed, for a population statistics database, for identification research and protocol development purposes, or for quality control purposes; and

"(3) the laboratory and each analyst performing DNA analyses at the laboratory shall undergo, at regular intervals not exceeding 180 days, external proficiency testing by a DNA proficiency testing program that meets the standards issued under section 210303 of the DNA Identification Act of 1994.

"SEC. 2404. ADMINISTRATIVE PROVISIONS.

"(a) REGULATION AUTHORITY.—The Attorney General may promulgate guidelines, regulations, and procedures, as necessary to carry out the purposes of this part, including limitations on the number of awards made during each fiscal year, the submission and review of applications, selection criteria, and the extension or continuation of awards.

"(b) AWARD AUTHORITY.—The Attorney General shall have final authority over all funds awarded under this part.

"(c) TECHNICAL ASSISTANCE.—To assist and measure the effectiveness and performance of programs and activities funded under this part, the Attorney General may provide technical assistance as required.

"SEC. 2405. RESTRICTIONS ON USE OF FUNDS.

"(a) FEDERAL SHARE.—The Federal share of a grant, contract, or cooperative agreement made under this part may not exceed 75 percent of the total costs of the project described in the application submitted for the fiscal year for which the project receives assistance.

"(b) ADMINISTRATIVE COSTS.—A State or unit of local government may not use more than 10 percent of the funds it receives from this part for administrative expenses.

"SEC. 2406. REPORTS.

"(a) REPORTS TO ATTORNEY GENERAL.—Each State or unit of local government which receives a grant under this part shall submit to the Attorney General, for each year in which funds from a grant received under this part is expended, a report at such time and in such manner as the Attorney General may reasonably require which contains—

"(1) a summary of the activities carried out under the grant and an assessment of whether such activities are meeting the needs identified in the application submitted under section 2402; and

"(2) such other information as the Attorney General may require.

"(b) REPORTS TO CONGRESS.—Not later than 90 days after the end of each fiscal year for which grants are made under this part, the Attorney General shall submit to the Speaker of the House of Representatives and the President pro tempore of the Senate, a report that includes—

"(1) the aggregate amount of grants made under this part to each State or unit of local government for such fiscal year; and

"(2) a summary of the information provided in compliance with subsection (a)(1).

"SEC. 2407. EXPENDITURE RECORDS.

"(a) RECORDS.—Each State or unit of local government which receives a grant under this part shall keep records as the Attorney General may require to facilitate an effective audit.

"(b) ACCESS.—The Attorney General, the Comptroller General, or their designated agents shall have access, for the purpose of audit and examination, to any books, documents, and records of States and units of local government which receive grants made under this part if, in the opinion of the Attorney General, the Comptroller General, or their designated agents, such books, documents, and records are related to the receipt or use of any such grant.".

(2) TABLE OF CONTENTS.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et

seq.), as amended by section 210201(b), is amended by striking the matter relating to part X and inserting the following:

"PART X—DNA IDENTIFICATION GRANTS

"Sec. 2401. Grant authorization.
"Sec. 2402. Applications.
"Sec. 2403. Application requirements.
"Sec. 2404. Administrative provisions.
"Sec. 2405. Restrictions on use of funds.
"Sec. 2406. Reports.
"Sec. 2407. Expenditure records.

"PART Y—TRANSITION-EFFECTIVE DATE-REPEALER

"Sec. 2501. Continuation of rules, authorities, and proceedings.".

(3) AUTHORIZATION OF APPROPRIATIONS.—Section 1001 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793), as amended by section 210201(c), is amended—

(A) in paragraph (3) by striking "and W" and inserting "W, and X"; and

(B) adding at the end the following new paragraph:

"(22) There are authorized to be appropriated to carry out part X—

"(1) $1,000,000 for fiscal year 1996;
"(2) $3,000,000 for fiscal year 1997;
"(3) $5,000,000 for fiscal year 1998;
"(4) $13,500,000 for fiscal year 1999; and
"(5) $17,500,000 for fiscal year 2000.".

(4) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 60 days after the date of enactment of this Act.

SEC. 210303. QUALITY ASSURANCE AND PROFICIENCY TESTING STANDARDS.

(a) PUBLICATION OF QUALITY ASSURANCE AND PROFICIENCY TESTING STANDARDS.—(1)(A) Not later than 180 days after the date of enactment of this Act, the Director of the Federal Bureau of Investigation shall appoint an advisory board on DNA quality assurance methods from among nominations proposed by the head of the National Academy of Sciences and professional societies of crime laboratory officials.

(B) The advisory board shall include as members scientists from State, local, and private forensic laboratories, molecular geneticists and population geneticists not affiliated with a forensic laboratory, and a representative from the National Institute of Standards and Technology.

(C) The advisory board shall develop, and if appropriate, periodically revise, recommended standards for quality assurance, including standards for testing the proficiency of forensic laboratories, and forensic analysts, in conducting analyses of DNA.

(2) The Director of the Federal Bureau of Investigation, after taking into consideration such recommended standards, shall issue (and revise from time to time) standards for quality assurance, including standards for testing the proficiency of forensic laboratories, and forensic analysts, in conducting analyses of DNA.

(3) The standards described in paragraphs (1) and (2) shall specify criteria for quality assurance and proficiency tests to be applied to the various types of DNA analyses used by forensic laboratories. The standards shall also include a system for grading proficiency testing performance to determine whether a laboratory is performing acceptably.

(4) Until such time as the advisory board has made recommendations to the Director of the Federal Bureau of Investigation and the Director has acted upon those recommendations, the quality assurance guidelines adopted by the technical working group on DNA analysis methods shall be deemed the Director's standards for purposes of this section.

(b) ADMINISTRATION OF THE ADVISORY BOARD.—(1) For administrative purposes, the advisory board appointed under subsection (a) shall be considered an advisory board to the Director of the Federal Bureau of Investigation.

(2) Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply with respect to the advisory board appointed under subsection (a).

(3) The DNA advisory board established under this section shall be separate and distinct from any other advisory board administered by the FBI, and is to be administered separately.

(4) The board shall cease to exist on the date 5 years after the initial appointments are made to the board, unless the existence of the board is extended by the Director of the Federal Bureau of Investigation.

(c) PROFICIENCY TESTING PROGRAM.—(1) Not later than 1 year after the effective date of this Act, the Director of the National Institute of Justice shall certify to the Committees on the Judiciary of the House and Senate that—

(A) the Institute has entered into a contract with, or made a grant to, an appropriate entity for establishing, or has taken other appropriate action to ensure that there is established, not later than 2 years after the date of enactment of this Act, a blind external proficiency testing program for DNA analyses, which shall be available to public and private laboratories performing forensic DNA analyses;

(B) a blind external proficiency testing program for DNA analyses is already readily available to public and private laboratories performing forensic DNA analyses; or

(C) it is not feasible to have blind external testing for DNA forensic analyses.

(2) As used in this subsection, the term "blind external proficiency test" means a test that is presented to a forensic laboratory through a second agency and appears to the analysts to involve routine evidence.

(3) Notwithstanding any other provision of law, the Attorney General shall make available to the Director of the National Institute of Justice during the first fiscal year in which funds are distributed under this subtitle up to $250,000 from the funds available under part X of Title I of the Omnibus Crime Control and Safe Streets Act of 1968 to carry out this subsection.

SEC. 210304. INDEX TO FACILITATE LAW ENFORCEMENT EXCHANGE OF DNA IDENTIFICATION INFORMATION.

(a) ESTABLISHMENT OF INDEX.—The Director of the Federal Bureau of Investigation may establish an index of—

(1) DNA identification records of persons convicted of crimes;

(2) analyses of DNA samples recovered from crime scenes; and

(3) analyses of DNA samples recovered from unidentified human remains.

(b) INFORMATION.—The index described in subsection (a) shall include only information on DNA identification records and DNA analyses that are—

(1) based on analyses performed by or on behalf of a criminal justice agency in accordance with publicly available standards that satisfy or exceed the guidelines for a quality assurance program for DNA analysis, issued by the Director of the Federal Bureau of Investigation under section 210303;

(2) prepared by laboratories, and DNA analysts, that undergo, at regular intervals of not to exceed 180 days, external proficiency testing by a DNA proficiency testing program meeting the standards issued under section 210303; and

(3) maintained by Federal, State, and local criminal justice agencies pursuant to rules that allow disclosure of stored DNA samples and DNA analyses only—

(A) to criminal justice agencies for law enforcement identification purposes;

(B) in judicial proceedings, if otherwise admissible pursuant to applicable statutes or rules;

(C) for criminal defense purposes, to a defendant, who shall have access to samples and analyses performed in connection with the case in which such defendant is charged; or

(D) if personally identifiable information is removed, for a population statistics database, for identification research and protocol development purposes, or for quality control purposes.

(c) FAILURE TO COMPLY.—Access to the index established by this section is subject to cancellation if the quality control and privacy requirements described in subsection (b) are not met.

SEC. 210305. FEDERAL BUREAU OF INVESTIGATION.

(a) PROFICIENCY TESTING REQUIREMENTS.—

(1) GENERALLY.—(A) Personnel at the Federal Bureau of Investigation who perform DNA analyses shall undergo, at regular intervals of not to exceed 180 days, external proficiency testing by a DNA proficiency testing program meeting the standards issued under section 210303.

(B) Within 1 year after the date of enactment of this Act, the Director of the Federal Bureau of Investigation shall arrange for periodic blind external tests to determine the proficiency of DNA analysis performed at the Federal Bureau of Investigation laboratory.

(C) In this paragraph, "blind external test" means a test that is presented to the laboratory through a second agency and appears to the analysts to involve routine evidence.

(2) REPORT.—For 5 years after the date of enactment of this Act, the Director of the Federal Bureau of Investigation shall submit to the Committees on the Judiciary of the House and Senate an annual report on the results of each of the tests described in paragraph (1).

(b) PRIVACY PROTECTION STANDARDS.—

(1) GENERALLY.—Except as provided in paragraph (2), the results of DNA tests performed for a Federal law enforcement agency for law enforcement purposes may be disclosed only—

(A) to criminal justice agencies for law enforcement identification purposes;

(B) in judicial proceedings, if otherwise admissible pursuant to applicable statues or rules; and

(C) for criminal defense purposes, to a defendant, who shall have access to samples and analyses performed in connection with the case in which such defendant is charged.

(2) EXCEPTION.—If personally identifiable information is removed, test results may be disclosed for a population statistics database, for identification research and protocol development purposes, or for quality control purposes.

(c) CRIMINAL PENALTY.—(1) A person who—

(A) by virtue of employment or official position, has possession of, or access to, individually identifiable DNA information indexed in a database created or maintained by any Federal law enforcement agency; and

(B) knowingly discloses such information in any manner to any person or agency not authorized to receive it,

shall be fined not more than $100,000.

(2) A person who, without authorization, knowingly obtains DNA samples or individually identifiable DNA information indexed in a database created or maintained by any Federal law enforcement agency shall be fined not more than $100,000.

SEC. 210306. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to the Federal Bureau of Investigation to carry out sections 210303, 210304, and 210305—

(1) $5,500,000 for fiscal year 1996;
(2) $8,000,000 for fiscal year 1997;
(3) $8,000,000 for fiscal year 1998;
(4) $2,500,000 for fiscal year 1999; and
(5) $1,000,000 for fiscal year 2000.

Subtitle D—Police Pattern or Practice

SEC. 210401. CAUSE OF ACTION.

(a) UNLAWFUL CONDUCT.—It shall be unlawful for any governmental authority, or any

agent thereof, or any person acting on behalf of a governmental authority, to engage in a pattern or practice of conduct by law enforcement officers or by officials or employees of any governmental agency with responsibility for the administration of juvenile justice or the incarceration of juveniles that deprives persons of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

(b) CIVIL ACTION BY ATTORNEY GENERAL.—Whenever the Attorney General has reasonable cause to believe that a violation of paragraph (1) has occurred, the Attorney General, for or in the name of the United States, may in a civil action obtain appropriate equitable and declaratory relief to eliminate the pattern or practice.

SEC. 210402. DATA ON USE OF EXCESSIVE FORCE.

(a) ATTORNEY GENERAL TO COLLECT.—The Attorney General shall, through appropriate means, acquire data about the use of excessive force by law enforcement officers.

(b) LIMITATION ON USE OF DATA.—Data acquired under this section shall be used only for research or statistical purposes and may not contain any information that may reveal the identity of the victim or any law enforcement officer.

(c) ANNUAL SUMMARY.—The Attorney General shall publish an annual summary of the data acquired under this section.

Subtitle E—Improved Training and Technical Automation

SEC. 210501. IMPROVED TRAINING AND TECHNICAL AUTOMATION.

(a) GRANTS.—

(1) IN GENERAL.—The Attorney General shall, subject to the availability of appropriations, make grants to State, Indian tribal, and local criminal justice agencies and to nonprofit organizations for the purposes of improving criminal justice agency efficiency through computerized automation and technological improvements.

(2) TYPES OF PROGRAMS.—Grants under this section may include programs to—

(A) increase use of mobile digital terminals;

(B) improve communications systems, such as computer-aided dispatch and incident reporting systems;

(C) accomplish paper-flow reduction;

(D) establish or improve ballistics identification programs;

(E) increase the application of automated fingerprint identification systems and their communications on an interstate and intrastate basis; and

(F) improve computerized collection of criminal records.

(3) FUNDING.—No funds under this subtitle may be used to implement any cryptographic or digital telephony programs.

(b) TRAINING AND INVESTIGATIVE ASSISTANCE.—

(1) IN GENERAL.—The Attorney General shall, subject to the availability of appropriations—

(A) expand and improve investigative and managerial training courses for State, Indian tribal, and local law enforcement agencies; and

(B) develop and implement, on a pilot basis with no more than 10 participating cities, an intelligent information system that gathers, integrates, organizes, and analyzes information in active support of investigations by Federal, State, and local law enforcement agencies of violent serial crimes.

(2) IMPROVEMENT OF FACILITIES.—The improvement described in subsection (a) shall include improvements of the training facilities of the Federal Bureau of Investigation Academy at Quantico, Virginia.

(3) INTELLIGENT INFORMATION SYSTEM.—The intelligent information system described in paragraph (1)(B) shall be developed and implemented by the Federal Bureau of Investigation and shall utilize the resources of the Violent Criminal Apprehension Program.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

(1) to carry out subsection (a)—

(A) $10,000,000 for fiscal year 1996;

(B) $20,000,000 for fiscal year 1997;

(C) $23,000,000 for fiscal year 1998;

(D) $23,000,000 for fiscal year 1999; and

(E) $24,000,000 for fiscal year 2000.

(2) to carry out subsection (b)(1)—

(A) $4,000,000 for fiscal year 1996;

(B) $2,000,000 for fiscal year 1997;

(C) $3,000,000 for fiscal year 1998;

(D) $5,000,000 for fiscal year 1999; and

(E) $6,000,000 for fiscal year 2000; and

(3) to carry out subsection (b)(2)—

$10,000,000 for fiscal year 1996.

(d) DEFINITIONS.—In this section—

"Indian tribe" means a tribe, band, pueblo, nation, or other organized group or community of Indians, including an Alaska Native village (as defined in or established under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

"State" means a State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, and the United States Virgin Islands.

Subtitle F—Other State and Local Aid

SEC. 210601. REAUTHORIZATION OF OFFICE OF JUSTICE PROGRAMS.

Section 1001(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793(a)) is amended—

(1) in paragraph (1) by striking "1993 and 1994" and inserting "1994 and 1995";

(2) in paragraph (2) by striking "1993 and 1994" and inserting "1994 and 1995";

(3) in paragraph (3) by striking "1993 and 1994" and inserting "1994 and 1995";

(4) in paragraph (5) by striking "1993 and 1994" and inserting "1994 and 1995";

(5) in paragraph (6) by inserting "and 1995" after "1994";

(6) in paragraph (7) by striking "1991, 1992, 1993, and 1994," and inserting "1994 and 1995";

(7) in paragraph (8) by inserting "and 1995" after "1994"; and

(8) in paragraph (9) by inserting "and 1995" after "1994".

SEC. 210602. FEDERAL ASSISTANCE TO EASE THE INCREASED BURDENS ON STATE COURT SYSTEMS RESULTING FROM ENACTMENT OF THIS ACT.

(a) IN GENERAL.—The Attorney General shall, subject to the availability of appropriation, make grants for States and units of local government to pay the costs of providing increased resources for courts, prosecutors, public defenders, and other criminal justice participants as necessary to meet the increased demands for judicial activities resulting from the provisions of this Act and amendments made by this Act.

(b) APPLICATIONS.—In carrying out this section, the Attorney General may make grants to, or enter into contracts with public or private agencies, institutions, or organizations or individuals to carry out any purpose specified in this section. The Attorney General shall have final authority over all funds awarded under this section.

(c) RECORDS.—Each recipient that receives a grant under this section shall keep such records as the Attorney General may require to facilitate an effective audit.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $23,000,000 for fiscal year 1996;

(2) $30,000,000 for fiscal year 1997;

(3) $30,000,000 for fiscal year 1998;

(4) $32,000,000 for fiscal year 1999; and

(5) $35,000,000 for fiscal year 2000,

to remain available for obligation until expended.

SEC. 210603. AVAILABILITY OF VIOLENT CRIME REDUCTION TRUST FUND TO FUND ACTIVITIES AUTHORIZED BY THE BRADY HANDGUN VIOLENCE PREVENTION ACT AND THE NATIONAL CHILD PROTECTION ACT OF 1993.

(a) APPROPRIATIONS.—Of the amounts authorized in Sections 103(k) and 106(b)(2) of the Brady Handgun Violence Prevention Act (18 U.S.C. 922 note) and in section 4(b) of the National Child Protection Act of 1993 (42 U.S.C. 5119b(b)), a total of $100,000,000 for fiscal year 1995, $25,000,000 for fiscal year 1996, and $25,000,000 for fiscal year 1997 may be appropriated from the Violent Crime Reduction Trust Fund established by this Act.

(b) TECHNICAL AMENDMENT.—Sections 103(k) and 106(b) of the Brady Handgun Violence Prevention Act (18 U.S.C. 922 note) are each amended by striking ", which may be appropriated from the Violent Crime Reduction Trust Fund,".

TITLE XXII—MOTOR VEHICLE THEFT PREVENTION

SEC. 220001. SHORT TITLE.

This title may be cited as the "Motor Vehicle Theft Prevention Act".

SEC. 220002. MOTOR VEHICLE THEFT PREVENTION PROGRAM.

(a) IN GENERAL.—Not later than 180 days after the date of enactment of this section, the Attorney General shall develop, in cooperation with the States, a national voluntary motor vehicle theft prevention program (in this section referred to as the "program") under which—

(1) the owner of a motor vehicle may voluntarily sign a consent form with a participating State or locality in which the motor vehicle owner—

(A) states that the vehicle is not normally operated under certain specified conditions; and

(B) agrees to—

(i) display program decals or devices on the owner's vehicle; and

(ii) permit law enforcement officials in any State to stop the motor vehicle and take reasonable steps to determine whether the vehicle is being operated by or with the permission of the owner, if the vehicle is being operated under the specified conditions; and

(2) participating States and localities authorize law enforcement officials in the State or locality to stop motor vehicles displaying program decals or devices under specified conditions and take reasonable steps to determine whether the vehicle is being operated by or with the permission of the owner.

(b) UNIFORM DECAL OR DEVICE DESIGNS.—

(1) IN GENERAL.—The motor vehicle theft prevention program developed pursuant to this section shall include a uniform design or designs for decals or other devices to be displayed by motor vehicles participating in the program.

(2) TYPE OF DESIGN.—The uniform design shall—

(A) be highly visible; and

(B) explicitly state that the motor vehicle to which it is affixed may be stopped under the specified conditions without additional grounds for establishing a reasonable suspicion that the vehicle is being operated unlawfully.

(c) VOLUNTARY CONSENT FORM.—The voluntary consent form used to enroll in the program shall—

(1) clearly state that participation in the program is voluntary;

(2) clearly explain that participation in the program means that, if the participating vehicle

is being operated under the specified conditions, law enforcement officials may stop the vehicle and take reasonable steps to determine whether it is being operated by or with the consent of the owner, even if the law enforcement officials have no other basis for believing that the vehicle is being operated unlawfully;

(3) include an express statement that the vehicle is not normally operated under the specified conditions and that the operation of the vehicle under those conditions would provide sufficient grounds for a prudent law enforcement officer to reasonably believe that the vehicle was not being operated by or with the consent of the owner; and

(4) include any additional information that the Attorney General may reasonably require.

(d) SPECIFIED CONDITIONS UNDER WHICH STOPS MAY BE AUTHORIZED.—

(1) IN GENERAL.—The Attorney General shall promulgate rules establishing the conditions under which participating motor vehicles may be authorized to be stopped under this section. These conditions may not be based on race, creed, color, national origin, gender, or age. These conditions may include—

(A) the operation of the vehicle during certain hours of the day; or

(B) the operation of the vehicle under other circumstances that would provide a sufficient basis for establishing a reasonable suspicion that the vehicle was not being operated by the owner, or with the consent of the owner.

(2) MORE THAN ONE SET OF CONDITIONS.—The Attorney General may establish more than one set of conditions under which participating motor vehicles may be stopped. If more than one set of conditions is established, a separate consent form and a separate design for program decals or devices shall be established for each set of conditions. The Attorney General may choose to satisfy the requirement of a separate design for program decals or devices under this paragraph by the use of a design color that is clearly distinguishable from other design colors.

(3) NO NEW CONDITIONS WITHOUT CONSENT.—After the program has begun, the conditions under which a vehicle may be stopped if affixed with a certain decal or device design may not be expanded without the consent of the owner.

(4) LIMITED PARTICIPATION BY STATES AND LOCALITIES.—A State or locality need not authorize the stopping of motor vehicles under all sets of conditions specified under the program in order to participate in the program.

(e) MOTOR VEHICLES FOR HIRE.—

(1) NOTIFICATION TO LESSEES.—Any person who is in the business of renting or leasing motor vehicles and who rents or leases a motor vehicle on which a program decal or device is affixed shall, prior to transferring possession of the vehicle, notify the person to whom the motor vehicle is rented or leased about the program.

(2) TYPE OF NOTICE.—The notice required by this subsection shall—

(A) be in writing;

(B) be in a prominent format to be determined by the Attorney General; and

(C) explain the possibility that if the motor vehicle is operated under the specified conditions, the vehicle may be stopped by law enforcement officials even if the officials have no other basis for believing that the vehicle is being operated unlawfully.

(3) FINE FOR FAILURE TO PROVIDE NOTICE.—Failure to provide proper notice under this subsection shall be punishable by a fine not to exceed $5,000.

(f) NOTIFICATION OF POLICE.—As a condition of participating in the program, a State or locality must agree to take reasonable steps to ensure that law enforcement officials throughout the State or locality are familiar with the program, and with the conditions under which motor vehicles may be stopped under the program.

(g) REGULATIONS.—The Attorney General shall promulgate regulations to implement this section.

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to carry out this section.

(1) $1,500,000 for fiscal year 1996;

(2) $1,700,000 for fiscal year 1997; and

(3) $1,800,000 for fiscal year 1998.

SEC. 220003. ALTERING OR REMOVING MOTOR VEHICLE IDENTIFICATION NUMBERS.

(a) BASIC OFFENSE.—Subsection (a) of section 511 of title 18, United States Code, is amended to read as follows:

"(a) A person who—

"(1) knowingly removes, obliterates, tampers with, or alters an identification number for a motor vehicle or motor vehicle part; or

"(2) with intent to further the theft of a motor vehicle, knowingly removes, obliterates, tampers with, or alters a decal or device affixed to a motor vehicle pursuant to the Motor Vehicle Theft Prevention Act,

shall be fined under this title, imprisoned not more than 5 years, or both.".

(b) EXCEPTED PERSONS.—Paragraph (2) of section 511(b) of title 18, United States Code, is amended—

(1) by striking "and" after the semicolon in subparagraph (B);

(2) by striking the period at the end of subparagraph (C) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(D) a person who removes, obliterates, tampers with, or alters a decal or device affixed to a motor vehicle pursuant to the Motor Vehicle Theft Prevention Act, if that person is the owner of the motor vehicle, or is authorized to remove, obliterate, tamper with or alter the decal or device by—

"(i) the owner or his authorized agent;

"(ii) applicable State or local law; or

"(iii) regulations promulgated by the Attorney General to implement the Motor Vehicle Theft Prevention Act.".

(c) DEFINITION.—Section 511 of title 18, United States Code, is amended by adding at the end thereof the following:

"(d) For purposes of subsection (a) of this section, the term 'tampers with' includes covering a program decal or device affixed to a motor vehicle pursuant to the Motor Vehicle Theft Prevention Act for the purpose of obstructing its visibility.".

(d) UNAUTHORIZED APPLICATION OF A DECAL OR DEVICE.—

(1) IN GENERAL.—Chapter 25 of title 18, United States Code, is amended by adding after section 511 the following new section:

"§511A. Unauthorized application of theft prevention decal or device

"(a) Whoever affixes to a motor vehicle a theft prevention decal or other device, or a replica thereof, unless authorized to do so pursuant to the Motor Vehicle Theft Prevention Act, shall be punished by a fine not to exceed $1,000.

"(b) For purposes of this section, the term 'theft prevention decal or device' means a decal or other device designed in accordance with a uniform design for such devices developed pursuant to the Motor Vehicle Theft Prevention Act.".

(2) TECHNICAL AMENDMENT.—The chapter analysis for chapter 25 of title 18, United States Code, is amended by adding after the item relating to section 511 the following new item:

"511A. Unauthorized application of theft prevention decal or device.".

TITLE XXIII—VICTIMS OF CRIME

Subtitle A—Victims of Crime

SEC. 230101. VICTIM'S RIGHT OF ALLOCUTION IN SENTENCING.

(a) MODIFICATION OF PROPOSED AMENDMENTS.—The proposed amendments to the Federal Rules of Criminal Procedure which are embraced by an order entered by the Supreme Court of the United States on April 29, 1994, shall take effect on December 1, 1994, as otherwise provided by law, but with the following amendments:

(b) IN GENERAL.—Rule 32 of the Federal Rules of Criminal Procedure is amended by—

(1) striking "and" following the semicolon in subdivision (c)(3)(C);

(2) striking the period at the end of subdivision (c)(3)(D) and inserting "; and";

(3) inserting after subdivision (c)(3)(D) the following:

"(E) if sentence is to be imposed for a crime of violence or sexual abuse, address the victim personally if the victim is present at the sentencing hearing and determine if the victim wishes to make a statement or present any information in relation to the sentence.";

(4) in subdivision (c)(3)(D), striking "equivalent opportunity" and inserting in lieu thereof "opportunity equivalent to that of the defendant's counsel";

(5) in the last sentence of subdivision (c)(4), striking "and (D)" and inserting "(D), and (E)";

(6) in the last sentence of subdivision (c)(4), inserting "the victim," before "or the attorney for the Government."; and

(7) adding at the end the following:

"(f) DEFINITIONS.—For purposes of this rule—

"(1) 'victim' means any individual against whom an offense has been committed for which a sentence is to be imposed, but the right of allocution under subdivision (c)(3)(E) may be exercised instead by—

"(A) a parent or legal guardian if the victim is below the age of eighteen years or incompetent; or

"(B) one or more family members or relatives designated by the court if the victim is deceased or incapacitated;

if such person or persons are present at the sentencing hearing, regardless of whether the victim is present; and

"(2) 'crime of violence or sexual abuse' means a crime that involved the use or attempted or threatened use of physical force against the person or property of another, or a crime under chapter 109A of title 18, United States Code.".

(c) EFFECTIVE DATE.—The amendments made by subsection (b) shall become effective on December 1, 1994.

SEC. 230102. SENSE OF THE SENATE CONCERNING THE RIGHT OF A VICTIM OF A VIOLENT CRIME OR SEXUAL ABUSE TO SPEAK AT AN OFFENDER'S SENTENCING HEARING AND ANY PAROLE HEARING.

It is the sense of the Senate that—

(1) the law of a State should provide for a victim's right of allocution at a sentencing hearing and at any parole hearing if the offender has been convicted of a crime of violence or sexual abuse;

(2) such a victim should have an opportunity equivalent to the opportunity accorded to the offender to address the sentencing court or parole board and to present information in relation to the sentence imposed or to the early release of the offender; and

(3) if the victim is not able to or chooses not to testify at a sentencing hearing or parole hearing, the victim's parents, legal guardian, or family members should have the right to address the court or board.

Subtitle B—Crime Victims' Fund

SEC. 230201. ALLOCATION OF FUNDS FOR COSTS AND GRANTS.

(a) GENERALLY.—Section 1402(d) of the Victims of Crime Act of 1984 (42 U.S.C. 10601(d)) is amended by—

(1) striking paragraph (2) and inserting the following:

"(2) the next $10,000,000 deposited in the Fund shall be available for grants under section 1404A.";

(2) striking paragraph (3) and inserting the following:

"(3) Of the remaining amount deposited in the Fund in a particular fiscal year—

"(A) 48.5 percent shall be available for grants under section 1403;

"(B) 48.5 percent shall be available for grants under section 1404(a); and

"(C) 3 percent shall be available for grants under section 1404(c).";

(3) striking paragraph (4) and inserting the following:

"(4) The Director may retain any portion of the Fund that was deposited during a fiscal year that is in excess of 110 percent of the total amount deposited in the Fund during the preceding fiscal year as a reserve for use in a year in which the Fund falls below the amount available in the previous year. Such reserve may not exceed $20,000,000."; and

(4) striking paragraph (5).

(b) CONFORMING CROSS REFERENCE.—Section 1402(g)(1) of the Victims of Crime Act of 1984 (42 U.S.C. 10601(g)(1)) is amended by striking "(d)(2)(D)" and inserting "(d)(2)".

SEC. 230202. RELATIONSHIP OF CRIME VICTIM COMPENSATION TO CERTAIN FEDERAL PROGRAMS.

Section 1403 of the Victims of Crime Act of 1984 (42 U.S.C. 10602) is amended by adding at the end the following new subsection:

"(e) Notwithstanding any other law, if the compensation paid by an eligible crime victim compensation program would cover costs that a Federal program, or a federally financed State or local program, would otherwise pay,—

"(1) such crime victim compensation program shall not pay that compensation; and

"(2) the other program shall make its payments without regard to the existence of the crime victim compensation program.".

SEC. 230203. ADMINISTRATIVE COSTS FOR CRIME VICTIM COMPENSATION.

(a) CREATION OF EXCEPTION.—The final sentence of section 1403(a)(1) of the Victims of Crime Act of 1984 (42 U.S.C. 10602(a)(1)) is amended by striking "A grant" and inserting "Except as provided in paragraph (3), a grant".

(b) REQUIREMENTS OF EXCEPTION.—Section 1403(a) of the Victims of Crime Act of 1984 (42 U.S.C. 10602(a)) is amended by adding at the end the following new paragraph:

"(3) Not more than 5 percent of a grant made under this section may be used for the administration of the State crime victim compensation program receiving the grant.".

SEC. 230204. GRANTS FOR DEMONSTRATION PROJECTS.

Section 1404(c)(1)(A) of the Victims of Crime Act of 1984 (42 U.S.C. 10603(c)(1)(A)) is amended by inserting "demonstration projects and" before "training".

SEC. 230205. ADMINISTRATIVE COSTS FOR CRIME VICTIM ASSISTANCE.

(a) CREATION OF EXCEPTION.—Section 1404(b)(2) of the Victims of Crime Act of 1984 (42 U.S.C. 10603(b)(2)) is amended by striking "An eligible" and inserting "Except as provided in paragraph (3), an eligible".

(b) REQUIREMENTS OF EXCEPTION.—Section 1404(b) of the Victims of Crime Act of 1984 (42 U.S.C. 10603(b)) is amended by adding at the end the following new subsection:

"(3) Not more than 5 percent of sums received under subsection (a) may be used for the administration of the State crime victim assistance program receiving such sums.".

SEC. 230206. MAINTENANCE OF EFFORT.

Section 1407 of the Victims of Crime Act of 1984 (42 U.S.C. 10604) is amended by adding at the end the following new subsection:

"(h) Each entity receiving sums made available under this Act for administrative purposes shall certify that such sums will not be used to supplant State or local funds, but will be used to increase the amount of such funds that would, in the absence of Federal funds, be made available for these purposes.".

SEC. 230207. CHANGE OF DUE DATE FOR REQUIRED REPORT.

Section 1407(g) of the Victims of Crime Act of 1984 (42 U.S.C. 10604(g)) is amended by striking "and on December 31 every two years thereafter", and inserting "and on June 30 every two years thereafter".

SEC. 230208. AMENDMENT OF THE VICTIMS OF CRIME ACT.

Section 1404(a)(5)(B) of the Victims of Crime Act of 1984 (42 U.S.C. 10603(a)(5)(B)) is amended to read as follows:

"(B) $200,000 thereafter.".

TITLE XXIV—PROTECTIONS FOR THE ELDERLY

SEC. 240001. MISSING ALZHEIMER'S DISEASE PATIENT ALERT PROGRAM.

(a) GRANT.—The Attorney General shall, subject to the availability of appropriations, award a grant to an eligible organization to assist the organization in paying for the costs of planning, designing, establishing, and operating a Missing Alzheimer's Disease Patient Alert Program, which shall be a locally based, proactive program to protect and locate missing patients with Alzheimer's disease and related dementias.

(b) APPLICATION.—To be eligible to receive a grant under subsection (a), an organization shall submit an application to the Attorney General at such time, in such manner, and containing such information as the Attorney General may require, including, at a minimum, an assurance that the organization will obtain and use assistance from private nonprofit organizations to support the program.

(c) ELIGIBLE ORGANIZATION.—The Attorney General shall award the grant described in subsection (a) to a national voluntary organization that has a direct link to patients, and families of patients, with Alzheimer's disease and related dementias.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $1,000,000 for fiscal year 1996;

(2) $1,000,000 for fiscal year 1997; and

(3) $1,000,000 for fiscal year 1998.

SEC. 240002. CRIMES AGAINST THE ELDERLY.

(a) IN GENERAL.—Pursuant to its authority under the Sentencing Reform Act of 1984 and section 21 of the Sentencing Act of 1987 (including its authority to amend the sentencing guidelines and policy statements) and its authority to make such amendments on an emergency basis, the United States Sentencing Commission shall ensure that the applicable guideline range for a defendant convicted of a crime of violence against an elderly victim is sufficiently stringent to deter such a crime, to protect the public from additional crimes of such a defendant, and to adequately reflect the heinous nature of such an offense.

(b) CRITERIA.—In carrying out subsection (a), the United States Sentencing Commission shall ensure that—

(1) the guidelines provide for increasingly severe punishment for a defendant commensurate with the degree of physical harm caused to the elderly victim;

(2) the guidelines take appropriate account of the vulnerability of the victim; and

(3) the guidelines provide enhanced punishment for a defendant convicted of a crime of violence against an elderly victim who has previously been convicted of a crime of violence against an elderly victim, regardless of whether the conviction occurred in Federal or State court.

(c) DEFINITIONS.—In this section—

"crime of violence" means an offense under section 113, 114, 1111, 1112, 1113, 1117, 2241, 2242, or 2244 of title 18, United States Code.

"elderly victim" means a victim who is 65 years of age or older at the time of an offense.

SEC. 240003. SAFE SENIOR CORRIDORS GRANTS.

(a) GENERAL AUTHORITY.—The Attorney General may make grants to States, units of local governments, Indian tribal governments, and other public agencies to support pilot projects for controlling crime and ensuring public safety in areas that have a high population density of senior citizens or related special needs.

(b) PURPOSE OF GRANTS.—A pilot project grant under subsection (a) shall have the explicit purpose of providing senior citizens with enhanced protections from crime, particularly violent predatory crime, in geographic areas where their population densities or their activities make senior citizens particularly vulnerable.

(c) APPLICATIONS.—

(1) IN GENERAL.—The Attorney General shall prescribe requirements for the manner of filing and content of applications for funding under this part.

(2) CONTENTS.—An application under this section shall, at a minimum—

(A) demonstrate innovative plans aimed at establishing corridors of safety for senior citizens by increasing the numbers, presence, and watchfulness of law enforcement officers, community groups, and business owners and employees; and

(B) demonstrate the use of broad and diverse community-based volunteer efforts.

(d) REGULATIONS.—The Attorney General may promulgate any necessary regulations, definitions, and guidelines to govern the program authorized by this section.

(e) USE OF FUNDS.—The use of grant funds awarded under this section shall be governed by this section, under such regulations and guidelines as may be issued by the Attorney General.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $1,000,000 for fiscal year 1996; and

(2) $1,000,000 for fiscal year 1997.

TITLE XXV—SENIOR CITIZENS AGAINST MARKETING SCAMS

SEC. 250001. SHORT TITLE.

This Act may be cited as the "Senior Citizens Against Marketing Scams Act of 1994".

SEC. 250002. ENHANCED PENALTIES FOR TELEMARKETING FRAUD.

(a) OFFENSE.—Part I of title 18, United States Code, is amended—

(1) by redesignating chapter 113A as chapter 113B; and

(2) by inserting after chapter 113 the following new chapter:

"CHAPTER 113A—TELEMARKETING FRAUD

"Sec.
"2325. Definition.
"2326. Enhanced penalties.
"2327. Mandatory restitution.

"§2325. Definition

"In this chapter, 'telemarketing'—

"(1) means a plan, program, promotion, or campaign that is conducted to induce—

"(A) purchases of goods or services; or

"(B) participation in a contest or sweepstakes,

by use of 1 or more interstate telephone calls initiated either by a person who is conducting the plan, program, promotion, or campaign or by a prospective purchaser or contest or sweepstakes participant; but

"(2) does not include the solicitation of sales through the mailing of a catalog that—

"(A) contains a written description or illustration of the goods or services offered for sale;

"(B) includes the business address of the seller;

"(C) includes multiple pages of written material or illustration; and

"(D) has been issued not less frequently than once a year,

if the person making the solicitation does not solicit customers by telephone but only receives calls initiated by customers in response to the catalog and during those calls take orders without further solicitation.

"§2326. Enhanced penalties

"A person who is convicted of an offense under section 1028, 1029, 1341, 1342, 1343, or 1344 in connection with the conduct of telemarketing—

"(1) may be imprisoned for a term of up to 5 years in addition to any term of imprisonment imposed under any of those sections, respectively; and

"(2) in the case of an offense under any of those sections that—

"(A) victimized ten or more persons over the age of 55; or

"(B) targeted persons over the age of 55,

may be imprisoned for a term of up to 10 years in addition to any term of imprisonment imposed under any of those sections, respectively.

"§2327. Mandatory restitution

"(a) IN GENERAL.—Notwithstanding section 3663, and in addition to any other civil or criminal penalty authorized by law, the court shall order restitution for any offense under this chapter.

"(b) SCOPE AND NATURE OF ORDER.—

"(1) DIRECTIONS.—The order of restitution under this section shall direct that—

"(A) the defendant pay to the victim (through the appropriate court mechanism) the full amount of the victim's losses as determined by the court, pursuant to paragraph (3); and

"(B) the United States Attorney enforce the restitution order by all available and reasonable means.

"(2) ENFORCEMENT BY VICTIM.—An order of restitution may be enforced by a victim named in the order to receive the restitution as well as by the United States Attorney, in the same manner as a judgment in a civil action.

"(3) DEFINITION.—For purposes of this subsection, the term 'full amount of the victim's losses' means all losses suffered by the victim as a proximate result of the offense.

"(4) ORDER MANDATORY.—(A) The issuance of a restitution order under this section is mandatory.

"(B) A court may not decline to issue an order under this section because of—

"(i) the economic circumstances of the defendant; or

"(ii) the fact that a victim has, or is entitled to, receive compensation for his or her injuries from the proceeds of insurance or any other source.

"(C)(i) Notwithstanding subparagraph (A), the court may take into account the economic circumstances of the defendant in determining the manner in which and the schedule according to which the restitution is to be paid.

"(ii) For purposes of this subparagraph, the term 'economic circumstances' includes—

"(I) the financial resources and other assets of the defendant;

"(II) projected earnings, earning capacity, and other income of the defendant; and

"(III) any financial obligations of the defendant, including obligations to dependents.

"(D) Subparagraph (A) does not apply if—

"(i) the court finds on the record that the economic circumstances of the defendant do not allow for the payment of any amount of a restitution order, and do not allow for the payment of any or some portion of the amount of a restitution order in the foreseeable future (under any reasonable schedule of payments); and

"(ii) the court enters in its order the amount of the victim's losses, and provides a nominal restitution award.

"(5) MORE THAN 1 OFFENDER.—When the court finds that more than 1 offender has contributed to the loss of a victim, the court may make each offender liable for payment of the full amount of restitution or may apportion liability among the offenders to reflect the level of contribution and economic circumstances of each offender.

"(6) MORE THAN 1 VICTIM.—When the court finds that more than 1 victim has sustained a loss requiring restitution by an offender, the court shall order full restitution of each victim but may provide for different payment schedules to reflect the economic circumstances of each victim.

"(7) PAYMENT SCHEDULE.—An order under this section may direct the defendant to make a single lump-sum payment or partial payments at specified intervals.

"(8) SETOFF.—Any amount paid to a victim under this section shall be set off against any amount later recovered as compensatory damages by the victim from the defendant in—

"(A) any Federal civil proceeding; and

"(B) any State civil proceeding, to the extent provided by the law of the State.

"(9) EFFECT ON OTHER SOURCES OF COMPENSATION.—The issuance of a restitution order shall not affect the entitlement of a victim to receive compensation with respect to a loss from insurance or any other source until the payments actually received by the victim under the restitution order fully compensate the victim for the loss.

"(10) CONDITION OF PROBATION OR SUPERVISED RELEASE.—Compliance with a restitution issued under this section shall be a condition of any probation or supervised release of a defendant. The court may revoke probation or a term of supervised release, modify the terms or conditions of probation or a term of supervised release, hold the defendant in contempt pursuant to section 3583(e), or suspend the offender's eligibility for any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or with appropriated funds of the United States if the defendant fails to comply with the order. In determining whether to revoke probation or a term of supervised release, modify the terms or conditions of probation or supervised release or hold a defendant serving a term of supervised release in contempt, the court shall consider the defendant's employment status, earning ability and financial resources, the willfulness of the defendant's failure to comply, and any other circumstances that may have a bearing on the defendant's ability to comply.

"(c) PROOF OF CLAIM.—

"(1) AFFIDAVIT.—Within 60 days after conviction and, in any event, not later than 10 days prior to sentencing, the United States Attorney (or the United States Attorney's delegee), after consulting with the victim, shall prepare and file an affidavit with the court listing the amounts subject to restitution under this section. The affidavit shall be signed by the United States Attorney (or the United States Attorney's delegee) and the victim. Should the victim object to any of the information included in the affidavit, the United States Attorney (or the United States Attorney's delegee) shall advise the victim that the victim may file a separate affidavit and shall provide the victim with an affidavit form which may be used to do so.

"(2) OBJECTION.—If, after the defendant has been notified of the affidavit, no objection is raised by the defendant, the amounts attested to in the affidavit filed pursuant to paragraph (1) shall be entered in the court's restitution order. If objection is raised, the court may require the victim or the United States Attorney (or the United States Attorney's delegee) to submit further affidavits or other supporting documents, demonstrating the victim's losses.

"(3) ADDITIONAL DOCUMENTATION AND TESTIMONY.—If the court concludes, after reviewing the supporting documentation and considering the defendant's objections, that there is a substantial reason for doubting the authenticity or veracity of the records submitted, the court may require additional documentation or hear testimony on those questions. The privacy of any records filed, or testimony heard, pursuant to this section shall be maintained to the greatest extent possible, and such records may be filed or testimony heard in camera.

"(4) FINAL DETERMINATION OF LOSSES.—If the victim's losses are not ascertainable by the date that is 10 days prior to sentencing as provided in paragraph (1), the United States Attorney (or the United States Attorney's delegee) shall so inform the court, and the court shall set a date for the final determination of the victim's losses, not to exceed 90 days after sentencing. If the victim subsequently discovers further losses, the victim shall have 60 days after discovery of those losses in which to petition the court for an amended restitution order. Such order may be granted only upon a showing of good cause for the failure to include such losses in the initial claim for restitutionary relief.

"(d) MODIFICATION OF ORDER.—A victim or the offender may petition the court at any time to modify a restitution order as appropriate in view of a change in the economic circumstances of the offender.

"(e) REFERENCE TO MAGISTRATE OR SPECIAL MASTER.—The court may refer any issue arising in connection with a proposed order of restitution to a magistrate or special master for proposed findings of fact and recommendations as to disposition, subject to a de novo determination of the issue by the court.

"(f) DEFINITION.—For purposes of this section, the term 'victim' includes the individual harmed as a result of a commission of a crime under this chapter, including, in the case of a victim who is incompetent, incapacitated, or deceased, the legal guardian of the victim or representative of the victim's estate, another family member, or any other person appointed as suitable by the court, but in no event shall the defendant be named as such representative or guardian.".

(b) TECHNICAL AMENDMENTS.—

(1) PART ANALYSIS.—The part analysis for part I of title 18, United States Code, is amended by striking the item relating to chapter 113A and inserting the following:

"113A. Telemarketing fraud 2325
"113B. Terrorism .... 2331".

(2) CHAPTER 113B.—The chapter heading for chapter 113B of title 18, United States Code, as redesignated by subsection (a)(1), is amended to read as follows:

"CHAPTER 113B—TERRORISM".

SEC. 250003. INCREASED PENALTIES FOR FRAUD AGAINST OLDER VICTIMS.

(a) REVIEW.—The United States Sentencing Commission shall review and, if necessary, amend the sentencing guidelines to ensure that victim related adjustments for fraud offenses against older victims over the age of 55 are adequate.

(b) REPORT.—Not later than 180 days after the date of enactment of this Act, the Sentencing Commission shall report to Congress the result of its review under subsection (a).

SEC. 250004. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(c)(1) In special circumstances and in the Attorney General's sole discretion, the Attorney General may make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution under section 2326 which results in a conviction.

"(2) A person is not eligible for a payment under paragraph (1) if—

"(A) the person is a current or former officer or employee of a Federal, State, or local government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

"(B) the person knowingly participated in the offense;

"(C) the information furnished by the person consists of an allegation or transaction that has been disclosed to the public—

"(i) in a criminal, civil, or administrative proceeding;

"(ii) in a congressional, administrative, or General Accounting Office report, hearing, audit, or investigation; or

"(iii) by the news media, unless the person is the original source of the information; or

"(D) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

"(3) For the purposes of paragraph (2)(C)(iii), the term 'original source' means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

"(4) Neither the failure of the Attorney General to authorize a payment under paragraph (1) nor the amount authorized shall be subject to judicial review.".

SEC. 250005. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for the purposes of carrying out this Act and the amendments made by this Act—

(1) for the Federal Bureau of Investigation to hire, equip, and train special agents and support staff to investigate telemarketing fraud cases—

(A) $750,000 for fiscal year 1996;

(B) $1,500,000 for fiscal year 1997;

(C) $1,500,000 for fiscal year 1998;

(D) $1,800,000 for fiscal year 1999; and

(E) $1,950,000 for fiscal year 2000;

(2) to hire, equip, and train Department of Justice attorneys, assistant United States Attorneys, and support staff to prosecute telemarketing fraud cases—

(A) $250,000 for fiscal year 1996;

(B) $500,000 for fiscal year 1997;

(C) $500,000 for fiscal year 1998;

(D) $600,000 for fiscal year 1999; and

(E) $650,000 for fiscal year 2000; and

(3) for the Department of Justice to conduct, in cooperation with State and local law enforcement agencies and senior citizen advocacy organizations, public awareness and prevention initiatives for senior citizens, such as seminars and training—

(A) $1,000,000 for fiscal year 1996;

(B) $2,000,000 for fiscal year 1997;

(C) $2,000,000 for fiscal year 1998;

(D) $2,500,000 for fiscal year 1999; and

(E) $2,500,000 for fiscal year 2000.

SEC. 250006. BROADENING APPLICATION OF MAIL FRAUD STATUTE.

Section 1341 of title 18, United States Code, is amended—

(1) by inserting "or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier," after "Postal Service,"; and

(2) by inserting "or such carrier" after "causes to be delivered by mail".

SEC. 250007. FRAUD AND RELATED ACTIVITY IN CONNECTION WITH ACCESS DEVICES.

Section 1029 of title 18, United States Code, is amended—

(1) in subsection (a)—

(A) by striking "or" at the end of paragraph (3); and

(B) by inserting after paragraph (4) the following new paragraphs:

"(5) knowingly and with intent to defraud effects transactions, with 1 or more access devices issued to another person or persons, to receive payment or any other thing of value during any 1-year period the aggregate value of which is equal to or greater than $1,000;

"(6) without the authorization of the issuer of the access device, knowingly and with intent to defraud solicits a person for the purpose of—

"(A) offering an access device; or

"(B) selling information regarding or an application to obtain an access device; or

"(7) without the authorization of the credit card system member or its agent, knowingly and with intent to defraud causes or arranges for another person to present to the member or its agent, for payment, 1 or more evidences or records of transactions made by an access device;";

(2) in subsection (c)(1) by striking "(a)(2) or (a)(3)" and inserting "(a) (2), (3), (5), (6), or (7)"; and

(3) in subsection (e)—

(A) by striking "and" at the end of paragraph (5);

(B) by striking the period at the end of paragraph (6) and inserting "; and"; and

(C) by adding at the end the following new paragraph:

"(7) the term 'credit card system member' means a financial institution or other entity that is a member of a credit card system, including an entity, whether affiliated with or identical to the credit card issuer, that is the sole member of a credit card system.".

SEC. 250008. INFORMATION NETWORK.

(a) HOTLINE.—The Attorney General shall, subject to the availability of appropriations, establish a national toll-free hotline for the purpose of—

(1) providing general information on telemarketing fraud to interested persons; and

(2) gathering information related to possible violations of this Act.

(b) ACTION ON INFORMATION GATHERED.—The Attorney General shall work in cooperation with the Federal Trade Commission to ensure that information gathered through the hotline shall be acted on in an appropriate manner.

TITLE XXVI—COMMISSION MEMBERSHIP AND APPOINTMENT

SEC. 260001. COMMISSION MEMBERSHIP AND APPOINTMENT.

(a) MEMBERSHIP.—Section 211(B)(f) of Public Law 101–515 (104 Stat. 2123) is amended to read as follows:

"(f) NUMBER AND APPOINTMENT.—

"(1) IN GENERAL.—The Commission shall be composed of 29 members as follows:

"(A) Nine individuals appointed from national law enforcement organizations representing law enforcement officers, of whom—

"(i) two shall be appointed by the Speaker of the House of Representatives;

"(ii) two shall be appointed by the majority leader of the Senate;

"(iii) two shall be appointed by the minority leader of the House of Representatives;

"(iv) two shall be appointed by the minority leader of the Senate; and

"(v) one shall be appointed by the President.

"(B) Nine individuals appointed from national law enforcement organizations representing law enforcement management, of whom—

"(i) two shall be appointed by the Speaker of the House of Representatives;

"(ii) two shall be appointed by the majority leader of the Senate;

"(iii) two shall be appointed by the minority leader of the House of Representatives;

"(iv) two shall be appointed by the minority leader of the Senate; and

"(v) one shall be appointed by the President.

"(C) Two individuals appointed with academic expertise regarding law enforcement issues, of whom—

"(i) one shall be appointed by the Speaker of the House of Representatives and the majority leader of the Senate; and

"(ii) one shall be appointed by the minority leader of the Senate and the minority leader of the House of Representatives.

"(D) Two Members of the House of Representatives, appointed by the Speaker and the minority leader of the House of Representatives.

"(E) Two Members of the Senate, appointed by the majority leader and the minority leader of the Senate.

"(F) One individual from the Department of Justice, appointed by the President.

"(G) Two individuals representing a State or local governmental entity, such as a Governor, mayor, or State attorney general, to be appointed jointly by the majority leader and the minority leader of the Senate.

"(H) Two individuals representing a State or local governmental entity, such as a Governor, mayor, or State attorney general, to be appointed jointly by the Speaker and the minority leader of the House of Representatives.

"(2) COMPTROLLER GENERAL.—The Comptroller General shall serve in an advisory capacity and shall oversee the methodology and approve of the Commission study.

"(3) CHAIRPERSON.—Upon their appointment the members of the Commission shall select one of their number to act as chairperson.

"(4) APPOINTMENT DATE.—Members of the Commission shall be appointed no later than 90 days of the enactment of this Act.".

(b) REPORT.—Section 211(B)(p) of Public Law 101–515 (104 Stat. 2124) is amended by striking "the expiration" and all that follows through "this Act," and inserting "March 31, 1996,".

(c) REIMBURSEMENT.—

(1) Section 211(B)(i) of Public Law 101–515 (104 Stat. 2124) is amended by striking "non-reimbursable" and inserting "a reimbursable".

(2) Section 211(b)(j) of Public Law 101–515 (104 Stat. 2124) is amended by adding after "Commission" the following: ", on a reimbursable basis,".

SEC. 260002. CONFORMING AMENDMENT.

Section 3404(a) of Public Law 101–647 (42 U.S.C. 3721 note) is repealed.

TITLE XXVII—PRESIDENTIAL SUMMIT ON VIOLENCE AND NATIONAL COMMISSION ON CRIME PREVENTION AND CONTROL

SEC. 270001. PRESIDENTIAL SUMMIT.

Congress calls on the President to convene a national summit on violence in America prior to convening the Commission established under this title.

SEC. 270002. ESTABLISHMENT; COMMITTEES AND TASK FORCES; REPRESENTATION.

(a) ESTABLISHMENT AND APPOINTMENT OF MEMBERS.—There is established a commission to be known as the "National Commission on Crime Control and Prevention". The Commission shall be composed of 28 members appointed as follows:

(1) 10 persons by the President, not more than 6 of whom shall be of the same major political party.

(2) 9 persons by the President pro tempore of the Senate, 5 of whom shall be appointed on the recommendation of the Majority Leader of the Senate and the chairman of the Committee on the Judiciary of the Senate, and 4 of whom shall be appointed on the recommendation of the Minority Leader of the Senate and the ranking minority member of the Committee on the Judiciary of the Senate.

(3) 9 persons appointed by the Speaker of the House of Representatives, in consultation with the chairman of the Committee on the Judiciary of the House of Representatives, and 4 of whom shall be appointed on the recommendation of the Minority Leader of the House of Representatives, in consultation with the ranking member of the Committee on the Judiciary.

(b) COMMITTEES AND TASK FORCES.—The Commission shall establish committees or task forces from among its members for the examination of specific subject areas and the carrying out of other functions or responsibilities of the Commission, including committees or task forces for the examination of the subject areas of crime and violence generally, the causes of the demand for drugs, violence in schools, and violence against women, as described in subsections (b) through (e) of section 270004.

(c) REPRESENTATION.—(1) At least 1 member of the Commission appointed by the President, at least 2 members of the Commission appointed by the President pro tempore of the Senate, and at least 2 members of the Commission appointed by the Speaker of the House of Representatives shall be persons well-qualified to participate in the Commission's examination of the subject area of crime and violence generally, with education, training, expertise, or experience in such areas as law enforcement, law, sociology, psychology, social work, and ethnography and urban poverty (including health care, housing, education, and employment).

(2) At least 1 member of the Commission appointed by the President, at least 2 members of the Commission appointed by the President pro tempore of the Senate, and at least 2 members of the Commission appointed by the Speaker of the House of Representatives shall be persons well-qualified to participate in the Commission's examination of the subject area of the causes of the demand for drugs, with education, training, expertise, or experience in such areas as addiction, biomedicine, sociology, psychology, law, and ethnography and urban poverty (including health care, housing, education, and employment).

(3) At least 1 member of the Commission appointed by the President, at least 2 members of the Commission appointed by the President pro tempore of the Senate, and at least 2 members of the Commission appointed by the Speaker of the House of Representatives shall be persons well-qualified to participate in the Commission's examination of the subject area of violence in schools, with education, training, expertise, or experience in such areas as law enforcement, education, school governance policy and teaching, law, sociology, psychology, and ethnography and urban poverty (including health care, housing, education, and employment).

(4) At least 1 member of the Commission appointed by the President, at least 2 members of the Commission appointed by the President pro tempore of the Senate, and at least 2 members of the Commission appointed by the Speaker of the House of Representatives shall be persons well-qualified to participate in the Commission's examination of the subject area of violence against women, as survivors of violence, or as persons with education, training, expertise, or experience in such areas as law enforcement, law, judicial administration, prosecution, defense, victim services or advocacy in sexual assault or domestic violence cases (including medical services and counseling), and protection of victims' rights.

SEC. 270003. PURPOSES.

The purposes of the Commission are as follows:

(1) To develop a comprehensive proposal for preventing and controlling crime and violence in the United States, including cost estimates for implementing any recommendations made by the Commission.

(2) To bring attention to successful models and programs in crime prevention and crime control.

(3) To reach out beyond the traditional criminal justice community for ideas for controlling and preventing crime.

(4) To recommend improvements in the coordination of local, State, Federal, and international crime control and prevention efforts, including efforts relating to crime near international borders.

(5) To make a comprehensive study of the economic and social factors leading to or contributing to crime and violence, including the causes of illicit drug use and other substance abuse, and to develop specific proposals for legislative and administrative actions to reduce crime and violence and the factors that contribute to it.

(6) To recommend means of utilizing criminal justice resources as effectively as possible, including targeting finite correctional facility space to the most serious and violent offenders, and considering increased use of intermediate sanctions for offenders who can be dealt with adequately by such means.

(7) To examine distinctive crime problems and the impact of crime on members of minority groups, Indians living on reservations, and other groups defined by race, ethnicity, religion, age, disability, or other characteristics, and to recommend specific responses to the distinctive crime problems of such groups.

(8) To examine the problem of sexual assaults, domestic violence, and other criminal and unlawful acts that particularly affect women, and to recommend Federal, State, and local strategies for more effectively preventing and punishing such crimes and acts.

(9) To examine the treatment of victims in Federal, State, and local criminal justice systems, and to develop recommendations to enhance and protect the rights of victims.

(10) To examine the ability of Federal, State, and local criminal justice systems to administer criminal law and criminal sanctions impartially without discrimination on the basis of race, ethnicity, religion, gender, or other legally proscribed grounds, and to make recommendations for correcting any deficiencies in the impartial administration of justice on these grounds.

(11) To examine the nature, scope, causes, and complexities of violence in schools and to recommend a comprehensive response to that problem.

SEC. 270004. RESPONSIBILITIES OF THE COMMISSION.

(a) IN GENERAL.—The responsibilities of the Commission shall include such study and consultation as may be necessary or appropriate to carry out the purposes set forth in section 270003, including the specific measures described in subsections (b) through (e) in relation to the subject areas addressed in those subsections.

(b) CRIME AND VIOLENCE GENERALLY.—In addressing the subject of crime and violence generally, the activities of the Commission shall include the following:

(1) Reviewing the effectiveness of traditional criminal justice approaches in preventing and controlling crime and violence.

(2) Examining the impact that changes in Federal and State law have had in controlling crime and violence.

(3) Examining the impact of changes in Federal immigration laws and policies and increased development and growth along United States international borders on crime and violence in the United States, particularly among the Nation's youth.

(4) Examining the problem of youth gangs and providing recommendations as to how to reduce youth involvement in violent crime.

(5) Examining the extent to which the use of dangerous weapons in the commission of crime has contributed to violence and murder in the United States.

(6) Convening field hearings in various regions of the country to receive testimony from a cross section of criminal justice professionals, business leaders, elected officials, medical doctors, and other persons who wish to participate.

(7) Reviewing all segments of the Nation's criminal justice systems, including the law enforcement, prosecution, defense, judicial, and corrections components in developing the crime control and prevention proposal.

(c) CAUSES OF THE DEMAND FOR DRUGS.—In addressing the subject of the causes of the demand for drugs, the activities of the Commission shall include the following:

(1) Examining the root causes of illicit drug use and abuse in the United States, including by compiling existing research regarding those root causes, and including consideration of the following factors:

(A) The characteristics of potential illicit drug users and abusers or drug traffickers, including age and social, economic, and educational backgrounds.

(B) Environmental factors that contribute to illicit drug use and abuse, including the correlation between unemployment, poverty, and homelessness and drug experimentation and abuse.

(C) The effects of substance use and abuse by a relative or friend in contributing to the likelihood and desire of an individual to experiment with illicit drugs.

(D) Aspects of, and changes in cultural values, attitudes and traditions that contribute to illicit drug use and abuse.

(E) The physiological and psychological factors that contribute to the desire for illicit drugs.

(2) Evaluating Federal, State, and local laws and policies on the prevention of drug abuse, control of unlawful production, distribution and use of controlled substances, and the efficacy of sentencing policies with regard to those laws.

(3) Analyzing the allocation of resources among interdiction of controlled substances entering the United States, enforcement of Federal laws relating to the unlawful production, distribution, and use of controlled substances, education with regard to and the prevention of the unlawful use of controlled substances, and treatment and rehabilitation of drug abusers.

(4) Analyzing current treatment and rehabilitation methods and making recommendations for improvements.

(5) Identifying any existing gaps in drug abuse policy that result from the lack of attention to the root causes of drug abuse.

(6) Assessing the needs of government at all levels for resources and policies for reducing the overall desire of individuals to experiment with and abuse illicit drugs.

(7) Making recommendations regarding necessary improvements in policies for reducing the use of illicit drugs in the United States.

(d) VIOLENCE IN SCHOOLS.—In addressing the subject of violence in schools, the activities of the Commission shall include the following:

(1) Defining the causes of violence in schools.

(2) Defining the scope of the national problem of violence in schools.

(3) Providing statistics and data on the problem of violence in schools on a State-by-State basis.

(4) Investigating the problem of youth gangs and their relation to violence in schools and providing recommendations on how to reduce youth involvement in violent crime in schools.

(5) Examining the extent to which dangerous weapons have contributed to violence and murder in schools.

(6) Exploring the extent to which the school environment has contributed to violence in schools.

(7) Reviewing the effectiveness of current approaches in preventing violence in schools.

(e) VIOLENCE AGAINST WOMEN.—In addressing the subject of sexual assault, domestic violence, and other criminal and unlawful acts that particularly affect women, the activities of the Commission shall include the following:

(1) Evaluating the adequacy of, and making recommendations regarding, current law enforcement efforts at the Federal, State, and local levels to reduce the incidence of such crimes and acts, and to punish those responsible for such crimes and acts.

(2) Evaluating the adequacy of, and making recommendations regarding, the responsiveness of prosecutors and courts to such crimes and acts.

(3) Evaluating the adequacy of rules of evidence, practice, and procedure to ensure the effective prosecution and conviction of perpetrators of such crimes and acts and to protect victims of such crimes and acts from abuse in legal proceedings, making recommendations, where necessary, to improve those rules.

(4) Evaluating the adequacy of pretrial release. sentencing, incarceration, and post-conviction release in relation to such crimes and acts.

(5) Evaluating the adequacy of, and making recommendations regarding, the adequacy of Federal and State laws on sexual assault and the need for a more uniform statutory response to sex offenses, including sexual assaults and other sex offenses committed by offenders who are known or related by blood or marriage to the victim.

(6) Evaluating the adequacy of, and making recommendations regarding, the adequacy of Federal and State laws on domestic violence and the need for a more uniform statutory response to domestic violence.

(7) Evaluating the adequacy of, and making recommendations regarding, the adequacy of current education, prevention, and protective services for victims of such crimes and acts.

(8) Assessing the issuance, formulation, and enforcement of protective orders, whether or not related to a criminal proceeding, and making recommendations for their more effective use in domestic violence and stalking cases.

(9) Assessing the problem of stalking and recommending effective means of response to the problem.

(10) Evaluating the adequacy of, and making recommendations regarding, programs for public awareness and public dissemination of information to prevent such crimes and acts.

(11) Evaluating the treatment of victims of such crimes and acts in Federal, State, and local criminal justice systems, and making recommendations designed to improve such treatment.

SEC. 270005. ADMINISTRATIVE MATTERS.

(a) CHAIR.—The President shall designate a member of the Commission to chair the Commission.

(b) NO ADDITIONAL PAY OR BENEFITS; PER DIEM.—Members of the Commission shall receive no pay or benefits by reason of their service on the Commission, but shall receive travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under sections 5702 and 5703 of title 5, United States Code.

(c) VACANCIES.—Vacancies on the Commission shall be filled in the same manner as initial appointments.

(d) MEETINGS OPEN TO THE PUBLIC.—The Commission shall be considered to be an agency for the purposes of section 552b of title 5, United States Code, relating to the requirement that meetings of Federal agencies be open to the public.

SEC. 270006. STAFF AND SUPPORT SERVICES.

(a) DIRECTOR.—With the approval of the Commission, the chairperson shall appoint a staff director for the Commission.

(b) STAFF.—With the approval of the Commission, the staff director may appoint and fix the compensation of staff personnel for the Commission.

(c) CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Staff compensation may be set without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates, but in no event shall any such personnel be compensated at a rate greater than the rate of basic pay for level ES-4 of the Senior Executive Service Schedule under section 5382 of that title. The staff director shall be paid at a rate not to exceed the rate of basic pay for level V of the Executive Schedule.

(d) CONSULTANTS.—With the approval of the Commission, the staff director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(e) STAFF OF FEDERAL AGENCIES.—Upon the request of the Commission, the head of any Federal agency may detail, on a reimbursable basis, personnel of that agency to the Commission to assist in carrying out its duties.

(f) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall provide suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for proper functioning.

SEC. 270007. POWERS.

(a) HEARINGS.—For the purposes of carrying out this title, the Commission may conduct such hearings, sit and act at such times and places, take such testimony, and receive such evidence, as the Commission considers appropriate. The Commission may administer oaths before the Commission.

(b) DELEGATION.—Any committee, task force, member, or agent, of the Commission may, if authorized by the Commission, take any action that the Commission is authorized to take under this title.

(c) ACCESS TO INFORMATION.—The Commission may request directly from any Federal agency or entity in the executive or legislative branch such information as is needed to carry out its functions.

(d) MAIL.—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

SEC. 270008. REPORT; TERMINATION.

Not later than 2 years after the date on which the Commission is fully constituted under section 270001, the Commission shall submit a detailed report to the Congress and the President containing its findings and recommendations. The Commission shall terminate 30 days after the submission of its report.

SEC. 270009. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this title—

(1) $1,000,000 for fiscal year 1996.

TITLE XXVIII—SENTENCING PROVISIONS

SEC. 280001. IMPOSITION OF SENTENCE.

Section 3553(a)(4) of title 18, United States Code, is amended to read as follows:

"(4) the kinds of sentence and the sentencing range established for—

"(A) the applicable category of offense committed by the applicable category of defendant as set forth in the guidelines issued by the Sentencing Commission pursuant to section 994(a)(1) of title 28, United States Code, and that are in effect on the date the defendant is sentenced; or

"(B) in the case of a violation of probation or supervised release, the applicable guidelines or policy statements issued by the Sentencing Commission pursuant to section 994(a)(3) of title 28, United States Code;".

SEC. 280002. TECHNICAL AMENDMENT TO MANDATORY CONDITIONS OF PROBATION.

Section 3563(a)(3) of title 18, United States Code, is amended by striking "possess illegal controlled substances" and inserting "unlawfully possess a controlled substance".

SEC. 280003. DIRECTION TO UNITED STATES SENTENCING COMMISSION REGARDING SENTENCING ENHANCEMENTS FOR HATE CRIMES.

(a) DEFINITION.—In this section, "hate crime" means a crime in which the defendant intentionally selects a victim, or in the case of a property crime, the property that is the object of the crime, because of the actual or perceived race, color, religion, national origin, ethnicity, gender, disability, or sexual orientation of any person.

(b) SENTENCING ENHANCEMENT.—Pursuant to section 994 of title 28, United States Code, the United States Sentencing Commission shall promulgate guidelines or amend existing guidelines to provide sentencing enhancements of not less than 3 offense levels for offenses that the finder of fact at trial determines beyond a reasonable doubt are hate crimes. In carrying out this section, the United States Sentencing Commission shall ensure that there is reasonable consistency with other guidelines, avoid duplicative punishments for substantially the same offense, and take into account any mitigating circumstances that might justify exceptions.

SEC. 280004. AUTHORIZATION OF PROBATION FOR PETTY OFFENSES IN CERTAIN CASES.

Section 3561(a)(3) of title 18, United States Code, is amended by inserting "that is not a petty offense" before the period.

SEC. 280005. FULL-TIME VICE CHAIRS OF THE UNITED STATES SENTENCING COMMISSION.

(a) ESTABLISHMENT OF POSITIONS.—Section 991(a) of title 28, United States Code, is amended—

(1) in the second sentence by striking the period and inserting "and two of whom shall be designated by the President as Vice Chairs.";

(2) in the fourth sentence by striking the period and inserting ", and of the Chair and the two Vice Chairs, no more than two shall be members of the same political party."; and

(3) in the sixth sentence by striking "Chairman" and inserting "Chair, Vice Chairs,".

(b) TERMS AND COMPENSATION.—Section 992(c) of title 28, United States Code, is amended—

(1) by amending the first sentence to read as follows: "The Chair and Vice Chairs of the Commission shall hold full-time positions and shall be compensated during their terms of office at the annual rate at which judges of the United States courts of appeals are compensated.";

(2) in the second sentence by striking "Chairman" and inserting "Chair and Vice Chairs"; and

(3) in the third sentence by striking "Chairman" and inserting "Chair and Vice Chairs,".

(c) TECHNICAL AMENDMENTS.—Chapter 58 of title 28, United States Code, is amended—

(1) by striking "Chairman" each place it appears and inserting "Chair";

(2) in the fifth sentence of section 991(a) by striking "his" and inserting "the Attorney General's";

(3) in the fourth sentence of section 992(c) by striking "his" and inserting "the judge's";

(4) in section 994(i)(2) by striking "he" and inserting "the defendant" and striking "his" and inserting "the defendant's"; and

(5) in section 996(a) by striking "him" and inserting "the Staff Director".

SEC. 280006. COCAINE PENALTY STUDY.

Not later than December 31, 1994, the United States Sentencing Commission shall submit a report to Congress on issues relating to sentences applicable to offenses involving the possession or distribution of all forms of cocaine. The report shall address the differences in penalty levels that apply to different forms of cocaine and include any recommendations that the Commission may have for retention or modification of such differences in penalty levels.

TITLE XXIX—COMPUTER CRIME

SEC. 290001. COMPUTER ABUSE AMENDMENTS ACT OF 1994.

(a) SHORT TITLE.—This subtitle may be cited as the "Computer Abuse Amendments Act of 1994".

(b) PROHIBITION.—Section 1030(a)(5) of title 18, United States Code, is amended to read as follows:

"(5)(A) through means of a computer used in interstate commerce or communications, knowingly causes the transmission of a program, information, code, or command to a computer or computer system if—

"(i) the person causing the transmission intends that such transmission will—

"(I) damage, or cause damage to, a computer, computer system, network, information, data, or program; or

"(II) withhold or deny, or cause the withholding or denial, of the use of a computer, computer services, system or network, information, data or program; and

"(ii) the transmission of the harmful component of the program, information, code, or command—

"(I) occurred without the authorization of the persons or entities who own or are responsible for the computer system receiving the program, information, code, or command; and

"(II)(aa) causes loss or damage to one or more other persons of value aggregating $1,000 or more during any 1-year period; or

"(bb) modifies or impairs, or potentially modifies or impairs, the medical examination, medical diagnosis, medical treatment, or medical care of one or more individuals; or

"(B) through means of a computer used in interstate commerce or communication, knowingly causes the transmission of a program, information, code, or command to a computer or computer system—

"(i) with reckless disregard of a substantial and unjustifiable risk that the transmission will—

"(I) damage, or cause damage to, a computer, computer system, network, information, data or program; or

"(II) withhold or deny or cause the withholding or denial of the use of a computer, computer services, system, network, information, data or program; and

"(ii) if the transmission of the harmful component of the program, information, code, or command—

"(I) occurred without the authorization of the persons or entities who own or are responsible for the computer system receiving the program, information, code, or command; and

"(II)(aa) causes loss or damage to one or more other persons of a value aggregating $1,000 or more during any 1-year period; or

"(bb) modifies or impairs, or potentially modifies or impairs, the medical examination, medical diagnosis, medical treatment, or medical care of one or more individuals;".

(c) PENALTY.—Section 1030(c) of title 18, United States Code is amended—

(1) in paragraph (2)(B) by striking "and" after the semicolon;

(2) in paragraph (3)(A) by inserting "(A)" after "(a)(5)";

(3) in paragraph (3)(B) by striking the period at the end thereof and inserting "; and"; and

(4) by adding at the end the following new paragraph:

"(4) a fine under this title or imprisonment for not more than 1 year, or both, in the case of an offense under subsection (a)(5)(B).".

(d) CIVIL ACTION.—Section 1030 of title 18, United States Code, is amended by adding at the end thereof the following new subsection:

"(g) Any person who suffers damage or loss by reason of a violation of the section, other than a violation of subsection (a)(5)(B), may maintain a civil action against the violator to obtain compensatory damages and injunctive relief or other equitable relief. Damages for violations of any subsection other than subsection (a)(5)(A)(ii)(II)(bb) or (a)(5)(B)(ii)(II)(bb) are limited to economic damages. No action may be brought under this subsection unless such action is begun within 2 years of the date of the act complained of or the date of the discovery of the damage.".

(e) REPORTING REQUIREMENTS.—Section 1030 of title 18 United States Code, is amended by adding at the end the following new subsection:

"(h) The Attorney General and the Secretary of the Treasury shall report to the Congress annually, during the first 3 years following the date of the enactment of this subsection, concerning investigations and prosecutions under section 1030(a)(5) of title 18, United States Code.".

(f) PROHIBITION.—Section 1030(a)(3) of title 18, United States Code, is amended by inserting "adversely" before "affects the use of the Government's operation of such computer".

TITLE XXX—PROTECTION OF PRIVACY OF INFORMATION IN STATE MOTOR VEHICLE RECORDS

SEC. 300001. SHORT TITLE.

This title may be cited as the "Driver's Privacy Protection Act of 1994".

SEC. 300002. PROHIBITION ON RELEASE AND USE OF CERTAIN PERSONAL INFORMATION FROM STATE MOTOR VEHICLE RECORDS.

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 121 the following new chapter:

"CHAPTER 123—PROHIBITION ON RELEASE AND USE OF CERTAIN PERSONAL INFORMATION FROM STATE MOTOR VEHICLE RECORDS

"§2721. Prohibition on release and use of certain personal information from State motor vehicle records

"(a) IN GENERAL.—Except as provided in subsection (b), a State department of motor vehicles, and any officer, employee, or contractor, thereof, shall not knowingly disclose or otherwise make available to any person or entity personal information about any individual obtained by the department in connection with a motor vehicle record.

"(b) PERMISSIBLE USES.—Personal information referred to in subsection (a) shall be disclosed for use in connection with matters of motor vehicle or driver safety and theft, motor vehicle emissions, motor vehicle product alterations, recalls, or advisories, performance monitoring of motor vehicles and dealers by motor vehicle manufacturers, and removal of non-owner records from the original owner records of motor vehicle manufacturers to carry out the purposes of the Automobile Information Disclosure Act, the Motor Vehicle Information and Cost Saving Act, the National Traffic and Motor Vehicle Safety Act of 1966, the Anti-Car Theft Act of 1992, and the Clean Air Act, and may be disclosed as follows:

"(1) For use by any government agency, including any court or law enforcement agency, in carrying out its functions, or any private person or entity acting on behalf of a Federal, State, or local agency in carrying out its functions.

"(2) For use in connection with matters of motor vehicle or driver safety and theft; motor vehicle emissions; motor vehicle product alterations, recalls, or advisories; performance monitoring of motor vehicles, motor vehicle parts and dealers; motor vehicle market research activities, including survey research; and removal of non-owner records from the original owner records of motor vehicle manufacturers.

"(3) For use in the normal course of business by a legitimate business or its agents, employees, or contractors, but only—

"(A) to verify the accuracy of personal information submitted by the individual to the business or its agents, employees, or contractors; and

"(B) if such information as so submitted is not correct or is no longer correct, to obtain the correct information, but only for the purposes of preventing fraud by, pursuing legal remedies against, or recovering on a debt or security interest against, the individual.

"(4) For use in connection with any civil, criminal, administrative, or arbitral proceeding in any Federal, State, or local court or agency or before any self-regulatory body, including the service of process, investigation in anticipation of litigation, and the execution or enforcement of judgments and orders, or pursuant to an order of a Federal, State, or local court.

"(5) For use in research activities, and for use in producing statistical reports, so long as the personal information is not published, redisclosed, or used to contact individuals.

"(6) For use by any insurer or insurance support organization, or by a self-insured entity, or its agents, employees, or contractors, in connection with claims investigation activities, antifraud activities, rating or underwriting.

"(7) For use in providing notice to the owners of towed or impounded vehicles.

"(8) For use by any licensed private investigative agency or licensed security service for any purpose permitted under this subsection.

"(9) For use by an employer or its agent or insurer to obtain or verify information relating to a holder of a commercial driver's license that is required under the Commercial Motor Vehicle Safety Act of 1986 (49 U.S.C. App. 2710 et seq.).

"(10) For use in connection with the operation of private toll transportation facilities.

"(11) For any other use in response to requests for individual motor vehicle records if the motor vehicle department has provided in a clear and conspicuous manner on forms for issuance or renewal of operator's permits, titles, registrations, or identification cards, notice that personal information collected by the department may be disclosed to any business or person, and has provided in a clear and conspicuous manner on such forms an opportunity to prohibit such disclosures.

"(12) For bulk distribution for surveys, marketing or solicitations if the motor vehicle department has implemented methods and procedures to ensure that—

"(A) individuals are provided an opportunity, in a clear and conspicuous manner, to prohibit such uses; and

"(B) the information will be used, rented, or sold solely for bulk distribution for surveys, marketing, and solicitations, and that surveys, marketing, and solicitations will not be directed at those individuals who have requested in a timely fashion that they not be directed at them.

"(13) For use by any requester, if the requester demonstrates it has obtained the written consent of the individual to whom the information pertains.

"(14) For any other use specifically authorized under the law of the State that holds the record, if such use is related to the operation of a motor vehicle or public safety.

"(c) RESALE OR REDISCLOSURE.—An authorized recipient of personal information (except a recipient under subsection (b)(11) or (12)) may resell or redisclose the information only for a use permitted under subsection (b) (but not for uses under subsection (b) (11) or (12)). An authorized recipient under subsection (b)(11) may resell or redisclose personal information for any purpose. An authorized recipient under subsection (b)(12) may resell or redisclose personal information pursuant to subsection (b)(12). Any authorized recipient (except a recipient under subsection (b) (11)) that resells or rediscloses personal information covered by this title must keep for a period of 5 years records identifying each person or entity that receives information and the permitted purpose for which the information will be used and must make such records available to the motor vehicle department upon request.

"(d) WAIVER PROCEDURES.—A State motor vehicle department may establish and carry out procedures under which the department or its agents, upon receiving a request for personal information that does not fall within one of the exceptions in subsection (b), may mail a copy of the request to the individual about whom the information was requested, informing such individual of the request, together with a statement to the effect that the information will not be released unless the individual waives such individual's right to privacy under this section.

"§2722. Additional unlawful acts

"(a) PROCUREMENT FOR UNLAWFUL PURPOSE.—It shall be unlawful for any person knowingly to obtain or disclose personal information, from a motor vehicle record, for any use not permitted under section 2721(b) of this title.

"(b) FALSE REPRESENTATION.—It shall be unlawful for any person to make false representation to obtain any personal information from an individual's motor vehicle record.

"§2723. Penalties

"(a) CRIMINAL FINE.—A person who knowingly violates this chapter shall be fined under this title.

"(b) VIOLATIONS BY STATE DEPARTMENT OF MOTOR VEHICLES.—Any State department of motor vehicles that has a policy or practice of substantial noncompliance with this chapter shall be subject to a civil penalty imposed by the Attorney General of not more than $5,000 a day for each day of substantial noncompliance.

"§2724. Civil action

"(a) CAUSE OF ACTION.—A person who knowingly obtains, discloses or uses personal information, from a motor vehicle record, for a purpose not permitted under this chapter shall be liable to the individual to whom the information pertains, who may bring a civil action in a United States district court.

"(b) REMEDIES.—The court may award—

"(1) actual damages, but not less than liquidated damages in the amount of $2,500;

"(2) punitive damages upon proof of willful or reckless disregard of the law;

"(3) reasonable attorneys' fees and other litigation costs reasonably incurred; and

"(4) such other preliminary and equitable relief as the court determines to be appropriate.

"§2725. Definitions

"In this chapter—

"(1) 'motor vehicle record' means any record that pertains to a motor vehicle operator's permit, motor vehicle title, motor vehicle registration, or identification card issued by a department of motor vehicles;

"(2) 'person' means an individual, organization or entity, but does not include a State or agency thereof; and

"(3) 'personal information' means information that identifies an individual, including an individual's photograph, social security number, driver identification number, name, address (but not the 5-digit zip code), telephone number, and medical or disability information, but does not include information on vehicular accidents, driving violations, and driver's status.".

(b) CLERICAL AMENDMENT.—The table of parts at the beginning of part I of title 18, United States Code, is amended by adding at the end the following new item:

"123. Prohibition on release and use of
certain personal information from
State motor vehicle records .... 2271"

SEC. 300003. EFFECTIVE DATE.

The amendments made by section 300002 shall become effective on the date that is 3 years after the date of enactment of this Act. After the effective date, if a State has implemented a procedure under section 2721(b) (11) and (12) of title 18, United States Code, as added by section 2902, for prohibiting disclosures or uses of personal information, and the procedure otherwise meets the requirements of subsection (b) (11) and (12), the State shall be in compliance with subsection (b) (11) and (12) even if the procedure is not available to individuals until they renew their license, title, registration or identification card, so long as the State provides some other procedure for individuals to contact the State on their own initiative to prohibit such uses or disclosures. Prior to the effective date, personal information covered by the amendment made by section 300002 may be released consistent with State law or practice.

TITLE XXXI—VIOLENT CRIME REDUCTION TRUST FUND

SEC. 310001. CREATION OF VIOLENT CRIME REDUCTION TRUST FUND.

(a) VIOLENT CRIME REDUCTION TRUST FUND.—There is established a separate account in the Treasury, known as the "Violent Crime Reduction Trust Fund" (referred to in this section as the "Fund") into which shall be transferred, in accordance with subsection (b), savings realized from implementation of section 5 of the Federal Workforce Restructuring Act of 1994 (5 U.S.C. 3101 note; Public Law 103–226).

(b) TRANSFERS INTO THE FUND.—On the first day of the following fiscal years (or as soon thereafter as possible for fiscal year 1995), the following amounts shall be transferred from the general fund to the Fund—

(1) for fiscal year 1995, $2,423,000,000;

(2) for fiscal year 1996, $4,287,000,000;

(3) for fiscal year 1997, $5,000,000,000;

(4) for fiscal year 1998, $5,500,000,000;

(5) for fiscal year 1999, $6,500,000,000; and

(6) for fiscal year 2000, $6,500,000,000.

(c) APPROPRIATIONS FROM THE FUND.—(1) Amounts in the Fund may be appropriated exclusively for the purposes authorized in this Act and for those expenses authorized by any Act enacted before this Act that are expressly qualified for expenditure from the Fund.

(2) Amounts appropriated under paragraph (1) and outlays flowing from such appropriations shall not be taken into account for purposes of any budget enforcement procedures under the Balanced Budget and Emergency Deficit Control Act of 1985 except section 251A of that Act as added by subsection (g), or for purposes of section 605(b) of the Congressional Budget Act of 1974. Amounts of new budget authority and outlays under paragraph (1) that are included in concurrent resolutions on the budget shall not be taken into account for purposes of sections 601(b), 606(b), and 606(c) of the Congressional Budget Act of 1974, or for purposes of section 24 of House Concurrent Resolution 218 (One Hundred Third Congress).

(d) LISTING OF THE FUND AMONG GOVERNMENT TRUST FUNDS.—Section 1321(a) of title 31, United States Code, is amended by inserting at the end the following new paragraph:

"(91) Violent Crime Reduction Trust Fund.".

(e) REQUIREMENT FOR THE PRESIDENT TO REPORT ANNUALLY ON THE STATUS OF THE TRUST FUND.—Section 1105(a) of title 31, United States Code, is amended by adding at the end the following new paragraphs:

"(30) information about the Violent Crime Reduction Trust Fund, including a separate statement of amounts in that Trust Fund.

"(31) an analysis displaying, by agency, proposed reductions in full-time equivalent positions compared to the current year's level in order to comply with section 5 of the Federal Workforce Restructuring Act of 1994.".

(f) ALLOCATION AND SUBALLOCATION OF AMOUNTS IN THE FUND.—

(1) IN GENERAL.—Section 602(a) of the Congressional Budget Act of 1974 is amended—

(A) in paragraph (1)(A) by striking "and" at the end of clause (ii), by striking the semicolon and inserting a comma at the end of clause (iii), and by adding after clause (iii) the following:

"(iv) new budget authority from the Violent Crime Reduction Trust Fund, and

"(v) outlays from the Violent Crime Reduction Trust Fund;";

(B) in paragraph (2) by striking "and" at the end of subparagraph (B) and by adding after subparagraph (C) the following:

"(D) new budget authority from the Violent Crime Reduction Trust Fund; and

"(E) outlays from the Violent Crime Reduction Trust Fund;"; and

(C) by adding at the end the following new paragraph:

"(4) NO DOUBLE COUNTING.—Amounts allocated among committees under clause (iv) or (v) of paragraph (1)(A) or under subparagraph (D) or (E) of paragraph (2) shall not be included within any other allocation under that paragraph.".

(2) FISCAL YEAR 1995.—The chairman of the Committee on the Budget shall submit to the House of Representatives or the Senate, as the case may be, appropriately revised allocations under clauses (iv) and (v) of paragraph (1)(A) or subparagraphs (D) and (E) of paragraph (2) of section 602(a) of the Congressional Budget Act of 1974 for fiscal year 1995 to carry out subsection (b)(1).

(g) VIOLENT CRIME REDUCTION TRUST FUND SEQUESTRATION.—

(1) SEQUESTRATION.—Part C of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by adding after section 251 the following new section:

"SEC. 251A. SEQUESTRATION WITH RESPECT TO VIOLENT CRIME REDUCTION TRUST FUND.

"(a) SEQUESTRATION.—Within 15 days after Congress adjourns to end a session, there shall be a sequestration to eliminate any budgetary excess in the Violent Crime Reduction Trust Fund as described in subsection (b).

"(b) ELIMINATING A BUDGETARY EXCESS.—

"(1) IN GENERAL.—Except as provided by paragraph (2), appropriations from the Violent Crime Reduction Trust Fund shall be reduced by a uniform percentage necessary to eliminate any amount by which estimated outlays in the budget year from the Fund exceed the following levels of outlays:

"(A) For fiscal year 1995, $703,000,000.
"(B) For fiscal year 1996, $2,334,000,000.
"(C) For fiscal year 1997, $3,936,000,000.
"(D) For fiscal year 1998, $4,904,000,000.

For fiscal year 1999, the comparable level for budgetary purposes shall be deemed to be $5,639,000,000. For fiscal year 2000, the comparable level for budgetary purposes shall be deemed to be $6,225,000,000.

"(2) SPECIAL OUTLAY ALLOWANCE.—If estimated outlays from the Fund for a fiscal year exceed the level specified in paragraph (1) for that year, that level shall be increased by the lesser of that excess or 0.5 percent of that level.

"(c) LOOK-BACK.—If, after June 30, an appropriation for the fiscal year in progress is enacted that causes a budgetary excess in the Violent Crime Reduction Trust Fund as described in subsection (b) for that year (after taking into account any sequestration of amounts under this section), the level set forth in subsection (b) for the next fiscal year shall be reduced by the amount of that excess.

"(d) WITHIN-SESSION SEQUESTRATION.—If an appropriation for a fiscal year in progress is enacted (after Congress adjourns to end the session for the budget year and before July 1 of that fiscal year) that causes a budgetary excess in the Violent Crime Reduction Trust Fund as described in subsection (b) for that year (after taking into account any prior sequestration of amounts under this section), 15 days later there shall be a sequestration to eliminate that excess following the procedures set forth in subsection (b).

"(e) PART-YEAR APPROPRIATIONS AND OMB ESTIMATES.—Paragraphs (4) and (7) of section 251(a) shall apply to appropriations from, and sequestration of amounts appropriated from, the Violent Crime Reduction Trust Fund under this section in the same manner as those paragraphs apply to discretionary appropriations and sequestrations under that section.".

(2) REPORTS.—Section 254(g) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively, and by inserting after paragraph (3) the following new paragraph:

"(4) REPORTS ON SEQUESTRATION TO REDUCE THE VIOLENT CRIME REDUCTION TRUST FUND.—The final reports shall set forth for the budget year estimates for each of the following:

"(A) The amount of budget authority appropriated from the Violent Crime Reduction Trust Fund and outlays resulting from those appropriations.

"(B) The sequestration percentage and reductions, if any, required under section 251A.".

SEC. 310002. CONFORMING REDUCTION IN DISCRETIONARY SPENDING LIMITS.

Upon enactment of this Act, the discretionary spending limits set forth in section 601(a)(2) of the Congressional Budget Act of 1974 (2 U.S.C. 665(a)(2)) (as adjusted in conformance with section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985, and in the Senate, with section 24 of House Concurrent Resolution 218 (103d Congress)) for fiscal years 1995 through 1998 are reduced as follows:

(1) for fiscal year 1995, for the discretionary category: $2,423,000,000 in new budget authority and $703,000,000 in outlays;

(2) for fiscal year 1996, for the discretionary category: $4,287,000,000 in new budget authority and $2,334,000,000 in outlays;

(3) for fiscal year 1997, for the discretionary category: $5,000,000,000 in new budget authority and $3,936,000,000 in outlays; and

(4) for fiscal year 1998, for the discretionary category: $5,500,000,000 in new budget authority and $4,904,000,000 in outlays.

For fiscal year 1999, the comparable amount for budgetary purposes shall be deemed to be $6,500,000,000 in new budget authority and $5,639,000,000 in outlays. For fiscal year 2000, the comparable amount for budgetary purposes shall be deemed to be $6,500,000,000 in new budget authority and $6,225,000,000 in outlays.

SEC. 310003. EXTENSION OF AUTHORIZATIONS OF APPROPRIATIONS FOR FISCAL YEARS FOR WHICH THE FULL AMOUNT AUTHORIZED IS NOT APPROPRIATED.

If, in making an appropriation under any provision of this Act or amendment made by this Act that authorizes the making of an appropriation for a certain purpose for a certain fiscal year in a certain amount, the Congress makes an appropriation for that purpose for that fiscal year in a lesser amount, that provision or amendment shall be considered to authorize the making of appropriations for that purpose for later fiscal years in an amount equal to the difference between the amount authorized to be appropriated and the amount that has been appropriated.

SEC. 310004. FLEXIBILITY IN MAKING OF APPROPRIATIONS.

(a) FEDERAL LAW ENFORCEMENT.—In the making of appropriations under any provision of this Act or amendment made by this Act that authorizes the making of an appropriation for a Federal law enforcement program for a certain fiscal year in a certain amount out of the Violent Crime Reduction Trust Fund, not to exceed 10 percent of that amount is authorized to be appropriated for that fiscal year for any other Federal law enforcement program for which appropriations are authorized by any other Federal law enforcement provision of this Act or amendment made by this Act. The aggregate reduction in the authorization for any particular Federal law enforcement program may not exceed 10 percent of the total amount authorized to be appropriated from the Violent Crime Reduction Trust Fund for that program in this Act or amendment made by this Act.

(b) STATE AND LOCAL LAW ENFORCEMENT.—In the making of appropriations under any provision of this Act or amendment made by this Act that authorizes the making of an appropriation for a State and local law enforcement program for a certain fiscal year in a certain amount out of the Violent Crime Reduction Trust Fund, not to exceed 10 percent of that amount is authorized to be appropriated for that fiscal year for any other State and local law enforcement program for which appropriations are authorized by any other State and local law enforcement provision of this Act or amendment made by this Act. The aggregate reduction in the authorization for any particular State and local law enforcement program may not exceed 10 percent of the total amount authorized to be appropriated from the Violent Crime Reduction Trust Fund for that program in this Act or amendment made by this Act.

(c) PREVENTION.—In the making of appropriations under any provision of this Act or amendment made by this Act that authorizes the making of an appropriation for a prevention program for a certain fiscal year in a certain amount out of the Violent Crime Reduction Trust Fund, not to exceed 10 percent of that amount is authorized to be appropriated for that fiscal year for any other prevention program for which appropriations are authorized by any other prevention provision of this Act or amendment made by this Act. The aggregate reduction in the authorization for any particular prevention program may not exceed 10 program of the total amount authorized to be appropriated from the Violent Crime Reduction Trust Fund for that program in this Act or amendment made by this Act.

(d) DEFINITIONS.—In this section—"Federal law enforcement program" means a program authorized in any of the following sections:

(1) section 190001(a);
(2) section 190001(b);
(3) section 190001(c);
(4) section 190001(d);
(5) section 190001(e);
(6) section 320925;
(7) section 150008;
(8) section 220002;
(9) section 130002;
(10) section 130005;
(11) section 130006
(12) section 130007
(13) section 250005;
(14) sections 210303–210306;
(15) section 180104; and
(16) section 270009.

"State and local law enforcement program" means a program authorized in any of the following sections:

(1) sections 10001–10003;
(2) section 210201;
(3) section 210603;
(4) section 180101;
(5) section 180103;
(6) sections 31701–31708;
(7) section 210602;
(8) sections 30801–30802;
(9) section 210302;
(10) section 210501;
(11) section 210101;
(12) section 320903;
(13) sections 20101–20109;
(14) section 20301;
(15) section 32201; and
(16) section 20201.

"prevention program" means a program authorized in any of the following sections:

(1) section 50001;
(2) sections 30101–30104;
(3) section 30201;
(4) sections 30301–30307;
(5) sections 30401–30403;
(6) sections 30501–30505;
(7) section 30601;
(8) sections 30701–30702;
(9) sections 30901–30906;
(10) sections 31001–31002;
(11) sections 31101–31133;
(12) sections 31201–31207;
(13) section 31301;
(14) sections 31401–31405;
(15) sections 31501–31505;
(16) sections 31601–31603;
(17) sections 31801–31808;
(18) sections 31901–31922;
(19) section 32001;
(20) section 32101;
(21) sections 32301–32307;
(22) section 32401;
(23) section 40114;
(24) section 40121;
(25) section 40151;
(26) section 40152;
(27) section 40155;
(28) section 40156;
(29) section 40211;
(30) section 40231;
(31) section 40241;
(32) section 40251;
(33) section 40261;
(34) section 40292;
(35) section 40293;
(36) section 40295;
(37) sections 40411–40414;
(38) sections 40421–40422;
(39) section 40506;
(40) sections 40601–40611;
(41) section 15004;
(42) section 15005;
(43) section 24001; and
(44) section 24003.

TITLE XXXII—MISCELLANEOUS

Subtitle A—Increases in Penalties

SEC. 320101. INCREASED PENALTIES FOR ASSAULT.

(a) CERTAIN OFFICERS AND EMPLOYEES.—Section 111 of title 18, United States Code, is amended—

(1) in subsection (a) by inserting ", where the acts in violation of this section constitute only simple assault, be fined under this title or imprisoned not more than one year, or both, and in all other cases," after "shall"; and

(2) in subsection (b) by inserting "or inflicts bodily injury" after "weapon".

(b) FOREIGN OFFICIALS, OFFICIAL GUESTS, AND INTERNATIONALLY PROTECTED PERSONS.—Section 112(a) of title 18, United States Code, is amended—

(1) by striking "not more than $5,000" and inserting "under this title";

(2) by inserting ", or inflicts bodily injury," after "weapon"; and

(3) by striking "not more than $10,000" and inserting "under this title".

(c) MARITIME AND TERRITORIAL JURISDICTION.—Section 113 of title 18, United States Code, is amended—

(1) in subsection (c)—

(A) by striking "of not more than $1,000" and inserting "under this title"; and

(B) by striking "five" and inserting "ten"; and

(2) in subsection (e)—

(A) by striking "of not more than $300" and inserting "under this title"; and

(B) by striking "three" and inserting "six".

(d) CONGRESS, CABINET, OR SUPREME COURT.—Section 351(e) of title 18, United States Code, is amended—

(1) by striking "not more than $5,000," and inserting "under this title,";

(2) by inserting "the assault involved in the use of a dangerous weapon, or" after "if";

(3) by striking "not more than $10,000" and inserting "under this title"; and

(4) by striking "for".

(e) PRESIDENT AND PRESIDENT'S STAFF.—Section 1751(e) of title 18, United States Code, is amended—

(1) by striking "not more than $10,000," both places it appears and inserting "under this title,";

(2) by striking "not more than $5,000," and inserting "under this title,"; and

(3) by inserting "the assault involved the use of a dangerous weapon, or" after "if".

SEC. 320102. INCREASED PENALTIES FOR MANSLAUGHTER.

Section 1112 of title 18, United States Code, is amended—

(1) in subsection (b)—

(A) by inserting "fined under this title or" after "shall be" in the first undesignated paragraph; and

(B) by inserting ", or both" after "years";

(2) by striking "not more than $1,000" and inserting "under this title"; and

(3) by striking "three" and inserting "six".

SEC. 320103. INCREASED PENALTIES FOR CIVIL RIGHTS VIOLATIONS.

(a) CONSPIRACY AGAINST RIGHTS.—Section 241 of title 18, United States Code, is amended—

(1) by striking "not more than $10,000" and inserting "under this title";

(2) by inserting "from the acts committed in violation of this section or if such acts include kidnapping or an attempt to kidnap, aggravated sexual abuse or an attempt to commit aggravated sexual abuse, or an attempt to kill" after "results";

(3) by striking "subject to imprisonment" and inserting "fined under this title or imprisoned"; and

(4) by inserting ", or both" after "life".

(b) DEPRIVATION OF RIGHTS.—Section 242 of title 18, United States Code, is amended—

(1) by striking "not more than $1,000" and inserting "under this title";

(2) by inserting "from the acts committed in violation of this section or if such acts include the use, attempted use, or threatened use of a dangerous weapon, explosives, or fire," after "bodily injury results";

(3) by inserting "from the acts committed in violation of this section or if such acts include kidnapping or an attempt to kidnap, aggravated sexual abuse, or an attempt to commit aggravated sexual abuse, or an attempt to kill, shall be fined under this title, or" after "death results";

(4) by striking "shall be subject to imprisonment" and inserting "imprisoned"; and

(5) by inserting ", or both" after "life".

(c) FEDERALLY PROTECTED ACTIVITIES.—Section 245(b) of title 18, United States Code, is amended in the matter following paragraph (5)—

(1) by striking "not more than $1,000" and inserting "under this title";

(2) by inserting "from the acts committed in violation of this section or if such acts include the use, attempted use, or threatened use of a dangerous weapon, explosives, or fire" after "bodily injury results;

(3) by striking "not more than $10,000" and inserting "under this title";

(4) by inserting "from the acts committed in violation of this section or if such acts include kidnapping or an attempt to kidnap, aggravated sexual abuse or an attempt to commit aggravated sexual abuse, or an attempt to kill," after "death results";

(5) by striking "subject to imprisonment" and inserting "fined under this title or imprisoned"; and

(6) by inserting ", or both" after "life".

(d) DAMAGE TO RELIGIOUS PROPERTY.—Section 247 of title 18, United States Code, is amended—

(1) in subsection (c)(1) by inserting "from acts committed in violation of this section or if such acts include kidnapping or an attempt to kidnap, aggravated sexual abuse or an attempt to commit aggravated sexual abuse, or an attempt to kill" after "death results";

(2) in subsection (c)(2)—

(A) by striking "serious"; and

(B) by inserting "from the acts committed in violation of this section or if such acts include the use, attempted use, or threatened use of a dangerous weapon, explosives, or fire" after "bodily injury results"; and

(3) by amending subsection (e) to read as follows:

"(e) As used in this section, the term 'religious property' means any church, synagogue, mosque, religious cemetery, or other religious property.".

(e) FAIR HOUSING ACT.—Section 901 of the Fair Housing Act (42 U.S.C. 3631) is amended—

(1) in the caption by striking "bodily injury; death;";

(2) by striking "not more than $1,000," and inserting "under this title";

(3) by inserting "from the acts committed in violation of this section or if such acts include the use, attempted use, or threatened use of a dangerous weapon, explosives, or fire" after "bodily injury results";

(4) by striking "not more than $10,000," and inserting "under this title";

(5) by inserting "from the acts committed in violation of this section or if such acts include kidnapping or an attempt to kidnap, aggravated sexual abuse or an attempt to commit aggravated sexual abuse, or an attempt to kill," after "death results";

(6) by striking "subject to imprisonment" and inserting "fined under this title or imprisoned"; and

(7) by inserting ", or both" after "life".

SEC. 320104. PENALTIES FOR TRAFFICKING IN COUNTERFEIT GOODS AND SERVICES.

(a) IN GENERAL.—Section 2320(a) of title 18, United States Code, is amended—

(1) in the first sentence—

(A) by striking "$250,000 or imprisoned not more than five years" and inserting "$2,000,000 or imprisoned not more than 10 years"; and

(B) by striking "$1,000,000" and inserting "$5,000,000"; and

(2) in the second sentence—

(A) by striking "$1,000,000 or imprisoned not more than fifteen years" and inserting "$5,000,000 or imprisoned not more than 20 years"; and

(B) by striking "$5,000,000" and inserting "$15,000,000".

(b) LAUNDERING MONETARY INSTRUMENTS.—Section 1956(c)(7)(D) of title 18, United States Code, is amended by striking "or section 2319 (relating to copyright infringement)," and inserting "section 2319 (relating to copyright infringement), or section 2320 (relating to trafficking in counterfeit goods and services),".

SEC. 320105. INCREASED PENALTY FOR CONSPIRACY TO COMMIT MURDER FOR HIRE.

Section 1958(a) of title 18, United States Code, is amended by inserting "or who conspires to do so" before "shall be fined" the first place it appears.

SEC. 320106. INCREASED PENALTIES FOR ARSON.

Section 844 of title 18, United States Code, is amended—

(1) in subsection (f)—

(A) by striking "not more than ten years, or fined not more than $10,000" and inserting "not more than 20 years, fined the greater of the fine under this title or the cost of repairing or replacing any property that is damaged or destroyed,"; and

(B) by striking "not more than twenty years, or fined not more than $10,000" and inserting "not more than 40 years, fined the greater of the fine under this title or the cost of repairing or replacing any property that is damaged or destroyed,";

(2) in subsection (h)—

(A) in the first sentence by striking "five years" and inserting "5 years but not more than 15 years"; and

(B) in the second sentence by striking "ten years" and inserting "10 years but not more than 25 years"; and

(3) in subsection (i)—

(A) by striking "not more than ten years or fined not more than $10,000" and inserting "not more than 20 years, fined the greater of the fine under this title or the cost of repairing or replacing any property that is damaged or destroyed,"; and

(B) by striking "not more than twenty years or fined not more than $20,000" and inserting "not more than 40 years, fined the greater of the fine under this title or the cost of repairing or replacing any property that is damaged or destroyed,".

SEC. 320107. INCREASED PENALTIES FOR DRUG TRAFFICKING NEAR PUBLIC HOUSING.

Section 419 of the Controlled Substances Act (21 U.S.C. 860) is amended—

(1) in subsection (a) by striking "playground, or within" and inserting "playground, or housing facility owned by a public housing authority, or within"; and

(2) in subsection (b) by striking "playground, or within" and inserting "playground, or housing facility owned by a public housing authority, or within".

SEC. 320108. TASK FORCE AND CRIMINAL PENALTIES RELATING TO THE INTRODUCTION OF NONINDIGENOUS SPECIES.

(a) TASK FORCE.—

(1) IN GENERAL.—The Attorney General is authorized to convene a law enforcement task force in Hawaii to facilitate the prosecution of violations of Federal laws, and laws of the State

of Hawaii, relating to the wrongful conveyance, sale, or introduction of nonindigenous plant and animal species.

(2) MEMBERSHIP.—(A) The task force shall be composed of representatives of—

(i) the Office of the United States Attorney for the District of Hawaii;

(ii) the United States Customs Service;

(iii) the Animal and Plant Health Inspection Service;

(iv) the Fish and Wildlife Service;

(v) the National Park Service;

(vi) the United States Forest Service;

(vii) the Military Customs Inspection Office of the Department of Defense;

(viii) the United States Postal Service;

(ix) the office of the Attorney General of the State of Hawaii;

(x) the Hawaii Department of Agriculture;

(xi) the Hawaii Department of Land and Natural Resources; and

(xii) such other individuals as the Attorney General deems appropriate.

(B) The Attorney General shall, to the extent practicable, select individuals to serve on the task force who have experience with the enforcement of laws relating to the wrongful conveyance, sale, or introduction of nonindigenous plant and animal species.

(3) DUTIES.—The task force shall—

(A) facilitate the prosecution of violations of Federal and State laws relating to the conveyance, sale, or introduction of nonindigenous plant and animal species into Hawaii; and

(B) make recommendations on ways to strengthen Federal and State laws and law enforcement strategies designed to prevent the introduction of nonindigenous plant and animal species.

(4) REPORT.—The task force shall report to the Attorney General, the Secretary of Agriculture, the Secretary of the Interior, and to the Committee on the Judiciary and Committee on Agriculture, Nutrition, and Forestry of the Senate and the Committee on the Judiciary, Committee on Agriculture, and Committee on Merchant Marine and Fisheries of the House of Representatives on—

(A) the progress of its enforcement efforts; and

(B) the adequacy of existing Federal laws and laws of the State of Hawaii that relate to the introduction of nonindigenous plant and animal species.

Thereafter, the task force shall make such reports as the task force deems appropriate.

(5) CONSULTATION.—The task force shall consult with Hawaii agricultural interests and representatives of Hawaii conservation organizations about methods of preventing the wrongful conveyance, sale, or introduction of nonindigenous plant and animal species into Hawaii.

(b) CRIMINAL PENALTY.—

(1) IN GENERAL.—Chapter 83 of title 18, United States Code, is amended by inserting after section 1716C the following new section:

"§1716D. Nonmailable injurious animals, plant pests, plants, and illegally taken fish, wildlife, and plants

"A person who knowingly deposits for mailing or delivery, or knowingly causes to be delivered by mail, according to the direction thereon, or at any place at which it is directed to be delivered by the person to whom it is addressed, anything that section 3015 of title 39 declares to be nonmailable matter shall be fined under this title, imprisoned not more than 1 year, or both.".

(2) TECHNICAL AMENDMENT.—The chapter analysis for chapter 83 of title 18, United States Code, is amended by inserting after the item relating to section 1716C the following new item:

"1716D. Nonmailable injurious animals, plant pests, plants, and illegally taken fish, wildlife, and plants.".

SEC. 320109. MILITARY MEDALS AND DECORATIONS.

Section 704 of title 18, United States Code, is amended—

(1) by striking "Whoever" and inserting (a) IN GENERAL.—Whoever";

(2) by striking "not more than $250" and inserting "under this title"; and

(3) by adding at the end the following new subsection:

"(b) CONGRESSIONAL MEDAL OF HONOR.—

"(1) IN GENERAL.—If a decoration or medal involved in an offense under subsection (a) is a Congressional Medal of Honor, in lieu of the punishment provided in that subsection, the offender shall be fined under this title, imprisoned not more than 1 year, or both.

"(2) DEFINITIONS.—(A) As used in subsection (a) with respect to a Congressional Medal of Honor, 'sells' includes trades, barters, or exchanges for anything of value.

"(B) As used in this subsection, 'Congressional Medal of Honor' means a medal awarded under section 3741 of title 10.".

Subtitle B—Extension of Protection of Civil Rights Statutes

SEC. 320201. EXTENSION OF PROTECTION OF CIVIL RIGHTS STATUTES.

(a) CONSPIRACY AGAINST RIGHTS.—Section 241 of title 18, United States Code, is amended by striking "inhabitant of" and inserting "person in".

(b) DEPRIVATION OF RIGHTS UNDER COLOR OF LAW.—Section 242 of title 18, United States Code, is amended—

(1) by striking "inhabitant of" and inserting "person in"; and

(2) by striking "such inhabitant" and inserting "such person".

Subtitle C—Audit and Report

SEC. 320301. AUDIT REQUIREMENT FOR STATE AND LOCAL LAW ENFORCEMENT AGENCIES RECEIVING FEDERAL ASSET FORFEITURE FUNDS.

(a) STATE REQUIREMENT.—Section 524(c)(7) of title 28, United States Code, is amended to read as follows:

"(7)(A) The Fund shall be subject to annual audit by the Comptroller General.

"(B) The Attorney General shall require that any State or local law enforcement agency receiving funds conduct an annual audit detailing the uses and expenses to which the funds were dedicated and the amount used for each use or expense and report the results of the audit to the Attorney General.".

(b) INCLUSION IN ATTORNEY GENERAL'S REPORT.—Section 524(c)(6)(C) of title 28, United States Code, is amended by adding at the end the following flush sentence: "The report should also contain all annual audit reports from State and local law enforcement agencies required to be reported to the Attorney General under subparagraph (B) of paragraph (7).".

SEC. 320302. REPORT TO CONGRESS ON ADMINISTRATIVE AND CONTRACTING EXPENSES.

Section 524(c)(6) of title 28, United States Code, is amended—

(1) by striking "and" at the end of subparagraph (B);

(2) by striking the period at the end of subparagraph (C) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(D) a report for such fiscal year containing a description of the administrative and contracting expenses paid from the Fund under paragraph (1)(A).".

Subtitle D—Coordination

SEC. 320401. COORDINATION OF SUBSTANCE ABUSE TREATMENT AND PREVENTION PROGRAMS.

The Attorney General shall consult with the Secretary of the Department of Health and Human Services in establishing and carrying out the substance abuse treatment and prevention components of the programs authorized under this Act, to assure coordination of programs, eliminate duplication of efforts and enhance the effectiveness of such services.

Subtitle E—Gambling

SEC. 320501. CLARIFYING AMENDMENT REGARDING SCOPE OF PROHIBITION AGAINST GAMBLING ON SHIPS IN INTERNATIONAL WATERS.

The paragraph of section 1081 of title 18, United States Code, defining the term "gambling ship" is amended by adding at the end the following: "Such term does not include a vessel with respect to gambling aboard such vessel beyond the territorial waters of the United States during a covered voyage (as defined in section 4472 of the Internal Revenue Code of 1986 as in effect on January 1, 1994).".

Subtitle F—White Collar Crime Amendments

SEC. 320601. RECEIVING THE PROCEEDS OF EXTORTION OR KIDNAPPING.

(a) PROCEEDS OF EXTORTION.—Chapter 41 of title 18, United States Code, is amended—

(1) by adding at the end the following new section:

"§880. Receiving the proceeds of extortion

"A person who receives, possesses, conceals, or disposes of any money or other property which was obtained from the commission of any offense under this chapter that is punishable by imprisonment for more than 1 year, knowing the same to have been unlawfully obtained, shall be imprisoned not more than 3 years, fined under this title, or both."; and

(2) in the table of sections, by adding at the end the following new item:

"880. Receiving the proceeds of extortion.".

(b) RANSOM MONEY.—Section 1202 of title 18, United States Code, is amended—

(1) by designating the existing matter as subsection "(a)"; and

(2) by adding the following new subsections:

"(b) A person who transports, transmits, or transfers in interstate or foreign commerce any proceeds of a kidnapping punishable under State law by imprisonment for more than 1 year, or receives, possesses, conceals, or disposes of any such proceeds after they have crossed a State or United States boundary, knowing the proceeds to have been unlawfully obtained, shall be imprisoned not more than 10 years, fined under this title, or both.

"(c) For purposes of this section, the term 'State' has the meaning set forth in section 245(d) of this title.".

SEC. 320602. RECEIVING THE PROCEEDS OF A POSTAL ROBBERY.

Section 2114 of title 18, United States Code, is amended—

(1) by striking "whoever" and inserting:

"(a) ASSAULT.—A person who"; and

(2) by adding at the end the following new subsection:

"(b) RECEIPT, POSSESSION, CONCEALMENT, OR DISPOSAL OF PROPERTY.—A person who receives, possesses, conceals, or disposes of any money or other property that has been obtained in violation of this section, knowing the same to have been unlawfully obtained, shall be imprisoned not more than 10 years, fined under this title, or both.".

SEC. 320603. CRIMES BY OR AFFECTING PERSONS ENGAGED IN THE BUSINESS OF INSURANCE WHOSE ACTIVITIES AFFECT INTERSTATE COMMERCE.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following new sections:

"§1033. Crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce

"(a)(1) Whoever is engaged in the business of insurance whose activities affect interstate commerce and knowingly, with the intent to deceive, makes any false material statement or report or willfully and materially overvalues any land, property or security—

"(A) in connection with any financial reports or documents presented to any insurance regulatory official or agency or an agent or examiner appointed by such official or agency to examine the affairs of such person, and

"(B) for the purpose of influencing the actions of such official or agency or such an appointed agent or examiner,

shall be punished as provided in paragraph (2).

"(2) The punishment for an offense under paragraph (1) is a fine as established under this title or imprisonment for not more than 10 years, or both, except that the term of imprisonment shall be not more than 15 years if the statement or report or overvaluing of land, property, or security jeopardized the safety and soundness of an insurer and was a significant cause of such insurer being placed in conservation, rehabilitation, or liquidation by an appropriate court.

"(b)(1) Whoever—

"(A) acting as, or being an officer, director, agent, or employee of, any person engaged in the business of insurance whose activities affect interstate commerce, or

"(B) is engaged in the business of insurance whose activities affect interstate commerce or is involved (other than as an insured or beneficiary under a policy of insurance) in a transaction relating to the conduct of affairs of such a business,

willfully embezzles, abstracts, purloins, or misappropriates any of the moneys, funds, premiums, credits, or other property of such person so engaged shall be punished as provided in paragraph (2).

"(2) The punishment for an offense under paragraph (1) is a fine as provided under this title or imprisonment for not more than 10 years, or both, except that if such embezzlement, abstraction, purloining, or misappropriation described in paragraph (1) jeopardized the safety and soundness of an insurer and was a significant cause of such insurer being placed in conservation, rehabilitation, or liquidation by an appropriate court, such imprisonment shall be not more than 15 years. If the amount or value so embezzled, abstracted, purloined, or misappropriated does not exceed $5,000, whoever violates paragraph (1) shall be fined as provided in this title or imprisoned not more than one year, or both.

"(c)(1) Whoever is engaged in the business of insurance and whose activities affect interstate commerce or is involved (other than as an insured or beneficiary under a policy of insurance) in a transaction relating to the conduct of affairs of such a business, knowingly makes any false entry of material fact in any book, report, or statement of such person engaged in the business of insurance with intent to deceive any person, including any officer, employee, or agent of such person engaged in the business of insurance, any insurance regulatory official or agency, or any agent or examiner appointed by such official or agency to examine the affairs of such person, about the financial condition or solvency of such business shall be punished as provided in paragraph (2).

"(2) The punishment for an offense under paragraph (1) is a fine as provided under this title or imprisonment for not more than 10 years, or both, except that if the false entry in any book, report, or statement of such person jeopardized the safety and soundness of an insurer and was a significant cause of such insurer being placed in conservation, rehabilitation, or liquidation by an appropriate court, such imprisonment shall be not more than 15 years.

"(d) Whoever, by threats or force or by any threatening letter or communication, corruptly influences, obstructs, or impedes or endeavors corruptly to influence, obstruct, or impede the due and proper administration of the law under which any proceeding involving the business of insurance whose activities affect interstate commerce is pending before any insurance regulatory official or agency or any agent or examiner appointed by such official or agency to examine the affairs of a person engaged in the business of insurance whose activities affect interstate commerce, shall be fined as provided in this title or imprisoned not more than 10 years, or both.

"(e)(1)(A) Any individual who has been convicted of any criminal felony involving dishonesty or a breach of trust, or who has been convicted of an offense under this section, and who willfully engages in the business of insurance whose activities affect interstate commerce or participates in such business, shall be fined as provided in this title or imprisoned not more than 5 years, or both.

"(B) Any individual who is engaged in the business of insurance whose activities affect interstate commerce and who willfully permits the participation described in subparagraph (A) shall be fined as provided in this title or imprisoned not more than 5 years, or both.

"(2) A person described in paragraph (1)(A) may engage in the business of insurance or participate in such business if such person has the written consent of any insurance regulatory official authorized to regulate the insurer, which consent specifically refers to this subsection.

"(f) As used in this section—

"(1) the term 'business of insurance' means—

"(A) the writing of insurance, or

"(B) the reinsuring of risks,

by an insurer, including all acts necessary or incidental to such writing or reinsuring and the activities of persons who act as, or are, officers, directors, agents, or employees of insurers or who are other persons authorized to act on behalf of such persons;

"(2) the term 'insurer' means any entity the business activity of which is the writing of insurance or the reinsuring of risks, and includes any person who acts as, or is, an officer, director, agent, or employee of that business;

"(3) the term 'interstate commerce' means—

"(A) commerce within the District of Columbia, or any territory or possession of the United States;

"(B) all commerce between any point in the State, territory, possession, or the District of Columbia and any point outside thereof;

"(C) all commerce between points within the same State through any place outside such State; or

"(D) all other commerce over which the United States has jurisdiction; and

"(4) the term 'State' includes any State, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands.

"§1034. Civil penalties and injunctions for violations of section 1033

"(a) The Attorney General may bring a civil action in the appropriate United States district court against any person who engages in conduct constituting an offense under section 1033 and, upon proof of such conduct by a preponderance of the evidence, such person shall be subject to a civil penalty of not more than $50,000 for each violation or the amount of compensation which the person received or offered for the prohibited conduct, whichever amount is greater. If the offense has contributed to the decision of a court of appropriate jurisdiction to issue an order directing the conservation, rehabilitation, or liquidation of an insurer, such penalty shall be remitted to the appropriate regulatory official for the benefit of the policyholders, claimants, and creditors of such insurer. The imposition of a civil penalty under this subsection does not preclude any other criminal or civil statutory, common law, or administrative remedy, which is available by law to the United States or any other person.

"(b) If the Attorney General has reason to believe that a person is engaged in conduct constituting an offense under section 1033, the Attorney General may petition an appropriate United States district court for an order prohibiting that person from engaging in such conduct. The court may issue an order prohibiting that person from engaging in such conduct if the court finds that the conduct constitutes such an offense. The filing of a petition under this section does not preclude any other remedy which is available by law to the United States or any other person.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 47 of such title is amended by adding at the end the following new items:

"1033. Crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce.
"1034. Civil penalties and injunctions for violations of section 1033.".

SEC. 320604. MISCELLANEOUS AMENDMENTS TO TITLE 18, UNITED STATES CODE.

(a) TAMPERING WITH INSURANCE REGULATORY PROCEEDINGS.—Section 1515(a)(1) of title 18, United States Code, is amended—

(1) by striking "or" at the end of subparagraph (B);

(2) by inserting "or" at the end of subparagraph (C); and

(3) by adding at the end thereof the following new subparagraph:

"(D) a proceeding involving the business of insurance whose activities affect interstate commerce before any insurance regulatory official or agency or any agent or examiner appointed by such official or agency to examine the affairs of any person engaged in the business of insurance whose activities affect interstate commerce; or".

(b) LIMITATIONS.—Section 3293 of such title is amended by inserting "1033," after "1014,".

(c) OBSTRUCTION OF CRIMINAL INVESTIGATIONS.—Section 1510 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(d)(1) Whoever—

"(A) acting as, or being, an officer, director, agent or employee of a person engaged in the business of insurance whose activities affect interstate commerce, or

"(B) is engaged in the business of insurance whose activities affect interstate commerce or is involved (other than as an insured or beneficiary under a policy of insurance) in a transaction relating to the conduct of affairs of such a business,

with intent to obstruct a judicial proceeding, directly or indirectly notifies any other person about the existence or contents of a subpoena for records of that person engaged in such business or information that has been furnished to a Federal grand jury in response to that subpoena, shall be fined as provided by this title or imprisoned not more than 5 years, or both.

"(2) As used in paragraph (1), the term 'subpoena for records' means a Federal grand jury subpoena for records that has been served relating to a violation of, or a conspiracy to violate, section 1033 of this title.".

SEC. 320605. FEDERAL DEPOSIT INSURANCE ACT AMENDMENT.

Section 19(a) of the Federal Deposit Insurance Act (12 U.S.C. 1829(a)) is amended in paragraph (2)(A)(i)(I)—

(1) by striking "or 1956"; and

(2) by inserting "1517, 1956, or 1957".

SEC. 320606. FEDERAL CREDIT UNION ACT AMENDMENTS.

Section 205(d) of the Federal Credit Union Act (12 U.S.C. 1785(d)) is amended to read as follows:

"(d) PROHIBITION.—

"(1) IN GENERAL.—Except with prior written consent of the Board—

"(A) any person who has been convicted of any criminal offense involving dishonesty or a breach of trust, or has agreed to enter into a pretrial diversion or similar program in connection with a prosecution for such offense, may not—

"(i) become, or continue as, an institution-affiliated party with respect to any insured credit union; or

"(ii) otherwise participate, directly or indirectly, in the conduct of the affairs of any insured credit union; and

"(B) any insured credit union may not permit any person referred to in subparagraph (A) to engage in any conduct or continue any relationship prohibited under such subparagraph.

"(2) MINIMUM 10-YEAR PROHIBITION PERIOD FOR CERTAIN OFFENSES.—

"(A) IN GENERAL.—If the offense referred to in paragraph (1)(A) in connection with any person referred to in such paragraph is—

"(i) an offense under—

"(I) section 215, 656, 657, 1005, 1006, 1007, 1008, 1014, 1032, 1344, 1517, 1956, or 1957 of title 18, United States Code; or

"(II) section 1341 or 1343 of such title which affects any financial institution (as defined in section 20 of such title); or

"(ii) the offense of conspiring to commit any such offense,

the Board may not consent to any exception to the application of paragraph (1) to such person during the 10-year period beginning on the date the conviction or the agreement of the person becomes final.

"(B) EXCEPTION BY ORDER OF SENTENCING COURT.—

"(i) IN GENERAL.—On motion of the Board, the court in which the conviction or the agreement of a person referred to in subparagraph (A) has been entered may grant an exception to the application of paragraph (1) to such person if granting the exception is in the interest of justice.

"(ii) PERIOD FOR FILING.—A motion may be filed under clause (i) at any time during the 10-year period described in subparagraph (A) with regard to the person on whose behalf such motion is made.

"(3) PENALTY.—Whoever knowingly violates paragraph (1) or (2) shall be fined not more than $1,000,000 for each day such prohibition is violated or imprisoned for not more than 5 years, or both.".

SEC. 320607. ADDITION OF PREDICATE OFFENSES TO FINANCIAL INSTITUTIONS REWARDS STATUTE.

Section 3059A of title 18, United States Code, is amended—

(1) by inserting "225," after "215";

(2) by striking "or" before "1344"; and

(3) by inserting ", or 1517" after "1344".

SEC. 320608. DEFINITION OF SAVINGS AND LOAN ASSOCIATION" FOR PURPOSES OF THE OFFENSE OF BANK ROBBERY AND RELATED OFFENSES.

Section 2113 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(h) As used in this section, the term 'savings and loan association' means—

"(1) a Federal savings association or State savings association (as defined in section 3(b) of the Federal Deposit Insurance Act (12 U.S.C. 1813(b))) having accounts insured by the Federal Deposit Insurance Corporation; and

"(2) a corporation described in section 3(b)(1)(C) of the Federal Deposit Insurance Act (12 U.S.C. 1813(b)(1)(C)) that is operating under the laws of the United States.".

SEC. 320609. DEFINITION OF 1-YEAR PERIOD FOR PURPOSES OF THE OFFENSE OF OBSTRUCTION OF A FEDERAL AUDIT.

Section 1516(b) of title 18, United States Code, is amended—

(1) by striking "section the term" and inserting "section—

"(1) the term";

(2) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraph:

"(2) the term 'in any 1 year period' has the meaning given to the term 'in any one-year period' in section 666.".

Subtitle G—Safer Streets and Neighborhoods

SEC. 320701. SHORT TITLE.

This subtitle may be cited as the "Safer Streets and Neighborhoods Act of 1994".

SEC. 320702. LIMITATION ON GRANT DISTRIBUTION.

(a) AMENDMENT.—Section 510(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3760(b)) is amended by inserting "non-Federal" after "with".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on October 1, 1994.

Subtitle H—Recreational Hunting Safety

SEC. 320801. SHORT TITLE.

This subtitle may be cited as the "Recreational Hunting Safety and Preservation Act of 1994".

SEC. 320802. OBSTRUCTION OF A LAWFUL HUNT.

It is a violation of this section intentionally to engage in any physical conduct that significantly hinders a lawful hunt.

SEC. 320803. CIVIL PENALTIES.

(a) IN GENERAL.—A person who violates section 320802 shall be assessed a civil penalty in an amount computed under subsection (b).

(b) COMPUTATION OF PENALTY.—The penalty shall be—

(1) not more than $10,000, if the violation involved the use of force or violence, or the threatened use of force or violence, against the person or property of another person; and

(2) not more than $5,000 for any other violation.

(c) RELATIONSHIP TO OTHER PENALTIES.—The penalties established by this section shall be in addition to other criminal or civil penalties that may be levied against the person as a result of an activity in violation of section 320802.

(d) PROCEDURE.—Upon receipt of—

(1) a written complaint from an officer, employee, or agent of the Forest Service, Bureau of Land Management, National Park Service, United States Fish and Wildlife Service, or other Federal agency that a person violated section 320802; or

(2) a sworn affidavit from an individual and a determination by the Secretary that the statement contains sufficient factual allegations to create a reasonable belief that a violation of section 320802 has occurred;

the Secretary may request the Attorney General of the United States to institute a civil action for the imposition and collection of the civil penalty under this section.

(e) USE OF PENALTY MONEY COLLECTED.—After deduction of costs attributable to collection, money collected from penalties shall be—

(1) deposited into the trust fund established pursuant to the Act entitled "An Act to provide that the United States shall aid the States in wildlife-restoration projects, and for other purposes", approved September 2, 1937 (16 U.S.C. 669) (commonly known as the "Pitman-Robertson Wildlife Restoration Act"), to support the activities authorized by such Act and undertaken by State wildlife management agencies; or

(2) used in such other manner as the Secretary determines will enhance the funding and implementation of—

(A) the North American Waterfowl Management Plan signed by the Secretary of the Interior and the Minister of Environment for Canada in May 1986; or

(B) a similar program that the Secretary determines will enhance wildlife management—

(i) on Federal lands; or

(ii) on private or State-owned lands when the efforts will also provide a benefit to wildlife management objectives on Federal lands.

SEC. 320804. OTHER RELIEF.

Injunctive relief against a violation of section 320802 may be sought by—

(1) the head of a State agency with jurisdiction over fish or wildlife management;

(2) the Attorney General of the United States; or

(3) any person who is or would be adversely affected by the violation.

SEC. 320805. RELATIONSHIP TO STATE AND LOCAL LAW AND CIVIL ACTIONS.

This subtitle does not preempt a State law or local ordinance that provides for civil or criminal penalties for conduct that violates this subtitle.

SEC. 320806. REGULATIONS.

The Secretary may issue such regulations as are necessary to carry out this subtitle.

SEC. 320807. RULE OF CONSTRUCTION.

Nothing in this subtitle shall be construed to impair a right guaranteed to a person under the first article of amendment to the Constitution or limit any legal remedy for forceful interference with a person's lawful participation in speech or peaceful assembly.

SEC. 320808. DEFINITIONS.

As used in this subtitle:

(1) FEDERAL LANDS.—The term "Federal lands" means—

(A) national forests;

(B) public lands;

(C) national parks; and

(D) wildlife refuges.

(2) LAWFUL HUNT.—The term "lawful hunt" means the taking or harvesting (or attempted taking or harvesting) of wildlife or fish, on Federal lands, which—

(A) is lawful under the laws applicable in the place it occurs; and

(B) does not infringe upon a right of an owner of private property.

(3) NATIONAL FOREST.—The term "national forest" means lands included in the National Forest System (as defined in section 11(a) of the Forest and Rangeland Renewable Resources Planning Act of 1974 (16 U.S.C. 1609(a))).

(4) NATIONAL PARK.—The term "national park" means lands and waters included in the National Park System (as defined in section 2(a) of the Act entitled "An Act to facilitate the management of the National Park System and miscellaneous areas administered in connection with that system, and for other purposes", approved August 8, 1953 (16 U.S.C. 1c(a))).

(5) PUBLIC LANDS.—The term "public lands" has the same meaning as is provided in section 103(e) of the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1702(e)).

(6) SECRETARY.—The term "Secretary" means—

(A) the Secretary of Agriculture with respect to national forests; and

(B) the Secretary of the Interior with respect to—

(i) public lands;

(ii) national parks; and

(iii) wildlife refuges.

(7) WILDLIFE REFUGE.—The term "wildlife refuge" means lands and waters included in the National Wildlife Refuge System (as established by section 4 of the National Wildlife Refuge System Administration Act of 1966 (16 U.S.C. 668dd)).

(8) CONDUCT.—The term "conduct" does not include speech protected by the first article of amendment to the Constitution.

Subtitle I—Other Provisions

SEC. 320901. WIRETAPS.

Section 2511(1) of title 18, United States Code, is amended—

(1) by striking "or" at the end of paragraph (c);

(2) by inserting "or" at the end of paragraph (d); and

(3) by adding after paragraph (d) the following new paragraph:

"(e)(i) intentionally discloses, or endeavors to disclose, to any other person the contents of any wire, oral, or electronic communication, intercepted by means authorized by sections 2511(2)(A)(ii), 2511(b)–(c), 2511(e), 2516, and 2518 of this subchapter, (ii) knowing or having reason to know that the information was obtained through the interception of such a communication in connection with a criminal investigation, (iii) having obtained or received the information in connection with a criminal investigation, and (iv) with intent to improperly obstruct, impede, or interfere with a duly authorized criminal investigation,".

SEC. 320902. THEFT OF MAJOR ARTWORK.

(a) OFFENSE.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following new section:

"§668. Theft of major artwork

"(a) DEFINITIONS.—In this section—

"'museum' means an organized and permanent institution, the activities of which affect interstate or foreign commerce, that—

"(A) is situated in the United States;

"(B) is established for an essentially educational or aesthetic purpose;

"(C) has a professional staff; and

"(D) owns, utilizes, and cares for tangible objects that are exhibited to the public on a regular schedule.

"'object of cultural heritage' means an object that is—

"(A) over 100 years old and worth in excess of $5,000; or

"(B) worth at least $100,000.".

"(b) OFFENSES.—A person who—

"(1) steals or obtains by fraud from the care, custody, or control of a museum any object of cultural heritage; or

"(2) knowing that an object of cultural heritage has been stolen or obtained by fraud, if in fact the object was stolen or obtained from the care, custody, or control of a museum (whether or not that fact is known to the person), receives, conceals, exhibits, or disposes of the object,

shall be fined under this title, imprisoned not more than 10 years, or both.".

(b) PERIOD OF LIMITATION.—Chapter 213 of title 18, United States Code, is amended by adding at the end the following new section:

"§3294. Theft of major artwork

"No person shall be prosecuted, tried, or punished for a violation of or conspiracy to violate section 668 unless the indictment is returned or the information is filed within 20 years after the commission of the offense.".

(d) TECHNICAL AMENDMENTS.—

(1) CHAPTER 31.—The chapter analysis for chapter 31 of title 18, United States Code, is amended by adding at the end the following new item:

"668. Theft of major artwork.".

(2) CHAPTER 213.—The chapter analysis for chapter 213 of title 18, United States Code, is amended by adding at the end the following new item:

"3294. Theft of major artwork.".

SEC. 320903. ADDITION OF ATTEMPTED ROBBERY, KIDNAPPING, SMUGGLING, AND PROPERTY DAMAGE OFFENSES TO ELIMINATE INCONSISTENCIES AND GAPS IN COVERAGE.

(a) ROBBERY AND BURGLARY.—(1) Section 2111 of title 18, United States Code, is amended by inserting "or attempts to take" after "takes".

(2) Section 2112 of title 18, United States Code, is amended by inserting "or attempts to rob" after "robs".

(3) Section 2114 of title 18, United States Code, is amended by inserting "or attempts to rob" after "robs".

(b) KIDNAPPING.—Section 1201(d) of title 18, United States Code, is amended by striking "Whoever attempts to violate subsection (a)(4) or (a)(5)" and inserting "Whoever attempts to violate subsection (a)".

(c) SMUGGLING.—Section 545 of title 18, United States Code, is amended by inserting "or attempts to smuggle or clandestinely introduce" after "smuggles, or clandestinely introduces".

(d) MALICIOUS MISCHIEF.—(1) Section 1361 of title 18, United States Code, is amended—

(A) by inserting "or attempts to commit any of the foregoing offenses" before "shall be punished", and

(B) by inserting "or attempted damage" after "damage" each place it appears.

(2) Section 1362 of title 18, United States Code, is amended by inserting "or attempts willfully or maliciously to injure or destroy" after "willfully or maliciously injures or destroys".

(3) Section 1366 of title 18, United States Code, is amended—

(A) by inserting "or attempts to damage" after "damages" each place it appears;

(B) by inserting "or attempts to cause" after "causes"; and

(C) by inserting "or would if the attempted offense had been completed have exceeded" after "exceeds" each place it appears.

SEC. 320904. GUN-FREE SCHOOL ZONES.

Section 922(q) of title 18, United States Code, is amended—

(1) by redesignating paragraphs (1), (2), and (3) as paragraphs (2), (3), and (4), respectively; and

(2) by inserting after "(q)" the following new paragraph:

"(1) The Congress finds and declares that—

"(A) crime, particularly crime involving drugs and guns, is a pervasive, nationwide problem;

"(B) crime at the local level is exacerbated by the interstate movement of drugs, guns, and criminal gangs;

"(C) firearms and ammunition move easily in interstate commerce and have been found in increasing numbers in and around schools, as documented in numerous hearings in both the Judiciary Committee of the House of Representatives and Judiciary Committee of the Senate;

"(D) in fact, even before the sale of a firearm, the gun, its component parts, ammunition, and the raw materials from which they are made have considerably moved in interstate commerce;

"(E) while criminals freely move from State to State, ordinary citizens and foreign visitors may fear to travel to or through certain parts of the country due to concern about violent crime and gun violence, and parents may decline to send their children to school for the same reason;

"(F) the occurrence of violent crime in school zones has resulted in a decline in the quality of education in our country;

"(G) this decline in the quality of education has an adverse impact on interstate commerce and the foreign commerce of the United States;

"(H) States, localities, and school systems find it almost impossible to handle gun-related crime by themselves; even States, localities, and school systems that have made strong efforts to prevent, detect, and punish gun-related crime find their efforts unavailing due in part to the failure or inability of other States or localities to take strong measures; and

"(I) Congress has power, under the interstate commerce clause and other provisions of the Constitution, to enact measures to ensure the integrity and safety of the Nation's schools by enactment of this subsection.".

SEC. 320905. INTERSTATE WAGERING.

Section 1301 of title 18, United States Code, is amended by inserting "or, being engaged in the business of procuring for a person in 1 State such a ticket, chance, share, or interest in a lottery, gift, enterprise or similar scheme conducted by another State (unless that business is permitted under an agreement between the States in question or appropriate authorities of those States), knowingly transmits in interstate or foreign commerce information to be used for the purpose of procuring such a ticket, chance, share, or interest;" after "scheme;".

SEC. 320906. SENSE OF CONGRESS WITH RESPECT TO VIOLENCE AGAINST TRUCKERS.

It is the sense of Congress that—

(1) when there is Federal jurisdiction, Federal authorities should prosecute to the fullest extent of the law murders, rapes, burglaries, kidnappings and assaults committed against commercial truckers; and

(2) appropriate Federal agencies should acknowledge this problem and place a priority on evaluating how best to prevent these crimes and apprehend those involved, and continue to coordinate their activities with multi-jurisdictional authorities to combat violent crimes committed against truckers.

SEC. 320907. SENSE OF THE SENATE REGARDING A STUDY ON OUT-OF-WEDLOCK BIRTHS.

It is the sense of the Senate that—

(1) the Secretary of Health and Human Services, in consultation with the National Center for Health Statistics, should prepare an analysis of the causes of the increase in out-of-wedlock births, and determine whether there is any historical precedent for such increase, as well as any equivalent among foreign nations, and

(2) the Secretary of Health and Human Services should report to Congress within 12 months after the date of the enactment of this Act on the Secretary's analysis of the out-of-wedlock problem and its causes, as well as possible remedial measures that could be taken.

SEC. 320908. SENSE OF THE SENATE REGARDING THE ROLE OF THE UNITED NATIONS IN INTERNATIONAL ORGANIZED CRIME CONTROL.

It is the sense of the Senate that—

(1) the United States should encourage the development of a United Nations Convention on Organized Crime; and

(2) the United Nations should—

(A) provide significant additional resources to the Commission on Crime Prevention and Criminal Justice;

(B) consider an expansion of the Commission's role and authority; and

(C) seek a cohesive approach to the international organized crime problem.

SEC. 320909. OPTIONAL VENUE FOR ESPIONAGE AND RELATED OFFENSES.

(a) IN GENERAL.—Chapter 211 of title 18, United States Code, is amended by inserting after section 3238 the following new section:

"§3239. Optional venue for espionage and related offenses

"The trial for any offense involving a violation, begun or committed upon the high seas or *elsewhere out of the jurisdiction of any particular State or district, of—*

"(1) section 793, 794, 798, or section 1030(a)(1) of this title;

"(2) section 601 of the National Security Act of 1947 (50 U.S.C. 421); or

"(3) section 4(b) or 4(c) of the Subversive Activities Control Act of 1950 (50 U.S.C. 783 (b) or (c));

may be in the District of Columbia or in any other district authorized by law.".

(b) TECHNICAL AMENDMENT.—The item relating to section 3239 in the table of sections of chapter 211 of title 18, United States Code, is amended to read as follows:

"3239. Optional venue for espionage and related offenses.".

SEC. 320910. UNDERCOVER OPERATIONS.

(a) IN GENERAL.—Chapter 1 of title 18, United States Code, is amended by adding at the end the following new section:

"§21. Stolen or counterfeit nature of property for certain crimes defined

"(a) Wherever in this title it is an element of an offense that—

"(1) any property was embezzled, robbed, stolen, converted, taken, altered, counterfeited, falsely made, forged, or obliterated; and

"(2) the defendant knew that the property was of such character;

such element may be established by proof that the defendant, after or as a result of an official representation as to the nature of the property, believed the property to be embezzled, robbed, stolen, converted, taken, altered, counterfeited, falsely made, forged, or obliterated.

"(b) For purposes of this section, the term 'official representation' means any representation made by a Federal law enforcement officer (as defined in section 115) or by another person at the direction or with the approval of such an officer.".

(b) TECHNICAL AMENDMENT.—The table of sections of chapter 1 of title 18, United States Code, is amended by adding at the end the following new item:

"21. Stolen or counterfeit nature of property for certain crimes defined.".

SEC. 320911. MISUSE OF INITIALS "DEA".

(a) AMENDMENT.—Section 709 of title 18, United States Code, is amended—

(1) in the thirteenth unnumbered paragraph by striking "words—" and inserting "words; or"; and

(2) by inserting after the thirteenth unnumbered paragraph the following new paragraph:

"A person who, except with the written permission of the Administrator of the Drug Enforcement Administration, knowingly uses the words 'Drug Enforcement Administration' or the initials 'DEA' or any colorable imitation of such words or initials, in connection with any advertisement, circular, book, pamphlet, software or other publication, play, motion picture, broadcast, telecast, or other production, in a manner reasonably calculated to convey the impression that such advertisement, circular, book, pamphlet, software or other publication, play, motion picture, broadcast, telecast, or other production is approved, endorsed, or authorized by the Drug Enforcement Administration;".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on the date that is 90 days after the date of enactment of this Act.

SEC. 320912. DEFINITION OF LIVESTOCK.

Section 2311 of title 18, United States Code, is amended by inserting after the second paragraph relating to the definition of "cattle" the following new paragraph:

"'livestock' means any domestic animals raised for home use, consumption, or profit, such as horses, pigs, llamas, goats, fowl, sheep, buffalo, and cattle, or the carcasses thereof.".

SEC. 320913. ASSET FORFEITURE.

(a) AMENDMENT.—Section 524(c)(1) of title 28, United States Code, is amended—

(1) by redesignating subparagraph (H) as subparagraph (I); and

(2) by inserting after subparagraph (G) the following new subparagraph:

"(H) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order; and".

(b) APPLICATION OF AMENDMENT.—The amendment made by subsection (a) shall apply to all claims pending at the time of or commenced subsequent to the date of enactment of this Act.

SEC. 320914. CLARIFICATION OF DEFINITION OF A "COURT OF THE UNITED STATES" TO INCLUDE THE DISTRICT COURTS FOR GUAM, THE NORTHERN MARIANA ISLANDS, AND THE VIRGIN ISLANDS.

(a) IN GENERAL.—Chapter 1 of title 18, United States Code, is amended by adding at the end the following new section:

"§23. Court of the United States defined

"As used in this title, except where otherwise expressly provided the term 'court of the United States' includes the District Court of Guam, the District Court for the Northern Mariana Islands, and the District Court of the Virgin Islands.".

(b) TECHNICAL AMENDMENT.—The chapter analysis for chapter 1 of title 18, United States Code, is amended by adding at the end the following new item:

"23. Court of the United States defined.".

SEC. 320915. LAW ENFORCEMENT PERSONNEL.

It is the sense of the Senate that law enforcement personnel should not be reduced and calls upon the President of the United States to exempt Federal law enforcement positions from Executive Order 12839 and other Executive memoranda mandating reductions in the Federal workforce.

SEC. 320916. AUTHORITY TO INVESTIGATE VIOLENT CRIMES AGAINST TRAVELERS.

(a) IN GENERAL.—Chapter 33 of title 28, United States Code, is amended by adding at the end the following new section:

"§540A. Investigation of violent crimes against travelers

"(a) IN GENERAL.—At the request of an appropriate law enforcement official of a State or political subdivision, the Attorney General and Director of the Federal Bureau of Investigation may assist in the investigation of a felony crime of violence in violation of the law of any State in which the victim appears to have been selected because he or she is a traveler.

"(b) FOREIGN TRAVELERS.—In a case in which the traveler who is a victim of a crime described in subsection (a) is from a foreign nation, the Attorney General and Director of the Federal Bureau of Investigation, and, when appropriate, the Secretary of State shall assist the prosecuting and law enforcement officials of a State or political subdivision to the fullest extent possible in securing from abroad such evidence or other information as may be needed for the effective investigation and prosecution of the crime.

"(c) DEFINITIONS.—In this section—

"'felony crime of violence' means an offense punishable by more than one year in prison that has as an element the use, attempted use, or threatened use of physical force against the person of another.

"'State' means a State, the District of Columbia, and any commonwealth, territory, or possession of the United States.

"'traveler' means a victim of a crime of violence who is not a resident of the State in which the crime of violence occurred.".

(b) TECHNICAL AMENDMENT.—The chapter analysis for chapter 33 of title 28, United States Code, is amended by adding at the end the following new item:

"540A. Investigation of violent crimes against travelers.".

SEC. 320917. EXTENSION OF STATUTE OF LIMITATIONS FOR ARSON.

(a) IN GENERAL.—Section 844(i) of title 18, United States Code, is amended by adding at the end the following: "No person shall be prosecuted, tried, or punished for any noncapital offense under this subsection unless the indictment is found or the information is instituted within 7 years after the date on which the offense was committed.".

(b) APPLICATION OF AMENDMENT.—The amendment made by subsection (a) shall not apply to any offense described in the amendment that was committed more than 5 years prior to the date of enactment of this Act.

SEC. 320918. SENSE OF CONGRESS CONCERNING CHILD CUSTODY AND VISITATION RIGHTS.

It is the sense of the Congress that in determining child custody and visitation rights, the courts should take into consideration the history of drunk driving that any person involved in the determination may have.

SEC. 320919. EDWARD BYRNE MEMORIAL FORMULA GRANT PROGRAM.

Nothing in this Act shall be construed to prohibit or exclude the expenditure of appropriations to grant recipients that would have been or are eligible to receive grants under subpart 1 of part E of the Omnibus Crime Control and Safe Streets Act of 1968.

SEC. 320920. SENSE OF THE SENATE REGARDING LAW DAY U.S.A.

It is the sense of the Senate that in celebration of "Law Day, U.S.A.", May 1, 1995, the grateful people of this Nation should give special emphasis to all law enforcement personnel of the United States, and the grateful people of this Nation should acknowledge the unflinching and devoted service law enforcement personnel perform as such personnel help preserve domestic tranquillity and guarantee the legal rights of all individuals of this Nation.

SEC. 320921. FIRST TIME DOMESTIC VIOLENCE OFFENDER REHABILITATION PROGRAM.

(a) SENTENCE OF PROBATION.—Section 3561 of title 18, United States Code, is amended—

(1) by redesignating subsection (b) as subsection (c); and

(2) by inserting the following new subsection after subsection (a):

"(b) DOMESTIC VIOLENCE OFFENDERS.—A defendant who has been convicted for the first time of a domestic violence crime shall be sentenced to a term of probation if not sentenced to a term of imprisonment. The term 'domestic violence crime' means a crime of violence for which the defendant may be prosecuted in a court of the United States in which the victim or intended victim is the spouse, former spouse, intimate partner, former intimate partner, child, or former child of the defendant, or any relative defendant, child, or former child of the defendant, or any other relative of the defendant.".

(b) CONDITIONS OF PROBATION.—Section 3563(a) of title 18, United States Code, is amended by—

(1) striking "and" at the end of paragraph (2);

(2) striking the period at the end of paragraph (3) and inserting "; and"; and

(3) by inserting the following new paragraph:

"(4) for a domestic violence crime as defined in section 3561(b) by a defendant convicted of

such an offense for the first time that the defendant attend a public, private, or private nonprofit offender rehabilitation program that has been approved by the court, in consultation with a State Coalition Against Domestic Violence or other appropriate experts, if an approved program is readily available within a 50-mile radius of the legal residence of the defendant.".

(c) Supervised Release.—Section 3583 of title 18, United States Code, is amended—

(1) in subsection (a) by inserting "or if the defendant has been convicted for the first time of a domestic violence crime as defined in section 3561(b)" after "statute"; and

(2) in subsection (d) by inserting the following after the first sentence: "The court shall order as an explicit condition of supervised release for a defendant convicted for the first time of a domestic violence crime as defined in section 3561(b) that the defendant attend a public, private, or private nonprofit offender rehabilitation program that has been approved by the court, in consultation with a State Coalition Against Domestic Violence or other appropriate experts, if an approved program is readily available within a 50-mile radius of the legal residence of the defendant.".

SEC. 320922. DISPLAY OF FLAGS AT HALFSTAFF.

(a) Public Law 87–726.—The first section of Public Law 87–726 (36 U.S.C. 167) is amended—

(1) by striking "(2)" and inserting "(3)";

(2) by inserting after clause (1) the following new clause: "(2) directing the officials of the Government to display at halfstaff the flag of the United States on all Government buildings on such day, as provided by section 3(m) of the Act of June 22, 1942 (Chapter 435; 56 Stat. 377; 36 U.S.C. 175),";

(3) by striking "(3)" and inserting "(4)"; and

(4) by inserting in paragraph (4) ", including the display at half-staff of the flag of the United States" after "activities".

(b) Act of June 22, 1942.—Section 3(m) of the Act of June 22, 1942 (Chapter 435; 56 Stat. 377; 36 U.S.C. 175) is amended by inserting "The flag shall be flown at half-staff on Peace Officers Memorial Day, unless that day is also Armed Forces Day." after "a Member of Congress.".

SEC. 320923. FINANCIAL INSTITUTION FRAUD.

Section 528 of Public Law 101–509, approved November 5, 1990, is amended by striking "with the authority of the Resolution Trust Corporation or its successor" at the end of subsection (b)(2) and inserting "on December 31, 2004".

SEC. 320924. DEFINITION OF "PARENT" FOR THE PURPOSES OF THE OFFENSE OF KIDNAPPING.

Section 1201 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(h) As used in this section, the term 'parent' does not include a person whose parental rights with respect to the victim of an offense under this section have been terminated by a final court order.".

SEC. 320925. NATIONAL CENTER FOR CRIMINAL JUSTICE RESEARCH AND EDUCATION.

(a) Establishment.—The Attorney General shall establish, at a qualified institution of post-secondary education, a National Center for Criminal Justice Research and Education (referred to as the "Center") as a means of developing, demonstrating, and implementing model criminal justice practices and policies.

(b) Program and Activities.—The Center, under guidelines established by the Attorney General, shall—

(1) provide criminal justice, drug treatment, and correctional education related research and development, instruction, technical assistance, and training, evaluation, and demonstration activities involving the 5 existing and approved Federal, State, and county correctional facilities in Jefferson County, Texas, as a means of demonstrating effective model programs, policies, and practices suitable for replication throughout the United States;

(2) carry out a program of research, development, demonstration, evaluation, education, training, and technical assistance involving applicable innovative technologies and approaches; and

(3) provide appropriate pre-employment and continuing education programs and services to the personnel of the participating correctional facilities, and when appropriate, other agencies.

(c) Acceptance of Support.—The Center shall be authorized to accept funding, in-kind services, and other forms of support from private and public agencies to carry out its purposes under this section.

(d) General Authorities.—The Attorney General may issue guidelines, make grants, and enter into contracts and cooperative agreements with States, units of local government, Indian tribal governments, and other public and private entities or individuals as appropriate to carry out this section.

(e) Revocation or Suspension of Funding.—The Attorney General may revoke or suspend funding in whole or in part, if the recipient of Federal assistance under this section is not in substantial compliance with the terms or requirements of any applicable grant, contract, or cooperative agreement.

(f) Definition.—In this section, "qualified institution of post-secondary education" means a university system-related institution with experience and currently active in criminal justice related educational activities, located in Jefferson County, Texas.

(g) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section—

$10,000,000 for fiscal year 1995; to remain available until expended.

SEC. 320926. HATE CRIME STATISTICS ACT.

Subsection (b)(1) of the first section of the Hate Crime Statistics Act (28 U.S.C. 534 note) is amended by inserting "disability," after "religion,".

SEC. 320927. EXEMPTION FROM BRADY BACKGROUND CHECK REQUIREMENT OF RETURN OF HANDGUN TO OWNER.

Section 922(s)(1) of title 18, United States Code, is amended in the first sentence by inserting "(other than the return of a handgun to the person from whom it was received)" after "handgun".

SEC. 320928. AMENDMENT OF THE NATIONAL CHILD PROTECTION ACT OF 1993.

(a) Protection of the Elderly and Individuals With Disabilities.—

(1) Background checks.—Section 3(a)(1) of the National Child Protection Act of 1993 (42 U.S.C. 5119a) is amended by striking "an individual's fitness to have responsibility for the safety and well-being of children" and inserting "the provider's fitness to have responsibility for the safety and well-being of children, the elderly, or individuals with disabilities".

(2) Guidelines.—Section 3(b) of the National Child Protection Act of 1993 (42 U.S.C. 5119b(b)) is amended—

(A) in paragraph (1)(E)—

(i) by striking "child" the first place it appears and inserting "person"; and

(ii) by striking "child" the second place it appears; and

(B) in paragraph (4) by striking "an individual's fitness to have responsibility for the safety and well-being of children" and inserting "the provider's fitness to have responsibility for the safety and well-being of children, the elderly, or individuals with disabilities".

(3) Definition of care.—Section 5 of the National Child Protection Act of 1993 (42 U.S.C. 5119c(5)) is amended—

(A) by amending paragraph (5) to read as follows:

"(5) the term 'care' means the provision of care, treatment, education, training, instruction, supervision, or recreation to children, the elderly, or individuals with disabilities;"; and

(B) in paragraph (8) by striking "child care" each place it appears and inserting "care".

(b) Information Required To Be Reported.—Section 2(a) of the National Child Protection Act of 1993 (42 U.S.C. 5119(a)) is amended by adding at the end "A criminal justice agency may satisfy the requirement of this subsection by reporting or indexing all felony and serious misdemeanor arrests and dispositions.".

(c) Clarification of Immunity Provision.—Section 3(d) of the National Child Protection Act of 1993 (42 U.S.C. 5119a(d)) is amended by inserting "(other than itself)" after "failure of a qualified entity".

(d) Defrayment of Costs to Volunteers of Conducting Background Checks.—Section 4(b) of the National Child Protection Act of 1993 (42 U.S.C. 5119b(b)) is amended—

(1) by striking "and" at the end of subparagraph (C);

(2) by striking the period at the end of subparagraph (D) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(E) to assist the State in paying all or part of the cost to the State of conducting background checks on persons who are employed by or volunteer with a public, not-for-profit, or voluntary qualified entity to reduce the amount of fees charged for such background checks.".

(e) Fees.—Section 3(e) of the National Child Protection Act of 1993 is amended by striking "the actual cost" and inserting "eighteen dollars, respectively, or the actual cost, whichever is less,".

(f) Costs of the FBI.—Funds authorized to be appropriated to the Federal Bureau of Investigation under section 190001(c) of this Act may be used to pay all or part of the cost to the Federal Bureau of Investigation of carrying out the National Child Protection Act of 1993, including the cost of conducting background checks on persons who are employed by or volunteer with a public, not-for-profit, or voluntary qualified entity to reduce the amount of fees charged for such background checks.

(g) Guidelines.—

(1) In general.—The Attorney General, in consultation with Federal, State, and local officials, including officials responsible for criminal history record systems, and representatives of public and private care organizations and health, legal, and social welfare organizations, shall develop guidelines for the adoption of appropriate safeguards by care providers and by States for protecting children, the elderly, or individuals with disabilities from abuse.

(2) Matters to be addressed.—In developing guidelines under paragraph (1), the Attorney General shall address the availability, cost, timeliness, and effectiveness of criminal history background checks and recommend measures to ensure that fees for background checks do not discourage volunteers from participating in care programs.

(3) Dissemination.—The Attorney General shall, subject to the availability of appropriations, disseminate the guidelines to State and local officials and to public and private care providers.

(h) Change of Report Deadline.—Section 2(f)(2) of the National Child Protection Act of 1993 (42 U.S.C. 5119(f)(2)) is amended by striking "1 year" and inserting "2 years".

(i) Change of Implementation Deadline.—Section 2(b)(2)(A) of the National Child Protection Act of 1993 (42 U.S.C. 5119(b)(2)(A)) is

amended by striking "3 years" and inserting "5 years".

(j) DEFINITION OF CHILD ABUSE CASES AND INDIVIDUALS WITH DISABILITIES.—Section 5 of the National Child Protection Act of 1993 (42 U.S.C. 5119c) is amended—

(1) by redesignating paragraph (6), (7), (8), and (9) as paragraph (8), (9), (10), and (11), respectively; and

(2) by inserting after paragraph (5) the following new paragraphs:

"(6) the term 'identifiable child abuse crime case' means a case that can be identified by the authorized criminal justice agency of the State as involving a child abuse crime by reference to the statutory citation or descriptive label of the crime as it appears in the criminal history record;

"(7) the term 'individuals with disabilities' means persons with a mental or physical impairment who require assistance to perform one or more daily living tasks;".

SEC. 320929. TENNESSEE VALLEY AUTHORITY LAW ENFORCEMENT PERSONNEL.

The Tennessee Valley Authority Act of 1933 (16 U.S.C. 831 et seq.) is amended by inserting after section 4 the following new section:

"SEC. 4A. LAW ENFORCEMENT.—(a) DESIGNATION OF LAW ENFORCEMENT AGENTS.—The Board may designate employees of the corporation to act as law enforcement agents in the area of jurisdiction described in subsection (c).

"(b) DUTIES AND POWERS.—

"(1) DUTIES.—A law enforcement agent designated under subsection (a) shall maintain law and order and protect persons and property in the area of jurisdiction described in subsection (c) and protect property and officials and employees of the corporation outside that area.

"(2) POWERS.—In the performance of duties described in paragraph (1), a law enforcement agent designated under subsection (a) may—

"(A) make arrests without warrant for any offense against the United States committed in the agent's presence, or for any felony cognizable under the laws of the United States if the agent has probable cause to believe that the person to be arrested has committed or is committing such a felony;

"(B) execute any warrant or other process issued by a court or officer of competent jurisdiction for the enforcement of any Federal law or regulation issued pursuant to law in connection with the investigation of an offense described in subparagraph (A);

"(C) conduct an investigation of an offense described in subparagraph (A) in the absence of investigation of the offense by any Federal law enforcement agency having investigative jurisdiction over the offense or with the concurrence of that agency; and

"(D) carry firearms in carrying out any activity described in subparagraph (A), (B), or (C).

"(c) AREA OF JURISDICTION.—A law enforcement agent designated under subsection (a) shall be authorized to exercise the law enforcement duties and powers described in subsection (b)—

"(1) on any lands or facilities owned or leased by the corporation or within such adjoining areas in the vicinities of such lands or facilities as may be determined by the board under subsection (e); and

"(2) on other lands or facilities—

"(A) when the person to be arrested is in the process of fleeing from such lands, facilities, or adjoining areas to avoid arrest;

"(B) in conjunction with the protection of property or officials or employees of the corporation on or within lands or facilities other than those owned or leased by the corporation; or

"(C) in cooperation with other Federal, State, or local law enforcement agencies.

"(d) FEDERAL INVESTIGATIVE JURISDICTION AND STATE CIVIL AND CRIMINAL JURISDICTION NOT PREEMPTED.—Nothing in this section shall be construed to—

"(1) limit or restrict the investigative jurisdiction of any Federal law enforcement agency; or

"(2) affect any right of a State or a political subdivision thereof to exercise civil and criminal jurisdiction on or within lands or facilities owned or leased by the corporation.

"(e) DETERMINATION OF ADJOINING AREAS.—

"(1) IN GENERAL.—The board shall determine and may from time-to-time modify the adjoining areas for each facility or particular area of land, or for individual categories of such facilities or lands, for the purposes of subsection (c)(1).

"(2) NOTICE.—A notice and description of each adjoining area determination or modification of a determination made under paragraph (1) shall be published in the Federal Register.

"(f) QUALIFICATIONS AND TRAINING.—The board, in consultation with the Attorney General, shall adopt qualification and training standards for law enforcement agents designated under subsection (a).

"(g) RELATION TO OTHER LAW.—A law enforcement agent designated under subsection (a) shall not be considered to be a law enforcement officer of the United States for the purposes of any other law, and no law enforcement agent designated under subsection (a) or other employee of the corporation shall receive an increase in compensation solely on account of this section.

"(h) RELATIONSHIP WITH ATTORNEY GENERAL.—The duties and powers of law enforcement agents designated under subsection (a) that are described in subsection (b) shall be exercised in accordance with guidelines approved by the Attorney General.".

SEC. 320930. CRIMINAL JUSTICE AND SUBSTANCE ABUSE TREATMENT TRAINING.

(a) ESTABLISHMENT.—The Attorney General shall establish a Criminal Justice and Substance Abuse Treatment and Prevention Training Center (referred to as the "Center") to develop and implement a program for training dislocated defense industry-related workers for careers in law enforcement, substance abuse treatment and counseling, and related criminal justice fields, and to carry out such other activities as may be required, such as creating a model database on related innovative and cost-effective distance learning techniques and technologies or facilitating placement of trainees and graduates.

(b) OPERATION.—The Center and its programs shall be operated by a consortium of not fewer than 2 qualified institutions of postsecondary education.

(c) PROGRAM AND ACTIVITIES.—The Center, under guidelines established by the Attorney General, shall—

(1) provide criminal justice and substance abuse treatment training, related research and development, instruction, technical assistance, evaluation, and demonstration activities involving the dislocated defense workers;

(2) establish a program of research, development, demonstration, evaluation, education, training, and technical assistance involving applicable innovative technologies and approaches; and

(3) provide such training and continuing education programs and services to dislocated defense industry workers.

(d) ACCEPTANCE OF SUPPORT.—The Center shall be authorized to accept funding, in-kind services, and other forms of support from private and public agencies to carry out its purposes under this section.

(e) COORDINATION OF ACTIVITIES.—All activities of the Center shall be coordinated with other appropriate and related Federal, federally assisted, State, Indian tribal, local, and private nonprofit activities to avoid duplication of effort.

(f) GENERAL AUTHORITIES.—The Attorney General may issue guidelines and make grants, enter into contracts and cooperative agreements with States, units of local government, Indian tribal governments, and other public and private entities or individuals as appropriate to carry out this section.

(g) REVOCATION OR SUSPENSION OF FUNDING.—The Attorney General may revoke or suspend funding in whole or in part if the recipient of Federal assistance under this section is not in substantial compliance with the terms or requirements of any applicable grant, contract, or cooperative agreement.

(h) DEFINITION.—In this section "qualified institution of postsecondary education" means a university system-related institution or college with experience and currently active in criminal justice related educational activities, located in Jefferson County, Texas, or in the vicinity of Huntsville, Texas.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

$1,000,000 for fiscal year 1995.

SEC. 320932. ASSISTANT UNITED STATES ATTORNEY RESIDENCY.

Section 545(a) of title 28, United States Code, is amended—

(1) by striking "and assistant United States attorney"; and

(2) by inserting the following after the first sentence: "Each assistant United States attorney shall reside in the district for which he or she is appointed or within 25 miles thereof.".

SEC. 320933. LABELS ON PRODUCTS.

To the extent any person introduces, delivers for introduction, sells, advertises, or offers for sale in commerce a product with a "Made in the U.S.A." or "Made in America" label, or the equivalent thereof, in order to represent that such product was in whole or substantial part of domestic origin, such label shall be consistent with decisions and orders of the Federal Trade Commission issued pursuant to section 5 of the Federal Trade Commission Act. This section only applies to such labels. Nothing in this section shall preclude the application of other provisions of law relating to labeling. The Commission may periodically consider an appropriate percentage of imported components which may be included in the product and still be reasonably consistent with such decisions and orders. Nothing in this section shall preclude use of such labels for products that contain imported components under the label when the label also discloses such information in a clear and conspicuous manner. The Commission shall administer this section pursuant to section 5 of the Federal Trade Commission Act and may from time to time issue rules pursuant to section 553 of Title 5, United States Code for such purpose. If a rule is issued, such violation shall be treated by the Commission as a violation of a rule under section 18 of the Federal Trade Commissions Act (15 U.S.C. 57a) regarding unfair or deceptive acts or practices. This section shall be effective upon publication in the Federal Register of a Notice of the provisions of this section. The Commission shall publish such notice within six months after the enactment of this section.

TITLE XXXIII—TECHNICAL CORRECTIONS

SEC. 330001. AMENDMENTS RELATING TO FEDERAL FINANCIAL ASSISTANCE FOR LAW ENFORCEMENT.

(a) CROSS REFERENCE CORRECTIONS.—Section 506 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3756) is amended—

(1) in subsection (a) by striking "Of" and inserting "Subject to subsection (f), of";

(2) in subsection (c) by striking "subsections (b) and (c)" and inserting "subsection (b)";

(3) in subsection (e) by striking "or (e)" and inserting "or (f)"; and

(4) in subsection (f)(1)—

(A) in subparagraph (A)—

(i) by striking ", taking into consideration subsection (e) but"; and

(ii) by striking "this subsection," and inserting "this subsection"; and

(B) in subparagraph (B) by striking "amount" and inserting "funds".

(b) CORRECTIONAL OPTIONS GRANTS.—(1) Section 515(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 is amended—

(A) by striking "subsection (a)(1) and (2)" and inserting "paragraphs (1) and (2) of subsection (a)"; and

(B) in paragraph (2) by striking "States" and inserting "public agencies".

(2) Section 516 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 is amended—

(A) in subsection (a) by striking "for section" each place it appears and inserting "shall be used to make grants under section"; and

(B) in subsection (b) by striking "section 515(a)(1) or (a)(3)" and inserting "paragraph (1) or (3) of section 515(a)".

(3) Section 1001(a)(5) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793(a)(5)) is amended by inserting "(other than chapter B of subpart 2)" after "and E".

(c) DENIAL OR TERMINATION OF GRANT.—Section 802(b) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3783(b)) is amended by striking "M,," and inserting "M,".

(d) DEFINITIONS.—Section 901(a)(21) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3791(21)) is amended by adding a semicolon at the end.

(e) PUBLIC SAFETY OFFICERS DISABILITY BENEFITS.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796) is amended—

(1) in section 1201—

(A) in subsection (a) by striking "subsection (g)" and inserting "subsection (h),"; and

(B) in subsection (b)—

(i) by striking "subsection (g)" and inserting "subsection (h)";

(ii) by striking "personal"; and

(iii) in the first proviso by striking "section" and inserting "subsection"; and

(2) in section 1204(3) by striking "who was responding to a fire, rescue or police emergency".

(f) HEADINGS.—(1) The heading for part M of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797) is amended to read as follows:

"PART M—REGIONAL INFORMATION SHARING SYSTEMS".

(2) The heading for part O of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797) is amended to read as follows:

"PART O—RURAL DRUG ENFORCEMENT".

(g) TABLE OF CONTENTS.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 is amended—

(1) in the item relating to section 501 by striking "Drug Control and System Improvement Grant" and inserting "drug control and system improvement grant";

(2) in the item relating to section 1403 by striking "Application" and inserting "Applications"; and

(3) in the items relating to part O by redesignating sections 1401 and 1402 as sections 1501 and 1502, respectively.

(h) OTHER TECHNICAL AMENDMENTS.—Title I of the Omnibus Crime Control and Safe Streets Act of 1968 is amended—

(1) in section 202(c)(2)(E) by striking "crime,," and inserting "crime,";

(2) in section 302(c)(19) by striking a period at the end and inserting a semicolon;

(3) in section 602(a)(1) by striking "chapter 315" and inserting "chapter 319";

(4) in section 603(a)(6) by striking "605" and inserting "606";

(5) in section 605 by striking "this section" and inserting "this part";

(6) in section 606(b) by striking "and Statistics" and inserting "Statistics";

(7) in section 801(b)—

(A) by striking "parts D," and inserting "parts";

(B) by striking "part D" each place it appears and inserting "subpart 1 of part E";

(C) by striking "403(a)" and inserting "501"; and

(D) by striking "403" and inserting "503";

(8) in the first sentence of section 802(b) by striking "part D," and inserting "subpart 1 of part E or under part";

(9) in the second sentence of section 804(b) by striking "Prevention or" and inserting "Prevention, or";

(10) in section 808 by striking "408, 1308," and inserting "507";

(11) in section 809(c)(2)(H) by striking "805" and inserting "804";

(12) in section 811(e) by striking "Law Enforcement Assistance Administration" and inserting "Bureau of Justice Assistance";

(13) in section 901(a)(3) by striking "and," and inserting ", and";

(14) in section 1001(c) by striking "parts" and inserting "part".

(i) CONFORMING AMENDMENT TO OTHER LAW.—Section 4351(b) of title 18, United States Code, is amended by striking "Administrator of the Law Enforcement Assistance Administration" and inserting "Director of the Bureau of Justice Assistance".

SEC. 330002. GENERAL TITLE 18 CORRECTIONS.

(a) SECTION 1031.—Section 1031(g)(2) of title 18, United States Code, is amended by striking "a government" and inserting "a Government".

(b) SECTION 208.—Section 208(c)(1) of title 18, United States Code, is amended by striking "Banks" and inserting "banks".

(c) SECTION 1007.—The heading for section 1007 of title 18, United States Code, is amended by striking "Transactions" and inserting "transactions".

(d) SECTION 1014.—Section 1014 of title 18, United States Code, is amended by striking the comma that follows a comma.

(e) ELIMINATION OF OBSOLETE CROSS REFERENCE.—Section 3293 of title 18, United States Code, is amended by striking "1008,".

(f) ELIMINATION OF DUPLICATE SUBSECTION DESIGNATION.—Section 1031 of title 18, United States Code, is amended by redesignating the second subsection (g) as subsection (h).

(g) TECHNICAL AMENDMENT TO PART ANALYSIS FOR PART I.—The item relating to chapter 33 in the part analysis for part I of title 18, United States Code, is amended by striking "701" and inserting "700".

(h) AMENDMENT TO SECTION 924(a)(1)(B).—Section 924(a)(1)(B) of title 18, United States Code, is amended by striking "(q)" and inserting "(r)".

(i) PUNCTUATION CORRECTION.—Section 207(c)(2)(A)(ii) of title 18, United States Code, is amended by striking the semicolon at the end and inserting a comma.

(j) CHAPTER ANALYSIS CORRECTION.—The chapter analysis for chapter 223 of title 18, United States Code, is amended by adding at the end the following:

"3509. Child Victims' and child witnesses' rights.".

(k) Elimination of Superfluous Comma.—Section 3742(b) of title 18, United States Code, is amended by striking "Government," and inserting "Government".

SEC. 330003. CORRECTIONS OF ERRONEOUS CROSS REFERENCES AND MISDESIGNATIONS.

(a) SECTION 1791 OF TITLE 18.—Section 1791(b) of title 18, United States Code, is amended by striking "(c)" each place it appears and inserting "(d)".

(b) SECTION 2703 OF TITLE 18.—Section 2703(d) of title 18, United States Code, is amended by striking "section 3126(2)(A)" and inserting "section 3127(2)(A)".

(c) SECTION 666 OF TITLE 18.—Section 666(d) of title 18, United States Code, is amended—

(1) by redesignating the second paragraph (4) as paragraph (5);

(2) by striking "and" at the end of paragraph (3); and

(3) by striking the period at the end of paragraph (4) and inserting "; and".

(d) SECTION 4247 OF TITLE 18.—Section 4247(h) of title 18, United States Code, is amended by striking "subsection (e) of section 4241, 4243, 4244, 4245, or 4246," and inserting "subsection (e) of section 4241, 4244, 4245, or 4246, or subsection (f) of section 4243,".

(e) SECTION 408 OF THE CONTROLLED SUBSTANCE.—Section 408(b)(2)(A) of the Controlled Substances Act (21 U.S.C. 848(b)(2)(A)) is amended by striking "subsection (d)(1)" and inserting "subsection (c)(1)".

(f) MARITIME DRUG LAW ENFORCEMENT ACT.—(1) Section 994(h) of title 28, United States Code, is amended by striking "section 1 of the Act of September 15, 1980 (21 U.S.C. 955a)" each place it appears and inserting "the Maritime Drug Law Enforcement Act (46 U.S.C. App. 1901 et seq.)".

(2) Section 924(e) of title 18, United States Code, is amended by striking "the first section or section 3 of Public Law 96–350 (21 U.S.C. 955a et seq.)" and inserting "the Maritime Drug Law Enforcement Act (46 U.S.C. App. 1901 et seq.)".

(g) SECTION 2596 OF THE CRIME CONTROL ACT OF 1990.—Section 2596(d) of the Crime Control Act of 1990 is amended, effective retroactively to the date of enactment of such Act, by striking "951(c)(1)" and inserting "951(c)(2)".

(h) FEDERAL RULES OF CRIMINAL PROCEDURE.—Rule 46(i)(1) of the Federal Rules of Criminal Procedure for the United States Courts is amended by striking "18 U.S.C. §3144" and inserting "18 U.S.C. §3142".

SEC. 330004. REPEAL OF OBSOLETE PROVISIONS IN TITLE 18.

Title 18, United States Code, is amended—

(1) in section 212 by striking "or of any National Agricultural Credit Corporation," and by striking "or National Agricultural Credit Corporations,";

(2) in section 213 by striking "or examiner of National Agricultural Credit Corporations";

(3) in section 709 by striking the seventh and thirteenth paragraphs;

(4) in section 711 by striking the second paragraph;

(5) by striking section 754 and amending the chapter analysis for chapter 35 by striking the item relating to section 754;

(6) in sections 657 and 1006 by striking "Reconstruction Finance Corporation," and striking "Farmers' Home Corporation,";

(7) in section 658 by striking "Farmers' Home Corporation,";

(8) in section 1013 by striking ", or by any National Agricultural Credit Corporation";

(9) in section 1160 by striking "white person" and inserting "non-Indian";

(10) in section 1698 by striking the second paragraph;

(11) by striking sections 1904 and 1908 and amending the chapter analysis for chapter 93 by striking the items relating to those sections;

(12) in section 1909 by inserting "or" before "farm credit examiner" and by striking "or an examiner of National Agricultural Credit Corporations,";

(13) by striking sections 2157 and 2391 and amending the chapter analysis for chapter 105 and for 115, respectively, by striking the items relating to those sections;

(14) in section 2257 by striking the subsections (f) and (g) that were enacted by Public Law 100–690;

(15) in section 3113 by striking the third paragraph;

(16) in section 3281 by striking "except for offenses barred by the provisions of law existing on August 4, 1939";

(17) in section 443 by striking "or (3) five years after 12 o'clock noon of December 31, 1946,";

(18) in sections 542, 544, and 545 by striking "the Philippine Islands,"; and

(19) in section 1073—

(A) by striking "or which, in the case of New Jersey, is a high misdemeanor under the laws of said State,"; and

(B) by striking "or which in the case of New Jersey, is a high misdemeanor under the laws of said State,".

SEC. 330005. CORRECTION OF DRAFTING ERROR IN THE FOREIGN CORRUPT PRACTICES ACT.

Section 104(a)(3) of the Foreign Corrupt Practices Act of 1977 (15 U.S.C. 78dd–2) is amended by striking "issuer" and inserting "domestic concern".

SEC. 330006. ELIMINATION OF REDUNDANT PENALTY PROVISION IN 18 U.S.C. 1116.

Section 1116(a) of title 18, United States Code, is amended by striking ", and any such person who is found guilty of attempted murder shall be imprisoned for not more than twenty years".

SEC. 330007. ELIMINATION OF REDUNDANT PENALTY.

Section 1864(c) of title 18, United States Code, is amended by striking "(b) (3), (4), or (5)" and inserting "(b)(5)".

SEC. 330008. CORRECTIONS OF MISSPELLINGS AND GRAMMATICAL ERRORS.

Title 18, United States Code, is amended—

(1) in section 513(c)(4) by striking "association or persons" and inserting "association of persons";

(2) in section 1956(e) by striking "Evironmental" and inserting "Environmental";

(3) in section 3125—

(A) in subsection (a)(2) by striking "use" and the quotation mark that immediately follows it and inserting "use;";

(B) by realigning the matter in subsection (a)(2) that begins with "may have installed" and ends with "section 3123 of this title" so that it is flush to the left margin; and

(C) by striking "provider for" and inserting "provider of" in subsection (d);

(4) in section 3731 by striking "order of a district courts" and inserting "order of a district court" in the second undesignated paragraph;

(5) in section 151 by striking "mean" and inserting "means";

(6) in section 208(b) by inserting "if" after "(4)";

(7) in section 209(d) by striking "under the terms of the chapter 41" and inserting "under the terms of chapter 41";

(8) in section 1014 by inserting a comma after "National Credit Union Administration Board"; and

(9) in section 3291 by striking "the afore-mentioned" and inserting "such".

SEC. 330009. OTHER TECHNICAL AMENDMENTS.

(a) Section 419 of Controlled Substances Act.—Section 419(b) of the Controlled Substances Act (21 U.S.C. 860(b)) is amended by striking "years Penalties" and inserting "years. Penalties".

(b) Section 667.—Section 667 of title 18, United States Code, is amended by adding at the end the following: "The term 'livestock' has the meaning set forth in section 2311 of this title.".

(c) Section 1114.—Section 1114 of title 18, United States Code, is amended by striking "or any other officer, agency, or employee of the United States" and inserting "or any other officer or employee of the United States or any agency thereof".

(d) Section 408 of Controlled Substances Act.—Section 408(q)(8) of the Controlled Substances Act (21 U.S.C. 848(q)(8)) is amended by striking "applications, for writ" and inserting "applications for writ".

SEC. 330010. CORRECTION OF ERRORS FOUND DURING CODIFICATION.

Title 18, United States Code, is amended—

(1) in section 212 by striking "218" and inserting "213";

(2) in section 1917—

(A) by striking "Civil Service Commission" and inserting "Office of Personnel Management"; and

(B) by striking "the Commission" in paragraph (1) and inserting "such Office";

(3) by transferring the subchapter analysis for each subchapter of each of chapters 227 and 229 to follow the heading of that subchapter;

(4) so that the heading of section 1170 reads as follows:

"§1170. Illegal trafficking in Native American human remains and cultural items";

(5) so that the item relating to section 1170 in the chapter analysis for chapter 53 reads as follows:

"1170. Illegal trafficking in Native American human remains and cultural items.";

(6) in section 3509(a) by striking paragraph (11) and redesignating paragraphs (12) and (13) as paragraphs (11) and (12), respectively;

(7) in section 3509—

(A) by striking "subdivision" each place it appears and inserting "subsection"; and

(B) by striking "government" each place it appears and inserting "Government";

(8) in section 2252(a)(3)(B) by striking "materails" and inserting " materials";

(9) in section 14 by striking "45," and "608, 611, 612,";

(10) in section 3059A—

(A) in subsection (b) by striking "this subsection" and inserting "subsection"; and

(B) in subsection (c) by striking "this subsection" and inserting "subsection";

(11) in section 1761(c)—

(A) by striking "and" at the end of paragraph (1);

(B) by inserting "and" at the end of paragraph (3); and

(C) by striking the period at the end of paragraph (2)(B) and inserting a semicolon;

(12) in the chapter analysis for chapter 11—

(A) in the item relating to section 203 by inserting a comma after "officers" and by striking the comma after "others"; and

(B) in the item relating to section 204 by inserting "the" before "United States Court of Appeals for the Federal Circuit";

(13) in the chapter analysis for chapter 23, in the item relating to section 437, by striking the period immediately following "Indians";

(14) in the chapter analysis for the beginning of chapter 25, in the item relating to section 491, by striking the period immediately following "paper used as money";

(15) in section 207(a)(3) by striking "Clarification of Restrictions" and inserting "Clarification of restrictions";

(16) in section 176 by striking "the government" and inserting "the Government";

(17) in section 3059A(e)(2)(iii) by striking "backpay" and inserting "back pay"; and

(18) by adding a period at the end of the item relating to section 3059A in the chapter analysis for chapter 203.

SEC. 330011. PROBLEMS RELATED TO EXECUTION OF PRIOR AMENDMENTS.

(a) Incorrect Reference.—Section 2587(b) of Public Law 101–647 is amended, effective as of the date on which that section took effect, by striking "The chapter heading for" and inserting "The chapter analysis for".

(b) Lack of Punctuation in Stricken Language.—Section 46(b) of the Criminal Law and Procedure Technical Amendments Act of 1986 is amended, effective as of the date on which that section took effect, so that—

(A) in paragraph (1), the matter proposed to be stricken from the beginning of section 201(b) of title 18, United States Code, reads "(b) Whoever, directly"; and

(B) in paragraph (2), a comma, rather than a semicolon, appears after "his lawful duty" in the matter to be stricken from paragraph (3) of section 201(b) of that title.

(c) Biological Weapons.—(1) Section 3(b) of the Biological Weapons Anti-Terrorism Act of 1989 is amended, effective as of the date on which that section took effect, by striking "2516(c)" and inserting "2516(1)(c)".

(2) The item in the part analysis for part I of title 18, United States Code, that relates to chapter 10 is amended by striking "Weapons" and inserting "weapons".

(d) Placement of New Section.—Section 404(a) of Public Law 101–630 is amended, effective on the date such section took effect, by striking "adding at the end thereof" each place it appears and inserting "inserting after section 1169".

(e) Elimination of Erroneous Characterization of Matter Inserted.—Section 225(a) of Public Law 101–647 is Amended, effective as of the date on which that section took effect, by striking "new rule".

(f) Clarification of Placement of Amendment.—Section 1205(c) of Public Law 101–647 is amended, effective as of the date on which that section took effect, by inserting "at the end" after "adding".

(g) Elimination of Duplicate Amendment.—Section 1606 of Public Law 101–647 (amending section 1114 of title 18, United States Code) is repealed effective as of the date of enactment of that section.

(h) Error in Amendment Phrasing.—Section 3502 of Public Law 101–647 is amended, effective as of the date on which that section took effect, by striking "10" and inserting "ten".

(i) Clarification That Amendments Were to Title 18.—Sections 3524, 3525, and 3528 of Public Law 101–647 are each amended, effective as of the date on which those sections took effect, by inserting "of title 18, United States Code" before "is amended".

(j) Correction of Paragraph Reference.—Section 3527 of Public Law 101–647 is amended, effective as of the date on which that section took effect, by striking "4th" and inserting "5th".

(k) Repeal of Obsolete Technical Correction to Section 1345.—Section 3542 of Public Law 101–647 is repealed, effective as of the date of its enactment.

(l) Repeal of Obsolete Technical Correction to Section 1956.—Section 3557(2)(E) of Public Law 101–647 is repealed, effective as of the date of its enactment.

(m) Clarification of Placement of Amendments.—Public Law 101–647 is amended, effective as of the date of its enactment—

(1) in section 3564(1) by inserting "each place it appears" after the quotation mark following "2251" the first place it appears; and

(2) in section 3565(3)(A) by inserting "each place it appears" after the quotation mark following "subchapter".

(n) Correction of Word Quoted in Amendment.—Section 3586(1) of Public Law 101-647 is amended, effective as of the date on which that section took effect, by striking "fines" and inserting "fine".

(o) Elimination of Obsolete Technical Amendment to Section 4013.—Section 3599 of Public Law 101-647 is repealed, effective as of the date of its enactment.

(p) Correction of Directory Language.—Section 3550 of Public Law 101–647 is amended, effective as of the date on which that section took effect, by striking "not more than".

(q) Repeal of Duplicate Provisions.—(1) Section 3568 of Public Law 101-647 is repealed, effective as of the date on which that section took effect.

(2) Section 1213 of Public Law 101–647 is repealed, effective as of the date on which that section took effect.

(r) Correction of Words Quoted in Amendment.—Section 2531(3) of Public Law 101–647 is amended, effective as of the date on which that section took effect, by striking "1679(c)(2)" and inserting "1679a(c)(2)".

(s) Forfeiture.—(1) Section 1401 of Public Law 101–647 is amended, effective as of the date on which that section took effect—

(A) by inserting a comma after ", 5316"; and

(B) by inserting "the first place it appears" after the quotation mark following "5313(a)".

(2) Section 2525(a)(2) of Public Law 101–647 is amended, effective as of the date on which that section took effect, by striking "108(3)" and inserting "2508(3)".

SEC. 330012. AMENDMENT TO SECTION 1956 OF TITLE 18 TO ELIMINATE DUPLICATE PREDICATE CRIMES.

Section 1956 of title 18, United States Code, is amended in subsection (c)(7)(E), by striking the period that follows a period.

SEC. 330013. AMENDMENTS TO PART V OF TITLE 18.

Part V of title 18, United States Code, is amended—

(1) by inserting after the heading for that part the following:

"CHAPTER 601—IMMUNITY OF WITNESSES";

(2) in section 6001(1)—

(A) by striking "Atomic Energy Commission" and inserting "Nuclear Regulatory Commission"; and

(B) by striking "the Subversive Activities Control Board,"

(3) by striking "part" the first place it appears and inserting "chapter"; and

(4) by striking "part" each other place it appears and inserting "title".

SEC. 330014. UPDATE OF CROSS REFERENCE.

Section 408(n)(11) of the Controlled Substances Act is amended by striking "section 405" and inserting "section 418".

SEC. 330015. CORRECTION OF ERROR IN AMENDATORY LANGUAGE.

Section 1904 of Public Law 101–647 is amended, effective as of the date on which that section took effect, by striking "by inserting a new subsection (e) as follows" and inserting "so that subsection (e) reads as follows".

SEC. 330016. CORRECTION OF MISLEADING AND OUTMODED FINE AMOUNTS IN OFFENSES UNDER TITLE 18.

Title 18, United States Code, is amended—

(1)(A) in sections 1693, 1694, 1695, and 1696 by striking "not more than $50" and inserting "under this title";

(B) in sections 333, 489, 754, 1303, 1699, 1701, 1703, 1710, 1723, 1726, 1730, and 2390 by striking "not more than $100" and inserting "under this title";

(C) in sections 1697 and 1698 by striking "not more than $150" and inserting "under this title";

(D) in sections 1165 and 2279 by striking "not more than $200" and inserting "under this title";

(E) in sections 701, 702, 703, 704, 705, 706, 707, 708, 710, 711, 711a, 713, 715, 1164, and 1858 by striking "not more than $250" each place it appears and inserting "under this title";

(F) in sections 916, 1501, 1502, 1719, 1725, and 1861 by striking "not more than $300" and inserting "under this title";

(G) in sections 4, 41, 42, 46, 47, 112, 154, 244, 288, 290, 336, 475, 501, 502, 755, 872, 875, 876, 877, 917, 1013, 1018, 1024, 1154, 1155, 1156, 1382, 1541, 1700, 1703, 1704, 1707, 1712, 1713, 1720, 1721, 1722, 1729, 1731, 1734, 1752, 1793, 1856, 1857, 1863, 1912, 1913, 1922, 2074, 2195, and 2511 by striking "not more than $500" each place it appears and inserting "under this title";

(H) in sections 81, 210, 211, 215, 217, 242, 245, 291, 292, 439, 442, 480, 483, 484, 490, 491, 494, 495, 503, 507, 510, 594, 595, 596, 597, 598, 599, 604, 605, 641, 643, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 661, 662, 665, 712, 751, 752, 756, 795, 796, 797, 836, 844, 871, 875, 876, 877, 879, 911, 912, 913, 924, 957, 959, 961, 1003, 1012, 1021, 1025, 1026, 1071, 1112, 1163, 1262, 1263, 1264, 1301, 1302, 1304, 1306, 1341, 1342, 1343, 1361, 1363, 1384, 1504, 1508, 1509, 1657, 1705, 1706, 1707, 1711, 1715, 1716, 1733, 1738, 1761, 1762, 2276, 2277, 2278, 2382, and 2389 by striking "not more than $1,000" each place it appears and inserting "under this title";

(I) in sections 331, 482, 486, 499, 755, 873, 958, 1016, 1154, 1156, 1381, 1542, 1543, 1544, 1545, 1586, 1621, 1622, 1702, 1708, 1709, 1920, 1921, 1923, 2071, 2193, 2233, 2386, and 2424 by striking "not more than $2,000" each place it appears and inserting "under this title";

(J) in sections 431, 432, 479, 960, 1859, 1901, 1911, and 1959 by striking "not more than $3,000" and inserting "under this title";

(K) in sections 35, 81, 112, 152, 153, 155, 212, 213, 214, 285, 334, 351, 435, 436, 438, 471, 472, 473, 476, 477, 478, 481, 485, 487, 488, 497, 498, 505, 506, 508, 509, 541, 542, 543, 544, 546, 547, 548, 549, 550, 551, 552, 592, 593, 602, 603, 606, 607, 642, 655, 658, 659, 660, 661, 663, 751, 799, 844, 872, 874, 875, 876, 877, 878, 914, 915, 924, 953, 954, 956, 1004, 1010, 1011, 1015, 1017, 1025, 1028, 1071, 1073, 1074, 1163, 1169, 1231, 1265, 1363, 1421, 1422, 1423, 1424, 1425, 1426, 1427, 1428, 1429, 1461, 1462, 1463, 1465, 1503, 1505, 1506, 1507, 1510, 1581, 1582, 1583, 1584, 1585, 1588, 1658, 1659, 1717, 1732, 1735, 1737, 1751, 1906, 1907, 1908, 1909, 1915, 1991, 2072, 2073, 2113, 2217, 2152, 2197, 2231, 2244, 2314, 2316, 2317, 2344, and 2701 by striking "not more than $5,000" each place it appears and inserting "under this title";

(L) in sections 33, 224, 231, 241, 245, 246, 286, 289, 332, 335, 337, 351, 371, 437, 440, 441, 493, 496, 500, 510, 545, 595, 599, 600, 601, 641, 664, 665, 667, 757, 792, 793, 798, 844, 892, 893, 894, 924, 952, 955, 962, 963, 964, 965, 966, 967, 970, 1001, 1002, 1003, 1019, 1020, 1022, 1023, 1027, 1082, 1084, 1115, 1202, 1361, 1362, 1364, 1365, 1385, 1461, 1462, 1464, 1587, 1623, 1654, 1656, 1735, 1737, 1751, 1902, 1903, 1904, 1910, 1951, 1952, 1953, 1954, 1958, 1992, 2101, 2113, 2153, 2154, 2155, 2156, 2231, 2232, 2271, 2274, 2275, 2314, 2315, 2383, 2386, 2387, 2388, and 2512 by striking "not more than $10,000" each place it appears and inserting "under this title";

(M) in section 1028 by striking "not more than $15,000" and inserting "under this title";

(N) in sections 844, 878, 1728, 1955, 1958, 2321, 2384, and 2385 by striking "not more than $20,000" each place it appears and inserting "under this title";

(O) in sections 32, 114, 753, 1028, 1365, 1512, 1792, and 2118 by striking "not more than $25,000" each place it appears and inserting "under this title";

(P) in section 2118 by striking "not more than $35,000" and inserting "under this title";

(Q) in sections 1365, 1958, and 2118 by striking "not more than $50,000" and inserting "under this title";

(R) in section 951 by striking "not more than $75,000" and inserting "under this title";

(S) in sections 32, 1167, 1365, 2251, and 2344 by striking "not more than $100,000" each place it appears and inserting "under this title";

(T) in section 2251 by striking "not more than $200,000" and inserting "under this title"; and

(U) in sections 1158, 1167, 1512, 1513, 2251, 2318, 2320, and 2701 by striking "not more than $250,000" and inserting "under this title";

(2)(A) in sections 3 and 373 by inserting "(notwithstanding section 3571)" before "fined not more than one-half";

(B) in section 113 by striking "fine of not more than" through the immediately following dollar amount each place it appears and inserting "a fine under this title";

(C) in sections 115, 513, 709, 831, 1366, 1511 and 1959 by striking "of not more than" through the immediately following dollar amount each place it appears and inserting "under this title";

(D) in section 201 by inserting "under this title or" after "be fined"; and by inserting "whichever is greater," before "or imprisoned";

(E) in section 402 by striking "fine" the first place it appears and inserting "a fine under this title";

(F) in section 443 by striking "shall, if a corporation, be fined not more than $50,000, and, if a natural person, be fined not more than $10,000" and inserting "shall be fined under this title";

(G) in sections 643, 644, 645, 647, 648, 649, 650, 651, 652, 653, and 1711 by inserting "under this title or" after "be fined" the first place it appears; and by inserting ", whichever is greater," before "or imprisoned the first place it appears;

(H) in sections 646 and 654 by inserting "under this title or" after "be fined" the first place it appears; and by inserting "whichever is greater," before "or imprisoned" the first place it appears;

(I) in section 1029 by striking "of not more than" through the immediately following dollar amount each place it appears and inserting "under this title"; and by inserting ", whichever is greater," before "or imprisonment" each place it appears;

(J) in section 2381 by inserting "under this title but" before "not less than $10,000"; and

(K) in section 3146(b)(1)(A)(iv) by striking "fine under this chapter" and inserting "fined under this title".

SEC. 330017. TECHNICAL CORRECTIONS TO TITLE 31 CRIMES.

(a) Title 31, U.S.C., Amendments.—

(1) Section 5321(a)(5)(A) of title 31, United States Code, is amended by inserting "any violation of" after "causing".

(2) Section 5324(a) of title 31, United States Code, is amended—

(A) by striking "section 5313(a), section 5325, or the regulations issued thereunder or section 5325 or regulations prescribed under such section 5325" each place it appears and inserting "section 5313(a) or 5325 or any regulation prescribed under any such section"; and

(B) by striking "with respect to such transaction".

(b) Amendment Relating to Title 31, U.S.C.—

(1) Effective as of the date of enactment of the Annunzio-Wylie Anti-Money Laundering Act, section 1517(b) of that Act is amended by striking "5314" and inserting "5318".

(2) Section 5239 of the Revised Statutes of the United States is amended by redesignating the second subsection (c) (as added by section 1502(a) of the Annunzio-Wylie Anti-Money Laundering Act) as subsection (d).

SEC. 330018. REPEAL OF SUPERFLUOUS STATUTE OF LIMITATION AND TRANSFER OF CHILD ABUSE STATUTE OF LIMITATION.

(a) IN GENERAL.—Section 3283 of title 18, United States Code, is amended to read as follows:

"§3283. Child abuse offenses

"No statute of limitations that would otherwise preclude prosecution for an offense involving the sexual or physical abuse of a child under the age of 18 years shall preclude such prosecution before the child reaches the age of 25 years.".

(b) CONFORMING REPEAL.—Section 3509(k) of title 18, United States Code, is amended by striking the subsection heading and the first sentence and inserting "STAY OF CIVIL ACTION.—".

(c) TECHNICAL AMENDMENT.—The item in the chapter analysis for chapter 213 of title 18, United States Code, that relates to section 3283 is amended to read as follows:

"3283. Child abuse offenses.".

SEC. 330019. TECHNICAL ERRORS IN SECTION 1956.

(a) TECHNICAL CORRECTIONS.—Section 1956 of title 18, United States Code, is amended—

(1) in subsection (c)(7)(B)(iii) by inserting a close parenthesis after "1978";

(2) by redesignating the second subsection (g) as subsection (h); and

(3) in subsection (a)(2) by inserting "not more than" before "$500,000".

(b) CROSS REFERENCE CORRECTION.—Section 1956(c)(7)(D) of title 18, United States Code, is amended by striking "section 9(c) of the Food Stamp Act of 1977" and inserting "section 15 of the Food Stamp Act of 1977".

SEC. 330020. TECHNICAL ERROR.

Section 1957(f)(1) of title 18, United States Code, is amended by striking the comma that follows a comma.

SEC. 330021. CONFORMING SPELLING OF VARIANTS OF "KIDNAP".

Title 18, United States Code, is amended—

(1) by striking "kidnaping" each place it appears and inserting "kidnapping"; and

(2) by striking "kidnaped" each place it appears and inserting "kidnapped".

SEC. 330022. MARGIN ERROR.

Section 2512(2) of title 18, United States Code, is amended by realigning the matter that begins with "to send through" and ends with "electronic communications" so that it is flush to the left margin.

SEC. 330023. TECHNICAL CORRECTIONS RELATING TO SECTION 248 OF TITLE 18, UNITED STATES CODE.

(a) IN GENERAL.—Chapter 13 of title 18, United States Code, is amended—

(1) in the chapter analysis so that the item relating to section 248 reads as follows:

"248. Freedom of access to clinic entrances.";

(2) so that the heading of section 248 reads as follows:

***"§248. Freedom of access to clinic entrances"**; and*

(3) in section 248(b) by inserting ", notwithstanding section 3571," before "be not more than $25,000".

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall take effect on the date of enactment of the Freedom of Access to Clinic Entrances Act of 1994.

SEC. 330024. TECHNICAL AMENDMENTS NECESSITATED BY THE ENACTMENT OF THE DOMESTIC CHEMICAL DIVERSION CONTROL ACT OF 1993.

(a) MISSING CONJUNCTION.—Section 102(39)(A)(iv) of the Controlled Substances Act (21 U.S.C. 802(39)(A)(iv)) is amended by striking the period at the end and inserting "; or".

(b) PUNCTUATION AND INDENTATION CORRECTION.—Section 102(34) of the Controlled Substances Act is amended—

(1) by moving subparagraphs (V) and (W) two ems toward the left margin;

(2) in subparagraph (V) by striking "b" and inserting "B"; and

(3) in subparagraph (W) by striking "n" the first place it appears and inserting "N".

(c) ERRONEOUS CROSS REFERENCES.—

(1) Section 5(a) of the Domestic Chemical Diversion Control Act of 1993 is amended by striking "section 1505(a)" and inserting "section 4".

(2) Section 9(b) of the Domestic Chemical Diversion Control Act of 1993 is amended by striking "Controlled Substances Act" and inserting "Controlled Substances Import and Export Act".

(d) CORRECTION OF AMENDATORY LANGUAGE.—

(1) Section 2(a)(4)(B) of the Domestic Chemical Diversion Control Act of 1993 is amended by inserting "the first place it appears" before the semicolon.

(2) Section 5(b)(3) of the Domestic Chemical Diversion Control Act of 1993 is amended by striking "at the end" and inserting "after paragraph (4)".

(e) MISSING CONFORMING AMENDMENT.—Section 304(g) of the Controlled Substances Act is amended by inserting "or chemical" after "such substance" in the last sentence.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect as of the date that is 120 days after the date of enactment of the Domestic Chemical Diversion Control Act of 1993.

SEC. 330025. VICTIMS OF CRIME ACT.

(a) INCORRECT SECTION REFERENCE.—Section 1402(d)(3) of the Victims of Crime Act of 1984 (42 U.S.C. 10601(d)(3)) is amended by striking "1404(a)" and inserting "1404A".

(b) MISSING TEXT.—Section 1403(b)(1) of the Victims of Crime Act of 1984 (42 U.S.C. 10602(b)(1)) is amended by inserting after "domestic violence" the following: "for—

"(A) medical expenses attributable to a physical injury resulting from compensable crime, including expenses for mental health counseling and care;

"(B) loss of wages attributable to a physical injury resulting from a compensable crime; and

"(C) funeral expenses attributable to a death resulting from a compensable crime".

And the House agree to the same.

That the Senate recede from its disagreement to the amendment of the House to the title of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the amendment of the House to the title of the bill, insert the following: "An Act to control and prevent crime.".

And the House agree to the same.

JACK BROOKS,
DON EDWARDS,
BILL HUGHES,
CHARLES SCHUMER,
JOHN CONYERS, Jr.,
MIKE SYNAR,

As additional conferees from the Committee on Agriculture, for consideration of sections 4601–08, 5105, and 5145 of the Senate amendment, and modifications committed to conference:

E DE LA GARZA,
CHARLIE ROSE,
CHARLES W. STENHOLM,
PAT ROBERTS,
RICHARD POMBO,

As additional conferees from the Committee on Banking, Finance and Urban Affairs, for consideration of sections 2201–04, 2301, and 4901–33 of the Senate amendment, and sections 1031(b), 1038, and 1099AA–1099CC of the House amendment and modifications committed to conference:

HENRY GONZALEZ,
STEVE NEAL,
BRUCE F. VENTO,

As additional conferees from the Committee on Education and Labor, for consideration of sections 631–33, 662(e), 662(f), 811–16, 921–28, 1121–50, 1331, 2801–03, 3261, 3263, 3311, 3341, 3351, 3361, 3381–83, 3501, 3707, 4001–09, 4301–04, 4701–02, 4801–09, 4901–33, 5120, 5122, 5135, 5140, 5142–43, and 5147 of the Senate amendment, and sections 1010–26, 1030–34, 1038, 1051–52, 1065–71, 1081–96, 1099A–1099G, 1099H–1099O, 1099P–1099T, 1606, 1610, 1653–54, 1902(e), 1902(f), 2201–02, 2701–39, 3061–62, 3089–90, of the House amendment, and modifications committed to conference:

WILLIAM D. FORD,
DALE E. KILDEE,
MATTHEW G. MARTINEZ,

As additional conferees from the Committee on Energy and Commerce, for consideration of sections 1503–04, 1511–23, 1532, 1534–35, 1537, 1902(e), 3101–03, 3261, and 5166 of the Senate amendment, and sections 1010–26, 1041–44, 1606, 2901–03, and 3086 of the House amendment, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
CARDIS COLLINS,

As additional conferees from the Committee on Government Operations, for consideration of sections 1353–54, 1535, and 5150 of the Senate amendment, and sections 1075–76 of the House amendment, and modifications committed to conference:

TOM LANTOS,
EDOLPHUS TOWNS,

Provided, Mr. Spratt and Mr. Kyl are appointed in lieu of Mr. Waxman and Mr. Clinger solely for the consideration of sections 1535 and 5150 of the Senate amendment.

JOHN M. SPRATT, Jr.,

As additional conferees from the Committee on Merchant Marine and Fisheries, for consideration of sections 713–15, 4601–08, 5105, and 5145 of the Senate amendment, and modifications committed to conference:

GERRY STUDDS,
SOLOMON P. ORTIZ,
GEORGE HOCHBRUECKNER,

As additional conferees from the Committee on Natural Resources, for consideration of sections 3232–33, 4601–08, and 5145 of the Senate amendment and sections 1099U–1099Z of the House amendment, and modifications committed to conference:

GEORGE MILLER,
BRUCE F. VENTO,
KAREN SHEPHERD,
DON YOUNG,
BARBARA VUCANOVICH,

Provided, Ms. English of Arizona is appointed in lieu of Ms. Shepherd solely for the consideration of sections 4601–08 of the Senate amendment.

KARAN ENGLISH,

Provided, Mr. Hinchey is appointed in lieu of Ms. Shepherd solely for the consideration of sections 1099U–1099Z of the House amendment.

MAURICE HINCHEY,

As additional conferees from the Committee on Post Office and Civil Service, for consideration of sections 1352 and 3371 of the Senate amendment, and modifications committed to conference:

WILLIAM CLAY,
FRANK MCCLOSKEY,
ELEANOR H. NORTON,
JOHN T. MYERS,
CONSTANCE A. MORELLA,

As additional conferees from the Committee on Public Works and Transportation, for consideration of sections 1533, 1536, and 3231 of the Senate amendment, and section 1801 of the House amendment, and modifications committed to conference:

NORMAN Y. MINETA,
NICK RAHALL,
BUD SHUSTER,
THOMAS E. PETRI,

As additional conferees from the Committee on Rules, for consideration of sections 1353-54 of the Senate amendment, and modifications committed to conference:

JOHN JOSEPH MOAKLEY,
BUTLER DERRICK,
TONY BEILENSON,

As additional conferees from the Committee on Ways and Means, for consideration of sections 311(b), 1502, 1515-16, 1802, 4702(e)(1), 5102, and 5113 of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
SAM GIBBONS,
J.J. PICKLE,

Managers on the Part of the House.

JOSEPH R. BIDEN, Jr.,
EDWARD M. KENNEDY,
HOWARD M. METZENBAUM,
DENNIS DECONCINI,
PATRICK J. LEAHY,

Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (H.R. 3355), to amend the Omnibus Crime Control and Safe Streets Act of 1968 to allow grants to increase police presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and otherwise to enhance public safety, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

TITLE I—PUBLIC SAFETY AND POLICING

House sections 1401-02 recede to Senate sections 101-02 and that portion of section 103 dealing with "Cops on the Beat" with the following modifications: the minimum amount for each qualified State is 0.5 percent; all applications will be direct to the Attorney General with special provisions for expedited submission and approval of applications from America's small jurisdictions as well as for small grants for non-police hiring; cost per police officer shall be limited to $75,000 which may be expended for periods up to five years; hiring funds may also be used to train new career law enforcement officers for community policing; 50 percent of the monies must be granted to jurisdictions with populations over 150,000, the remaining 50 percent must be allocated to jurisdictions with populations of 150,000 or less; the addition of the House provision regarding coordination of other Federal programs; a revised minority recruitment section; the addition of Indian tribal governments; and other modifications.

The Conferees are particularly concerned about those areas where members of racial and ethnic minority groups and women are highly under-represented in the law enforcement agency's sworn positions. The Conferees encourage the Attorney General to review this matter carefully in the applications from such areas.

One of the modifications permits additional flexibility in the use of grant funds. The Conferees were informed that, in some police departments, payment of overtime or purchase of computers or other technology or the employment of support personnel will enable officers to be deployed, or redeployed from non-patrol assignments, to community-oriented policing assignments. The additional flexibility is intended to achieve that goal.

Thus, in addition to the use of grant funds pursuant to 1701(b) to hire or rehire police officers, a limited amount of such funds can be used for the payment of overtime or procurement of equipment, technology or support systems or support personnel, provided that expenditures for such purposes enable additional officers to be deployed to community-oriented policing assignments. The Conferees also note that, in appropriate circumstances, the permissible uses of the funding pursuant to section 1701(d) could also include payment for overtime.

The Conferees intend that the Attorney General, in awarding grants that will be used for redeployment purposes, take into consideration the extent to which police departments are committed to consultation about such redeployment with representatives of local labor organizations that represent police officers.

The Conferees also note Congress has found with regard to this title that: (1) according to data compiled by the Federal Bureau of Investigation, in 1961, there was approximately 1 reported violent crime per city police officer; but, while from 1961-1991 there was no substantial increase in United States cities' police employment rate, during the same period the number of reported violent crimes per city police officer rose to approximately 4.6 per officer; (2) National Crime Survey figures indicate that nearly 5,000,000 households in the United States had at least 1 member who had been a victim of violent crime during 1991; (3) these victims of violence experienced more than 6,400,000 crimes of which about one-half were reported to law enforcement authorities; (4) community-oriented policing ("cops on the beat") enhances communication and cooperation between law enforcement and members of the community; (5) such communication and cooperation between law enforcement and members of the community significantly assists in preventing and controlling crime and violence, thus enhancing public safety; and (6) while increasing and maintaining police resources and presence in the community are the long-term responsibility of State and local governments, State and local law enforcement agencies are in need of immediate assistance to begin the process of rehiring officers who have been laid off for budgetary reasons and hiring new, additional officers to assist in the implementation of community-oriented policing.

TITLE II—PRISONS

SUBTITLE A—VIOLENT OFFENDER INCARCERATION AND TRUTH IN SENTENCING INCENTIVE GRANTS

Senate sections 1321 and 1341 recede to House sections 601-05 and 801-04 with modifications.

SUBTITLE B—PUNISHMENT FOR YOUNG OFFENDERS

Senate section 1203, Certainty of Punishment for Young Offenders, recedes to House sections 2101-03 with modifications.

SUBTITLE C—ALIEN INCARCERATION

Senate section 5136, reimbursement for the costs of incarcerating criminal illegal aliens, recedes to House section 2403 with modifications to change the compensation criteria and funding provision.

SUBTITLE D—MISCELLANEOUS

Section 20401—House recedes to Senate section 1301, offender's place of imprisonment.

Section 20402—House recedes to Senate section 1302, prison impact statements, with modifications.

Section 20403—House recedes to Senate section 1305, criminal fines to account for the cost of imprisonment.

Section 20404—House recedes to Senate section 1325, supervised release pertaining to probation or parole.

Section 20405—House recedes to Senate section 5101, "good time credits," with modification.

Section 20406-07—House section 3046 recedes to Senate section 5107, task force on prison design and construction and section 5112, encouraging and assessing low-cost construction components, with modifications. The Conferees note the sense of Congress that, in providing assistance to State and local governments, the Attorney General should emphasize the provision to technical assistance in implementing methods to promote cost efficiency and realization of savings.

Section 20408—House recedes to Senate section 5120, panel of correctional educational experts, with modification.

Section 20409—House section 3080, prison overcrowding, recedes to Senate section 5139. The Conferees note that this section has no effect on the certification or success of class action lawsuits.

Section 20410—House recedes to Senate section 5149, Sense of Senate regarding prison facilities in Lorton, with technical modifications.

Section 20411—Senate section 5135, Pell grants, recedes to House section 3089.

Section 20412—Senate recedes to House section 3095, requiring prisoners to earn a high school diploma or G.E.D., with modifications.

Section 20413—Senate recedes to House section 3021 with modifications to delete subsection (c), remove limit on facilities suitable for conversion, and conforming modifications.

Section 20414—House recedes to Senate section 1303 with modification.

Section 20415—House recedes to Senate section 1801-02, Bail Posting Reporting, with modifications to the reporting requirements regarding the Internal Revenue Service.

Section 20416—House sections 3070-74, Civil Rights of Institutionalized Persons, recedes to Senate section 5103 with modification to change subsection (b) to conform with current law.

Section 20417—House recedes to Senate section 1324, notification of release of prisoners, with modification to lodge responsibility in the appropriate Federal entity.

Section 20418—House recedes to Senate sections 4701-02, Correctional Job Training and Placement, with technical modification. The Conferees note with respect to this provision Congress finds that job training and placement are important to, and make a significant contribution to, the readjustment to society of incarcerated persons and ex-offenders; and there is a growing need for immediate action by the Federal Government to assist State and local job training programs, and job placement programs, that provides services to incarcerated persons or ex-offenders.

Senate section 1322, NIJ study of inmate transfers, recedes to House.

Senate section 1323, NIJ study of recidivism rates, recedes to House.

Senate section 5125, use of anti-loitering laws, recedes to House.

Senate section 5113 recedes to House.

Senate section 5138, improvement of federal and State fingerprinting systems, recedes to House.

Senate section 5153, Sense of Senate regarding Federal Prison Industries, recedes to House.

Senate section 5165, reviewing capacity of federal prisons to accommodate State prisoners, recedes to House.

House section 3066, strength training in prisons, recedes to Senate.

It is the intent of the Conferees that, with the exception of Subtitle B of Title II (which provides for correctional programming for offenders up to the age of 22), all programs and activities for juvenile offenders funded under this legislation shall be carried out in a manner consistent with the mandates of the Juvenile Justice and Delinquency Prevention Act (42 U.S.C. §5600 et seq.).

TITLE III—CRIME PREVENTION

SUBTITLE A—OUNCE OF PREVENTION COUNCIL

Section 30101—House section 1010 recedes to Senate section 103, Once of Prevention, with modifications including to: (1) give President the authority to designate chair, (2) give authority to the Council to coordinate any program under the bill not only at the request of the Council member with jurisdictional over the program; (3) revise Council's administrative responsibilities or powers; (4) revise evaluation component.

The Conferees note the work of the National Crime Prevention Council, which serves as a resource center for the prevention of crime, violence, and substance abuse. Such work is reflected in the design of a variety of programs in this bill.

Section 30102–04—Senate recedes to House section 1011 with modifications.

SUBTITLE B—YOUTH EMPLOYMENT AND SKILLS CRIME PREVENTION

Senate recedes to House sections 1081–96, Youth Employment Skills and Crime Prevention, with modifications.

SUBTITLE C—MODEL INTENSIVE GRANTS

Senate recedes to House sections 1001–07, Model Intensive Grants, with modifications to add a provision ensuring equitable distribution of grants; to include a definition of the term "State"; and to permit consultation with the Ounce of Prevention Council.

SUBTITLE D—FAMILY AND COMMUNITY ENDEAVOR SCHOOLS GRANT PROGRAM

House sections 1015–24, Community Schools, recede to Senate section 5142 with modifications which include dividing the program into two separate programs: (1) Community Schools, with responsibility lodged in the Secretary of Health and Human Services in consultation and coordination with the Attorney General, and (2) Family and Community Endeavor Schools (FACES), with responsibility lodged in the Secretary of Education.

Community schools

The Conferees note the sense of the Congress with regard to Community Schools that public-private partnerships between government and community-based organizations offer an opportunity to empower distressed and disconnected communities to develop their resources and abilities in order to meet the needs of children, forge innovative solutions to the challenges confronting the development of the children in such communities, and create environments where children grow up learning a healthy respect for themselves, for neighbors, and for their communities; increased resources should be invested in public-private partnerships; and community-based organizations, acting through such public-private partnerships should provide year-round supervised sports programs, and extracurricular and academic programs, for children in the communities, and in providing such extracurricular and academic programs, should promote the positive character development of such children through programs such as curriculum-based supervised educational, work force preparation, entrepreneurship, cultural, and health programs, social activities, arts and crafts programs, dance programs, tutorial and mentoring programs, and other related activities.

The Conferees also note that Congress has found with regard to this program the following: parents are devoting less time than in previous generations to the supervision, education, and nurturing of their children; the lack of supervision and meaningful activity after school contributes to the spread of violent juvenile delinquency in the form of youth and gang violence, drug trafficking, dangerous and self-destructive behavior, and lack of hope among children in our Nation; every child has the capacity to be productive and law abiding and deserves to grow in a safe and protected environment; communities have a responsibility to develop the children of our Nation into productive adults; because of their centrality, public schools are among the best facilities that communities can use to provide needed space and support services for programs for children; schools are most effective at serving a community when the people of the community are involved in activities designed to fulfill the needs of children in the community; and activities provided in community centers, recreational facilities, and other places where children gather, have a significant impact and influence on the behavior and attitudes of children.

Family and community endeavors schools

The Conferees note that Congress has found with regard to this program that: (1) children in areas with a high incidence of poverty are more likely to be exposed to problems created by economic deprivation, poor housing, overwhelming family responsibilities, inadequate parental educational background or parental substance abuse and are at risk of failure; (2) students from poor families are 3 times more likely to drop out of school than students from more advantaged homes; (3) without social intervention, at-risk children are often unable to improve academic performance; (4) schools are accessible, central resources in every community where social and education services can be coordinated and disseminated to at-risk children and their families; (5) schools are most effective at serving a community when the people of the community are involved in school management and help design activities to fulfill the needs of children in the community; and (6) many schools have successfully improved the academic performance and social development of at-risk children by instituting an organizational and management plan that incorporates parental involvement in school management and incorporates mental health and social intervention services in the daily academic curriculum.

SUBTITLE E—POLICE PARTNERSHIPS FOR CHILDREN

Senate sections 4801–09, Police Partnerships for Children, recede to House sections 1030–34 with modifications which include adding an in-kind contribution for grant recipients and clarifying the 24-hour basis of the program.

The Conferees note that Congress finds the following with respect to police partnerships: Homicide is the second leading cause of juvenile injury deaths for all youth 15 to 24 years of age. Homicide rates for children and youth have more than doubled since 1950. Teenagers are more than twice as likely as adults to be victims of violent crime, such as rape, robbery or assault. Physical fighting severe enough to require medical treatment for at least one participant occurs among high school students in patterns similar to those of homicide. The incidence rates of such physical fighting are higher for males than females, higher for minorities than for non-minorities, and more frequent between acquaintances than among strangers. Children increasingly live amidst chronic community violence and experience trauma as a result of such violence. One survey of inner-city children 6 to 10 years of age found that over 90 percent had witnessed some type of violence. A Chicago housing project survey found that virtually all children in such survey had firsthand experiences with shootings by the age of 5. Children who have been the victims of, or who have witnessed violence, are at risk of becoming involved in further violence if the trauma such children have experienced is not addressed. Police frequently encounter children who have been the victims of violence or who have witnessed violence in the course of the police work, but the police often lack the resources necessary to adequately respond to such children's needs. Child and family service agencies have expertise in child development and family issues that could support police efforts. Community-based police, by their visibility at the neighborhood level and their engagement in benign activities, can provide role models and resources to promote the well-being of children and families, as well as to identify and refer those at risk for behavioral problems.

SUBTITLE F—MIDNIGHT SPORTS

Senate recedes to House section 1038, Midnight Sports, with modifications.

SUBTITLE G—ASSISTANCE FOR DELINQUENT AND AT-RISK YOUTH

Senate recedes to House sections 1051–52, Assistance for Delinquent and At-Risk Youth, with technical modification.

SUBTITLE H—POLICE RECRUITMENT

Senate recedes to House sections 1061–62, Police Recruitment, with technical modification. The term 'non-profits' includes, but is not limited to, public institutions of higher education that so qualify under section 501(c)(3) of the Internal Revenue Code.

SUBTITLE I—NATIONAL TRIAD PROGRAM

Senate sections 921–28 recede to House sections 1065–71, National Triad Program, with a modification to designate the Attorney General as the responsible official and technical modifications.

The Conferees note that at least one of the pilot programs funded shall consist of a Triad cooperative model sponsored by the National Sheriff's Association (NSA), the International Association of Chiefs of Police (IACP), and the American Association of Retired Persons (AARP).

The Conferees also note that Congress finds with regard to this program that: older Americans are among the most rapidly growing segments of our society; currently, older Americans comprise 15 percent of our society, and predictions are that by the turn of the century they will constitute 18 percent of the nation's population; older Americans find themselves uniquely situated in the society, environmentally and physically; many older Americans are experiencing increased social isolation due to fragmented and distant familial relations, scattered associations, limited access to transportation, and other insulating factors; physical conditions such as hearing loss, poor eyesight, lessened agility, and chronic and debilitating illnesses often contribute to a senior citizen's susceptibility to criminal victimization; older Americans are too frequently the victims of abuse and neglect, violent crime, property crime, consumer fraud, medical quackery, and confidence games; studies have found that older Americans who are victims of violent crime are more likely to be injured and require medical attention than are younger victims; victimization data on crimes against older Americans are incomplete and out of date, and data sources are partial, scattered, and not easily obtained; although a few studies have attempted to define and estimate the extent of abuse and neglect of older Americans, both in their homes and in institutional settings, many experts believe that abuse and neglect crimes are substantially underreported and undetected; similarly, while some evidence suggests that older Americans may be targeted in a range of fraudulent schemes, neither the Uniform Crime Report nor the National Crime Survey collects data on individual- or household-level fraud; many law enforcement agencies do not have model practices for responding to the criminal abuse of older Americans; law enforcement officers and social service providers come from different disciplines and frequently bring different perspectives to the problem of crimes against older Americans; the differences in approaches can inhabit a genuinely effective response; there are a few efforts currently under way that seek to forge partnerships to coordinate criminal justice and social service approaches to victimization of older Americans; the Triad program, sponsored by the National Sheriffs' Association (NSA), the International Association of Chiefs of Police (IACP), and the American Association of Retired Persons (AARP), is one such effort; the Assistant Secretary for Aging, as the senior executive branch officer formulating older Americans policy is an appropriate leader in efforts to reduce violent crime against older Americans; and recognizing that older Americans have the same fundamental desire as other members of our society to live freely, without fear or restriction due to the criminal element, the Federal government should seek to expand efforts to reduce crimes against this growing and uniquely vulnerable segment of our population.

Subtitle J—Local Partnership Act

Senate recedes to House section 1075–76, Local Partnership Act, with various modifications including the clarification of the purposes for which funds under this program can be used. The Local Partnership Act ("LPA") is authorized for fiscal years 1995 through 2000 rather than for fiscal years 1995 and 1996. At the request of the Administration, the LPA will be administered by the Secretary of Housing and Urban Development ("HUD") rather than the Secretary of Treasury, and HUD may delegate some or all of its administrative responsibilities to other Executive branch departments and agencies. Two and one-half percent of the total funds authorized for the LPA are authorized to be appropriated for fiscal years 1995 through 2000 for administrative costs of HUD in administering the LPA. Checks will be sent to local governments by HUD within 90 days of the actual appropriation of funds rather than 60 days. Technical changes are made in the LPA's allocation formula so that HUD will be able to replicate for fiscal year 1995 the dollar allocations to 39,000 local governments produced by the General Accounting Office ("GAO") on April 25, 1994; for later years HUD is free to use more reliable data—if available—than the data used by GAO.

The Conferees note that, in some areas of the country, public functions such as transportation, education, and hospitals are supported by property or sales taxes collected by separate taxing jurisdictions. The Conferees expect HUD, in consultation with the Governments Division of the Bureau of the Census, to report to the Committee on Government Operations on the operation of the Local Partnership Act in such areas and to include in its report any suggestions on changes to the statutory definition of the general tax effort factor.

The Conferees agreed to an amendment dealing with payments of less than $5,000 to Indian tribes and Alaskan native villages.

The Conferees also agreed to an amendment providing that GAO will report to Congress on a comparison of waste and efficiency under the LPA compared to other comparable Federal programs.

The Local Partnership Act contains a one percent set-aside for the Commonwealth of Puerto Rico, Guam, American Samoa, and the Virgin Islands. The allocation formula for local governments within the 50 States does not apply to these four jurisdictions. The Conferees expect, however, that objective criteria, such as population and/or per capita income, will be used to ensure an equitable distribution of these funds regarding the local governments within these four jurisdictions.

Subtitle K—National Community Economic Partnership

House recedes to Senate sections 4901–33, Community Economic Partnership Act.

Subtitle L—Gang Prevention Services for Boys and Girls

Senate recedes to House sections 1099I–99O, Gang Prevention Services for Boys and Girls, with modification to designate the Attorney General as the responsible official.

The Conferees note with regard to this program that Congress finds services provided through existing federally supported gang prevention programs do not adequately address the needs of boys and girls in communities with high levels of gang activity and other barriers to service (such as large concentrations of minority populations who have limited English speaking proficiency, geographically isolated populations, and communities in which social service providers are limited or nonexistent); children who are exposed to gang activity at an early age are more likely to become gang-involved than children who are exposed to such activity later in life, or children who are never exposed to such activity; gangs are increasingly targeting younger children for recruitment, especially children at middle schools and elementary schools; Federal studies indicate that violent crime has increased more significantly in the gang population compared to the adult population; and small community-based service agencies with strong ties to the educational and law enforcement systems offer the best chance to prevent young children from becoming involved in gangs.

Subtitle M—Olympic Youth Development Centers

House recedes to Senate section 5143, Olympic Youth Development Centers, with minor and conforming modifications.

Subtitle N—Anticrime Youth Councils

Senate recedes to House section 1099P–99T, Anti-Crime Youth Councils, with modification to designate the Attorney General as the responsible official.

Subtitle O—Urban Recreation and At-Risk Youth

Senate recedes to House sections 1099U–99Z, Urban Recreation and At-Risk Youth, with modifications.

Subtitle P—Boys and Girls Clubs in Public Housing

Senate recedes to House sections 1099AA–99C, Boys and Girls Clubs in Public Housing, with technical modifications.

Subtitle Q—Community Based Grants for Prosecutors

Senate recedes to House sections 1099DD–99KK, Community Based Justice Grants for Local Prosecutors, with modifications.

Subtitle R—Child Safety

House recedes to Senate sections 4001–09, Child Safety, with a modification to prohibit participation of persons denied visitation rights by court order and other modifications.

The Conferees note that Congress finds with regard to this program the following: the problem of family violence does not necessarily cease when the victimized family is legally separated, divorced, or otherwise not sharing a household. During separation and divorce, family violence often escalates, and child custody and visitation become the new forum for the continuation of abuse. Some perpetrators use the children as pawns to control the abused party after the couple is separated. Every year an estimated 1,000 to 5,000 children are killed by their parents in the United States. In 1988, the Department of Justice reported that 354,100 children were abducted by family members who violated custody agreements or decrees (most victims were children from ages 2 to 11 years). Approximately 160,000 children are seriously injured or impaired by abuse or neglect each year. Studies by the American Humane Association indicate that reports of child abuse and neglect have increased by over 200 percent from 1976 to 1986; approximately 90 percent of children in homes in which their mothers are abused witness the abuse. Data indicates that women and children are at elevated risk for violence during the process of and after separation; and 50 to 70 percent of men who abuse their spouses or partners also abuse their children. Up to 75 percent of all domestic assaults reported to law enforcement agencies were inflicted after the separation of the couples; in one study of spousal homicide, over half of the male defendants were separated from their victims, seventy-three percent of battered women seeking emergency medical services do so after separation.

Subtitle S—Family Unity Demonstration Project

House recedes to Senate sections 4101–22, Family Unity Demonstration Project, with the following modifications: a child is defined as less than seven years of age; the definition of eligible offender as well as the definition of a State are clarified; the Attorney General is designated as the responsible official; and technical modification.

The Conferees note that Congress finds with regard to this program an increasing number of children are becoming separated from their primary caretaker parents due to the incarceration of the parents in prisons and jails; such separation of children from their primary caretaker parents can cause harm to children's psychological well-being and hinder their growth and development; a significant number of children are born shortly before or during the incarceration of their mothers and are then quickly separated from their mothers, preventing the parent-child bonding that is crucial to developing in children a sense of security and trust; maintaining close relationships with their children provides a powerful incentive for prisoners to participate in and successfully benefit from rehabilitative programs; and maintaining strong family ties during imprisonment has been shown to decrease recidivism, thereby reducing prison costs.

SUBTITLE T—SUBSTANCE ABUSE TREATMENT IN FEDERAL PRISONS

Senate section 1304, Drug Treatment in Federal Prisons, recedes to House section 2001 with modifications to subject the program to the availability of appropriations, to require the Bureau of Prisons to provide residential treatment, and to limit the early release incentive for successful program completion to non-violent offenders.

The authority provided to the Bureau of Prisons under this section is not to be construed as limiting any authority already possessed by the Bureau of Prisons with respect to the release of inmates.

SUBTITLE U—RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR STATE PRISONERS

Senate section 1204 recedes to House sections 2301–02, Substance Abuse Treatment in State Prisons, with modifications to clarify that certain local detention facilities are eligible; extend the time for approval of an application to not later than 90 days; change the time period for residential substance abuse treatment programs to those lasting between 6 and 12 months; and designate the Attorney General as the responsible official.

SUBTITLE V—PREVENTION, DIAGNOSIS, AND TREATMENT OF TUBERCULOSIS IN CORRECTIONAL INSTITUTIONS

House recedes to Senate section 5121, tuberculosis prevention, with modification to include National Institute of Corrections rather than National Institute of Justice.

SUBTITLE W—HOPE IN YOUTH PROGRAM

Senate recedes to House section 1099B–99G, Hope in Youth, with technical modifications and the addition of the definition of the term "State". The Conferees note that Congress finds with respect to this program that: larger cities around the country, particularly those involved in empowerment zones, are attempting to empower low-income and ethnic minority communities; programs that involve local government and local community leaders and that include significant participation by service providers, service participants, and service funders, as equal partners in the design and direction of a myriad of social service support programs have been among the most effective demonstration models; programs that attempt to link disenfranchised and disconnected citizens through an umbrella organization that provides guidance to public and private service providers have proven to be an effective strategy for empowering local low-income communities; families in low-income communities have not attained their full potential as productive citizens, and Federal efforts thus far have been insufficient to assist them in fully realizing that potential.

SUBTITLE X—GREAT

House recedes to Senate section 5163, Gang Resistance Education and Training Projects, with modifications. The Conferees intend that the Secretary of the Treasury will consult with the Director of the BATF regarding the selection of communities for participation in this program.

TITLE IV—VIOLENCE AGAINST WOMEN

SUBTITLE A—SAFE STREETS FOR WOMEN

CHAPTER 1—FEDERAL PENALTIES FOR SEX CRIMES

Section 40111—House recedes to Senate section 3211, increasing penalties for repeat offenders, with modifications regarding foreign country convictions.

Section 40112—House recedes to Senate section 3212, Federal penalties.

Section 40113—House section 1609 recedes to Senate sections 3213 and the restitution provisions of 3321 and 3704–05, with modifications including: if a court finds a defendant is unable to pay any amount of restitution under any reasonable schedule of payments, the court must enter an order providing for a nominal restitution award; victims are permitted to enforce restitution awards; victims can recover costs in obtaining civil protection orders; the provision on compensation to third party payers is eliminated; privacy of records is expanded; compliance with a restitution order is made a condition of probation or supervised release; petition to modify order is added; court authority to refer, subject to de novo review, a matter to a magistrate or special master is added.

Section 40114—House recedes to Senate section 3214, Federal victims' counselors.

CHAPTER 2—LAW ENFORCEMENT AND PROSECUTION GRANTS TO REDUCE VIOLENT CRIMES AGAINST WOMEN

House recedes to Senate section 3221, grants to combat violent crimes against women, with the following modifications: the merger of three grant programs in Senate bill: grants for high intensity crime areas, general grants to States, and Domestic Violence and Family Support Grants (§3341); the addition of purposes to strengthen victim services programs in diverse populations, and programs addressing the needs of Indian tribes; the addition of a matching fund requirement (which tribal governments may satisfy with federal funds from the Bureau of Indian Affairs); and the designation of the Attorney General as the responsible official. With regard to the matching fund requirement, the Conferees intend that in disbursing grants for nongovernmental victim services, States shall not pass through to the subgrantees the amount of any required State match. With regard to this program, the Conferees acknowledge the critical role probation agencies play in monitoring and controlling the perpetrators of family violence; the Conferees intend that probation agencies receive appropriate consideration under this program.

Senate section 3262 recedes to House sections 1603–04, rape exam payments and filing costs, with modifications to extend the requirements to units of local government and Indian tribal governments except (in the case of rape exams) where another governmental entity incurs the costs of the exams; and to give States a period for bringing laws, policies, and practices into compliance with filing cost requirements.

CHAPTER 3—SAFETY FOR WOMEN IN PUBLIC TRANSIT AND PUBLIC PARKS

Section 40131—House recedes to Senate section 3231, grants for capital improvements to prevent crime in public transportation, with modification to clarify that Trust Fund money is not available for this program, and other modifications.

Section 40132—House recedes to Senate section 3232, National Park System Crime Prevention Assistance, with modification to clarify that Trust Fund money is not available for this program.

Section 40133—House recedes to Senate section 3233, Grants for Capital Improvements to Prevent Crime in Public Parks, with modification to clarify that Trust Fund money is not available for this program.

CHAPTER 4—NEW EVIDENTIARY RULES

Section 40141—House recedes to Senate sections 3251–3254 and 3706 with a modification to substitute the revisions of Federal Rule of Evidence 412 as transmitted to Congress by the Supreme Court on April 29, 1994 with an additional modification to extend evidentiary protection to civil cases (as proposed by the Judicial Conference of the United States to the Supreme Court on October 25, 1993). The Conferees intend that the Advisory Committee Note on Rule 412, as transmitted by the Judicial Conference of the United States to the Supreme Court on October 25, 1993, applies to Rule 412 as enacted by this section. This section, which modifies Rule 412 of the Federal Rules of Evidence as transmitted to the Congress by the United States Supreme Court, is enacted pursuant to the Rules Enabling Act.

CHAPTER 5—ASSISTANCE TO VICTIMS OF SEXUAL ASSAULT

Section 40151—House recedes to Senate section 3261, Education and Prevention Grants to Reduce Sexual Assaults Against Women, with modification to allocate funds to States on the basis of population.

Section 40152—House recedes to Senate section 1607, National Institute of Justice Training Program, to assist court personnel in treating sex offenders.

Section 40153—House recedes to Senate proposal regarding confidentiality of communications between sexual assault or domestic violence victims and their counselors, with modifications.

Section 40154—House recedes to Senate section 1608 with regard to information about sex offender treatment programs.

Section 40155—House recedes to Senate section 3263 with modification to make runaway youth education and prevention grants gender-neutral and to cover juveniles.

Section 40156—House recedes to Senate section 5126, Victims of Child Abuse Act, with modifications.

SUBTITLE B—SAFE HOMES FOR WOMEN

CHAPTER 1—NATIONAL DOMESTIC VIOLENCE HOTLINE

Section 40211—House section 1653 recedes to Senate section 3311, grant for a national domestic violence hotline, with modifications as follows: (1) a grant may extend for 5 years, subject to annual approval; (2) applicants must include a plan for assisting non-English speaking callers and the hearing-impaired; and (3) applicants must demonstrate support from advocacy groups, such as State coalitions and recognized national domestic violence groups. The Conferees note Congress has found with regard to this program that (1) 4,000,000 women are battered by their partners each year, of which 4,000 die as a result of such abuse; (2) victims of domestic violence need access to resources which will refer such victims and their children to safe homes and shelters; and (3) there is a need for a national domestic violence hotline to provide information and assistance to victims of domestic violence because a privately funded national domestic violence hotline which previously handled more than 65,000 crisis calls annually no longer exits.

CHAPTER 2—INTERSTATE ENFORCEMENT

Section 40221—Senate section 3321, Interstate Enforcement, recedes to House section

1622 with modifications including: the addition of penalties for causing the crossing of State lines to commit a crime of violence; the revision of the new Federal crime for crossing a State line; the addition of a penalty where the crime results in disfigurement or life-threatening bodily injury; the modification of the mandatory restitution provisions to comport with the mandatory restitution provisions for sex crimes and crimes involving the sexual exploitation and abuse of children; and the modification of the definition of "spouse or intimate partner."

CHAPTER 3—ARREST POLICIES IN DOMESTIC VIOLENCE CASES

Section 40231—Senate section 3331 recedes to House section 1623, grants to encourage arrest polices, with modifications to include a two-year period for grantees to comply, and a modification to the definition of "domestic violence."

CHAPTER 4—SHELTER GRANTS

Section 40241—House recedes to Senate section 3341(j), authorizing money for battered women's shelters. (The remainder of Senate section 3341 was incorporated into Subtitle A, Chapter 2, of this title.)

CHAPTER 5—YOUTH EDUCATION

Section 40251—House recedes to Senate section 3361, youth education and domestic violence, with modification to permit the Secretary of Health and Human Services to consult with the Secretary of Education to select, implement, and evaluate four model programs.

CHAPTER 6—COMMUNITY PROGRAMS ON DOMESTIC VIOLENCE

Section 40261—House section 1654 recedes to Senate section 5140, community programs on domestic violence, with modifications. Senate section 5122 is deleted as duplicative.

CHAPTER 7—FAMILY VIOLENCE PREVENTION AND SERVICES ACT AMENDMENTS

Section 40271—House recedes to Senate section 3351, grantee reporting.

Section 40272—House recedes to Senate section 3381–83, technical amendments.

CHAPTER 8—CONFIDENTIALITY FOR ABUSED PERSONS

Section 40281—House recedes to Senate section 3371, confidentiality for abused persons, with modification to give Postal Service additional regulatory guidance.

CHAPTER 9—DATA AND RESEARCH

Section 40291—House recedes to Senate section 3391, data and research agenda, with modification to include diversity considerations for panel and to require the issuance of a report no later than 12 months rather than 9 months after enactment.

Section 40292—House recedes to Senate section 3392, State data bases, with modification to place responsibility for the study and report with the appropriate Department of Justice entities.

Section 40293—House recedes to Senate section 3393, number and cost of injuries.

CHAPTER 10—RURAL DOMESTIC VIOLENCE AND CHILD ABUSE ENFORCEMENT

Section 40295—House section 2521 recedes to Senate section 1421, rural domestic violence and child abuse enforcement assistance.

SUBTITLE C—CIVIL RIGHTS FOR WOMEN

Sections 40301–03—House recedes to Senate sections 3401–03, Civil Rights. The Conferees note that the applicable standard of proof in a civil rights cause of action under this section is preponderance of the evidence. The Conferees also note that the Congress has found that crimes of violence motivated by gender constitute bias crimes in violation of the victim's right to be free from discrimination on the basis of gender; current law provides a civil rights remedy for gender crimes committed in the workplace, but not for crimes of violence motivated by gender committed on the street or in the home; State and Federal criminal laws do not adequately protect against the bias element of crimes of violence motivated by gender, which separates these crimes from acts of random violence, nor do these adequately provide victims of gender-motivated crimes the opportunity to vindicate their interests; existing bias and discrimination in the criminal justice system often deprives victims of crimes of violence motivated by gender of equal protection of the laws and the redress to which they are entitled; crimes of violence motivated by gender have a substantial adverse effect on interstate commerce, by deterring potential victims from traveling interstate, from engaging in employment in interstate business, and from transacting with business, and in places involved, in interstate commerce; crimes of violence motivated by gender have a substantial adverse effect on interstate commerce, by diminishing national productivity, increasing medical and other costs, and decreasing the supply of and the demand for interstate products; a Federal civil rights action as specified in this section is necessary to guarantee equal protection of the laws and to reduce the substantial adverse effects on interstate commerce caused by crimes of violence motivated by gender; and the victims of crimes of violence motivated by gender have a right to equal protection of the laws, including a system of justice that is unaffected by bias or discrimination and that, at every relevant stage, treats such crimes as seriously as other violent crimes.

Section 40304—House recedes to Senate section 3404, Sense of the Senate concerning protection of privacy of rape victims, with technical modifications. The Conferees note that the Senate finds with regard to this provision that: (1) there is a need for a strong and clear Federal response to violence against women, particularly with respect to the crime of rape; (2) Rape is an abominable and repugnant crime, and one that is severely underreported to law enforcement authorities because of its stigmatizing nature: (3) The victims of rape are often further victimized by a criminal justice system that is insensitive to the trauma caused by the crime and are increasingly victimized by news media that are insensitive to the victim's emotional and psychological needs; (4) Rape victims' need for privacy should be respected; (5) Rape victims need to be encouraged to come forward and report the crime of rape without fear of being revictimized through involuntary public disclosure of their identities; (6) Rape victims need a reasonable expectation that their physical safety will be protected against retaliation or harassment by an assailant; (7) The news media should, in the exercise of their discretion, balance the public's interest in knowing facts reported by free news media against important privacy interests of a rape victim, and an absolutist view of the public interest leads to insensitivity to a victim's privacy interest; and (8) The public's interest in knowing the identify of a rape victim is small compared with the interests of maintaining the privacy of rape victims and encouraging rape victims to report and assist in the prosecution of the crime of rape.

Senate section 3501, safe campuses for women, is deleted because it has already been enacted.

SUBTITLE D—EQUAL JUSTICE FOR WOMEN IN THE COURTS ACT

CHAPTER 1—EDUCATION AND TRAINING FOR JUDGES AND COURT PERSONNEL IN STATE COURTS

Sections 40411–14—House sections 1661–64 recede to Senate sections 3601–14, Equal Justice for Women in the Courts Act, with modifications to include Indian tribal governments as grantees and to modify grant purposes.

CHAPTER 2—EDUCATION AND TRAINING FOR JUDGES AND COURT PERSONNEL IN FEDERAL COURTS

Section 40421–22—House sections 1665–67 recede to Senate sections 3621–22 with modifications to designate the Administrative Office of the United States Courts as the clearinghouse for the dissemination of reports and to delete circuit court allocation limits.

SUBTITLE E—VIOLENCE AGAINST WOMEN ACT IMPROVEMENTS

Section 40501—House recedes to Senate section 3701, pre-trial detention in sex offense cases.

Section 40502—House recedes to Senate section 3702, increased penalties for sex offenses against victims below the age of 16. Senate section 801, sexual abuse amendments, is deleted as duplicative.

Section 40503—Senate sections 3703(a)–(b) recede to House section 1652, payment of cost of victim testing for sexually transmitted disease, with modification to ensure confidentiality and anonymity of the test, subject to waiver by the victim. Senate sections 3703(c)–(f) recede to House. House recedes to Senate section 3703(g), penalties for intentional transmission of HIV.

Section 40504—House recedes to Senate section 3704, extension and strengthening of restitution.

Section 40505—House recedes to Senate section 3705, with modifications.

Section 40506—House recedes to Senate section 3707, National Baseline Study on Campus Sexual Assault, with technical modification.

Section 40507—Senate section 3708, Report on Battered Women's Syndrome, recedes to House section 121. Senate section 2964 is deleted as duplicative.

Section 40508—House recedes to Senate section 3709, Report on Confidentiality of Addresses for Victims of Domestic Violence.

Section 40509—House recedes to Senate section 3710, Report on Record Keeping Relating to Domestic Violence.

Senate section 3711, Report on Fair Treatment in Legal Proceedings, recedes to House.

Senate section 3712 recedes to House.

Senate section 3713 recedes to House.

SUBTITLE F—NATIONAL STALKER AND DOMESTIC VIOLENCE REDUCTION

Senate recedes to House sections 2801–12, Stalking, with modifications.

SUBTITLE G—PROTECTIONS FOR BATTERED IMMIGRANT WOMEN AND CHILDREN

Senate recedes to House sections 1626–28, Battered Immigrant Women, with modifications.

TITLE V—DRUG COURTS

Senate sections 1201–02 recede to House sections 1041–44 with modifications to prohibit violent offenders from participating, to add a GAO study, and with technical and conforming changes.

The Conferees recognize that drug court programs may support costs of judges, magistrates, quasi-judicial personnel, probation officers, drug testing personnel, prosecutors, defense attorneys, other criminal justice participants, drug treatment personnel, persons involved in programmatic and aftercare services, and other personnel necessary to implement drug court programs.

The Conferees note the diversity of court structures under which jurisdictions throughout the United States are organized and intend that the Attorney General, in implementing this program, issue regulations that are as flexible as possible in this regard.

TITLE VI—DEATH PENALTY

Procedures: The House recedes to the Senate with the following exceptions: (1) Senate recedes to the House regarding the firearm aggravator; (2) Senate recedes to the House to add the aggravator for sexual assault or child molestation; (3) the Conferees modified the provision regarding information presented at sentencing to reflect current law.

Offenses: The House recedes to the Senate death penalties, including terrorism death penalties, with the following modifications: (1) the deletion of Senate section 203(a)(8), attempted assassination of the President; (2) the deletion of the part of Senate section 202(a) which adds section 3591(b)(3) to title 18 regarding unintentional deaths due to overdose; (3) the addition of the Hyde amendment to section 203(a)(2), espionage; (4) Senate section 504 recedes to House section 708 regarding correctional officers; (5) Senate section 716, torture, recedes to House section 713 with modifications to delete already enacted provisions; (6) the addition of an intent standard for carjacking; (7) Senate recedes to the House intent standard; (8) Senate section 2406, to federalize all murders committed with guns, recedes to House; (9) Senate section 711, weapons of mass destruction, recedes to House section 710; and (10) the modification of Senate section 215, alien smuggling, to increase penalties. House recedes to Senate section 501–01 and 505.

House sections 901–02, racially discriminatory capital sentencing, recede to Senate.

Senate section 1021, racial and ethnic bias study grants, recedes to House.

Section 60026—Senate recedes to House proposal regarding appointment of counsel.

TITLE VII—MANDATORY LIFE IMPRISONMENT FOR PERSONS CONVICTED OF CERTAIN FELONIES

Senate sections 2408 and 5111 recede to House sections 501–02 with modifications. The authority provided to the Bureau of Prisons under this section is not to be construed as limiting any authority already possessed by the Bureau of Prisons with respect to the release of inmates.

TITLE VIII—APPLICABILITY OF MANDATORY MINIMUM PENALTIES

Senate section 2404 recedes to House sections 201–03 with technical and conforming modifications.

TITLE IX—DRUG CONTROL

SUBTITLE A—ENHANCED PENALTIES AND GENERAL PROVISIONS

In carrying out directions from the Congress, the U.S. Sentencing Commission shall assure reasonable consistency with other guidelines, avoid duplicative punishment for substantially the same offense, and take into account any mitigating circumstances which might justify exceptions. The Commission shall also carry out such directions in light of the factors set forth in subsection 3535(a) of title 18, United States Code.

Section 90101—House recedes to Senate section 1501, drug trafficking in prisons.

Section 90102—House recedes to Senate section 1505, drug-dealing in drug free zones, with modifications.

Section 90103—House recedes to Senate section 1506, illegal drug use in prisons, with technical modification.

Section 90104—House recedes to Senate section 1531, clarification of narcotics and other dangerous drugs.

Section 90105—House recedes to Senate section 1532, conforming amendments to recidivist penalty provisions of the Controlled Substance Act and the Controlled Substances Import and Export Act.

Section 90106—House recedes to Senate section 1534, Advertising, with modifications.

Section 90107—House recedes to Senate section 1538, Violent Crime and Drug Emergency Areas, with modifications.

SUBTITLE B—NATIONAL NARCOTICS LEADERSHIP ACT AMENDMENTS

Section 90201–08—House recedes to Senate section 5150, which reauthorizes the Office of National Drug Control Policy through September 30, 1997, with modifications.

In addition to the Director's authority to recommend to Federal agencies appropriate drug budget levels by July 1 of each year as those agencies are first developing their budgets for the following fiscal year, authority is granted to ensure that the agencies' budget submissions to the Office of Management and Budget are consistent with the National Drug Control Strategy.

The provision also provides authority to detail temporarily drug control personnel to other Departments or agencies to implement the National Drug Control Strategy. It further provides authority, except to the extent that the Director's authority is limited in an annual appropriations Act, to transfer up to 2% among National Drug Control Program accounts, upon advance approval of the Committees on Appropriations of each House of Congress. It is the intent of the Conferees that such advance approval be obtained from each of the Appropriations Subcommittees with jurisdiction over accounts increased or decreased by such budget shifts.

Several additional goals are added to the National Drug Control Strategy, including the "consequences" of drug abuse (such as emergency room overdoses and drug-related crime), assessment of national drug treatment system, and other evaluations of the strategy. Drug treatment and prevention are added to the mission of the Counter-Drug Technology Assessment Center. And, the provision prohibits the Director and other officials in the Office who are confirmed by the Senate from participating in Federal election campaigns.

Senate section 1504, anabolic steroids penalties, recedes to House as duplicative of stronger current law.

Senate section 1533, Program to provide public awareness of the provisions of Public Law 101–516, recedes to House.

Senate section 1537, Drug paraphernalia amendment, recedes to House.

Senate section 1511–23, Precursor Chemicals Act, deleted because already enacted.

Senate section 1536 recedes to House.

Senate section 1535, national drug control strategy, recedes to House.

Senate section 1502 is deleted because already enacted.

Senate section 2407 recedes to House.

TITLE X—DRUNK DRIVING PROVISIONS

Section 100002—House recedes to Senate section 1602, applying State law in areas of federal jurisdiction.

Section 100003—House sections 1801–02, Driving While Intoxicated Prosecution Program, recede to Senate section 5115.

TITLE XI—FIREARMS

SUBTITLE A—ASSAULT WEAPONS

House recedes to Senate sections 4501–10, with modifications.

The Conferees recognize that some workers will be adversely impacted by the enactment of this Subtitle. The Conferees note that the Department of Labor has made available, as of July 1, more than $1.1 billion through Title III of the Job Training Partnership Act to assist dislocated workers. The types of assistance available to dislocated workers under that Act include retraining, job search assistance, job counseling, on-the-job training, and other services. The Conferees expect that any employees dislocated as a result of enactment of this Subtitle will be eligible to apply for such benefits in accordance with Department of Labor criteria.

SUBTITLE B—YOUTH HANDGUN SAFETY

Section 110201—House sections 1901–02 recede to Senate section sections 661–62 with the deletion of Senate section 662(a) and technical modifications. Senate section 663 recedes to House.

The Conferees note Congress finds with regard to these sections that: Crime, particularly crime involving drugs and guns, is a pervasive, nationwide problem; problems with crime at the local level are exacerbated by the interstate movement of drugs, guns, and criminal gangs; firearms and ammunition, and handguns in particular, move easily in interstate commerce, as documented in numerous hearings in both the Judiciary Committee of the House of Representatives and Judiciary Committee of the Senate. Even before the sale of a handgun, its component parts, ammunition, and the raw materials from which they are made have considerably moved in interstate commerce. While criminals freely move from State to State, ordinary citizens may fear to travel to or through certain parts of the country due to the concern that violent crime is not under control, and people from other countries may decline to travel in the United States for the same reason. Just as hardened drug kingpins often begin their lives in the illicit drug culture by exposure to drugs at a young age, violent criminals often start their criminal careers on streets where the ready availability of guns to young people results in the acceptability of their random use. Violent crime and the use of illicit drugs go hand-in-hand, and attempts to control one without controlling the other may be fruitless. Individual States and localities find it impossible to handle the problem by themselves; even States and localities that have made a strong effort to prevent, detect, and punish crime find their efforts unavailing due in part to the failure or inability of other States and localities to take strong measures. Inasmuch as illicit drug activity and related violent crime overflow State lines and national boundaries, the Congress has power, under the interstate commerce clause and other provisions of the Constitution, to enact measures to combat these problems. The Congress finds that it is necessary and appropriate to assist the States in controlling crime by stopping the commerce in handguns with juveniles nationwide, and allowing the possession of handguns by juveniles only when handguns are possessed and used for legitimate purposes under appropriate conditions.

SUBTITLE C—LICENSURE

Sections 110301–07—House recedes to Senate section 311–17, Firearms Licensure.

SUBTITLE D—DOMESTIC VIOLENCE

Section 110401—Senate sections 301, Persons Subject to Restraining Orders, and 4201–03, Prohibition Against Disposal of Firearms to, or Receipt of Firearms by, Persons Who Have Committed Domestic Violence, recede to House sections 1624–25, with modifications.

The Conferees intend that the term "child" be read with common sense and normal meaning, and to include a child over whom a person's parental rights have been terminated by a court order. The Conferees also note that Congress finds with respect to this provision that domestic violence is the leading cause of injury to women in the United States between the ages of 15 and 44; firearms are used by the abuser in 7 percent of domestic violence incidents and produces an adverse effect on interstate commerce; and individuals with a history of domestic abuse should not have easy access to firearms.

SUBTITLE E—GUN CRIME PENALTIES

In carrying out directions from the Congress, the U.S. Sentencing Commission shall assure reasonable consistency with other guidelines, avoid duplicative punishment for substantially the same offense, and take into account any mitigating circumstances which might justify exceptions. The Commission shall also carry out such directions in light of the factors set forth in subsection 3553(a) of title 18, United States Code.

Section 110501—House recedes to Senate section 401, enhanced penalty for use of semiautomatic weapons during crime of violence or drug trafficking crime.

Section 110502—House section 3031 recedes to Senate section 402, second conviction for using or carrying explosives.

Section 110503—House recedes to Senate section 403, new offense for smuggling firearms.

Section 110504—House section 3032 recedes to Senate section 404, new offense for theft of guns and explosives moving in interstate commerce.

Section 110505—House recedes to Senate section 405, revocation of supervised release, with modifications. Senate section 2403, supervised release after imprisonment, recedes to House as incorporated in Senate section 405.

Section 110506—House recedes to Senate section 406, revocation of probation, with modifications.

Section 110507—House recedes to Senate section 407, knowingly making false material statement on a gun application.

Section 110508—House section 3033 recedes to Senate section 408, felon possessing explosives.

Section 110509—House recedes to Senate section 409, explosives destruction.

Section 110510—House recedes to Senate section 410, technical correction regarding parole.

Section 110511—House recedes to Senate section 411, prohibition against transactions involving stolen firearms or stolen guns.

Section 110512—House recedes to Senate section 412, using firearm in commission of forgery.

Section 110513—House recedes to Senate section 413, firearm possession by violent felons and serious drug offenders.

Section 110514—House recedes to Senate section 414, receipt of firearms by nonresident.

Section 110515—House section 3034 recedes to Senate section 417, stealing guns or explosives from a licensee.

Section 110516—House section 3035 recedes to Senate section 418, disposing of explosives to prohibited person.

Section 110517—House recedes to Senate section 420, interstate gun trafficking.

Section 110518—House recedes to Senate section 415, firearms conspiracy, with modification.

Section 110519—House recedes to Senate section 5168, Definition of Armor Piercing Ammunition, with modification.

Senate section 416, study of incendiary ammunition, recedes to House.

Senate section 419 recedes to House.

TITLE XII—TERRORISM

In carrying out directions from the Congress, the United State Sentencing Commission shall assure reasonable consistency with other guidelines, avoid duplicative punishment for substantially the same offense, and take into account any mitigating circumstances which might justify exceptions. The Commission shall also carry out such directions in light of the factors set forth in subsection 3553(a) of title 18, United States Code.

Section 120001—House recedes to Senate section 717, extension of statute of limitations, with modifications.

Section 120002—House recedes to Senate section 718, jurisdiction over crimes against U.S. nationals.

Section 120003—House recedes to Senate section 721, counterfeiting currency abroad, with modification to increase penalty.

Section 120004—House recedes to Senate section 724, Terrorist Felonies.

Section 120005—House recedes to Senate section 726, material support to terrorists, with modification.

Senate section 718, FBI access to telephone subscriber information, is deleted because already enacted.

Senate section 720, preventing acts of terrorism, recedes to House.

Senate section 722, economic terrorism task force, recedes to House.

Senate section 713, extension of territorial sea, recedes to House.

Senate section 714, assimilated crimes in extended territorial sea, recedes to House.

TITLE XIII—CRIMINAL ALIENS AND IMMIGRATION ENFORCEMENT

Section 130001—House recedes to Senate section 5005, enhancing penalties for failure to depart, with modification to delete subsection (c) regarding collateral review.

Section 130002—House recedes to Senate section 5007, criminal alien tracking center, with modification to conform to current law.

Section 130003—House recedes to Senate section 725, Protection of Recipients in Counter-Terrorism Rewards Program, with modifications to incorporate this section into Senate section 5117, and other modifications.

Section 130004—House recedes to Senate section 5002, deportation procedures for certain criminal aliens, with modifications.

Section 130005—Senate section 5158, expedited deportation for asylum applicants, recedes to House section 2411 with modification to clarify that asylum applicants have no right to work in the United States.

Section 130006—Senate section 5159, improving border controls, recedes to House section 2412 with modifications regarding report requirement and to incorporate House section 2421.

Section 130007—House section 2413, special deportation proceedings, recedes to Senate section 5160 with modifications. Senate section 5161, construction of INS service processing centers, recedes to House section 2414, which is incorporated into Senate section 5160, with modifications. The Conferees intend that the Attorney General should consider the availability of legal assistance in an area in determining where to locate the facilities.

Section 130008—Senate recedes to House section 2402, authority of the Attorney General to accept assistance in deporting criminal aliens, with modifications.

The Conferees note that many States and localities are burdened with the financial costs of housing and processing deportable aliens who are unlawfully within the United States and who are arrested for violating criminal statutes. The Immigration and Naturalization Service is not permitted under current law to accept State and local assistance in carrying out its deportation responsibilities. This section is intended to aid communities with criminal alien populations to expedite the removal of deportable aliens who are arrested for the violation of criminal statutes by providing transportation-related services or property to the Immigration and Naturalization Service.

Section 130009—Senate section 712 recedes to House section 2431 with modification increasing the penalty for employment document fraud to five years. Senate section 5124 is deleted as duplicative.

This section is intended to target person who commit document fraud for the purpose of commercial advantage, or to facilitate drug trafficking or international terrorism. The Conferees intend that the Attorney General implement these provisions so as not to prosecute bona fide applicants for asylum.

Section 130010—House recedes to Senate section 5131, asylum, which is modified to a Sense of the Senate, with other modifications.

Senate section 5006, miscellaneous and technical changes regarding alien deportation, recedes to House.

Senate section 5102, prohibition on payment of federal benefits to illegal aliens, recedes to House.

Senate section 5119, State and local cooperation with INS, recedes to House.

Senate section 5110, removal of alien terrorists, recedes to House.

House section 2401, Congressional findings regarding criminal aliens, recedes to Senate.

Senate section 5144, authority to release confidential information regarding aliens, recedes to House.

Senate section 5001, aggravated felony, recedes to House.

Senate section 5003, judicial deportation, recedes to House.

Senate section 5004, recedes to House.

Senate section 5157, Extradition, recedes to House.

TITLE XIV—YOUTH VIOLENCE

Sections 140001–03—Senate section 651 recedes to House section 1101 regarding adult prosecution of juveniles with modification to delete section 1101(b).

Section 140004—House recedes to Senate section 641 with modification to correct typographical error regarding the age for the bindover of juveniles.

Section 140005—House recedes to Senate section 618 with modifications.

Section 140006—House recedes to Senate section 615, increased penalties for employing children to distribute drugs near schools and playgrounds, with modification.

Section 140007—House recedes to Senate section 2906, increased penalties for travel act violations. Senate section 617 deleted as duplicative.

Section 140008—House recedes to Senate section 5130, solicitation of minor to commit crime.

TITLE XV—CRIMINAL STREET GANGS

Section 150001—House recedes to Senate section 611 with an amendment to provide increased penalties for federal gang crimes.

Section 150002—House recedes to Senate section 614 with modification to delete simple drug possession as basis of adult prosecution of juveniles.

Section 150003—House recedes to Senate section 619 to authorize use of Byrne funds for programs relating to gangs.

Section 150004—House sections 2201–02 recede to Senate section 631 with technical modifications and deletion of formula.

Section 150005—Senate section 632 recedes to House.

Section 150006—House recedes to Senate section 633 with technical modifications and the addition of mentoring program.

Section 150007—House recedes to Senate section 5167.

Section 150008—House recedes to Senate section 622, Gang Investigation Coordination and Information Collection.

Section 150009—Senate section 624 recedes to House section 1098, Multijurisdictional Gang Task Forces.

Senate section 612 recedes to House regarding use of minors as RICO predicate.

Senate section 613 recedes to House.

Senate section 623 is deleted because already enacted.

TITLE XVI—CHILD PORNOGRAPHY

Section 160001–02—House sections 1201–02 recede to Senate sections 824–25, child pornography.

Section 160003—House section 3083 recedes to Senate section 2410, Confirmation of intent of Congress in enacting sections 2252 and 2256 of title 18, United States Code.

TITLE XVII—CRIMES AGAINST CHILDREN

SUBTITLE A—JACOB WETTERLING CRIMES AGAINST CHILDREN AND SEXUALLY VIOLENT OFFENDER REGISTRATION ACT

Section 170101—Senate sections 821–23, Jacob Wetterling Crimes Against Children Registration Act, recede to House section 1301 with modification to include the program contained in Senate sections 841–44 and other modifications.

SUBTITLE B—ASSAULTS AGAINST CHILDREN

Section 170201—Senate recedes to House section 301, assaults against children, with technical and conforming modifications.

SUBTITLE C—MISSING AND EXPLOITED CHILDREN

Sections 170301–03—House recedes to Senate sections 4301–04, Missing and Exploited Children, with modifications. The Conferees note Congress finds with regard to this program that the victimization of children in our nation has reached epidemic proportions; recent Department of Justice figures show that 4,600 children were abducted by non-family members; two-thirds of the abductions of children by non-family members involve sexual assault; more than 354,000 children were abducted by family members; and 451,000 children ran away; while some local law enforcement officials have been successful in the investigation and resolution of such crimes, most local agencies lack the personnel and resources necessary to give this problem the full attention it requires; a majority of the nation's 17,000 police departments have 10 or fewer officers; and locating missing children requires a coordinated law enforcement effort; supplementing local law enforcement agencies with a team of assigned active Federal agents will allow Federal agents to pool their resources and expertise in order to assist local agents in the investigation of the nation's most difficult cases involving missing children.

Senate section 5129, Parent Locator Service, recedes to House.

Senate section 2701, International Parental Kidnapping, is deleted because already enacted.

TITLE XVIII—RURAL CRIME

Section 180101–201 House sections 2501–21 recede to Senate sections 1401–21 with modification regarding the structure of rural drug task forces, the placement of section 1421 in the Violence Against Women title, and other modifications.

Section 180301—Senate recedes to House section 2531, Sense of Congress Regarding Funding for Rural Areas.

TITLE XIX—FEDERAL LAW ENFORCEMENT

Section 190001—House section 3016 recedes to Senate section 5132, federal judiciary, with modifications to incorporate section 621, additional Federal prosecutors for the prosecution of violent youth gangs, and other modifications.

TITLE XX—POLICE CORPS AND LAW ENFORCEMENT OFFICERS TRAINING AND EDUCATION

House sections 2701–39 recede to Senate sections 1121–50 with modification to delete Senate section 1124 (b) and (c) with regard to the appointment of a Director.

TITLE XXI—STATE AND LOCAL LAW ENFORCEMENT

SUBTITLE A—BYRNE PROGRAM

Section 210101—Senate recedes to House section 1098A, extension of Byrne grant funding, with modification to authorize specified funds.

SUBTITLE B—LAW ENFORCEMENT FAMILY SUPPORT

Section 210201—House recedes to Senate section 1101, Law Enforcement Family Support, with modification to designate the Attorney General as the responsible official, and other minor modifications.

SUBTITLE C—DNA IDENTIFICATION

Sections 210301–06—House sections 1501–06 recede to Senate sections 1001–6, DNA Identification, with modification to ensure the establishment of a blind proficiency testing program for DNA analysis.

DNA Advisory Board

The Act requires the Director of the Federal Bureau of Investigation to appoint an advisory board on DNA quality assurance methods. The Conferees intend that, in making appointments to the advisory board, the Director of the FBI shall adhere strictly to all applicable conflict of interest and ethics laws. In particular, the FBI Director will ensure that no member of the board will have a commercial or proprietary interest in matters addressed by the board. To that end, the Director may obtain disclosure statements from nominees to the board. The Conferees expect that a review of any potential conflict of interest or ethical considerations will be conducted with the assistance of the Bureau's Legal Counsel Division, with the FBI Director retaining final authority regarding appointments to the board.

Proficiency Testing Program

The Conferees, in adopting the DNA Identification Act, recognize the significance of the development of a blind external proficiency testing program for DNA analyses. A blind external proficiency test means a test that is presented to a forensic laboratory through a second agency and appears to the analysts to involve routine evidence.

Under this Act, the Director of the National Institute of Justice is directed to study this issue and certify to Congress within one year that (1) the NIJ has undertaken steps to ensure that an appropriate entity or entities will establish a blind external proficiency testing program for DNA analyses, which shall be available to public and private laboratories performing forensic DNA analyses; (2) that a blind proficiency testing program for DNA analyses is already available; or (3) that it is not feasible to have a DNA blind proficiency testing program.

The Conferees fully expect that NIJ will report either that there are one or more existing DNA blind proficiency testing programs or that it has undertaken steps to ensure the establishment of one. There are many private DNA testing laboratories and commercial manufacturers of DNA testing products that have the technical expertise, individually or through professional and trade associations, necessary to establish the aforementioned program.

If the NIJ study determines blind external proficiency testing is feasible, neither State nor local DNA laboratories covered by the Act (i.e., those participating in the national DNA index or receiving grants), will be required by the Act to subscribe to such a blind testing program. The FBI Laboratory will not be required by the Act to subscribe to a particular blind testing program identified by NIJ. Participation by State and local governments should be voluntary and at their own discretion—although participation in such a program will be an important element of demonstrating quality control for purposes of having DNA evidence introduced into evidence.

SUBTITLE D—POLICE PATTERN OR PRACTICE

Sections 210401–02—House recedes to Senate sections 111–12, Police Pattern or Practice, with modification to section 1112.

SUBTITLE E—IMPROVED TRAINING AND TECHNICAL AUTOMATION

Section 210501—House recedes to Senate section 1031, improved training and technical automation, with technical and conforming modifications. The Conferees believe one appropriate use of this program would be to ensure that States, Indian Tribal governments, and local governments are made aware of advanced law enforcement technologies.

SUBTITLE F—OTHER STATE AND LOCAL AID

Section 210606—Senate recedes to House proposal to reauthorize the Office of Justice Programs.

Section 210602—House recedes to Senate section 5137, assistance to ease the increased burdens on State court systems, with modifications.

Section 210603—Senate recedes to House proposal to make money from the Violent Crime Reduction Trust Fund available to fund activities authorized by the Brady Handgun Violence Prevention Act and the National Child Protection Act of 1993.

Section 103(k) of the "Brady Bill" authorizes "such sums as are necessary" for the Attorney General to establish a "national instant criminal background check system." Section 106(b) of "Brady" authorizes $200 million for grants to States for the improvement of criminal records. Section 4(b) of the National Child Protection Act of 1993 authorizes $20 million for grants to States for the improvement of criminal records regarding child abuse. The Conference Report provides that a total of $150 million may be appropriated from the Trust Fund for these purposes.

TITLE XXII—MOTOR VEHICLE THEFT PREVENTION

House recedes to Senate sections 1901–03, motor vehicle theft prevention.

TITLE XXIII—VICTIMS OF CRIME

Senate sections 901–02, 912–17, crime victims, recede to House sections 101–21, with the following modifications: allocations of funds are changed to 48.5%, 48.5%, and 3%; the report on battered women's syndrome is moved to title IV, Violence Against Women. House section 101, with a conforming amendment, is enacted pursuant to the Rules Enabling Act. House recedes to Senate section 903, Sense of the Senate regarding Rights to Victims Allocation, with conforming modification. Senate section 3264 is deleted as duplicative. Senate section 911 is deleted because already enacted. House recedes to Senate proposal to amend 10603(a)(5)(B) of title 42, United States Code.

TITLE XXIV—PROTECTION FOR THE ELDERLY

Section 240001—House recedes to Senate section 2001, Missing Alzheimer's Disease Patient Alert Program.

Section 240002—House recedes to Senate section 2002, crimes against the elderly.

Section 240003—Senate recedes to House proposal regarding Safe Senior Corridors.

TITLE XXV—SENIOR CITIZENS AGAINST MARKETING SCAMS

Sections 250001–05, 250008—House recedes to Senate sections 3901–03, 3905–07 and 3910, Senior Citizens Against Marketing Scams (SCAMS), with modifications. Senate section 3904 recedes to House.

Section 250006—House recedes to Senate section 2103, mail fraud. Senate section 3908 is deleted as duplicative.

Section 250007—House recedes to Senate section 2102, Consumer Protection Against Credit Card Fraud Act. Senate section 3909 is deleted as duplicative.

The Conferees note that Congress has found with regard to this issue the following: Unprecedented Federal law enforcement investigations have uncovered a national network of illicit telemarketing operations; most of the telemarketing industry is legitimate, employing over 3,000,000 people through direct and indirect means; illicit telemarketers, however, are an increasing problem which victimizes our nation's senior citizens in disproportionate numbers; interstate telemarketing fraud has become a problem of such magnitude that the resources of the Department of Justice are not sufficient to ensure that there is adequate investigation of, and protection from, such fraud; telemarketing differs from other sales activities in that it can be carried out by sellers across State lines without direct contact; telemarketers can also be very mobile, easily moving from State to State; it is estimated that victims lose billions of dollars a year as a result of telemarketing fraud; consequently, this legislation is intended to enhance federal law enforcement resources, ensure adequate punishment for telemarketing fraud, and educate the public.

TITLE XXVI—COMMISSION MEMBERSHIP AND APPOINTMENT

Senate sections 1721–30 recede to House sections 3026–27, Commission to Support Law Enforcement, with modifications.

TITLE XXVII—PRESIDENTIAL SUMMIT ON VIOLENCE AND NATIONAL COMMISSION ON CRIME PREVENTION AND CONTROL

House sections 1643–51 and 2601–07 recede to Senate sections 1701–18, 1741–49 and 3241–49 with a modification to establish a National Commission on Crime Prevention and Control charged with developing a comprehensive proposal for preventing and controlling crime and violence in America. This Commission must establish committees or task forces for the following specific purposes: one to focus on crime and violence generally, one to focus on the causes of the demand for drugs, one to focus on violence in schools, and one to focus on violence against women. House recedes to Senate sections 1731–32, Presidential Summit on Violence, with modification.

TITLE XXVIII—SENTENCING PROVISIONS

Section 280001—House recedes to Senate section 2401, imposition of a sentence.

Section 280002—House recedes to Senate section 2402, technical amendment to mandatory conditions of probation.

Section 280003—House section 1701 recedes to Senate section 2409, Hate Crime Sentencing.

Section 280004—House recedes to Senate section 2501, authorization of probation for petty offenses in certain cases.

Section 280005—House recedes to Senate section 5152 with modifications to create two full-time vice chairs of the U.S. Sentencing Commission, and to specify that of the chair and the two vice chairs, no more than two shall be of the same political party.

Section 280006—House recedes to Senate section 3092, Cocaine Penalty Study.

Senate section 2405, mandatory minimums for use or possession of firearm during a State crime, recedes to House.

Senate section 2502, trial by a magistrate in petty cases, recedes to House.

TITLE XXIX—COMPUTER CRIME

House recedes to Senate section 2601, computer crime, with minor modifications.

TITLE XXX—PROTECTION OF PRIVACY INFORMATION IN STATE MOTOR VEHICLE RECORDS

Senate section 3101–03, Driver's Privacy Protection Act, recede to House sections 2901–03 with modifications.

This title prohibits the release and use of certain personal information except under certain circumstances. One of these exceptions, found in subsection (b)(3), permits disclosures where a person or entity is seeking correct information about an individual who presented false information or information that is no longer correct, "but only for the purpose of preventing fraud by, pursuing legal remedies against, or recovering on a debt or security interest against, the individual."

Some State motor vehicle departments may require requestors seeking to use this exception to certify or state the purpose for which the information is being sought. While in most cases this practice by the State will not give rise to further concern, it could pose a problem for debt collectors covered under the Fair Debt Collection Practices Act (FDCPA). Section 804 of the FDCPA provides: "Any debt collector communicating with any person other than the consumer for the purpose of acquiring location information about the consumer shall . . . (2) not state that such consumer owes any debt."

The interaction of section 804(2) of the FDCPA and subsection (b)(3) of the Driver's Privacy Protection Act could be interpreted as barring a covered debt collector from indicating to a State DMV that it was seeking information for a permitted purpose, thereby barring the debt collector from receiving information crucial to collecting a debt.

This was clearly not the intention of the drafters of the legislation and it is not the intention of the Conferees. To the contrary, the drafters of the legislation and the Conferees intend for debt collectors to be able to obtain motor vehicle record information without violating section 804(2) of the FDCPA. In this case, the purpose of disclosing the existence of a debt is solely to establish the basis for receiving DMV data, not to harass the debtor. Therefore, the Conferees believe that a statement that the information is being sought for the purposes of recovering on a debt would not violate section 804(2). In addition, the Conferees believe it would be adequate for debt collectors under (b)(3) to state that they are "pursuing legal remedies against . . . the individual," as provided in (b)(3), without stating that the legal remedies related to a debt. The Conferees believe that such a statement would not violate section 804 of the FDCPA, which is intended to prevent debt collectors from harassing a consumer by telling third parties that the consumer owes a debt. The Conferees believe that a collector is in no way harassing a consumer by telling a State DMV that information is sought in connection with "pursuing legal remedies."

The opportunity to prohibit disclosure of personal information under (b)(11) and (b)(12) does not have to be provided each time a request for such information is made. Instead, the opportunity to prohibit these disclosures should be provided at the time an individual registers for or renews his or her driver's license, title registration or identity card and at any other time an individual contacts the State on his or her own initiative to prohibit such disclosures.

Under subsection (b)(13), any requestor may obtain access to an individual's personal information if the requestor has obtained written consent from the individual whose personal information is sought. The Conferees intend that each State must provide that the requestor's demonstration include a written consent that has been notarized.

TITLE XXXI—VIOLENT CRIME REDUCTION TRUST FUND

Sections 310001–02—House recedes to Senate sections 1352–54 with modifications as follows: (1) the trust fund covers fiscal years 1995–2000 and totals $30.210 billion; (2) annual outlays from trust fund appropriations are subject to limits enforceable through sequestration procedures similar to those applied under the Balanced Budget and Emergency Deficit Control Act of 1985 to appropriations in the regular budget process; and (3) the limitations on the number of total Federal Government personnel is deleted because it has already been enacted into law (Federal Workforce Restructuring Act of 1994, P.L. 103–226).

Section 310003—Senate recedes to House proposal to provide for the extension of authorizations of appropriations.

This section is an "authorization extender" provision intended to assure the complete and efficient use of all authorizations contained in the Report and all monies transferred into the Violent Crime Reduction Trust Fund. Under this provision, if the amount appropriated from the Trust Fund for a given program in a particular fiscal year is less than the amount authorized for that program in that year, the unused portion of the authorization remains available for use for that program in later fiscal years.

For example, if $100 million is authorized for program "A" for fiscal year 1996 but only $75 million is actually appropriated, the remaining $25 million will be available for appropriations from the Trust Fund in fiscal years 1997 and beyond for that program. The $25 million in authorizations "extended" beyond fiscal year 1996 need not all be used in fiscal year 1997; it remains available until funds are appropriated for such authorizations.

Section 310004—Senate recedes to House proposal to provide for flexibility in making appropriations.

This Section provides "transfer authority" to give the Appropriations Committees some flexibility in allocating appropriations from the Trust Fund among the programs included within each of three specified functional categories. Under these provisions, the $30.2 billion in authorizations contained in the Report is divided into the following categories: (1) State and Local Law Enforcement, (2) Federal Law Enforcement and (3) Prevention. Within each of these categories, the Appropriations Committees will, in any fiscal year, be permitted to transfer up to 10 percent of the authorization for a particular program to any other program within the same category.

For example, within the "Federal law enforcement" category, the Appropriations Committees could decrease the fiscal year 1996 authorization for program "A" by up to 10 percent and transfer that money to program "B" by increasing the authorization for "B" by the dollar amount subtracted from "A".

The transfer authority provided in the Conference Report is subject to three additional limitations (1) the aggregate amount of authorizations transferred away from a program over the life of the Trust Fund may not exceed 10 percent of the program's total authorization; (2) transfer authority may not be used to increase total authorizations for any of the three categories for any fiscal year above the level authorized for that category by the Report; and (3) no transfers between categories are permitted, *e.g.*, authorizations for "Prevention" programs may not be transferred to "Federal Law Enforcement" programs.

The following is a list of the programs included in each of the three broad functional categories:

FEDERAL LAW ENFORCEMENT

(1) Authorization of Additional Appropriations for the Federal Judiciary, Section 190001(a)
(2) Authorization of Additional Appropriations for the Department of Justice, Section 190001 (b)
(3) Authorization of Additional Appropriations for the Federal Bureau of Investigation, Section 190001 (c)
(4) Authorization of Additional Appropriations for United States Attorneys, Section 190001 (d)
(5) Authorization of Additional Appropriations for the Department of Treasury, Section 190001 (e)
(6) National Center for Criminal Justice Research and Education, Section 320925
(7) Gang Investigation Coordination and Information Collection, Section 150008
(8) Motor Vehicle Theft Prevention, Section 220002
(9) Criminal Alien Tracking Center, Section 130002
(10) Expeditious Deportation for Denied Asylum Applicants, Section 130005
(11) Improving Border Controls, Section 130006
(12) Expanded Special Deportation Proceedings, Section 130007
(13) FBI and U.S. Attorney activities regarding Senior Citizens Against Marketing Scams, Section 250005
(14) FBI Activities Regarding DNA, Sections 210303-210306
(15) Agents for the Drug Enforcement Administration, Section 180104
(16) Presidential Summit on Violence and National Commission on Crime Prevention and Control, Section 270009

STATE AND LOCAL LAW ENFORCEMENT

(1) Public Safety and Policing, Sections 10001-10003
(2) Law Enforcement Family Support, Section 210201
(3) Availability of Violent Crime Reduction Trust Fund to fund activities authorized by the Brady Handgun Violence Protection Act and the National Child Protection Act of 1993, Section 210603
(4) Rural Law Enforcement Agencies, Section 180101
(5) Rural Drug Enforcement Training, Section 180103
(6) Community-based Justice Grants for Prosecutors, Sections 31701-31708
(7) Federal assistance to State court systems, Section 210602
(8) Police Recruitment, Sections 30801-30802
(9) DNA Grants to States, Section 210302
(10) Improved training and technical automation, Section 210501
(11) Extension of Byrne Grant Program, Section 210101
(12) Criminal Justice and Substance Abuse Treatment Training, Section 320930
(13) Violent Offender Incarceration and Truth-in-Sentencing Incentive Grants, Sections 20101-20109
(14) Incarceration of Undocumented Criminal Aliens, Section 20301
(15) Prevention, Diagnosis, and Treatment of Tuberculosis in Correctional Institutions, Section 32201
(16) Certainty of Punishment for Young Offenders, Section 20201

PREVENTION

(1) Drug Courts, Section 50001
(2) Ounce of Prevention, Section 30101-30104
(3) Youth Employment and Skills Crime Prevention, Section 30201
(4) Model Intensive Grants, Sections 30301-30307
(5) Family and Community Endeavor Schools Grant Program and Community Schools Youth Services and Supervision Grant Program, Sections 30401-30403
(6) Police Partnerships for Children and Grants for Police Residence in High Crime Areas, Sections 30501-30505
(7) Midnight Sports, Section 30601
(8) Assistance for Delinquent and At-Risk Youth, Sections 30701-30702
(9) National Triad Program, Sections 30901-30906
(10) Local Partnership Act, Sections 31001-31002
(11) National Community Economic Partnership, Sections 31101-31133
(12) Gang Prevention Services for Boys and Girls, Sections 31201-31207
(13) Olympic Youth Development Centers, Section 31301
(14) Anti-Crime Youth Councils, Sections 31401-31405
(15) Urban Recreation and At-Risk Youth, Sections 31501-31505
(16) Boys and Girls Clubs in Public Housing, Sections 31601-31603
(17) Child Safety, Sections 31801-31808
(18) Family Unity Demonstration Project, Sections 31901-31922
(19) Substance Abuse Treatment in Federal Prisons, Section 32001
(20) Substance Abuse Treatment for State Prisoners, Section 32101
(21) Hope in Youth Program, Sections 32301-32307
(22) Gang Resistance Education and Training, Section 32401
(23) Federal Victim's Counselors, Section 40114
(24) Grants to Combat Violent Crimes Against Women, Section 40121
(25) Education and Prevention Grants to Reduce Sexual Assaults Against Women, Section 40151
(26) Training Programs, Section 40152
(27) Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless, and Street Youth, Section 40155
(28) Victims of Child Abuse Programs, Section 40156
(29) National Domestic Violence Hotline, Section 40211
(30) Encouraging Arrest Policies in Domestic Violence Cases, Section 40231
(31) Battered Women Shelters, Section 40241
(32) Youth Education and Domestic Violence, Section 40251
(33) Community Programs on Domestic Violence, Section 40261
(34) Study on State Databases, Section 40292
(35) Study on Number and Cost of Domestic Violence Injuries, Section 40293
(36) Rural Domestic Violence and Child Abuse Enforcement Assistance, Section 40295
(37) Education and Training for Judges and Court Personnel in State Courts, Sections 40411-40414
(38) Education and Training for Judges and Court Personnel in Federal Courts, Sections 40421-40422
(39) National Baseline Study on Campus Sexual Assault, Section 40506
(40) National Stalker and Domestic Violence Reduction, Sections 40601-40611
(41) Juvenile Drug Trafficking and Gang Prevention Grants, Section 150004
(42) Grants for Youth Development Centers, Section 150005
(43) Missing Alzheimer's Disease Patient Alert Program, Section 240001
(44) Safe Senior Corridors Grants, Section 240003

TITLE XXXII—MISCELLANEOUS

SUBTITLE A—INCREASES IN PENALTIES

Section 320101—House recedes to Senate Section 2901, increased penalties for assault.

Section 320102—House recedes to Senate section 2902, increased penalties for manslaughter.

Section 320103—House recedes to Senate section 2903, increased penalties for civil rights violations.

Section 320104—Senate section 2904(a) recedes to House section 3051, Penalties for Trafficking in Counterfeit Goods and Services; House recedes to Senate section 2904(b), laundering monetary instruments.

Section 320105—House recedes to Senate section 2905, penalty for committing murder for hire.

Section 320106—House recedes to Senate section 2907, increased penalties for arson, with modifications to delete mandatory minimum and increase the maximum penalty range.

Section 320107—House recedes to Senate section 616, increased penalties for drug trafficking near public housing. Senate section 1503 is deleted as duplicative.

Section 320108—House recedes to Senate section 5105, penalties for nonindigenous species, with modifications.

Section 320109—Senate recedes to House section 3056, military medals and decorations.

Senate section 2967, balanced in the criminal justice system, recedes to House.

SUBTITLE B—EXTENSION OF PROTECTION OF CIVIL RIGHTS STATUTES

Section 320201—House recedes to Senate section 2911, extension of civil rights statutes.

SUBTITLE C—AUDIT AND REPORT

Sections 320301-02—House recedes to Senate sections 2921-22, audit and report.

SUBTITLE D—COORDINATION

Section 320401—House recedes to Senate section 5166, coordination of treatment and prevention programs.

SUBTITLE E—GAMBLING

Section 320501—House recedes to Senate section 2932, clarifying amendment regarding scope of prohibition against gambling on ships in international waters, with technical modifications.

Senate section 2931, enforcement of laws relating to gaming, recedes to House.

SUBTITLE F—WHITE COLLAR CRIME AMENDMENTS

Section 320601—House recedes to Senate section 2941, receiving proceeds of extortion or kidnapping.

Section 320602—House recedes to Senate section 2942, receiving the proceeds of a postal robbery.

Sections 320603-04—Senate section 2101 recedes to House sections 401-02, Insurance Fraud.

Sections 320605-06—House recedes to Senate sections 2201-03, Financial Institution Fraud.

Section 320607—House recedes to Senate section 2944, addition of predicate offenses.

Section 320608—House recedes to Senate section 2945, definition of savings & loan.

Section 320609—House recedes to Senate section 2946, definition of 1-year sentence.

Senate section 2943 recedes to House.

Senate sections 3801-21, enhanced penalties for health care fraud enforcement efforts, recede to House.

Senate section 2301, savings and loan task force, recedes to House.

Senate sections 4401-04, public corruption, recede to House.

Senate section 2204 recedes to House.

Senate section 5146, Bankruptcy, recedes to House.

SUBTITLE G—SAFER STREETS AND NEIGHBORHOODS

Sections 320701-02—House recedes to Senate sections 2951-52, Safer Streets and Neighborhoods, with technical modifications.

SUBTITLE H—RECREATIONAL HUNTING SAFETY

House recedes to Senate sections 4601-08, Recreational Hunting Safety, with modifications.

The conference report contains a modified version of Title XLVI of the Senate amendment, the Recreational Hunting Safety and Preservation Act of 1994. The purpose of this subtitle is to protect the safety and rights of persons to lawfully engage in hunting and fishing activities on Federal land.

In fashioning the provisions of this subtitle, the Conferees took care to not infringe on the first amendment right of free speech. The civil penalty provisions of this subtitle only apply to intentional physical conduct that significantly hinders a lawful hunt. Conduct is defined to exclude any activity protected by the first amendment. None of the provisions of this subtitle are intended to affect or limit in any way first amendment rights. Nor does the subtitle affect Federal land managers' existing authority to subject speech to reasonable regulation as to time, place and manner to the extent it is Constitutionally permissible.

In the interest of clarity, the Conferees have adopted a concise standard of violation, defined as intentional physical conduct that significantly hinders a lawful hunt. The Conferees intend that the physical conduct and the hinderance by considered as unitary; that is, both must be intentional. In other words, the conduct must be intentional, and must be done with the intention of significantly hindering a lawful hunt. A violation only occurs if the hinderance is significant; that is, it must have a negative influence or effect. The Conferees intend this to mean that incidental conduct which has *de minimis* effect on a hunt would not violate this subtitle.

With the principles described above in mind, examples of violations of this subtitle would include, but not be limited to, driving or disturbing wildlife; blocking or impeding hunters; using visual, aural, olfactory, or physical stimuli to affect wildlife behavior; erecting barriers to deny ingress or egress to areas where a lawful hunt takes place; placing a person or object in the line of fire; taking, disturbing or damaging property, such as a hunting blind; abusing a hunting dog; or other conduct intended to slow or make difficult the progress of a lawful hunt.

SUBTITLE I—OTHER PROVISIONS

Section 320901—House recedes to Senate section 2965, wiretaps, with technical modification.

Section 320902—House recedes to Senate section 2966, theft of major artwork, with modifications.

Section 320903—House recedes to Senate section 2969, addition of attempted robbery, kidnapping, smuggling and property damage offenses.

Section 320904—House recedes to Senate section 2972, to include findings with respect to the gun-free school zone provisions of the Crime Control Act of 1990.

Section 320905—House recedes to Senate section 5109, interstate wagering.

Section 320906—Senate recedes to House section 3005 with technical modifications. The Conferees note that Congress finds with regard to this section that there are 8,000,000 workers in the trucking industry in the United States, some working for large carriers and some for small carriers, some for private carriers and some owner operators, all assisting the free flow of commerce by transporting all types of commodities that enter, leave, or move within this country. Unemployment, crime, and drug use have contributed to an increase of violence against commercial truckers, an increase that has gone unrecognized by the public at large. As few state or local authorities report violent crimes against truckers as such to the Federal Bureau of Investigation, statistics do not reflect this fast-growing and increasingly violent segment of crime. The Federal Bureau of Investigation investigated 282 truck hijackings involving crimes of violence in 1993, not including attempted crimes and crimes addressed by State, county, and local authorities. The Federal Government in large measure finances the highway system the trucking industry uses, collecting large sums in taxes from the industry and licenses, and regulates the industry and its drivers, entailing a concomitant responsibility to protect them against crime. Federal law provides protections to truckers in, among others, sections 33 and 1951 of title 18, United States Code, but currently Federal prosecutions are not undertaken unless certain monetary thresholds of loss are met.

Section 320907—House recedes to Senate section 5148 with technical modifications. The Conferees note the Senate finds with regard to this section that: (1) the National Center for Health Statistics has reported that the out-of-wedlock birth rate reached 29.5 percent in 1991 (66.3 percent in Washington DC., 71.0 percent in Detroit); (2) the out-of-wedlock birth rate has increased without interruption since 1970, and, as pointed out recently by George Will, "the rate of increase is not slowing even at extraordinary levels"; (3) Dr. Lee Rainwater of Harvard University predicts that the rate will reach 40 percent within 7 years; (4) Professor James Q. Wilson has described the erosion of the family structure in the United States and Western nations as "a major cultural convulsion" that is inextricably associated with the rise of violent urban crime; (5) President Clinton has stated on the national television program "Meet the Press" that there is "absolutely" a correlation between crime and drugs and the breakdown of the family.

Section 320908—House recedes to Senate section 5106 with technical modifications. The Conferees note the Senate finds with regard to this section that (1) international criminal activity has increased dramatically over the past decade and has been facilitated by modern developments in transportation and communications, relaxed travel restrictions, and the greatly increased volume of international trade; (2) The expansion of international criminal activity is reflected in the growth of requests for mutual legal assistance and extradition made between the United States and other countries, the number of such requests having increased from 535 in 1984 to 2,238 in 1992; (3) The global reach of organized crime constitutes a serious threat to the security and stability of sovereign nations; (4) the expanding scope of international organized crime necessitates greater cooperation among nations to prosecute and eliminate organized criminal groups; (5) there is an urgent need for new approaches to allow the international law enforcement community to pursue international criminals across national boundaries; (6) The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances has helped bring about improved international cooperation with respect to narcotics; (7) The current role of the United Nations with respect to international organized crime is limited by the lack of a binding international convention dealing with the broad range of organized criminal activity beyond narcotics; (8) The United Nations Commission on Crime Prevention and Criminal Justice has successfully facilitated the negotiation and implementation of mutual legal assistance and extradition treaties between certain nations, and has helped train nations to effectively execute the terms of such treaties; (9) The United Nations Commission on Crime Prevention and Criminal Justice currently has limited authority and resources.

Section 320909—House recedes to Senate section 2961, optional venue for espionage.

Section 320910—House recedes to Senate section 2962, undercover operations.

Section 320911—House recedes to Senate section 2968, misuse of DEA initials.

Section 320912—House recedes to Senate section 2970, definition of livestock, with modification.

Section 320913—House recedes to Senate section 5155, asset forfeiture.

Section 320914—House recedes to Senate section 5156, clarification of court.

Section 320915—House recedes to Senate section 5164. The Conferees note that the Senate has found regarding this provision that we are losing control of our streets and our neighborhoods to gangs, drugs and violent crime; Americans tolerate a level of violence 5 times that of Canada and 10 times that of England; this bill establishes a Violent Crime Reduction Trust Fund. The conference report authorizes the revenues to fund the Trust Fund be derived from savings resulting from a reduction in Federal personnel; and the Federal law enforcement agencies charged with carrying out the provisions of this Act will require substantial manpower to implement the Act.

Section 320916—Senate recedes to House section 3041, traveler protection.

Section 320917—House recedes to Senate section 2971, extension of statute of limitations for arson, with modifications.

Section 320918—House recedes to senate section 1603, Sense of Congress concerning child custody and visitation rights.

Section 320919—Senate recedes to House section 3048, Edward Byrne Memorial Formula Grant Program.

Section 320920—House recedes to Senate section 5127, Law Day USA with modification. The Conferees note that the Senate has found with regard to this program that the first day of May each year has been designated as "Law Day U.S.A." and set aside as a special day to advance equality and justice under law, to encourage citizens and support for law enforcement and law observance, and to foster respect for law and an understanding of the essential place of law in the life of every citizen of the United States; each day police officers and other law enforcement personnel perform their duties unflinchingly and without hesitation; each year tens of thousands of law enforcement personnel are injured or assaulted in the course of duty and many are killed; law enforcement personnel are devoted to their jobs, are underpaid for their efforts and are tireless in their work; and law enforcement personnel perform their duties without adequate recognition.

Section 320921—House recedes to Senate section 5154 with modifications. This section ensures that a defendant convicted for the first time will attend an appropriate rehabilitation program. The Conferees intend that the courts ensure that defendants who may suffer from organic brain damage or severe mental illness are referred to the most appropriate rehabilitative care addressing their specific needs. Further, any rehabilitation program may refer the defendant back to the court if it determines that its program is inappropriate for the defendant.

Section 320922—Senate recedes to House section 3001, Display of Flags at Half Staff.

Section 320923—Senate recedes to House section 3011, Financial Institution Fraud.

Section 320924—House recedes to Senate section 5114, definition of parent.

Section 320925—Senate recedes to House proposal regarding National Center for Criminal Justice Research and Education.

Section 320926—House recedes to Senate section 5123, Hate Crime Statistics Act.

Section 320927—Senate recedes to House proposal exempting return of handgun to owner from Brady background check requirement.

Section 320928—House recedes to Senate sections 811–16, Protection of Children, the Elderly, and Individuals with Disabilities, with modifications to delete already enacted provisions and with other modifications.

Section 320929—Senate recedes to House proposal regarding Tennessee Valley Authority Law Enforcement.

Section 320930—Senate recedes to House proposal for Criminal Justice and Substance Abuse Training.

Section 320932—House recedes to Senate section 5162, Assistant United States Attorney Residency, with modification to 25 miles.

Section 320933—Senate recedes to House section 3086 with modifications.

Senate section 5128, treatment of Indian tribes, recedes to House because Indian tribal governments are incorporated throughout the bill.

Senate section 5133, Control and Prevention of Crime in Indian Country, recedes to House because Indian Tribes are incorporated throughout the bill.

Senate section 5151, Supreme Court marshals and police, deleted because already enacted.

Senate section 5116, parental accountability, recedes to House.

Senate section 831, admissibility of evidence, recedes to House.

Senate section 5108, Report on Success of Royal Hong Kong Police Recruiting, recedes to House.

Senate section 5147 recedes to House. The Conferees note that the substance of this provision is included in the provisions for alternative punishment for young offenders.

Senate section 5145, Children and Youth Utilizing Federal Land, recedes to House.

Senate section 5104 recedes to House.

Senate section 5134, extension of RTC statute of limitations, recedes to House.

House section 3061–62, Age Discrimination in Employment, recede to Senate.

House section 1098B, Benefit for Chaplains, recedes to Senate because Senate budget point of order lies against this section.

Senate sections 2801–03, Safe Schools, are deleted because already enacted.

Senate sections 1011–12, community substance abuse prevention, recede to House.

House section 1605 recedes to Senate.

TITLE XXXIII—TECHNICAL CORRECTIONS

Sections 330001–025—Senate sections 3001–13 recede to the technical corrections found in H.R. 3131 with conforming changes and additional technical corrections.

JACK BROOKS,
DON EDWARDS,
BILL HUGHES,
CHARLES SCHUMER,
JOHN CONYERS, Jr.,
MIKE SYNAR,

As additional conferees from the Committee on Agriculture, for consideration of sections 4601–08, 5105, and 5145 of the Senate amendment, and modifications committed to conference:

E DE LA GARZA,
CHARLIE ROSE,
CHARLES W. STENHOLM,
PAT ROBERTS,
RICHARD POMBO,

As additional conferees from the Committee on Banking, Finance and Urban Affairs, for consideration of sections 2201–04, 2301, and 4901–33 of the Senate amendment, and sections 1031(b), 1038, and 1099AA–1099CC of the House amendment, and modifications committed to conference:

HENRY GONZALEZ,
STEVE NEAL,
BRUCE F. VENTO,

As additional conferees from the Committee on Education and Labor, for consideration of sections 631–33, 662(e), 662(f), 811–16, 921–28, 1121–50, 1331, 2801–03, 3261, 3263, 3311, 3341, 3351, 3361, 3381–83, 3501, 3707, 4001–09, 4301–04, 4701–02, 4801–09, 4901–33, 5120, 5122, 5135, 5140, 5142–43, and 5147 of the Senate amendment, and sections 1010–26, 1030–34, 1038, 1051–52, 1065–71, 1081–96, 1099A–1099G, 1099H–1099O, 1099P–1099T, 1606, 1610, 1653–54, 1902(e), 1902(f), 2201–02, 2701–39, 3061–62, 3089–90, of the House amendment, and modifications committed to conference:

WILLIAM D. FORD,
DALE E. KILDEE,
MATTHEW G. MARTINEZ,

As additional conferees from the Committee on Energy and Commerce, for consideration of sections 1503–04, 1511–23, 1532, 1534–35, 1537, 1902(e), 3101–03, 3261, and 5166 of the Senate amendment, and sections 1010–26, 1041–44, 1606, 2901–03, and 3086 of the House amendment, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
CARDISS COLLINS,

As additional conferees from the Committee on Government Operations, for consideration of sections 1553–54, 1535, and 5150 of the Senate amendment, and sections 1075–76 of the House amendment, and modifications committed to conference:

TOM LANTOS,
EDOLPHUS TOWNS,

Provided Mr. Spratt and Mr. Kyl are appointed in lieu of Mr. Waxman and Mr. Clinger solely for the consideration of sections 1335 and 5150 of the Senate amendment.

JOHN M. SPRATT, Jr.,

As additional conferees from the Committee on Merchant Marine and Fisheries, for consideration of sections 713–15, 4601–08, 5105, and 5145 of the Senate amendment, and modifications committed to conference:

GERRY STUDDS,
SOLOMON P. ORTIZ,
GEORGE HOCHBRUECKNER,

As additional conferees from the Committee on Natural Resources, for consideration of sections 3232–33, 4601–08, and 5145 of the Senate amendment and sections 1099U–1099Z of the House amendment, and modifications committed to conference:

GEORGE MILLER,
BRUCE F. VENTO,
KAREN SHEPHERD,
DON YOUNG,
BARBARA VUCANOVICH,

Provided, Ms. English of Arizona is appointed in lieu of Ms. Shepherd solely for the consideration of sections 4601–08 of the Senate amendment.

KARAN ENGLISH,

Provided, Mr. Hinchey is appointed in lieu of Ms. Shepherd solely for the consideration of sections 1099U–1099Z of the House amendment.

MAURICE HINCHEY,

As additional conferees from the Committee on Post Office and Civil Service, for consideration of sections 1352 and 3371 of the Senate amendment, and modifications committed to conference:

WILLIAM CLAY,
FRANK MCCLOSKEY,
ELEANOR H. NORTON,
JOHN T. MYERS,
CONSTANCE A. MORELLA,

As additional conferees from the Committee on Public Works and Transportation, for consideration of sections 1533, 1536, and 3231 of the Senate amendment, and section 1801 of the House amendment and modifications committed to conference:

NORMAN Y. MINETA,
NICK RAHALL,
BUD SHUSTER,
THOMAS E. PETRI,

As additional conferees from the Committee on Rules, for consideration of sections 1353–54 of the Senate amendment, and modifications committed to conference:

JOHN JOSEPH MOAKLEY,
BUTLER DERRICK,

TONY BEILENSON,

As additional conferees from the Committee on Ways and Means, for consideration of sections 311(b), 1502, 1515–16, 1802, 4702(e)(1), 5102, and 5113 of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
SAM GIBBONS,
J.J. PICKLE,
Managers on the Part of the House.

JOSEPH R. BIDEN, Jr.,
EDWARD M. KENNEDY,
HOWARD M. METZENBAUM,
DENNIS DECONCINI,
PATRICK J. LEAHY,
Managers on the Part of the Senate.

ANNOUNCEMENT OF EVENING MEETING OF COMMITTEE ON RULES

(Mr. SOLOMON asked and was given permission to address the House for 1 minute.)

Mr. SOLOMON. Mr. Speaker, we have been notified that there will be a Committee on Rules meeting at 8 p.m. this evening.

Is that on the conference report that the gentleman just presented?

Mr. BROOKS. Mr. Speaker, will the gentleman yield?

Mr. SOLOMON. I yield to the gentleman from Texas.

Mr. BROOKS. Mr. Speaker, the gentleman is correct.

Mr. SOLOMON. Are there copies in the Committee on Rules of that report now?

Mr. BROOKS. The copies will be there in 3 minutes. As we speak, they are moving over here.

Mr. SOLOMON. In 3 minutes. We appreciate that. That means we will have 57 minutes to look at it before we take it up in the Committee on Rules?

Mr. BROOKS. Maybe 58. If the gentleman reads fast.

Mr. SOLOMON. Please hurry, Mr. Chairman.

HEALTH CARE: START OVER NEXT YEAR

(Mr. DOOLITTLE asked and was given permission to address the House for 1 minute and to revise and extend his remarks, and include extraneous matter.)

Mr. DOOLITTLE. Mr. Speaker, it is not just the Republicans who do not like the Democrats' socialistic health care bills. Liberal Democrat columnist Robert Samuelson in today's Washington Post has written a column called "Health Care: Start Over Next Year. They don't know what they're doing up there."

Here is what he says:

Among other things, the Democratic health care plans contain a large—and unjustified—multi-billion-dollar tax on younger workers. You wonder whether most members of Congress know this or even care. The whole health care debate is now completely out of control. The desperate effort to craft something that can be advertised as "universal coverage" means that Congress literally no longer knows what it's doing. Anything resembling the Democrats' bills, if enacted, would produce massive unintended side effects.

Apparently, most Americans grasp this. In a Newsweek poll last week, respondents were asked whether Congress ought to "pass reform this year" or "start over next year." By a two-to-one margin (65–31 percent) they said "start over" * * *

Republicans * * * are now correct that a bad bill would be worse than none.

Mr. Speaker, the full text of the column by Robert Samuelson is as follows:

HEALTH CARE: START OVER NEXT YEAR—THEY DON'T KNOW WHAT THEY'RE DOING UP THERE

(By Robert J. Samuelson)

Among other things, the Democratic health care plans contain a large—and unjustified—multi-billion dollar tax on younger workers. You wonder whether most members of Congress know this or even care. The whole health care debate is now completely out of control. The desperate effort to craft something that can be advertised as "universal coverage" means that Congress literally no longer knows what it's doing. Anything resembling the Democrats' bills, if enacted, would produce massive unintended side effects.

Apparently, most Americans grasp this. In a Newsweek poll last week, respondents were asked whether Congress ought to "pass reform this year" or "start over next year." By a two-to-one margin (65–31 percent), they said "start over." They sense that the versions of health reform crafted by House and Senate leaders are hodgepodges of conflicting provisions whose only purpose is to win passage. But what is clear to ordinary Americans is denied in Washington. In the capital, the fiction is that legislators know what they're doing and are debating rational alternatives.

"I think you're going to see a very good, erudite back-and-forth," says House majority leader Richard Gephardt, sponsor of the House bill. Well, it won't be "erudite" if members of Congress don't understand the consequences of their actions.

Gephardt's plan, for instance, would create a new Medicare Part C program for the unemployed, workers in small companies and many existing Medicaid recipients. The Congressional Budget Office estimates that the program might enroll 90 million people. But the projection could easily err by millions in either direction. More important, Medicare Part C emphasizes "fee for service" medicine (patients selecting individual doctors), while the rest of the bill emphasizes "managed competition" (reliance on health maintenance organizations and similar plans).

In a single stoke, the bill would separate the under-65 population into two groups, mainly based on income and size of employer. Each group would be crudely steered toward a different type of medicine. In practice, this division may not be politically acceptable or economically workable. Many Americans may find one type of medicine more appealing than the other and resent being excluded. Or the artificial segmenting of the medical market may raise costs for both "managed competition" and "fee for service." Gephardt doesn't know; no one does.

Now, consider the tax on young workers. It arises from "community rating." As people age, their health costs and insurance premiums rise. But "community rating" requires that everyone pay the same rate. This provision is included in the House bill, and in a modified version, in the Senate bill. The effect would be to raise insurance for younger workers (say those below 45); the amounts are hard to estimate, but a good guess is at least $300 to $500 a worker. If employers have to pay higher insurance, they will pay lower salaries. The invisible tax on young workers might total $15 billion to $25 billion annually.

Is this fair? No. If enacted, it would compound the existing bias against the young. Already, one-third of the federal budget goes to the elderly; the young are taxed to support the old. How much farther is this to go? Or is it a cynical reaction to voting patterns (the young vote less than the middle-aged or old)?

Questions like these swirl around both Gephardt's plan and Senate majority leader George Mitchell's. It is hard even to describe Mitchell's plan. He says it's voluntary and lacks a "mandate." Wrong. It's true that it doesn't mandate companies to buy insurance for workers. But it does mandate a standard benefit package for firms—the vast majority—that offer insurance. Because the mandated benefits are above average, this would probably raise health spending. Companies below the new standard would increase benefits; those above would have trouble lowering them.

Next, Mitchell hopes to achieve 95 percent insurance coverage by offering subsidies for low-income workers to buy it. But there's a "fail-safe" mechanism to limit subsidies if the budget costs exceed projected costs. However, if 95 percent coverage doesn't occur by 2000, Congress could require employers to pay 50 percent of their workers' insurance. But this would apply only to firms with more than 25 workers. Got it? Neither Mitchell nor anyone else knows whether this would reach 95 percent coverage.

These plans are confusing because the health debate evaded the basic tension between expanding health services ("universal coverage" etc.) and controlling health spending. It's hard to do both at the same time. The plans' complexities—as with the original Clinton plan's—aim to disguise this conflict. Republicans haven't been especially constructive in this debate because they haven't faced up to it either. But they are now correct that a bad bill would be worse than none.

Chaos is now the most important (and largely unreported) reality about the health care debate. Dozens of provisions in these bill would have huge unappreciated consequences. John Sheils of Lewin-VHI, a health consulting firm, says premiums for small businesses in the Mitchell bill could be 25 percent higher than for big companies. The CBO agrees a gap exists but puts it lower. Who's right? Do most members of Congress understand the gap? Probably not. Still, the pretense in Washington is that Congress is making conscious choices.

The pretense is sustained because in Washington politics is sport, especially at the climax of a legislative battle. All attention fixes on who wins and loses—and the deals that enliven the game. Rhetorical blasts are taken for reality; political reporters know little of how legislation would work and care less. This often leads to bad laws, and in health care, the potential for blunders is huge because Congress is tinkering with one-seventh of the economy and most aspects of medicine.

In May, Robert Reischauer, head of the CBO, warned that trying to find a compromise by combining provisions from different bills might make the health system worse. He compared it to building an auto engine with incompatible parts: "You can't say I want a piston from Ford, a fuel pump from Toyota * * * and expect the engine to run." Well, that's precisely what's happened. The contraption is no longer even a car made with incompatible parts. It's now part car, part tractor and part rollerblades. It's a clunker. Most Americans seem to understand this. Will Congress?

SPECIAL ORDERS

The SPEAKER pro tempore (Mr. CLYBURN). Under the Speaker's announced policy of February 11, 1994, June 10, 1994, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

BEGINNING OF THE END FOR CASTRO DICTATORSHIP

The SPEAKER pro tempore. Under a previous order of the House, the gentlemen from New Jersey [Mr. MENENDEZ] is recognized for 5 minutes.

Mr. MENENDEZ. Mr. Speaker, I join my colleagues from Florida and New Jersey in calling upon the Cuban-American community to continue showing restraint in the face of taunts by Fidel Castro to create another exodus like we had in 1980. Castro continues to inflict pain upon the Cuban community both in Cuba and in exile, by seeking to exploit the strong yearning for family reunification.

However, we all know that the only reason that Castro seeks to create another *Mariel* type exodus is to release the pressure valve building within Cuba. Castro cannot sustain the public demonstrations that have taken place in unprecedented numbers, and the constant civil disobedience that human rights activists, and average Cubans exhibit by taking to the seas in search of freedom. He seeks to divert attention from his own abuse of human rights and acts of murder, such as the deliberate killing by the Cuban Government of 40 innocent men, women, and children on the high seas.

I believe that at long last we are witnessing the beginning of the end for the Castro dictatorship. Last Friday's demonstrations represent a watershed event in totalitarian Cuba, as similar demonstrations did throughout Eastern Europe. The Cuban people are saying loud and clear that they no longer fear Fidel.

Mr. Speaker, the Castro regime has begun to unravel.

In my view the disturbances will continue. Castro's headaches will not go away. His grip on power will continue to loosen as Cuba's failed economy continues to go down the drain; and, as the Cuban people make clear to Castro: "Mr. Dictator, we have absolutely no fear of you."

However, I call upon the Clinton administration not to play into Castro's hand by treating this latest threat as simply an immigration problem. If we do so, we will once again have let him set the agenda and divert the attention from the real problem; namely, the lack of economic and political reform.

The real solution to the problem is not the exodus of 100,000 or 200,000 people, but the departure of one tyrant.

The present situation is not only a challenge but an opportunity. Now is the time to use our technology to make sure that both Radio and Television Marti fully penetrate Cuba so that we can communicate with the Cuban people. We have the ability to make sure TV Marti's signal reaches a greater part of the population by transmissions from ship to shore, air to shore, satellite transmissions, or by raising the level of TV Marti's present signal technology. The powerful images that the average Cuban would see, the risks of dying at sea, the funerals that have taken place, how we debate these issues in Congress, as well as the images of fellow Cubans demonstrating against the dictatorship would stem the tide of immigration, show how democracy works, and foster hope for democratic change in Cuba.

The administration must have the will that others have lacked to give the people of Cuba, who live in a closed society, an open window on the world. Fidel Castro has challenged our national security at a time that we find ourselves busy in both humanitarian missions in Rwanda and the restoration of democracy in Haiti. It is in the national interests to respond by providing free and unfettered information to the Cuban people.

This is also the time to respond to my singular call to prepare for a post-Castro Cuba. Immediate support for my Free and Independent Cuba Assistance Act would send a message to the Cuban people and the international community that we are in solidarity with the Cuban people, that we want to assist them, but that we oppose the dictator that enslaves them and keeps them hungry. Finally, we must break Castro's stranglehold in making this a problem between Castro and Washington, or Castro and the exile community in Miami. Since there are no democratic elections in Cuba, the Cuban people are voting with their feet, by risking their lives and fleeing Cuba. They have also voiced their discontent by massive demonstrations, funeral observances in defiance of government admonitions, and other acts of civil disobedience.

It is time for the Clinton administration to seek a resolution in the United Nations condemning the Castro government for the murder of the 40 innocent men, women, and children aboard the vessel, *13 de Marzo*.

It is time for the administration to get other member countries, especially within the Western Hemisphere, to call for U.N. human rights observers to be sent to Cuba. They could observe the admitted actions of the rapid response brigades' brutality against average Cubans, whom Fidel Castro calls private citizens not government thugs. Civil society in Cuba is disintegrating and human rights abuses are at an all-time high.

It is time to internationalize the concern for the rights of Cuban citizens and break the myth that this is strictly a Castro versus Washington problem. This is a problem of hemispheric proportions which those countries who call themselves democracies cannot ignore as they seek greater hemispheric integration.

It is time to be proactive, not reactive. It is time to stop dancing to Castro's tune, and time to change the music. History will do justice to the Castro dictatorship. Once Castro wrote, "History will absolve me." Instead, history will condemn him. Let us not absolve Castro by blaming the United States: The blame rests squarely with Fidel Castro.

□ 1910

CONGRESSIONAL ACCOUNTABILITY ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Wisconsin [Mr. BARRETT] is recognized for 5 minutes.

Mr. BARRETT of Wisconsin. Mr. Speaker, there are many days when the American people are frustrated if they watch what the House of Representatives does during the course of their day. But today is one of the days when the American people would be very proud of what the House of Representatives did, because the House of Representatives today, by an overwhelming vote, showed the American people that we are willing and able to abide by the same laws that we impose on other Americans.

There are three provisions of today's Congressional Accountability Act that I think are of particular importance and interest to the American people, and I am proud to have been a supporter of all three.

The first is the provision put forth by the gentlewoman from Arizona [Ms. ENGLISH] dealing with the frequent flier issue. I am a strong supporter of the measure which would restrict the use of frequent flier miles.

The policy of the House regarding the use of official travel miles has come under fire from those who argue that Members of Congress are taking advantage of their official positions. Under current law, Members of the House who receive frequent flier miles from taxpayer-funded travel may redeem these benefits for personal use. Every other Federal agency, including the U.S. Senate, restricts this practice. It is time for the House to do the same.

Since the American taxpayers pay the cost of the travel, they should reap the benefits. If Members of Congress receive frequent flier miles from flights paid for by the taxpayer, then those miles should be used for official use only. Until personal use is prohibited, Members will be open to the charge that they are looking for a free ride from the American public. I was proud when the House today on a voice vote accepted the amendment to limit that.

The second amendment that the American people I am sure would be proud of is the amendment that ensures that whatever health care reforms we institute in this body will be the same as the benefits that other Americans receive. I actually think there are many Americans out there who are under the mistaken perception that Walter Reed is our personal physician. As the people here know, we pay probably a third of the cost of our health care insurance. But it is important for us to let the American people know that we are not better or we are no worse than they are.

If we pass health care reform, and I sincerely hope we pass health care reform within the next 12 days, it is my strong belief that whatever plan we pass should include Members of Congress as well.

The third issue that the American people would be proud of is the measures that were put forth by the gentleman from New Hampshire [Mr. SWETT] and the gentleman from Connecticut [Mr. SHAYS]. Those provisions ensure that many of the laws, if not all of the laws we pass as a body will apply to the Members of Congress as well as to the American public. Again the concern is the perception that somehow we feel we should be treated differently. Most, if not all Members of this House know how hard we work, and that we are not treated differently. But it is important that the American people also recognize that we do not place ourselves above them.

As a freshman member of Congress, it is a great honor to be a Member of this body. I believe that all Members know or should know what a tremendous honor it is to serve the American people in the House of Representatives.

Consequently, it is our duty to let the American people also know that we believe that we are still servants of the people and should be treated like every other American.

For those reasons, I am proud today Congress, by an overwhelming vote, passed the Congressional Accountability Act.

UNITED STATES HAITI POLICY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida [Mr. GOSS] is recognized for 5 minutes.

Mr. GOSS. Mr. Speaker, I spoke earlier in this Chamber this week about the situation in Haiti, and I made the proposition do the American people really want to spend a billion dollars—a million precious—a billion dollars from our United States taxpayers on such a frivolous event as an invasion of Haiti, which is a friendly, neighboring country. I think not.

I also wanted to examine some of the other damage of this very inept foreign policy that the Clinton administration is persisting in. We are not making any friends in the Western Hemisphere.

The one ally we had who sort of tentatively supported the idea of perhaps a multiforce invasion of Haiti was Argentina, and the President of Argentina, when he went back home and checked with the people in his country, changed his mind, suddenly decided that his word about joining us in a multilateral invasion of Haiti would not be possible because the people of his country had reversed his position. They did not want to invade Haiti either. That puts them very much in the majority opinion in this country and, frankly, in this Chamber. I am not sure that there is anybody who is calling for the invasion of Haiti in a serious way except the Clinton administration.

Our friends in Mexico, our new trading partners, are strenuously urging against it. Our friends from Uruguay, another trading partner and longtime Democratic ally in the Western Hemisphere also say no, do not invade. Brazil, "for heaven's sakes, what are you talking about?" All of these players, and Brazil is a major player in this hemisphere, I would point out, are saying look, why have we got such a clumsy policy? Why are we trying to force people to do something they do not want to do, that does not fit, which is not going to help the Haitians, and certainly not going to help the United States of America?

In fact, it is not helping the cause of peace and human rights either, because now the embassy of Colombia and Argentina have closed their doors and have moved across the border from Haiti into the Dominican Republic because of threats of mischief and trouble stemming from all of this violence going on, caused by the pressure cauldron of our sanctions and embargo.

Just as much trouble as President Clinton has had in selling his Haitian policy to our allies in the Western Hemisphere he is having selling it to Americans in his own country because the polls clearly shows Americans are not supporting this any more than the Members of Congress are supporting it.

What is a little confusing to me is if the President has gone to the United Nations, and they have spoken, and the other body has spoken, why has not the Democratic leadership in this body brought the subject of Haiti to this floor? It is a legitimate question. It is a foreign policy question. It is certainly a question of human rights violations and suffering. All that we hear about the social needs, all we hear about the problems of the world, we are causing suffering by our policy in Haiti by withholding the medicines, the food, the support, the logistics that the very poor need there in that country which has been trashed. I challenge the leadership, the Democratic leadership: Why do we not bring forward some debate on our policy in Haiti?

It is not just a question about the War Powers Act, it is not, it is about the misuse of our military for a misguided foreign policy. It is also a misguided foreign policy that has frankly encouraged the extremes in Haiti at the expense of the moderate concerns.

Lawrence Pezzullo, who was formally the top man on Haiti for the White House, who has been fired, has written I think a very good piece, and I will read rather than paraphrase it. This comes from the Washington Post of Thursday, May 5, 1994, quoting Mr. Pezzullo: In February and March we saw legitimate parliamentarians who previously had opposed Aristide's return join forces with pro-Aristide legislators to call for his return. We saw conservative businessmen joining more progressive younger businessmen and pro-Aristide labor unions in calling for the departure of the country's military head.

"Unfortunately, this movement fell victim to intensive lobbying campaigns by both the extreme right, who saw the threat to their power, and Aristide's expatriate entourage, which incorrectly labeled the idea of a coalition with the majority of parliament 'power sharing' with the military. Ultimately, the extremes succeeded in killing the center."

There was no room for the moderates.

"The United States helped bring this about. Despite initial support for the parliamentary proposal, the United States Government was once again unable to stay the course on Haiti. A week after Vice President AL GORE advised Aristide of our considered position of support for the proposal, the U.S. administration was in full retreat. Why? Quite simply, the administration could not withstand domestic pressures against the proposal emanating from congressional supporters of President Aristide."

In other words, our foreign policy, if Haiti being driven by domestic, political considerations rather than legitimate foreign policy interests of the United States of America, that is absolutely intolerable, and that is exactly why we have a House of Representatives to debate, discuss and guide this abuse of power by the White House.

□ 1920

TRUTH TIME ON CRIME

The SPEAKER pro tempore (Mr. CLYBURN). Under a previous order of the House, the gentleman from Washington [Mr. KREIDLER] is recognized for 5 minutes.

Mr. KREIDLER. Mr. Speaker, we have come to the moment of truth on the crime bill. It is time to stop striking poses, stop playing politics with people's fears, stop the phony rhetoric, and start facing up to the facts.

Fact: This bill will put more cops on the streets and more criminals behind bars, all over this country. We could add 2,000 officers to local police forces, and more than 500 more prison cells, in Washington State.

Fact: This bill will help the courts deal with criminals, by supporting drug courts like the ones already planned for Pierce County and King County, WA.

Fact: This bill does more to help victims of domestic violence and sexual assault than anything we have ever passed before. It will help groups like the Seattle-King County and Tacoma, YWCA's, DAWN, and Safeplace, which provide safe havens for women and children in my district.

Fact: This bill will help stop crime before it starts, with prevention programs that work—programs like Safe Streets, in Pierce County, where they have organized 120,000 people, block by block, and shut down over 800 drug locations. Where they organized an effort to help the people of Tillicum take back their community.

Fact: This bill will help children and young people survive the war zone of adolescence with programs like Youth Fair Chance, which provides a second chance for young people out of school; the Jam Session Teen Program at the Klahanee Lake Community Center in Federal Way; the Pierce County Alliance, which runs a number of programs to help at-risk youth; the Eastside Neighborhood Center and the Eastside Family Support Center in Shalishan, which serve the children and families of East Tacoma.

Fact: This bill will stop the spread of deadly semiautomatic assault weapons—killing machines that no responsible gun owner would use.

If you are going to vote against this bill because it isn't "tough" enough, explain that to the women who are beaten by their husbands, to the families who have lost loved ones to random gunfire, to the victim whose attacker goes free because the prisons are full.

Explain that to Mary Glenn of SeaTac, whose 15-year-old son, Shaun Proctor, was robbed and killed with a Chinese-made assault rifle when he went out for pizza.

Explain that to Jackie Spears of Federal Way, whose 16-year-old son, Zachary, was killed by a 15-year-old with a gun.

Explain that to the girl who has been sexually abused but has to wait weeks or months for help because rape crisis centers are overwhelmed.

Explain that to the widow of the police officer who was slain by teenagers in June. She supports prevention programs like the ones in this bill. She said, "There's got to be better programs out there for kids to build their self-esteem * * *. We've got to make sure on the Federal, State and local levels that funding—for programs—has got to be there for those kids."

Some people will look for any excuse to kill this bill because it does not include something they wanted, or has something they do not like—or just because they do not want the President and the Congress to get any credit for doing the right thing.

Just this morning, the Republican whip complained because this bill is paid for by reducing the number of Federal employees. That shows how far some people will go to make sure gridlock wins, instead of the American people.

Other Republicans say they will not vote for the bill because it does not require that communities be notified when sexual predators have completed their sentences—it only requires notice to the police. I voted for community notification, and I am disappointed too. But I came here to produce results, not to walk away if I don't get 100 percent my way.

This is not a perfect bill. But this is not the time for sour grapes. Let us get on with it, quit the partisan bickering, and pass this bill.

GOOD HEALTH CARE POLICY NEEDS BIPARTISANSHIP

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. HORN] is recognized for 5 minutes.

Mr. HORN. Mr. Speaker, next week this House is scheduled to consider the subject of health care reform. Already, the normal August session has been extended in order to recognize the reality that the legislative counsel—who must draft thousands of pages of legal language of all the different health care proposals—and the Congressional Budget Office—which must officially score the various proposals for their budget impact—simply could not finish their jobs before August 12. Unfortunately, I am not sure an extra week will make their job any easier. We have already heard that at least one individual from the legislative counsel's office fell off his chair, soundly asleep from exhaustion.

More important, not a single Member of Congress will have seen the text of the bills upon which we are supposed to vote until just days before we are to make our decision on health care. That is a recipe for disaster. Mussolini made the trains run on time, but wrecked his country. Simply put, under the current schedule, the House of Representatives will vote without knowing what it is voting on. On the subject of health care, the details are critically important. They cannot be glossed over and ignored. With health care, a detail could be $10 billion spent wisely or simply wasted. The House should not be forced to make a gigantic leap of faith—with America's health care system at stake.

We owe it to the American people to be deliberate and thorough in our consideration of health care reform.

That does not mean I support delay. Where there is consensus, let us act now. And on many issues, consensus is widespread. Provisions such as insurance reforms—the elimination of preexisting conditions, portability, and community rating in some form. There is a consensus around the need for subsidies for individuals with low incomes as well as for malpractice reform, antifraud, and waste and abuse provisions as well as administrative simplification and medical savings accounts. There is a consensus for the expansion of community health providers. These issues would pass the House today.

But where there is controversy and confusion, let us debate, deliberate, and consult with the people who sent us here. As it is—and as rumor has it—many of the most controversial changes do not take place for many years. Why should we be so rushed during the decisionmaking process when much of what we decide will have no useful effect for years?

I regret that, increasingly, it is no longer health care that is at the center of our discussions. A few have forgotten how the wheels of health care reform began moving. It was to help these fellow citizens who were not covered by some form of health care insurance or who faced a situation where their health care insurance would lapse in their time of need.

This debate has now degenerated to the point where egos and power grabs have replaced good intentions, where some seem to look for political victories instead of good policy. Have we forgotten that the American people sent us here not to bicker, but to have a meeting of the minds? Not to bicker, but to acknowledge legitimate differences? Not to bicker, but to recognize different perspectives and experiences? Not to bicker, but to hear informed testimony and gather, weigh, and decide among good ideas?

The American people expect us to put partisanship to the side. On a subject as all-encompassing as health care reform, the American people expect bipartisanship. Sadly, it is the desire for bipartisan action that is missing in terms of the White House and the majority party leadership.

One night in 1993, I mentioned the lack of bipartisanship to the President while chatting at a White House function. He said, smiling, "If I send a bill up and you vote for it, that makes it bipartisan." I replied, "No, Mr. President, that is not bipartisanship. What I mean by "Bipartisanship" is best reflected by a conversation held between a great internationalist, Republican Senator Arthur H. Vandenberg, and his friend Democratic President Harry S. Truman, when Vandenberg said "Mr. President, we want to be in on the takeoffs, not just the crash landings."

Passage of an unknown and unread bill by the barest of margins along strict partisan and ideological lines is unacceptable. It is a crash landing. Health Care Reform deserves and requires bipartisan cooperation. It deserved that from the beginning.

I urge the House Democratic leadership to give the subject of health care the time it deserves—a proper period of time to study and to listen and to debate. Prior to the vote, we should have spent time in our constituencies explaining the health care reform proposals we will consider. We should hear our constituents and then return to Washington to cast our votes on proposals that could affect our Nation more dramatically than any law in a generation, after that process, we might deal correctly with the very real problems that exist in our health care system.

It is through understanding that we will achieve acceptance, and that is a precondition for health care reform that will be applauded by the American people. It is not too late for this Chamber and the House leadership to allocate a proper period of time for consideration of health care reform. There is more than sufficient time left in this congressional session to pass a thoroughly understood and debated bill. Let us take the time to do it right.

Mr. Speaker, I attach a chart prepared by my colleague, PETER HOEKSTRA (R-Michigan). It shows the deliberative and consultative process which should occur in considering the important subject of health care.

HEALTH CARE DEBATE—SUGGESTED TIMELINE

August 8: Introduction of bills.

August 9–11: Scheduled walk-through of each bill; Congressional Budget Office scoring due; Rules Committee meets to craft rule for debate.

August 12: Debate rule (open with requirement that amendments be printed in the CONGRESSIONAL RECORD at least 24 hours in advance of debate).

August 13: Rule and details finalized before scheduled recess.

August 13–September 6: Public input and evaluation of proposed legislation; determination of amendments.

September 8: Amendments due to be printed in CONGRESSIONAL RECORD.

September 9: Debate begins (total debate 5–10 days); House votes.

September 19–26: Conference Committee meets.

October 5: Final vote in House and Senate.

October 7: Scheduled adjournment.

□ 1930

WE MUST PASS THE CRIME BILL

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Nebraska [Mr. HOAGLAND] is recognized for 5 minutes.

Mr. HOAGLAND. Mr. Speaker and colleagues, it is a pleasure to be here this evening and have this opportunity to address the problem of crime in America and the status of the crime bill here in the House. As my colleagues know, I wish I were able to stand here and say we are going to pass a crime bill that is going to make America safer, and I wish I were able to stand here and say we responded to the voice of America, to all that are concerned.

Let me say I urge all my colleagues on both sides of the aisle to vote for the rule, and it is scheduled to come up, perhaps, as early as tomorrow, so we can get this legislation passed and so hopefully in future years we will not have to read headlines like this from the Omaha World-Herald just recently.

This figure is truly striking, an 18-percent increase in the first 6 months of this year over the first 6 months of the year before. The article goes on to describe numbers from the Omaha police department that show that in nearly every area crime has gone up; more robberies over last year, more auto thefts over last year, more homicides over last year, more lives touched by crime and more lives shattered by crime. Mr. Speaker, more than 20,000 people in America were murdered last year.

Now if this were something done by a foreign army or in the context of international relations, we would view it as one of the highest possible threats to America, and we would view it as something to which we should respond in emergency fashion. We would declare a national emergency to try to do everything we could to bring an end to the violence, and I think clearly what we have to do is take immediate action to get this crime bill passed with the assault weapons ban.

Now each of us can take out parts of the bill they are uncomfortable with. Lord knows there are many aspects of the bill that I am uncomfortable with. I think it probably authorizes too much money in many areas, money that in a sense is a false promise because it will never be appropriated. But when it comes right down to it, Mr. Speaker, we need to pass the bill because passing the bill is going to save lives.

And when we pass the bill, shortly thereafter we will begin to put 100,000 more police officers on the street. We will have three strikes and you're out as part of Federal law that will help put away for long, long periods of time the most dangerous offenders in America.

Remember fewer than 15 percent of all criminals commit over 70 percent of the violent crimes in America. Let us identify those 15 percent and put them away for a long, long time.

This bill also deals with domestic violence by ensuring that offenders are prosecuted and the victims get help, and of course the bill bans 19 kinds of semiautomatic assault weapons. I am hearing from police officers throughout Omaha that we need to get assault weapons off the street. The fifth most commonly seized firearm in Omaha today is an assault weapon. Some police officers told me that the bullets of many assault weapons penetrate their bullet-proof vests. Really what is the use? What is the public purpose served by allowing these things to be legal?

Mr. Speaker, I say, "Let's take advantage of this legislation. Ban those 19 assault weapons and their progeny and get on with saving lives."

When I think about the importance of passing this bill, I think about some of the people talked to in Omaha by the Omaha World-Herald in a recent story that was done on crime:

People like Cornell Williams who is confined to a wheelchair because of a wound he received in a drive-by shooting 4 years ago. Cornell was training for a job as an electrician when a bullet paralyzed him from the waist down.

I think about people like Mary Beth Harrold who is so afraid that she won't drive to the mall to go shopping by herself anymore. Reports of assaults and robberies are always in the back of her mind.

I think about a young man in Omaha who at 15 has to watch his back when he is walking in his neighborhood because a gang member might not like the kinds of clothes that he is wearing or the people he is associating with.

So, these people know that tough action is necessary. We know that tough action is necessary, and the value is evident in a recent drug seizure in Omaha where 14 law enforcement agencies from four States worked through the task force, the metropolitan drug task force, to seize 70 guns, having served 19 search warrants, and having confiscated thousands of dollars in cash and 60 pounds of manufactured cocaine or methamphetamines.

Now the metropolitan drug task force gets a great deal of its funding through the Byrne grant program which is included in this crime bill. Over the last few years in eastern Nebraska this task force has made more than 2,000 arrests, seized 600 guns, and put drug dealers and gang members behind bars.

My colleagues, we need this legislation. Let us pass it quickly.

PROMOTING NEW ENVIRONMENTAL TECHNOLOGIES

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington [Mr. SWIFT] is recognized for 5 minutes.

Mr. SWIFT. Mr. Speaker, I am introducing today, the Landfill Technical Improvement Act of 1994. This legislation will allow us to utilize technical advances of the last decade in implementing our Nation's environmental protection strategy.

In 1984, Congress passed the Hazardous and Solid Waste Amendments. This Act required the Environmental Protection Agency [EPA] to issue regulations restricting the disposal of, among other things, organic absorbents in hazardous waste landfills.

In the past 10 years, Mr. Speaker, natural absorbent technologies have been developed which may be more efficient for some uses than traditional sorbents produced from fossil fuels. Normal landfill conditions are anaerobic, and studies have shown that no biodegradation takes place in the anaerobic environment of landfills. In the anaerobic landfill environment of RCRA landfills, these sorbents will not degrade. These organic absorbents, made totally from recycled/reclaimed materials, may actually outperform current chemical absorbents. However, because of the 1984 amendments and EPA regulations resulting therefrom, these absorbents have been effectively shut out from the landfill disposition.

This disposition issue threatens to undermine the existence of these new technologies, since that which cannot be disposed economically will not be used. Moreover, innovative and environmentally conscious technologies, such as those developed by a company in Bellingham, WA, which manufactures organic absorbents from a local paper mill's sludge, are discriminated against. The administration has clearly stated its preference for such recycled/reclaimed materials, but this outmoded regulation has prejudiced the widespread availability and use of these products. This is to the detriment of our national environmental goals.

My bill would rectify this situation by permitting environmentally sound current and future landfill technologies to be utilized to their fullest extent.

REFORMING THE WAY EPA ASSESSES RISKS AND INFORMS THE AMERICAN PUBLIC

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Nebraska [Mr. BEREUTER] is recognized for 5 minutes.

Mr. BEREUTER. Mr. Speaker, this Member rises this evening to speak about the urgent need for a practice of more effective and truthful risk assessment by the U.S. Environmental Protection Agency. Some public attention has been focused on the problems of risk assessment in government during Supreme Court nominee Judge Stephen Breyer's successful confirmation hearings since he has written extensively on the manner in which our government wastes money and misleads the public in the areas of risk assessment and management. The regulatory public policy issue epitomizes the problems of mindless, inflexible regulations that are too commonly a part of Federal mandates which hamper farmers, businesses and local governments in Nebraska and across the United States.

Mr. Speaker, the distinguished gentleman from California [Mr. BROWN] has helped craft a workable, bipartisan product during committee consideration of H.R. 4306, the Risk Assessment Improvement Act, including perfecting amendments by the distinguished gentlemen from Pennsylvania [Mr. WALKER] and New Jersey [Mr. ZIMMER]. The Science, Space, and Technology Committee's passage of this legislation on July 20, 1994, was a step in the right direction. There are three main goals of this legislation. First, H.R. 4306 would make risk assessment guidelines legally binding on the EPA. Second, risk assessment will be conducted by the EPA under the guidelines of H.R. 4306 by formulating the most plausible and unbiased assumptions to a health hazard. Third, H.R. 4306 ensures that risk assessment will be communicated to the public in terms which can be readily understood—not scientific jargon. All of these are laudable goals which need to be implemented in order to better assure that common sense and rational thinking will win out in environmental policymaking.

This Member urges swift passage of H.R. 4306, because approval of this legislation will provide relief to Nebraska businesses, local communities, as well as this Member's State government which are all spending millions of dollars annually to comply with Federal mandates, many of which are unnecessarily burdensome. The same is surely true in all parts of America.

Mr. Speaker, other recent congressional action that would take steps toward alleviating our current risk assessment problems include the amendments by the full House to the Environmental Technologies Act, H.R. 3870, offered by the gentleman from Pennsylvania [Mr. WALKER] to reflect goals contained in H.R. 4306. In addition, this Member has agreed to cosponsor H.R. 2910, the Risk Communication Act, a bill with similar goals as H.R. 4306, which would further reform the way the EPA assess risks and informs the American public.

The fact is that the EPA often presents situations thought to be hazardous to the environment or to human health in exaggerated terms that do not reflect the real situation or in biased scientific terms that deceive the public. If the damage and cost was not so great, it would almost be humorous to look at some of these health threats that have been blown out of proportion by both the EPA and by an American media with an appetite for sensationalism.

In the area of pesticides, for example there are those who have tried to convince the EPA and the American public that all pesticides must be removed from the production of our food supply. In an opinion piece that appeared in the January, 1992, issue of Progressive Farmer Magazine, Dr. C. Everett Koop, former Surgeon General of the United States, documented the overblown risk assessments of the health hazards involving pesticides in this country. To quote Dr. Koop:

> Americans are concerned because they are confused. They are confused because no one sorts out for them various components of what has become the food safety issue. The public does not have a very good grasp of the relationship between the dose of a toxic substance and its risk in human beings. Their information comes from those who revel in using scare tactics instead of science to warn the public about dangers in the food supply. These scare tactics lead us down the wrong path. We end up creating concern where it isn't necessary and ignoring concerns that are real.

Pesticides are in fact a benefit to modern farming, if used responsibly and in a scientifically sound manner. According to Dr. Bruce Ames, Director of the National Institute of Environmental Health Sciences Center at the University of California-Berkeley, in a July 5, 1994, article in The New York Times, "99.9% of the toxic chemicals we're exposed to are completely natural." Dr. Ames goes on to say that, "We're shooting ourselves in the foot with environmental regulations that cost over 2% of the G.N.P., much of it to regulate trivia." Lest one regard this as a statement of a biased source, it should be noted that Dr. Ames does no consulting for businesses and is indeed a highly respected scientist. He defends the proper use of pesticide by American agriculture. Dr. Ames states, "If our resources are diverted from important things to unimportant things, this does not serve the public." This Member wholeheartedly agrees.

In a November 10, 1993 article in the Journal of the American Medical Association entitled, "Review of Actual Causes of Death in the United States," by Dr. Michael McGinnis of the U.S. Department of Health and Human Services and Dr. William Foege of the Carter Presidential Center, documentation shows that deaths directly related to dietary and physical activity problems number over 300,000 a year. Since, according to Dr. Ames of Berkeley, only 9 percent of Americans eat the recommended serving of five servings of vegetables, and fruit daily, those dietary problems come from not eating enough of the very fruits, vegetables, and foods that help prevent cancer. Drs. McGinnis, Foege—pronounced FOAG—and Ames all conclude that pesticides help make these foods more bountiful and less expensive, which allows the public greater access to cancer-fighting fruits and vegetables. According to the Journal of the American

Medical Association, the 300,000 American deaths due to dietary and physical activity problems is more than the 260,000 annual, collective American deaths which are due to infectious disease, toxic pollutants, firearms, sexual behavior, motor vehicles, and illicit use of drugs. Maybe we need public service ads which show an inactive couch potato eating fatty foods with a voice in the background saying, "Just Say No."

In all seriousness, Mr. Speaker, Americans need sensible information in order to make educated judgements as we balance out life's risks and benefits. Many times, the media hypes the most unusual and freakish occurrences in hopes of attracting high Nielsen ratings. We hardly ever see reports on the dangerous things we participate in each and every day. According to an article written by Robert J. Samuelson in the May 4, 1994 Washington Post, entitled, "The Triumph of the Psycho-Fact," 1 in every 167,000 Americans can expect to die in an airplane crash, 1 in every 9,100 child-bearing American women die in child birth, 1 in every 3,700 Americans die every year from car crashes, and 1 in every 300,000 Americans die every year on bicycles. Walking across the street is far more dangerous than eating foods protected by pesticides, yet the American media, and to some extent the EPA, only concentrates on the sensational or the unusual.

In addition to these concerns, this Member believes that we must also consider Federal, State and local governments' financial problems when discussing this issue. This country should not mindlessly spend millions, perhaps even billions, of dollars on what is increasingly an area of diminishing returns. As Federal fiscal resources are increasingly scarce, we must focus our money and efforts in areas of high risk and hazard to both the American public and the environment. Common sense would tell us that mandating local governments to spend millions of dollars on unwarranted Federal mandates is not a wise idea. We must also consider that these mandates, which can often cost people their jobs, slow down the economy and create unnecessary poverty. According to a May 3, 1994, Washington Times article entitled "Scaring Ourselves to Death", just by being poor, out of a job, and in the bottom 20 percent of our Nation's social structure, an American's life will be shortened by 7 to 10 years.

Mr. Speaker, examples like these illustrate why passage of H.R. 4306 is necessary. This Member urges his colleagues to support H.R. 4306, as well as any amendments offered during consideration of this important legislation which would make risk assessment more realistic, less expensive, and more responsive to the public.

Special appreciation is also noted to a member of my staff this summer, Mr. Andrew Loudon, who has been of great assistance in research assistance to this Member on the subject of risk-assessment.

□ 1940

CONGRESSIONAL ACCOUNTABILITY ACT: A PROUD DAY IN THE HOUSE

The SPEAKER pro tempore (Mr. CLYBURN). The gentleman from Wisconsin [Mr. BARCA] is recognized for 5 minutes.

Mr. BARCA of Wisconsin. Mr. Speaker, today is a proud day in the U.S. House of Representatives because today we passed the bill that is long overdue. It is a bill that the American people have long wondered why Congress has been unable to adopt. It is the Congressional Accountability Act.

When I was running for Congress and even before I had a dream of serving in Congress, I and other Americans have wondered why in bill after bill that Congress had passed they exempted themselves from the key provisions of those bills, and in some cases they had entirely exempted Congress from those provisions of the bills that were passed.

Well, today I think we did right by the American people. We sent forward the message that we will ensure that Congress will be included and in compliance with the key laws of this country, and hopefully we have set a precedent that in the future we will keep that faith.

Today, in bills such as the Fair Labor Standards Act, the Civil Rights Act, the Americans With Disabilities Act, the Family and Medical Leave Act, and the Employee Polygraph Protection Act, to just name a few, Congress will now be included and in full compliance with these laws. We also included laws protecting people such as occupational safety laws to a myriad of different labor enforcement bills in this country.

Additionally, we brought forward a measure that I think is very important, because on the eve of debating health care reform, one of the things that I had talked about and I had introduced 10 months ago, last September, is House Concurrent Resolution 156, which states that Members should live by whatever health care reform laws we pass. Today we were able to accomplish that as well, to make sure that whatever bill we are able to pass, that Congress will participate in.

I believe that a special part of our responsibility when we serve in Congress is to keep faith with the American people, to set an example for the people who will serve in years to come, to make them aware that Congress must comply with the laws that we pass, that Congress will honor the obligations that we are putting forward for other Americans. It is an important day and a day that I am proud to be serving in the U.S. House of Representatives.

SOCIALIZED HEALTH CARE IN AMERICA

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Georgia [Mr. KINGSTON] is recognized for 5 minutes.

Mr. KINGSTON. Mr. Speaker, within the next 8 days, Americans have a very critical period in our history to face us. Now, in Washington we are certainly going to be in the center of that history. But it is going to be something that will, in the words of the Speaker of the Senate, affect every American. I think we all agree on that. That is why I believe it is very important for us as we begin the debate on health care on the floor to look at it very cautiously.

Today at 6:30 we were supposed to get a copy of the House bill, the Clinton-Gephardt bill. We will don't have it. The Clinton-Mitchell version has been introduced in the other body. Here we don't have it. The other bill in the Senate is 1,400 pages long. Our bill over here may be 800 pages, it may be 1,600 pages. We still don't have the bill. Tomorrow is Thursday. A week from tomorrow we are supposed to be voting on this bill.

I like to read. I stay up late often at night reading books. But I don't know if I am going to be able to read an 1,800 page health care bill.

I do have some concerns that I wanted to submit in terms of a government-sponsored insurance program, governments-sponsored medicine, which when we talk about universal health care, that is basically what we are going to have, because you cannot have universal health care without an oversight committee making sure that everybody in America has health care, and that oversight committee is the Federal Government. And, as I understand it, the bills that we are considering will have this National Health Care Board in them. So I think you could certainly make the argument that this is socialized medicine we are debating.

With that, I wanted to read a letter by one of my constituents, Mrs. Angela Hine of Savannah, GA. She wrote this letter to me and said.

> I appreciate your stand against socialized medicine and would like to share some of my experiences with government-controlled health care in England. In November 1984 I was to see socialized medicine at work firsthand.

She talks about some of the things that goes on. I am going to try to skip parts of the letter. She says,

> My aunt was having a bad heart attack in November of that year. I went to see her.
>
> Upon arriving in England, I immediately went to the hospital. On the way I was told my aunt had been in the men's ward as no beds were available when she was admitted, but now she had been moved to the women's ward. I stood in the doorway of that ward and couldn't believe my eyes. There were several beds in the ward. Curtains separated each bed. The toilets were at the end of the ward. A doctor had been assigned to her and

had been taking care of her for many years. Upon her return home she had a visit from her regular doctor, who commented to me that if I brought her back to the United States, she could probably live another ten years, but she would never make it under the current system.

□ 1950

Then she talked about in a previous visit she went to see her aunt and she had an inflamed eye. Her lower eyelid turned inward and the lashes irritated her eyeball. She had been given an eye clean by her doctor, but it was obvious that she needed to see a specialist.

After several phone calls and pleadings for her condition, I was finally able to get her to a specialist where surgery was performed to correct the problem.

She talked about a cousin of hers that had a husband who was treated in England under the socialized medicine over there for a hernia, finally, when that did not work, the doctor set up an appointment with a specialist and by the time they determined that his problem was not a hernia but cancer, it was too late. The cancer had already spread and he died shortly thereafter.

She goes on to talk about in 1985 returning to England and visiting her aunt again and how the horrible conditions of the hospital were just very sad and distressing and not just for the aunt but for the patient.

I want to say that let us just say that even if the quality is the same under socialized medicine, the relationship is not. We are talking about human beings here. So I think it is very important to remember that.

This is something, though, that I think one of the lines she was talking about giving her aunt morphine for the pain and one of the British doctors said to her in the hall, he said,

> We could have helped her live another two or three years, but as she is 88 years old and lived a good life; what is the point?

That was directly from a doctor's mouth.

I do not want government doctors telling me that my loved ones, my parents, my grandparents, just because they are 88 years old, they are going to get less than the best service. I do not want that decision, those critical family decisions to be made by health care bureaucrats running our family.

Yet that is the experience that Mrs. Hines had with her family. I will just summarize her letter.

> Socialzied medicine is not a success as the media and certain politicians are saying. In fact, it is a disaster and should be voted down at all cost. The American people need to urgently study the plan that is now being considered for America. If this form of medicine is brought to the law, the people are in for a rude awakening.

I think that this letter, which is the authentic issue, I would like to also say, I have got many, many letters like this, has a lesson for us. So as we debate health care, we need to know exactly what it is we are voting on.

Are we voting for socialized medicine? I think if we were voting on a Mitchell type plan or a Clinton type plan, certainly we would be voting on socialized medicine. But as of right now, we do not have a bill. We are going to have 8 days to read it.

I hope, Madam Speaker, that we get the bill tomorrow and that we all spend the weekend reading up on it so that the American people know that their representatives have voted intelligently and with full knowledge of what is in the fine print.

THE CRIME BILL

The SPEAKER pro tempore (Ms. McKINNEY). Under a previous order of the House, the gentleman from California [Mr. CUNNINGHAM] is recognized for 5 minutes.

Mr. CUNNINGHAM. Madam Speaker, the gentleman from Nebraska [Mr. HOAGLAND] a minute ago talked about an 18-percent crime rate in Omaha. That very same paper that that article was taken from, the Omaha World Herald strongly, and I say strongly, recommended that area Members of Congress vote against the crime bill. They editorialized against the crime bill. The gentleman should have put that up to read.

Several speakers have attempted to minimize the negative effects that the present crime bill has by stating there might be some Members that might find some little thing in the crime bill that would cause us to vote against the bill.

Madam Speaker, let me explain some of those items in which we may vote against the crime bill: $9 billion in social spending. Many of us would like that $9 billion to be spend to fight crime; $9 billion is not just a little thing.

I would like to read, Madam Speaker, a letter that was sent to the President of the United States from the Republican leadership. That Republican leadership was made up of BOB MICHEL, a respected Member on both sides of the aisle, Mr. DICK ARMEY, NEWT GINGRICH, HENRY HYDE, and BILL MCCOLLUM, the conference vice chairman for the crime bill.

I quote:

> Contrary to the assertions in your Administration, the crime conference report is not stalled because of assault weapons provisions, but instead due to the more than $9 billion in new social welfare spending. We are writing to offer our assistance in moving a real crime bill that will get more police on the streets and move violent criminals in prison now. The law enforcement provisions of the crime bill could be beefed up, and the social welfare spending dramatically trimmed.

Madam Speaker, I would like to submit most of this for the RECORD, but I would like to read just a couple more. But how do you do this?

"Remove the more than $9 billion in social welfare spending and replace it with the Senate's full funding for the Byrne grant program," full funding. What does this do? It makes sure that that money that we spend toward a crime bill will be used in the bill truly directed at crime prevention.

> Because we realize there are some in your party who feel strongly about the new social spending provisions, Republicans would be willing to support a rule allowing for the consideration of a social welfare spending package as a separate bill after we have passed the consensus crime bill outlined above. That means Congress would have an opportunity to pass both a tough anti-crime bill that puts more police on the street and more violent criminals in prison, and consider a package of new social welfare spending. This approach would avoid the gridlock that has developed within your party as a result of the current strategy of tying these issues together in one bill assuming that Members would hold their nose and vote for anything that has police and prison funding.

Now, the simple little thing of $9 billion, the White House, Janet Reno have been calling Members on this side of the aisle and offering them, what can we give you in your district to get you to vote for the rule. What can we give you, what kind of payoff can we give you to vote with us?

The President has done the same deal with another caucus. There is a caucus in this House that strongly, by principle, supported an amendment called the racial justice amendment. That was stripped from the crime bill. That, I am sure, upset the caucus. They truly believed in what the principle stated. But it was stripped, and it upset that caucus. So what can we give you? We can give you $9 billion in the inner cities of pork-barrel spending.

The gentlewoman from California wanted to put a $100 stipend a month on teenagers. This was pointed at the gangs, $100 a month stipend for good grooming. Now, it is termed a different way in this bill, but it is there. Dancing lessons in prisons?

Madam Speaker, are we going to have murderers and rapists lead on Monday, Tuesday; sex abusers on Tuesday, Thursday? I do not think so.

The night basketball game, I changed my position on night basketball. I went down into the cities and said, hey, this is working, but we would like it to go back to conference and not include where the community has to be 2-percent HIV or drug abuse users. Maybe Magic Johnson could play in that league, but I do not want my kids playing in it.

Another thing where we could replace and put more strength in a crime bill would be to take out the 40,000 social workers, more social workers actually than the amount of police that will in actuality be funded. The FBI came out with a news article today that this crime bill will cut in effect their ability to deal with not only white collar crime but the drug abuse as well.

□ 2000

The gentlewoman from Washington [Ms. DUNN], myself, and the gentleman from New Jersey [Mr. ZIMMERMAN], offered an amendment that was passed by this House, and on the Senate, for sexual predators.

In New Jersey, a little girl was buried last Thursday. The sexual predator had been convicted twice before for preying on children. He moved in with two other sexual predators, males, across the street. The little girl was enticed into the home by a puppy and was strangled and murdered.

The amendment said that when these dirty, miserable rats get out of prison, that the community will know about it. If those guys would have been in my community, Madam Speaker, and your community, I do not think you would have let your children go over there or even see them.

It also cleared the liability of police officers in notifying those communities. However, that is being held hostage on the other side of the aisle. That is an amendment that should be in. It was passed by the Senate, and only 13 Members of this House voted against it.

Madam Speaker, these are no little things. We are asking the leadership of this house to get together with the Republican leadership and ask for a separate vote on the socialized $9 billion in spending, and let us put some real teeth into our crime bill.

HEALTH CARE REFORM FOR AMERICA

The SPEAKER pro tempore (Ms. MCKINNEY.) Under the Speaker's announced policy of February 11, 1994, and June 10, 1994, the gentleman from South Carolina [Mr. CLYBURN] is recognized for 60 minutes as the designee of the majority leader.

Mr. CLYBURN. Madam Speaker, I would like to thank you on behalf of our fellow freshmen colleagues for allowing us to participate in special orders tonight. Joining us tonight are our colleagues from Georgia—Congressman BISHOP and Congresswoman MCKINNEY, from California—Congresswoman ESHOO, our colleague—Congresswoman CLAYTON from North Carolina, and from Mississippi, our distinguished colleague, Congressman THOMPSON.

Since we were elected almost 2 years ago, we have learned many things. We have voted on many significant pieces of legislation. And we have listened to many debates. However, few of these are as important as the debate raging today over health care reform legislation and what is right for our country. Just yesterday, I was in my district in South Carolina for the primary elections. As most of my colleagues probably do, I got up early and visited voting precincts throughout the district.

As I did, I noticed the large number of people who had come to cast their votes, some before going to work. There were people in uniforms belonging to the local utility company, there were nurses on their way to hospitals, there were business men and women heading to their offices and to their plants.

These people are no different from the millions of others in our country who work hard to make a living for themselves and their families. These people are no different from others in that they deserve affordable health care insurance that can never be taken away.

While greeting these voters as they slowly moved through the lines, I was reminded of some recent figures on uninsured Americans. In my district alone, there are 94,000 people from working families who have no health insurance and 4,000 people living in the Columbia area alone who lose their health insurance each month.

Twenty-six thousand of these uninsured in my district are children. The uninsured are the people who have unexpected medical emergencies and need preventive care, they are children who have ear infections and need childhood immunizations that should be covered under their families' health insurance plans.

Last night, during his evening health care message, President Clinton mentioned the studies recently done for the Catholic Health Association. I would like to commend the association for compiling this nonpartisan, up-to-the-minute information about the state of health care insurance in our country, and my colleagues and I would like to share some of this information with you tonight.

Currently, there are 37 million uninsured people in the United States. If we pass health care legislation without universal coverage, there is no way to guarantee that these middle-class, working Americans and their families will have health coverage they can never lose.

Take a look at this pie chart. It is a very simple chart and the message is very clear. The gold portion represents the 1.1 million currently uninsured Americans that will receive coverage under a plan with insurance market reforms. That's a very small piece of the pie.

If you look at the blue portion, you will see about 40 percent or 13.8 million of the uninsured Americans who will receive insurance when subsidies are added for low-income populations.

After taking these 2 pieces of the pie, there is still an enormous red slice containing 22.3 million Americans who will remain without health care coverage. This piece of the pie is too big to think we can get away with passing any kind of legislation with less than universal coverage.

Madam Speaker, I yield to my distinguished colleague, the gentlewoman from California [Ms. ESHOO].

Ms. ESHOO. Madam Speaker, I thank the gentleman from South Carolina, who, in addition to the great service that he renders on behalf of his constituents here in the House of Representatives, also serves as the president of the freshman class of the second year of the 103d Congress. Actually, this evening, Madam Speaker, we have our president from the first year of the 103d Congress, and you will be hearing from her shortly.

Madam Speaker, we have heard a lot in the last several days about the problems with reforming our health care system incrementally. That means step-by-step, piece-by-piece, the piecemeal, slow step approach. Yet many of our colleagues continue to insist that we should only tinker with the system, rather than pass meaningful reform.

Therefore, tonight, I want to spend my time talking about what the differences are if in fact we tinker with the system and take an incremental approach, versus what most Americans have heard about and talk about themselves, and that is universal coverage, wherein all Americans would be brought in under the tent and be covered, and what the financial consequences are under both scenarios.

Madam Speaker, let me pose a question to all of my colleagues. That is, do any of us want to go home to our constituents and tell them that they have to pay more for health care? I don't think so. I sure as heck don't want to go home and tell my constituents that.

I don't want to have to pay more. I don't want my constituents to have to do that. That is why I support comprehensive reform, which guarantees private health coverage for every U.S. citizen, and will reduce the average health care costs for the middle class.

Madam Speaker, what seems counter intuitive to most people is that by bringing everyone in, that it would supposedly cost more. However, I would like to pull from a recent study. These are not my numbers, these are the numbers that were produced, as I said, very recently by the Lewin-VHI, the largest nonpartisan health care research organization in our country.

Their study confirms that incremental reform is a short-term, short-sighted solution. Madam Speaker, while it may seem politically palatable for some, it would hurt the very people we are trying to help the most, and that is the middle class of our Nation.

As this chart illustrates, Madam Speaker, the study shows that incremental reform would force families making between $20,000 and $30,000 a year, and there are many families where that is the income, to pay more than $200 more a year, not just $200, but $200 more a year than what they are paying now in their annual health care costs. Families making between $30,000 and $40,000 a year would have to pay almost $345 more a year for their family premium.

Madam Speaker, you can see this very well on the chart. It is not a complicated chart. I think Johnny Carson could have used this, because it has a lot of clarity; not to make jokes with, but because it is very clear in terms of what it is stating.

□ 2010

Those making between $40,000 and $50,000 a year would pay almost $140 a year more for their premium, and those making between $50,000 and $75,000 a year would pay $75 a year more on health care costs. Maybe it does not mean that much to them because they are way up there in terms of their annual income, but suffice it to say that it is more than less.

In other words, if we pass an incremental health care reform plan, more than half of all the families in the United States will spend more on health care and it will hit the middle class the hardest. The middle class is usually the group that picks up the brunt of most things, anyway, and I do not think the 1990's is the time to do that. I think that we stand tall and stand next to the middle class and say enough is enough and let us bring everyone in under the tent.

In contrast, if, in fact, we bring everyone in, the universal coverage approach linked to cost controls, which is very important in our system and employer/employee contributions, I believe that everyone needs to pay something—no one should get off for free—this would lower spending on health care for every family making less than $100,000 a year. That takes in a lot of families in the United States of America.

As the chart shows, those families making between $20,000 and $30,000 a year would pay approximately $40 less, those making between $30,000 and $40,000 would pay $165 a year less, those making between $40,000 and $50,000 a year would pay almost $150 less per year, and families earning between $50,000 and $75,000 per year would pay $115 less. These are for the premiums.

For those who are watching this at home, I know that you have heard for more than 2 years so much about the health care debate. It is a huge one, it is complex, but if we are wondering why there is so much debate about the controversy if comprehensive reform achieves these results, I will tell you why: Over $50 million has been spent to date by the special interests in this country advertising, advertising, advertising, and not only planting the seeds of suspicion in the American citizen's mind but to make you fearful. This is the largest sum of money that has ever been spent to lobby a single issue before the Congress of the United States in the history of the Congress. This is not called the health care industry for nothing. So what we need to look at and why I brought onto the floor this evening indisputable numbers by the most respected, nonpartisan health organization, and these numbers I present to you.

I believe that we need to have guaranteed private health insurance coverage that cannot be taken away. There are those that will tell you that Congress should proceed cautiously and not attempt to cover everyone. But who is that "not everyone"? Is that you? Is it your family? Is it your child?

In my district, there are 88,000 working individuals from families, 88,000 workers, not welfare individuals, but workers. Of that 88,000, 13,000 are children. None of them are covered. They either cannot afford it, it is not made accessible to them through their employment, or they have a preexisting condition or someone does in their family and they simply are not eligible. I do not really think that is the American way. That simply is not fair and I know that we can do better.

While this again seems counter intuitive to bring everyone in and the costs go down, let me explain this for a moment.

Higher costs drive younger, healthier people out of an insurance pool. We have seen that happen. It has been demonstrated in many States. If, in fact, we bring in those that are more vulnerable and keep the younger, healthier people in the mix, it lessens the risk pool of those that are being insured and, therefore, the premium comes down.

In contrast, if all of us cannot be covered, obviously the premiums will go up. I believe, along with so many others, and poll after poll shows that the American people want everyone covered. I think it is time for Congress to act. I think the moment of truth has arrived. We have debated, we have had our public hearings, we have certainly heard much from our constituents. I urge my colleagues to deliver what the American people really want. They do not want a $50,000 ad campaign. Instead, they want us to stand next to them, to the middle class, to the workers of this country and their families and once and for all say to them that no insurance company can take your insurance away from you, that we will all be covered by private insurance plans, a solid, good plan for the solid, good citizens of this country.

Mr. Speaker, I would like to thank the president of our freshman class, the gentleman from South Carolina [Mr. CLYBURN], who serves with great distinction for bringing us together once again on this I think one of the greatest domestic issues facing our Nation and as freshmen I think we are going to help make history, not just shape the bill, but make history by passing legislation that is truly meaningful, worthwhile and noble for the American people.

Mr. CLYBURN. Madam Speaker, I thank the gentlewoman from California [Ms. ESHOO] for giving us such a concise and clear picture of what is going to happen with the people of the middle class if we fail to do universal coverage with our health care reform.

Madam Speaker, I yield 8 minutes to the gentleman from Georgia [Mr. BISHOP].

Mr. BISHOP. Madam Speaker, I thank my colleague, the gentleman from South Carolina [Mr. CLYBURN] for organizing this special order on health reform and the need for universal coverage.

I would like to thank my colleague, the gentlewoman from California [Ms. ESHOO] for helping to explain how health care reform will fail without universal coverage. Not only will premiums be driven up so that they are unaffordable for even middle class Americans, but reform without universal coverage will fail because it will destabilize our insurance markets and it will make insurance unaffordable for many of America's businesses and families.

This is what I would like to discuss tonight. If Congress passes a health care reform bill that attempts to provide universal coverage incrementally rather than immediately, we will not be providing a prolific health care reform measure that will grow to cover all Americans. Rather, we will be providing a sparse reform measure that will increase premiums and decrease the collective number of insured individuals.

In a recent study prepared for the Catholic Health Association, Lewin VHI, which undertook the study, said that universal coverage reduces consumer exit and entry into health insurance markets because if people can move freely in and out of the system, the healthy will tend to avoid insurance coverage until they get sick.

To the extent that this issue is not addressed in a real reform proposal, premiums are driven up, encouraging more people to become uninsured. The result is the vicious, upward spiral that is shown on this illustration.

Step one. Under reform plans that attain universal coverage incrementally, by certain dates and with so-called triggers, insurance reforms will extend coverage to sick and high users of health care. This will allow many people currently without coverage to become covered. I applaud that result. That is great. However, there is an inescapable reality that will occur when we include the sick and the high users of medical care without providing 100 percent universal coverage.

□ 2020

Under this plan, utilizing community rating, the newly insured sick will drive up average premiums for the currently insured. This is the beginning of the vicious upward spiral. These higher premiums will naturally cause healthy individuals and firms currently with plans to drop their coverage.

Why? Because under a plan that requires coverage for those in need, there is no reason to pay for it when you are healthy. Under an incremental plan, it is fiscally illogical for a healthy individual to continue to pay escalating health insurance premiums and stay on a plan. The reform system will allow them to reenter the insurance pool when they need health care, when they are sick, when paying for health care makes no sense to them. For healthy people to continue paying for insurance when it is in fact guaranteed later when they might need it would be merely earning more and more of their own money by buying an insurance plan with rising costs.

What happens next? When these healthy people and companies begin to leave their plans, the insurance resource pools will shrink and the average cost per customer will increase. This will cause premiums to rise yet again, the upward spiral caused by incremental reform. Fewer and fewer healthy people will remain on plans, premiums will continue to skyrocket, and insurance pools will shrink while the average cost per customer rises.

Do not think for a moment that this will die down, because it will not. The spiral will be perennial and will be as damaging to the insurance markets as a tornado is to a home in its path. The goal of universal coverage will be nothing but a pipe dream because healthy people will never spend money on expensive premiums to join a plan. Only when they become ill or in need of medical assistance will they join.

This is the ironic impact of expanded insurance availability without universal coverage.

Universal coverage, Mr. Speaker, is the only way to avert this problem by including healthier, lower cost individuals in the insurance pool, thereby holding down average premiums.

In a June 15 study that explains this phenomenon, the Wall Street Journal called the notion of a reform plan that prohibits insurance companies from increasing rates for the sick who are at risk of accumulating stacks of medical bills, "the health care proposal everyone loves. There's just one problem with the idea," the Journal continues, "Experts insist and real life evidence shows it probably won't work without universal coverage."

This is not just theory, but it is reality. Let us look at facts.

Signs of this impact are already evident in the State of New York. According to the State's insurance department's own data, 25,477 fewer people, fewer people had insurance in the individual and small group market at the beginning of this year than when community rating and other nonuniversal coverage reforms took place 9 months earlier.

Why? According to the Journal, New York tried community rating without a law requiring everyone to have health insurance. The result has been a rise in insurance premiums for healthier individuals. Consequently, those healthy people left their health care plans figuring they either will not need to have coverage or they will be able to get it at a reasonable rate when they do.

Mr. Speaker, our attempt to reform health care will be not only fruitless and senseless without immediate universal coverage, but harmful to insurance markets as well. We need universal coverage, and we need it immediately upon passage of any health reform measure.

In Georgia, in the Second Congressional District that I represent, our people need health insurance coverage desperately. We are determined to do whatever is necessary to fairly and impartially and rightfully provide for decent Americans' health insurance. If every criminal can be afforded a lawyer regardless of ability to pay, certainly every decent, hardworking American can be guaranteed universal health insurance coverage.

I thank the gentleman from South Carolina for organizing these special orders.

Mr. CLYBURN. Mr. Speaker, I thank the gentleman from Georgia [Mr. BISHOP] for giving us such a good, comprehensive statement of what can be expected to happen with our insurance markets if we fail to have universal coverage as we move to reform our health care financing business.

Mr. Speaker, I yield to our distinguished colleague, the gentlewoman from North Carolina [Mrs. EVA CLAYTON] the first-year president of the freshman class.

Mrs. CLAYTON. Mr. Speaker, I thank you for allowing me this opportunity to address my colleagues in the House about the importance of universal coverage in any health care reform bill that we consider, and hopefully pass. I also, want to extend my appreciation to the distinguished gentleman from South Carolina and president of the freshman class for his leadership in organizing this debate on health care reform.

I am confident of the fact that without universal coverage, any health care reform legislation we adopt will not solve the problem. At the very core of requiring all Americans to be covered, is the argument that universal coverage will improve the quality of health care and control cost-shifting. Universal coverage will correct the imbalance that currently exists between those who pay for health coverage and those who obtain coverage without paying.

Right now, individual farmers, small and big businesses, and rural hospitals all pay a very high price when someone without coverage obtains emergency care rather than primary care from a doctor's office. The cost of this expensive care is passed on to those individuals who pay for health coverage. Hospital prices go up when they provide uncompensated care which increases rates. How many of us have experienced paying $5 for aspirins at hospitals?

Small businesses that currently provide health coverage for their employees are affected with these rate increases. In fact, in recent years small businesses that provide coverage for their employees have experienced rate increases far higher than those of large businesses, rising by 10 percent to 30 percent each year. This can be devastating to small businesses which are trying to do the right thing by providing this essential coverage. Without employer participation which I prefer to think of as an employer-based system of shared responsibility instead of a mandate, it is unlikely we will get to universal coverage. Without universal coverage, those who currently pay the price will continue to do so, and they will pay even more in the future.

Contrary to what we have heard on TV or read from special interest organizations, a majority of small businesses, 58 percent, provide health insurance for their workers. Those who do not provide coverage are in the minority. Should we allow this minority of businesses to block passage of a universal health care system that upholds their own interests? Can we continue to allow them a free ride on the backs of the majority of small businessowners who do provide health coverage for their employees?

We must recognize that there are small businesses who are not now providing health coverage who will have difficulty in providing coverage without assistance. Any health care proposal should provide assistance. In fact, the House health bill provides subsidies and tax credits for small businesses with fewer than 50 employees.

However, the responsible small businesses that now provide coverage for their employees pay three times higher than they need to. This chart illustrates this unfair overpayment by those who can least afford it: First, they provide coverage for their own employees; second, they pay for the dependents of their employees who may work but don't get health care from their own jobs, and third, they pay for those uninsured—most of them working people—who receive health coverage in America's emergency rooms, whose costs are borne by the insured. I argue that this cost shifting is a hidden tax on small businesses that do provide insurance.

I have heard from small employers in my First Congressional District of North Carolina that provide health insurance coverage for their workers. I have heard from pharmacy owners, dry-cleaner operators, and homebuilders among others who support universal coverage. They not only see the problem, they feel the problem in their pocketbook.

Small businesses cannot be required to pay a much higher rate than large businesses, just because they recognize the value of insuring their workers and don't have the economy of scale in purchasing health insurance. These small businesses, realize that with the passage of universal coverage their rates will decrease if everyone participates in the health care system. No longer will some citizens be able to participate in America's great health care system without paying their fair share, without shouldering some responsibility for their care.

We cannot allow this cost shifting situation to continue. We have the power in this legislative body to make a real difference, to provide health coverage for all Americans. I for one intend to take a stand for my constituents, and for all those citizens who have suffered because we have allowed them to slip through the cracks without a safety net to ensure their care.

In my rural district in North Carolina, some 75,000 people in working families, largely employed by small businesses, have no health coverage. Of these families—there are 27,000 children—this is a despicable statistic. These are the individuals who will be the winners with a health care plan that provides for universal coverage.

I submit to you Mr. Speaker, that health care reform that does not provide for universal coverage will not improve the quality of health for many in my district and in many areas across the nation. Without universal coverage we will not stop or contain cost shifting. Without universal coverage Mr. Speaker, we will not have health care reform.

□ 2030

Mr. CLYBURN. I thank the gentlewoman from North Carolina so much for giving us that very comprehensive view on what is going to happen with cost shifting. I think that what you have shown to us with your presentation is that for the middle class, if we pass health care reform legislation which provides universal coverage, what we will have is, in fact, a middle-class tax cut that everybody has been asking about.

So thank you very much for pointing that out so clearly to us.

Mr. Speaker, I would now like to yield to our distinguished colleague, the gentlewoman from Georgia [Ms. McKINNEY].

Ms. McKINNEY. Mr. Speaker, I thank the gentleman from South Carolina [Mr. CLYBURN] for yielding and also for organizing this special order tonight.

Mr. Speaker, let me just say that health care reform is no reform at all without universal coverage.

I am happy to join my freshman class members this evening as we underscore the need for universal coverage for everyone.

I want to give a snapshot of the 11th Congressional District of Georgia tonight and to tell why Georgia's 11th Congressional District needs universal coverage. Presently under the current system 98,000 people in working families have no health coverage; 82 percent of all people without health coverage are in working families, and, of course, that means that 37,000 children in Georgia's 11th Congressional District have no health coverage.

With universal coverage, that means that 98,000 people in working families will have health coverage, 37,000 children will have health coverage, 33,000 women will have improved coverage for breast cancer screening, 5,000 2-year-olds will have improved coverage for immunization, 170,000 people will no longer have lifetime limits on their coverage, 89,000 people will no longer have preexisting-condition exclusions on their insurance.

With nonuniversal reform, every middle-class family earning between $20,000 and $75,000 will be forced to pay on average $622 more each year on insurance premiums. That is 110,000 families in Georgia's 11th Congressional District.

Now, in the health care reform bill that Congress will be voting on, there are six principles that are contained there: Security, simplicity, savings, quality, choice, responsibility, and after waiting so long and so hard, hard-working families from Georgia's 11th Congressional District and, quite frankly, hard-working families throughout America, just do not need to wait any longer for health security.

The interests of the 11th Congressional District and the interests of this country will not be served by tinkering on the margins. Mr. Speaker, I believe we were sent here to Washington with a mandate from the people to change business-as-usual politics. We want a Government that looks after the needs of people.

We anticipated resistance from the obstructionist, divisive, Republican gridlock gang, and quite frankly we have to fight every day with full force at every step of the way. Politics, gridlock, partisan positioning should not keep us from doing what we must do, and that is to perfect a health care reform bill that guarantees that health care will always be there when Americans need it.

Without universal coverage, health care reform is just a meaningless phrase. We cannot fall short of the promise.

Mr. CLYBURN and Mr. Speaker, I would like to thank all of you who are participating in tonight's special order. I would also like to thank my staff for allowing me to be able to participate tonight. I would like to thank the information that came to us from various sources, particularly the Catholic Health Association of the United States, and I would just like to close by reminding you that health care reform is no reform at all if it does not include universal coverage.

Mr. CLYBURN. I thank the gentlewoman from Georgia [Ms. McKINNEY]. I think that what you have shared with us about the conditions which could be expected in your congressional district if we fail to do universal coverage is something that can be repeated over and over again as we look at the congressional districts across the Nation.

Now, Mr. Speaker, we want to close out this special order this evening by calling upon our colleague, the gentleman from Mississippi [Mr. THOMPSON], who will share with us some insight as to what we can expect to happen with access if we fail to do universal coverage.

Mr. THOMPSON. Mr. Speaker, I want to thank my colleague, the gentleman from South Carolina, for chairing this special order this evening dealing with health care.

The topic that I have is one that I think is absolutely key to the whole issue of health care reform in this country, and it is the notion that reform will fail without universal coverage. Without universal coverage, hospitals and physicians that serve the uninsured, the poor, and the elderly will be put most at risk.

One of the things that I share often with a number of my colleagues, Mr. Speaker, is that I represent one of the poorest districts in the country, and in that district we have a number of uninsured individuals. I hear from hospital administrators as well as physicians who feel that they are bearing an undue burden on servicing the poor and uninsured in my district. I agree with them.

I support the notion that in the richest country in the world that individuals should not have to make the choice between buying medicine and paying the rent or paying utility bills and going to the doctor. So many of the issues around universal coverage are addressed in the whole notion of health care reform.

□ 2040

As we talk about this, my chart will explain this to those of us here. It is comparing the uninsured counterparts with the insured. The uninsured are twice as likely to have no regular source of care. That means that those individuals who are without coverage basically do not have a doctor, do not have anybody to call when they are feeling bad, and consequently they are the ones that are falling through the system.

In my district alone there are 94,000 working people who have no coverage at all. Of that number, 83 percent of those individuals without coverage are from working families.

So what am I saying to my colleagues? Mr. Speaker, that even a number of the people who are without coverage are working, but they cannot afford the care.

So, we have almost 100,000 people in my congressional district alone who are working, but who cannot afford the coverage. Of that number, 37,000 are children, and my colleagues and I know that, as preventative health goes, those formative years are the years that are very important, even on through adulthood, but if 37,000 children in my district alone have no form of health coverage, then my colleagues can understand why infant mortality rates and other things are higher simply because they are not getting the prenatal and other care.

Also the uninsured are twice as likely to use the emergency room as a regular source of care, and there is no question that billions of dollars are written off every year in this country by emergency rooms and hospitals because individuals are using those facilities as doctors' offices because, as we said earlier, they do not have a physician, and generally they wait until it is too late to go anywhere other than the emergency room, and consequently they get an $800, $900 office visit in the emergency room.

In my district alone, $67 million was written off last year as bad debt, debt that could have been paid for had we had universal coverage, and I say:

> Mind you, that debt is still picked up by the taxpayers whether we pay for it in the emergency room or we pay for it with universal coverage.

We will pay, so I think it is clear we will have to understand that the notion of universal coverage is also the notion of paying for health care, but at a different rate. So, it is important.

Also the uninsured are over 3 times as likely to report that there was a time that they needed medical care and did not get it for financial reasons.

What am I saying? These individuals cannot afford it.

So we asked them, "The last time that you had a headache, did you go to the doctor?"

They said, "No, I couldn't afford it."

So any time people have to make the choices between affordability and how they feel, then we know that they are seriously jeopardizing their health.

But also 72 to 100 percent of the uninsured are most likely to go without a physician visit for acute earache, recurring ear infections, or asthma, and that is young people. So, most of us who have children know that they get sick, and I ask my colleagues:

> Can you imagine in the richest country in the world, when children are sick, they can't go to the doctor? Or if they go, they go to the most expensive provider, which is the emergency room?

We can do better if we have universal coverage.

One in three poor adolescents are not covered by Medicaid, and private insurance coverage for adolescents is increasingly restrictive; 42 to 60 percent are less likely, specially among women, to receive adequate preventive screening of hypertension, cervical cancer, breast cancer, and glaucoma.

The basic issue is that the majority of the people in my district who are without coverage are also women, and because of this the incidences of illnesses related to screening that is not taking place is greater, and also those illnesses, for the most part, are the ones that cost more money.

And I guess in summing it up, the tragedy is that 25 percent of those individuals who are without insurance die prematurely. In my district 163 infants die per 1,000 live births. We had the third highest infant mortality rate in the United States.

So, in conclusion, Mr. Speaker, I offer this chart to justify having universal coverage. But also we have to have increased competition, and to have that without universal coverage can only worsen the patterns that presently are going on in this country.

Last, I implore my colleagues that, as we discuss health care reform, let us make one of the main tenets of it universal coverage. If we do not have universal coverage, then indeed, Mr. Speaker, we do not have health reform.

Ms. McKINNEY. Mr. Speaker, I think the gentleman has very eloquently reminded us that we are down here to do the business for the people, and through what he has talked about just now he reminded us that behind all of the statistics are very real people. We are talking about working people, we are talking about babies, we are talking about children, and this, quite frankly, is very serious business.

We are not here to do the business of special interests. We are not here to do the business for special businesses. We are not here to do the business of particular industries. We are here to do the people's business, and I thank the gentleman for such a touching and eloquent delivery, and a reminder really for why we are here.

Mr. CLYBURN. Mr. Speaker, I thank the gentleman from Mississippi [Mr. THOMPSON] for that very comprehensive overview of exactly what universal coverage is all about.

Mr. Speaker, I thank you for allowing us the time to participate tonight and I thank my freshman colleagues for all of the work they have put into the health care reform legislation that will come to the House floor in a few days.

On radios and televisions, in newspapers, and dinner conversations across the country—the hot topic right now is health care reform. As we contribute to this ongoing conversation from the Chamber where decisions affecting each and every one of us will be made in the coming days, Mr. Speaker, I remind you and my colleagues universal health care coverage which can never be lost should be guaranteed to every American, because there is no such thing as a lifetime guarantee of good health.

DO NOT SOCIALIZE HEALTH CARE

The SPEAKER pro tempore (Mr. CLYBURN). Under the Speaker's announced policy of February 11, 1994, and June 10, 1994, the gentleman from California [Mr. HUNTER] is recognized for 60 minutes as the designee of the minority leader.

Mr. HUNTER. Mr. Speaker, I listened with interest to my colleagues who talked about what they saw as the benefits of universal coverage and, I think, a very eloquent closing by the gentlewoman from Georgia [Ms. McKINNEY], who spoke of the necessity of this House doing the people's business, and the people not being special interests, not being necessarily corporations or industries, but people. And I think what America has heard, Mr. Speaker I want to speak very strongly against the first President Clinton plan that came out that now apparently is dead, not because of Republican opposition, but because we are outnumbered by 100 votes in this House and by quite a few in the other body, but because American people, business people, employees who wanted to keep their jobs, talked to their Democrat Representatives and their Democrat Senators, not to Republicans, who were in the minority and cannot control things, and told them not to pass this plan.

□ 2250

So you have the unique situation where a Democrat President, President Clinton, having total power, total control with his party over both bodies of the U.S. Congress, with the power to write a bill, deliver it to his desk within a few days, and sign it, with the Republican party being basically powerless to stop it, with all those things going for him, the President of the United States, Bill Clinton, was not able to push his first health care plan through.

Now, why did the people stop that plan? Why did Democrat Members of Congress and Members of the Senate stop that plan?

Well, I think it is fairly clear, Mr. Speaker. They sopped the plan because they perceived that it would be bad for them. And it was not just a few industries, because I don't think the Democrat Party in the House is controlled by a few industries. I think that the Members of the House who are Democrats have the same representative reflection of their constituencies that those on the Republican side have. They do what their constituents ask them to do, and they try to reflect the feelings of their constituents.

Now, why would not Americans, when faced with what has been described as this nirvana of health care, this great new benefit, where nobody is ever left out, everybody has a guarantee for life, from cradle to grave, you are going to be taken care of, and that very appealing personality of this President, who can look at an audience, whether it is a talk show or people in the White House, and you see a little glisten of a tear in his eye, and he talks about giving them security, why would not Americans walk right up and sign up for that program?

It is because Americans are a little bit different from folks in the other parts of the world. We are a country full of people that appreciate when Government gives you some security, it takes away some of your freedom. This debate over health care is a debate between Government control and freedom. And I hate to hear the word "reform" used when Members first started to describe the President's own health care plan, because for practical purposes, President Clinton's first plan was socialism. If it did not socialize the delivery of health care itself, it at least socialized the financing mechanism.

I have never considered socialism to be a reform of any kind. Certainly Cuba has all-inclusive health care coverage. They have got universal coverage. Communist China has universal coverage. All of the nations we have taught over the last 40 years concerning the faults of socialism have universal health coverage. The problem is they don't have any quality, and they don't have any quality of life for the people.

You know, John Papageorge, a former commander in the 101st Airborne, described quality of life in America as being a function of the amount of control that you have over your own life. I think that was a very good description of freedom and quality of life in this country.

A lot of people looked at the President's health care package and decided that they did not like what I would like to call Clinton I, President Clinton's first health care package.

That was a health care package in which everybody had to march down and sign up for the Government health care program. And if you did not sign up for the Government health care program, Government caught you and fined you a double premium if they caught you not signing up for the plan. So nobody had the option to say I want to pay for it myself, or I would rather go somewhere else, or I don't like this plan. Every American was obligated to go down and sign up with Government and pay Government money.

Everybody had to take a plan that was dished out under a Government system in which large cooperatives or purchasing alliances, Senator PHIL GRAMM called them collectives, but large purchasing alliances would make big deals with big insurance companies, and theoretically get good rates for packages. And those packages could either be an assigned doctor, where you basically spin a rotary wheel and if the doctor you get happens to be the guy who just immigrated from Bangladesh and has credentials to practice medicine in America, he was your doctor whether you liked him or not. Or maybe the preferred provider list, where you had a menu of doctors, but you might still not have the right to have the doctor you wanted. Or, in some cases under President Clinton's first plan, if an insurance company, and only if an insurance company, came forward and had a plan for what is known as fee for service, that is where you can pick any doctor you want, you could be under the government plan and still have a choice of doctors and go to your own doctor.

Well, the American people did not like that deal. They weren't the French, they weren't the British, they weren't the German, they weren't the Japanese nor the Canadians. They didn't like that deal and wanted to maintain more freedom.

I don't think it is unusual or unexpected that of all the nations in the world, the people of the United States like freedom maybe a little better than anybody else. And I think that is kind of a good thing.

So they didn't sign up for President Clinton's first plan. Incidentally, I think another reason they didn't sign up for President Clinton's first plan was because they looked at some of these countries which had socialized medicine and although they looked pretty good at first, when you saw a few figures, if you looked through the figures and looked to the quality of medicine that was delivered, you saw some pretty ugly things. And let's go around the world and look at some of the things we saw that we could expect President Clinton to drive us toward with this first health care plan.

First, we looked at Canada. Canada was offered to us in the United States Congress as the heaven of health care. This was the place were you had a single payer system where government had finally come to grips and "reformed health care."

Well, let me tell you what health care reform did to Canada, now that we have looked at it a little closer.

We now have discovered that the largest hospital in Ontario had to close down for 2 weeks last Christmas because they ran out of money. Then we discovered that there are now 177,000 Canadians waiting in line for operations.

I asked the question when I was in Minnesota recently, why are all these Canadians coming down for operations in Minnesota, Detroit, MI, and other American cities? I was told it was because they don't have to wait in line if they come to America. They get first-class health care and get it now. So they come to America.

We discovered in some places in Canada women in childbirth are not given epidural anesthetic. You may recall one of the articles that was in a national newspaper about a woman undergoing childbirth who was shivering in pain as her doctor passed her and said I know it hurts and I wish there were something I could do for you, but we just can't afford it.

So we looked at Canada and we also saw of those 177,000 Canadians waiting for operations, over 25 percent of them surveyed say they are in some sort of pain. So we decided maybe Canada wasn't the great model for "health care reform" or socialized medicine.

Well, some Members of the House talked about Japan, because Japan dedicates a smaller percentage of their Gross National Product to health care than the United States. We know what they have in Japan. They have a medical system in which doctors see approximately 49 patients a day on the average. Now, ladies and gentlemen, that is whipping people through pretty doggone fast.

My first question was how can you possibly do that? One answer was mass examinations. Well, Americans, especially Americans who have been in uniform, don't like the idea of mass examinations. They like a little bit of privacy.

You know, when I saw that figure, 49 patients a day per doctor, I thought about the subway system in Tokyo, where they have the professional packers, and these guys look like former sumo wrestlers to me, maybe they are not. They don't hurt anybody. But when the last Japanese passenger gets on that subway system who can possibly get in, they physically pack the people into the subway, and those big strong packers don't hurt anybody, but they get the last body in. That is kind of the image you get when you think about 49 patients a day going through each doctor's office in Tokyo. So we decided maybe we didn't want to have that kind of socialized medicine.

We looked at Great Britain, where they have socialized medicine. And yet if you are a senior citizen, if you have passed a certain age, and you need a life saving operation, you don't get it. The reason you don't get it is because socialized medicine always operates ineffectively and they run out of money. When they run out of money, their philosophy to senior citizens in Great Britain is, you have lived a long and fruitful life and it is time for you to float from the tree, kind of like a leaf in the autumn time. You have had a full life and we will save these life saving operations for younger people.

□ 2100

That sounds fine if you look at it on paper. But when those senior citizens are your grandparents or your parents, you want to be able to have a chance to save their lives. So Americans have looked at Great Britain, and they do not like that socialized medicine system either.

The President has staked quite a bit on making a health care plan go this year. Although it is clear that a majority of the American people say, wait a minute, we do not want you to rush anything through in the immediacy of this election season. We want you to take your time, if you are going to do health care, because health care is a giant contract with the American people. And I do not think the American people like the 1,300-page document that President Clinton sent down the first time.

You know it took almost a year for the American people to be able to look at enough parts of that document and believe me, like a lot of Members of the House, I was pretty surprised when I would meet people at town hall meetings who had read that entire document, many others who knew the outlines, many others who knew the key provisions.

Americans read these things, folks. Ultimately they find out what we vote on. So we better doggone well read the documents ourselves before we vote on them.

So it took about a year for the American people to read President Clinton's health care plan and read it and understand it so well that there were enough people who objected to the plan that President Clinton, with a 100-seat majority in the House of Representatives being Democrat, could not pass that health care plan. Republicans did not beat that health care plan. The people of the United States beat that health care plan.

We have got a couple of days until recess. We are told that there is another plan coming up in the House and another plan coming up in the Senate and that we are going to vote on these plans in the next several days. These plans that are comprised of thousands and thousands of pages of regulations, every one of which will have some impact on Americans' lives.

I think that is wrong. I think the Democrat leadership in both bodies knows that it was the time that the American people took to look at this plan, the first plan that President Clinton offered, that caused it to lose and to be dropped, not by Republicans but by Democrats. And I think if we give the same light of day to this second plan, what I call the Gephardt-Clinton plan, named after distinguished majority leader in the House and the Mitchell-Clinton plan, named after the Democrat leader in the Senate, if the American people get a chance to see President Clinton's plan 2 and 3, they will be just as offended and just as put off and just as resistive of these two plans as they were of the first.

Let me talk about just a couple of things with respect to this plan.

First, I saw the exchange between President Clinton and the black entrepreneur Herb Kane, the gentleman who is the president and CEO of Godfather Pizzas. He did a businesslike thing, which I guess is sometimes unfair to do to politicians, especially when they are as smooth as our President is. He said, Mr. President, I am paraphrasing, I have looked at your plan. I am going to have to lay off people under this plan. I am going to have to close down franchises.

And the President said, essentially, to him, and I am paraphrasing the President, I do not know why you just cannot raise the price of your pizzas.

And I noticed on Mr. Kane's face, after the President said that, what I consider to be a pretty naive statement to a businessman who understands you cannot just raise the price of your goods to accommodate added costs, I saw kind of a look of surprise. And later on he told a number of us in the House, he said, if I could get more money for my pizzas, I would be getting it. But the point is, this plan is going to kill jobs. It is going to force me to close down some franchises that are marginal.

And he said another thing that I thought was interesting and goes to the heart of this whole debate. Because this whole debate is developed on the Democrat idea that we are going to make employers, small businesses and larger businesses, pay for all the health care for their employees.

Mr. Kane, once again I am paraphrasing him but I thought this was important, he was asked why he did not think that he owed giving health care or a health care program to every one of his employees. He said, because my first duty to my employees it to give them a job. And sometimes you cannot do both. That is the point with Clinton 2, with the second Clinton package which is being put together on the Senate side by Senator MITCHELL and Clinton 3, the third Clinton package which is being put together by Mr. GEPHARDT and the Democrat leadership behind closed doors on the House side, these plans are going to kill jobs.

I come from a State in which we have done what we thought were wonderful things for workers. The only thing we forgot to include was a job. We have got a workmen's compensation program in California that allows people to sue for stress and we have had a ton of fraudulent claims for stress. That has not helped workers. It has hurt the good workers because the fraudulent workers have gone out and collected their dollars, and the good workers have kept on working and the good businesses have moved out of California and moved to other States. And there is a continuing exodus.

So with the legislature of California attempting to be so kind to the workers, they forgot one thing. Blue collar workers cannot hire each other. White collar workers cannot hire each other. You have to have a businessman or a businesswomen, a business owner to hire you. And you cannot make the environment so unfriendly to them or so unprofitable or so burdensome that they go out of business, because if they go out of business, you are out of a job.

Well, the Clinton 2 and Clinton 3 health care plans put a lot of folks out of jobs.

Let me tell you how many they put out of jobs. This is an estimate that is taken off the CONSAD study, "Employment Impact of Ways and Means plans and Approximate Impact under the Gephardt Plan." The plan that the Democrat leadership is putting together in the House of Representatives is going to destroy almost a million jobs and it is doing to affect many times a million jobs. What do I mean by saying affect?

I mean this: If you have a business that is selling a particular product and they are only making a $20,000-a-year profit on this small business and they discover that the mandated health care plan under President Clinton 2 or 3 or 1 is going to cost them an additional $30,000, then they close up. Let us say they are still making slight profit and they intended to put that profit into giving their employees raises so they could increase productivity. Now they have to forgo the raises because there is no money there to do it with.

When you take money out of the payroll, especially when so many American businesses are having trouble meeting that Friday payroll, you either detract from the amount of money you are paying the present employees or you have to lay off employees. That is what this health care bill is all about. It kills jobs and it degrades jobs.

Let me tell the American people what the CONSAD study says. I want to read the States and I am going to read the numbers of jobs that are lost and the number of jobs that are downgraded because of President Clinton's second plan, that is Clinton-Gephardt.

Alabama, they lose 13,000 jobs; 716,000 jobs affected. Alaska, Alaska loses 1,200 jobs; 74,000 jobs are affected.

Arizona loses 11,000 jobs; 641,000 jobs are affected. Arkansas loses 7,000 jobs; 398,000 jobs are affected in Arkansas.

California, my State, loses 108,000 jobs. Over half the jobs that we lost with the aerospace flight are going to be lost with the Clinton health care plan. Over 5 million jobs will be affected.

Colorado, 11,000 jobs are lost; 638,000 jobs are affected. Connecticut, 15,000 jobs are lost under the Clinton health care plan; 796,000 jobs are affected. Delaware, 2,800 jobs are lost under the Clinton-Gephardt health care plan; 154,000 jobs are affected.

District of Columbia, 4,900 jobs are lost. That is like a large company leaving the District of Columbia and taking all of its jobs with them, except in this case, the jobs do not go anywhere, they are just destroyed. But under the Clinton-Gephardt health care plan, 4,900 jobs are lost in the District of Columbia; 240,000 jobs are downgraded.

□ 2110

Florida, 41,000 jobs are lost, 2.3 million jobs are downgraded; Georgia, 23,000 jobs are lost, 1,200,000 jobs are downgraded under the Clinton-Gephardt health care plan.

Idaho, 2,000 jobs are lost, 153,000 jobs affected; Illinois, 47,000 jobs are lost, 2,478,000 jobs are affected, Indiana, 22,000 jobs are lost, 1,168,000 jobs are affected; Iowa, 9,000 jobs are lost, 530,000 jobs are affected.

Kansas, 8,000 jobs are lost, 469,000 jobs are affected or downgraded under the Clinton-Gephardt health care plan; Kentucky, 11,000 jobs are lost, 610,000 jobs are downgraded; Louisiana, 11,000 jobs are lost, 645,000 jobs are downgraded.

Maine, 4,000 jobs are lost, 227,000 jobs are downgraded under the Clinton-Gephardt health care plan; Maryland, 16,000 jobs are lost, 953,000 jobs are downgraded; Massachusetts, 29,000 jobs are lost, 1.4 million jobs are downgraded; Michigan, 36,000 jobs are lost, 1.8 million jobs are downgraded.

Minnesota, 18,000 jobs are lost, 931,000 jobs are downgraded; Mississippi, 7,000 jobs are lost, 375,000 are downgraded; Missouri, 20,000 jobs are lost in Missouri under the Clinton-Gephardt health care plan, and over 1 million jobs are downgraded; Montana, 1,700 jobs are lost in the Big Sky country, 105,000 jobs are downgraded.

Nebraska, 5,000 jobs are lost, 313,000 jobs are downgraded; Nevada, 6,400 jobs are lost, 320,000 jobs are downgraded; New Hampshire, 4,000 jobs lost, 223,000 jobs downgraded, New Jersey, 29,000 jobs lost under the Clinton-Gephardt health care plan, 1.6 million jobs downgraded in New Jersey.

New Mexico, 3,000 jobs lost, 205,000 jobs downgraded; New York, 76,000 jobs lost in New York under the Clinton-Gephardt health care plan, 3.9 million jobs downgraded; North Carolina, 28,000 jobs lost, 1.4 million jobs are downgraded; North Dakota, 1,600 jobs lost, 96,000 jobs downgraded.

Ohio, 44,000 jobs lost, 2.26 million jobs downgraded; Oklahoma, 8,000 jobs lost, 466,000 jobs are downgraded under the Clinton-Gephardt health care plan; Oregon, 8,000 jobs are lost, 499,000 jobs downgraded.

Pennsylvania, here is a whopper, 47,000 jobs are lost in Pennsylvania under Clinton-Gephardt, 2,453,000 jobs are downgraded; Rhode Island, 3,800 jobs lost, 202,000 jobs downgraded; South Carolina, 12,000 jobs lost, 681,000 downgraded; South Dakota, 1,700 jobs lost, 103,000 jobs downgraded under the Clinton-Gephardt health care plan.

Tennessee, 19,000 jobs lost, 987,000 jobs downgraded; Texas, 55,000 jobs lost, 3 million jobs are downgraded. No wonder Texans, Democrat and Republican, have not been happy about this brand of socialized medicine.

Utah, 5,000 jobs lost, 309,000 jobs downgraded; Vermont, 1,800 jobs lost, 102,000 jobs downgraded; Virginia, 21,000 jobs lost, 1.2 million jobs downgraded.

Washington, 16,000 jobs lost, 936,000 jobs downgraded; West Virginia, 4,000 jobs lost, 238,000 jobs downgraded; Wisconsin, 19,000 jobs lost, 1,100,000 jobs are downgraded under the Clinton-Gephardt health care plan. We end up with Wyoming, 930 jobs lost, 60,000 jobs downgraded.

Mr. Speaker, it is clear that this administration and a few Members on the Democrat side are willing to sacrifice American jobs for Government control of health care.

Mr. Speaker, I did not give the figures of jobs that are going to be lost under so-called Clinton-Mitchell, but I would say that it is not going to be much less than the jobs that are lost under Clinton-Gephardt, which are close to 1 million jobs, and there are a couple of other things about the Mitchell plan, the Clinton-Mitchell plan, that I think are important to talk to the American people about.

Mr. Speaker, I want to quote the author of the plan, Senator MITCHELL, July 21, 1994. He said these words: "Our plans will be less bureaucratic," he said this, "more voluntary, and will be phased in over a longer period of time."

Let me just read to you a few of the 50 new Government agencies that we are going to establish if we pass the Clinton-Mitchell health care plan. Ready to go? Fifty new bureaucracies.

He said this is going to be less bureaucratic and more voluntary. Let me tell you about a few of the nonvoluntary bureaucracies which are going to be employing hundreds of thousands of new Federal workers.

We are going to have a National Health Benefits Board. That is section 1211. We are going to have the Health Insurance Purchasing Cooperatives set up by States or local governments. That is section 1321.

There will be the Health Insurance Purchasing Cooperative set up by the Federal Office of Personnel Management, section 1341. We are going to have a National Guaranty Fund for Multi-State Self-Insured Plans.

We are going to have an assistant secretary for the Office of Rural Health Policy. We are going to have a Federal Accreditation, Certification and Enforcement Program. That is going to be called ACE.

We are going to have a State Accreditation, Certification, and Enforcement Program under section 1501. We are going to have a Health Plan Service That is under section 1502.

We are going to have State Risk Adjustment Organizations. That is section 1504. We are going to have an Advisory Committee for Risk Adjustment Programs, section 1504.

We are going to have State Guaranty Funds. That is section 1505. We are going to have State Public Access Sites for Medically Underserved Areas, 1508. We are going to have the Prescription Drug Payment Review Commission, that is section 2004.

Incidentally, Mr. Speaker, let me just say with respect to drugs and the cost of medicines in America, the reason you don't want to have socialized medicine in America is this: An interesting fact that a lot of Americans discovered after the First Lady and the President went on their binge against the companies that develop medicines and cures, we discovered—and this was a surprise to me, and I think to a lot of our constituents across the country, but it is a fact—the United States of America develops more cures for diseases than all the rest of the nations of the world combined.

Isn't that incredible? That means you take Great Britain, France, Germany, Canada, all the rest of these civilized nations, and Third World nations, and you add them all up, and the good old United States of America, that has what the Democrat leadership calls this backward system, produces more cures that save the lives of your family and families around the world that all the rest of these so-called progressive nations, remember, Cuba is in that group, too, combined.

Why do we produce more cures than all the rest of the nations combined? I would submit it is not because Japan does not have great universities, and probably some pretty smart people; it is not because France and Great Britain do not have good universities. It is because none of them have the free enterprise system that we have.

Mr. Speaker, I have a gentleman in San Diego, a friend of mine named Bill Otterson, who suffers from a fairly rare disease. He and some other folks told me about a drug called Intron-A. Intron-A tells you why you do not want to pull the free enterprise system out of the development of medicine.

□ 2120

Intron-A costs $100 million to develop and when they first put it together, when they first took a chance on it and decided to burn up $100 million and bet that it would be a winner, they knew that there was only a small group of Americans initially who would be able to access or use that drug, and that was this very small pool of people who have what is known as hairy cell leukemia, a very unique type of leukemia. There are only about 1,000 folks in the United States who have that brand of leukemia. Yet a group of private investors put $100 million forward to develop this drug called Intron-A. They knew that initially it would take care of folks that had hairy cell leukemia. Of course those folks were pretty happy it was being developed. But they thought it also might, if it succeeded and if their gamble paid off, be able to address 17 or 18 other types of diseases. They were right. Today Intron-A is used to treat about 17 or 18 major diseases. It is a big success. It brings in about $500 million a year to the United States from countries all over the world that use it. It was dropped because we have a free enterprise system. All those people, including people like Bill Otterson who are themselves afflicted with these medical diseases that are treated by these miracle drugs say, "Please don't socialize medicine" because if Mrs. Clinton, respectfully, had been around to tell the Intron-A people, "If you develop Intron-A and put $100 million of your own money into it, I am only going to let you charge $1 a pill when you develop it," would it ever have been developed? Would the people who have hairy cell leukemia ever have had a chance to be cured or helped? Would Bill Otterson and the other hundreds of thousands who now use Intron-A to save their lives have a chance to have it? Absolutely not.

Mr. Speaker, the consensus of the medical community, including experts from places likes Johns Hopkins and other great medical centers is, if we socialize medicine and the creation of new medical cures, what the companies will do is simply this: They will go to a system in which they do not take any medical risks, because nobody is going to go out and put $50 million into a drug that you can only get $1 a pill for. So what they will do is they will take our present inventory of drugs and they will incrementally increase the capability of those drugs. They will try to research them a little bit and make them a little bit better, but they will never go out there and try to whip that new disease that nobody has beaten so far. They will not find a cure for cancer. They will not find any of the wonderful cures that America has found under freedom. it is kind of interesting, is it not?

A person does not have to be a wealthy person to understand how very, very important it is to have a free enterprise system in which people go out and take a risk and having taken a risk, they develop a system that saves lives by the thousands, by the tens of thousands, by the millions.

Mr. Speaker, I see my friend, the gentleman from Maryland has come to the floor and I would be happy to yield to him if he wants me to yield.

Mr. HOYER. Mr. Speaker, I thank my friend for yielding.

Mr. Speaker, I was working in my office and happened to see his discourse and, of course, there is nobody else on the floor, so there was not an opportunity for somebody perhaps to give the gentleman a question.

The gentleman referred to the Clinton plan as socialized medicine. He then referred to the Gephardt plan as well, as if they were the same. But in any event, would my friend describe for me what he perceives to be socialized medicine?

Mr. HUNTER. I would be happy to describe it.

In the first Clinton plan that was initiated——

Mr. HOYER. I am not asking the gentleman about the Clinton plan at this point in time. What does my friend describe socialized medicine as being?

Mr. HUNTER. My answer to my friend is it is a system in which not only is the medical service itself controlled, which is a pure socialized medicine that is practiced in some other places, but also a system in which the financing of the medical system is controlled.

If the gentleman would listen, I had read about 10 of the various new Federal Government agencies that will control medicine under the plan that is being developed by the Democrat leader in the Senate.

I think at least what I have seen of the Gephardt-Clinton plan is we are going to have a lot of government agencies helping to run that plan. So my answer to the gentleman is it is a system in which the financing——

Mr. HOYER. Does the gentleman believe that Medicare is a socialized system?

Mr. HUNTER. I think it is a small piece of a socialized system, yes.

Mr. HOYER. Would my friend be in favor of eliminating Medicare?

Mr. HUNTER. No, I would not.

Mr. HOYER. So the gentleman likes a little bit of socialized medicine?

Mr. HUNTER. No, I would say to the gentleman who says that Medicare is a little bit of socialism——

Mr. HOYER. I did not say that.

Mr. HUNTER. Mr. Speaker, I am going to take my time back and I am going to answer my friend freely, and I am going to allow him to answer me freely.

To the gentleman and others who would say that Social Security is a little bit of socialism and that Medicare is a little bit of socialism, my answer to them would be that we have built a system around that and we now have built thousands and millions of Americans who now have, for better or for worse, become part of those programs, who have put their money in, and who now feel that they have a contract with government that took money that they might have better used in other programs and that those people are now locked into those programs.

I would submit to my friend that that is not a rationale for now creating a new Medicare Type C which the Gephardt-Clinton plan does, which will now bring almost 50 percent of the American population under Medicare.

So my answer to my friend is no. The fact that we have a Medicare program, which incidentally my friend knows that the costs are going up fairly radically in that program and that people have paid their money and many Americans feel they now have a contract.

How many times has the gentleman had a senior citizen said, "You know, if you had let me keep my money and do something else with it"—whether it is Social Security, Medicare, or other things—"I could have done a lot better than government did for me. But since you did it, I want mine"?

Mr. HOYER. If my friend would yield, I have never had anybody on Medicare tell me that. I have heard that on Social Security, where they thought they could have put it into an annuity program, but I have frankly never had anyone tell me that on Medicare. But let me ask the gentleman a question——

Mr. HUNTER. Before my friend asks me a question, let me ask him a question.

Is the gentleman saying that because Medicare exists and is part of our system now—and the gentleman is a Democrat leader, he is a distinguished member of the leadership, he has been through this analysis in which he has seen that there are a lot of problems in Canada, there are a lot of problems in Great Britain with rationing, there are problems in Canada where they have run out of money. I am sure the gentleman read The Washington Post that the biggest hospital in Ontario ran out of money.

Does the gentleman think the fact that we have a Medicare system and it is a small part of our health care now, is a reason to extend it or to extend government control to the entire system?

Mr. HOYER. Let me say, that is a major part——

Mr. HUNTER. The gentleman asked me a question. I want to ask it back to him.

Mr. HOYER. I understand, and I am going to answer.

I would say to my friend, the reason I came over here, the gentleman talked very glibly about socialized medicine and very frankly, opponents of this bill are going around the country scaring people with socialized medicine. We do have socialized medicine as the gentleman knows in this country.

Mr. HUNTER. First I want to take my time back for a second and just say this to my friend who is a member of the Democrat leadership. The Clinton I plan was not killed by a Republican. As the gentleman knows, they outnumber us by 100 votes in this House. It was killed by members of his caucus, Democrats, who went home and talked to their people who initially when they heard about health security said, "Hey, we're for that." When his people read the bill, they did not like it.

Mr. HOYER. So the gentleman's proposition is that the Clinton I plan was killed?

Mr. HUNTER. Mr. Speaker, I am reclaiming my time. The gentleman will have to suffer that. I have suffered that with him many times in our debates over the years.

Reclaiming my time, your voters read the bill. They read the first Clinton bill and they came back and told the gentleman, "As a Democrat, I don't like it."

When the first Clinton plan——

Mr. HOYER. So the gentleman's proposition is the Clinton plan is dead?

Mr. HUNTER. Let me finish my statement and I guarantee I will let my friend answer.

When the first Clinton plan came up for a vote in the House Committee on Ways and Means, I understand that not a single Democrat Congressman voted for it. So that was not a result of Republicans glibly scaring people, that was a result of people reading the plan and being scared because of what it did to them.

Mr. HOYER. If the gentleman will yield, I appreciate the fact he says the Clinton plan was killed. My point is this, though: We ought to have an honest debate about this. No American, or very few, are looking for socialized medicine. I would suggest to my friend that we do have a form of socialized medicine in America as my friend knows.

□ 2130

That is the health care that is given to our members of the armed services in the sense the hospitals are owned by the Government, the doctors work for the Government, and the members of the military go to the doctors who are available to them.

I do not criticize that system. It is, however, I would suggest to my friend, in the classic sense a socialized system because the doctors work for the Government, the nurses work for the Government, the technicians in the hospital work for the Government, and the hospital itself is owned by the Government, and that is socialized medicine, that is Government delivery of health services.

What concerns me, and I know the gentleman does not want to do this, is that we mislead the American people. There is nothing in either Clinton I, or the Gephardt plan, or the Mitchell plan which suggests that the doctors work for the Government. There is nothing that suggests that the hospitals be bought by the Government and in effect socialize, if you will. There is nothing to suggest that in fact the choice of the citizens will be restricted in their doctor or hospital by any of the plans that I know of and, therefore, I think if we are going to be honest in terms of our debate with the American public, we can differ, and the gentleman can take positions and say I do not like this proposal, but to characterize it as socialized medicine, I would suggest to my friend, is simply inaccurate by any proper definition of what socialized medicine is.

In fact, Medicare, I would suggest to my friend, from my perspective is not socialized medicine. It is, he is correct, as single-payer system where the Government collects money and pays the medical providers. But as my friend knows, those on Medicare choose their doctors who work for themselves, who work for an HMO or work for a hospital. They choose their hospital, not owned by the Government. In fact, it is a reimbursement to the private sector. And I would suggest further to my friend the fact that we have had that medical insurance system for our senior citizens has not only given them a much healthier environment and much healthier population for senior citizens, it has also done some of the things that my friend was talking about in terms of allowing sufficient funds in the system to provide for research, to provide for innovation, to provide for entrepreneurship.

So I would suggest to my friend that this plan is very much like in many respects a plan that already works.

Mr. HUNTER. I thank my friend for his statement and I want to reclaim my time and address his first statement.

The care that is given to members of the Armed Forces, I would suggest, is not socialized medicine for a very simple reason. If the gentleman watched, as I did, our troops who went ashore at Normandy into that hail of bullets, or watched some of the deprivations that have taken place in the Somalia situation before that, Desert Storm before that, and many, many military operations, military people who sign up for a contract with their employer, who happens to be Uncle Sam, he is not an employer down the street getting something for signing up.

Mr. HOYER. I am not criticizing.

Mr. HUNTER. I am not yielding to the gentleman.

Mr. HOYER. You are taking it as a criticism. I am not criticizing at all.

Mr. HUNTER. I am not saying the gentleman is criticizing the military, but I want to make the point, and I would not want the gentleman to interrupt me.

The point is that people who serve in the armed services give something for their medical care. They give service to their country.

Mr. HOYER. Nobody questions that. It is the same kind of thing, the reason I came over here. Nobody questions that.

Mr. HUNTER. I ask for regular order.

The SPEAKER pro tempore (Mr. CLYBURN). The time is controlled by the gentleman from California.

Mr. HUNTER. I just want to make this point that the gentleman said you could describe that as socialized medicine. I do not describe that as socialized medicine because people who serve their country have given to their employer, they have made a contract with them, and they have received something in return.

A very important question was asked during the debate that we had on health care, the Oxford-style debate. The question was asked of one of the gentleman's side of the aisle, and this was when the first Clinton health care plan came up, and I want to ask the gentleman about it. They said what if you have somebody who says, "I ain't working. I refuse to work and I want to lounge around, and I want to watch television, and I want free health care"? The question was never answered. So does that person get health care under Clinton I? The question was never answered.

That person to me is a different person from a person who joins the military and serves their country under a contract. I would just ask the gentleman the same question that was asked during the Oxford debates concerning Clinton I. In Clinton II or the Gephardt plan that we are now talking about, what happens there to somebody who says, "I simply want health care. I want to sign up and have free health care, and I don't intend to work for it, and I don't intend to pay for it." What happens to that person, and I yield to the gentleman.

Mr. HOYER. Frankly, my opinion is that as we adopt welfare reform and health care reform, which are going to be very closely intertwined, as the gentleman knows, that that person ought not to get health care. Very frankly, what the President has said, what we believe on this side of the aisle is those who play by the rules ought to be able to participate in the system. In my opinion, that person is not playing by the rules.

Mr. HUNTER. Let me answer that point and then I will yield to the gentleman for a second statement.

I looked through the first Clinton plan to look for the answer to that question. If somebody says, "I just want to be lazy and I want free health care," what would he do? I cannot find a provision that says that they do not get health care. I just want to ask the gentleman, I have not read a provision in the Gephardt-Clinton plan yet that says that that person will not be served. Has the gentleman got an answer? Is there a provision denying that coverage to a person who simply refuses to work?

Mr. HOYER. Frankly, I do not have the answer to that question, but I will get it so I can point to the provision.

But again, let me reiterate on that aspect. Under welfare reform, as the President has proposed it, and as I hope we pass it, it is going to say to people, first of all, if you just want to sit around, if you want to not work and you are able, and you want to be lazy, you are off the system, you are not playing by the rules, and we are not going to support you. Hardworking Americans ought not to be supporting people like that, and frankly, it ought to tie into health care.

Having said that, let me go back to the central question, because the gentleman tried to say oh, we are for the military. I am a strong supporter of the military as the gentleman knows. Under the Reagan administration I was a strong supporter of the buildup.

Having said that, I am not questioning the validity of a program which offers to our men and women in the armed services health care. They ought to have it, and we send them to places where they cannot access it. So what we do is we provide it.

But my suggestion of the gentleman, and he wants to avoid I fear the question because he would much prefer to politically tell the American public that what we are proposing is a socialized system, but it is not. My point is that by any fair definition, a socialized system is a system in which the government owns either the means of production or the means of the delivery of the service. Clinton I did not propose it, GEPHARDT is not proposing it and MITCHELL does not propose it, and it is not accurate for the gentleman to tell the American people on one of the most important issues that confront them as a people, I suggest to you, as families and individuals that we are proposing or that people are proposing a socialized system. That simply is not true.

Mr. HUNTER. I thank the gentleman for his statement. I am going to have the last word and then yield to the chairman of the Rules Committee.

My last statement is this: The gentleman left out one category of socialization, and that is the socialization of the means of financing. I would simply submit to my friend that under Clinton I, Clinton II, or Clinton III, meaning Clinton-Gephardt or Clinton-Mitchell, the means of financing is controlled by Government and is socialized. Even though the doctors are private ostensibly and are hired in a private capacity, the means of financing the system is socialized.

I yield briefly to the gentleman.

Mr. HOYER. I thank the gentleman. He does control the time and he has given me the time to have this discourse with him, which hopefully will be helpful to the American public, who will ultimately have to make this decision and tell us what they think. The fact is insurance companies, private sector insurance companies will continue to be involved in the system of selling insurance to employers and employees and individuals involved in the system.

Yes, the gentleman is correct. The Medicare Part C provides for those in some respects who cannot afford insurance or employers and employees who choose the Part C aspect. But the fact is we do not replace the private sector insurance.

Mr. HUNTER. I would suggest to my friend that the private sector is used by Government in this sense by making business pay for this plan by the 80-20 split, or what you might call the 50-50 split in the Mitchell plan. By forcing that payment they are using what otherwise would be funds of private people just as surely as if they took them out of general revenues and ran the plan themselves.

□ 2140

So in my estimation, the financing of the system is a socialized method of financing, very clever, very subtle, has exactly the same affect, and with that, I have enjoyed this exchange of views with my friend from Maryland, and I will defer to the chairman of the Committee on Rules.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 4908, HYDROGEN AND FUSION RESEARCH AND DEVELOPMENT PROGRAMS AUTHORIZATION ACT

Mr. MOAKLEY, from the Committee on Rules, submitted a privileged report (Rept. No. 103-695) on the resolution (H. Res. 515) providing for consideration of the bill (H.R. 4908) to authorize the hydrogen and fusion research, development, and demonstration programs, and the high energy physics and nuclear physics programs, of the Department of Energy, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 3433, TO PROVIDE FOR THE MANAGEMENT OF THE PRESIDIO

Mr. MOAKLEY, from the Committee on Rules, submitted a privileged report (Rept. No. 103-696) on the resolution (H. Res. 516) providing for consideration of the bill (H.R. 3433) to provide for the management of portions of the Presidio under the jurisdiction of the Secretary of the Interior, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION WAIVING POINTS OF ORDER AGAINST THE CONFERENCE REPORT ON H.R. 3355, VIOLENT CRIME CONTROL AND LAW ENFORCEMENT ACT OF 1993

Mr. MOAKLEY, from the Committee on Rules, submitted a privileged report (Rept. No. 103-697) on the resolution (H. Res. 517) waiving points of order against the conference report to accompanying the amendments of the House to the amendment of the Senate to the bill (H.R. 3355) to amend the Omnibus Crime Control and Safe Streets Act of 1968 to allow grants to increase police presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and otherwise to enhance public safety, which was referred to the House Calendar and ordered to be printed.

DO NOT SOCIALIZE HEALTH CARE

THE CONFERENCE REPORT ON THE CRIME BILL

Mr. HUNTER. Mr. Speaker, I yield to the distinguished gentleman from New York [Mr. SOLOMON], the ranking member of the Committee on Rules.

Mr. SOLOMON. Mr. Speaker, I thank the gentleman for yielding me a little time to perhaps explain that one of the reports that was just presented by the chairman of the Committee on Rules, my distinguished friend from Boston, MA, was a report that will bring the rule for the crime conference report to the floor as early as the second item on the agenda before the House tomorrow morning.

This rule, I am sorry to say, waives all points of order against everything that is in the bill including scope, which means many of the Members are very much concerned about what still remains in the bill or what has been added to the bill since it left this House and went to conference.

According to press reports from many newspapers, there have been many items added to the bill which Members are not aware of. It is a 972-page bill, and the bill Members are going to be forced to vote on—that crime conference report—by probably about noontime tomorrow, since we are limited to just 1 hour of debate on this conference report.

I am very much concerned about it. I am told that the bill as it is being presented to us tomorrow will repeal minimum mandatory sentences for people who have committed crimes with guns, yet in the same bill, it will take away the guns of law-abiding citizens. If that is the case, we need to know what is in the bill.

Mr. HUNTER. The gentleman has mentioned something that is a very critical aspect of this conference bill, that the American people, when they see it, become enraged about. During the drug wars, and the gentleman was one of the leaders fighting to get tough on drugs a couple of years ago, as was the gentleman from California [Mr. DREIER], the gentleman from Pennsylvania [Mr. WALKER], and we enacted what are known as mandatory minimum sentences on drug traffickers. That means when people came across international borders with backpacks full of cocaine for our children, we got tough on them, and we gave mandatory minimum sentences. That means you did not see these guys getting out in 2 years when they were given 10 by the judge or when there was a severe crime with respect to drugs, you did not give them 5 months or 6 months. You gave them a real sentence.

What we are doing now is repealing mandatory minimum sentences for these drug carriers, and when the President signs this thing, my estimate is 10,000 to 16,000 drug criminals are going to be released on the street.

I yield to the gentleman from California [Mr. DREIER].

Mr. DREIER. I thank my friend from San Diego for yielding.

I would like to respond to an argument that was made upstairs in the Committee on Rules, and we will continue to hear tomorrow. We have heard it, frankly, since the President first started talking about it. He said we are going to get 100,000 police officers onto the street with this crime bill. That sounds fantastic, sounds wonderful.

Well, one of the staff members from the Committee on the Judiciary told me, and the source for this was a survey that was done nationwide in metropolitan areas throughout the country, that the average cost per police officer is $65,000 a year. Now, that is for everything that is involved, not just salary. And yet this bill provides, if the funding is actually there, $14,700, and based on those figures, less than a quarter of the number that has been promised of this great 100,000 out there that police chiefs and mayors around the country have been promised will actually be provided.

It seems to me that if we look at how shallow these figures are that have been given to us, just on that one case, that we will hear time and time again tomorrow, 100,000 police officers out there, I think it is important for us to actually look at these figures.

It is a very unfortunate thing, and, as the gentleman from New York [Mr. SOLOMON], was saying, this rule waives all points of order.

Now, when we had asked the chairman of the Committee on the Judiciary when he testified before us on this conference report, which we just got about 2 hours ago provided to us, and he had not even seen it at that point, because it just recently had been printed, we asked him what kinds of points of order are being waived, and he said that he did not know, and even if he did know, he would not tell us.

Now, that seems to be a real slap in the face at our Committee on Rules, and I believe a very unfortunate precedent as we try to deal with responsible legislation.

I know my friend from East Petersburg, PA, has a sneaking suspicion of what just one of those points of order that are waived in this rule for the conference report to come up, and I think I might like him to enlighten our colleagues on that.

Mr. HUNTER. I yield to the gentleman from Pennsylvania [Mr. WALKER].

Mr. WALKER. Mr. Speaker, I was disturbed. I sat through a fairly contentious Committee on Rules meeting listening to all of this and was disturbed to hear that at the hearing held by the committee the chairman of the Committee on the Judiciary refused to detail what the points of order are that we are going to be waiving in tomorrow's bill, and so we have absolutely no idea what these points of order are that are being waived. One of them is going to be on the question of scope, and one of the things we know is out of scope is a $10 million pork-barrel project going into the District of the chairman of the Committee on the Judiciary.

We do not know what else may be down in there. I can understand why the chairman of the Committee on the Judiciary would not want to tell us some of the items that are out of scope when, in fact, one of the items is a major $10 million pork-barrel project going into his district.

If this is what this bill has been larded up with, the fact is the American people ought to have a better idea that we are going to have by tomorrow just what is in it.

I thank the gentleman for yielding. I think it is important we begin the discussion tonight about just how bad what we are going to have on the floor tomorrow may really be.

Mr. SOLOMON. If the gentleman will yield further, my good friend, the gentleman from California [Mr. DREIER], mentioned this bill will create some new police officer jobs, and they are needed.

The fact of the matter is they are temporary, and they are going to be unfunded after a period of a couple of years, and then the local municipalities are going to have to pick up the costs for those police officers.

But the point I was trying to make was that, you know, for every new police officer temporary job this bill creates, it creates two social workers. It creates a spate of new CETA program, and if all of you recall back in the 1970's how we had all of these government-run Federal programs that were a total disaster and were thrown out because they were such a disaster, you know, we do not want to go back to that.

I mentioned upstairs, why are liberals who always vote against tough crime bills for this bill, and why are conservatives who always vote for tough crime bills, why are they opposed to this bill? It is because it is a bad bill that is soft on crime and is filled with pork-barrel largesse. That is why we need to defeat this rule and bring back our bill that is really tough on crime.

I really thank the gentleman for giving us a few minutes of his time.

Mr. HUNTER. I thank the gentleman.

I know we have Border Patrol men in this bill on an amendment I offered along with the gentleman from California [Mr. MOORHEAD] and the gentleman from California [Mr. DREIER] and the gentleman from California [Mr. CUNNINGHAM], and we got a large number of Border Patrol men in the bill. That is important to us, but I will say to my friends I do not think that I can look my constituents in the eye and tell them I voted for a bill that is going to release 10,000 to 16,000 drug dealers back on the street with this retroactive repeal of mandatory minimum sentences.

I know we have just a second here. I want to yield to my friend again, the gentleman from California [Mr. DREIER].

Mr. DREIER. I think that is a very important point. We all want to deal with the problem of those who are committing crimes, crossing the border, and those coming into this country illegally. The fact of the matter is they made an attempt to engage in a political grab bag to try and get the support from virtually everyone. It is a bill that they are trying to make as all things to all people, and I know that we are not going to support it on this side, and the rule itself is a crime.

□ 2150

Mr. HUNTER. Mr. Speaker, I thank the gentleman from California [Mr. DREIER], and I am going to conclude my special order and simply hold up the list of some 50 new Government agencies that are going to be developed under this so-called free enterprise health care plan that the majority leader in the Senate will be offering, the Mitchell-Gephardt bill. We will talk more about that tomorrow.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. BEREUTER) to revise and extend their remarks and include extraneous material:)

Mr. BEREUTER, for 5 minutes, today.

Mrs. BENTLEY, for 5 minutes, today.

Mr. KOLBE, for 5 minutes, today and August 11.

Mr. KINGSTON, for 5 minutes, today.

Mr. DORNAN, for 5 minutes, today.

Mr. CUNNINGHAM, for 5 minutes, today.

(The following Members (at the request of Mr. MENENDEZ) to revise and extend their remarks and include extraneous material:)

Mr. MENENDEZ, for 5 minutes, today.

Mr. BARRETT of Wisconsin, for 5 minutes, today.

Mr. SWIFT, for 5 minutes, today.

Mr. KREIDLER, for 5 minutes, today.

Mrs. MINK of Hawaii, for 5 minutes, today.

Mr. HOAGLAND, for 5 minutes, today.

Mr. BARCA of Wisconsin, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

(The following Members (at the request of Mr. BEREUTER) and to include extraneous matter:)

Mr. BALLENGER.

Mr. GOODLING.

Mr. PACKARD.

Mr. KOLBE.

Mr. LEWIS of Florida.

Mr. SOLOMON.

Ms. SNOWE in two instances.

Mr. CRANE.

Mr. EHLERS.

Mr. LEWIS of California.

The following Members (at the request of Mr. MENENDEZ) and to include extraneous matter:)

Mr. FRANK of Massachusetts.

Mr. UNDERWOOD.

Mr. HAMILTON.

Mrs. MEEK of Florida.

Mr. COOPER.

Mrs. COLLINS of Illinois.

Mr. TORRES in two instances.

Ms. WOOLSEY.

Mr. LEHMAN in two instances.

Mr. REED.

Mr. APPLEGATE.

Mr. GEJDENSON.

Mr. KLEIN.

Mr. HALL of Texas.

Mr. TUCKER in two instances.

ENROLLED BILLS SIGNED

Mr. ROSE, from the Committee on House Administration, reported that the committee had examined and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 1631. An act to amend title 11, District of Columbia Code, to increase the maximum amount in controversy permitted for cases under the jurisdiction of the Small Claims and Conciliation Branch of the Superior Court of the District of Columbia;

H.R. 2739. An act to amend the Airport and Airway Improvement Act of 1982 to authorize appropriations for fiscal years 1994, 1995, and 1996, and for other purposes; and

H.R. 4429. An act to authorize the transfer of naval vessels to certain foreign countries.

SENATE ENROLLED JOINT RESOLUTION SIGNED

The SPEAKER announced his signature to an enrolled Joint Resolution of the Senate of the following title:

S.J. Res. 204, Joint Resolution recognizing the American Academy in Rome, an American overseas center for independent study and advanced research, on the occasion of the 100th anniversary of its founding.

ADJOURNMENT

Mr. HOYER. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 9 o'clock and 51 minutes p.m.), under its previous order, the House adjourned until tomorrow, Thursday, August 11, 1994, at 11 a.m.

EXECUTIVE COMMUNCIATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

3665. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Air Force's proposed Letter(s) of Offer and Acceptance [LOA] to Italy for defense articles and services (Transmittal No. 94-34), pursaunt to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

3666. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Navy's proposed Letter(s) of Offer and Acceptance [LOA] to Thailand for defense articles and services (Transmittal No. 94-50), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

3667. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Navy's proposed Letter(s) of Offer and Acceptance [LOA] to Japan for defense articles and services (Transmittal No. 94-38), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

3668. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Air Force's proposed Letter(s) of Offer and Acceptance [LOA] to Italy for defense articles and services (Transmittal No. 94-35), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

3669. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Air Force's proposed Letter(s) of Offer and Acceptance [LOA] to Japan for defense articles and services (Transmittal No. 94-37), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

3670. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Navy's proposed Letter(s) of Offer and Acceptance [LOA] to Japan for defense articles and services (Transmittal No. 94-39), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

3671. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Navy's proposed Letter(s) of Offer and Acceptance [LOA] to Japan for defense articles and services (Transmittal No. 94-40), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

3672. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Navy's proposed Letter(s) of Offer and Acceptance [LOA] to Japan for defense articles and services (Transmittal No. 94-41), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

3673. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Navy's proposed Letter(s) of Offer and Acceptance [LOA] to the United Kingdom for defense articles and services (Transmittal No. 94-42), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

3674. A letter from the Acting Director, Defense Security Assistance Agency, transmitting notification of the Department of the Air Force's proposed Letter(s) of Offer and Acceptance [LOA] to the Netherlands for defense articles and services (Transmittal No. 94-45), pursuant to 22 U.S.C. 2776(b); to the Committee on Foreign Affairs.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. DINGELL: Committee on Energy and Commerce. H.R. 4867. A bill to authorize appropriations for high-speed rail transportation, and for other purposes; with an amendment (Rept. 103-692). Referred to the Committee of the Whole House on the State of the Union.

Mr. DINGELL: Committee on Energy and Commerce. H.R. 4868. A bill to amend the Railroad Unemployment Insurance Act to reduce the waiting period for benefits payable under that Act, and for other purposes; with an amendment (Rept. 103-693). Referred to the Committee of the Whole House on the State of the Union.

Mr. BROOKS: Committee of Conference. Conference report on H.R. 3355. A bill to amend the Omnibus Crime Control and Safe Streets Act of 1968 to allow grants to increase police presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and otherwise to enhance public safety (Rept. 103-694). Ordered to be printed.

Mr. GORDON: Committee on Rules. House Resolution 515. Resolution providing for consideration of the bill (H.R. 4908) to authorize the hydrogen and fusion research, development, and demonstration programs, and the high energy physics and nuclear physics program, of the Department of Energy, and for other purposes (Rept. 103-695). Referred to the House Calendar.

Ms. SLAUGHTER: Committee on Rules. House Resolution 516. Resolution providing for consideration of the bill (H.R. 3433) to provide for the management of portions of the Presidio under the jurisdiction of the

Secretary of the Interior. (Rept. 103–696). Referred to the House Calendar.

Mr. DERRICK: Committee on Rules. House Resolution 517. Resolution waiving points of order against the conference report to accompany the amendments of the House to the amendment of the Senate to the bill (H.R. 3355) to amend the Omnibus Crime Control and Safe Streets Act of 1968 to allow grants to increase police presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and otherwise to enhance public safety (Rept. 103–697).

PUBLIC BILLS AND RESOLUTIONS

Under clause 5 of rule X and clause 4 of rule XXII, public bills and resolutions were introduced and severally referred as follows:

By Mr. UNDERWOOD (for himself, Mr. de Lugo, Mr. Faleomavaega, Mr. Murphy, Ms. Norton, and Mr. Romero-Barceló):

H.R. 4927. A bill to provide for a nonvoting delegate to the House of Representatives to represent the Commonwealth of the Northern Mariana Islands; to the Committee on Natural Resources.

By Mr. BALLENGER (for himself, Mr. Goodling, Mr. Fawell, and Mr. Barrett of Nebraska):

H.R. 4928. A bill to amend the Individuals with Disabilities Education Act to improve the individualized education program, to increase parental participation in the development of the improving information about the special education program, to provide for the establishment of mediation procedures relating to services provided to children under that act, and for other purposes; to the Committee on Education and Labor.

By Mr. BROWN of Ohio:

H.R. 4929. A bill to amend the Public Health Service Act to establish a program of demonstration projects to provide outreach services regarding the utilization of health benefits under Federal, State, and local programs; to the Committee on Energy and Commerce.

By Ms. SNOWE:

H.R. 4930. A bill to amend the Magnuson Fishery Conservation and Management Act to authorize the Secretary of Commerce to prepare fishery management plans and amendments to fishery management plans under negotiated rulemaking procedures; to the Committee on Merchant Marine and Fisheries.

H.R. 4931. A bill to strengthen protection of the natural resources of the Gulf of Maine through greater cooperation and coordination between Federal agencies and the Gulf of Maine Council on the Marine Environment, and for other purposes; to the Committee on Merchant Marine and Fisheries.

H.R. 4932. A bill to amend the Magnuson Fishery Conservation and Management Act to require the Secretary of Commerce to prepare conservation and management measures for the northeast multispecies—groundfish—fishery under negotiated rulemaking procedures; to the Committee on Merchant Marine and Fisheries.

By Mr. SWIFT:

H.R. 4933. A bill to amend the Solid Waste Disposal Act, and for other purposes; to the Committee on Energy and Commerce.

By Mr. ARCHER:

H.R. 4934. A bill to restore immigration to traditional levels by curtailing illegal immigration and imposing a ceiling on legal immigration; jointly, to the Committees on the Judiciary and Ways and Means.

By Mr. JOHNSTON of Florida:

H.R. 4935. A bill to provide that recipients of export promotion assistance should meet certain requirements; jointly, to the Committees on Foreign Affairs and Energy and Commerce.

By Mr. REED (for himself, Mr. Sensenbrenner, Mr. Synar, Mr. Rose, Mr. Gekas, and Mr. Zeliff):

H.R. 4936. A bill to amend title 17, United States Code, to exempt business establishments from copyright fees for the public performance of nondramatic musical works by television and radio sets, to exempt certain choral groups from paying copyright fees, to provide for court-annexed arbitration in royalty disputes involving performing rights societies, and to ensure computer access to music repertoire; to the Committee on the Judiciary.

By Mr. GUTIERREZ:

H.J. Res. 400. Joint resolution to designate October 20, 1994, as "Leyte Landing Day"; to the Committee on Post Office and Civil Service.

PRIVATE BILLS AND RESOLUTIONS

Under clause 1 of rule XXII,

Mr. SHAW introduced a bill (H.R. 4937) to authorize the Secretary of Transportation to issue a certificate of documentation with appropriate endorsement for employment in the coastwise trade for the vessel *Fifty One;* which was referred to the Committee on Merchant Marine and Fisheries.

ADDITIONAL SPONSORS

Under clause 4 of rule XXII, sponsors were added to public bills and resolutions as follows:

H.R. 24: Ms. Snowe.

H.R. 291: Mr. Paxon, Mr. McInnis, and Mr. Stearns.

H.R. 300: Mr. Manton.

H.R. 627: Mr. Klink.

H.R. 799: Mr. Packard.

H.R. 1171: Mr. Gutierrez.

H.R. 1671: Mr. Barlow.

H.R. 2292: Mr. Deutsch.

H.R. 2488: Mr. Coleman.

H.R. 2708: Mr. Dickey and Mr. Lewis of Kentucky.

H.R. 2803: Mr. Payne of Virginia, Mr. Ridge, Mr. Chapman, and Mr. Darden.

H.R. 2873: Mr. Towns, Mr. Schiff, and Mrs. Vucanovich.

H.R. 3059: Mr. Lantos.

H.R. 3271: Mrs. Maloney.

H.R. 3320: Mr. Kingston, Mr. Emerson, and Mr. Schaefer.

H.R. 3392: Ms. Snowe.

H.R. 3397: Mr. Beilenson.

H.R. 3458: Mr. Zeliff.

H.R. 3475: Mr. Hoke.

H.R. 3661: Mr. Istook.

H.R. 3739: Mrs. Byrne, Mr. Gallegly, and Mr. Bacchus of Florida.

H.R. 3762: Mr. Lipinski.

H.R. 3820: Mr. Owens.

H.R. 3885: Mr. Torkildsen, Mr. Serrano, Mr. Yates, and Mr. Gutierrez.

H.R. 3906: Mr. Stupak.

H.R. 4050: Mr. Fields of Louisiana.

H.R. 4116: Ms. Molinari, Ms. Slaughter, and Ms. Velazquez.

H.R. 4200: Mr. Brown of Ohio, Mr. Fingerhut, and Mr. Mann.

H.R. 4291: Ms. Furse, Mr. Hoekstra, Mr. Stump, and Mr. Neal of North Carolina.

H.R. 4412: Mr. Gunderson and Mr. Towns.

H.R. 4413: Mr. Watt.

H.R. 4514: Mr. Rose and Mr. Andrews of Maine.

H.R. 4557: Ms. Pryce of Ohio and Mr. Bereuter.

H.R. 4643: Mr. Hansen and Mr. McInnis.

H.R. 4737: Ms. Shepherd.

H.R. 4767: Mr. Watt.

H.R. 4803: Mr. Gilman, Mr. Andrews of New Jersey, and Mr. Pastor.

H.R. 4805: Mr. LaRocco, Mr. Johnson of South Dakota, Mr. Manzullo, Mr. Inhofe, Mr. Lightfoot, Mr. Crapo, Mr. Brown of Ohio, and Mr. Peterson of Minnesota.

H.R. 4814: Mrs. Collins of Illinois.

H.R. 4840: Mr. Calvert.

H.R. 4902: Mrs. Roukema.

H.J. Res. 369: Mrs. Kennelly, Mr. Stenholm, Mr. Lucas, Mr. Hutchinson, Mr. Smith of Michigan, Mr. Everett, Mr. Knollenberg, Mr. Crane, Mr. Whitten, Mr. Rogers, Mr. Walsh, Mr. Gonzalez, Mr. Martinez, Mr. Gilchrest, Mr. Nadler, Mr. Rahall, Mr. Sundquist, Mr. Lazio, Mr. Frank of Massachusetts, Ms. Brown of Florida, Mr. Frost, Mr. McNulty, Mr. Upton, Mr. Gutierrez, Mr. LaRocco, Mr. Quinn, Mr. Tucker, Mr. Tejeda, Mr. Kleczka, Mr. Costello, Mr. Fazio, Mr. Bacchus of Florida, Mr. Hoekstra, Mrs. Johnson of Connecticut, Mr. Jefferson, Mr. Kingston, Mr. Sanders, Mr. Greenwood, Mr. Filner, Mr. Manzullo, Mrs. Collins of Illinois, Mr. Stokes, Mr. Goodling, Mr. Houghton, Mr. Baker of California, Mr. Ortiz, Mr. de la Garza, Mr. Mfume, Mr. Evans, and Mr. Sabo.

H.J. Res. 381: Mr. Parker, Mr. Meehan, Mr. Emerson, Mr. Dellums, Mr. Thompson, Mr. Calvert, Mr. Romero-Barceló, Mr. LaFalce, Mr. Johnson of South Dakota, Mr. Kasich, and Mr. Hilliard.

H.J. Res. 385: Mrs. Maloney, Mr. Shays, Mr. Studds, and Mr. Owens.

H. Con. Res. 69: Mr. Spratt and Mr. Dellums.

H. Con. Res. 148: Mr. Packard.

H. Res. 425: Mr. Goss, Mr. McCollum, Mr. Dornan, Mr. Bateman, Mr. Hastert, Mr. Solomon, Mr. Shays, Mr. Livingston, Mr. Royce, Mr. Schiff, and Mr. Fish.

H. Res. 432: Mr. Fingerhut, Mr. Rush, and Mr. Andrews of Texas.

H. Res. 463: Mr. Hilliard.

H. Res. 472: Mr. Linder, Mr. Hoke, Mr. Coble, and Mr. Kim.

H. Res. 497: Mr. Owens, Mrs. Roukema, Mr. Engel, Ms. Pelosi, Mr. Lazio, Mr. LaFalce, Mr. Frost, Mr. Frank of Massachusetts, Mr. Evans, Mr. Greenwood, Mr. McNulty, Mr. Underwood, Mr. Deutsch, and Mr. Shays.

AMENDMENTS TO H.R. 3600

Amendment to H.R. 3600, as Reported Offered by Mr. Gekas of Pennsylvania

Strike all after the enacting clause and insert the following:

SECTION. 1. ESTABLISHMENT OF COMMISSION.

(a) Establishment.—There is established an independent commission to be known as the Bipartisan Health Care Reform Commission (in this Act referred to as the "Commission").

(b) Appointment.—The Commission shall consist of 3 members appointed by the President, 2 members appointed by the Majority Leader of the Senate, 1 by the Minority Leader of the Senate, 2 members appointed by the Speaker of the House of Representatives, and 1 member by the Minority Leader of the House of Representatives. Members shall be appointed on the basis of their expertise and national recognition in the fields of health economics, provider reimbursement, health insurance, health benefits design, and related fields. In selecting members of the Commission, the President shall consult with the Congress.

(c) TERM.—Members of the Commission shall be appointed for the life of the Commission.

(d) VACANCY.—A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

SEC. 2. RESPONSIBILITIES.

(a) ANALYSES.—The Commission shall—

(1) conduct an analysis of the health care system reforms proposed or enacted by the States,

(2) conduct an analysis of the problems and potential solutions to the Federal health care programs, including the programs under titles XVII (medicare) and XIX (medicaid), and the Veterans health programs, and

(3) make recommendations on additional reforms that the Congress may want to consider in response to the findings of the analyses.

(b) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Commission shall submit a report to the Congress on the state of health care in the United States. Such report shall include analyses of the following issues:

(1) The rate of growth in health care costs by type of provider, by type of payer, and by State.

(2) The success or failure of the private and public sectors in keeping their costs within the Gross Domestic Product Deflator (an inflation indicator).

(3) The utility of various mechanisms to empower purchasers of health care with information about comparative cost, quality, and access, including the effect of such information on patient's behavior in the medical marketplace.

(4) The success or failure of different types of group health plans, such as medical savings account/catastrophic insurance plans, managed care plans, voluntary cooperative plans, and traditional indemnity plans in cost, quality, and access.

(5) The success or failure of various Medicaid reform proposals, including privatization through managed care, voucherization, and government cost controls.

SEC. 3. CONSIDERATION OF RECOMMENDATIONS.

(a) IN GENERAL.—If the recommendations of the Commission under section 2 are accompanied by a statement provided by the Director of the Congressional Budget Office that the recommendations would not increase the deficit, the recommendations shall be considered in accordance with this section.

(b) PROCEDURE.—The following procedure shall apply to recommendations:

"(1) REFERRAL AND INTRODUCTION.—The recommendations shall be referred to the committees with jurisdiction over the matters in the recommendations and the chairmen of such committees shall introduce a bill, within 20 days of the receipt of such recommendations, which carries out such recommendations.

(2) COMMITTEE CONSIDERATION.—If any committee to which a bill introduced under paragraph (1) is referred has not reported the bill at the close of the 45th day since its introduction, such committee shall be automatically discharged from further consideration of the bill and it shall be place on the appropriate calendar.

(3) OPEN RULE.—The Committee on Rules shall provide an open rule for consideration of a bill introduced under paragraph (1). If such a bill differs from the recommendation of the Commission, the Committee on Rules shall provide that the recommendation of the Commission shall be considered as an amendment in the nature of a substitute for such bill. Debate shall not be limited.

(4) SENATE CONSIDERATION.—If a bill introduced under paragraph (1) is a revenue raising bill, the Senate shall be given an additional 15 days following passage by the House for consideration in Committee and an additional 15 days for consideration by the Senate.

Amendment to H.R. 3600

Offered by Mr. Gephardt of Missouri

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUBTITLES.

(a) SHORT TITLE.—This Act may be cited as the "Guaranteed Health Insurance Act of 1994".

(b) TABLE OF TITLES AND SUBTITLES IN ACT.—The following are the titles and subtitles contained in this Act:

TITLE I—UNIVERSAL COVERAGE AND SHARED RESPONSIBILITIES

Subtitle A—Universal Coverage and Individual Responsibilities
Subtitle B—Employer Responsibilities

TITLE II—INDIVIDUAL AND EMPLOYER RESPONSIBILITIES

Subtitle A—Individual Responsibilities
Subtitle B—Employer Responsibilities

TITLE III—BENEFITS

Subtitle A—Guaranteed National Benefit Package
Subtitle B—Coverage of Outpatient Prescription Drugs and Other Changes in Medicare Benefits

TITLE IV—STATE PROGRAMS

Subtitle A—State Single-Payer Systems
Subtitle B—State Managed Competition Programs
Subtitle C—State Provider Reimbursement Systems
Subtitle D—General Rules, Coordination, and Transition

TITLE V—HEALTH PLANS AND COOPERATIVES

Subtitle A—Standards for Carriers and Insured Health Benefit Plans
Subtitle B—Standards for Sponsors and Self-Insured Health Benefit Plans
Subtitle C—Standards for Supplemental Health Plans
Subtitle D—Universal FEHBP
Subtitle E—Consumer Purchasing Cooperatives
Subtitle F—General Provisions
Subtitle G—Transitional Insurance Reforms

TITLE VI—STANDBY COST CONTAINMENT IN THE PRIVATE SECTOR

Subtitle A—National Health Expenditure Estimates
Subtitle B—State Health Expenditure Estimates
Subtitle C—Stand-By Federal Cost Containment
Subtitle D—Maximum Payment Rates
Subtitle E—Administrative and Judicial Review
Subtitle F—National Health Cost Commission

TITLE VII—PUBLIC HEALTH INITIATIVES

Subtitle A—Health Workforce Priorities
Subtitle B—Certain Direct Spending Programs of Public Health Service
Subtitle C—Assistance for Capital Costs of Safety-Net Hospitals
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Subtitle E—Mental Health
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Subtitle H—Occupational Safety and Health
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TITLE VIII—MEDICARE AND MEDICAID

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Subtitle B—Benefits for Low-Income Individuals; State Maintenance of Effort
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Subtitle D—Revisions to Medicare Part A and Part B
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Subtitle F—Provisions Relating to the Medicaid Program
Subtitle G—Miscellaneous and Technical Medicaid Amendments
Subtitle H—Provision Relating to AFDC Program

TITLE IX—QUALITY AND CONSUMER AND WORKFORCE PROTECTION

Subtitle A—Quality Management and Improvement
Subtitle B—Information Systems and Administrative Simplification
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Subtitle G—Workforce Protection and Training

TITLE X—LONG-TERM CARE

Subtitle A—Long-Term Care Program
Subtitle B—Federal Standards for Private Long-Term Care Insurance Policies
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TITLE XI—REVENUE PROVISIONS

Subtitle A—Increase in Excise Taxes on Tobacco Products
Subtitle B—Treatment of Employer-Provided Health Care
Subtitle C—Extending Medicare Coverage of, and Application of Hospital Insurance Tax to, All State and Local Government Employees
Subtitle D—Treatment of Organizations Providing Health Care Services and Related Organizations
Subtitle E—Treatment of Accelerated Death Benefits Under Life Insurance Contracts
Subtitle F—Employment Status Provisions
Subtitle G—Tax Treatment of Funding of Retiree Health Benefits
Subtitle H—Excise Taxes on Insured and Self-Insured Health Plans
Subtitle I—Other Provisions

TITLE XII—AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

TITLE XIII—COORDINATION OF MEDICAL PORTION WORKERS' COMPENSATION AND AUTOMOBILE INSURANCE

Subtitle A—Workers' Compensation Insurance
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TITLE XIV—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
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TITLE XV—DEPARTMENT OF VETERANS AFFAIRS
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SEC. 2. GENERAL DEFINITIONS.

For purposes of this Act, except as otherwise specifically provided:

(1) AFDC RECIPIENT.—The term "AFDC recipient" means, for a month, an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act for the month.

(2) CERTIFIED HEALTH PLAN.—

(A) IN GENERAL.—The term "certified health plan" means a health plan that is certified (or deemed to be certified) as meeting the requirements of subtitle A or B of title V, and, except as otherwise provided, does not include the medicare program or medicare part C.

(B) TREATMENT OF CERTAIN PLANS.—Each of the following is deemed to have been certified as meeting the requirements described in subparagraph (A):

(i) The Civilian Health and Medical Program of the Uniformed Services (as defined in section 1072(4) of title 10, United States Code).

(ii) Any State single-payer system approved under subtitle A of title IV.

(C) CERTIFICATION PROCESS FOR CERTAIN FEDERAL HEALTH PLANS.—For provisions providing for certification of—

(i) health programs of the Indian Health Service (within the meaning of section 901 of the Indian Health Care Improvement Act), see section 5501(b), and

(ii) health plans of the Department of Veterans Affairs, see section 5501(c).

(3) CLASS OF ENROLLMENT.—The term "class of enrollment" means a class for enrollment of families specified in section 3(b).

(4) ELIGIBLE INDIVIDUAL.—The term "eligible individual" has the meaning given such term in section 1001(c).

(5) GUARANTEED NATIONAL BENEFIT PACKAGE.—The term "guaranteed national benefit package" means the package of health benefits described in subtitle A of title III.

(6) MEDICAID PROGRAM.—The term "medicaid program" means a State plan for medical assistance approved under title XIX of the Social Security Act.

(7) MEDICARE PART A BENEFICIARY.—The term "medicare part A beneficiary" means an individual who is entitled to benefits under part A of the medicare program.

(8) MEDICARE PART C.—The term "medicare part C" means the program of health insurance benefits under part A of title XXI of the Social Security Act (as added by section 8001).

(9) MEDICARE PROGRAM.—The term "medicare program" means the programs under title XVIII of the Social Security Act.

(10) SSI RECIPIENT.—The term "SSI recipient" means, for a month, an individual—

(A) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

(B) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93-66 for the month,

(C) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month, or

(D) who is treated under section 1619(b) of the Social Security Act as receiving supplemental security income benefits in a month for purposes of title XIX of such Act.

(11) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(12) STATE.—The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(13) UNITED STATES.—The term "United States" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and Northern Mariana Islands.

SEC. 3. DEFINITIONS AND RULES RELATING TO FAMILY MEMBERS.

(a) FAMILY DEFINED.—In this Act, unless otherwise provided, the term "family"—

(1) means, with respect to an eligible individual who is not a young dependent, the individual; and

(2) includes the following persons (if any):

(A) The individual's spouse if the spouse is an eligible individual.

(B) The individual's young dependents (and, if applicable, the young dependents of the individual's spouse) if they are eligible individuals.

In this section, the term "young dependent" has the meaning given such term in section 1003(b)(1)(B).

(b) CLASSES OF ENROLLMENT; TERMINOLOGY.—In this Act:

(1) IN GENERAL.—Each of the following is a separate class of enrollment:

(A) Coverage only of an individual (referred to in this Act as the "individual" enrollment or class of enrollment).

(B) Coverage of an unmarried individual and one or more children (referred to in this Act as the "single parent" enrollment or class of enrollment).

(C) Coverage of a married couple and one or more children (referred to in this Act as the "family" enrollment or class of enrollment).

(2) COUPLES ENROLLED IN DIFFERENT PLANS.—In the case of a couple—

(A) without young dependents in which each spouse is enrolled in a different health plan, each spouse is considered to be enrolled in an individual class of enrollment, and

(B) with young dependents in which a spouse is enrolled in one plan and the other spouse and young dependents are enrolled in another plan, the former spouse is considered to be enrolled in an individual class of enrollment and the latter spouse and young dependents are considered to be enrolled in a single parent class of enrollment.

(c) SPOUSE; MARRIED; COUPLE.—In this Act:

(1) IN GENERAL.—The terms "spouse" and "married" mean, with respect to a person, another individual who is the spouse of the person or married to the person, as determined under applicable State law.

(2) COUPLE.—The term "couple" means an individual and the individual's spouse.

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SEC. 1000. PROTECTION OF CONSUMER CHOICE.

Nothing in this Act shall be construed as prohibiting the following:

(1) An individual from choosing the individual's own health provider.

(2) An individual from purchasing any health care services.

(3) An individual from purchasing supplemental insurance (offered consistent with this Act) to cover health care services not covered under the guaranteed national benefit package.

(4) Employers from providing coverage (consistent with this Act) for benefits in addition to the guaranteed national benefit package.

(5) Employers from making contributions (consistent with this Act) toward employee premiums in excess of any contributions required under this Act.

Subtitle A—Universal Coverage and Individual Responsibilities

SEC. 1001. UNIVERSAL HEALTH COVERAGE.

(a) COVERAGE.—In accordance with this Act, each eligible individual is entitled to the benefits covered under the guaranteed national benefit package under title III.

(b) REQUIREMENT.—In accordance with this Act and the applicable provisions of the Internal Revenue Code of 1986, individuals are required to obtain health insurance coverage for themselves and their family members.

(c) ELIGIBLE INDIVIDUAL DEFINED.—In this Act, the term "eligible individual" means an individual who is—

(1) a citizen or national of the United States;

(2) an alien permanently residing in the United States under color of law (as defined in section 1005(b)(1)); or

(3) a long-term nonimmigrant (as defined in section 1005(b)(2)).

Such term does not include an undocumented alien or a prisoner.

(c) GENERAL EFFECTIVE DATE.—This section takes effect on January 1, 1999.

(d) ISSUANCE OF HEALTH SECURITY CARDS.—Each eligible individual is entitled to be issued a health security card by the certified health plan (or under the medicare program or medicare part C) in which the individual is enrolled.

SEC. 1002. SATISFACTION OF RESPONSIBILITY THROUGH ENROLLMENT IN CERTIFIED HEALTH PLANS, MEDICARE PART C, AND MEDICARE.

(a) COVERAGE UNDER CERTIFIED HEALTH PLAN.—An individual meets the requirement of section 1001(b) for a month only through coverage—

(1) under a certified health plan (as defined in section 2), or

(2) under medicare part C (if the individual is eligible to enroll under medicare part C).

(b) COVERAGE UNDER MEDICARE PROGRAM.—An individual is considered to have met the requirement of section 1001(b) if the individual is a part A medicare beneficiary, and the provision of benefits under the medicare program is deemed to constitute the entitlement described in section 1001(a).

SEC. 1003. SPECIAL RULES FOR COVERED INDIVIDUALS WHO ARE NOT REQUIRED TO CONTRIBUTE.

(a) IN GENERAL.—In the case of an individual who is a covered, noncontributing individual (as defined in subsection (b)) with respect to all months in a taxable year, the individual shall not be required under section 1001(b) to make any contribution toward obtaining health insurance coverage with respect to the taxable year.

(b) COVERED, NONCONTRIBUTING INDIVIDUAL DEFINED.—In subsection (a), the term "covered, noncontributing individual", with respect to a taxable year, means either of the following individuals:

(1) YOUNG DEPENDENTS.—

(A) IN GENERAL.—An individual who is a young dependent of any taxpayer for a taxable year of such taxpayer which begins in the calendar year in which such taxable year begins.

(B) YOUNG DEPENDENT.—For purposes of this section, the term "young dependent" means, with respect to periods in any calendar year, any individual if—

(i) an exemption is allowable under section 151(c) of the Internal Revenue Code of 1986 with respect to such individual to the taxpayer for a taxable year beginning in such calendar year, and

(ii) such individual—

(I) has not attained the age of 19 as of the close of such calendar year, or

(II) is a student (as defined in section 151(c)(4) of such Code) who has not attained age 24 as of the close of such calendar year.

(2) CERTAIN CASH RECIPIENTS.—

(A) IN GENERAL.—An individual who for each month in the taxable year is—

(i) an AFDC recipient (as defined in section 2), or

(ii) an SSI recipient (as defined in such section).

(B) LIMITATION FOR SSI RECIPIENTS.—Subparagraph (A)(ii) shall not apply to an individual filing a joint return unless both spouses are SSI recipients.

(c) REFERENCE TO LOW-INCOME INDIVIDUALS WHO ARE COVERED AND NOT REQUIRED TO FULLY CONTRIBUTE.—

(1) LOW-INCOME INDIVIDUALS WITH BELOW-THRESHOLD INCOME NOT REQUIRED TO CONTRIBUTE.—For exemption from requirement to contribute toward health insurance coverage for low-income individuals, see paragraph (1) of section 59B(b) of the Internal Revenue Code of 1986 or section 2122(c)(1) of the Social Security Act.

(2) REDUCED CONTRIBUTION FOR OTHER LOW-INCOME INDIVIDUALS.—For reduction in contribution requirement toward health insurance coverage for other low-income individuals, see paragraph (2) of section 59B(b) of the Internal Revenue Code of 1986 or section 2122(c)(2) of the Social Security Act.

SEC. 1004. SPECIAL RULES FOR INDIVIDUALS NEITHER COVERED NOR REQUIRED TO CONTRIBUTE.

(a) IN GENERAL.—In the case of an individual who is a noncovered, noncontributing individual (as defined in subsection (b)) with respect to a month in a taxable year, the individual is deemed to have waived entitlement to benefits under section 1001(a) and is not required to make a contribution toward health insurance coverage.

(b) NONCOVERED, NONCONTRIBUTING INDIVIDUAL DEFINED.—In subsection (a), the term "noncovered, noncontributing individual", with respect to a month, means any of the following individuals:

(1) RELIGIOUS EXEMPTION.—An individual if, as of the first day of such month, there is in

effect for such individual, a qualified religious exemption (as defined in subsection (c)(1)).

(2) DISABLED VETERANS.—An individual if, as of the first day of such month, there is in effect for the individual, a qualified disabled veteran exemption (as defined in subsection (c)(2)).

(3) ACTIVE DUTY MILITARY.—An individual if as of the first day of such month, the individual is on active duty as a member of the uniformed services (as defined in section 101 of title 10, United States Code).

(4) PRISONERS.—An individual if as of the first day of such month, the individual is imprisoned under Federal, State, or local authority after conviction.

(c) RELIGIOUS AND VETERANS EXEMPTIONS DESCRIBED.—For purposes of subsection (b)—

(1) QUALIFIED RELIGIOUS EXEMPTION.—

(A) IN GENERAL.—The term "qualified religious exemption" means an exemption granted by the Secretary to an individual—

(i) who is a member of a recognized religious sect or division thereof with respect to which such Secretary makes the findings referred to in subparagraphs (C), (D), and (E) of section 1402(g)(1) of the Internal Revenue Code of 1986,

(ii) who is an adherent of established tenets or teachings of such sect or division as described in such section, and

(iii) who submits an application for such exemption which contains or is accompanied by the evidence described in section 1402(g)(1)(A) of such Code and a waiver described in section 1402(g)(1)(B) of such Code.

For purposes of the clause (iii), section 1402(g)(1)(B) of such Code shall be treated as including a reference to medicare part C.

(B) LIMITATION.—An exemption granted under this paragraph shall cease to apply beginning on the date such Secretary determines that the individual, or the sect or division, ceased to meet the requirements of subparagraph (A).

(2) QUALIFIED DISABLED VETERAN EXEMPTION.—

(A) IN GENERAL.—The term "qualified disabled veteran exemption" means an exemption granted by the Secretary to an eligible person (within the meaning of section 1710(a)(1) of title 38, United States Code) who waives all benefits and payments under all certified health plans of any employer and under medicare part C with respect to the guaranteed national benefit package described in title III.

(B) MINIMUM PERIOD OF EXEMPTION.—Such an exemption may not be granted for a period of less than 1 year and shall not take effect earlier than the month beginning after the month in which the eligible person requests such waiver.

(C) TERMINATION BY INDIVIDUAL.—Such an exemption may be terminated by the eligible person. Such a termination shall not take effect earlier than the month beginning after the month in which notice of such termination is sent to the Secretary. No subsequent exemption under this paragraph may be granted to such person until one year after the date such termination took effect.

SEC. 1005. MISCELLANEOUS DEFINITIONS AND RELATED PROVISIONS.

(a) RELATED DEFINITIONS.—In this subtitle—

(1) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term "alien permanently residing in the United States under color of law" means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

(A) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(B) An alien who is granted asylum under section 208 of such Act.

(C) An alien whose deportation is withheld under section 243(h) of such Act.

(D) An alien whose deportation is suspended under section 244 of such Act.

(E) An alien who is granted conditional entry pursuant to section 203(a)(7) of such Act, as in effect before April 1, 1980.

(F) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(G) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group, temporary protected status, or deferred enforced departure.

(H) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(I) An alien eligible for work authorization granted by the Immigration and Naturalization Service (other than as a nonimmigrant).

(J) An alien within such other classification of permanent resident aliens as the Secretary may establish by regulation. Such regulation shall include categories of such aliens who are included in regulations as in effect on the date of the enactment of this Act under title XIX of the Social Security Act.

(2) LONG-TERM NONIMMIGRANT.—The term "long-term nonimmigrant" means a nonimmigrant described in subparagraph (E), (H), (I), (K), (L), (N), (O), (P), (Q), or (R) of section 101(a)(15) of the Immigration and Nationality Act.

(3) PRISONER.—The term "prisoner" means, as specified by the Secretary, an individual during a period of imprisonment under Federal, State, or local authority after conviction.

(b) ADDITIONAL RECOMMENDATIONS AND RULES REGARDING ALIENS; RECOMMENDATIONS REGARDING CITIZENS RESIDING OUTSIDE THE UNITED STATES.—

(1) RECOMMENDATIONS CONCERNING ALIENS.—The Secretary, in consultation with the Attorney General, shall make recommendations to Congress with respect to classes of eligibility for aliens and modifications of rules concerning eligibility and coverage for aliens.

(2) RULES.—In making the recommendations under paragraph (1), the Secretary shall consider—

(A) appropriate treatment of diplomatic personnel and employees of international organizations,

(B) appropriate rules for minors who are not dependents of eligible individuals, and

(C) appropriate rules for the treatment of spouses who are dependents of ineligible individuals.

(3) RECIPROCAL TREATMENT OF OTHER NONIMMIGRANTS.—With respect to those classes of individuals who are lawful nonimmigrants but who are not long-term nonimmigrants (as defined in section (b)(2)), the Secretary, in consultation with the Attorney General, shall submit to Congress such recommendations relating to reciprocal agreements between the United States and foreign states with respect to coverage of some or all classes of such nonimmigrants as may be appropriate.

(4) RECOMMENDATIONS CONCERNING UNITED STATES CITIZENS RESIDING OUTSIDE THE UNITED STATES.—The Secretary shall make recommendations to Congress with respect to coverage of United States citizens residing outside the United States.

Subtitle B—Employer Responsibilities

PART 1—EMPLOYER COVERAGE RESPONSIBILITIES

SEC. 1101. EMPLOYER RESPONSIBILITIES.

(a) IN GENERAL.—In accordance with this Act and the applicable provisions of the Internal Revenue Code of 1986, employers are required to provide or contribute to health insurance coverage of employees and their family members.

(b) APPLICATION OF RULES.—In carrying out such requirement, the provisions in the following sections of this part apply.

(c) GENERAL EXEMPTION.—Subsection (a) shall not apply with respect to a generally excludable employee (as defined in section 1105(b)).

(d) EFFECTIVE DATE.—This section takes effect on January 1, 1997, with respect to large employers and January 1, 1999, with respect to other employers.

SEC. 1102. SATISFACTION OF RESPONSIBILITY BY LARGE EMPLOYERS THROUGH ENROLLMENT IN CERTIFIED HEALTH PLANS.

(a) REQUIREMENT.—

(1) IN GENERAL.—Subject to paragraph (2), in order for a large employer to meet the requirements of section 1101(a) with respect to an employee for a month, the employee must be a qualified employer-covered employee (as defined in section 1104).

(2) TREATMENT OF PART-TIME, SEASONAL, OR TEMPORARY EMPLOYEES.—In the case of an exempt part-time, seasonal, or temporary employee (as defined in subsection (c)), in order for a large employer to meet the requirements of section 1101(a) with respect to such an employee for a month, either—

(A) the employee must be a qualified employer-covered employee (as defined in section 1104), or

(B) the employer must contribute to medicare part C.

(b) EXCEPTION FOR VOLUNTARILY EXCLUDED EMPLOYEES WHO MAY ELECT TO DECLINE COVERAGE.—

(1) IN GENERAL.—Subsection (a) shall not apply with respect to a voluntarily excluded employee (as defined in paragraph (2)), if the employee was offered coverage in accordance with section 1104(c)).

(2) VOLUNTARILY EXCLUDED EMPLOYEE.—For purposes of paragraph (1), subject to paragraph (3), the term "voluntarily excluded employee" means, with respect to a month, any of the following employees:

(A) OTHER HEALTH COVERAGE.—

(i) IN GENERAL.—Any employee if there is in effect as of the first day of such month a withholding exemption certificate stating that such employee is covered under medicare part A or a certified health plan other than a plan of such employer.

(ii) SPECIAL RULE FOR INDIVIDUALS COVERED UNDER INDIAN HEALTH SERVICE OR VETERANS PLAN.—Clause (i) shall not apply to an employee by reason of coverage under a plan described in clause (iii) unless the employer makes a contribution toward such coverage in the amount described in section 1104(d)(2).

(iii) PLANS DESCRIBED.—A plan described in this clause is—

(I) a health plan of the Indian Health Service, or

(II) an HSA-certified VA health plan (as defined in section 1801 of title 38, United States Code) in the case of an employee who is a veteran (within the meaning of section 101 of such title) or a family member of a veteran.

(B) INDIVIDUALS ELECTING MEDICARE PART C.—Any employee if there is in effect as of the first day of such month a withholding exemption certificate stating that such employee—

(i) is an eligible individual who is an AFDC or SSI recipient, and

(ii) waives coverage under all certified health plans of the employer for such month.

(C) WAIVER DURING TRANSITION PERIOD.—In the case of a month before January 1999, any employee who waives coverage under all certified health plans of the employer for such month.

(3) SPECIAL RULE IN CASE OF ENROLLMENT OF EMPLOYEES OF LARGE EMPLOYERS IN COMMUNITY-RATED PLANS.—

(A) IN GENERAL.—In the case of an employee of a large employer who is enrolled in a certified health plan other than an exempt plan described in subparagraph (B), the employee is deemed to be covered under the certified health plan of the large employer and such plan shall make payment, in relation to other certified health plans, in the same manner as a group health plan is a primary plan (as described in section 1862(b)(2)(A)) in relation to the medicare program.

(B) EXEMPT PLAN.—An exempt plan described in this subparagraph with respect to an employee is—

(i) a certified health plan offered by another employer of the employee,

(ii) a certified health plan offered by an employer of the employee's spouse, or

(iii) a certified health plan offered by an employer of another person with respect to whom the employee is a young dependent.

(c) EXEMPT PART-TIME, SEASONAL, OR TEMPORARY EMPLOYEES.—For purposes of this part, the term "exempt part-time, seasonal, or temporary employee" means, with respect to a month, any of the following employees:

(1) CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal work week is reasonably expected as of the first day of such month to be less than 25 hours.

(2) SEASONAL OR TEMPORARY EMPLOYEES.—Any employee who is not reasonably expected as of the first day of such month to be employed by the employer for a period of 120 consecutive days during any 365-day period that includes such first day.

(3) DELAY FOR CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal work week is reasonably expected as of the first day of such month to be at least 25 hours, but less than 35 hours, and the normal work week of the employee during the preceding 3 months was less than 25 hours.

SEC. 1103. SATISFACTION OF RESPONSIBILITY FOR SMALL EMPLOYERS THROUGH CERTIFIED HEALTH PLANS OR MEDICARE PART C.

(a) IN GENERAL.—In order for a small employer to meet the requirements of section 1101(a) with respect to an employee for a month, the employee must be—

(1) a qualified employer-covered employee (as defined in section 1104) or an employee described in subsection (b)(2)(B), or

(2) covered under medicare part C.

(b) LIMITATION ON EMPLOYER CHOICE.—

(1) IN GENERAL.—Subject to paragraph (2), a small employer is not considered to have met the requirements of section 1101(a) by reason of subsection (a)(1) of this section unless all employees of such employer are qualified employer-covered employees.

(2) EXCEPTIONS.—A small employer is not required under paragraph (1) to provide coverage (under a certified health plan as a qualified employer-covered employee) of any employee who is—

(A) a medicare part C eligible individual described in paragraph (4) or (5) of section 2101(b) of the Social Security Act,

(B) a voluntarily excluded employee (as defined in section 1102(b)) described in section 1102(b)(2)(A) if the employee was offered such coverage in accordance with section 1104(c), or

(C) an exempt part-time, seasonal, or temporary employee (as defined in section 1102(c)).

For purposes of subparagraph (B), section 1102(b)(2)(A) shall be applied by treating clause (iii) thereof as including a reference to a certified health plan offered through Universal FEHBP.

SEC. 1104. QUALIFIED EMPLOYER-COVERED EMPLOYEE DEFINED.

(a) IN GENERAL.—In this part, the term "qualified employer-covered employee" means any employee if (and only if)—

(1) such employee is covered under a certified health plan of the employee's employer,

(2) such employee's coverage under such plan is in accordance with subsection (b),

(3) such employee was offered such coverage in accordance with subsection (c), and

(4) the employer makes a contribution for such coverage in accordance with subsection (d).

(b) COVERAGE REQUIREMENTS.—

(1) IN GENERAL.—An employee's coverage under a certified health plan is in accordance with this subsection if—

(A) such plan (which may be a high deductible plan, as defined in subsection (d)(2)(E)) was selected by the employee from plans offered consistent with subsection (c),

(B) family members of the employee are covered under such plan if such family coverage is elected in accordance with such subsection, and

(C) such coverage does not terminate by reason of termination of employment until the end of the month in which such termination occurs.

(2) COVERAGE DEFINED.—For purposes of this subsection, an individual is considered to be covered with respect to a plan at such time as the plan bears a legal responsibility for provision of (or payment for) services for which benefits are included under the plan.

(c) OFFERING REQUIRED.—

(1) IN GENERAL.—Coverage is offered in accordance with this subsection with respect to an employee only if the employee is offered coverage under a choice of certified health plans, including at least—

(A) 1 managed care plan (as defined in section 5504(7)), if available to the employer with respect to the employee, and

(B) 1 unlimited-choice-of-provider plan (as defined in section 5504(17)), which may be a point-of-service plan (as defined in section 5504(10)).

(2) OFFERING FAMILY COVERAGE.—

(A) IN GENERAL.—Coverage is offered in accordance with this subsection with respect to an employee only if coverage also is offered for family members under the plan in which the employee obtains coverage.

(B) FAMILY MEMBERS DEFINED.—For purposes of this section, the term "family member" means, with respect to an employee—

(i) the employee's spouse, if the spouse is an eligible individual, and

(ii) any young dependent of the employee, if the dependent is an eligible individual.

(3) TERMS OF OFFERING.—An employer shall not be treated as offering coverage in accordance with this subsection unless the following requirements are met:

(A) ANNUAL OPEN ENROLLMENT PERIODS.—The employer has an annual open enrollment period of at least 45 days during which employees may change the plan under which they are provided coverage.

(B) CHANGES IN ENROLLMENT DURING 1ST YEAR OF EMPLOYMENT.—Once during the 1st year of employment with an employer, each employee may change the plan under which the employee is provided coverage. Such a change shall be effective on the first day of the first month beginning at least 45 days after the date the employer receives a notice of change of coverage.

(C) CHANGES IN FAMILY STATUS.—The offer of family coverage under paragraph (2) is made (in accordance with regulations prescribed by the Secretary) at such times and in such manner as may be necessary to take into account changes in family status and changes in employment of family members.

(4) TREATMENT OF COOPERATIVES, UNIVERSAL FEHBP, AND STATE SINGLE-PAYER SYSTEMS.—An employer is deemed to meet the requirement of the paragraph (1) with respect to an employee if—

(A) in the case of a small employer, the employer makes available a choice of certified health plans through a consumer purchasing cooperative or through Universal FEHBP; or

(B) the employee resides in a State which has a State single-payer system approved under subtitle A of title IV and the employer meets the requirements applicable to the employer under such system.

(d) REQUIRED CONTRIBUTION.—

(1) IN GENERAL.—An employer makes a contribution for coverage under a certified health plan in accordance with this subsection with respect to an employee only if—

(A) the employer pays the employer contribution amount specified in paragraph (2) for an employee (and family members) covered under a certified health plan under subsection (b), and

(B) the portion of the premium for coverage not paid by the employer, net of the value of any premium certificates provided under part A of title XXII of the Social Security Act or other premium subsidies provided with respect to the employee, is withheld from wages paid the employee.

(2) EMPLOYER CONTRIBUTION AMOUNT.—

(A) FULL-TIME EMPLOYEES.—For purposes of paragraph (1)—

(i) COVERED UNDER MANAGED CARE PLANS.—In the case of an employee who is covered under a managed care plan (as defined in section 5504(7)), the employer contribution amount specified in this paragraph is equal to at least 80 percent of the premium for the qualified managed care plan offered under subsection (c) to the employee that has the lowest premium for the class of enrollment involved.

(ii) COVERED UNDER UNLIMITED-CHOICE-OF-PROVIDER PLAN.—In the case of an employee who is covered under an unlimited-choice-of-provider plan (other than a high deductible plan) the employer contribution amount specified in this paragraph is equal to at least 80 percent of the premium for the qualified unlimited-choice-of-provider plan offered under subsection (b) to the employee that has the lowest premium for the class of enrollment involved and that is not a high deductible plan.

(iii) COVERED UNDER HIGH DEDUCTIBLE PLAN.—In the case of an employee who is covered by a certified health plan that is a high deductible plan, the employer contribution amount specified in this paragraph is the same percent of the premium for such coverage as the percent that would apply under clause (ii) if the employee were covered under an unlimited-choice-of-provider plan that is not a high deductible plan.

(B) REDUCTION FOR PART-TIME EMPLOYEES.—

(i) IN GENERAL.—In the case of a part-time employee (as defined in section 1106(a)), the amount specified in this paragraph is an amount that is not less than the part-time fraction (as defined in such section) of the amount otherwise provided under subparagraph (A).

(ii) EMPLOYER ELECTION TO INCREASE SHARE.—An employer may elect to specify, with respect to any part-time employee for any month, an part-time fraction which is greater than the part-time fraction which would (but for this clause) apply to such employee for such month but not greater than 1. Any fraction so specified shall apply to the employee for the month for which made and all succeeding months beginning before the date it is revoked by the employer.

(C) CONTRIBUTION TO MEDICAL SAVINGS ACCOUNT REQUIRED IF COVERAGE UNDER HIGH DEDUCTIBLE MEDICAL SAVINGS ACCOUNT PLAN.—

(i) IN GENERAL.—An employer shall not be treated as making a contribution for coverage under a certified health plan in accordance with this subsection in the case of an employee covered under a high deductible plan offered by the employer, unless the employer also makes a contribution in the amount of the medical savings contribution amount specified in clause (ii) into a medical savings account (as defined in section 7705(a) of the Internal Revenue Code of 1986) on behalf of the employee. Such a contribution shall be made not later than the date of the premium payment to which it relates.

(ii) MSA CONTRIBUTION AMOUNT.—For purposes of clause (i), the term "medical savings contribution amount" means, for an employee covered under a high deductible plan, an amount equal to the excess of—

(I) the employer contribution amount that would apply under this paragraph if the employee were covered under an unlimited-choice-of-provider plan that was not a high deductible plan, over

(II) the employer contribution amount made for coverage under the high deductible plan.

(D) TREATMENT OF PLANS OFFERED THROUGH A COOPERATIVE OR UNIVERSAL FEHBP.—With respect to certified health plans offered through a consumer purchasing cooperative or Universal FEHBP by an employer to an employee, the contribution amount under this paragraph shall be determined as if all the certified health plans offered by the cooperative or Program were offered by the employer.

(E) HIGH DEDUCTIBLE PLAN.—For purposes of this paragraph, the term "high deductible plan" has the meaning given such term by section 5504(5).

(3) DETERMINATION OF PREMIUM.—

(A) IN GENERAL.—For purposes of this subsection, the term "premium" means, with respect to—

(i) a certified health plan that is offered by a carrier (as defined in section 5504(2)), the premium established by the carrier for the plan with respect to the guaranteed national benefit package described in title II ; or

(ii) any other certified health plan, a reasonable estimate of the aggregate accident and health coverage expenditures of the plan (as determined under section 4376(d) of the Internal Revenue Code of 1986) for the period involved with respect to the guaranteed national benefit package which—

(I) is determined on an actuarial basis for different classes of enrollment (consistent with section 5108), and

(II) takes into account such factors as the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, may prescribe.

(B) PREMIUM BASED ON CLASS OF ENROLLMENT.—The premium with respect to an employee for a month shall be based on the class of enrollment with respect to which the employee is provided coverage as of the first day of the month.

(C) ADDITIONAL RULES.—Rules similar to the rules in clauses (ii) and (iii) of subparagraph (B), and subparagraph (C), of section 4980B(f)(4) of the Internal Revenue Code of 1986 shall apply to the determination of the premium, except that the adjustment under subparagraph (B)(ii)(II) of such section shall be by the sum described in section 6001(c) of the Guaranteed Health Insurance Act of 1994).

(4) COMPLIANCE WITH PREMIUM CERTIFICATE REQUIREMENTS.—An employer is not considered to have made a contribution for coverage with respect to an employee in accordance with this subsection unless—

(A) the employer provides the employee, upon request, with such documentation, in such form and in such a timely manner, as the Secretary specifies, as the employee may require to apply for and obtain a premium certificate under part A of title XXII of the Social Security Act; and

(B) if the employee tenders to the employer a premium certificate issued under such subpart, the employer reduces by the value of the certificate the amount of any premium required to be paid by the employee for periods beginning after the date of tender of the certificate unless otherwise provided.

SEC. 1105. EMPLOYEES NOT SUBJECT TO REQUIREMENT.

(a) IN GENERAL.—An employer is not required to provide or contribute to health insurance coverage with respect to employment of a generally excludable employee (as defined in subsection (b)).

(b) GENERALLY EXCLUDABLE EMPLOYEE DEFINED.—For purposes of subsection (a), the term "generally excludable employee" means any employee for any month if—

(1) such employee began work for the employer after the first day of such month;

(2) there is in effect as of the first day of such month a withholding exemption certificate stating that such employee reasonably expects to be a young dependent (as defined in section 1003(b)(1)(B)) of any taxpayer for the taxable year of such taxpayer which includes such month;

(3) as of the first day of such month, there is in effect for such employee—

(A) a qualified religious exemption (as defined in section 1004(c)(1)), or

(B) a qualified disabled veteran exemption (as defined in section 1004(c)(2));

(4) as of the first day of such month, such individual is on active duty as a member of the uniformed services (as defined in section 101 of title 10, United States Code);

(5) the only services performed by such employee for the employer during such month are services the income from which is excluded from gross income for purposes of section 151(c)(1)(A) of the Internal Revenue Code of 1986 by reason of section 151(c)(5) of such Code; or

(6) the amount of wages paid by the employer to such employee during such month does not exceed $100.

(c) INFLATION ADJUSTMENT OF WAGE AMOUNT.—In the case of months in any calendar year after 1997, the dollar amount contained in subsection (b)(6) shall be increased by an amount equal to—

(1) such dollar amount, multiplied by

(2) the cost-of-living adjustment determined under section 1(f)(3) of the Internal Revenue Code of 1986 for the calendar year which includes such month, by substituting "calendar year 1994" for "calendar year 1992" in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of $5, such increase shall be rounded to the nearest multiple of $5.

SEC. 1106. DEFINITIONS AND SPECIAL RULES.

(a) FULL-TIME EMPLOYEE; PART-TIME EMPLOYEE; PART-TIME FRACTION.—For purposes of this part—

(1) FULL-TIME EMPLOYEE.—The term "full-time employee" means any employee of an employer whose normal work week for such employer is not less than 35 hours.

(2) PART-TIME EMPLOYEE.—The term "part-time employee" means any employee who is not a full-time employee.

(3) PART-TIME FRACTION.—The part-time fraction is a fraction—

(A) the numerator of which is the number of hours in the employee's normal work week, and

(B) the denominator of which is 35.

(4) AGGREGATION RULES.—For purposes of this subsection—

(A) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

(B) all employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(b) LARGE EMPLOYER; SMALL EMPLOYER DEFINED.—

(1) IN GENERAL.—For purposes of this part—

(A) LARGE EMPLOYER.—The term "large employer" means, with respect to any calendar year, any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed more than 100 employees for some portion of the day.

(B) SMALL EMPLOYER.—The term "small employer" means an employer other than a large employer.

(2) AGGREGATION RULES.—For purposes of paragraph (1)—

(A) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

(B) all employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(c) TREATMENT OF EMPLOYEES OF EDUCATIONAL ORGANIZATIONS.—For purposes of this part—

(1) IN GENERAL.—Notwithstanding subsection (b)(4), an employee of an educational organization shall be treated as a full-time employee if such employee's normal work week is the customary hours that constitute full-time employment for such organization (as determined by such organization).

(2) PART-TIME EMPLOYEES.—The part-time fraction of an employee of an educational organization who is not treated as a full-time

employee under paragraph (1) shall be the fraction which such employee's normal work week bears to the customary hours that constitute full-time employment for such organization (as so determined).

(3) SUMMER MONTHS, ETC.—In the case of a period between 2 successive academic years or terms, if—

(A) an employee of an educational organization performs services in the first of such academic years or terms,

(B) such employee performs substantially reduced services (if any) during such period, and

(C) there is a reasonable assurance that such employee will perform such services in the second of such academic years or terms,

then the employee shall be treated as an employee of such organization during such period and as having the same normal work week (and compensation) as such employee had in the first of such years or terms.

(4) EMPLOYEE OF EDUCATIONAL ORGANIZATION DEFINED.—For purposes of paragraphs (1) and (2), an individual is an employee of an educational organization if such individual—

(A) is an employee of an institution of higher education (as defined in section 1201(a) of the Higher Education Act of 1965) or an elementary or secondary school (as defined in section 1471 of the Elementary and Secondary Education Act of 1965), and

(B) is employed in a capacity described in so much of section 13(a)(1) of the Fair Labor Standards Act of 1936 as ends with "secondary schools)".

(d) OTHER DEFINITIONS.—

(1) IN GENERAL.—For purposes of this part, the terms "wages", "employer", "employment", and "employee" have the same meanings as when used in chapter 21 of the Internal Revenue Code of 1986: except that, for purposes of this part, the following provisions of chapter 21 of such Code shall not apply:

(A) Paragraph (1) of section 3121(a).

(B) Paragraph (5) of section 3121(b).

(C) Paragraph (7) of section 3121(b) (other than subparagraph (C) or (F) thereof).

(D) Paragraph (9) of section 3121(b).

(2) CONSUMER PURCHASING COOPERATIVE.—The term "consumer purchasing cooperative" means such a cooperative under subtitle B of title IV or subtitle E of title V.

(3) UNIVERSAL FEHBP.—The term "Universal FEHBP" means the program established under subtitle D of title V.

PART 2—ADDITIONAL EMPLOYER RESPONSIBILITIES

SEC. 1111. MAINTENANCE-OF-EFFORT IN PROVIDING HEALTH BENEFITS TO EMPLOYEES.

(a) EMPLOYERS TO WHICH SECTION APPLIES.—This section shall apply to any employer if such employer (or any predecessor) offered as of January 1, 1994, health benefits to any employee.

(b) REQUIREMENTS.—An employer meets the requirements of this section only if the employer offers, throughout the 5-year period beginning on the date of the enactment of this Act, at least the level of health benefits offered as of January 1, 1994, to—

(1) the employees, spouses, and dependents to whom such benefits were offered as of such date, and

(2) similarly situated employees, spouses, and dependents.

(c) COLLECTIVE BARGAINING AGREEMENTS.—To the extent health benefits are provided pursuant to a collective bargaining agreement between employee representatives and 1 or more employers which was ratified before the date of the enactment of this Act, the 5-year period referred to in subsection (b) shall not expire before the date on which such agreement terminates (determined without regard to any extension thereof on or after the date of the enactment of this Act). The preceding sentence shall cease to apply with respect to any such agreement on the effective date of any modification of such agreement on or after June 29, 1994.

(d) EFFECTIVE DATE.—The requirements of this section shall apply to benefits offered on or after the date of the enactment of this Act.

SEC. 1112. NONDISCRIMINATION REQUIREMENTS IN PROVIDING ADDITIONAL HEALTH BENEFITS TO FULL-TIME EMPLOYEES.

(a) EMPLOYERS TO WHICH SUBSECTION APPLIES.—This section shall apply to any employer who makes an additional health benefit payment on behalf of any full-time employee.

(b) REQUIREMENTS.—An employer meets the requirements of this section only if all full-time employees are offered the same amount of additional health benefit payments. The requirements of this subsection shall be applied separately with respect to employees enrolled in different classes of enrollment.

(c) SAFE HARBOR RULES RELATING TO PREMIUM PAYMENTS.—In any case in which an additional health benefit payment is an additional premium payment for a certified health plan, the employer shall not be treated as failing to meet the requirements of this section if such payment meets the requirements of any (or any combination) of the following paragraphs:

(1) LEVEL PERCENTAGE CONTRIBUTION FOR PLAN SELECTED.—The additional payment amount is a fixed percentage of the premium under each certified health plan offered. Such percentage may vary based on class of enrollment.

(2) LEVEL PERCENTAGE CONTRIBUTION FOR CATEGORY OF PLAN.—The additional payment amount is a fixed percentage of the premium for the lowest cost plan within each category of certified health plans offered. Such percentage may vary based on class of enrollment.

(3) EQUALIZING DOLLAR AMOUNTS OF REQUIRED CONTRIBUTIONS.—The additional payment amount is the minimum dollar amount, within such a class of enrollment, that is required to assure that the total dollar contribution by the employer (including both the minimum required contribution and the additional payment amount) for all employees is equal to the greater of—

(A) the minimum level of employer contribution required for a managed care plan, or

(B) the minimum level of employer contribution required for an unlimited-choice-of-provider plan,

without regard to the plan selected. Such dollar amount may vary based on class of enrollment.

(4) LEVEL DOLLAR AMOUNTS OF ADDITIONAL CONTRIBUTIONS.—The payment is a fixed equal dollar amount per full-time employee, without regard to the plan selected. Such premium contribution may vary, or not vary, based on such a class of enrollment.

For purposes of applying this subsection, the term "premium" includes, with respect to a high deductible medical savings plan, a contribution to a medical savings account.

(d) DIFFERENT TREATMENT OF UNLIMITED-CHOICE-OF-PROVIDER PLANS AND MANAGED CARE PLANS.—If any additional benefit consists of a reduction in the cost sharing otherwise required under the guaranteed national benefit package—

(1) such reduction shall be treated as an additional health benefit payment, and

(2) the requirements of this section shall be met only if any difference in such reduction between unlimited-choice-of-provider plans and managed care plans meets such terms and conditions as may be prescribed by the Secretary by regulations.

(e) RECOMMENDATIONS ON INCLUSION OF PART-TIME EMPLOYEES.—The Secretary of Labor shall analyze and submit to Congress a report on how the provisions of this section may be applied in the case of part-time employees.

(f) DEFINITIONS.—For purposes of this section—

(1) ADDITIONAL HEALTH BENEFIT PAYMENT.—The term "additional health benefit payment" means any payment designed to be used exclusively (or primarily) towards the cost of health insurance coverage and does not include any tax imposed by chapter 25 of the Internal Revenue Code of 1986.

(2) FULL-TIME EMPLOYEE.—The term "full-time employee" means any full-time employee (as defined in section 1106(a)(1)) with respect to whom the employer is required to make a contribution under section 1104(d).

(3) AGGREGATION RULES.—For purposes of this subsection—

(A) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

(B) all employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(g) EXCEPTION FOR COLLECTIVE BARGAINING AGREEMENT.—This section shall not apply with respect to additional health benefits provided pursuant to a bona fide collective bargaining agreement or to a multiemployer plan.

(h) EFFECTIVE DATE.—

(1) IN GENERAL.—This section shall apply to benefits provided—

(A) by a large employer (as defined in section 1106(b)) on or after January 1, 1997, or

(B) by another employer on or after January 1, 1999.

(2) RELATIONSHIP TO TRANSITIONAL MAINTENANCE-OF-EFFORT REQUIREMENTS.—An employer shall not be considered to have failed to comply with the requirements of this subsection because of the provision of additional health benefit payments that are required to be provided pursuant to section 1111.

SEC. 1113. MAINTENANCE-OF-EFFORT REQUIREMENTS WITH RESPECT TO FORMER EMPLOYEES.

(a) EMPLOYERS TO WHICH SECTION APPLIES.—This section shall apply to any employer if such employer (or any predecessor), as of January 1, 1994, was paying any portion of the health costs for a qualified retiree or a qualified spouse or child.

(b) REQUIREMENTS.—

(1) IN GENERAL.—An employer meets the requirements of this section only if—

(A) each individual who is a qualified retiree or a qualified spouse or child is offered coverage under a health benefit plan of such employer which covers benefits comparable to the benefits covered by the employer with respect to qualified retirees as of January 1, 1994, and

(B) with respect to such individuals who elect coverage under a certified health plan of such employer, the employer contribution for each month is an amount equal to 80 percent of the cost of providing such coverage.

(2) OPTION TO PROVIDE EMPLOYER CONTRIBUTION TO MEDICARE PART C.—For periods beginning on or after January 1, 1999, an employer also shall meet the requirements of this section if—

(A) each individual who is a qualified retiree or a qualified spouse or child is offered coverage under medicare part C, and

(B) the employer contribution for each month for each such individual who elects coverage (or is covered) under medicare part C is an amount equal to the employer's share of applicable medicare part C premium for such month (as determined under section 3455 of the Internal Revenue Code of 1986).

(c) QUALIFIED RETIREE DEFINED.—For purposes of this section, the term "qualified retiree" means an eligible individual who—

(1) has attained age 55 but not age 65,

(2) is not a full-time employee, and

(3) is not a medicare part A beneficiary.

(d) QUALIFIED SPOUSE OR CHILD DEFINED.—For purposes of this section, the term "qualified spouse or child" means, in relation to a qualified retiree, an eligible individual with respect to whom the requirements in one of the following paragraphs is met:

(1) The individual (A) is under 65 years of age and is (and has been for a period of at least one year) married to a qualified retiree or (B) is a child of the qualified retiree.

(2) In the case of a person who was a qualified retiree at the time of the person's death—

(A) the individual was (and had for a period of at least one year been) married to the retiree at the time of the person's death,

(B) the individual is under 65 years of age,

(C) the individual is not a full-time employee,

(D) the individual is not remarried, and

(E) the deceased spouse would still be a qualified retiree if such spouse had not died.

(3) The individual is a child of an individual described in paragraph (2).

(e) EMPLOYER.—For purposes of this section, the term "employer" includes, with respect to any qualified retiree under a State or local retirement system (or the qualified spouse or child of such a retiree), such system.

(f) EFFECTIVE DATE.—This section shall apply to coverage for periods beginning on or after the date of the enactment of this Act.

SEC. 1114. ENFORCEMENT BY CIVIL MONEY PENALTIES OF SECRETARY OF LABOR.

(a) APPLICATION.—

(1) IN GENERAL.—Except as otherwise specifically provided, in the case of a person that violates a requirement of this part, the Secretary of Labor may impose a civil money penalty, in an amount not to exceed $10,000, for each violation with respect to each individual with respect to whom a violation occurred.

(b) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this section, the Secretary of Labor shall take into account the previous record of compliance of the person being assessed with the applicable requirements of this Act and the gravity of the violation.

(c) ADMINISTRATIVE REVIEW.—

(1) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an opportunity for hearing by the Secretary of Labor upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing all factual determinations shall be determined on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(2) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary of Labor modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under subsection (d).

(d) JUDICIAL REVIEW.—

(1) FILING OF ACTION FOR REVIEW.—Any person against whom an order imposing a civil money penalty has been entered after an agency hearing under this section may obtain review by the United States district court for any district in which such person is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice be registered mail to the Secretary of Labor.

(2) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary of Labor shall promptly certify and file in such court the record upon which the penalty was imposed.

(3) STANDARD FOR REVIEW.—The findings of the Secretary of Labor shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(4) APPEAL.—Any final decision, order, or judgment of such district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28 of such Code.

(e) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(1) FAILURE TO PAY ASSESSMENT.—If any person fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary of Labor, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(2) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(f) PAYMENT OF PENALTIES.—Penalties collected under this section shall be paid to the Secretary of Labor (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions of this part.

TITLE II—INDIVIDUAL AND EMPLOYER RESPONSIBILITIES

SEC. 2001. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Individual Responsibilities

SEC. 2101. INDIVIDUAL SHARE OF MEDICARE PART C PREMIUMS.

(a) GENERAL RULE.—Subchapter A of chapter 1 (relating to determination of tax liability) is amended by adding at the end the following new part:

"PART VIII—INDIVIDUAL SHARE OF MEDICARE PART C PREMIUMS

"Sec. 59B. Individual share of medicare part C premiums.

"SEC. 59B. INDIVIDUAL SHARE OF MEDICARE PART C PREMIUMS.

"(a) IMPOSITION OF TAX.—In the case of an individual, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax for the taxable year in the amount equal to the medicare part C premium liability (if any) of such individual for such taxable year.

"(b) EXEMPTION FOR LOW-INCOME INDIVIDUALS.—

"(1) IN GENERAL.—No tax shall be imposed by subsection (a) on any taxpayer whose modified adjusted gross income for the taxable year does not exceed the threshold amount.

"(2) PHASE-IN OF TAX.—

"(A) IN GENERAL.—If the modified adjusted gross income of the taxpayer for the taxable year exceeds the threshold amount by less than the phase-in amount, the amount of the tax imposed by subsection (a) for such taxable year shall be the phase-in percentage of the medicare part C premium liability of such taxpayer for such taxable year.

"(B) PHASE-IN PERCENTAGE.—For purposes of subparagraph (A), the phase-in percentage shall be determined under tables prescribed by the Secretary which—

"(i) shall have income brackets of not more than $50, and

"(ii) provide for a ratable increase in the amount of tax imposed by subsection (a) for modified adjusted gross incomes between the threshold amount and the sum of the threshold amount and the phase-in amount.

"(C) PHASE-IN AMOUNT.—For purposes of subparagraphs (A) and (B), the phase-in amount is the amount equal to the applicable percentage (determined in accordance with the following table) of the threshold amount.

"In the case of taxable years ending with or within—	The applicable percentage is—
1999, 2000, or 2001	100 percent
2002 or 2003	120 percent
2004 or thereafter	140 percent.

"(c) MEDICARE PART C PREMIUM LIABILITY.—For purposes of this section—

"(1) IN GENERAL.—The medicare part C premium liability of any individual for any taxable year is the excess (if any) of—

"(A) the sum of the applicable medicare part C premiums for each month of medicare part C coverage during the taxable year, over

"(B) the sum of—

"(i) the aggregate mandatory employer taxes with respect to the employment of such individual during the calendar year in which the taxable year begins, and

"(ii) the aggregate elective employer taxes with respect to the employment of such individual during such calendar year.

For purposes of this paragraph, the term 'month of medicare part C coverage' means any month as of the first day of which the individual, the spouse of the individual, or any young dependent of the individual is a medicare part C covered individual.

"(2) LIMITATION ON MANDATORY EMPLOYER TAXES TAKEN INTO ACCOUNT.—The amount of mandatory employer taxes which are taken into account under paragraph (1)(B)(i) with respect to any individual for any taxable year shall not exceed 80 percent of the amount referred to in paragraph (1)(A).

"(3) APPLICABLE MEDICARE PART C PREMIUM.—

"(A) TAXPAYERS WITH YOUNG DEPENDENTS.—Except as provided in subparagraph (C), if, as of the first day of a month, the individual (or, in the case of a joint return, either spouse) has a young dependent who is a medicare part C covered individual, the applicable medicare part C premium for such month is—

"(i) the applicable family premium for such month in the case of a joint return filed by spouses both of whom are medicare part C covered individuals for such month, and

"(ii) the applicable single parent premium for such month in any other case.

"(B) TAXPAYERS WITHOUT YOUNG DEPENDENTS.—Except as provided in subparagraph (C), if, as of the first day of a month, the individual does not have (or, in the case of a joint return, neither spouse has) a young dependent who is a medicare part C covered individual, the applicable medicare part C premium for such month is—

"(i) the applicable individual premium for such month, or

"(ii) in the case of a joint return, the sum of the applicable individual premiums for each spouse who is a medicare part C covered individual for such month.

"(C) SPOUSES NOT FILING JOINT RETURNS BY REASON OF DIVORCE OR OTHERWISE.—If—

"(i) the individual was married as of the first day of a month,

"(ii) the applicable medicare part C premium for such month would have been the applicable family premium if the individual had filed a joint return for the taxable year which includes such month with the spouse of such individual as of such first day, and

"(iii) the individual does not file a joint return for such taxable year,

the applicable medicare part C premium for such month is ½ the applicable family premium.

"(D) APPLICABLE PREMIUMS.—The applicable individual premium, the applicable family premium, and the applicable single parent premium of an individual for any month shall be determined—

"(i) under tables prescribed under section 2121(a) of the Social Security Act by the Secretary of Health and Human Services which are effective for such month, and

"(ii) on the basis of the State (or place outside the United States) in which such individual has his principal place of abode as of the first day of such month.

"(d) MEDICARE PART C COVERED INDIVIDUAL.—For purposes of this section—

"(1) IN GENERAL.—An individual shall be treated as a medicare part C covered individual for any month unless—

"(A) for such month, such individual is covered under a certified health plan or medicare part A, and

"(B) such individual furnishes to the Secretary (at such time and in such manner as the Secretary may prescribe) the required certification of such coverage for such month.

"(2) CERTIFIED HEALTH PLAN.—The term 'certified health plan' has the meaning given such term by section 2 of the Guaranteed Health Insurance Act of 1994.

"(3) MEDICARE PART A.—The term 'medicare part A' means the insurance program established by part A of title XVIII of the Social Security Act.

"(e) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) THRESHOLD AMOUNT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'threshold amount' means—

"(i) $7,400 in the case of a return with respect to which 1 personal exemption is allowable under section 151,

"(ii) $11,500 in the case of a return with respect to which 2 or 3 personal exemptions are allowable under section 151, and

"(iii) $16,000 in the case of a return with respect to which 4 or more personal exemptions are allowable under section 151.

"(B) CERTAIN SEPARATE RETURNS.—The threshold amount shall be zero in the case of a taxpayer who—

"(i) is married as of the close of the taxable year but does not file a joint return for such taxable year, and

"(ii) does not live apart from his spouse at all times during the last 6 months of the taxable year.

"(C) INFLATION ADJUSTMENTS.—In the case of a taxable year beginning in a calendar year after 1998, each dollar amount contained in subparagraph (A) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, by substituting 'calendar year 1994' for 'calendar year 1992' in subparagraph (B) thereof.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 911, 931, and 933, and

"(B) increased by the amount of interest received or accrued by the individual during the taxable year which is exempt from tax.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

"(3) MANDATORY EMPLOYER TAXES.—The term 'mandatory employer taxes' means the tax imposed by section 3455 determined without regard to any election under section 3455(b)(2).

"(4) ELECTIVE EMPLOYER TAXES.—The term 'elective employer taxes' means the taxes imposed by section 3455 which are not mandatory employer taxes.

"(5) YOUNG DEPENDENT.—The term 'young dependent' has the meaning given such term by section 1003(b)(1) of the Guaranteed Health Insurance Act of 1994.

"(6) REQUIRED CERTIFICATION.—The term 'required certification' means the statement required to be provided under section 6050Q(b) (or a copy thereof) or any other statement approved by the Secretary for purposes of this section.

"(7) ALLOCATION OF EMPLOYER'S SHARE OF PREMIUMS FOR SPOUSES NOT FILING JOINT RETURN.—Individuals who are married to each other as of the first day of any month and who do not file a joint return with each other for the taxable year which includes such month may allocate mandatory and elective employer taxes for such month to such extent and subject to such conditions as the Secretary shall prescribe.

"(f) COORDINATION WITH OTHER PROVISIONS.—

"(1) TREATMENT AS MEDICAL EXPENSE.—For purposes of section 213, the tax imposed by this section for any taxable year shall be treated as an expense paid during such taxable year for medical care of the taxpayer.

"(2) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The tax imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(A) the amount of any credit allowable under this chapter, or

"(B) the amount of the minimum tax imposed by section 55.

"(3) TREATMENT UNDER SUBTITLE F.—For purposes of subtitle F, the tax imposed by this section shall be treated as if it were a tax imposed by section 1.

"(4) TAXES IMPOSED BY POSSESSIONS.—The tax imposed by this section shall not apply to a bona fide resident of a possession with respect to which the requirements of section 2101(c)(3)(A) of the Social Security Act are met.

"(g) EXEMPTIONS.—

"(1) IN GENERAL.—No tax shall be imposed by this section on any individual for any taxable year if such individual is—

"(A) a covered, noncontributing individual (as defined in section 1003(b) of the Guaranteed Health Insurance Act of 1994) for such taxable year, or

"(B) a nonresident alien (as defined in section 7701(b)).

"(2) CERTAIN INDIVIDUALS NOT TAKEN INTO ACCOUNT IN DETERMINING AMOUNT OF TAX.—

"(A) IN GENERAL.—For purposes of this section, an individual shall be treated as not being a medicare part C covered individual for any month if—

"(i) the individual is a noncovered, noncontributing individual (as defined in section 1004(b) of the Guaranteed Health Insurance Act of 1994) for such month, or

"(ii) the first day of such month is included in any period for which such individual is a qualified individual (as defined in section 911(d)(1)).

Clause (ii) shall not apply to any individual for any taxable year if, at any time during such taxable year, such individual receives services under medicare part C.

"(B) MEDICARE PART C.—For purposes of subparagraph (A), the term 'medicare part C' means the program of health insurance benefits under title XXI of the Social Security Act.

"(h) REGULATIONS.—The Secretary may prescribe such regulations as may be appropriate to carry out the purposes of this section, including—

"(1) regulations determining the applicable premium for spouses having different principal places of abode, and

"(2) regulations, prescribed after consultation with the Secretary of Health and Human Services, treating health plans of foreign governments or foreign employers outside the United States as certified health plans."

(b) ADJUSTMENTS TO WITHHOLDING.—Subsection (a) of section 3402 (relating to income tax collected at source) is amended by adding at the end the following new paragraph:

"(3) SPECIAL RULE FOR TAX IMPOSED BY SECTION 59B.—

"(A) IN GENERAL.—In determining the amount required to be deducted and withheld from wages paid to an individual during any month by such individual's employer, the tax imposed by section 59B shall be taken into account.

"(B) WAGES NOT REDUCED BY EXEMPTIONS.—In determining the amount to be deducted and withheld by reason of subparagraph (A), the amount of wages shall not be reduced as provided in paragraph (2)."

(c) RELIEF FROM ESTIMATED TAX PENALTIES WHERE EMPLOYMENT TERMINATED.—Paragraph (3) of section 6654(e) (relating to failure by individual to pay estimated income tax) is amended by adding at the end the following new subparagraph:

"(C) UNDERPAYMENT OF MEDICARE PART C PREMIUMS FOR MONTHS AFTER INVOLUNTARY TERMINATION OF EMPLOYMENT.—If the Secretary determines that—

"(i) an individual's employment was involuntarily terminated during the taxable year, and

"(ii) the medicare part C portion of any underpayment for such year was due to reasonable cause and not due to willful neglect,

no addition to tax shall be imposed under subsection (a) with respect to such portion. For purposes of the preceding sentence, the medicare part C portion of an underpayment is the amount of the underpayment to the extent that it does not exceed the amount of the tax imposed by section 59B which is attributable to the portion of such taxable year after such termination."

(d) TECHNICAL AMENDMENTS.—

(1) Subsection (a) of section 6012 is amended by inserting after paragraph (9) the following new paragraph:

"(10) Every individual if—

"(A) such individual, or the spouse or any young dependent (as defined in section 1003(b)(1) of the Guaranteed Health Insurance Act of 1994) of such individual, is a medicare part C covered individual (as defined in section 59B(d)) for any month in the taxable year, and

"(B) such individual is not exempt from the tax imposed by section 59B by reason of subsection (b)(1) or (g) thereof."

(2) Section 31 is amended by adding at the end the following new subsection:

"(d) CERTAIN PAYMENTS OF MEDICARE PART C PREMIUMS.—The amount paid by an individual to the Secretary of Health and Human Services under section 2123(b) of the Social Security Act shall be allowed to such individual as a credit against the tax imposed by this subtitle for the taxable year which includes the month for which such amount was required to be paid. Individuals who are married to each other as of the first day of any month and who do not file a joint return with each other for the taxable year which includes such month may allocate the amounts described in the preceding sentence for such month to such extent and subject to such conditions as the Secretary shall prescribe."

(3) Subparagraph (A) of section 1(f)(6) is amended by inserting "section 59B(e)(1)(C)," after paragraph (2)(A),".

(4)(A) Subsection (b) of section 6521 is amended to read as follows:

"(b) INDIVIDUAL AND EMPLOYER MEDICARE PART C PREMIUMS.—In the case of the tax imposed by section 59B (relating to individual share of medicare part C premiums) and the tax imposed by section 3455 (relating to employer share of medicare part C premiums), if—

"(1) an amount is erroneously treated under section 59B as the medicare part C premium liability of an individual, or an amount is erroneously treated under section 3455 as the employer share of the applicable medicare part C premium with respect to such individual,

"(2) the correction of the error would require an assessment of one such tax and the refund or credit of the other tax, and

"(3) at any time the correction of the error is authorized as to one such tax but is prevented as to the other tax by any law or rule of law (other than section 7122, relating to compromises),

then, if the correction authorized is made, the amount of the assessment, or the amount of the credit or refund, as the case may be, authorized as to the one tax shall be reduced by the amount of the credit or refund, or the amount of the assessment, as the case may be, which would be required with respect to such other tax for the correction of the error if such credit or refund, or such assessment, of such other tax were not prevented by any law or rule of law (other than section 7122, relating to compromises)."

(B) Subsection (a) of section 6521 is amended by adding at the end the following new sentence: "For purposes of this subsection, the terms 'self-employment income' and 'wages' shall have the same meanings as when used in section 1402(b)."

(e) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end the following new item:

"Part VIII. Individual share of medicare part C premiums."

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 1998, in taxable years ending after such date.

Subtitle B—Employer Responsibilities

SEC. 2201. HEALTH-RELATED EMPLOYER TAXES AND CREDITS.

(a) GENERAL RULE.—Subtitle C (relating to employment taxes) is amended by redesignating chapter 25 as chapter 26 and by inserting after chapter 24 the following new chapter:

"CHAPTER 25—HEALTH-RELATED EMPLOYER TAXES AND CREDITS

"Subchapter A. Employer Taxes.
"Subchapter B. Employer Credits.
"Subchapter C. General Provisions.

"Subchapter A—Employer Taxes

"Part I. Tax on noncomplying large employers.
"Part II. Employer share of medicare part C premiums.
"Part III. Tax with respect to employees covered by certain other health plans.

"PART I—TAX ON NONCOMPLYING LARGE EMPLOYERS

"Sec. 3451. Imposition of tax.

"SEC. 3451. IMPOSITION OF TAX.

"(a) IMPOSITION OF TAX.—In addition to other taxes, there is hereby imposed on every large employer an excise tax, with respect to the employment of any employee during any month unless, for such month—

"(1) such employee is a qualified employer-covered employee of such employer, or

"(2) such employee is a voluntarily excluded employee.

"(b) AMOUNT OF TAX.—The amount of the tax imposed by subsection (a) with respect to any employee for any month shall be an amount equal to 25 percent of the wages paid during such month by such employer to such employee.

"(c) TAX NOT TO APPLY TO EMPLOYMENT OF CERTAIN EMPLOYEES.—

"(1) EMPLOYEES PERMITTED TO BE EXCLUDED FROM COVERAGE UNDER PRIVATE EMPLOYER PLANS.—No tax shall be imposed by this section on the employment for any month of any exempt part-time, seasonal, or temporary employee (as defined in section 1102(c) of the Guaranteed Health Insurance Act of 1994).

"(2) GENERALLY EXCLUDABLE EMPLOYEES.—

"For exemption from tax for employment of generally excludable employees, see section 3465.

"(d) DEFINITIONS.—For purposes of this section—

"(1) LARGE EMPLOYER.—The term 'large employer' has the meaning given to such term by section 1106 of the Guaranteed Health Insurance Act of 1994.

"(2) VOLUNTARILY EXCLUDED EMPLOYEE.—The term 'voluntarily excluded employee' has the meaning given to such term by section 1102 of the Guaranteed Health Insurance Act of 1994.

"(3) QUALIFIED EMPLOYER-COVERED EMPLOYEE.—The term 'qualified employer-covered employee' has the meaning given to such term by section 1104 of the Guaranteed Health Insurance Act of 1994 are met.

"(e) WAIVER OF TAX IN CERTAIN CASES.—If—

"(1) a large employer failed—

"(A) to correctly determine that it is a large employer, or

"(B) to cover any employee as a qualified employer-covered employee of such employer (other than an employee referred to in paragraph (1) or (2) of subsection (c)),

"(2) such failure is due to reasonable cause and not to willful neglect, and

"(3) the employer takes such corrective action as the Secretary may require,

the Secretary may waive part or all of the tax imposed by subsection (a) if the Secretary determines that the payment of such tax would be excessive relative to the failure involved.

"PART II—EMPLOYER SHARE OF MEDICARE PART C PREMIUMS

"Sec. 3455. Imposition of tax.

"SEC. 3455. IMPOSITION OF TAX.

"(a) IMPOSITION OF TAX.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to the employment of any medicare part C covered employee during any calendar month, equal to the employer share of the applicable medicare part C premium for such month.

"(b) EMPLOYER SHARE OF MEDICARE PART C PREMIUM.—For purposes of subsection (a)—

"(1) IN GENERAL.—The employer share of the applicable medicare part C premium for any calendar month is an amount equal to 80 percent of the applicable medicare part C premium for such month.

"(2) EMPLOYER ELECTION TO INCREASE SHARE.—At the election of the employer, paragraph (1) shall be applied by substituting for '80 percent' any percentage specified by the employer which is greater than 80 percent and not greater than 100 percent. Any percentage so specified shall apply to the month for which made and all succeeding months beginning before the date it is revoked by the employer. Any percentage so specified shall apply to all medicare part C covered employees of such employer.

"(3) REDUCTION FOR PART-TIME EMPLOYEES.—

"(A) IN GENERAL.—In the case of any part-time employee (as defined in section 1106 of the Guaranteed Health Insurance Act of 1994), the employer share of the applicable medicare part C premium for any month is the part-time fraction (as defined in such section 1106) of the amount determined under paragraphs (1) and (2).

"(B) EMPLOYER ELECTION TO INCREASE SHARE.—Any employer may elect to specify, with respect to any part-time employee for any month, a part-time fraction which is greater than the part-time fraction which would (but for this subparagraph) apply to such employee for such month but not greater than 1. Any fraction so specified shall apply to such employee for the month for which made and all succeeding months beginning before the date it is revoked by the employer.

"(4) SPECIAL RULE FOR STATES WITH APPROVED STATE MANAGED COMPETITION PROGRAMS.—With respect to an employee who resides in a State with a managed competition program approved under subtitle B of title IV of the Guaranteed Health Insurance Act of 1994, the employer share of the applicable medicare part C premium for any calendar month is amount equal to 25 percent of the wages paid during such month by such employer to such employee.

"(c) APPLICABLE MEDICARE PART C PREMIUM.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the applicable medicare part C premium for a medicare part C covered employee for any month is the applicable individual premium for such month.

"(2) EMPLOYEES WITH YOUNG DEPENDENTS.—If, for any month, an employee has a young dependent who is not covered by a certified health plan or medicare part A—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable medicare part C premium for such employee for such month is—

"(i) the applicable family premium for such month if such employee is married and both spouses are not covered by any certified health plan or medicare part A, and

"(ii) the applicable single parent premium for such month in any other case.

"(B) FULL FAMILY PREMIUM PAID BY ANOTHER EMPLOYER.—If, for such month, another employer pays an unreduced applicable family premium for such month with respect to such employee or the spouse of such employee, the applicable medicare part C premium for such employee for such month is zero. For purposes of this subparagraph, the term 'unreduced' means, with respect to any premium, a premium which is not reduced under subsection (b)(3).

"(3) EMPLOYEES WITH SPOUSES FOR WHOM NO EMPLOYER PAYS PART C PREMIUM.—If, for any month—

"(A) an employee is married but does not have a young dependent who is not covered by a certified health plan or medicare part A,

"(B) neither such employee nor such employee's spouse is covered by a certified health plan or medicare part A, and

"(C) no other employer pays the employer's share of an unreduced (as defined in paragraph (2)(B)) applicable medicare part C premium for such spouse for such month,

then the applicable medicare part C premium for such employee for such month is twice the applicable individual premium for such month.

"(4) APPLICABLE PREMIUMS.—The applicable individual premium, the applicable family premium, and the applicable single parent premium of an employee for any month shall be determined—

"(A) under tables prescribed under section 2121(a) of the Social Security Act by the Secretary of Health and Human Services which are effective for such month, and

"(B) on the basis of the State or place outside the United States (which such employee certifies in the withholding exemption certificate which is in effect as of the first day of such month) in which such employee has his principal place of abode.

"(5) CERTAIN INDIVIDUALS NOT TAKEN INTO ACCOUNT IN DETERMINING AMOUNT OF TAX.—An individual who is married to a noncovered, noncontributing individual (as defined in section 1004(b) of the Guaranteed Health Insurance Act of 1994) shall be treated as not married for purposes of this subsection.

"(6) FAILURE TO DISCLOSE PRINCIPAL PLACE OF ABODE.—If an employee does not have in effect with his employer a withholding exemption certificate which certifies the employee's principal place of abode, such employee's principal place of abode shall be treated for purposes of paragraph (4)(B) as being in the State which includes such employee's principal place of employment with his employer.

"(7) DETERMINATIONS MADE ON BASIS OF WITHHOLDING CERTIFICATE.—Determinations of the applicable medicare part C premium for an employee for any month shall be made on the basis of such employee's withholding exemption certificate (if any) which is in effect as of the first day of such month unless the employer has actual knowledge that the information provided on such certificate is incorrect.

"(d) DEFINITIONS.—For purposes of this section—

"(1) MEDICARE PART C COVERED EMPLOYEE.—An employee of the employer shall be treated as a medicare part C covered employee for any month unless—

"(A)(i) such employee is a qualified employer-covered employee of such employer for such month, or

"(ii) there is in effect as of the first day of such month a withholding exemption certificate stating that such employee is covered under a certified health plan (other than a plan of such employer) or medicare part A, and

"(B)(i) each young dependent (if any) of such employee is covered for such month under the certified health plan of the employer under which such employee is covered, or

"(ii) there is in effect as of the first day of such month a withholding exemption certificate stating that each young dependent (if any) of such employee is covered under a plan described in subparagraph (A)(ii).

"(2) YOUNG DEPENDENT.—The term 'young dependent' has the meaning given such term by section 1003(b)(1) of the Guaranteed Health Insurance Act of 1994.

"(3) EMPLOYEE.—For purposes of this section, the term 'employee' includes a former employee of an employer if the requirements of section 1113 of the Guaranteed Health Insurance Act of 1994 apply to such employer and the employer elects to satisfy such requirements as described in section 1113(b)(2) of such Act.

"(e) TREATMENT OF INDIANS EMPLOYED OTHER THAN BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—

"(1) IN GENERAL.—For purposes of this section—

"(A) the term 'certified health plan' shall not include any health program of the Service (as defined in section 901 of the Indian Health Care Improvement Act), and

"(B) any employee who (but for this subsection) would not be a medicare part C covered employee solely by reason of coverage under such a health program shall be treated as a medicare part C covered employee.

"(2) EXCEPTION FOR EMPLOYMENT BY INDIAN TRIBE, ETC.—Paragraph (1) shall not apply if the employer is—

"(A) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)), or

"(B) a tribal organization (as defined in such section 4).

"(3) TRANSFER OF TAX TO HEALTH PROGRAMS OF THE INDIAN HEALTH SERVICE.—

"For transfer of taxes received in the Medicare Part C Trust Fund by reason of this subsection for programs of the Indian Health Service, see section 2124(c)(2)(A) of the Social Security Act.

"(f) TREATMENT OF VETERANS IN AN GHIA-QUALIFIED VA HEALTH PLAN.—

"(1) IN GENERAL.—For purposes of this section—

"(A) the term 'certified health plan' shall not include any GHIA-qualified VA health plan (as defined in section 1801 of title 38, United States Code) in the case of an employee who is a veteran (within the meaning of section 101 of such title) or a spouse or dependent of such an employee, and

"(B) any employee who (but for this subsection) would not be a medicare part C covered employee solely by reason of coverage under such a health plan shall be treated as a medicare part C covered employee.

"(2) TRANSFER OF TAX TO HEALTH PROGRAMS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

"For transfer of taxes received in the Medicare Part C Trust Fund by reason of this subsection for programs of the Department of Veterans Affairs, see section 2124(c)(2)(B) of the Social Security Act.

"(g) CREDIT FOR TAXES PAID BASED ON INCORRECT INFORMATION.—If—

"(1) on or before January 31 of any calendar year, an employer determines (in such manner as the Secretary shall prescribe) that such employer overpaid the tax imposed by this section with respect to an employee for any month during the preceding calendar year by reason of incorrect information shown on any withholding exemption certificate of such employee which was in effect for such month, and

"(2) the statement furnished to such employee under section 6051 on or before such January 31 for the preceding calendar year reflects the tax which would have been paid by such employer if the information shown on such certificate had been correct,

then the excess of the tax paid under this section by such employer during such preceding calendar year over the amount of tax referred to in paragraph (2) shall be treated as an overpayment of the tax.

"(h) TAX TREATED AS EMPLOYER-PROVIDED HEALTH COVERAGE.—

"(1) INCOME TAX.—For purposes of chapter 1, payment of the taxes imposed by this section shall be treated as the providing of coverage by the employer under an accident or health plan.

"(2) EMPLOYMENT TAXES.—For purposes of this subtitle, no amount shall be included in the remuneration of any individual by reason of the payment of the taxes imposed by this section.

"PART III—TAX WITH RESPECT TO EMPLOYEES COVERED BY CERTAIN OTHER HEALTH PLANS

"Sec. 3458. Imposition of tax.

"SEC. 3458. IMPOSITION OF TAX.

"(a) IMPOSITION OF TAX.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to the employment of any employee described in subsection (b) during any month, equal to 80 percent of the applicable individual premium (as defined in section 3455(c)(4)) for such month with respect to each such employee. In applying section 3455(c)(4) for purposes of the preceding sentence, such employee's principal place of abode shall be treated as being in the State which includes such employee's principal place of employment with such employer.

"(b) EMPLOYEES DESCRIBED.—For purposes of subsection (a), an employee is described in this subsection for any month if—

"(1) such employee is covered for such month under a certified health plan other than a plan of his employer and (but for such coverage) such employer would be liable for tax under section 3451 or 3455 with respect to the employment of such employee for such month, or

"(2) such employee is a medicare part C covered individual (as defined in section 59B(d)) for such month, and the applicable medicare part C premium for such employee is zero by reason of section 3455(c)(2)(B).

For purposes of paragraph (1), it shall be assumed that the employee would not become a qualified employer-covered employee of his employer.

"(c) Reduction of Tax for Part-time Employees.—With respect to any part-time employee, the tax imposed by this section for any month shall be an amount equal to the part-time fraction of the amount determined under subsection (a).

"(d) Treatment of Indians Employed by Indian Tribes and Tribal Organizations.—No tax shall be imposed by this section with respect to the employment of any employee if—

"(1) such employee is described in subsection (b)(1) solely by reason of being covered under a health program of the Service (as defined in section 901 of the Indian Health Care Improvement Act), and

"(2) the employer is an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) or a tribal organization (as defined in such section 4).

"Subchapter B—Employer Credits

"Sec. 3461. Family premium credit.

"Sec. 3462. Small employer credit.

"SEC. 3461. FAMILY PREMIUM CREDIT.

"(a) General Rule.—Every employer shall be entitled to treat an amount equal to the applicable percentage of such employer's family premium amount for any calendar quarter as a payment by such employer of such employer's employment tax liability for such calendar quarter.

"(b) Family Premium Amount.—

"(1) In general.—For purposes of this section, the family premium amount of an employer for any calendar quarter is an amount equal to the sum of—

"(A) such employer's aggregate liability for tax under section 3455 for such quarter with respect to employees for whom the applicable medicare part C premium is the applicable family premium, and

"(B) the aggregate imputed part C family premiums for such quarter for qualified employer-covered employees of such employer receiving family coverage under any certified health plan of such employer.

"(2) Part C family premium liability.—The determination under paragraph (1)(A) shall be made without regard to any election under section 3455(b)(2).

"(3) Imputed part C family premium.—

"(A) In general.—For purposes of paragraph (1)(B), the imputed part C family premium for any qualified employer-covered employee is an amount equal to 80 percent of the applicable family premium determined under section 3455 on the basis of the State which includes such employee's principal place of employment with his employer.

"(B) Lower percentage in certain cases.—If, in determining the amount of the employer contribution to any certified health plan of such employer with respect to any part-time employee who is a qualified employer-covered employee, the part-time fraction applied by the employer is less than 1, the imputed part C family premium for such employee is such fraction of the amount determined under subparagraph (A).

"(c) Applicable Percentage.—For purposes of this section—

"(1) In general.—The applicable percentage for any calendar year is the percentage which the Secretary estimates (in consultation with the Secretary of Health and Human Services) will result in the aggregate amount of the deemed payments determined under this section for all employers for such year being equal to the product of the phase-in percentage and the Secretary's estimate of the taxes imposed by section 3458 which will be paid for such year. Proper adjustments shall be made in the applicable percentage determined for succeeding calendar years to the extent that the applicable percentage determined for such calendar year was greater than or less than the correct percentage.

"(2) Phase-in percentage.—For purposes of paragraph (1), the phase-in percentage is—

"(A) 25 percent for calendar year 1999,

"(B) 40 percent for calendar year 2000,

"(C) 60 percent for calendar year 2001, and

"(D) 100 percent for calendar years after 2001.

"(d) Coordination With Depository Requirements.—Any employer who is entitled to treat any amount as a payment under subsection (a) for any calendar quarter may reduce, in such manner as the Secretary may by regulations prescribe, by a like amount, the amount otherwise required to be deposited during such quarter by reason of the employment tax liability of such employer.

"(e) Special Rules.—

"(1) Payment treated as made on due date.—Notwithstanding subsection (d), for purposes of determining interest, any deemed payment under subsection (a) for any calendar quarter shall be treated as made on the due date for the return for such quarter.

"(2) Denial of deduction.—The amount of any deduction otherwise allowable under chapter 1 for the taxes imposed by this chapter or for expenditures under any certified health plan of such employer shall be reduced by any payment treated as made under subsection (a).

"(f) Employment Tax Liability.—For purposes of this section, the term 'employment tax liability' means liability for the taxes imposed by this chapter and chapters 21 and 24.

"SEC. 3462. SMALL EMPLOYER CREDIT.

"(a) General Rule.—Every eligible small employer shall be entitled to treat an amount equal to the applicable percentage of such employer's total premium amount for any calendar year as a payment by such employer of such employer's employment tax liability (as defined in section 3461(f)) for such calendar year.

"(b) Total Premium Amount.—

"(1) In general.—For purposes of this section, the total premium amount of an employer for a calendar year is an amount equal to the excess of—

"(A) the sum of—

"(i) such employer's aggregate liability for tax under sections 3455 and 3458 for such year, and

"(ii) the aggregate imputed part C premiums for such year for qualified employer-covered employees of such employer receiving coverage under any certified health plan of such employer, over

"(B) the aggregate deemed payments by the employer for such year under section 3461.

"(2) Imputed part C premium.—For purposes of paragraph (1), the imputed part C premium for any qualified employer-covered employee is an amount equal to 80 percent of the applicable medicare part C premium determined under section 3455 for such employee on the basis of the State which includes such employee's principal place of employment with his employer and the type of coverage provided to such employee under the certified health plan. Rules similar to the rules of section 3461(b)(3)(B) shall apply for purposes of the preceding sentence.

"(3) Certain individuals not taken into account.—The total premium amount of an employer shall be determined without regard to—

"(A) in the case of an employer which is a corporation, any employee who owns (directly or by application of section 318) more than 10 percent of—

"(i) the outstanding stock of such corporation, or

"(ii) the total combined voting power of all stock of the corporation,

"(B) in the case of an employer which is an estate or trust, any grantor, beneficiary, or fiduciary of the estate or trust, and

"(C) any member of the family (within the meaning of section 267(c)(4)) of—

"(i) an individual described in subparagraph (A) or (B),

"(ii) in the case of an employer which is a sole proprietorship, the sole proprietor, or

"(iii) in the case of an employer which is a partnership, any partner who owns more than 10 percent of the capital interest or profits interest of such partnership.

In the case of an employer who is not a corporation, the total premium amount also shall be determined without regard to any individual not performing services in a trade or business of the employer.

"(c) Applicable Percentage.—For purposes of this section—

"(1) In general.—Except as otherwise provided in this subsection, the applicable percentage is—

"(A) 37.5 percent for calendar years after 1998 and before 2004,

"(B) 20 percent for calendar year 2004,

"(C) 10 percent for calendar year 2005, and

"(D) 0 for calendar years after 2005.

"(2) Smaller employers.—In the case of an employer who would be an eligible small employer if '25 employees' were substituted for '50 employees' in subsection (d)(1), the applicable percentage is—

"(A) 50 percent for calendar years after 1998 and before 2004,

"(B) 30 percent for calendar year 2004,

"(C) 15 percent for calendar year 2005, and

"(D) 0 for calendar years after 2005.

"(3) Phaseout of credit where higher average employee wage.—If the average employee wage of an eligible small employer for any calendar year exceeds $12,000, the applicable percentage which would (but for this paragraph) apply for such calendar year shall be reduced (but not below zero) by the number of percentage points which bears the same ratio to such applicable percentage as such excess bears to $14,000.

"(d) Eligible Small Employer.—For purposes of this section—

"(1) In general.—The term 'eligible small employer' means, with respect to any calendar year, any employer unless—

"(A) on each of 20 days during such year (each day being in a different week), such employer (or any predecessor) employed more than 50 employees for some portion of the day, or

"(B) the average employee wage of such employer for such year exceeds $26,000.

"(2) Average employee wage.—The average employee wage of an employer for any calendar year is an amount equal to—

"(A) the total payroll of such employer for such calendar year, divided by

"(B) the number of full-time equivalent employees of such employer for such calendar year.

"(3) TOTAL PAYROLL.—The total payroll of an employer for any calendar year is an amount equal to the sum of—

"(A) the total wages paid by the employer during such calendar year,

"(B) in the case of a sole proprietorship, the net earnings from self-employment of the proprietor from such trade or business for the taxable year ending with or within such calendar year, and

"(C) in the case of a partnership, the net income of the partnership for the taxable year ending with or within such calendar year which will be treated as net earnings from self-employment by the partners.

"(4) NET EARNINGS FROM SELF-EMPLOYMENT.—The term 'net earnings from self-employment' has the meaning given such term by section 1402; except that the amount thereof may never be less than zero.

"(5) FULL-TIME EQUIVALENT EMPLOYEES.—The number of full-time equivalent employees of an employer for any calendar year is the sum of—

"(A) the number of employees who worked on a substantially full-time basis for the employer throughout the calendar year, and

"(B) a fraction for each other employee based on the number of hours such employee worked during the calendar year compared to a full-time, full-year employee.

For purposes of this paragraph, the proprietor shall be treated as an employee of a sole proprietorship, and each partner who has net earnings from self-employment from a partnership shall be treated as an employee of such partnership.

"(6) AGGREGATION RULES.—For purposes of this subsection—

"(A) all employers treated as a single employer under subsection (a) or (b) of section 52 shall be treated as a single employer, and

"(B) all employees of the members of an affiliated service group (as defined in section 414(m)) shall be treated as employed by a single employer.

"(e) COORDINATION WITH DEPOSITORY REQUIREMENTS.—

"(1) IN GENERAL.—Any employer who reasonably expects to be entitled to treat any amount as a payment under subsection (a) for any calendar year may reduce, in such manner as the Secretary may by regulations prescribe, by a like amount, the amount otherwise required to be deposited during such year by reason of the employment tax liability (as defined in section 3461(f)) of such employer.

"(2) QUARTERLY DETERMINATIONS.—The amount of reduction permitted under paragraph (1) for any calendar quarter shall be based on a separate estimate for such quarter of the amount of deemed payments to which the employer reasonably expects to be entitled under subsection (a) for the calendar year which includes such quarter and shall be properly adjusted (under regulations prescribed by the Secretary) to reflect the amount by which prior reductions under subsection (a) during such calendar year were in excess of, or less than, the amounts which would be proper under such estimate.

"(3) YEAR-END ADJUSTMENTS.—

"(A) EXCESS OF DEEMED PAYMENTS ALLOWABLE OVER DEPOSITORY BENEFIT CLAIMED.—If the amount of deemed payments to which an employer is entitled under subsection (a) for any calendar year exceeds the amount claimed by the employer under paragraph (1) during such year, such excess shall be treated for purposes of this title as an overpayment made by such employer. For purposes of determining interest, such overpayment shall be treated as made on January 31 of the following calendar year.

"(B) DEPOSITORY BENEFIT CLAIMED EXCEEDS DEEMED PAYMENT ALLOWABLE.—If the amount claimed by the employer under paragraph (1) during the calendar year exceeds the amount of deemed payments to which such employer is entitled under subsection (a) for such year, such excess shall be treated for purposes of this title as an underpayment of the tax imposed by this chapter for such calendar year. For purposes of determining interest, such underpayment shall be allocated ratably among the calendar quarters in such year (or in such other manner as the Secretary may by regulations prescribe).

"(f) SPECIAL RULES.—

"(1) PAYMENT TREATED AS MADE ON DUE DATE.—Notwithstanding subsection (e), for purposes of determining interest, a payment shall be treated as made under subsection (a) on the due date for the return for each calendar quarter in an amount equal to the amount of the reduction permitted under subsection (e) for such quarter.

"(2) DENIAL OF DEDUCTION.—The amount of any deduction otherwise allowable under chapter 1 for the taxes imposed by this chapter or for expenditures under any certified health plan of such employer shall be reduced by any payment treated as made under subsection (a).

"Subchapter C—General Provisions

"Sec. 3465. Exemption for employment of generally excludable employees.

"Sec. 3466. Definitions and special rules.

"SEC. 3465. EXEMPTION FOR EMPLOYMENT OF GENERALLY EXCLUDABLE EMPLOYEES.

"No tax shall be imposed by subchapter A with respect to the employment of any employee during any month if such employee is a generally excludable employee (as defined in section 1105(b) of the Guaranteed Health Insurance Act of 1994) for such month.

"SEC. 3466. DEFINITIONS AND SPECIAL RULES.

"(a) CERTIFIED HEALTH PLAN; MEDICARE PART A.—For purposes of this chapter—

"(1) CERTIFIED HEALTH PLAN.—The term 'certified health plan' has the meaning given such term by section 2 of the Guaranteed Health Insurance Act of 1994.

"(2) MEDICARE PART A.—The term 'medicare part A' means the insurance program established by part A of title XVIII of the Social Security Act.

"(b) FULL-TIME EMPLOYEE; PART-TIME EMPLOYEE; PART-TIME FRACTION.—For purposes of this chapter—

"(1) IN GENERAL.—Except as provided in paragraph (2)—

"(A) the terms 'full-time employee', 'part-time employee', and 'part-time fraction' have the meanings given to such terms by section 1106 of the Guaranteed Health Insurance Act of 1994, and

"(B) the rules of section 1106(c) of the Guaranteed Health Insurance Act of 1994 shall apply.

"(2) EXCEPTION.—Subparagraphs (A) and (B) of section 1106(a)(4) of the Guaranteed Health Insurance Act of 1994, and section 1106(c) of such Act, shall not apply for purposes of section 3462.

"(c) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this chapter shall be covered over to any possession of the United States.

"(d) OTHER DEFINITIONS.—For purposes of this chapter, the terms 'State', 'wages', 'employer', 'employment', and 'employee' have the same respective meanings as when used in chapter 21: except, that, for purposes of this chapter, the following provisions of chapter 21 shall not apply:

"(1) Paragraph (1) of section 3121(a).

"(2) Paragraph (5) of section 3121(b).

"(3) Paragraph (7) of section 3121(b) (other than subparagraph (C) or (F) thereof).

"(4) Paragraph (9) of section 3121(b).

"(e) REGULATIONS.—The Secretary may prescribe such regulations as may be appropriate to carry out the purposes of this chapter, including regulations prescribing 1 or more simplified methods (including brackets of hours) for determining the part-time fraction and full-time equivalent employees."

(b) MODIFICATION OF WITHHOLDING EXEMPTION CERTIFICATE REQUIREMENTS.—Subsection (f) of section 3402 is amended by adding at the end the following new paragraph:

"(8) CERTIFICATE TO INCLUDE INFORMATION RELATED TO MEDICARE PART C STATUS.—

"(A) INITIAL CERTIFICATE.—On the withholding exemption certificate furnished by an employee under paragraph (2)(A), the employee shall certify—

"(i) whether the employee—

"(I) is covered under medicare part A or a certified health plan (as defined in section 2 of the Guaranteed Health Insurance Act of 1994) other than a plan of such employer, or

"(II) reasonably expects to be a young dependent (as defined in section 1003(b)(1) of the Guaranteed Health Insurance Act of 1994) of any taxpayer,

"(ii) whether the employee has a young dependent (as so defined),

"(iii) the State (or place outside the United States) in which such employee has his principal place of abode, and

"(iv) such other information as the Secretary may require.

"(B) CHANGE OF STATUS.—If, on any day, there is a change in any item of information required to be certified under subparagraph (A) on the withholding exemption certificate then in effect with respect to an employee, such employee shall within 10 days thereafter furnish the employer with a new withholding exemption certificate containing the information described in subparagraph (A)."

(c) MODIFICATION OF PENALTY FOR FAILURE TO MAKE DEPOSIT OF TAXES.—Section 6656 (relating to failure to make deposit of taxes) is amended by adding at the end the following new subsection:

"(c) REDUCTIONS IN DEPOSITS BY REASON OF HEALTH-RELATED CREDITS.—No penalty shall be imposed by subsection (a) on any underpayment attributable to the depositor's estimate of any deemed payment under subchapter B of chapter 25 (relating to health-related employer credits) unless there is no reasonable basis for such estimate."

(d) CLERICAL AMENDMENT.—The table of chapters for subtitle C is amended by striking the item relating to chapter 25 and inserting the following:

"Chapter 25. Health-related employer taxes and credits.

"Chapter 26. General provisions relating to employment taxes."

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on January 1, 1999.

(2) APPLICATION OF SECTION 3451 TO LARGER EMPLOYERS.—Section 3451 of the Internal Revenue Code of 1986 (as added by this section) shall take effect on January 1, 1997.

SEC. 2202. REPORTING REQUIREMENTS.

(a) EMPLOYER SHARE OF MEDICARE PART C PREMIUM SHOWN ON W-2.—Subsection (a) of section 6051 (relating to receipts for employees) is amended by striking "and" at the end of paragraph (8), by striking the period at the end of paragraph (9) and inserting a comma, and by inserting after paragraph (9) the following new paragraphs:

"(10) the total mandatory employer taxes (as defined in section 59B(e)(3)) with respect to such employee, and

"(11) the total elective employer taxes (as defined in section 59B(e)(4)) with respect to such employee."

(b) RETURNS RELATING TO CERTIFIED HEALTH PLANS AND MEDICARE PART A, DIRECT PREMIUM PAYMENTS TO HHS, AND MEDICARE PART C COVERAGE OF EMPLOYEES.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with others) is amended by adding at the end the following new sections:

"SEC. 6050Q. RETURNS RELATING TO CERTIFIED HEALTH PLANS AND MEDICARE PART A.

"(a) REQUIREMENT OF REPORTING.—The administrator of any certified health plan (as defined in section 2 of the Guaranteed Health Insurance Act of 1994) and the Secretary of Health and Human Services with respect to medicare part A (as defined in such section) shall make a return for each calendar year setting forth—

"(1) the name and TIN of each individual covered under such plan or program at any time during such taxable year as a primary insured or as the spouse of a primary insured,

"(2) the name and TIN (to the extent available) of each individual covered under such plan or program at any time during such taxable year as a young dependent (as defined in section 1003(b)(1) of the Guaranteed Health Insurance Act of 1994) of a primary insured, and

"(3) the months during such calendar year for which such individuals were so covered.

Such return shall be made at such time and in such form as the Secretary may by regulations prescribe.

"(b) STATEMENTS TO PRIMARY INSURED INDIVIDUALS.—Every administrator (and the Secretary of Health and Human Services) required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return by reason of being a primary insured a written statement showing—

"(1) the name of the certified health plan (or medicare part A) and the address of its administrator (or of the Secretary), and

"(2) the information required to be shown on the return with respect to such primary insured.

The written statement required under the preceding sentence shall be furnished to the person on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"(c) STATEMENT TO SPOUSE OR YOUNG DEPENDENTS OF PRIMARY INSURED ON REQUEST.—At the request of an individual who, at any time during a calendar year, was the spouse or a young dependent (as defined in section 1003(b)(1) of the Guaranteed Health Insurance Act of 1994) of a primary insured who is required to receive a statement under subsection (b) from an administrator, such administrator shall furnish to such individual a copy of such statement with respect to such insured for such calendar year.

"SEC. 6050R. RETURNS RELATING TO MEDICARE PART C PREMIUM PAYMENTS TO DEPARTMENT OF HEALTH AND HUMAN SERVICES.

"(a) REQUIREMENT OF REPORTING.—The Secretary of Health and Human Services shall make a return for each calendar year setting forth—

"(1) the name and TIN of each individual from whom such Secretary received payments during such year under section 2123(b) of the Social Security Act for coverage under medicare part C, and

"(2) the amount of such payments during such year.

Such return shall be made at such time and in such form as the Secretary may by regulations prescribe.

"(b) STATEMENTS TO INDIVIDUALS.—The Secretary of Health and Human Services shall furnish to each individual whose name is required to be set forth in such return a written statement showing the aggregate payments described in subsection (a) received by such Secretary from such individual. The written statement required under the preceding sentence shall be furnished to the person on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"(c) MEDICARE PART C.—For purposes of this section, the term 'medicare part C' means the program of health insurance benefits under part title XXI of the Social Security Act.

"SEC. 6050S. RETURNS RELATING TO EMPLOYER MEDICARE PART C PREMIUM PAYMENTS.

"Every employer who pays tax under section 3455 (relating to employer share of medicare part C premiums) with respect to the employment of any employee during any calendar year shall make a return for such year setting forth—

"(1) the name and TIN of each such employee,

"(2) the class of enrollment on which such tax was determined with respect to each such employee for each month of such year,

"(3) the name and TIN of the spouse of such employee,

"(4) the name and TIN (to the extent available) of each young dependent (as defined in section 1003(b)(1) of the Guaranteed Health Insurance Act of 1994) of such employee.

Such return shall be made at such time and in such form as the Secretary may by regulations prescribe."

(c) MONTHLY STATEMENTS TO EMPLOYEES TO SPECIFY EMPLOYER SHARE OF MEDICARE PART C PREMIUM.—Section 6051 (relating to receipts for employees) is amended by adding at the end the following new subsection:

"(g) EMPLOYER SHARE OF MEDICARE PART C PREMIUM.—Every employer required to pay a tax under section 3455 with respect to any employee for any month shall furnish to each such employee a written statement showing the aggregate amount of such tax paid by such employer with respect to such employee for such month. Such statement shall be furnished with the employer's payment of wages for the payroll period which includes the last day of such month or at such times as may be specified by the Secretary by regulations."

(d) UNIFORM PENALTY PROVISIONS MADE APPLICABLE.—

(1) Subparagraph (B) of section 6724(d)(1) is amended by inserting after the item relating to clause (viii) the following new items (and redesignating the following clauses accordingly):

"(ix) section 6050Q(a) (relating to returns regarding certified health plans and medicare part A),

"(x) section 6050R(a) (relating to returns relating to medicare part C premium payments to Department of Health and Human Services),

"(xi) section 6050S (relating to returns relating to employer medicare part C premium payments),".

(2) Paragraph (2) of section 6724(d) is amended by inserting after subparagraph (P) the following new subparagraph (and by redesignating the following subparagraphs accordingly):

"(Q) subsection (b) or (c) of section 6050Q (relating to returns regarding certified health plans and medicare part A),

"(R) section 6050R(b) (relating to returns relating to medicare part C premium payments to Department of Health and Human Services),".

(e) DISCLOSURE OF INFORMATION BY SECRETARY.—

(1) Subsection (l) of section 6103 is amended by adding at the end the following new paragraphs:

"(15) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT HEALTH PREMIUM CERTIFICATE PROGRAM.—The Secretary shall, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Department of Health and Human Services return information for purposes of determining or verifying whether any taxpayer is entitled to a premium certificate under part A of title XXII of the Social Security Act and the amount thereof. Such return information shall be limited to—

"(A) such taxpayer's marital status,

"(B) the adjusted gross income of such taxpayer,

"(C) the interest received by such taxpayer which is exempt from tax, and

"(D) the number of personal exemptions of such taxpayer.

Return information disclosed under this paragraph may be used by such officers and employees only for the purposes of, and to the extent necessary in, making such determination or verification.

"(16) DISCLOSURE OF RETURN INFORMATION RELATING TO SUBSIDIES TO STATES ADOPTING STATE BENEFIT MANAGEMENT PROGRAMS.—The Secretary shall, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Department of Health and Human Services return information necessary to determine or verify the proper amount payable under section 2124(c)(1)(C) of the Social Security Act to a State which has a State benefit management program approved under subtitle B of title IV of the Guaranteed Health Insurance Act of 1994. Return information disclosed under this paragraph may be used by such officers and employees only for the purposes of, and to the extent necessary in, making such determination or verification."

(2) Paragraph (4) of section 6103(p) is amended by striking "or (14)" each place it appears and inserting "(14), (15), or (16)".

(f) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new items:

"Sec. 6050Q. Returns relating to certified health plans and medicare part A.

"Sec. 6050R. Returns relating to medicare part C premium payments to Department of Health and Human Services.

"Sec. 6050S. Returns relating to employer medicare part C premium payments."

(g) EFFECTIVE DATE.—The amendments made by this section (other than subsection (e)) shall apply to calendar years after 1998.

SEC. 2203. TRANSITIONAL CONTINUATION COVERAGE REQUIREMENT FOR GROUP HEALTH PLANS.

Clause (i) of section 4980B(f)(2)(B) is amended by adding at the end the following new sentence: "In the case of an individual whose period of coverage under this clause would (but for this sentence) end after the date of the enactment of the Guaranteed Health Insurance Act of 1994 and before January 1, 1999, such period shall in no event terminate by reason of this clause before January 1, 1999."

TITLE III—BENEFITS

Subtitle A—Guaranteed National Benefit Package

PART 1—BENEFITS DESCRIBED

SEC. 3001. ESTABLISHMENT OF PACKAGE.

(a) COVERAGE OF EXPANDED MEDICARE BENEFITS.—

(1) IN GENERAL.—Except as otherwise provided in this subtitle, for purposes of this Act and the Social Security Act, the guaranteed national benefit package shall consist of the same items and services for which payment may be made under title XVIII of the Social Security Act (as amended by the Guaranteed Health Insurance Act of 1994) to individuals entitled to benefits under part A, and enrolled under part B, of title XVIII of such Act, subject to the same exclusions from coverage as are provided under section 1862(a) of such Act.

(2) EXCEPTIONS RELATING TO PRESCRIPTION DRUGS.—

(A) MEDICARE REBATES NOT APPLICABLE.—An outpatient prescription drug shall be included in the guaranteed national benefit package notwithstanding any exclusion from coverage that may be made with respect to the drug under section 1862(a)(17) of the Social Security Act.

(B) NONAPPLICATION OF PRIOR AUTHORIZATION AND DRUG USE REVIEW BY SECRETARY.—The provisions of section 1834(d)(6) of the Social Security Act shall not apply with respect to an outpatient prescription drug furnished to an individual who is not enrolled under part B of title XVIII of such Act or under medicare part C. A health plan may subject an outpatient prescription drug furnished to any other individual to prospective review, prior authorization, or drug use review, but only if the plan meets the requirements described in section 5007(d).

(b) ENHANCED MEDICARE BENEFITS DESCRIBED.—In addition to the items and services covered under title XVIII of the Social Security Act as of the date of the enactment of this title, the guaranteed national benefit package shall include the following items and services for which coverage is provided under such title XVIII as a result of the amendments to such title made by subtitle B.

(1) Outpatient prescription drugs (as added by section 3101).

(2) Limitations on out-of-pocket expenditures (as added by section 3111).

(3) Unlimited days of coverage for inpatient hospital services (as added by section 3112).

(4) Newborn, well-baby, and well-child services and hearing aids (as added by section 3113).

(5) Expanded coverage of screening mammography (provided under section 3114(a)) and screening pap smears (provided under section 3114(b)).

(6) Screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy (as added by section 3114(c)).

(7) Screening for sexually-transmitted diseases (as added by section 3114(d)).

(8) Screening for tuberculosis (as added by section 3114(e)).

(9) Pregnancy-related services and voluntary family planning services (as added by section 3115).

(10) Expanded coverage for mental health and substance abuse services (as provided under section 3116).

(11) Expanded coverage for certain chiropractic services (as provided under section 3117).

SEC. 3002. COVERAGE OF ITEMS AND SERVICES NOT COVERED UNDER MEDICARE.

(a) EXPERIMENTAL TREATMENTS.—

(1) IN GENERAL.—In the absence of a national coverage decision under the medicare program, the guaranteed national benefit package may, at the option of a certified health plan, include coverage of an experimental item, service, or treatment. Nothing in the previous sentence may be construed to permit a certified health plan to include in the guaranteed national benefit package an item or service for which the Secretary does not have the authority to make such a national coverage decision.

(2) CONSTRUCTION.—For purposes of paragraph (1), a service covered as an incident to a qualifying investigational treatment under subsection (b) shall not be considered an experimental item, service, or treatment.

(b) SERVICES INCIDENT TO INVESTIGATIONAL TREATMENTS.—

(1) IN GENERAL.—The guaranteed national benefit package shall include coverage of any item or service provided to an individual incident to a qualifying investigational treatment if the item or service is otherwise included in the guaranteed national benefit package.

(2) QUALIFYING INVESTIGATIONAL TREATMENT DEFINED.—In this subsection, a "qualifying investigational treatment" means an investigational treatment provided under a clinical research trial approved by the Secretary or a qualified non-governmental research entity (as defined in guidelines of the National Institutes of Health, including guidelines for designated cancer support grants of the National Cancer Institute), or a peer-reviewed and approved research program (as defined by the Secretary), conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for the treatment to be medically necessary.

(3) EXCLUSIONS.—Nothing in this subsection may be construed to provide for coverage under the guaranteed national benefit package of an item or service of a class or type for which the Secretary determines that payment is generally made from sources other than certified health plans, including the investigational agent or device itself or the investigational procedure, any non-health services that might be required for a person to receive the qualifying investigational treatment, or the costs of managing the research.

(c) MODIFICATION OF COVERAGE FOR PREVENTIVE SERVICES.—In consultation with appropriate experts in the area of preventive medicine (including the Advisory Council on Immunological Practices of the Centers for Disease Control and Prevention), the Secretary may modify the coverage of immunizations and other preventive services otherwise provided under the guaranteed national benefit package under this part to provide for coverage of additional services or to increase the frequency of coverage, but only if—

(1) any such modification is determined to be clinically appropriate;

(2) in the case of preventive services related to communicable diseases, such services shall be provided pursuant to modification without the application of any deductible or coinsurance; and

(3) in the case of behavioral preventive services (as specified by the Secretary), the coverage of such services will not result in any increase in the premium imposed under medicare part C.

(d) COVERAGE OF CERTAIN OTHER PROVIDERS.—

(1) IN GENERAL.—For purposes of a certified health plan or medicare part C, the guaranteed national benefit package shall include—

(1) coverage of services provided at an individual's home by a Christian Science practitioner or Christian Science nurse; and

(2) coverage of services provided in a Christian Science Sanitorium (as defined in section 1861(y) by a Christian Science practitioner.

(2) QUALIFICATIONS OF PROVIDERS.—A Christian Science practitioner or Christian Science nurse is qualified for purposes of paragraph (1) if the practitioner or nurse is listed as such a practitioner or nurse by the First Church of Christ, Scientist, in Boston, Massachusetts.

SEC. 3003. MODIFICATION OF MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS UNDER APPROVED MANAGED MENTAL HEALTH PROGRAMS.

(a) SUBSTITUTION OF MENTAL HEALTH BENEFITS PROVIDED UNDER PROGRAM FOR BENEFITS PROVIDED UNDER GUARANTEED NATIONAL BENEFIT PACKAGE.—In the case of an individual who is a resident of a State operating a comprehensive managed mental health program approved by the Secretary under section 1981 of the Public Health Service Act for a month, the individual is considered to have waived the right to benefits for mental health services under the guaranteed national benefit package under this subtitle in consideration of receipt of benefits for mental health services through such program.

(b) MENTAL HEALTH SERVICES DESCRIBED.—In this section, the term "mental health services" means the following items and services:

(1) Inpatient psychiatric services (as described in section 1812(a)(5) of the Social Security Act).

(2) Any items or services furnished under part B of title XVIII of such Act for the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital.

(3) Intensive community-based mental health services (as described in section 1861(ff) of such Act).

(4) Intensive residential services (as described in section 1861(qq) of such Act).

PART 2—COST-SHARING

SEC. 3011. APPLICATION OF COST-SHARING SCHEDULES.

(a) IN GENERAL.—Benefits provided under the guaranteed national benefit package shall be subject to one of the following cost-sharing schedules offered by a certified health plan and medicare part C:

(1) The standard cost-sharing schedule described in section 3013.

(2) The managed care cost-sharing schedule described in section 3014.

(b) TREATMENT OF DEDUCTIBLES.—

(1) APPLICATION ON AN ANNUAL BASIS.—The deductibles for a year under the schedules referred to in subsection (a) shall be applied based upon expenses incurred for items and

services covered under the guaranteed national benefit package that are furnished in the year.

(2) INDIVIDUAL AND FAMILY GENERAL DEDUCTIBLES.—

(A) INDIVIDUAL.—Subject to subparagraphs (B) and (C), with respect to an individual enrolled under a certified health plan or medicare part C (regardless of the class of enrollment), any individual general deductible in the cost sharing schedule offered by the plan represents the amount of countable expenses (as defined in subparagraph (D)) that the individual may be required to incur in a year before the plan incurs liability for expenses for items and services covered under the guaranteed national benefit package that are furnished to the individual.

(B) FAMILY.—Subject to subparagraph (C), in the case of an individual enrolled under a certified health plan or medicare part C other than under an individual class of enrollment (as defined in section 3(b)), the individual general deductible under subparagraph (A) shall not apply to countable expenses incurred by any member of the individual's family in a year at such time as the family members included in such enrollment have incurred, in the aggregate, countable expenses in the amount of the family general deductible for the year.

(C) SPECIAL RULE FOR HIGH DEDUCTIBLE PLANS.—In the case of an individual enrolled under a certified health plan that is a high deductible plan (as defined in section 5504(5)) in a class of enrollment other than an individual class of enrollment, subparagraph (A) shall not apply and the family general deductible represents the amount of countable expenses (as defined in subparagraph (D)) that the members of family may be required to incur in the aggregate in a year before the plan incurs liability for expenses for items and services covered under the guaranteed national benefit package that are furnished to such members.

(D) COUNTABLE EXPENSE.—In this paragraph, the term "countable expense" means, with respect to an individual for a year, an expense for an item or service covered under the guaranteed national benefit package that is subject to the general deductible and for which, but for such deductible and any other cost sharing under this part, a health plan is liable for payment. The amount of countable expenses for an individual for a year under this paragraph shall not exceed the individual general deductible for the year.

(c) TREATMENT OF COINSURANCE AND COPAYMENTS.—After a general or separate deductible that applies to an item or service covered under the guaranteed national benefit package has been satisfied for a year, coinsurance and copayments are amounts (expressed as a percentage of an amount otherwise payable or as a dollar amount, respectively) that an individual may be required to pay with respect to the item or service.

(d) ROUNDING OF AMOUNTS.—Any amount expressed in dollars in this part shall be rounded to the nearest multiple of $1.

SEC. 3012. LIMITS ON OUT-OF-POCKET EXPENDITURES.

(a) ANNUAL OUT-OF-POCKET LIMIT ON COST-SHARING FOR SERVICES OTHER THAN OUTPATIENT PRESCRIPTION DRUGS.—The total amount of cost-sharing incurred in a year (beginning with 1997) with respect to items and services covered under the guaranteed national benefit package (other than outpatient prescription drugs) may not exceed the following:

(1) In the case of an individual enrolled under a certified health plan or medicare part C under an individual class of enrollment (as defined in section 3(b))—

(A) for 1997, an amount equal to $3,000, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during each of the years 1994 through 1996;

(B) for 1998, the amount determined under this paragraph for 1997, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during 1997; and

(C) for each succeeding year, the amount determined under this paragraph for the previous year, increased by the national medicare growth factor established for the year under section 8201(c).

(2) In the case of an individual enrolled under a certified health plan or medicare part C under any other class of enrollment—

(A) for 1997, an amount equal to $6,000, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the period of 1994 through 1996;

(B) for 1998, the amount determined under this paragraph for 1997, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during 1997; and

(C) for each succeeding year, the amount determined under this paragraph for the previous year, increased by the national medicare growth factor established for the year under section 8201(c).

(b) SEPARATE OUT-OF-POCKET LIMIT ON COST-SHARING FOR OUTPATIENT PRESCRIPTION DRUGS.—The amount of cost-sharing incurred in a year with respect to outpatient prescription drugs may not exceed—

(1) for 1997, $1,000, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during each of the years 1994 through 1996;

(2) for 1998, the amount applicable under this paragraph for 1997, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during 1997; and

(3) for 1999 and each succeeding year, the amount applicable under this paragraph for the previous year, increased by the percentage increase computed under section 8206(b) for the year.

SEC. 3013. STANDARD COST-SHARING SCHEDULE DESCRIBED.

(a) DEDUCTIBLE.—

(1) IN GENERAL.—Except as provided in paragraphs (3) and (4), with respect to expenses incurred for items and services in the comprehensive benefit package during a year (other than expenses incurred for items and services described in paragraph (2)), the standard cost-sharing schedule offered by a certified health plan and medicare part C shall have—

(A) for 1997—

(i) an annual individual general deductible of $500, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the period of 1994 through 1996, and

(ii) an annual family general deductible of $750, increased by such average annual percentage increase;

(B) for 1998, the annual individual general deductible and the annual family general deductible applicable for 1997, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during 1997; and

(C) for 1999 and each succeeding year, the annual individual general deductible and the annual family general deductible applicable for the previous year, increased by the national medicare growth factor established for the year under section 8201(c).

(2) SEPARATE DEDUCTIBLE FOR COVERED OUTPATIENT DRUGS.—With respect to expenses incurred for covered outpatient drugs in a year, the standard cost-sharing schedule offered by a certified health plan and medicare part C shall have—

(A) for 1997, an annual general deductible of $500, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during each of the years 1994 through 1996;

(B) for 1998, the amount applicable under this paragraph for 1997, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during 1997; and

(C) for 1999 and each succeeding year, the amount applicable under this paragraph for the previous year, increased by the percentage increase computed under section 8206(b) for the year.

(3) WAIVER OF DEDUCTIBLE FOR CERTAIN SERVICES.—No deductible shall be applied under the standard cost-sharing schedule offered by a certified health plan or medicare part C with respect to expenses incurred—

(A) for screening mammography (described in section 1834(c) of such Act);

(B) for screening pap smear and pelvic exams (described in section 1861(s)(14);

(C) for screening for sexually-transmitted diseases (described in section 1861(s)(19) of such Act); and

(D) for screening for tuberculosis (described in section 1861(s)(20)) of such Act).

(E) for pregnancy-related services consisting of prenatal services (described in section 1861(s)(21) of such Act);

(F) for voluntary family planning services (described in section 1861(s)(22) of such Act);

(G) for newborn and well-baby services (described in section 1861(oo)(1) of the Social Security Act); and

(H) for well-child services (described in section 1861(pp)(1) of such Act).

(4) SPECIAL RULES FOR HIGH DEDUCTIBLE PLAN.—In the case of a high deductible plan (as defined in section 5504(5))—

(A) the reference in paragraph (1)(A)(i) to "$500" shall be considered a reference to an amount established by the carrier offering the plan, except that such amount may not be less than $1,500 and may not exceed $2,500; and

(B) the reference in paragraph (1)(A)(ii) to "$750" shall be considered a reference to an amount established by the carrier offering the plan, except that such amount may not be less than $2,150 and may not exceed $3,750.

(b) APPLICATION OF MEDICARE COINSURANCE RATES AND COPAYMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the coinsurance rates applicable to an item or service under title XVIII of the Social Security Act shall apply under the standard cost-sharing schedule offered by a certified health plan and medicare part C with respect to the same item or service covered under the guaranteed national benefit package.

(2) WAIVER OF COINSURANCE AND COPAYMENTS FOR CERTAIN INPATIENT SERVICES.—

Under the standard cost-sharing schedule offered by a certified health plan and medicare part C, inpatient hospital services (as defined in section 1861(b) of the Social Security Act) and intensive residential services (as defined in section 1861(qq) of such Act) shall not be subject to the coinsurance otherwise applicable under the second sentence of section 1813(a)(1) of such Act.

(3) COVERAGE OF EXTENDED CARE SERVICES WITHOUT REGARD TO SPELL OF ILLNESS.—With respect to post-hospital extended care services (as defined in section 1861(i) of such Act) furnished in a skilled nursing facility (as defined in section 1861(j) of such Act), such services may be furnished to an individual notwithstanding that the services are not furnished during a spell of illness (as described in section 1861(a)).

SEC. 3014. MANAGED CARE COST-SHARING SCHEDULE.

(a) IN GENERAL.—Items and services covered under the guaranteed national benefit package provided through a provider network (as defined in section 5504(10)) of a certified health plan or medicare part C—

(1) are not subject to a deductible or to payment of any coinsurance (except as may be provided in subsection (b)), and

(2) are subject to the applicable copayment described in this section.

(b) COPAYMENTS IMPOSED IN 1997.—

(1) IN GENERAL.—The copayment applicable under this section with respect to items and services provided during 1997 shall be equal to the following amounts, adjusted in accordance with paragraph (2):

(A) In the case of physician visits and other health professional visits, $15.

(B) In the case of emergency room services (or any other emergency services) for non-emergency treatment, $30.

(C) In the case of hospital outpatient and other ambulatory medical and surgical services, $15.

(D) In the case of a covered outpatient drug—

(i) which is a generic product or which is not a generic product if an equivalent generic product is not available, the lesser of $10 or an amount equal to a coinsurance of 20 percent; or

(ii) which is not a generic product if an equivalent generic product is available, the greater of $10 or an amount equal to a coinsurance of 20 percent.

(E) In the case of pregnancy-related services and family planning services (other than prenatal visits), $15.

(F) In the case of intensive community mental illness and substance abuse services, $30.

(G) In the case of outpatient mental health and substance abuse services (other than psychotherapy) $15 per visit.

(H) In the case of outpatient mental health and substance abuse services consisting of psychotherapy, $25 per visit.

(2) INDEXING OF AMOUNTS PROVIDED.—The amounts described in paragraph (1) shall be increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the period of 1994 through 1996.

(c) COPAYMENTS IMPOSED IN SUBSEQUENT YEARS.—The copayment applicable under this section with respect to items and services provided—

(1) in 1998 is equal to the amount applicable under this section for 1997, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during 1997; and

(2) in 1999 and each succeeding year is equal to the amount applicable under this section for the previous year, increased by the national medicare growth factor established for the year under section 8201(c).

PART 3—MISCELLANEOUS PROVISIONS

SEC. 3021. REFERENCES TO MEDICARE PROVISIONS.

In this subtitle, except as otherwise specifically provided, any references to provisions of title XVIII of the Social Security Act are deemed to be references to such provisions as in effect on the day after the date of the enactment of this Act, taking into account the amendments made to such title by this Act as if the effective date of such amendments were January 1, 1997.

SEC. 3022. RELATION BETWEEN PACKAGE AND CERTAIN STATE LAWS.

(a) PERMITTING STATES TO REQUIRE BENEFITS UNDER CERTIFIED HEALTH PLANS TO BE FURNISHED BY CERTAIN PROVIDERS.—Nothing in this subtitle may be construed to prohibit a State from requiring that an item or service covered under the guaranteed national benefit package be furnished to an individual enrolled in a certified health plan by any particular class or type of provider who is legally authorized to provide such item or service under the law of the State (or under a State regulatory mechanism provided by State law) in which the item or service is provided.

(b) REQUIRING HEALTH PLANS TO OFFER BENEFITS IN EXCESS OF NATIONAL PACKAGE.—No State may require a certified health plan to offer any item or service not included in the guaranteed national benefit package.

(c) COVERAGE OF SERVICES NOT FURNISHED BY MEDICARE PROVIDERS.—

(1) IN GENERAL.—Nothing in this subtitle shall be construed to prohibit coverage of an item or service otherwise described in section 3001 under the guaranteed national benefit package furnished to an individual under a certified health plan solely on the ground that the individual or entity providing the item or service is not an eligible medicare provider, so long as the individual or entity is legally authorized to provide such item or service under the law of the State (or under a State regulatory mechanism provided by State law) in which the item or service is provided.

(2) ELIGIBLE MEDICARE PROVIDER DEFINED.—In paragraph (1), an "eligible medicare provider" is an individual or entity providing an item or service for which payment may be made under title XVIII of the Social Security Act who is participating in such title or otherwise eligible to receive payment for providing such an item or service under such title.

SEC. 3023. PROVISION OF ITEMS OR SERVICES CONTRARY TO RELIGIOUS BELIEF OR MORAL CONVICTION.

A health professional or a health facility may not be required to provide an item or service in the guaranteed national benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction.

SEC. 3024. ESTABLISHMENT OF COMMISSIONS.

(a) ADVISORY COMMISSION ON MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—

(1) ESTABLISHMENT OF COMMISSION.—

(A) IN GENERAL.—The Director of the Office of Technology Assessment (hereafter in this section referred to as the "Director" and the "Office", respectively) shall provide for the appointment of an Advisory Commission on Mental Health and Substance Abuse Services (hereafter in this subsection referred to as the "Commission") to be composed of individuals appointed by the Director without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(B) NUMBER; TIMING OF APPOINTMENT.—The Commission shall consist of 15 individuals. Members of the Commission shall first be appointed not later than 1 year after the date of the enactment of this subsection for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

(C) COMPOSITION.—The membership of the Commission shall include (but need not be limited to)—

(i) physicians,

(ii) other health professionals,

(iii) individuals with knowledge of and experience in the delivery of mental health and substance abuse services,

(iv) representatives of public mental health and substance abuse treatment service systems, and

(v) consumers.

To the greatest extent feasible, the membership of the Commission shall reflect the racial, ethnic, and gender composition of the population of the United States.

(2) ISSUES STUDIED BY COMMISSION.—The Commission shall examine the following issues:

(A) The variety of mental health and substance abuse services provided in the United States, together with the types of providers furnishing such services and the methods under which the providers receive payment for furnishing such services.

(B) The means available to appropriately manage the delivery of mental health and substance abuse services and coordinate the delivery of such services with the delivery of other health services, and to achieve parity in the scope of mental health and substance abuse services covered under the guaranteed national benefit package under this title with the scope of other health services covered under the package.

(C) The variations in the utilization of and costs associated with mental health and substance abuse services among different geographic regions and demographic groups.

(D) The incidence and prevalence of severe mental illness and substance abuse among incarcerated adults and juveniles and the relation between the mental health and substance abuse treatment provided to these individuals and the length of time these individuals are incarcerated.

(E) The standards for training and certifying providers of mental health and substance abuse services.

(F) The standards used to measure the quality of mental health and substance abuse services and to review the utilization of such services.

(G) Such other issues relating to mental health and substance abuse services in the United States as the Commission considers appropriate.

(3) SUBMISSION OF ANNUAL REPORT.—Not later than January 1, 1998 (and not later than January 1 of the first 4 years thereafter), the Commission shall submit to Congress a report—

(A) describing the issues examined by the Commission under paragraph (2) during the preceding year;

(B) evaluating the effectiveness of the guaranteed national benefit package under this subtitle in assuring adequate coverage for mental health and substance abuse services;

(C) analyzing the progress made in achieving parity in the delivery of mental health and substance abuse services and the delivery of other health services for individuals in the United States;

(D) evaluating State comprehensive managed mental health programs operated during the preceding year under section 1981 of the Public Health Service Act and the extent of the integration of public and private systems of mental health and substance abuse treatment services in the State;

(E) analyzing trends in the delivery of mental health and substance abuse services and the costs associated with the delivery of such services; and

(F) analyzing whether any distinctions in limitations on coverage and determinations of payment amounts between mental health and substance abuse services and other services in the guaranteed national benefit package under this subtitle should be maintained, modified, or eliminated.

(4) APPLICABILITY OF OTHER ADMINISTRATIVE PROVISIONS.—The following provisions of section 1886(e)(6) of the Social Security Act shall apply to the Commission in the same manner as such provisions apply to the Prospective Payment Assessment Commission:

(A) Subparagraph (C) (relating to staffing and administration generally).

(B) Subparagraph (D) (relating to compensation of members).

(C) Subparagraph (F) (relating to access to information).

(D) Subparagraph (G) (relating to use of funds).

(E) Subparagraph (H) (relating to periodic GAO audits).

(F) Subparagraph (J) (relating to requests for appropriations).

(5) TERMINATION.—The Commission shall terminate 30 days after submitting the final report required under paragraph (3).

(b) NATIONAL HEALTH ADVISORY COMMISSION.—

(1) ESTABLISHMENT OF COMMISSION.—

(A) IN GENERAL.—The Director of the Office of Technology Assessment (hereafter in this section referred to as the "Director" and the "Office", respectively) shall provide for the appointment of a National Health Advisory Commission (hereafter in this subsection referred to as the "Commission").

(B) COMPOSITION.—The Commission shall consist of the following individuals:

(i) The Chair and Vice-Chair of the Prospective Payment Assessment Commission.

(ii) The Chair and Vice-Chair of the Physician Payment Review Commission.

(iii) The Chair and Vice-Chair of the Prescription Drug Payment Review Commission.

(iv) The Chair and Vice-Chair of the Advisory Commission on Mental Health and Substance Abuse Services.

(v) 3 other individuals appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service) with expertise in health economics, health insurance, benefits, and provider reimbursement.

To the greatest extent feasible, the membership of the Commission shall reflect the racial, ethnic, and gender composition of the population of the United States.

(C) TIMING OF APPOINTMENT.—Members of the Commission shall first be appointed not later than 15 months after the date of the enactment of this subsection for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

(2) DUTIES.—Based on detailed information provided by the Commissions referred to in paragraph (1), the Commission shall monitor the impact of this Act on individuals, employers, and governments.

(3) ANNUAL REPORTS.—Not later than January 1, 1998, and each January 1 thereafter, the Commission shall submit to Congress a report on the impact of this Act on individuals, employers, and governments, and shall include in the report recommendations for changes in this Act, including (but not limited to) changes in the guaranteed national benefit package described in this subtitle.

(4) APPLICABILITY OF OTHER ADMINISTRATIVE PROVISIONS.—The following provisions of section 1886(e)(6) of the Social Security Act shall apply to the Commission in the same manner as such provisions apply to the Prospective Payment Assessment Commission:

(A) Subparagraph (C) (relating to staffing and administration generally).

(B) Subparagraph (D) (relating to compensation of members).

(C) Subparagraph (F) (relating to access to information).

(D) Subparagraph (G) (relating to use of funds).

(E) Subparagraph (H) (relating to periodic GAO audits).

(F) Subparagraph (J) (relating to requests for appropriations).

SEC. 3025. STUDY ON COVERAGE OF EMERGENCY DENTAL SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine whether coverage for emergency dental services should be included in the guaranteed national benefit package under this subtitle.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate regarding the conditions under which emergency dental services should be covered and the methodology under which payment may be made for such services.

SEC. 3026. STUDY ON COVERAGE OF SCREENING FOR ADULT DIABETES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine the appropriateness and cost-effectiveness of screening for adult diabetes for purposes of determining whether coverage for such service should be included in the guaranteed national benefit package under this subtitle.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate regarding the conditions under which screening for adult diabetes should be covered and the methodology under which payment may be made for such service.

Subtitle B—Coverage of Outpatient Prescription Drugs and Other Changes in Medicare Benefits

PART 1—COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS

SEC. 3101. COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS.

(a) COVERED OUTPATIENT DRUGS AS MEDICAL AND OTHER HEALTH SERVICES.—Section 1861(s)(2)(J) (42 U.S.C. 1395x(s)(2)(J)) is amended to read as follows:

"(J) covered outpatient drugs;".

(b) DEFINITION OF COVERED OUTPATIENT DRUG.—Section 1861(t) (42 U.S.C. 1395x(t)) is amended—

(1) in the heading, by adding at the end the following: "; Covered Outpatient Drugs";

(2) in paragraph (1)—

(A) by striking "paragraph (2)" and inserting "the succeeding paragraphs of this subsection", and

(B) by striking the period at the end and inserting ", but only if used for a medically accepted indication (as described in paragraph (4))."; and

(3) by striking paragraph (2) and inserting the following:

"(2) Except as otherwise provided in paragraph (3), the term 'covered outpatient drug' means any of the following products used for a medically accepted indication (as described in paragraph (4)):

"(A) A drug which may be dispensed only upon prescription and—

"(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

"(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

"(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

"(B) A biological product which—

"(i) may only be dispensed upon prescription,

"(ii) is licensed under section 351 of the Public Health Service Act, and

"(iii) is produced at an establishment licensed under such section to produce such product.

"(C) Insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

"(D) Enteral nutrients provided as a covered home infusion drug.

"(E) Medical foods (other than enteral nutrients described in subparagraph (D)) that comply with the requirements of the Federal Food, Drug, and Cosmetic Act and that are prescribed by a physician for persons with Phenylketonuria (PKU) and other inborn errors of metabolism, in accordance with guidelines established by the Secretary.

An item described in subparagraph (D) or (E) shall not be considered a covered outpatient drug for purposes of section 1850.

"(3) The term 'covered outpatient drug' does not include any product—

"(A) which is administered through infusion in a setting described in paragraph (5)(A)(ii) unless the product is a covered home infusion drug (as defined in paragraph (5));

"(B) when furnished as part of, or as incident to, a diagnostic service or any other item or service for which payment may be made under this title (other than physicians' services or services which would be physicians' services if furnished by a physician);

"(C) which is listed under paragraph (2) of section 1927(d) (other than subparagraph (B), (I), or (J) of such subparagraph) as a drug which may be excluded from coverage under a State plan under title XIX and which the Secretary elects to exclude from coverage under part B; or

"(D) which is a contraceptive drug described in section 1861(s)(21).

"(4) For purposes of paragraph (2), the term 'medically accepted indication', with respect to the use of an outpatient drug, includes—

"(A) any use which has been approved by the Food and Drug Administration for the drug, and

"(B) any other use of the drug, unless the Secretary determines that such use is not medically appropriate.

"(5)(A) For purposes of paragraph (3), the term 'covered home infusion drug' means a covered outpatient drug dispensed to an individual that—

"(i) is administered intravenously, subcutaneously, or epidurally, using an access device that is inserted into the body and an infusion device to control the rate of flow of the drug (or through other means of administration determined by the Secretary);

"(ii) is administered—

"(I) in the individual's home,

"(II) an institution used as the individual's home, but only if the drug is administered during an inpatient day for which payment is not made to the institution under part A for inpatient or extended care services furnished to the individual, or

"(III) in a facility other than the individual's home if the administration of the drug at the facility is determined by the Secretary to be cost-effective (in accordance with such criteria as the Secretary may establish); and

"(iii) with respect to a drug furnished in a home setting—

"(I) is an antibiotic drug and the Secretary has not determined, for the specific drug or the indication to which the drug is applied, that the drug cannot generally be administered safely and effectively in such a setting, or

"(II) is not an antibiotic drug and the Secretary has determined, for the specific drug or the indication to which the drug is applied, that the drug can generally be administered safely and effectively in such a setting.

"(B) Not later than January 1, 1998 (and periodically thereafter), the Secretary shall publish a list of the drugs, and indications for such drugs, that are covered home infusion drugs for purposes of this title.".

(c) CONFORMING AMENDMENTS REPEALING SEPARATE COVERAGE OF CERTAIN DRUGS AND PRODUCTS.—(1) Effective January 1, 1998, section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (A), by striking "(including drugs" and all that follows through "self-administered)";

(B) by striking subparagraphs (G) and (I);

(C) by adding "and" at the end of subparagraph (M); and

(D) by striking subparagraphs (O), (P), and (Q).

(2) Effective January 1, 1998, section 1861 (42 U.S.C. 1395x) is amended by striking the subsection (jj) added by section 4156(a)(2) of OBRA–1990.

(3) Effective January 1, 1998, section 1881(b) (42 U.S.C. 1395rr(b)) is amended—

(A) in the first sentence of paragraph (1)—

(i) by striking ", (B)" and inserting ", and (B)", and

(ii) by striking ", and (C)" and all that follows and inserting a period;

(B) in paragraph (11)—

(i) by striking "(11)(A)" and inserting "(11)", and

(ii) by striking subparagraphs (B) and (C).

SEC. 3102. PAYMENT RULES AND RELATED REQUIREMENTS FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

"(d) PAYMENT FOR AND CERTAIN REQUIREMENTS CONCERNING COVERED OUTPATIENT DRUGS.—

"(1) DEDUCTIBLE.—

"(A) IN GENERAL.—Payment shall be made under paragraph (2) only for expenses incurred by an individual for a covered outpatient drug during a calendar year after the individual has incurred expenses in the year for such drugs (during a period in which the individual is entitled to benefits under this part) equal to the deductible amount for that year.

"(B) DEDUCTIBLE AMOUNT.—

"(i) For purposes of subparagraph (A), the deductible amount is—

"(I) for 1998, an amount equal to $500, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during each of the years 1994 through 1997; and

"(II) for any succeeding year, the amount applicable under this subparagraph for the previous year, increased by the percentage increase computed under section 8206(b) of the Guaranteed Health Insurance Act of 1994 for that succeeding year.

"(ii) The Secretary shall promulgate the deductible amount for 1998 and each succeeding year not later than October 1 of the previous year.

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to the deductible established under paragraph (1), the amount payable under this part for a covered outpatient drug furnished to an individual during a calendar year shall be equal to—

"(i) 80 percent of the payment basis described in paragraph (3), in the case of an individual who has not incurred expenses for covered outpatient drugs during the year (including the deductible imposed under paragraph (1)) in excess of the out-of-pocket limit for the year under subparagraph (B); and

"(ii) 100 percent of the payment basis described in paragraph (3), in the case of any other individual.

"(B) OUT-OF-POCKET LIMIT DESCRIBED.—

"(i) For purposes of subparagraph (A), the out-of-pocket limit for a year is equal to—

"(I) for 1998, $1000, increased by the average annual percentage increase in private sector per capita outpatient prescription drug expenditures (as determined by the Secretary) during each of the years 1994 through 1997; and

"(II) for any succeeding year, the amount applicable under this subparagraph for the previous year, increased by the percentage increase computed under section 8206(b) of the Guaranteed Health Insurance Act of 1994 for that succeeding year.

"(ii) The Secretary shall promulgate the out-of-pocket limit for 1998 and each succeeding year not later than October 1 of the previous year.

"(3) PAYMENT BASIS.—For purposes of paragraph (2), the payment basis is the lesser of—

"(A) the actual charge for a covered outpatient drug, or

"(B) the applicable payment limit established under paragraph (4).

"(4) PAYMENT LIMITS.—

"(A) PAYMENT LIMIT FOR SINGLE SOURCE DRUGS AND MULTIPLE SOURCE DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—In the case of a covered outpatient drug that is a multiple source drug which has a restrictive prescription, or that is single source drug, the payment limit for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the per unit estimated acquisition cost for the drug product (determined under subparagraph (C)) for the period.

"(B) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that is a multiple source drug which does not have a restrictive prescription, the payment limit for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the unweighted median of the unit estimated acquisition cost (determined under subparagraph (C)) for the drug products for the period.

"(C) DETERMINATION OF UNIT PRICE.—

"(i) INITIAL PAYMENT CALCULATION PERIOD.—Subject to clause (ii), the Secretary shall determine, for the dispensing of a covered outpatient drug product in the payment calculation period beginning January 1, 1998, the estimated acquisition cost for the drug product, based upon—

"(I) in the case of a single source drug or multiple source drug with a restrictive prescription, based upon information from the period beginning in 1994 updated (in a compound manner) by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 4 12-month periods ending with June 1997; or

"(II) in the case of a multiple source drug without a restrictive prescription, based upon information from the most recent year for which data is available.

"(ii) LIMITATION.—With respect to any covered outpatient drug product, the estimated acquisition cost in the payment calculation period described in clause (i) may not exceed 93 percent of the published average wholesale price for the drug, as determined one month prior to the beginning of the payment calculation period.

"(iii) SUBSEQUENT PERIODS.—The estimated acquisition cost for a covered outpatient drug product applicable under this subparagraph for the dispensing of a drug product in a payment calculation period beginning in January of each year (beginning with 1999) shall be equal to the estimated acquisition cost for the product determined under this subparagraph for the period ending in January of the previous year, increased by the uniform percentage increase determined under section 8206(a) of the Guaranteed Health Insurance Act of 1994 for the class of services that includes prescription drugs for the year involved. Notwithstanding the previous sentence, with respect to any covered outpatient drug product, such cost may not exceed 93 percent of the published average wholesale price for the drug, as determined one month prior to the beginning of the payment calculation period.

"(iv) COMPLIANCE WITH REQUEST FOR INFORMATION.—If a wholesaler or direct seller of a covered outpatient drug refuses, after being requested by the Secretary, to provide price information requested to carry out clauses (i), (ii), or (iii), or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as they apply to a penalty or proceeding under section 1128A(a). Information gathered pursuant to clause (i), (ii), or (iii) shall not be disclosed except as the Secretary determines to be necessary to carry out the purposes of this part and to permit the Comptroller General and the Director of the Congressional Budget Office to review the information provided.

"(D) UPDATES TO PAYMENT LIMITS.—Notwithstanding any other provision of this paragraph, the payment limit determined under this paragraph with respect to a payment calculation period may not exceed the payment limit for the preceding year, increased by the percentage increase computed under section 8206(b) of the Guaranteed Health Insurance Act of 1994.

"(5) ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMIT.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the administrative allowance established under this paragraph is—

"(i) for 1998, an amount equal to $5, adjusted by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 2 12-month periods ending with June 1997; and

"(ii) for each succeeding year, the amount for the previous year, adjusted by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that previous year.

"(B) REDUCTION FOR MAIL ORDER PHARMACIES.—The Secretary may, after consulting with representatives of pharmacists, individuals enrolled under this part, and of private insurers, reduce the administrative allowances established under subparagraph (A) for any covered outpatient drug dispensed by a mail order pharmacy, based on differences between such pharmacies and other pharmacies with respect to operating costs and other economies.

"(C) NO DISPENSING FEE FOR CERTAIN DRUGS AND PRODUCTS.—No administrative allowance may be provided under this paragraph with respect to any of the following covered outpatient drugs:

"(i) Erythropoietin provided to dialysis patients.

"(ii) Drugs and biologicals provided as an incident to a physician's service or to a service which would be a physician's service if furnished by a physician.

"(iii) Covered home infusion drugs.

"(6) ASSURING APPROPRIATE PRESCRIBING AND DISPENSING PRACTICES.—

"(A) IN GENERAL.—The Secretary shall develop a program to—

"(i) provide on-line prospective review of prescriptions on a 24-hour basis (in accordance with subparagraph (B)) and retrospective review of claims;

"(ii) establish standards for counseling individuals to whom covered outpatient drugs are prescribed; and

"(iii) identify (and to educate physicians, patients, and pharmacists concerning)—

"(I) instances or patterns of unnecessary or inappropriate prescribing or dispensing practices for covered outpatient drugs,

"(II) instances or patterns of substandard care with respect to such drugs,

"(III) potential adverse reactions, and

"(IV) appropriate use of generic products.

"(B) PROSPECTIVE REVIEW.—

"(i) IN GENERAL.—The program under this paragraph shall provide for on-line prospective review of each covered outpatient drug prescribed for a patient before the prescription is filled or the drug is furnished, including screening for potential drug therapy problems due to therapeutic duplication, drug-to-drug interactions, and incorrect drug dosage or duration of drug treatment.

"(ii) DISCUSSION OF APPROPRIATE USE.—In conducting prospective review under this subparagraph, any individual or entity that dispenses a covered outpatient drug shall offer to discuss with the patient to whom the drug is furnished or the patient's caregiver (in person if practicable, or through access to a toll-free telephone service) information regarding the appropriate use of the drug, potential interactions between the drug and other drugs dispensed to the individual, and such other matters as the Secretary may require.

"(iii) ADDITIONAL DUTIES.—In carrying out this subparagraph, the Secretary shall—

"(I) develop public domain software which could be used by carriers and pharmacies to provide the on-line prospective review; and

"(II) study the feasibility and desirability of requiring patient diagnosis codes on prescriptions and the feasibility of expanding the prospective review program to include the identification of drug-disease contraindications, interactions with over-the-counter drugs, and drug-allergy interactions.

"(C) PRIOR AUTHORIZATION.—

"(i) IN GENERAL.—The Secretary shall establish a process under which (subject to clause (ii)) the Secretary may require advance approval for any covered outpatient drug.

"(ii) RESTRICTIONS ON DENIAL OF APPROVAL.—The Secretary may not deny the approval of a drug under the process established under clause (i) before its dispensing unless the process—

"(I) provides responses by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

"(II) provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in emergency situations.

"(D) DRUG USE REVIEW.—As part of the program established under subparagraph (A), the Secretary shall provide for a drug use review program to provide for the ongoing periodic examination of claims data and other records on covered outpatient drugs furnished to patients under this title in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients.

"(E) EXCEPTION FOR MANAGED CARE PROGRAMS.—The Secretary may waive the application of any provision of this paragraph to the dispensing of covered outpatient drugs by an organization described in section 1833(a)(1)(A) or an eligible organization with an agreement in effect under section 1876 to the extent the Secretary finds that the organization has in effect a program that meets the objectives of such provision.

"(F) ADOPTION OF MEDICAID PROGRAMS.—To the extent considered appropriate by the Secretary, the program developed under this paragraph with respect to drugs furnished in a State may include elements applicable to the furnishing of covered outpatient drugs under the State medicaid program under section 1927.

"(7) ADMINISTRATIVE AND REPORTING REQUIREMENTS.—

"(A) REQUIREMENTS RELATING TO CONTROLLED SUBSTANCES AND ILLEGAL USES.—The Secretary shall require an entity furnishing covered outpatient drugs under this part to report electronically to the appropriate State agency on any covered outpatient drugs dispensed to individuals enrolled under this part that are controlled substances under schedules II through V of the Controlled Substance Act, and on the illegal use or diversion of any such drugs furnished by the entity.

"(B) REPORTS ON DEATHS AND INJURIES RESULTING FROM USE OF DRUGS.—

"(i) IN GENERAL.—The Secretary shall require individuals and entities furnishing items and services for which payment may be made under this title to report electronically to the Secretary on any incidents within the knowledge of the individual or entity of death or serious injury (including initial or prolonged hospitalization, impairment, damage or disruption in the patient's body function, congenital anomaly, or life-threatening outcome) resulting from the prescribing, dispensing, or administration of a covered outpatient drug dispensed to an individual enrolled under this part.

"(ii) PRIVACY PROTECTION.—The Secretary shall establish standards to protect from public disclosure the identity of individuals or institutions that report information under this subparagraph and the identity of any individual (whether a patient or an individual involved in the prescribing, dispensing, or administration of the drug) who is the subject of such information.

"(C) OBTAINING INFORMATION ON FEDERAL ASSISTANCE FOR DRUG DEVELOPMENT.—The Secretary may request that any Federal department or agency provide the Secretary with information on the amount of assistance provided by the department or agency for the research, development, or manufacture of any drug or drug product.

"(D) STANDARD CLAIMS FORM.—The Secretary shall develop, in consultation with representatives of pharmacies and of other interested persons, a standard claims form for covered outpatient drugs in accordance with title IX of the Guaranteed Health Insurance Act of 1994.

"(8) BILLING REQUIREMENTS.—

"(A) MANDATORY ASSIGNMENT.—(i) Payment under this part for a covered outpatient drug may only be made on an assignment-related basis.

"(ii) Except for deductible, coinsurance, or copayment amounts applicable under this part, no person may bill or collect any amount from an individual enrolled under this part or other person for a covered outpatient drug for which payment may be made under this part, and no such individual or person is liable for payment of any amounts billed in violation of this clause. If a person knowingly and willfully bills or collects an amount in violation of the previous sentence, the Secretary may apply sanctions against such person in accordance with section 1842(j)(2). Paragraph (4) of section 1842(j) shall apply in this clause in the same manner as such paragraph applies to such section.

"(B) USE OF ELECTRONIC SYSTEM.—Carriers and pharmacies shall submit information respecting covered outpatient drugs in accordance with the applicable information system established under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994.

"(9) REQUIRING PHARMACY SUPPLIER NUMBERS.—Payment may not be made under this part with respect to a covered outpatient drug dispensed by a pharmacy unless—

"(A) the entity has obtained a supplier number from the Secretary; and

"(B) the entity demonstrates to the Secretary that it will maintain patient records (in accordance with such standards as the Secretary may impose) and meet the other applicable requirements of this subsection and section 1848(g).

"(10) DEFINITIONS.—In this subsection:

"(A) MULTIPLE AND SINGLE SOURCE DRUGS.—The terms 'multiple source drug' and 'single source drug' have the meanings of those terms under section 1927(k)(7), except that the reference in such section to a 'covered outpatient drug' shall be considered a reference to a covered outpatient drug under this part.

"(B) RESTRICTIVE PRESCRIPTION.—A drug has a 'restrictive prescription' only if—

"(i) in the case of a written prescription, the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that a particular drug product must be dispensed, or

"(ii) in the case of a prescription issued by telephone—

"(I) the physician or other person prescribing the drug (through use of such an appropriate phrase) states that a particular drug product must be dispensed, and

"(II) the physician or other person submits to the pharmacy involved, within 30 days after the date of the telephone prescription, a written confirmation which is in the handwriting of the physician or other person prescribing the drug and which indicates with such appropriate phrase that the particular drug product was required to have been dispensed.

"(C) PAYMENT CALCULATION PERIOD.—The term 'payment calculation period' means a caledar year.".

(b) REQUIRING PHARMACIES TO SUBMIT CLAIMS.—Section 1848(g)(4) (42 U.S.C. 1395w–4(g)(4)) is amended—

(1) in the heading—

(A) by striking "PHYSICIAN", and

(B) by inserting "BY PHYSICIANS AND SUPPLIERS" after "CLAIMS";

(2) in the matter in subparagraph (A) preceding clause (i)—

(A) by striking "For services furnished on or after September 1, 1990, within 1 year" and inserting "Within 1 year (or 90 days in the case of covered outpatient drugs)",

(B) by striking "a service" and inserting "an item or service", and

(C) by inserting "or of providing a covered outpatient drug," after "basis,"; and

(3) in subparagraph (A)(i), by inserting "item or" before "service".

(c) SPECIAL RULES FOR CARRIERS.—

(1) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

"(D) With respect to activities related to covered outpatient drugs, the Secretary may enter into contracts with carriers under this section to perform the activities on a regional basis.".

(2) ADDITIONAL FUNCTIONS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (H);

(B) by adding "and" at the end of subparagraph (L);

(C) by redesignating subparagraph (L) as subparagraph (I); and

(D) by inserting after subparagraph (I) (as so redesignated) the following new subparagraphs:

"(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

"(i) receive information transmitted under the electronic system referred to in section 1834(d)(8)(B), and

"(ii) respond to requests by pharmacies (and individuals entitled to benefits under this part) as to whether or not such an individual has met the prescription drug deductible established under section 1834(d)(1)(A) for a year; and

"(K) will enter into such contracts with organizations described in subsection (f)(3) as the Secretary determines may be necessary to implement and operate (and for related functions with respect to) the electronic system referred to in section 1834(d)(8)(B) for covered outpatient drugs under this part;".

(3) PAYMENT ON OTHER THAN A COST BASIS.—Section 1842(c)(1)(A) (42 U.S.C. 1395u(c)(1)(A)) is amended—

(A) by inserting "(i)" after "(c)(1)(A)",

(B) in the first sentence, by inserting ", except as otherwise provided in clause (ii)," after "under this part, and", and

(C) by adding at the end the following:

"(ii) To the extent that a contract under this section provides for activities related to covered outpatient drugs, the Secretary may provide for payment for those activities based on any method of payment determined by the Secretary to be appropriate.".

(4) BATCH PROMPT PROCESSING OF CLAIMS.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

(A) in paragraphs (2)(A) and (3)(A), by striking "Each" and inserting "Except as provided in paragraph (4), each";

(B) by adding at the end the following new paragraph:

"(4)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), with respect to claims for payment for covered outpatient drugs shall provide for a payment cycle under which each carrier will, on a monthly basis, make a payment with respect to all claims which were received and approved for payment in the period since the most recent date on which such a payment was made with respect to the participating pharmacy or individual submitting the claim.

"(B) If payment is not issued, mailed, or otherwise transmitted within 5 days of when such a payment is required to be made under subparagraph (A), interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after such 5-day period and ending on the date on which payment is made.".

(5) USE OF OTHER ENTITIES FOR COVERED OUTPATIENT DRUGS.—Section 1842(f) (42 U.S.C. 1395u(f)) is amended—

(A) by striking "and" at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting "; and", and

(C) by adding at the end the following:

"(3) with respect to activities related to covered outpatient drugs, any other private entity which the Secretary determines is qualified to conduct such activities.".

(6) DESIGNATED CARRIERS TO PROCESS CLAIMS OF RAILROAD RETIREES.—Section 1842(g) (42 U.S.C. 1395u(g)) is amended by inserting "(other than functions related to covered outpatient drugs)" after "functions".

(d) CONFORMING AMENDMENTS.—

(1)(A) Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking "and" at the end of clause (O), and

(ii) by inserting before the semicolon at the end the following: ", and (Q) with respect to covered outpatient drugs, the amounts paid shall be as prescribed by section 1834(d)".

(B) Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ", except for covered outpatient drugs," after "and (I) of such section".

(2) Section 1833(b)(2) (42 U.S.C. 1395l(b)(2)) is amended by inserting "or with respect to covered outpatient drugs" before the comma.

(3) Section 1834(j)(3)(F) (42 U.S.C. 1395m(j)(4)(F)), as added by section 8421(a)(1) and as redesignated by section 8423(a), is amended—

(A) in clause (i), by adding "and" at the end;

(B) by striking clauses (ii), (iv), and (v) and redesignating clause (iii) as clause (ii); and

(C) in clause (ii) (as so redesignated), by striking the comma at the end and inserting a period.

(4) The first sentence of section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended by inserting "(other than a carrier described in subsection (f)(3))" after "Each carrier".

(5) The first sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) in clause (i), by inserting "section 1834(d)," after "section 1833(b),", and

(B) in clause (ii), by inserting ", other than for covered outpatient drugs," after "provider)".

SEC. 3103. MEDICARE REBATES FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Part B of title XVIII is amended by adding at the end the following new section:

"REBATES FOR OUTPATIENT DRUGS

"SEC. 1850. (a) REQUIREMENT FOR REBATE AGREEMENT.—In order for payment to be available under this part for drugs of a manufacturer dispensed or provided on or after January 1, 1998, the manufacturer must have entered into and have in effect a rebate agreement with the Secretary meeting the requirements of subsection (b) and an agreement to give equal access to discounts in accordance with subsection (e), and must meet the requirements of section 1927(a)(1).

"(b) TERMS, IMPLEMENTATION, AND ENFORCEMENT OF REBATE AGREEMENT.—

"(1) PERIODIC REBATES.—

"(A) IN GENERAL.—A rebate agreement under this section shall require the manufacturer to pay to the Secretary for each calendar quarter, not later than 30 days after the date of receipt of the information described in paragraph (2) for such quarter, a rebate in an amount determined under subsection (c) for all covered outpatient drugs of the manufacturer described in subparagraph (B).

"(B) DRUGS INCLUDED IN QUARTERLY REBATE CALCULATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), drugs subject to a rebate with respect to a calendar quarter are covered outpatient drugs which are single source and innovator multiple source drugs, and contraceptive drugs described in section 1861(s)(21), which are dispensed or provided during such quarter to individuals (other than individuals enrolled with an eligible organization with a contract under section 1876) eligible for benefits under this part, as reported to the Secretary.

"(ii) Exception for certain biological products.—A covered outpatient drug consisting of a biological product is not subject to a rebate under this section if payment was made for the product under part B prior to the date of the enactment of this section.

"(2) Information furnished to manufacturers.—

"(A) In general.—The Secretary shall report to each manufacturer, not later than 60 days after the end of each calendar quarter, information on the total number, for each covered outpatient drug described in paragraph (1)(B), of units of each dosage form, strength, and package size dispensed or provided under the plan during the quarter, on the basis of the data reported to the Secretary described in paragraph (1)(B).

"(B) Audit.—The Comptroller General may audit the records of the Secretary to the extent necessary to determine the accuracy of reports by the Secretary pursuant to subparagraph (A). Adjustments to rebates shall be made to the extent determined necessary by the audit to reflect actual units of drugs dispensed.

"(3) Provision of price information by manufacturer.—

"(A) Quarterly pricing information.—Each manufacturer with an agreement in effect under this section shall report to the Secretary, not later than 30 days after the last day of each calendar quarter, on the average manufacturer retail price and the average manufacturer non-retail price for each dosage form and strength of each covered outpatient drug described in paragraph (1)(B) for the quarter.

"(B) Base quarter prices.—Each manufacturer of a covered outpatient drug with an agreement under this section shall report to the Secretary, by not later than 30 days after the effective date of such agreement (or, if later, 30 days after the end of the base quarter), the average manufacturer retail price, for such base quarter, for each dosage form and strength of each such covered drug.

"(C) Verification of average manufacturer price.—The Secretary may inspect the records of manufacturers, and survey wholesalers, pharmacies, and institutional purchasers of drugs, as necessary to verify prices reported under subparagraph (A).

"(D) Penalties.—

"(i) Civil money penalties.—The Secretary may impose a civil money penalty on a manufacturer with an agreement under this section—

"(I) for failure to provide information required under subparagraph (A) on a timely basis, in an amount up to $10,000 per day of delay;

"(II) for refusal to provide information about charges or prices requested by the Secretary for purposes of verification pursuant to subparagraph (C), in an amount up to $100,000; and

"(III) for provision, pursuant to subparagraph (A) or (B), of information that the manufacturer knows or should know is false, in an amount up to $100,000 per item of information.

Such civil money penalties are in addition to any other penalties prescribed by law. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(ii) Termination of agreement.—If a manufacturer with an agreement under this section has not provided information required under subparagraph (A) or (B) within 90 days of the deadline imposed, the Secretary may suspend the agreement with respect to covered outpatient drugs dispensed after the end of such 90-day period and until the date such information is reported (but in no case shall a suspension be for less than 30 days).

"(4) Length of agreement.—

"(A) In general.—A rebate agreement shall be effective for an initial period of not less than one year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

"(B) Termination.—

"(i) By the secretary.—The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall afford a manufacturer an opportunity for a hearing concerning such termination, but such hearing shall not delay the effective date of the termination.

"(ii) By a manufacturer.—A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

"(iii) Effective date of termination.—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

"(iv) Notice to pharmacies.—In the case of a termination under this subparagraph, the Secretary shall notify pharmacies and physician organizations not less than 30 days before the effective date of such termination.

"(c) Amount of Rebate.—

"(1) Base rebate.—Each manufacturer shall remit a basic rebate to the Secretary for each calendar quarter in an amount, with respect to each dosage form and strength of a covered outpatient drug equal to the product of—

"(A) the total number of units subject to rebate for such quarter, as described in subsection (b)(1)(B); and

"(B)(i) in the case of a single-source drug or an innovator-multiple source drug (other than insulin furnished over-the-counter), 15 percent of the average manufacturer retail price, or

"(ii) in the case of insulin furnished over-the-counter, 10 percent of the average manufacturer retail price.

"(2) Additional rebate.—Each manufacturer shall remit to the Secretary, for each calendar quarter, an additional rebate for each dosage form and strength of a single-source drug or an innovator-multiple source drug, in an amount equal to—

"(A) the total number of units subject to rebate for such quarter, as described in subsection (b)(1)(B), multiplied by

"(B) the amount, if any, by which the average manufacturer retail price for such drugs of the manufacturer exceeds the average manufacturer retail price for the base quarter, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from the end of such base quarter to the month before the beginning of such calendar quarter.

"(3) Deposit of rebates.—The Secretary shall deposit rebates under this section in the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"(d) Confidentiality of Information.—Notwithstanding any other provision of law, information disclosed by a manufacturer under this section is confidential and shall not be disclosed by the Secretary (or a carrier), except—

"(1) as the Secretary determines to be necessary to carry out this section,

"(2) to permit the Comptroller General to review the information provided, and

"(3) to permit the Director of the Congressional Budget Office to review the information provided.

"(e) Agreement to Give Equal Access to Discounts.—An agreement under this subsection by a manufacturer of covered outpatient drugs shall guarantee that the manufacturer will offer, to each wholesaler or retailer (or other purchaser representing a group of such wholesalers or retailers) that purchases such drugs on substantially the same terms (including such terms as prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other terms effectively reducing the manufacturer's costs) as any other purchaser (including any institutional purchaser) the same price for such drugs as is offered to such other purchaser. In determining a manufacturer's compliance with the previous sentence, there shall not be taken into account prices that are merely nominal in amount or prices excluded under section 1927(c)(1)(C)(i).

"(f) Definitions.—For purposes of this section—

"(1) Average manufacturer retail price.—The term 'average manufacturer retail price' means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price (inclusive of discounts for cash payment, prompt payment, volume purchases, and rebates (other than rebates under this section), but exclusive of nominal prices) paid to the manufacturer for the drug in the United States for drugs distributed to the retail pharmacy class of trade.

"(2) Average manufacturer non-retail price.—The term 'average manufacturer non-retail price' means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the weighted average price (inclusive of discounts for cash payment, prompt payment, volume purchases, and rebates (other than rebates under this section), but exclusive of nominal prices) paid to the manufacturer for the drug in the United States by hospitals and other institutional purchasers that purchase drugs for institutional use and not for resale.

"(3) Base quarter.—The term 'base quarter' means, with respect to a covered outpatient drug of a manufacturer, the calendar quarter beginning April 1, 1993, or (if later) the first full calendar quarter during which the drug was marketed in the United States.

"(4) Drug.—The terms 'innovator multiple source drug', 'noninnovator multiple source drug', and 'single source drug' have the meanings of those terms under section 1927(k)(7), except that the reference in such section to a 'covered outpatient drug' shall be considered a reference to a covered outpatient drug under this part.

"(5) Manufacturer.—The term 'manufacturer' means, with respect to a covered outpatient drug—

"(A) the entity whose National Drug Code number (as issued pursuant to section 510(e) of the Federal Food, Drug, and Cosmetic Act) appears on the labeling of the drug; or

"(B) if the number described in subparagraph (A) does not appear on the labeling of the drug, the person named as the applicant in a human drug application (in the case of a new drug) or the product license application (in the case of a biological product) for such drug approved by the Food and Drug Administration.".

(b) Exclusions From Coverage.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking "and" at the end of paragraph (15),

(2) by striking the period at the end of paragraph (16) and inserting "; or", and

(3) by inserting after paragraph (16) the following new paragraph:

"(17) consisting of a covered outpatient drug (as described in section 1861(t)) furnished during a year for which the drug's manufacturer does not have in effect a rebate agreement with the Secretary that meets the requirements of section 1850 for the year.".

SEC. 3104. PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION.

Part B of title XVIII is amended by adding at the end the following new section:

"PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

"Sec. 1847. (a) Appointment; Membership.—(1) The Director of the Congressional Office of Technology Assessment (in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Prescription Drug Payment Review Commission (in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of covered outpatient drugs appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed by no later than January 1, 1996, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

"(3) The membership of the Commission shall include recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as at least one individual who is a medicare beneficiary and one individual representing a research-based pharmaceutical and biotechnology company. To the greatest extent feasible, the membership of the Commission shall reflect the racial, ethnic, and gender composition of the population of the United States.

"(b) Reports.—(1) The Commission shall submit to Congress an annual report no later than May 1 of each year, beginning with 1997, concerning methods of determining payment for covered outpatient drugs under this part, including recommendations on the prescription drug allocation of national private and medicare health care expenditure estimates for a year and the annual target rate of increase for such allocation under title VI of the Guaranteed Health Insurance Act of 1994.

"(2) The report described in paragraph (1), in 1998 and thereafter, shall include, with respect to the previous year, information on—

"(A) the relation between the costs of covered outpatient drugs and the costs of other items and services provided for the treatment of similar illnesses and conditions,

"(B) the level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(C) administrative costs relating to covered outpatient drugs.

"(3) The first report submitted by the Commission under paragraph (1) shall include an analysis of—

"(A) the feasibility and desirability of excluding manufacturers from the requirement to provide a rebate under section 1850 on the basis of the manufacturers' discounts, rate of increase in prices charged, profits, and other appropriate criteria;

"(B) the appropriateness of the payment methodology provided under this part for the professional services of pharmacists, including the reasonableness of the charges for varying levels of services (including patient consultation); and

"(C) the appropriateness of providing for public disclosure of the information submitted to the Secretary under section 1850 by manufacturers of covered outpatient drugs on the prices charged and other similar information, and the effect of such disclosure on the competitiveness of such prices.

"(c) Consumer Guide.—The Commission shall publish a consumer guide to prescription drugs to assist individuals in reducing expenditures for covered outpatient drugs and to assist providers in determining the cost-effectiveness of such drugs.

"(d) Administration.—Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

"(e) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund and the Medicare Part C Trust Fund under section 2124, in an allocation that reasonably reflects the proportion of expenditures for outpatient prescription drugs under this part and under title XXI.".

SEC. 3105. COVERAGE OF HOME INFUSION DRUG THERAPY SERVICES.

(a) In General.—Section 1832(a)(2)(A) (42 U.S.C. 1395k(a)(2)(A)) is amended by inserting "and home infusion drug therapy services" before the semicolon.

(b) Home Infusion Drug Therapy Services Defined.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by redesignating the subsection (jj) inserted by section 4156(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as subsection (kk); and

(2) by inserting after such subsection the following new subsection:

"Home Infusion Drug Therapy Services

"(ll)(1) The term 'home infusion drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

"(A) in a setting described in section 1861(t)(5)(A)(ii),

"(B) by a qualified home infusion drug therapy provider (as defined in paragraph (3)) or by others under arrangements with them made by that provider, and

"(C) under a plan established and periodically reviewed by a physician.

"(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively a drug regimen through use of a covered home infusion drug (as defined in subsection (t)(5)), but do not include such covered home infusion drugs.

"(3) The term 'qualified home infusion drug therapy provider' means any entity that the Secretary determines meets the following requirements (or, in the case of a home health agency or an entity with respect to which the only items and services described in paragraph (2) furnished by the entity are enteral nutrition therapy services, meets any of the following requirements which the Secretary considers appropriate):

"(A) The entity is capable of providing or arranging for the items and services described in paragraph (2) and covered home infusion drugs.

"(B) The entity maintains clinical records on all patients.

"(C) The entity adheres to written protocols and policies with respect to the provision of items and services.

"(D) The entity makes services available (as needed) seven days a week on a 24-hour basis.

"(E) The entity coordinates all service with the patient's physician.

"(F) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

"(G) The entity assures that only trained personnel provide covered home infusion drugs (and any other service for which training is required to provide the service safely).

"(H) The entity assumes responsibility for the quality of services provided by others under arrangements with the entity.

"(I) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, the entity (i) is licensed pursuant to such law, or (ii) is approved, by the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

"(J) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home infusion drug therapy services and the efficient administration of the home infusion drug therapy benefit.".

(c) Payment.—

(1) In general.—Section 1833 (42 U.S.C. 1395l) is amended—

(A) in subsection (a)(2)(B), by striking "or (E)" and inserting "(E), or (F)",

(B) in subsection (a)(2)(D), by striking "and" at the end,

(C) in subsection (a)(2)(E), by striking the semicolon and inserting "; and",

(D) by inserting after subsection (a)(2)(E) the following new subparagraph:

"(F) with respect to home infusion drug therapy services, the amounts described in section 1834(j);", and

(E) in the first sentence of subsection (b), by striking "services, (3)" and inserting "services and home infusion drug therapy services, (3)".

(2) Amount described.—Section 1834 is amended by adding at the end the following new subsection:

"(j) Home Infusion Drug Therapy Services.—

"(1) In general.—With respect to home infusion drug therapy services, payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee schedule established under paragraph (2).

"(2) Establishment of fee schedule.—

"(A) In general.—The Secretary shall establish by regulation before the beginning of 1998 and each succeeding year a fee schedule for home infusion drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis.

"(B) ADJUSTMENT FOR SERVICES FURNISHED BY INSTITUTIONS.—The fee schedule established by the Secretary under subparagraph (A) shall provide for adjustments in the case of home infusion drug therapy services for which payment is made under this part that are furnished by a provider of services to avoid duplicative payments under this title for the service costs associated with such services.".

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) by striking "and" at the end of subparagraph (E),

(2) by striking the period at the end of subparagraph (F) and inserting "; and", and

(3) by inserting after subparagraph (F) the following:

"(G) in the case of home infusion drug therapy services, (i) such services are or were required because the individual needed such services for the administration of a covered home infusion drug, (ii) a plan for furnishing such services has been established and is reviewed periodically by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.".

(e) CERTIFICATION OF HOME INFUSION DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) (42 U.S.C. 1395x(u)) is amended by inserting "home infusion drug therapy provider," after "hospice program,".

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 (42 U.S.C. 1395z) is amended by striking "and (dd)(2)" and inserting "(dd)(2), and (ll)(3)".

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) (42 U.S.C. 1395aa(a)) is amended—

(A) in the first sentence, by striking "an agency is a hospice program" and inserting "an agency or entity is a hospice program or a home infusion drug therapy provider,"; and

(B) in the second sentence—

(i) by striking "institution or agency" and inserting "institution, agency, or entity", and

(ii) by striking "or hospice program" and inserting "hospice program, or home infusion drug therapy provider".

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 (42 U.S.C. 1395w2) is amended—

(A) in the heading, by adding "AND FOR QUALIFIED HOME INFUSION DRUG THERAPY PROVIDERS" at the end,

(B) in subsection (a), by inserting "or that a qualified home infusion drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(ll)(3)" after "under this part", and

(C) in subsection (b)(2)(A)(iv), by inserting "or home infusion drug therapy services" after "clinical diagnostic laboratory tests".

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

"(k) With respect to carrying out functions relating to payment for home infusion drug therapy services and covered home infusion drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.".

(g) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(B) (42 U.S.C. 1395m(h)(4)(B)) is amended by striking ", except that" and all that follows through "equipment".

(2) Section 1861(n) (42 U.S.C. 1395x(n)) is amended by adding at the end the following: "Such term does not include any home infusion drug therapy services described in section 1861(ll) or any covered outpatient drug used as a supply related to the furnishing of an item of durable medical equipment.".

(3) Section 1861(s)(8) (42 U.S.C. 1395x(s)(8)) is amended by inserting after "dental" the following: "devices or enteral and parenteral nutrients, supplies, and equipment".

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

PART 2—CHANGES IN MEDICARE BENEFITS TO CONFORM TO GUARANTEED NATIONAL BENEFIT PACKAGE

SEC. 3111. IMPOSITION OF CAP ON OUT-OF-POCKET EXPENDITURES.

(a) IN GENERAL.—Title XVIII is amended by adding at the end the following new section:

"LIMIT ON COST-SHARING INCURRED DURING YEAR

"SEC. 1894. (a) IN GENERAL.—Notwithstanding any other provision of this title, the total amount of cost-sharing incurred by an individual in a year (beginning with 2004) with respect to items and services provided to the individual under this title shall be subject to a limit equal to—

"(1) with respect to items and services furnished in 2004, an amount equal to $5,500, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during each of the years 1994 through 1998 and by the national medicare growth factors established for each of the years 1999 through 2004 under section 8201(c) of the Guaranteed Health Insurance Act of 1994; and

"(2) with respect to items and services furnished in any succeeding year, the amount determined under this paragraph for the previous year, increased by the national medicare growth factor established for the year under section 8201(c) of the Guaranteed Health Insurance Act of 1994.

"(b) NOTICE FOR BENEFICIARIES REACHING LIMIT.—The Secretary shall provide each individual, who is determined to have incurred (or has had paid on the individual's behalf) cost-sharing in a calendar year in the amount described in subsection (a) with a notice that states that the individual has reached the limit on out-of-pocket cost sharing for the year.

"(c) COST-SHARING DEFINED.—In subsection (a), the term 'cost-sharing' means expenses incurred by an individual that are attributable to—

"(1) the deductibles and coinsurance described in section 1813;

"(2) the deductibles established under section 1833(b); and

"(3) the difference between the payment amount provided under part B and the payment amount that would be provided if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in sections 1833(a), 1833(i)(2), 1833(i)(3), 1833(n)(1)(B)(i)(II), 1834(a)(1)(A), 1834(c)(1)(C), 1834(h)(1)(A), 1834(i)(1), 1835(b)(2), 1866(a)(2)(A), 1881(b)(2), and 1881(b)(3).".

(b) LIMIT ON CHARGES WHEN CAP REACHED.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: "A provider of services may not impose a charge under the first sentence of this subparagraph for services furnished to an individual during a year after the amount of cost-sharing incurred by the individual during the year reaches the limit on such cost-sharing established under section 1894.".

SEC. 3112. REPEAL OF LIMIT ON LIFETIME RESERVE DAYS OF INPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.—Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by striking "for up to" and all that follows through "payment made)".

(b) CONFORMING AMENDMENTS.—Section 1812 (42 U.S.C. 1395d) is further amended—

(1) in subsection (b), by striking paragraph (1);

(2) by striking subsection (c); and

(3) in subsection (e), by striking "subsections (b) and (c)" and all that follows through "extended care services" and inserting "subsection (b), services".

(c) ADMINISTRATION; TRANSITION.—The Secretary of Health and Human Services may take such actions as the Secretary finds appropriate to adjust the payments made to hospitals under title XVIII of the Social Security Act for hospital services to take into account the amendments made by this section.

SEC. 3113. COVERAGE OF SERVICES FOR INFANTS AND CHILDREN.

(a) SERVICES DESCRIBED.—Section 1861(s) (42 U.S.C. 1395x(s)(2)) is amended—

(1) by striking "and" at the end of paragraph (12);

(2) by striking the period at the end of paragraph (14) and inserting "; and"; and

(3) by inserting after paragraph (14) the following new paragraphs:

"(15) newborn and well-baby services (as defined in subsection (oo)(1));".

"(16) well-child services (as defined in subsection (pp)(1)) provided to an individual who is under 19 years of age; and

"(17) medically necessary and appropriate hearing aids provided to an individual who is under 19 years of age (in accordance with such periodicity schedule as the Secretary may establish in consultation with the Academy of Otolaryngology-Head and Neck Surgery and the American Speech-Language Hearing Association).".

(b) SERVICES DEFINED.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Newborn and Well-Baby Services

"(oo)(1) The term 'newborn and well-baby services' means well-baby care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests (including lead screening), and includes the services of pediatricians during high-risk delivery (as determined in accordance with criteria established by the Secretary).

"(2) The Secretary, in consultation with the American Academy of Pediatrics and other entities considered appropriate by the Secretary, shall establish a schedule of periodicity which reflects the appropriate frequency with which the services referred to in paragraph (1) should be provided.".

"Well-Child Services

"(pp)(1) The term 'well-child services' means well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests (including lead screening in accordance with recommendations of the Centers for Disease Control and Prevention), child abuse assessment, and dental care (including preventive dental services described in paragraph (2), routine fillings, and oral surgery), provided in accordance with the periodicity schedule established with respect to the services under paragraph (3).

"(2) In paragraph (1), the term 'preventive dental services' means oral dental examinations, radiographs, dental sealants, fluoride application, and dental prophylaxis.

"(3) The Secretary, in consultation with the American Academy of Pediatrics, the Academy of Pediatric Dentistry, and other entities considered appropriate by the Secretary, shall establish a schedule of periodicity which reflects the appropriate frequency with which the services referred to in paragraph (1) should be provided to healthy children.".

(2) CONFORMING AMENDMENTS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking "and" at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting a comma, and

(iii) by adding at the end the following new subparagraphs:

"(G) in the case of newborn and well-baby services, which are performed more frequently than is provided under the schedule of periodicity established by the Secretary under section 1861(oo)(2) for such services, and

"(H) in the case of well-child services, which are provided more frequently than is provided under the schedule of periodicity established by the Secretary under section 1861(pp)(2) for such services;"; and

(B) in paragraph (7), by striking "section 1861(s)(10) and paragraph (1)(B) or under paragraph (1)(F)" and inserting "section 1861(s)(10), section 1861(s)(17), and subparagraphs (B), (F), (G), or (H) of paragraph (1)".

(3) PAYMENT; WAIVER OF COST-SHARING.—

(A) AMOUNT OF PAYMENT; WAIVER OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 3102(d)(1)(A), is amended—

(i) by striking "and (Q)" and inserting "(Q)"; and

(ii) by striking the semicolon at the end and inserting the following: ", (R) with respect to newborn and well-baby services (as described in section 1861(oo)(1)), the amounts paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, and (S) with respect to well-child services (as described in section 1861(pp)(1)), the amounts paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(B) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(i) by striking "and (5)" and inserting "(5)"; and

(ii) by striking the period at the end and inserting the following: ", (6) such deductible shall not apply with respect to newborn and well-baby services (as described in section 1861(oo)(1)), and (7) such deductible shall not apply with respect to well-child services (as described in section 1861(pp)(1)).".

(4) COVERAGE OF SERVICES UNDER MAINTENANCE OR PREVENTION PROGRAM FOR CERTAIN CHILDREN AS REHABILITATION SERVICES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended by adding at the end the following: "In the case of a child under 19 years of age with a congenital condition, the term 'outpatient physical therapy services' shall include the following rehabilitation services that are used to prevent deterioration of, or restore or maintain, functional capacity:

"(A) The initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional.

"(B) the designing by such professional of a maintenance or prevention program that is appropriate to the capacity and tolerance of the patient and the treatment objectives;

"(C) the instruction of the patient, family members, and any personnel providing rehabilitation-related assistance to the individual, in carrying out such program; and

"(D) reevaluations of such program.".

(c) GENERAL CONFORMING AMENDMENTS.—The Social Security Act is amended—

(1) in section 1861(s)(2)(C) (42 U.S.C. 1395x(s)(2)(C)), by striking "(C)" and inserting "(C) subject to section 1890(b),";

(2) in section 1861(s)(3) (42 U.S.C. 1395x(s)(3)), by striking "(3)" and inserting "(3) subject to section 1890(a)";

(3) by striking the second and third sentences of section 1861(s); and

(4) by inserting after section 1889 the following new section:

"SPECIAL RULES FOR LABORATORY AND DIAGNOSTIC TESTS AND SERVICES

"SEC. 1890. (a) REQUIRING DIAGNOSTIC LABORATORY AND SCREENING TESTS TO BE FURNISHED IN CERTIFIED SETTINGS.—No payment may be made under this title for any diagnostic and screening test performed in any laboratory (including a laboratory that is part of a rural health clinic or any institution considered a hospital for purposes of section 1814(d)), including a routine laboratory test for purposes of section 1861(oo)(1) or section 1861(pp)(1), unless such laboratory meets the following requirements:

"(1) If the laboratory is situated in any State in which State or applicable local law provides for licensing of establishments of this nature, the laboratory—

"(A) is licensed pursuant to such law, or

"(B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing.

"(2) The laboratory meets—

"(A) the certification requirements under section 353 of the Public Health Service Act; and

"(B) such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

"(b) EXCLUSION OF DIAGNOSTIC SERVICES NOT MEETING REQUIREMENTS FOR INPATIENT HOSPITAL SERVICES.—

"(1) IN GENERAL.—No item or service may be included as a diagnostic service specified in section 1861(s)(2)(C) if the item or service would not be included as an inpatient hospital service under section 1861(b) if furnished to an inpatient of a hospital.

"(2) EXCEPTION FOR PHYSICIANS' SERVICES.—Paragraph (1) shall not apply with respect to any service consisting of a physicians' service."; and

(5) by striking "paragraphs (15) and (16) of section 1861(s)" each place it appears in section 1864(a) and the third sentence of section 1865(a) and inserting "subsections (a) and (b) of section 1890".

SEC. 3114. EXPANDING COVERAGE OF PREVENTIVE BENEFITS.

(a) SCREENING MAMMOGRAPHY.—

(1) PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 49.—SECTION 1834(C)(2)(A) (42 U.S.C. 1395M(C)(2)(A)) IS AMENDED—

(A) in clause (iv), by striking "but under 65 years of age,"; and

(B) by striking clause (v).

(2) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 3113(b)(3), is amended—

(A) by striking "and (7)" and inserting "(7)"; and

(B) by striking the period at the end and inserting the following: ", and (8) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)).".

(3) CONFORMING AMENDMENT.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking ", subject to the deductible established under section 1833(b),".

(b) COVERAGE OF SCREENING PAP SMEAR AND PELVIC EXAMS.—

(1) COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(A) in the heading, by striking "Smear" and inserting "Smear; Screening Pelvic Exam";

(B) by striking "(nn)" and inserting "(nn)(1)";

(C) by striking "3 years" and all that follows and inserting "3 years, or during the preceding year in the case of a woman described in paragraph (3)."; and

(D) by adding at the end the following new paragraphs:

"(2) The term 'screening pelvic exam' means a pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

"(3) A woman described in this paragraph is a woman who—

"(A) is of childbearing age and has not had a test described in this subsection during each of the preceding 3 years that did not indicate the presence of cervical cancer; or

"(B) is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary).".

(2) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 3113(b)(3) and subsection (a)(2), is amended—

(A) by striking "and (8)" and inserting "(8)"; and

(B) by striking the period at the end and inserting the following: ", and (9) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)).".

(3) CONFORMING AMENDMENTS.—(A) Section 1861(s)(14) (42 U.S.C. 1395x(s)(14)) is amended by inserting "and screening pelvic exam" after "screening pap smear".

(B) Section 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended by inserting "and screening pelvic exam" after "screening pap smear".

(c) COVERAGE OF COLORECTAL SCREENING.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m), as amended by section 3102(a), is amended by inserting after subsection (d) the following new subsection:

"(e) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS, SCREENING FLEXIBLE SIGMOIDOSCOPIES, AND SCREENING COLONOSCOPY.—

"(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

"(A) LIMITING COVERAGE FOR NON-ELDERLY TO HIGH-RISK INDIVIDUALS.—No payment may be made under this part for a screening fecal-occult blood test provided for the purpose of early detection of colon cancer to an individual who is under 65 years of age unless the individual is at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary).

"(B) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer if the test is performed—

"(i) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

"(ii) in the case of any other individual, within the 11 months following the month in which a previous screening fecal-occult blood test was performed.

"(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

"(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

"(B) LIMITING COVERAGE FOR NON-ELDERLY TO HIGH-RISK INDIVIDUALS.—No payment may be made under this part for a screening flexible sigmoidoscopy provided for the purpose of early detection of colon cancer to an individual who is under 65 years of age unless the individual is at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary).

"(C) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer if the procedure is performed—

"(i) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

"(ii) in the case of any other individual, within the 59 months following the month in which a previous screening flexible sigmoidoscopy was performed.

"(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

"(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening colonoscopy for individuals at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary) provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

"(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening colonoscopy for individuals at high risk for colorectal cancer provided to an individual for the purpose of early detection of colon cancer if the procedure is performed within the 47 months following the month in which a previous screening colonoscopy was performed.

"(C) FACTORS CONSIDERED IN ESTABLISHING CRITERIA FOR DETERMINING INDIVIDUALS AT HIGH RISK.—In establishing criteria for determining whether an individual is at high risk for colorectal cancer for purposes of this paragraph, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

"(4) REVISION OF FREQUENCY.—

"(A) REVIEW.—The Secretary shall review periodically the appropriate frequency for performing screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy based on age and such other factors as the Secretary believes to be pertinent.

"(B) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection, but no such revision shall apply to tests or procedures performed before January 1, 2002.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer or a screening colonoscopy provided to an individual at high risk for colorectal cancer for the purpose of early detection of colon cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as defined in section 1848(g)(2)).

"(B) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(2) CONFORMING AMENDMENTS.—(A) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by striking "subsection (h)(1)," and inserting "subsection (h)(1) or section 1834(e)(1),".

(B) Clauses (i) and (ii) of section 1848(a)(2)(A) (42 U.S.C. 1395w-4(a)(2)(A)) are each amended by striking "a service" and inserting "a service (other than a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer or a screening colonoscopy provided to an individual at high risk for colorectal cancer for the purpose of early detection of colon cancer)".

(C) Section 1861(s) (42 U.S.C. 1395x(s)) as amended by section 3113(a), is amended—

(i) by striking "and" at the end of paragraph (16);

(ii) by striking the period at the end of paragraph (17) and inserting "; and"; and

(iii) by inserting after paragraph (17) the following new paragraph:

"(18) screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy provided for the purpose of early detection of colon cancer.".

(D) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 3113(b)(2), is amended—

(i) in paragraph (1)—

(I) in subparagraph (G), by striking "and" at the end;

(II) in subparagraph (H), by striking the semicolon at the end and inserting ", and"; and

(III) by adding at the end the following new subparagraph:

"(I) in the case of screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy provided for the purpose of early detection of colon cancer, which are performed more frequently than is covered under section 1834(e);"; and

(ii) in paragraph (7), by striking "or (H)" and inserting "(H), or (I)".

(d) COVERAGE OF SCREENING FOR SEXUALLY-TRANSMITTED DISEASES.—

(1) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)(2)), as amended by section 3113(a) and subsection (c)(2)(C), is amended—

(A) by striking "and" at the end of paragraph (17);

(B) by striking the period at the end of paragraph (18) and inserting "; and"; and

(C) by inserting after paragraph (18) the following new paragraph:

"(19) screening for sexually-transmitted diseases for an individual over 12 years of age and under 50 years of age who is at risk for sexually-transmitted disease (as determined pursuant to factors identified by the Secretary) and who has not had such a screening during the preceding 1-year period.".

(2) AMOUNT OF PAYMENT; WAIVER OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 3102(f), section 3113(b)(3), and subsection (b)(2), is amended—

(A) by striking "and (S)" and inserting "(S)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (T) with respect to screening for sexually-transmitted diseases (as described in section 1861(s)(19)), the amounts paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(3) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b), (42 U.S.C. 1395l(b)) as amended by section 3113(b)(3), subsection (a)(2), and subsection (b)(2), is amended—

(A) by striking "and (9)" and inserting "(9)"; and

(B) by striking the period at the end and inserting the following: ", and (10) such deductible shall not apply with respect to screening for sexually-transmitted diseases (as described in section 1861(s)(19)).".

(4) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 3113(b)(2) and subsection (c)(2)(C), is amended—

(A) in paragraph (1)—

(i) in subparagraph (H), by striking "and" at the end;

(ii) in subparagraph (I), by striking the semicolon at the end and inserting ", and"; and

(iii) by adding at the end the following new subparagraph:

"(J) in the case of screening for sexually-transmitted diseases, which is performed more frequently than is covered under section 1861(s)(19);"; and

(B) in paragraph (7), by striking "or (I)" and inserting "(I), or (J)".

(e) COVERAGE OF SCREENING FOR TUBERCULOSIS.—

(1) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)(2)), as amended by section 3113(a), subsection (c)(2)(C), and subsection (d)(1), is amended—

(A) by striking "and" at the end of paragraph (18);

(B) by striking the period at the end of paragraph (19) and inserting "; and"; and

(C) by inserting after paragraph (19) the following new paragraph:

"(20) screening for tuberculosis for an individual who is at risk for tuberculosis (as determined pursuant to factors identified by the Secretary) and who has not had such a screening during the preceding 1-year period.".

(2) AMOUNT OF PAYMENT; WAIVER OF COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by sections 3102(f), 3113(b)(3), and subsection (d)(2), is amended—

(A) by striking "and (T)" and inserting "(T)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (U) with respect to screening for tuberculosis (as described in section 1861(s)(20)), the amounts paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(3) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b), (42 U.S.C. 1395l(b)) as amended by section 3113(b)(3), subsection (a)(2), subsection (b)(3), and subsection (d)(3), is amended—

(A) by striking "and (10)" and inserting "(10)"; and

(B) by striking the period at the end and inserting the following: ", and (11) such deductible shall not apply with respect to screening for tuberculosis (as described in section 1861(s)(20)).".

(4) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 3113(b)(2), subsection (c)(2)(C), and subsection (d)(4), is amended—

(A) in paragraph (1)—

(i) in subparagraph (I), by striking "and" at the end;

(ii) in subparagraph (J), by striking the semicolon at the end and inserting ", and"; and

(iii) by adding at the end the following new subparagraph:

"(K) in the case of screening for tuberculosis, which is performed more frequently than is covered under section 1861(s)(20);"; and

(B) in paragraph (7), by striking "or (J)" and inserting "(J), or (K)".

SEC. 3115. COVERAGE OF PREGNANCY-RELATED SERVICES AND FAMILY PLANNING.

(a) IN GENERAL.—Section 1861(s) (42 U.S.C. 1395x(s)(2)), as amended by sections 3113(a), 3114(c)(2)(C), 3114(d)(1), and 3114(e)(1) is amended—

(1) by striking "and" at the end of paragraph (19);

(2) by striking the period at the end of paragraph (20) and inserting "; and"; and

(3) by inserting after paragraph (20) the following new paragraphs:

"(21) pregnancy-related services furnished by an individual or entity legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law); and

"(22) voluntary family planning services, including contraceptive drugs and devices that—

"(A) may only be dispensed upon prescription, and

"(B) are subject to approval by the Secretary under the Federal Food, Drug, and Cosmetic Act.".

(b) WAIVER OF COINSURANCE AND DEDUCTIBLE FOR CERTAIN SERVICES.—

(1) WAIVER OF COINSURANCE FOR PRENATAL SERVICES.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by sections 3102(f), 3113(b)(3), section 3114(d)(2), and section 3114(e)(2), is amended—

(A) by striking "and (U)" and inserting "(U)"; and

(B) by striking the semicolon at the end and inserting the following: ", and (V) with respect to pregnancy-related services (as described in section 1861(s)(20)), the amounts paid shall be 80 percent (or, in the case of services consisting of prenatal services, 100 percent) of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(2) WAIVER OF DEDUCTIBLE FOR PRENATAL AND FAMILY PLANNING SERVICES.—The first sentence of section 1833(b), (42 U.S.C. 1395l(b)) as amended by sections 3113(b)(3), 3114(a)(2), 3114(b)(3), and 3114(d)(3), is amended—

(A) by striking "and (11)" and inserting "(11)"; and

(B) by striking the period at the end and inserting the following: ", and (12) such deductible shall not apply with respect to pregnancy-related services consisting of prenatal services (described in section 1861(s)(21)) or to voluntary family planning services (described in section 1861(s)(22)).".

(c) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 3113(b)(2), section 3114(c)(2)(C), section 3114(d)(4), and section 3114(e)(2), is amended—

(A) in paragraph (1)—

(i) in subparagraph (J), by striking "and" at the end;

(ii) in subparagraph (K), by striking the semicolon at the end and inserting ", and"; and

(iii) by adding at the end the following new subparagraphs:

"(L) in the case of pregnancy-related services, which do not meet the requirements of section 1861(s)(21);

"(M) in the case of voluntary family planning services, which do not meet the requirements of section 1861(s)(22);"; and

(B) in paragraph (7), by striking "or (K)" and inserting "(K), (L), or (M)".

SEC. 3116. EXPANDING COVERAGE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

(a) INPATIENT PSYCHIATRIC HOSPITAL SERVICES.—

(1) SERVICES COVERED.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(A) by striking "and" at the end of paragraph (3);

(B) by striking the period at the end of paragraph (4) and inserting "; and"; and

(C) by adding at the end the following new paragraph:

"(5) inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse for up to 60 days during a year.".

(2) LIMITATION ON COVERAGE.—Section 1812(b)(3) (42 U.S.C. 1395d(b)) is amended to read as follows:

"(3) inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse that are furnished to the individual during a year after such services have been furnished to the individual for a total of 60 days during the year.".

(3) CONFORMING AMENDMENTS.—(A) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by inserting "(other than services described in paragraph (5))" after "inpatient hospital services" the first place it appears.

(B) Section 1812(b)(1) (42 U.S.C. 1395d(b)(1)) is amended by inserting "(other than services described in paragraph (3))" after "inpatient hospital services" the first place it appears.

(C) Section 1812 (42 U.S.C. 1395d) is amended by striking subsection (c).

(D) Section 1814(a) (42 U.S.C. 1395f(a)) is amended—

(i) in paragraph (2), by striking subparagraph (A);

(ii) in paragraph (3), by striking "(other than inpatient psychiatric hospital services)"; and

(iii) by striking paragraph (4).

(E) Section 1861 (42 U.S.C. 1395x) is amended by striking subsection (c).

(4) EFFECTIVE DATE; TRANSITION.—The amendments made by this section shall take effect January 1, 1998, except that—

(A) an individual who at any time prior to such date has been furnished inpatient psychiatric hospital services (as defined for purposes of title XVIII of the Social Security Act as of the date of the enactment of this Act) for 190 consecutive days is not entitled to any services under section 1812(a)(5) (as added by paragraph (1)(C)); and

(B) in the case of an individual who is not described in subparagraph (A) and is receiving inpatient psychiatric hospital services (as defined for purposes of title XVIII of the Social Security Act as of the date of the enactment of this Act) on December 31, 1997, for which payment may be made under section 1812 of such Act, the number of days of services for which the individual is entitled under section 1812(a)(5) (and the number of days applicable under section 1812(b)(3)) shall be equal to the greater of 60 or the difference between 190 days and the number of days of such inpatient psychiatric hospital services furnished to the individual prior to January 1, 1998.

(b) INTENSIVE RESIDENTIAL SERVICES.—

(1) COVERAGE UNDER PART A.—Section 1812(a) (42 U.S.C. 1395d(a)), as amended by subsection (a)(1), is amended—

(A) by striking "and" at the end of paragraph (4);

(B) by striking the period at the end of paragraph (5) and inserting "; and"; and

(C) by adding at the end the following new paragraph:

"(6) intensive residential services (as described in section 1861(qq)) furnished to an individual for up to 120 days during any calendar year, except that such services may be furnished to the individual for additional days during the year if necessary for the individual to complete a course of treatment to the extent that the number of days of inpatient hospital services described in paragraph (5) that may be furnished to the individual during the year (as reduced under such paragraph) is not less than 15.".

(2) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 3113(b), is further amended by adding at the end the following new subsection:

"Intensive Residential Services

"(qq)(1) Subject to paragraph (2), the term 'intensive residential services' means inpatient services provided in any of the following facilities:

"(A) Residential detoxification centers.

"(B) Crisis residential programs or mental illness residential treatment programs.

"(C) Therapeutic family or group treatment homes.

"(D) Residential centers for substance abuse treatment.

"(2) No service may be treated as an intensive residential service under paragraph (1) unless the facility at which the service is provided—

"(A) is legally authorized to provide such service under the law of the State (or under a State regulatory mechanism provided by State law) in which the facility is located or is certified to provide such service by an appropriate accreditation entity approved by the State in consultation with the Secretary; and

"(B) meets such other requirements as the Secretary may impose to assure the quality of the intensive residential services provided.

"(3) No service may be treated as an intensive residential service under paragraph (1) unless the service is furnished in accordance with standards established by the Secretary for the management of such services.".

(3) REDUCTION IN DAYS OF COVERAGE FOR INPATIENT SERVICES.—Section 1812(a)(5) and section 1812(b)(3), as amended by subsection (a), are each amended by striking the period at the end and inserting the following: ", reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of inpatient residential services furnished to the individual under paragraph (6) during the year after such services have been furnished to the individual for 120 days during the year (rounded to the nearest day).".

(4) AMOUNT OF PAYMENT.—Section 1814 (42 U.S.C. 1395f) is amended—

(A) in subsection (b) in the matter preceding paragraph (1), by inserting "other than intensive residential services," after "hospice care,"; and

(B) by adding at the end the following new subsection:

"Payment for Intensive Residential Services

"(m) The amount of payment under this part for intensive residential services under section 1812(a)(6) shall be equal to—

"(1) the lesser of—

"(A) the reasonable cost of such services, as determined under section 1861(v), or

"(B) the customary charges with respect to such services,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A):

"(2) if such services are furnished by a public provider of services or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, the amount determined in accordance with subsection (b)(2); and

"(3) if (and for so long as) the conditions described in subsection (b)(3) are met, the amounts determined under the reimbursement system described in such section.".

(c) LOWERING COINSURANCE FOR CERTAIN OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—

(1) IN GENERAL.—Section 1833(c) (42 U.S.C. 1395l(c)) is amended by striking "mental, psychoneurotic, and personality disorders" and all that follows through "are incurred" and inserting the following: "mental illness or substance abuse of an individual who, at the time such expenses are incurred, is over 18 years of age, is not an inpatient of a hospital, and has received 5 or more sessions of such treatment during the calendar year,".

(2) REQUIRING SERVICES TO BE FURNISHED IN ACCORDANCE WITH MANAGEMENT STANDARDS.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 3103(b), is amended—

(A) by striking "and" at the end of paragraph (16);

(B) by striking the period at the end of paragraph (17) and inserting "; or"; and

(C) by inserting after paragraph (17) the following:

"(18) in the case of any items or services furnished under part B for the treatment of mental illness or emotional disturbance (including substance abuse), if the services are not furnished in accordance with standards established by the Secretary for the management of such services.".

(d) INTENSIVE COMMUNITY-BASED SERVICES.—

(1) COVERAGE.—

(A) IN GENERAL.—Section 1832(a)(2)(J) (42 U.S.C. 1395k(a)(2)(J)) is amended to read as follows:

"(J) intensive community-based services (as described in section 1861(ff))—

"(i) for an unlimited number of days during any calendar year, in the case of services described in section 1861(ff)(2)(E) that are furnished to an individual who is a seriously mentally ill adult, a seriously emotionally disturbed child, or an adult or child with serious substance abuse disorder (as determined in accordance with criteria established by the Secretary),

"(ii) in the case of services described in section 1861(ff)(2)(C), for up to 180 days during any calendar year, except that such services may be furnished to the individual for a number of additional days during the year equal to the difference between the total number of days of intensive residential services which the individual may receive during the year under part A (as determined under section 1812(a)(6)) and the number of days of such services which the individual has received during the year, or

"(iii) in the case of any other such services, for up to 90 days during any calendar year, except that such services may be furnished to the individual for the number of additional days during the year described in clause (ii).".

(B) REDUCTION IN NUMBER OF DAYS OF INTENSIVE RESIDENTIAL SERVICES.—Section 1812(a)(6) (42 U.S.C. 1395d(a)(6)), as added by subsection (b)(1), is amended—

(i) by inserting "(A)" before "such services"; and

(ii) by striking the period at the end and inserting the following: ", and (B) reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of intensive community-based services furnished to the individual under section 1832(a)(2)(J) during the year after such services have been furnished to the individual for 90 days (or, in the case of services described in section 1832(a)(2)(J)(ii), for 180 days) during the year (rounded to the nearest day).".

(2) SERVICES DESCRIBED.—Section 1861(ff)(2) (42 U.S.C. 1395x(ff)(2)) is amended—

(A) in the matter preceding subparagraph (A), by striking "are—" and inserting "are as follows:";

(B) in subparagraph (C)—

(i) by inserting "behavioral aide services," after "nurses", and

(ii) by adding at the end the following: "(to the extent authorized under State law)";

(C) by adding "and" at the end of subparagraph (G);

(D) in subparagraph (H), by striking ", and" and inserting a period;

(E) by redesignating subparagraphs (A) through (H) as clauses (i) through (viii) and moving such subparagraphs 2 ems to the right;

(F) by inserting before clause (i) (as so redesignated) the following:

"(A) Partial hospitalization services consisting of—";

(G) by inserting after clause (viii) (as so redesignated) the following new subparagraphs:

"(B) Psychiatric rehabilitation services.

"(C) Day treatment services for individuals under 19 years of age.

"(D) In-home services.

"(E) Case management services, including collateral services designated as such case management services by the Secretary.

"(F) Ambulatory detoxification services.".

(3) PERMITTING NON-PHYSICIAN PROVIDERS TO SUPERVISE INDIVIDUAL PROGRAM OF TREATMENT.—Section 1861(ff)(1) (42 U.S.C. 1395x(ff)(1)) is amended by inserting after "supervision of a physician" the following: "(or, to the extent permitted under the law of the State in which the services are furnished, a non-physician mental health professional)".

(4) REQUIRING SERVICES TO MEET MANAGEMENT STANDARDS.—Section 1861(ff)(1) (42 U.S.C. 1395x(ff)(1)) is amended by striking the period at the end and inserting the following: ", but does not include any item or service that is not furnished in accordance with standards established by the Secretary for the management of such services.".

(5) PROGRAMS ELIGIBLE TO PROVIDE SERVICES.—Section 1861(ff)(3) (42 U.S.C. 1395x(ff)(3)) is amended to read as follows:

"(3) A program described in this paragraph is a program (whether facility-based or freestanding) which is furnished by an entity—

"(A) legally authorized to furnish such a program under State law (or the State regulatory mechanism provided by State law) or certified to furnish such a program by an appropriate accreditation entity approved by the State in consultation with the Secretary; and

"(B) meeting such other requirements as the Secretary may impose to assure the quality of the intensive community-based services provided.".

(6) WAIVER OF COPAYMENT FOR CASE MANAGEMENT SERVICES FURNISHED TO CERTAIN INDIVIDUALS.—Section 1832(a)(3) (42 U.S.C. 1395k(a)(2)) is amended—

(A) in subparagraph (B), by striking "or (E)" and inserting "(E), or (F)";

(B) by striking "and" at the end of subparagraph (D);

(C) by adding "and" at the end of subparagraph (E); and

(D) by adding at the end the following new subparagraph:

"(F) with respect to services described in section 1832(a)(2)(J)(i), the amount determined under subparagraph (B), except that '100 percent' shall be substituted for any reference in such subparagraph to '80 percent';".

(7) CONFORMING AMENDMENTS.—(A) Section 1835(a)(2)(F) (42 U.S.C. 1395n(a)(2)(F)) is amended—

(i) by striking "partial hospitalization" and inserting "intensive community-based"; and

(ii) in clause (ii), by striking "physician" and inserting "physician (or, to the extent permitted under the law of the State in which the services are furnished, a non-physician mental health professional)".

(B) Section 1861(s)(2)(B) (42 U.S.C. 1395x(s)(2)(B)) is amended by striking "partial hospitalization" and inserting "intensive community-based".

(C) Section 1861(ff) (42 U.S.C. 1395x(ff)) is amended—

(i) in the heading, by striking "Partial Hospitalization" and inserting "Intensive Community-Based"; and

(ii) in paragraph (1), by striking "partial hospitalization" and inserting "intensive community-based".

(D) Section 1866(e)(2) (42 U.S.C. 1395cc(e)(2)) is amended by striking "partial hospitalization" and inserting "intensive community-based".

(e) REQUIREMENT FOR PROVISION OF SERVICES THROUGH ORGANIZED SYSTEMS OF CARE FOR AT-RISK CHILDREN.—

(1) REQUIRING COORDINATION OF MENTAL HEALTH SERVICES THROUGH ORGANIZED SYSTEMS OF CARE.—

(A) PSYCHIATRIC HOSPITAL SERVICES.—Section 1812(a)(5) (42 U.S.C. 1395d(a)(5)), as added by subsection (a)(1), is amended by striking the period at the end and inserting the following: ", but only if (with respect to services furnished to an at-risk child described in section 1861(rr)) such services are furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1861(rr).".

(B) OTHER PART B ITEMS AND SERVICES.—Section 1862(a)(18), as added by subsection (c)(2), is amended by striking the period at the end and inserting the following: ", and, in the case of services furnished to an at-risk child described in section 1861(rr) who is not an inpatient of a hospital, if the services are not furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1861(rr).".

(C) INTENSIVE RESIDENTIAL SERVICES.—Section 1861(qq) (42 U.S.C. 1395x(qq)) as added by subsection (b)(2), is amended—

(i) in paragraph (1), by striking "paragraph (2)" and inserting "paragraphs (2) and (3)"; and

(ii) by adding at the end the following new paragraph:

"(3) In the case of services furnished to an at-risk child described in section 1861(rr), no service may be treated as an intensive residential service under this subsection unless the service is furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1861(rr).".

(D) INTENSIVE COMMUNITY-BASED SERVICES.—Section 1861(ff)(1) (42 U.S.C. 1395x(ff)(1)) is amended by inserting after "by a physician" the following: "(or, in the case of services furnished to an at-risk child described in section 1861(rr), by an organized system of care for mental health and substance abuse services in accordance with such section)".

(2) ORGANIZED SYSTEMS OF CARE DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Organized System of Care for Mental Health and Substance Abuse Services

"(rr)(1) The term 'organized system of care for mental health and substance abuse services' means, with respect to mental health services provided to an at-risk child, a community-based service delivery network consisting of public or private providers that a State determines meets the following requirements (in accordance with guidelines of the Secretary):

"(A) The system has established linkages with existing mental illness and substance abuse service delivery programs in the area in which the child resides (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

"(B) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile or criminal justice, health care, mental health, and substance abuse treatment.

"(C) The system provides for the involvement of the families of children to whom mental illness and substance abuse services are provided in the planning of treatment and the delivery of services.

"(D) The system provides for the development and implementation by multidisciplinary and multi-agency teams of individualized treatment plans that are recognized and followed by the requisite providers in the area.

"(E) The system ensures the delivery and coordination of the range of mental illness and substance abuse services required for at-risk children.

"(F) The system provides for the management of the individualized treatment plans and for a flexible response to treatment changes over time.

"(G) In the case of individuals receiving substance abuse treatment services, the system places such individuals in treatment programs in accordance with uniform patient placement criteria established by the Secretary in consultation with the States.

"(H) The system provides for assessment of clinical outcomes of individuals receiving services through the system.

"(2) In this subsection—

"(A) the term 'at-risk child' means an individual under 19 years of age who has a serious emotional disorder or substance abuse disorder (in accordance with criteria established by the Secretary for purposes of this subsection) and is currently involved or at imminent risk of being involved with one or more public agencies providing services to children, including agencies relating to child welfare, special education, and juvenile or criminal justice; and

"(B) the term 'mental health services' has the meaning given such term in section 1893(c).".

(3) ESTABLISHMENT OF CRITERIA FOR SEVERITY OF ILLNESS BY SECRETARY.—Not later 1 year after the date of the enactment of this Act, the Secretary shall develop criteria for determining whether an individual has a serious emotional disorder or substance abuse disorder for purposes of section 1861(rr)(2).

(f) SPECIAL RULE FOR BENEFICIARIES IN STATES WITH MANAGED PROGRAMS.—Title XVIII is amended by inserting after section 1892 the following new section:

"COVERAGE OF MENTAL HEALTH SERVICES FOR INDIVIDUALS IN STATES WITH MANAGED MENTAL HEALTH PROGRAMS

"SEC. 1893. (a) APPLICATION OF STATE COVERAGE RULES.—Notwithstanding any other provision of this title, in the case of an individual entitled to benefits under part A or enrolled under part B who is a resident of a State or a member of a tribe or tribal organization operating a comprehensive managed mental health program under section 1981 of the Public Health Service Act and who is enrolled in the program during a month—

"(1) the individual is considered to have waived the right to benefits for mental health services under this title in consideration of receipt of benefits for mental health services through such program;

"(2) the Secretary shall make a per capita payment to the State or the tribe or tribal organization, in the amount specified in subsection (b)(1), on behalf of the individual; and

"(3) no other payment may be made under this title with respect to mental health services furnished to the individual during the month.

Payments under paragraph (2) shall be made on a monthly basis.

"(b) AMOUNT OF CAPITATION PAYMENT.—

"(1) IN GENERAL.—In the case of a State or tribe or tribal organization operating a program described in subsection (a) for a month, the amount specified in this subsection is the Secretary's estimate of the sum of the following products:

"(A) The product of—

"(i) the part A per enrollee mental health payment described in paragraph (2) for the month; and

"(ii) the number of individuals who are entitled to benefits under part A during the month and (as estimated prior to the month based on information provided by the State or the tribe or tribal organization) who are enrolled in the program described in subsection (a).

"(B) The product of—

"(i) the part B per enrollee mental health payment described in paragraph (2) for the month; and

"(ii) the number of individuals who are enrolled under part B during the month and (as estimated prior to the month based on information provided by the State or the tribe or tribal organization) who are enrolled in the program described in subsection (a).

"(2) PER ENROLLEE PAYMENTS.—In paragraph (1)—

"(A) the 'part A per enrollee payment' for a month is an amount equal to the Secretary's estimate of the average actuarial value of the mental health services for which payment would be made under part A for the month on behalf of individuals enrolled in the State program described in subsection (a) during the month if the individuals were not enrolled in the State program during the month; and

"(B) the 'part B per enrollee payment' for a month is an amount equal to the Secretary's estimate of the average actuarial value of the mental health services for which payment would be made under part B for the month on behalf of individuals enrolled in the State program described in subsection (a) during the month if the individuals were not enrolled in the State program during the month.

"(3) ADJUSTMENTS.—The Secretary shall adjust the amount of payment otherwise made to a State or a tribe or tribal organization under this subsection for a month—

"(A) to reduce such payment to take into account any amounts paid to the State or tribe or tribal organization under other programs towards the costs of providing mental health services to individuals enrolled in the program; and

"(B) to take into account overpayments or underpayments made under this subsection in previous months.

"(c) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES DESCRIBED.—In this section, the term 'mental health and substance abuse services' means the following items and services:

"(1) Inpatient psychiatric services (as described in section 1812(a)(5)).

"(2) Any items or services furnished under part B for the treatment of mental illness or substance abuse for an individual who is not an inpatient of a hospital.

"(3) Intensive community-based mental health services (as described in section 1861(ff)).

"(4) Intensive residential services (as described in section 1861(qq).".

SEC. 3117. EXPANDED COVERAGE OF CERTAIN CHIROPRACTIC SERVICES.

Section 1861(r)(5) (42 U.S.C. 1395x(r)(5)) is amended by striking "sections 1861(s)(1) and

1861(s)(2)(A)" and inserting "paragraphs (1), (2)(A), (3), and (4) of subsection (s)".

SEC. 3118. MANAGED CARE OPTIONS.

Section 1876(g) (42 U.S.C. 1395mm(g)) is amended by adding at the end the following new paragraph:

"(7) An eligible organization with a risk-sharing contract under this section may provide services under part A and B to individuals enrolled with the organization through an unlimited-choice-of-provider plan described in section 5504(15) of the Guaranteed Health Insurance Act of 1994, except that in no case could the cost sharing requirements imposed under such option with respect to services furnished through providers who are not members of the organization's provider network (as defined in section 5504(10) of such Act) exceed the cost-sharing requirements that would otherwise be imposed with respect to the services if the services were furnished under this title other than through the eligible organization.".

SEC. 3119. EFFECTIVE DATE.

The amendments made by this part shall apply to items and services furnished on or after January 1, 1998.

TITLE IV—STATE PROGRAMS

Subtitle A—State Single-Payer Systems

SEC. 4001. STANDARDS FOR STATE SINGLE-PAYER SYSTEMS.

(a) ESTABLISHMENT OF SYSTEMS.—

(1) IN GENERAL.—As an alternative to the method otherwise provided in this Act to achieving universal health insurance coverage for residents of a State, a State may operate a State single-payer system approved by the Secretary of Health and Human Services and the Secretary of Labor (in this title jointly referred to as the "Secretaries") under this subtitle.

(2) REQUIREMENTS.—For purposes of this section, a State single-payer system is a system established by a State under which meets the following requirements:

(A) DIRECT PAYMENT TO PROVIDERS.—

(i) IN GENERAL.—Under the system, the State makes payments directly to providers who furnish items and services included in the guaranteed national benefit package to individuals covered under the system and assume (subject to clause (ii)) all financial risk associated with making such payments.

(ii) CAPITATED PAYMENTS PERMITTED.—Nothing in clause (i) shall be construed to prohibit providers furnishing items and services under the system from receiving payments from the State on a capitated, at risk-basis based on prospectively determined amounts.

(B) GUARANTEED NATIONAL BENEFIT PACKAGE.—The system guarantees coverage for at least the guaranteed national benefit package, including pediatric services for children, for all eligible individuals who are residents of the State, subject to section 4002.

(C) BUDGETARY COMPLIANCE.—The system controls aggregate health care expenditures in the State subject to the same tests as a State operating a State provider reimbursement system under subtitle C, without regard to the adjustment described in section 4203(a)(2)(A).

(b) CONDITIONS FOR APPROVAL.—The Secretaries may not approve a single-payer system under this subtitle unless—

(1) the State submits to the Secretaries an application in such form and manner as the Secretaries may require [under the coordinated process established under section 4301], and

(2) the Secretaries determine to their satisfaction that the State and the system meet the applicable requirements of section 4002.

(c) TERMINATION OF APPROVAL.—Either Secretary shall terminate approval of a system in accordance with section 4006 if that Secretary determines that the State or the system no longer meet the applicable requirements of section 4002.

SEC. 4002. GENERAL REQUIREMENTS FOR APPROVAL.

(a) UNIVERSAL COVERAGE.—

(1) IN GENERAL.—Except as provided in this subsection and section 4003, the single-payer system shall cover all eligible individuals who are residents of the State.

(2) EXCEPTION FOR INDIANS.—

(A) IN GENERAL.—A State may not require an individual described in subparagraph (B) to be covered under the system, but shall allow such an individual the option of coverage under such system.

(B) INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is an individual who is—

(i) eligible to receive services pursuant to sections 36.1—36.14 of title 42, Code of Federal Regulations (1986);

(ii) an urban Indian (as defined in section ____ of the Indian Health Care Improvement Act); or

(iii) an Indian described in section 809(b) of the Indian Health Care Improvement Act.

(3) EXCEPTION FOR QUALIFIED RELIGIOUS EXEMPTION, VETERANS, AND ACTIVE DUTY MILITARY.—A State may not require any of the following individuals to be covered under the single-payer system:

(A) An individual who is described in section 1004(b)(1).

(B) An eligible person (within the meaning of section 1710(a)(1) of title 38, United States Code).

(C) An individual on active duty as a member of the uniformed services (as defined in section 101 of title 10, United States Code).

(4) INCLUSION OF CHAMPUS AND FEHBP.—For provisions authorizing inclusion of—

(A) certain CHAMPUS-eligible individuals in State single-payer systems, see section ____ of title 10, United States Code; or

(B) Federal employees and annuitants in State single-payer systems, see section ____ of title 5, United States Code.

(5) DETERMINATION OF RESIDENCE IN STATE.—

(A) IN GENERAL.—For the purposes of determining eligibility for coverage under a State single-payer system, an individual shall be considered a "resident" of the State if the individual lives in the State with the intention of remaining there permanently or indefinitely.

(B) CERTAIN INDIVIDUALS EXCLUDED.—The State may not deny coverage under the State single-payer system to an individual described in subparagraph (A) because the individual has not resided in the State for a specified period, or because the individual is temporarily absent from the State. However, a State may deny eligibility for benefits under the system to an individual if the State determines that the individual is residing in the State substantially for the purpose of receiving medical treatment in that State.

(b) ENSURING ACCESS TO BENEFITS.—

(1) IN GENERAL.—The system shall provide for coverage of not less than the guaranteed national benefit package, including the cost sharing provided under the package (subject to paragraph (2)), to all individuals required to be covered under the system.

(2) IMPOSITION OF REDUCED COST SHARING.—The system may decrease the cost sharing otherwise provided in the package with respect to any class of individuals enrolled in the system or any class of items or services included in the package, so long as the system does not increase the cost sharing otherwise imposed with respect to any other class of individuals, items, or services.

(3) ACCESS TO SERVICES.—Services covered under the guaranteed national benefit package shall be reasonably accessible to individuals required to be covered under subsection (a).

[*New (8/9):*] (4) ACCESS TO CHOICE OF PROVIDERS.—The system shall provide individuals with unlimited choice of providers for receiving services under the system, except that nothing in this paragraph shall be construed to prohibit the State from imposing cost-sharing requirements that result in variations in out-of-pocket expenses based on the provider chosen, so long as such variations do not impose a significant financial impairment on the individual's choice.

(c) PUBLIC OPERATION AND ACCOUNTABILITY.—

(1) IN GENERAL.—The system shall be established under State law and State law shall provide for mechanisms to enforce the requirements of the system.

(2) OPERATION BY STATE.—The State single-payer system shall be operated by the State, a designated agency of the State, or a nonprofit entity established through State law in a manner that provides for public accountability with respect to the operation of the system.

(3) USE OF CONTRACTS.—During the 5-year period beginning the date of the approval of the application under this subtitle, nothing in this subsection shall be construed to prohibit a State from contracting with private organizations to assist in the administration of the system, but only if, under any contract entered into with such a private organization pursuant to this paragraph, such private organization is required to limit administrative expenses under the system to a rate of not more than 3 percent of program expenses. Any arrangement under the system under which items or services are provided by carriers shall meet such standards under title V as the Secretaries shall determine appropriate by regulation.

(d) NONDISCRIMINATORY FINANCING.—Any taxes, fees, or other assessments imposed with respect to the financing of the State single-payer system may not be imposed in a manner that discriminates, with respect to employment or employers, on the basis of the type of sponsor, or the size, self-insured nature, or other characteristics of an employer.

[*New (8/9)*] (e) APPLICATION OF CERTAIN INSURANCE REFORM STANDARDS.—The State single-payer system shall meet the following additional requirements:

(1) The system shall meet such standards applicable to insured health benefit plans under subtitle A of title V as the Secretary determines to be appropriate for a single-payer system.

(2) The system shall provide coverage for emergency and urgent care services furnished to individuals enrolled in the system by out-of-State providers.

(3) The system provides coverage and coordination of payment for services provided to individuals enrolled in the system by out-of-State providers.

(4) The system has in effect procedures to coordinate the delivery and payment of benefits for individuals enrolled in health benefit plans outside of the State who receive services from providers in the State, individuals who are employees of employers in the State but are not residents of the State, and

other individuals for whom coordination of enrollment and delivery and payment of benefits is necessary.

(f) ONGOING REPORTS.—A State operating an approved State single-payer system shall submit annual reports to the Secretaries on the operation of the system, together with such other reports as either of the Secretaries may require.

SEC. 4003. TREATMENT OF MEDICARE BENEFICIARIES.

(a) PERMITTING STATES TO COVER MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—A State single-payer system may cover an individual who is a medicare part A beneficiary and who resides in the State, but only if the State demonstrates to the satisfaction of the Secretary [of Health and Human Services], in its application under this subtitle, that—

(A) all services for which such beneficiaries would otherwise be eligible under the medicare program shall be provided under the system without additional cost to such beneficiaries and shall be reasonably accessible to all such beneficiaries residing in the State; and

(B) such beneficiaries shall be eligible for the same benefits and provided the same opportunities with respect to choice of providers as other residents of the State under the system.

For purposes of subparagraph (A), coverage determinations under the system shall be made under rules that are no more restrictive than are otherwise applicable under the medicare program.

(2) TIMING OF COVERAGE.—The coverage of medicare part A beneficiaries shall begin no earlier than the beginning of the fourth year that occurs after the Secretaries have approved the system pursuant to this subtitle and only if the State provides evidence, satisfactory to the Secretary, that all of the requirements for the system will be met, and that all benefits guaranteed to such beneficiaries will be provided.

(3) CONTROL OF MEDICARE EXPENDITURES.—If medicare part A beneficiaries are included in a system under this section, the State shall guarantee that total expenditures under the medicare program in the State during the year will not exceed the expenditures that would otherwise have been made with respect to such beneficiaries residing in the State during the year if the system were not approved under this section.

[*New (8/9):*] (4) EFFECT ON FINANCING.—Nothing in this section shall be construed to prohibit a State from subjecting medicare beneficiaries to any generally applicable taxes used to finance the State system.

(b) REFERENCE TO MEDICARE PAYMENT RULES.—In the case of a State single-payer system that covers medicare part A beneficiaries, such beneficiaries shall receive benefits under the State system, and the Secretary shall make payments to the State, in accordance with section 1894 of the Social Security Act (as added by section 8361).

(c) REINSTATEMENT OF MEDICARE IN EVENT OF FAILURE TO MEET SYSTEM REQUIREMENTS.—In the case of a State system which covers medicare part A beneficiaries or medicare part C beneficiaries and fails substantially to meet requirements of this section or of the medicare program or medicare part C, the Secretary shall terminate coverage of such beneficiaries under the State system and make payment for any services covered under the medicare program or medicare part C that were provided to such beneficiaries but were not reimbursed under the State system.

(d) MEDICARE PART C BENEFICIARY DEFINED.—In this section, the term "medicare part C beneficiary" means an individual who would be eligible for benefits under medicare part C but for approval of a State single-payer system under this subtitle.

SEC. 4004. OPTIONS RELATING TO PAYMENT FOR PREMIUM SUBSIDIES AND WRAP-AROUND BENEFITS.

(a) PREMIUM SUBSIDIES.—

(1) PREMIUM CERTIFICATE ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—Under a State single-payer system, payment shall be made directly to the State under section 2124(c)(1)(C)(i) of the Social Security Act in an amount described in subparagraph (B).

(B) DETERMINATION OF AMOUNT OF PERIODIC PAYMENTS.—The amount described in this subparagraph is, subject to subparagraph (C), with respect to periods occurring during a year, the Secretary's estimate of the aggregate amount of the payments that would have been made for premium certificates under part A of title XXII of the Social Security Act to individuals covered under the State single-payer system during the most recent preceding year if payment had been made as provided in such subpart, increased by the Secretary's estimate of the rate of increase in the total amount of such payments with respect to such individuals during the year.

(C) SPECIAL RULE FOR PAYMENT TO STATES FOR YEARS BEFORE 2000.—In the case of periods occurring during a year before 2000, the State shall submit to the Secretary such information as the Secretary may require to appropriately estimate the amounts described in subparagraph (B) based on a system established by the State to determine the eligibility of State residents for the premium certificates described in part A of title XXII of the Social Security Act (using the same eligibility criteria applicable under such part).

(2) TREATMENT OF PART C ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—The Secretary shall make payments to the State under section 2124(c)(1)(C)(iii) of the Social Security Act in the amount described in subparagraph (B).

(B) AMOUNT.—The amount described in this subparagraph is the Secretary's estimate of the aggregate amount of the reduction in the tax imposed under section 59B of the Internal Revenue Code of 1986 that would have resulted from the application of subsection (b) of such section with respect to individuals enrolled in the system during the applicable period if the State did not have an approved system under this subtitle.

(C) USE OF DATA.—In computing amounts under subparagraph (B), the Secretary may use information made available under section 6103(l)(16) of the Internal Revenue Code of 1986.

(3) RECONCILIATION FOR PREVIOUS ERRORS IN ESTIMATION.—The Secretary shall adjust the amount of payment made to the State pursuant to this subsection for periods occurring in a year to take into account any errors in the estimations made in previous payments, based on information furnished by the Secretary of the Treasury and such other information as the Secretary deems necessary.

(b) WRAP-AROUND BENEFITS.—

(1) IN GENERAL.—Under a State single-payer system, payment shall be made under section 2124(c)(1)(C)(ii) of the Social Security Act directly to the State in an amount described in paragraph (B).

(2) DETERMINATION OF AMOUNT.—The amount described in this paragraph is, subject to paragraph (3), the Secretary's estimate of the aggregate amount of the payments that would been made under part B of title XXII of the Social Security Act if payment had been made as provided in such part.

(3) SPECIAL RULE FOR PAYMENT TO STATES FOR YEARS PRIOR TO 2000.—In the case of periods occurring during a year prior to 2000, the State shall submit to the Secretary such information as the Secretary may require to appropriately estimate the amounts described in paragraph (2), based on a system established by the State to determine the individuals enrolled in the single-payer system who would be wrap-around eligible individuals but for the election under the State single-payer system (applying the same criteria and a similar process used by the Secretary to determine whether individuals are wrap-around eligible individuals under part B of title XXII of the Social Security Act).

(4) RECONCILIATION FOR PREVIOUS ERRORS IN ESTIMATION.—The Secretary shall adjust the amount of payment made to the State under this subsection for periods occurring in a year to take into account any errors in the estimations made under this subsection.

(5) DEFINITIONS.—In this subsection:

(A) The term "State wrap-around benefits" means a package of benefits consisting of items and services not covered under the guaranteed national benefit package that the Secretary finds is comparable to the wrap-around benefits provided under part B of title XXII of the Social Security Act.

(B) The term "wrap-around benefits" means the benefits described in section 2212 of the Social Security Act (as added by section 8102(a)).

(C) The term "wrap-around eligible individual" has the meaning given such term in section 2211(b) of the Social Security Act (as added by section 8102(a)).

SEC. 4005. OFFSET TO DIRECT PAYMENTS FOR OUTSTANDING MAINTENANCE OF EFFORT PAYMENTS.

The Secretary shall reduce the amount of any payment made directly to the State under section 4003(b) or subsection (a) or (b)]of section 4004 for a period by the amount of any payments owed by the State under part 2 of subtitle B of title VIII for such period.

SEC. 4006. TERMINATION OF APPROVAL.

(a) ANNUAL DETERMINATION OF BUDGETARY COMPLIANCE BY SECRETARIES.—The Secretaries shall annually determine whether a State system has met the tests described in section 4001(a)(2)(C) for the most recent 3-year period, determined based on all classes of services covered under the system.

(b) PROCESS FOR TERMINATION.—If either Secretary finds under subsection (a) that the single-payer system approved under this subtitle fails the tests described in section 4001(a)(2)(C), or no longer meets any of the other applicable requirements of section 4001(a)(2) or section 4002, such Secretary shall terminate approval of the system, in accordance with the process described in section 4204(b) (relating to termination of a State provider reimbursement system under subtitle C).

Subtitle B—State Managed Competition Programs

SEC. 4101. STANDARDS FOR STATE MANAGED COMPETITION PROGRAMS.

(a) ESTABLISHMENT OF STATE PROGRAMS.—As an alternative to the method otherwise provided in this Act to achieving universal health insurance coverage for residents of a State, a State may operate a managed competition program approved by the Secretary of Health and Human Services and the Secretary of Labor (in this subtitle jointly referred to as the "Secretaries") under this subtitle under which the State, subject to subsection (b), requires eligible individuals to obtain coverage through a consumer purchasing cooperative established under subtitle E of title V. In this subtitle, the term "State managed competition program" means a managed competition program approved by the Secretaries under this subtitle.

(b) CONDITIONS FOR APPROVAL.—The Secretaries may not approve a managed competition program under this subtitle unless—

(1) the State submits to the Secretaries an application in such form and manner as the Secretaries may require, and

(2) the Secretaries determine to their satisfaction that the State and the program meets the applicable requirements of sections 4102.

(c) TERMINATION OF APPROVAL.—Either Secretary shall terminate approval of a managed competition program in accordance with section 4106 if that Secretary determines that the State or the program no longer meet the applicable requirements of sections 4102.

SEC. 4102. GENERAL REQUIREMENTS FOR STATE MANAGED COMPETITION PROGRAMS.

(a) PROVISION OF COVERAGE THROUGH QUALIFIED INSURED HEALTH BENEFIT PLANS OFFERED BY CONSUMER PURCHASING COOPERATIVES.—

(1) REQUIREMENT.—

(A) IN GENERAL.—Except as provided in this paragraph, under the managed competition program eligible individuals residing in the State are required to obtain health coverage through enrollment in a qualified insured health benefit plan offered through a consumer purchasing cooperative.

(B) APPLICATION OF COMMUNITY-RATING TO ALL PLANS AND ENROLLEES.—All such plans shall meet the requirements of section 5008 (relating to community-rating of premiums) with respect to all individuals and employers covered under the program.

(2) EXCEPTION FOR INDIANS, QUALIFIED RELIGIOUS EXEMPTION, VETERANS, ACTIVE DUTY MILITARY, CHAMPUS ELIGIBLE INDIVIDUALS, FEHBP ENROLLEES, MEDICARE PART A BENEFICIARIES.—Paragraph (1) shall not apply to—

(A) individuals described in paragraph (2) or (3) of section 4002(a);

(B) individuals who are entitled to benefits under the Civilian Health and Medical Program of the Uniformed Services (as defined in section 1072(4) of title 10, United States Code);

(C) individuals who are enrolled in a health plan under chapter 89 of title 5, United States Code;

(D) medicare part A beneficiaries.

(3) EXCEPTION FOR FULL-TIME EMPLOYEES IN LARGE FIRMS OR IN MULTIEMPLOYER PLANS.—

(A) FULL-TIME EMPLOYEES OF LARGE EMPLOYERS.—A managed competition program may not require an individual who is a full-time employee of an employer that has more than 1,000 full-time employees in the United States to participate in the program.

(B) BENEFICIARIES AND PARTICIPANTS IN MULTIEMPLOYER PLANS.—

(i) IN GENERAL.—A managed competition program may not require an individual who is a participant or beneficiary (as defined in clause (ii)) under a multiemployer plan described in clause (iii) to participate in the program.

(ii) PARTICIPANT AND BENEFICIARY DEFINED.—In clause (i), subject to clause (iv), the terms "participant" and "beneficiary" have the meaning given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

(iii) PLAN DESCRIBED.—A plan described in this clause is a multiemployer plan that—

(I) covers more than 1,000 active participants in the United States whose coverage under such plan is on terms at least as favorable as those provided under this Act with respect to a full-time employee, or

(II) is maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering more than 1,000 such active participants.

(iv) ELIGIBILITY STANDARDS.—A multiemployer plan may establish eligibility standards for those individuals who will be treated as participants and beneficiaries for purposes of this section. Such standards shall not discriminate on the basis of race, national origin, sex, religion, language, socioeconomic status, age, disability, sexual orientation, health status, or anticipated need for health services, but may take into account the level and rate at which employer contributions are paid on behalf of employees. Nothing in this clause shall be construed as affecting the ability of a multiemployer plan to provide health or other benefits to participants and beneficiaries who are not treated as participants and beneficiaries with respect to the plan.

(C) RURAL ELECTRIC AND TELEPHONE COOPERATIVES.—

(i) IN GENERAL.—A managed competition program may not require an individual who is a full-time employee of a member of a rural cooperative described in clause (ii), or a family member of such an employee, to participate in the program.

(ii) RURAL COOPERATIVE DESCRIBED.—A rural cooperative described in this clause is a rural electric cooperative or rural telephone cooperative association if the cooperative or association (or members of the cooperative or association) maintain a health plan under which at least 1,000 full-time employees in the United States are entitled to health benefits.

(D) OPTION.—A managed competition program may permit individuals otherwise exempt under this paragraph to participate in the program.

(b) ENSURING ACCESS OF LOW-INCOME INDIVIDUALS TO PLANS.—The managed competition program shall provide such financial assistance toward the premiums of low-income individuals described in section 2211(b)(1)(A)as will assure that such individuals may obtain coverage under a certified health plan upon the presentation of premium certificate issued under part A of title XXII of the Social Security Act.

(c) COMPLIANCE WITH PLAN REQUIREMENTS.—

(1) IN GENERAL.—The plans offered under the managed competition program shall comply with the requirements of subtitle A (and, if applicable, subtitle C) title V, except that the Secretaries may waive such provisions of such title as may be necessary to permit the operation of such a program under this subtitle.

(2) EXCLUSIVE OFFER THROUGH COOPERATIVES.—The managed competition program shall require carriers to offer certified health plans (other than to individuals exempt from participation under subsection (a)(3)) through consumer purchasing cooperatives.

(d) BUDGETARY COMPLIANCE.—The managed competition program shall control aggregate health care expenditures in the State subject to the same tests as a State operating a State provider reimbursement system under subtitle C, without regard to the adjustment described in section 4203(a)(2)(A).

(e) APPLICATION OF CERTAIN RULES.—

(1) DETERMINATION OF RESIDENCE AND ONGOING REPORTS.—Subsections (a)(5) and (e) of section 4002 apply to a managed competition program under this section in the same manner as they apply to a single-payer system under such section.

(2) NONDISCRIMINATORY FINANCING.—

(A) IN GENERAL.—Section (d) of section 4002 applies to a managed competition program under this section in the same manner as it applies to a single-payer system under such section, except that no tax, fee, or other assessment may be imposed with respect to coverage of individuals who do not participate in the program pursuant to subsection (b)(3).

(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as permitting apply with respect to only apply with respect to In carrying out subparagraph (A).

SEC. 4103. TERMINATION OF APPROVAL.

(a) ANNUAL DETERMINATION OF BUDGETARY COMPLIANCE BY SECRETARY.—The Secretary shall annually determine whether a managed competition program has met the tests described in subsection 4101(a)(2) for the most recent 3-year period, determined based on all classes of services covered under the program.

(b) PROCESS FOR TERMINATION.—If the Secretary finds under subsection (a) that the managed competition program fails the tests described in section 4101(a)(2), or no longer meets any of the applicable requirements of section 4102, the Secretary shall terminate approval of the program, in accordance with the process described in section 4204(b) (relating to termination of a State provider reimbursement system under subtitle C).

(c) REINSTATEMENT OF MEDICARE PART C IN EVENT OF FAILURE TO MEET PROGRAM REQUIREMENTS.—In the case of a managed competition program which covers individuals who would (but for approval of the program) be medicare part C eligible individuals and fails substantially to meet requirements of this section with respect to such individuals, the Secretary shall terminate the approval of the program with respect to medicare part C eligible individuals.

Subtitle C—State Provider Reimbursement Systems

SEC. 4201. STANDARDS FOR STATE PROVIDER REIMBURSEMENT SYSTEMS.

(a) IN GENERAL.—During the period in which a State provider reimbursement system (in this subtitle referred to as a "State payment system") is approved under this section—

(1) the payment rates provided under such system shall apply to services covered under the system and furnished in the State;

(2) maximum payment rates shall not apply to such services under subtitle D of title VI, in accordance with section 6201(b)(2)(A); and

(3) the requirements relating to the determination of payment amounts under the medicare program, medicare part C, and medicaid programs are waived insofar as such waiver is necessary to implement such system.

State preemption requirements under the Employee Retirement Income Security Act of 1974 are waived under section 514(b)(11) of such Act (as added by section 12____) in order to carry out such a system.

(b) APPLICATION.—

(1) IN GENERAL.—Subject to subsection (e), the Secretaries may not approve a state payment system under this subtitle unless—

(A) the State submits to the Secretaries an application in such form and manner and containing such information and assurances (consistent with this subtitle) as the Secretaries may require, and

(B) the Secretaries determine to their satisfaction that the State and the system meet the applicable requirements of sections 4202 and 4203 are met.

(2) LIMITATION ON DISAPPROVAL.—The Secretaries cannot deny the application of a State for a State payment system on the ground that the methodology used under the system to control payments for inpatient hospital services is based on a payment methodology other than on the basis of a diagnosis-related group.

(c) TERMINATION OF APPROVAL.—

(1) IN GENERAL.—Either Secretary may terminate approval of a State payment system in accordance with section 4204 if that Secretary—

(A) determines that the State or the system no longer meets the requirements of section 4202(b)(1) (relating to all payers), section 4202(b)(3)(B) (relating to limitation on differentials for medicaid services), or section 4202(e) (relating to certain requirements for hospitals); or

(B) has reason to believe that the assurances described in any of the following sections are not being (or will not be) met:

(i) Section 4202(b)(2) (relating to equitable treatment of all payers).

(ii) Section 4202(f) (relating to special requirements for hospital admissions and exclusions).

(iii) Section 4203 (relating to limiting aggregate expenditures).

(2) ADDITIONAL AUTHORITY.—Either of the Secretaries may terminate such approval if such Secretary determines that the system no longer continues to meet another condition for approval described in section 4202 or 4203.

(e) DEEMED APPROVAL OF CERTAIN SYSTEMS.—

(1) IN GENERAL.—In the case of a hospital reimbursement control system approved under section 1886(c)(4) of the Social Security Act or described in section 1814(b)(3) of such Act and used for payment of hospital services in the State under the medicare program, the system is deemed to be a State payment system approved under this section with respect to payment for hospital services.

(2) TERMINATION.—Insofar as paragraph (1) applies to a State payment system, the continuation of the approval of the system is conditioned only upon the system's compliance with the requirements described in such paragraph.

SEC. 4202. GENERAL CONDITIONS FOR STATE PROVIDER REQUIREMENTS FOR STATE SYSTEMS.

(a) APPLICATION TO SERVICES.—

(1) IN GENERAL.—Subject to paragraph (2), the state payment system applies to services described in any (or all) of the following subparagraphs:

(A) Inpatient hospital services (including services of exempt hospitals (as defined in section 6311(a)(4)) statewide.

(B) Outpatient hospital services (including services of exempt hospitals (as so defined)) statewide.

(C) Physicians services statewide.

For purposes of this part, services described in each of subparagraphs (A), (B), and (C) shall be treated as a separate class of services.

(2) ADDITIONAL SERVICES ONLY BY CLASS OF SERVICE.—The system may apply to services in addition to services described in paragraph (1) only if the system applies to all services within the class (established under section 6002) in which the services are classified.

(b) APPLICATION TO ALL PAYERS; EQUITABLE TREATMENT.—

(1) APPLICATION TO ALL PAYERS.—

(A) IN GENERAL.—The system applies to substantially all payers (including the medicaid program in the State) for services to which the system applies.

(B) EXCLUSION OF MEDICARE PROGRAM.—A State may elect not to include the medicare program under the system.

(2) EQUITABLE TREATMENT OF PAYERS.—Assurances satisfactory to both Secretaries have been provided as to the equitable and nondiscriminatory treatment of all payers (including the medicare program, medicare part C, and medicaid programs and other Federal and State programs) under the system.

(3) PAYMENT RATE DIFFERENTIALS PERMITTED.—

(A) IN GENERAL.—Subject to subparagraph (B), a State may provide for payment rates for services furnished under the medicaid program that are different from the payment rates for services for which payment is made by other payers.

(B) LIMITATION ON DIFFERENTIALS FOR SERVICES UNDER MEDICAID.—The ratio of the average rate of payment for services under the medicaid program to such average rate of payment for the same services by health benefit plans (other than the medicare program, medicare part C, and medicaid programs) may not be less than the ratio of the average of the rates of payment within the class of services for which payment is provided under the medicaid program to such average rate of payment under other health benefit plans (other than the medicare program, medicare part C, and medicaid programs) during the most recent year before the implementation of the state payment system, as determined jointly by the Secretaries.

(4) SEPARATE RATE NEGOTIATIONS PERMITTED FOR HEALTH MAINTENANCE ORGANIZATIONS.—

(A) IN GENERAL.—A State may provide that a health maintenance organization (as defined in subparagraph (B)) may negotiate directly with a provider of services covered under the system with respect to the organization's rate of payment for such services.

(B) DEFINITION.—In subparagraph (A), the term "health maintenance organization" means an eligible organization with a contract under section 1876 of the Social Security Act or a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act).

(5) MINIMUM PAYMENT RATES.—Under the state payment system, the State may provide that the amount of payment for any service within a class of services under the system may not be less than a minimum payment rate established by the State for the services.

(6) LIMITING USE OF ADDITION PAYMENT AMOUNTS TO BAD DEBT AND CHARITY.—Under the State payment system, amounts required to be paid (for items or services) that are in excess of the reasonable cost or charges or other reasonable measure (as may be designated by the Secretaries) of cost for such items and services shall be accounted for separately and applied solely for the purpose of covering bad debts or charity care (as defined by the Secretary).

(c) OPERATION.—The system is operated directly by the State or by a State agency or other public authority. The previous sentence shall be construed to prohibit a State from contracting with private organizations to carry out the requirements of the State payment system.

(d) REPORTS REQUIRED.—Providers of services covered under the system must make such reports as the Secretaries may jointly require in order to monitor assurances provided under section 4203 and make determinations under section 4204.

(e) CONTINUED ACCESS.—The State must demonstrate to the satisfaction of the Secretaries that operation of the system will not result in any change in hospital admission practices or the provision of other services which result in—

(1) a significant reduction in the proportion of patients (receiving services covered under the system) who have no third-party coverage and who are unable to pay for such services,

(2) a significant reduction in the proportion of individuals provided services for which payment is (or is likely to be) less than the anticipated charges or costs of such services, or

(3) the refusal to provide services to individuals who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available from the provider.

(f) SPECIAL REQUIREMENTS FOR HOSPITAL ADMISSIONS AND EXCLUSIONS.—If the system applies to payment for hospital services, the system requires hospitals to which the system applies to meet the requirement of section 1866(a)(1)(G) of the Social Security Act with respect to the medicare program and the system provides for the exclusion of certain costs in accordance with section 1862(a)(14) of such Act (except for such waivers thereof as the Secretaries jointly provide by regulation).

SEC. 4203. CONTROL OF AGGREGATE EXPENDITURES REQUIREMENT FOR STATE SYSTEMS.

(a) ASSURANCES REQUIRED.—

(1) IN GENERAL.—A State payment system may not be approved until the Secretaries have been provided assurances satisfactory to the Secretaries that under the system, during a 3-year period (the first such period beginning with the first month in which this section applies to that system in the State) the following 2 tests are met:

(A) AGGREGATE EXPENDITURE TEST.—The sum of—

(i) aggregate private sector expenditures (as defined in paragraph (4)), and

(ii) the aggregate medicare expenditures (as defined in paragraph (5)) for such class (or classes) under the system,

will not exceed the applicable total limit specified in paragraph (2).

(B) MEDICARE EXPENDITURE TEST.—The aggregate medicare expenditures for such class (or classes) under the system will not exceed the applicable medicare limit specified in paragraph (3).

(2) APPLICABLE TOTAL LIMIT.—The applicable total limit specified in this paragraph is the total of the maximum amount of payments that would be payable in the State for the covered class (or classes) of services if the State payment system were not in effect. With respect to payments for individuals who are not enrolled under the medicare program or medicare part C, such amount shall

be based on the State private per capita expenditure estimate (established under subtitle B of title VI) for the State, adjusted—

(A) to remove the effect of the adjustment described in section 6101(b)(3), and

(B) to take into account only the proportion of such estimate that is attributable to the covered class (or classes).

(3) APPLICABLE MEDICARE LIMIT.—The applicable medicare limit specified in this paragraph is the sum of—

(A) the maximum amount of payments that would be payable in the State for the covered class (or classes) of services under the medicare program if the state payment system were not in effect, and

(B) the maximum amount of payments that would be payable in the State for the covered class (or classes) of services under medicare part C if the state payment system were not in effect.

(4) AGGREGATE PRIVATE SECTOR EXPENDITURES DEFINED.—In this subtitle, the term "aggregate private sector expenditures" means the product of—

(A) the State private per capita expenditure estimate (referred to in paragraph (2), subject to the adjustment described in such paragraph) for the class (or classes) of services covered under the system, and

(B) the average number of residents of the State enrolled in certified health plans.

(5) AGGREGATE MEDICARE EXPENDITURES DEFINED.—In this subtitle, the term "aggregate medicare expenditures" means expenditures under the medicare program and medicare part C for items and services included in the class (or classes) of services covered under the system.

(6) WAIVER OF AGGREGATE EXPENDITURE TEST FOR YEARS PRIOR TO 1997.—The aggregate expenditure test described in paragraph (1) shall not apply with respect to a State payment system for any year prior to 1997.

(b) ANNUAL DETERMINATION BY SECRETARIES.—The Secretaries shall jointly determine annually whether a State payment system has met the tests described in subsection (a)(1) for the most recent 3-year period, determined based on all classes of services covered under the system.

(c) USE OF MEDICARE SAVINGS.—

(1) IN GENERAL.—If the Secretaries jointly determine that a State payment system under this subtitle has resulted in medicare savings over a period of 3 consecutive years, in the 4th year there shall be paid to the State an amount equal to the medicare savings in the first year of such 3-year period. Such payments shall be made from the Federal Hospital Insurance Trust Fund, the Federal Supplementary Medical Insurance Trust Fund, Medicare Part C Trust Fund in such amounts as reflects the medicare savings attributable to the respective Trust Fund in such first year.

(2) DEFINITIONS.—In this subsection:

(A) The term "medicare spending" means, with respect to a State in a year, aggregate medicare expenditures incurred under the medicare program and medicare part C in the State in the year.

(B) The term "baseline medicare spending" means, with respect to a State in a year, the amount of aggregate medicare expenditures that the Secretaries jointly estimate would have been incurred under the medicare program and medicare part C in the State in the year if this subtitle did not apply in the State.

(C) The term "medicare savings" means, with respect to a State in a year, the amount by which the baseline medicare spending for the State in the year exceeds the medicare spending for the State in the year.

SEC. 4204. TERMINATION OF APPROVAL OF STATE SYSTEM.

(a) IN GENERAL.—Either of the Secretaries shall terminate approval of a state payment system in accordance with this section if such Secretary determines under section 4203(b) that the State has not met the tests referred to in such section.

(b) PROCESS.—

(1) NOTICE.—Either of the Secretaries may terminate the approval of a State payment system under this subtitle only after the expiration of a 90-day period beginning on the date such Secretary informs the State of such Secretary's intention to terminate such approval, unless, during such 90-day period, the State requests a hearing with such Secretary.

(2) HEARING.—If the State requests a hearing during the 90-day period described in paragraph (1), such Secretary shall conduct a hearing during which the State may present evidence showing that such Secretary should not terminate the approval of its system. If such Secretary decides to reject such evidence, such Secretary shall terminate the approval of the State's system beginning with the first day of the first month that begins after the date of such Secretary's decision.

(3) JUDICIAL REVIEW PROHIBITED.—There shall be no administrative or judicial review of a decision by either of the Secretaries with respect to the approval (or termination of approval) of a State payment system under this subsection.

(c) ADJUSTMENTS TO RECAPTURE EXCESS SPENDING.—

(1) ADJUSTMENT OF MAXIMUM PAYMENT RATES.—If either of the Secretaries terminates the approval of a State payment system under this section due to—

(A) a failure to meet the test described in section 4203(a)(1)(A) (relating to aggregate private sector and medicare expenditures), the maximum payment rates otherwise established for services within the class (or classes) of services under subtitle D of title VI shall be adjusted in accordance with paragraph (2)(A), but only for that State; or

(B) a failure to meet the test described in section 4203(a)(1)(B) (relating to aggregate medicare expenditures), the payment rates otherwise established for items and services within the class (or classes) of services under subtitle C of title VIII shall be adjusted in accordance with paragraph (2)(B), but only for that State.

(2) ADJUSTMENTS.—

(A) IN MAXIMUM PAYMENT RATES FOR PRIVATE SECTOR EXPENDITURES.—The adjustment described in this subparagraph is such a reduction in the maximum payment rates for the class (or classes) of services covered under the system as such Secretary determines necessary to decrease—

(i) the amount of aggregate private sector expenditures that would otherwise be made for services provided in the State, by

(ii) the amount by which aggregate private sector expenditures for such class (or classes) of services for the 3-year period involved exceeded the applicable private sector limit specified in section 4203(a)(4) for such period.

(B) IN MEDICARE PAYMENT RATES.—The adjustment described in this subparagraph for a State is such a reduction in the applicable medicare payment rate for the class (or classes) of services covered under the system as the Secretary determines necessary to decrease—

(i) the amount of aggregate medicare expenditures that would otherwise be made for services provided in the State, by

(ii) the amount by which aggregate medicare expenditures for such class (or classes) of services for the 3-year period involved exceeded the applicable medicare limit specified in section 4203(a)(3) for such period.

(C) PERIOD OF ADJUSTMENT.—The adjustments under subparagraphs (A) and (B) shall be made—

(i) during the year following the termination of the system, or

(ii) during each year in the 3-year period following the termination, if such Secretary determines that a reduction over such 3-year period is appropriate in the case of a State.

Subtitle D—General Rules, Coordination, and Transition

SEC. 4301. PROCEDURES.

The Secretaries shall prescribe by regulation a process for coordinating the procedures of each such Secretary governing submission, consideration, and determination of applications for approval, ongoing reports, and termination procedures under this title. Under such process, no approval of any system or program under this title may apply to the portions of a metropolitan statistical area which are located in the counties of Monroe, Wayne, Ontario, and Livingston.

SEC. 4302. AVAILABILITY OF PRIVATE RIGHT OF ACTION FOR AGGRIEVED INDIVIDUALS.

(a) IN GENERAL.—Any person aggrieved by an act or omission of a State under this title which constitutes a failure to comply with an applicable requirement of this title may obtain from the State in any court of competent jurisdiction appropriate relief, including actual and compensatory damages and equitable relief.

(b) EXCEPTION FOR CERTAIN VIOLATIONS.—Subsection (a) does not apply in the case of an act or omission upon which a complaint may be filed in a complaint review office pursuant to section 9304 or for which a remedy may be sought under section 9331.

(c) ATTORNEY'S FEES AND COSTS.—In any action under this section in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(d) EXHAUSTION OF REMEDIES.—In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

SEC. 4303. REFERENCES TO WAIVERS UNDER THE MEDICARE PROGRAMS.

For waiver of certain provisions of the medicare program, see section 1894 of the Social Security Act, as added by section 8361 of this Act.

SEC. 4304. EXEMPTIONS FROM ERISA PREEMPTION.

For exemptions from preemption of State law, under the Employee Retirement Income Security Act of 1974, see paragraphs (9), (10), and (11) of section 514(b) of such Act, as added by section 12004 of this Act.

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Subtitle A—Standards for Carriers and Insured Health Benefit Plans

SEC. 5001. REQUIREMENTS FOR CERTIFICATION OF CARRIERS AND PLANS.

(a) CERTIFICATION REQUIRED FOR CARRIERS PROVIDING INSURED HEALTH BENEFIT PLANS.—

(1) IN GENERAL.—No carrier may sell, issue, or renew a contract under an insured health benefit plan (as defined in section 5504) in a State, or sell, issue, or renew a contract under a supplemental health benefit policy (as defined in section 5504(11)) in a State, unless the carrier, in relation to the plan, and the plan have been certified as meeting the applicable standards established under section 5501 consistent with this subtitle—

(A) by a State regulatory program of the State (approved under section 5502), or

(B) in the case of a State without such an approved program, by the Secretary (in accordance with such procedures as the Secretary establishes).

(2) PLAN DISAPPROVED.—If the applicable regulatory authority determines that a carrier with respect to an insured health benefit plan or a supplemental health benefit policy does not meet the applicable standards of this subtitle on or after the effective date described in subsection (b), the carrier may not provide coverage under the plan to individuals not enrolled as of the date of the determination and may not continue to provide the plan for plan years beginning after the date of such determination until the authority determines that such carrier and plan are in compliance with such standards.

(3) SPECIAL RULE FOR CARRIERS OFFERING PLANS IN MULTI-STATE METROPOLITAN STATISTICAL AREAS.—In the case of a carrier offering an insured health benefit plan in a portion of a State that is located in a metropolitan statistical area, the carrier may not sell, issue, or renew a contract under the plan with respect to an individual or employer in such metropolitan statistical area unless the carrier, in relation to the plan, and the plan have been certified as meeting the applicable standards established under section 5501 by the State regulatory program of each State in which the metropolitan statistical area is located. The Secretary may waive the application of this paragraph to a carrier with respect to a State with an approved single-payer system under subtitle A of title IV, or under unusual circumstances.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subsection (a) shall apply to contracts under insured health benefit plans sold, issued, or renewed on or after January 1, 1997.

(2) EXCEPTION FOR PLANS OFFERED IN STATES REQUIRING LEGISLATION.—In the case of an insured health benefit plan sold, issued, or renewed in a State which the Secretary identifies, in consultation with the NAIC, as—

(A) requiring State legislation (other than legislation appropriating funds) in order for carriers and plans to meet the requirements of this subtitle, but

(B) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered, the date specified in this subsection is January 1, 1998, or, if earlier, the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1997. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 5002. NONDISCRIMINATION.

(a) NO DISCRIMINATION BASED ON HEALTH STATUS.—A carrier may not deny, limit, or condition the coverage under (or benefits of) an insured health benefit plan based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

(b) OTHER DISCRIMINATION PROHIBITED.—A carrier may not engage in any activity in relation to an insured health benefit plan offered in a market sector that directly or through contractual arrangements would have the effect of discriminating against an individual on the basis of race, national origin, religion, gender, sexual orientation, language, socioeconomic status, age, status of an eligible individual as a citizen of the United States, health status, or anticipated need for health services.

SEC. 5003. OPEN ENROLLMENT.

(a) ENROLLMENT REQUIREMENTS.—Subject to the succeeding provisions of this section, a carrier that offers an insured health benefit plan in a market sector to individuals residing (or to employers located) in a community-rating area (described in section 5008(c)) must offer the same plan to any other resident of (or employer located in) such area who is eligible to seek coverage through such a sector.

(b) ENROLLMENT PERIODS.—

(1) IN GENERAL.—Except as provided under paragraph (2), the requirement described in subsection (a) shall apply on a continuous, year-round basis.

(2) ENROLLMENT FOR INDIVIDUALS IN COMMUNITY-RATED MARKET SECTOR.—With respect to eligible individuals seeking enrollment in an insured health benefit plan offered in the community-rated market sector who are seeking coverage on behalf of themselves (and their dependents) and not seeking coverage on the basis of employment or through a consumer purchasing cooperative, the following rules apply:

(A) ANNUAL OPEN ENROLLMENT PERIOD.—The State shall establish an annual open enrollment period of at least 45 days during which a carrier may not refuse to enroll such individuals. Before and during each such open enrollment period, the carrier shall make public information on the availability of coverage in the community-rated market sector (in accordance with section 5010).

(B) CONTINUOUS OPEN ENROLLMENT FOR NEW MARKET ENTRANTS.—A carrier may not refuse to enroll such an individual who is not enrolled in an insured health benefit plan offered in the community-rated market sector.

(C) PERMITTING CHANGE IN PLAN.—

(i) GROUNDS FOR CHANGE.—An individual may change the plan under which the individual is provided coverage under an insured health benefit plan—

(I) during the individual's first year of coverage; or

(II) for good cause during any year of the individual's coverage (under procedures developed by the Secretary).

(ii) TIMING OF CHANGE.—A change in plan described in clause (i) shall be effective on the first day of the first month beginning at least 45 days after the date the individual provides notice to the carrier offering the plan in which the individual seeks coverage.

(D) PERMITTING CONTINUOUS OPEN ENROLLMENT.—Nothing in this subparagraph may be construed to prohibit a carrier from permitting enrollment of any individual at any other time, so long as the carrier permits enrollment of any individual eligible to enroll and does not discriminate among such individuals in violation of section 5002.

(3) EXCEPTION FOR YEARS BEFORE 1999.—

(A) INDIVIDUALS.—Notwithstanding any other provision of this title, during any year prior to 1999, a carrier offering an insured health benefit plan offered in the community-rated market sector may refuse to enroll an individual who seeks coverage under the plan on behalf of the individual (and the individual's dependents) and not seeking coverage on the basis of employment or membership in a qualifying association, or through a consumer purchasing cooperative, except during an annual 30-day open enrollment period established by the Secretary for States during which the plan would be required to provide for enrollment of any such eligible individual. Before and during such open enrollment period, the carrier shall make public information on the availability of coverage under such plans (in accordance with section 5010).

(B) SMALL EMPLOYERS.—Notwithstanding any other provision of this title, during any year prior to 1999, a carrier may refuse to provide coverage with respect to a small employer through the community-rated market sector if the employer does not meet standards of the carrier relating to the minimum participation of employees of the employer in insured health benefit plans offered through such sector (in accordance with standards established by the Secretary), except during the annual 30-day open enrollment period described in subparagraph (A) during which the plan would be required to provide for coverage with respect to any small employer. Prior to and during such open enrollment period, the carrier shall make public information on the availability of coverage under such plans (in accordance with section 5010).

(4) EXCEPTION FOR TERMINATED PLANS.—A carrier may refuse to enroll an individual in an insured health benefit plan offered in a market sector if the carrier is terminating enrollment in the plan pursuant to section 5006(c).

(c) SPECIAL RULES FOR PLANS OFFERED THROUGH QUALIFYING ASSOCIATIONS.—

(1) OFFERING OF PLANS PERMITTED.—Subject to paragraph (2), a carrier may offer an insured health benefit plan through an association that is a qualifying association defined in subsection (e)(4).

(2) SPECIAL RULES FOR ASSOCIATION PLANS.—With respect to an insured health benefit plan offered by a carrier through a qualifying association—

(A) the carrier shall offer the same plan to all individuals and employers eligible to seek coverage through the community-rated sector; and

(B) the carrier may not offer the plan to a large employer seeking coverage through the association on behalf of its employees.

(3) CARRIERS THAT ARE QUALIFYING ASSOCIATIONS.—In the case of a qualifying association that—

(A) is a religious fraternal organization, and

(B) is a carrier (and was a carrier as of December 31, 1993),

the association may limit enrollment in health plans it offers as a carrier to members of the association.

(d) CAPACITY LIMITATION.—

(1) IN GENERAL.—A carrier offering an insured health benefit plan may apply to the applicable regulatory authority to cease enrolling new employers or individuals in part or all of the service area of the plan if it can demonstrate that its financial or administrative capacity (or, in the case of a staff model or dedicated group model health maintenance organization, its service capacity) to serve previously enrolled employers and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled employers) will be impaired if it is required to enroll new employers or individuals.

(2) PRIORITIES IN CASE OF OVERSUBSCRIPTION.—

(A) IN GENERAL.—The applicable regulatory authority in a State shall establish a method for establishing enrollment priorities in the case of an insured health benefit plan offered by a carrier that is permitted to limit enrollment under this subsection. Except as provided in subparagraph (B), such priorities shall not take into account personal characteristics of potential enrollees, such as health status, socioeconomic status, anticipated need for health care, age, occupation, sexual orientation, race, sex, national origin, or affiliation with any person or entity.

(B) PRIORITIES.—Such method shall provide that in the case of such an oversubscribed plan—

(i) individuals already enrolled in the plan are given priority in continuing enrollment in the plan, and

(ii) to the extent that other individuals may be enrolled, such enrollment shall be in accordance with a method that provides equal opportunity for all individuals who seek enrollment during the same enrollment period, regardless of when during the period the enrollment has been sought.

(e) MARKET SECTORS DESCRIBED.—For purposes of this title, each of the following is a separate market sector:

(1) COMMUNITY-RATED MARKET SECTOR.—The community-rated market sector, consisting of (subject to subsection (f))—

(A) individuals seeking coverage on behalf of themselves (and their dependents) and not seeking coverage on the basis of employment or membership in a qualifying association, or through a consumer purchasing cooperative; and

(B) small employers seeking coverage on behalf of their employees (and dependents) and on behalf of other individuals on the basis of their employment (or similar business relationship) with the employer and not seeking coverage on the basis of membership in a qualifying association or through a consumer purchasing cooperative.

(2) LARGE GROUP MARKET SECTOR.—The large group market sector, consisting of eligible large group sponsors seeking coverage on behalf of individuals eligible to seek coverage through such sponsors.

(3) ELIGIBLE LARGE GROUP SPONSOR DEFINED.—In this section, the term "eligible large group sponsor" means an eligible sponsor described in section 5102(b).

(4) OTHER DEFINITIONS.—

(A) CONSUMER PURCHASING COOPERATIVE.—The term "consumer purchasing cooperative" means a cooperative described in section subtitle E, without regard to whether or not a grant is made under such subtitle for the area in which the cooperative is established.

(B) EMPLOYEE INCLUDING SELF-EMPLOYED.—The term "employee" includes, with respect to an employer that is a self-employed individual, the self-employed individual.

(C) LARGE EMPLOYER.—The term "large employer" has the meaning given such term in section 1106(b)(1)(A).

(D) QUALIFYING ASSOCIATION.—The term "qualifying association" means an association, religious fraternal organization, or other organization (which may be a trade, industry, or professional association, a chamber of commerce, or a public entity association) that the Secretary finds—

(i) has been formed for purposes other than the sale of health insurance and does not restrict membership based on any characteristic described in section 5002(a),

(ii) does not exist solely or principally for the purpose of selling insurance,

(iii) has at least 1,000 individual members or 200 employer members,

(iv) offered a health benefit plan as of December 31, 1993,

(v) any health benefit plan it offers to its members is made available consistent with the requirements of section 5002(a), and

(vi) any health benefit plan it offers to its members is not made available to any eligible large group sponsor described in paragraph (3).

Such term includes a subsidiary or corporation that is wholly owned by one or more qualifying organizations.

(E) SMALL EMPLOYER.—The term "small employer" means an employer that is not a large employer and employs at least 2 employees.

(f) CERTAIN INDIVIDUALS NOT INCLUDED IN COMMUNITY-RATED MARKET SECTOR.—The following individuals are not included in the community-rated market sector under subsection (e)(1):

(1) MEDICARE ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—Subject to subparagraph (B), an individual who is entitled to benefits or enrolled under part A of title XVIII of the Social Security Act.

(B) EXCEPTION WHERE MEDICARE SECONDARY PAYER.—Subparagraph (A) shall not apply to an individual if the certified health plan in which the individual enrolls (or will be enrolled) under this subtitle is (or would be) a primary plan (as defined in section 1862(b)(2)(A) of the Social Security Act) with respect to the individual.

(2) ENROLLED AS A DEPENDENT.—An individual who is enrolled under another health plan as a dependent of an individual.

(3) SPECIAL REQUIREMENT FOR MEDICAID-ELIGIBLE INDIVIDUALS.—An individual who is entitled to benefits with respect to the guaranteed national benefit package under a State medicaid plan under title XIX of the Social Security Act.

(4) FULL-TIME EMPLOYEE OF SMALL EMPLOYERS ENROLLED IN MEDICARE PART C.—An individual who is a medicare part C covered employee and who is a full-time employee of an employer who is not a large employer.

SEC. 5004. PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—A carrier may not exclude or limit coverage under an insured health benefit plan with respect to services covered under the plan related to treatment of a preexisting condition.

(b) TRANSITION FOR YEARS PRIOR TO 1999.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier providing an insured health benefit plan may exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months and such exclusion shall not apply with respect to services furnished to newborns, pregnancy-related services, or to a plan for which such exclusion did not apply as of the effective date of subtitle F.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A carrier providing an insured health benefit plan shall provide that if an individual covered under such a plan is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(B) DEFINITIONS.—As used in this paragraph:

(i) PERIOD OF CONTINUOUS COVERAGE.—The term "period of continuous coverage" means, with respect to particular services, the period beginning on the date an individual is enrolled under a health benefit plan, the medicare program, a State medicaid plan, or other health benefit arrangement which provides benefits with respect to the same or substantially similar services (as determined in accordance with criteria established by the Secretary) and ends on the date the individual is not so enrolled for a continuous period of more than 3 months (or for a longer period with respect to individuals who lose employment and meet such other conditions as the Secretary may specify).

(ii) PREEXISTING CONDITION.—The term "preexisting condition" means, with respect to coverage under a health benefit plan, a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

SEC. 5005. PROHIBITION AGAINST WAITING PERIODS.

(a) IN GENERAL.—Except as otherwise provided in this section, a carrier shall provide coverage of an individual under an insured health benefit plan as of the first day of the month following the month of enrollment. A carrier may not impose any waiting period on an enrollee before providing coverage under an insured health benefit plan.

(b) COVERAGE AFTER ENROLLMENT DURING ANNUAL OPEN ENROLLMENT PERIOD.—In the case of an individual who enrolls in an insured health benefit plan during an open enrollment period described in section 5003(b)(3)(A), the carrier shall provide coverage of the individual under the plan effective as of such date as the Secretary may establish with respect to enrollments made during such period.

SEC. 5006. CONTINUATION OF COVERAGE REQUIREMENTS.

(a) IN GENERAL.—A carrier may not refuse to enroll, refuse to renew the enrollment of, or terminate the enrollment of, an individual or employer in an insured health benefit plan except for—

(1) nonpayment of premiums, or

(2) fraud or misrepresentation of material fact.

(b) TRANSITION FOR NONCONFORMING POLICIES.—Notwithstanding State law or the provision of any agreement to the contrary, effective January 1, 1999, a carrier may cancel or refuse to renew a health insurance policy issued in a State prior to the application of this part to health benefit plans sold or issued in the State if the policy does not provide for coverage of the guaranteed national benefit package, but only if the carrier offers the policyholder affected the opportunity to obtain coverage under an insured health benefit plan meeting the standards established under this part.

(c) EXCEPTION FOR PLANS EXITING MARKET.—

(1) IN GENERAL.—A carrier may refuse to renew the enrollment of, or terminate the enrollment of, an individual or employer in an insured health benefit plan offered in a market sector if—

(A) the carrier is terminating the enrollment of all individuals in such plan with the approval of the applicable regulatory authority, or

(B) the carrier is terminating the plan pursuant to a joint marketing agreement entered into prior to January 1, 1994.

(2) LIMITATION ON OFFERING OF OTHER PLANS IN MARKET SECTOR.—If a carrier terminates the enrollment of individuals in a plan offered in a market sector pursuant to paragraph (1) in a State, the carrier may not offer a plan (that is the same type as the type of plan terminated) in the market sector to individuals or employers in the State until the expiration of the 5-year period that begins on the date that no individual is enrolled in the plan in the State.

SEC. 5007. BENEFIT REQUIREMENTS.

(a) REQUIRING OFFER OF PLAN CONSISTING OF GUARANTEED NATIONAL BENEFIT PACKAGE.—

(1) IN GENERAL.—Each carrier that offers an insured health benefit plan shall offer such a plan that only includes coverage for the benefits contained in the guaranteed national benefit package. A carrier may offer a plan within each type of plan within each market sector.

(2) LIMITATION ON OFFERING OF HIGH DEDUCTIBLE PLANS.—A carrier may not offer an insured health benefit plan that is a high deductible plan other than to an employer who demonstrates that the employer is making contributions to medical savings accounts in accordance with section 3466(d)(2)(C)(i) of the Internal Revenue Code of 1986.

(b) PREEMPTION OF STATE LAWS REQUIRING PLANS TO COVER ADDITIONAL BENEFITS.—Subsection (a)(1) shall preempt any State law requiring a carrier to include in an insured health benefit plan coverage for any benefit not contained in the guaranteed national benefit package.

(c) SPECIAL RULE FOR ENROLLEES COVERED UNDER MANAGED MENTAL HEALTH PROGRAMS.—

(1) PAYMENT TO STATE OF CAPITATED PAYMENT.—In the case of an individual enrolled in an insured health benefit plan who is enrolled in a managed mental health program of a State or an Indian tribe or tribal organization approved under section 1981 of the Public Health Service Act for a month—

(A) the individual is considered to have waived the right to benefits for mental health services through the plan in consideration of receipt of benefits for mental health services through such program;

(B) the carrier providing the plan shall make a per capita payment to the State or Indian tribe or tribal organization, in the amount specified in paragraph (2), on behalf of the individual; and

(C) the carrier is not obligated to make any other payment under the plan with respect to mental health services furnished to the individual during the month.

Payments under subparagraph (B) shall be made on a monthly basis.

(2) CAPITATED PAYMENT AMOUNTS.—The amount of the per capita payment required under paragraph (1) shall be an amount determined in accordance with a methodology established by the Secretary (similar to the methodology used under section 1893(b) to determine capitated payments to States and Indian tribes or tribal organizations on behalf of medicare beneficiaries enrolled in such programs) that reflects the portion of the premium associated with the coverage of mental health services under the guaranteed national benefit package that would be provided to the individual under the plan if the individual were not enrolled in the managed mental health program.

(3) MENTAL HEALTH SERVICES DESCRIBED.—In this subsection, the term 'mental health services' has the meaning given such term in section 1893(c) of the Social Security Act.

(d) SPECIAL REQUIREMENTS RELATING TO PRESCRIPTION DRUGS.—With respect to outpatient prescription drugs covered under an insured health benefit plan, the plan may subject the coverage of the drug to prospective review, prior authorization, or drug use review, but only if such review or authorization is conducted in the same manner and under the same terms as provided under section 1834(d)(6) of the Social Security Act.

SEC. 5008. REQUIREMENTS RELATING TO COMMUNITY RATING OF PREMIUMS.

(a) RATING REQUIREMENT.—Subject to subsections (b) and (e), the premium rate charged by a carrier for a type of insured health benefit plan in a community-rating area (as specified under subsection (c)) within the community-rated market sector shall not vary except by class of enrollment in accordance with subsection (d).

(b) TRANSITION.—

(1) GENERAL TRANSITION.—Except in the case of a State described in paragraph (2):

(A) FIRST YEAR.—In the first year for which this part applies to a carrier in a State, the premium rate charged by the carrier for an insured health benefit plan providing the guaranteed national benefit package in a community-rating area may vary within a class of enrollment so long as the premium range percentage (as defined in paragraph (3)) does not exceed ⅔ of the premium range percentage of premium rates charged by the carrier for insured health benefit plans providing similar benefits in the community-rating area in the previous year.

(B) SECOND YEAR.—In the second year for which this part applies to a carrier in a State, the premium rate charged by the carrier for an insured health benefit plan providing the guaranteed national benefit package in a community-rating area may vary within a class of enrollment so long as the premium range percentage does not exceed ½ of the maximum premium range percentage permitted under paragraph (1) for the previous year.

(2) SPECIAL TRANSITION FOR STATES SUBJECT TO DELAYED IMPLEMENTATION.—In the case of a State described in section 5001(b)(2), in the first year for which this part applies to a carrier in the State, the premium rate charged by the carrier for an insured health benefit plan providing the guaranteed national benefit package in a community-rating area may vary within a class of enrollment so long as the premium range percentage (as defined in paragraph (3)) does not exceed ½ of the premium range percentage of premium rates charged by the carrier for insured health benefit plans providing similar benefits in the community-rating area in the previous year.

(3) PREMIUM RANGE PERCENTAGE DEFINED.—In this subsection, the term "premium range percentage" means—

(A) the highest premium rate minus the lowest premium rate, divided by

(B) the lowest premium rate,

expressed as a percentage.

(4) PERMISSIBLE VARIATION.—Section 5002(a) and 5002(b) (insofar as such sections relate to age, health status, or anticipated need for health services) shall not apply to variations in premiums permitted under this subsection.

(5) NO TRANSITION PERMITTED AFTER 1998.—In no event may any variation in premiums be permitted pursuant to this subsection after December 31, 1998.

(c) SPECIFICATION OF COMMUNITY-RATING AREA.—

(1) IN GENERAL.—For purposes of this section, a community-rating area shall be determined consistent with this subsection.

(2) NO SPLITTING OF MSA.—The entire part of a metropolitan statistical area shall be in the same community-rating area.

(3) TREATMENT OF NON-MSA.—

(A) IN GENERAL.—Except as provided in subparagraph (B), all portions of a State that are outside a metropolitan statistical area shall be in a single community-rating area.

(B) STATE MAY DIVIDE.—A State may divide the portions of a State that are outside a metropolitan statistical area into more than one community-rating area.

(4) NO OVERLAPPING AREAS PERMITTED.—No portion of a State may be in more than one community-rating area.

(5) SPECIAL RULE.—Notwithstanding paragraph (2), the State of New York shall define a community-rating area to be the same area as an area defined (as of August 1, 1994) pursuant to section 4317 of the Insurance Law of the State of New York.

(d) CHARGING RATES BY CLASS OF ENROLLMENT.—

(1) IN GENERAL.—Each carrier shall establish separate premium rates for each of the three classes of enrollment described in section 3(b) for each market sector (including the large employer market sector).

(2) VARIATIONS ONLY BY ACTUARIAL VALUE.—The differences among such rates for an insured health benefit plan shall reflect only differences in the actuarial value of the guaranteed national benefit package among the classes of enrollment, consistent with standards established by the Secretary.

(e) RISK ADJUSTMENT.—

(1) DEVELOPMENT OF MODELS BY SECRETARY.—

(A) IN GENERAL.—The Secretary shall develop one or more model risk adjustment systems under which premiums applicable to insured health plans offered by carriers in the community-rated market sector would be adjusted to take into account such factors as the Secretary considers appropriate to predict the future need and use of services by individuals enrolled in such plans, which may include—

(i) the age, gender, geographic residence, health status, socioeconomic status, or other demographic characteristics of individuals enrolled in such plans; and

(ii) the proportion of individuals enrolled in such plans who are AFDC recipients (as defined in section 2(1)) or SSI recipients (as defined in section 2(11)).

(B) UPDATING MODELS.—The Secretary may periodically modify the model risk adjustment systems developed under subparagraph (A) as the Secretary considers appropriate.

(C) ADJUSTMENT FOR PEDIATRIC RISK FACTORS.—In addition to the risk adjustment methodology developed under subparagraph (A), the Secretary shall develop such a model methodology for pediatric risk factors, based on factors that predict solely the future need and use of health services by children enrolled in health benefit plans.

(2) APPLICATION OF METHODOLOGY TO PLANS.—The State shall require carriers providing insured health plans in the State in the community-rated market sector to meet the requirements of one of the model risk adjustment systems developed by the Secretary under paragraph (1)(A), or the requirements of an alternative system adopted by the State and approved by the Secretary.

(f) EXTENSION OF COMMUNITY RATES TO LARGE GROUP MARKET SECTOR.—Nothing in this section shall be construed to prohibit a carrier from offering a plan in the large group market sector at the rate applicable to the plan in the community-rated market sector.

SEC. 5009. SPECIAL REQUIREMENTS FOR MANAGED CARE AND POINT-OF-SERVICE PLANS.

(a) IN GENERAL.—The additional requirements of this section shall apply—

(1) in the case of a managed care plan; and

(2) with respect to the furnishing of items and services through a provider network of a point-of-service plan.

(b) ARRANGEMENTS WITH PROVIDERS.—

(1) IN GENERAL.—The carrier shall enter into such agreements with health care providers (including primary and specialty providers for children) or have such other arrangements as may be necessary to assure that individuals enrolled with the plan have reasonably prompt access to all items and services contained in the guaranteed national benefit package (including access to services on a 24-hour basis where medically necessary), in a manner that assures the continuity of the provision of such items and services.

(2) PROVISION OF PHYSICIANS' SERVICES.—In the case of a managed care plan, the plan provides for coverage of physicians' services primarily—

(A) directly through physicians who are either employees or partners of the carrier offering the plan; or

(B) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(3) ACCESS TO CENTERS OF EXCELLENCE.—

(A) IN GENERAL.—The carrier shall demonstrate that individuals enrolled in a plan (including individuals with acute life-threatening and chronic diseases) have access through the plan's provider network to specialized treatment expertise of designated centers of excellence. The carrier shall demonstrate such access according to standards developed by the Secretary, including requirements relating to plan arrangements with such centers and plan referral of patients to such centers.

(B) DESIGNATION PROCESS FOR CENTERS OF EXCELLENCE.—The Secretary shall establish a process for the designation of facilities as centers of excellence for purposes of this paragraph. Such process may include the use of treatment outcomes data.

(C) REQUIREMENTS FOR DESIGNATION.—A facility may not be designated pursuant to subparagraph (B) unless the facility is determined—

(i) to provide specialty care,

(ii) to deliver care for complex cases requiring specialized treatment and for individuals with acute life-threatening or chronic diseases, and

(iii) to meet any other requirements that shall be established by the Secretary relating to specialized education and training of health professionals, participation in peer-reviewed research or clinical trials, or treatment of patients from outside the geographic area of the facility.

(4) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—A carrier may not require an individual to obtain a referral in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

(5) PROTECTIONS FOR INDIVIDUALS WITH DISABILITIES.—A carrier take such measures as may be necessary to ensure the provision of covered items and services for individuals with disabilities, including such measures as may be necessary to ensure access to centers of excellence and essential community providers.

(c) PROVISION OF EMERGENCY AND URGENT CARE SERVICES.—

(1) IN GENERAL.—The plan must cover medically necessary emergency and urgent care services provided to enrollees (including trauma services provided by designated trauma centers), without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the plan to provide items or services to enrollees of the plan and, in the case of services furnished for the treatment of an emergency medical condition (as defined in section 1867(e)(1) of the Social Security Act), without regard to prior authorization.

(2) DESIGNATED TRAUMA CENTERS DEFINED.—In paragraph (1), the term "designated trauma center"—

(A) has the meaning given such term in section 1231 of the Public Health Service Act, and

(B) includes (for years prior to 2001) a trauma center that—

(i) is located in a State that has not designated trauma centers under section 1213 of such Act, and

(ii) the Secretary finds meets the standards under such section to be a designated trauma center.

(d) STANDARDS RELATING TO PROVIDER NETWORKS.—

(1) LIMITATIONS ON ABILITY TO EXCLUDE PROVIDERS FROM NETWORK.—

(A) IN GENERAL.—Except as provided in subparagraph (C), a carrier offering an insured health plan may not exclude from the provider network of the plan any provider of covered items or services (including a nonphysician provider) who is willing to accept the terms for participation in the network, including terms relating to the schedule of fees, covered expenses, and quality standards.

(B) CONSTRUCTION.—Nothing in this section may be construed to prohibit a carrier from carrying out any of the following activities with respect to providers who are members of a plan's provider network:

(i) Instituting criteria for the credentialing of providers.

(ii) Requiring providers to accept discounts in fees.

(iii) Matching the availability of providers with the needs of individuals enrolled in the plan.

(iv) Establishing measures to maintain quality and control costs.

(C) EXCEPTION FOR DEDICATED GROUP AND STAFF MODEL HEALTH MAINTENANCE ORGANIZATIONS.—Subparagraph (A) shall not apply with respect to a managed care plan that is a health maintenance organization if the organization—

(i) is treated as described in section 501(c)(3) of the Internal Revenue Code of 1986 pursuant to section 501(n)(2) of such Code, or

(ii) is not so treated but substantially all of its primary care health services are provided by the organization to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization.

(2) DUE PROCESS PROTECTIONS FOR PROVIDERS.—

(A) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—

(i) ESTABLISHMENT.—The carrier shall establish standards to be used by the carrier for contracting with health care providers with respect the plan's provider network. Such standards shall be established in consultation with providers who are members of the network.

(ii) DISTRIBUTION OF INFORMATION.—Descriptive information regarding these standards shall be made available to enrollees, providers who are members of the network, and prospective enrollees and prospective participating providers.

(B) NOTICE REQUIREMENT.—

(i) IN GENERAL.—The carrier may not terminate or refuse to renew an agreement with a provider to participate in the plan's provider network unless the carrier provides written notification to the provider of the carrier's decision to terminate or refuse to renew the agreement. The notification shall include a statement of the reasons for the carrier's decision, consistent with the standards established under subparagraph (A).

(ii) TIMING OF NOTIFICATION.—The carrier shall provide the notification required under clause (i) at least 60 days prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of an individual enrolled with the plan.

(C) REVIEW PROCESS.—

(i) IN GENERAL.—The carrier shall provide a process under which the provider may request a review of the carrier's decision to terminate or refuse to renew the provider's participation agreement. Such review shall be conducted by a group of individuals the majority of whom are health care providers who are members of the plan's provider network or employees of the carrier, and who are members of the same profession as the provider who requests the review.

(ii) COUNSEL.—If the provider requests in advance, the carrier shall permit an attorney representing the provider to be present at the provider's review.

(iii) REVIEW ADVISORY.—The findings and conclusions of a review under this subparagraph shall be advisory and nonbinding.

(D) CONSTRUCTION.—Nothing in this paragraph shall be construed to affect any other provision of law that provides an appeals process or other form of relief to a provider of health care services.

(3) DEVELOPMENT OF MEDICAL POLICIES.—The carrier shall consult with physicians who are members of the plan's network in the development of the plan's medical policy, quality and credentialing criteria, and medical management procedures.

SEC. 5010. STANDARDS FOR MARKETING OF HEALTH BENEFIT PLANS.

(a) MARKETING RESTRICTIONS ON CARRIERS.—

(1) IN GENERAL.—Each carrier—

(A) shall file any marketing materials for insured health benefit plans it provides for approval by the applicable regulatory authority prior to distributing them within the plan's service area;

(B) may not distribute any such materials that have not been previously approved by such authority, and

(C) shall comply with such other requirements as the Secretary may impose, including requirements to assure that marketing materials do not include false or materially misleading information and other requirements designed to inappropriate marketing practices, including abusive enrollment procedures.

(2) RESTRICTION ON USE OF MARKETING MATERIALS.—All such approved marketing materials—

(A) shall be made available uniformly to all individuals eligible to enroll in plans of the carrier pursuant to section 5003, and

(B) may not be used to attract or limit enrollment of certain individuals or groups on the basis of personal characteristics or anticipated need for health services.

(3) PROHIBITION OF TIE-INS.—A carrier may not seek to influence an individual's choice to enroll in a health benefit plan in conjunction with the offering or sale of any other product. The Secretary may establish rules to carry out this paragraph.

(b) NONDISCRIMINATION IN AGENT COMPENSATION.—A carrier—

(1) may not vary or condition the compensation provided to an agent or broker related to the sale or renewal of an insured health benefit plan because of the health status or claims experience of any individuals enrolled with the carrier through the agent or broker; and

(2) may not terminate, fail to renew, or limit its contract or agreement of representation with an agent or broker for any reason related to the health status or claims experience of any individuals enrolled with the carrier through the agent or broker.

(c) CONSTRUCTION.—Nothing in this subtitle (other than subsection (b)) may be construed to permit a State (including the enrollment assistance program established in the State under section 5011(b)) or a consumer purchasing cooperative to restrict the ability of a carrier to contract with an agent or broker for the sale of an insured health plan offered by the carrier.

SEC. 5011. COLLECTION AND DISSEMINATION OF PLAN INFORMATION.

(a) PROVISION OF INFORMATION BY CARRIERS.—A carrier providing an insured health benefit plan in a State shall provide to the applicable regulatory authority information requested by the State to disseminate under this section.

(b) ENROLLMENT ASSISTANCE PROGRAM.—Each applicable regulatory mechanism in a State shall establish and operate an enrollment assistance program which—

(1) provides for enrollment assistance with respect to all insured health benefit plans offered in the community-rated market sector in the State;

(2) provides for sites that are readily available to individuals and employers eligible to seek coverage through plans in such areas and that are not controlled by any carrier (or group or association of carriers), and

(3) must be coordinated with the preparation and provision of annual information on insured health benefit plans under subsection (c).

(c) PROVIDING ANNUAL INFORMATION ON INSURED HEALTH BENEFIT PLANS.—

(1) IN GENERAL.—Each applicable regulatory authority in a State shall annually prepare and make available to consumers, in a uniform format, information on insured health benefit plans sold in the State.

(2) INFORMATION DESCRIBED.—Such information shall include summary information—

(A) for each plan, on—

(i) the premium for the plan and the 3-year rate of increase in such premium,

(ii) identity, location, qualifications and availability of providers in any provider networks of the plan, including the ratio of primary care providers to enrollees during the previous year,

(iii) the number of individuals enrolling and disenrolling from the plan in the previous year,

(iv) procedures used by the plan to control utilization of services and expenditures,

(v) procedures used by the plan to assure quality of care,

(vi) the plan's loss ratio, and

(vii) rights and responsibilities of enrollees, including rights described in title IX;

(B) in addition, for each managed care plan, on—

(i) restrictions on payment for services provided outside the plan's provider network,

(ii) the process by which services may be obtained through the plan's provider network,

(iii) coverage for out-of-area services, and

(iv) any exclusions in the types of providers participating in the plan's provider network;

(C) the means by which individuals may contact the Consumer Health Advocacy Office available for consumers in the State (as established under part O of title III of the Public Health Service Act, as added by title VII); and

(D) such other information as the Secretary may require.

(3) DISSEMINATION OF INFORMATION.—Carriers, agents, and brokers shall provide the information described in this subsection to individuals and employers seeking to purchase health coverage.

(d) DISCLOSURE OF UTILIZATION REVIEW AND QUALITY STANDARDS.—Upon the request of any individual with respect to an insured health plan offered in the State, the State shall make available information on—

(1) procedures used by the plan to control utilization of services and expenditures, and

(2) procedures used by the plan to assure quality of care.

SEC. 5012. REQUIREMENTS FOR ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.

(a) IN GENERAL.—

(1) AGREEMENTS REQUIRED.—Each carrier providing an insured health benefit plan shall, with respect to each essential community provider (as defined in subsection (c)) located within the plan's service area (except as provided in paragraph (2)), offer to enter into a written provider participation agreement (described in subsection (b)) with any such provider who is willing to accept the generally applicable terms for participation, including terms relating to the schedule of fees, covered expenses, and quality standards.

(2) EXCEPTION FOR AGREEMENTS BETWEEN CERTAIN HEALTH MAINTENANCE ORGANIZATIONS AND HOSPITALS.—Paragraph (1) shall not apply with respect to any essential community provider that is a hospital in the case of an insured health benefit plan described as follows:

(A) The plan is a managed care plan that is a dedicated group or staff model health maintenance organization (as described in section 5009(d)(1)(C)) and is treated as described in section 501(c)(3) of the Internal Revenue Code of 1986 pursuant to section 501(n)(2) of such Code.

(B) The hospitals through which the plan provides services to its enrollees are owned and operated by the plan, or owned and operated by an organization that shares common ownership and control with the plan.

(b) PARTICIPATION AGREEMENT.—A participation agreement between a carrier and an essential community provider under this subsection shall provide that the plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers with a participation agreement with the plan with respect to each of the following:

(1) The scope of items and services for which payment is made by the plan to the provider.

(2) The rate of payment for covered care and services.

(3) The applicability of financial incentives to participating providers.

(4) Limitations on financial risk provided to other participating providers.

(5) Assignment of enrollees to participating providers.

(c) ESSENTIAL COMMUNITY PROVIDERS DESCRIBED.—In this section, an "essential community provider" means any of the following:

(1) CERTAIN MEDICARE DISPROPORTIONATE SHARE HOSPITALS.—A hospital—

(A) described in section 1886(d)(5)(F)(i)(II) of the Social Security Act;

(B) described in section 1886(d)(5)(F)(iv)(I) of such Act with a disproportionate patient percentage (as defined in section 1886(d)(5)(F)(vi) of such Act) greater than 20.2; or

(C) that would be described in subparagraph (A) or (B) if—

(i) the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act), or

(ii) in the case of a hospital whose inpatients are predominantly individuals under 18 years of age, if the hospital were a subsection (d) hospital with more than 100 beds.

(2) DESIGNATED CANCER HOSPITALS.—A hospital that the Secretary has classified as a hospital involved extensively in treatment for or research on cancer, as described in section 1886(d)(1)(B)(v) of such Act.

(3) SOLE COMMUNITY HOSPITALS.—A sole community hospital (as described in section 1886(d)(5)(D)(iii) of such Act).

(4) MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—A medicare-dependent, small rural hospital (as described in section 1886(d)(5)(G)(iii) of such Act), or a hospital that would be a medicare-dependent, small rural hospital if the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act).

(5) FEDERALLY QUALIFIED HEALTH CENTERS.—A Federally qualified health center (as defined in section 1905(l)(2)(B) of such Act) or an entity that would be such a center but for its failure to meet the requirement described in section 329(f)(2)(G)(i) of the Public Health Service Act or the requirement described in section 330(e)(3)(G)(i) of such Act (relating to the composition of the entity's governing board).

(6) RURAL HEALTH CLINICS.—A rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act).

(7) FAMILY PLANNING CLINICS.—A family planning project receiving funds under title X of the Public Health Service Act (or receiving funds from a State pursuant to such title) or receiving funds under title V or XX of the Social Security Act (or receiving funds from a State pursuant to such a title).

(8) CERTAIN DIAGNOSTIC AND TREATMENT CENTERS.—A nonprofit center or clinic that is licensed under a State law in effect as of January 1, 1994, as a diagnostic and treatment center which provides primary care services (including obstetric and gynecology services) in an area—

(A) designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act, or

(B) with a significant number of individuals who are members of a medically underserved population designated by the Secretary under section 330 of such Act.

(9) LOCAL HEALTH DEPARTMENTS.—A health department of a unit of State or local government which provides health services directly to individuals.

(10) PROVIDERS SERVING UNDERSERVED AREAS.—

(A) IN GENERAL.—Any provider of health care services who meets the requirement of subparagraph (B) (if applicable) and is described as follows (in accordance with certification standards of the Secretary):

(i) The provider furnishes services not less than 20 hours per week—

(I) in an area designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act, or

(II) in an area with a significant number of individuals who are members of a medically underserved population designated by the Secretary under section 330 of such Act.

(ii) The provider—

(I) serves for at least 20 hours per week at the principal site in a neighborhood or community in which persons reside who are at risk of being medically underserved (in accordance with criteria established by the Secretary), and

(II) is available to patients evenings and weekends at the principal site.

(B) REQUIREMENT FOR PHYSICIANS.—In the case of an individual provider who is a physician, the provider must be board certified, hold hospital staff privileges, or be affiliated with one or more physicians holding hospital staff privileges.

(11) INDIAN HEALTH FACILITIES.—A health program of the Indian Health Service electing treatment as an essential community provider under section 903(c) of the Indian Health Care Improvement Act.

(12) CERTAIN PROVIDERS OF SERVICES FOR HIV.—Any public or private nonprofit entity receiving funds from a State or unit of local government pursuant to title XXVI of the Public Health Service Act that the Secretary determines provides primary care services, or any entity receiving a grant under subpart 2 of part C of such title.

(13) PROVIDER OF SCHOOL HEALTH SERVICES.—A provider of school health services that is eligible to receive funds under subtitle D of title VII, without regard to whether the provider receives such funds, but only with respect to services for which the provider may receive funding under such subtitle.

(14) NATIVE HAWAIIAN HEALTH CENTERS.—A Native Hawaiian Health Center (as defined in section 8(4) of the Native Hawaiian Health Care Act of 1988).

(15) RURAL PRIMARY CARE HOSPITAL.—A rural primary care hospital (as designated by the Secretary under section 1820(i)(2)).

(16) RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT WOMEN.—A program receiving a grant under section 508 of the Public Health Service Act.

(17) MEDICAL ASSISTANCE FACILITIES.—A facility participating in a demonstration project described in section 4008(i) of the Omnibus Budget Reconciliation Act of 1990.

(18) HEMOPHILIA TREATMENT CENTERS.—A comprehensive hemophilia diagnostic and treatment center receiving a grant under section 501(a)(2) of the Social Security Act.

(19) CERTAIN COMMUNITY CLINICS.—A community clinic organized as a nonprofit, public benefit corporation under California Health and Safety Code §1204(a) that does not charge patients directly for services rendered.

(d) SPECIAL RULE FOR PAYMENTS TO CERTAIN ESSENTIAL COMMUNITY PROVIDERS.—In the case of services in the guaranteed national benefit package that are furnished to an enrollee of an insured health benefit plan by any Federally qualified health center (described in subsection (c)(5)) or rural health clinic (described in subsection (c)(6)), the amount of payment made to the center or clinic for such services shall be determined in accordance with the payment methodology used to determine the amount of payment to such a center for services furnished under part B of title XVIII, unless the center or clinic elects to receive payment under an alternative methodology.

(e) REQUIRING ESSENTIAL COMMUNITY PROVIDERS TO PROVIDE SERVICES TO CERTAIN INDIVIDUALS.—An individual or entity may not be treated as an essential community provider under this section unless the individual or entity—

(1) provides services to individuals without regard to their ability to pay for such services (in accordance with standards established by the Secretary); and

(2) effective January 1, 1999, is a participating provider under medicare part C.

SEC. 5013. REQUIREMENTS RELATING TO PLAN SOLVENCY.

(a) In General.—A carrier shall comply with the following procedures and requirements in order to assure solvency of insured health benefit plans provided by the carrier:

(1) The carrier shall meet the capital requirements established by the applicable regulatory authority.

(2) The carrier shall arrange for an annual audit by an independent accountant of financial statements reporting its financial position and its financial activities with regard to its health plan business.

(3) The carrier shall arrange for an annual opinion by its appointed actuary on the reasonableness of assets held by the carrier.

(4) The carrier shall maintain separate records of finances, financial transactions, assets, and liabilities related to all business undertaken with respect to its health plan or plans.

(5) The carrier shall participate in the health plan guaranty fund established by the applicable regulatory authority.

(6) The carrier shall comply with such corrective actions, and shall cease such practices which, if not corrected, would jeopardize the financial solvency of the carrier, as the applicable regulatory authority may require.

(7) The carrier shall comply with all other solvency standards and requirements established by the Secretary.

(b) Authority of Applicable Regulatory Authorities in Relation to Financial Solvency.—Each applicable regulatory authority, with respect to carriers and insured health benefit plans over which it exercises authority—

(1) may examine the financial and operating records of the carriers (and each plan of such carriers) and plans,

(2) may order a carrier to take corrective actions and to cease practices which, if not corrected, would jeopardize the financial solvency of the carrier, and

(3) shall take any actions necessary to assure the payment of claims on behalf of individuals enrolled in insured health benefit plans provided by carriers declared to be financially impaired, in a financially hazardous condition, or insolvent.

(c) Response to Carrier Financial Instability.—

(1) Notification.—Upon determining that a carrier may be financially impaired, in a financially hazardous condition, or insolvent, the applicable regulatory authority of a State in which a carrier is licensed to operate shall—

(A) notify the Secretary of such determination in a timely manner; and

(B) notify the applicable regulatory authority of the State in which the carrier is domiciled (if the carrier is domiciled in a State other than the State providing the notification).

(2) Proceedings to rehabilitate or liquidate insolvent carriers.—Upon receiving a notification under paragraph (1)(B) (if applicable), the applicable regulatory authority of the State in which the carrier is domiciled shall take the carrier into conservatorship and begin proceedings to rehabilitate or liquidate the carrier in accordance with State law.

(3) Protections for enrollees.—In the case of an insured health benefit plan in a State for which the applicable regulatory authority in the State has made a determination that the carrier offering the plan may be financially impaired, in a financially hazardous condition, or insolvent—

(A) a provider of items and services covered under the plan may not charge or collect payment for such an item or service furnished to an individual enrolled in the plan (other than any cost-sharing otherwise applicable with respect to the item or service); and

(B) a provider of items and services covered under the plan shall continue to provide such items and services to individuals enrolled in the plan until such individuals are no longer enrolled in the plan.

(d) State Health Plan Guaranty Fund.—Each State shall assure that there is a health plan guaranty fund in operation in the State that meets requirements established by the Secretary in order to provide for the payment of outstanding provider claims and obligations of an insured health benefit plan offered by a carrier determined to be financially impaired, in a financially hazardous condition, or insolvent by the applicable regulatory authority in the State.

SEC. 5014. UTILIZATION REVIEW.

(a) Requiring Review to Meet Standards.—A carrier offering an insured health benefit plan may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets the standards established by the Secretary under this section.

(b) Establishment of Standards by Secretary.—The Secretary shall establish standards for utilization review programs of insured health benefit plans, consistent with subsection (c), and shall periodically review and update such standards to reflect changes in the delivery of health care services. The Secretary shall establish such standards in consultation with appropriate parties.

(c) Requirements for Standards.—Under the standards established under subsection (b)—

(1) individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage;

(2) negative determinations of the medical necessity or appropriateness of services or the site at which services are furnished may be made only by clinically qualified personnel;

(3) the utilization review program shall provide for a process under which an enrollee or provider may obtain timely review of a denial of coverage;

(4) utilization review shall be conducted in accordance with uniformly applied standards that are based on the most currently available medical evidence;

(5) providers shall participate in the development of the utilization review program;

(6) the timing of the utilization review and the information required to be reviewed shall be commensurate with the medical need of the individual for whom the service is to be furnished; and

(7) prior authorization for the delivery of services shall not be permitted in inappropriate circumstances.

SEC. 5015. ACCEPTANCE OF PREMIUM CERTIFICATES.

(a) In General.—If an individual covered under an insured health benefit plan offered by a carrier tenders to the carrier a premium certificate issued under part A of title XXII of the Social Security Act, the carrier shall reduce by the value of the certificate the amount of any premium required to be paid by the individual for periods beginning after the date of tender of the certificate unless otherwise provided by the Secretary.

(b) Tender of Certificate.—

(1) In general.—If an individual tenders to a carrier a premium certificate under subsection (a), the carrier may tender such a certificate to the Secretary, in a manner specified by the Secretary, and, upon such tender, is entitled to receive the value of the certificate so tendered.

(2) Tender through universal FEHBP or cooperatives.—Paragraph (1) shall apply with respect to an individual on whose behalf a premium certificate is tendered by the Director of the Office of Universal FEHBP under subtitle D or a consumer purchasing cooperative under subtitle E.

SEC. 5016. ADDITIONAL REQUIREMENTS FOR INSURED HEALTH BENEFIT PLANS.

In addition to the requirements imposed by the preceding provisions of this part, each carrier providing an insured health benefit plan shall meet the following additional requirements:

(1) Issuance of health security cards; coordination of individual entitlement.—The carrier shall issue health security cards and carry out other administrative functions in accordance with regulations developed by the Secretary including the issuance of an annual written statement to enrollees verifying enrollment in a private health plan and the provision of information on enrollees to the Secretary which the Secretary may forward to the Secretary of the Treasury.

(2) Compliance with payment rules.—The carrier provides for payment for items and services consistent with any State system approved under title IV.

(3) Other requirements.—The carrier shall meet the applicable requirements of the following provisions of this Act:

(A) Subtitle A of title IX (relating to grievance and appeals procedures, participation in the National Quality Management Program, and the privacy of information on enrollees).

(B) Subtitle B of title IX (relating to data management and reporting and administrative simplification).

Subtitle B—Standards for Sponsors and Self-Insured Health Benefit Plans

PART 1—GENERAL REQUIREMENTS

SEC. 5101. REQUIREMENT FOR CERTIFICATION OF SPONSORS AND PLANS.

(a) In General.—No sponsor may offer a self-insured health benefit plan (as defined in section 5504(11)) during a year on or after the effective date specified in subsection (b) (or enroll any individual under such a plan beginning on or after such effective date) unless the sponsor and the plan have been certified for the year by the Secretary of Labor (in accordance with such procedures as the Secretary of Labor establishes) as meeting the applicable standards established under section 5501(a)(2) consistent with this subtitle.

(b) Effective Date.—Subsection (a) shall apply to contracts under a self-insured health benefit plan sold, issued, or renewed on or after January 1, 1997.

SEC. 5102. LIMITATION ON ELIGIBLE SPONSORS.

(a) In General.—No entity may serve as the sponsor of a self-insured health benefit plan unless the entity is an eligible sponsor (as defined in subsection (b)) who elects, in a form and manner specified by the Secretary of Labor consistent with this subtitle, to be treated as the sponsor of such a plan and to be subject to the standards established by the Secretary of Health and Human Services for such plans under section 5501(a)(2).

(b) Eligible Sponsors.—

(1) In general.—In this section, each of the following is an eligible sponsor:

(A) LARGE EMPLOYER.—An employer that is a large employer as of the date of an election under subsection (a), with respect to employees, former employees, and family members.

(B) PLAN SPONSOR OF A MULTIEMPLOYER PLAN.—A plan sponsor described in section 3(16)(B)(iii) of Employee Retirement Income Security Act of 1974, but only with respect to participants and beneficiaries (as defined in section 3 of such Act) covered under a group health plan that is a multiemployer plan (as defined in subsection (c)(3)) maintained by the sponsor and only if (as of the date of an election under subsection (a)) such plan—

(i) covers more than 100 full-time employees in the United States, or

(ii) the plan is maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering more than 100 full-time employees.

(C) RURAL ELECTRIC COOPERATIVE AND RURAL TELEPHONE COOPERATIVE ASSOCIATION.—A rural electric cooperative or a rural telephone cooperative association, but only with respect to employees, former employees, and family members covered under a group health plan that is maintained by such cooperative or association (or members of such cooperative or association) and only if such plan has more than 100 employees in the United States entitled to benefits under the plan.

(2) EXCLUSION OF SPONSORS OF MEWAS.—The plan sponsor of a multiple employer welfare arrangement may not be considered an eligible sponsor under this subsection.

(c) DEFINITIONS.—In this section, except as otherwise provided:

(1) GROUP HEALTH PLAN.—The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries (as defined in section 3 of the Employee Retirement Income Security Act of 1974) directly or through insurance, reimbursement, or otherwise.

(2) LARGE EMPLOYER.—The term "large employer" has the meaning given such term in section 1106(b)(1)(A).

(3) MULTIEMPLOYER PLAN.—The term "multiemployer plan" has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such Act.

(4) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—The term "multiple employer welfare arrangement" has the meaning given such term in section 3(40) of the Employee Retirement Income Security Act of 1974 (as in effect on the day before the date of the enactment of this Act).

(5) RURAL ELECTRIC COOPERATIVE.—The term "rural electric cooperative" has the meaning given such term in section 3(40)(A)(iv) of the Employee Retirement Income Security Act of 1974.

(6) RURAL TELEPHONE COOPERATIVE ASSOCIATIONS.—The term "rural telephone cooperative association" has the meaning given such term in section 3(40)(A)(v) of the Employee Retirement Income Security Act of 1974.

SEC. 5103. NON-DISCRIMINATION.

(a) IN GENERAL.—Section 5002 shall apply with respect to a sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

(b) PROHIBITING OFFERING INDUCEMENT TO ENROLL IN INSURED HEALTH BENEFIT PLANS.—A sponsor of a self-insured health benefit plan may not offer any inducement to any individual eligible to seek coverage through the sponsor to seek coverage elsewhere.

SEC. 5104. REQUIREMENTS RELATING TO ENROLLMENT.

(a) ENROLLMENT IN CHOSEN PLAN.—The sponsor of a self-insured health benefit plan shall enroll an individual eligible to seek coverage through the sponsor in the plan chosen by the individual from among the plans offered by the sponsor (in accordance with the requirements of section 5107).

(b) ANNUAL OPEN ENROLLMENT PERIOD.—The sponsor of a self-insured health benefit plan shall provide for an annual open enrollment period of at least 45 days during which individuals eligible to enroll in the plan may change the health benefit plan under which they are provided coverage.

(c) CHANGES IN ENROLLMENT DURING 1ST YEAR OF ENROLLMENT.—Once during the first year for which an individual is enrolled in a plan offered by the sponsor of a self-insured health benefit plan, the individual may change the health benefit plan in which the individual is enrolled. Such a change shall be effective on the first day of the first month beginning at least 45 days after the date the sponsor receives a notice of change of coverage.

(d) ENROLLMENT OF NEWLY ELIGIBLE INDIVIDUALS.—The sponsor of a self-insured health benefit plan may not refuse to enroll an individual who is eligible to enroll in a health benefit plan offered by the sponsor and is not enrolled in such a plan.

SEC. 5105. PROHIBITION ON PRE-EXISTING CONDITION EXCLUSIONS.

The provisions of section 5004(a) shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

SEC. 5106. PROHIBITION ON WAITING PERIODS.

(a) IN GENERAL.—The provisions of section 5005(a) shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

(b) COVERAGE AFTER ENROLLMENT DURING ANNUAL OPEN ENROLLMENT PERIOD.—In the case of an individual who enrolls in a self-insured health benefit plan during an open enrollment period described in section 5104(b), the sponsor shall provide coverage of the individual under the plan effective as of such date as the sponsor may establish with respect to enrollments made during such period (consistent with the standards established by the Secretary of Health and Human Services under section 5501(c)).

SEC. 5107. BENEFIT REQUIREMENTS.

(a) OFFER OF PLAN CONSISTING OF GUARANTEED NATIONAL BENEFIT PACKAGE.—Each sponsor of a self-insured health benefit plan—

(1) shall offer all enrollees a health benefit plan consisting only of coverage for the benefits (including cost-sharing) contained in the guaranteed national benefit package; and

(2) may offer a health benefit plan consisting of coverage for the benefits described in paragraph (1) and (subject to subsection (d)) additional benefits.

(b) OFFER OF PLAN PROVIDING UNLIMITED CHOICE OF PROVIDERS.—Each sponsor of a self-insured health benefit plan shall assure that all enrollees are offered coverage in—

(1) at least one managed care plan (unless there is no such plan available in the area); and

(2) at least one unlimited-choice-of-provider plan, which may be a point-of-service plan.

(c) SPECIAL RULE FOR ENROLLEES COVERED UNDER STATE MANAGED MENTAL HEALTH PROGRAMS.—The provisions of section 5007(c) shall apply to sponsors of self-insured health benefit plans in the same manner as they apply to carriers providing insured health benefit plans.

(d) NON-DISCRIMINATION IN ADDITIONAL BENEFITS FOR NON-EMPLOYER PLANS.—In the case of a self-insured health benefit plan with an eligible sponsor described in subparagraph (B) or (C) of section 5102(b)(1), if the sponsor offers additional benefits pursuant to subsection (a)(2) that consist of a reduction in the cost-sharing imposed under a plan, the sponsor shall provide such additional benefits to all enrollees in the same manner as an employer would be required under 1112.

SEC. 5108. REQUIREMENTS RELATING TO RATING OF PREMIUMS.

(a) CHARGING RATES BY CLASS OF ENROLLMENT.—The sponsor of a self-insured health benefit plan shall establish separate premium rates for each of the three classes of enrollment described in section 3(b) of the Guaranteed Health Insurance Act of 1994.

(b) VARIATIONS ONLY BY ACTUARIAL VALUE.—

(1) IN GENERAL.—The differences among premium rates established under subsection (a) shall reflect only differences in the actuarial value of the guaranteed national benefit package among the classes of enrollment, consistent with standards established by the Secretary of Health and Human Services.

(2) PERMITTING VARIATION BY GEOGRAPHIC AREA OF ENROLLMENT.—At the option of the sponsor of a self-insured health benefit plan, in applying paragraph (1) the sponsor may vary premium rates based on differences in the actuarial value of the package among classes of enrollment in geographic areas, but only if the geographic areas applied are the same as the community-rating areas established under section 5008(d) with respect to insured health benefit plans offered in the State.

(c) EXCEPTION FOR SPONSORS PAYING ENTIRE PREMIUM.—Subsections (a) and (b) shall not apply in the case of a self-insured health benefit plan offered by a sponsor for which the sponsor does not require the enrollee to contribute any portion of the applicable premium.

SEC. 5109. ADDITIONAL STANDARDS FOR MANAGED CARE PLANS AND POINT-OF-SERVICE PLANS.

The provisions of section 5009 shall apply with respect to a managed care plan and a point-of-service plan provided by the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a managed care plan and point-of-service plan provided by the carrier providing an insured health benefit plan.

SEC. 5110. PROVISION OF PLAN INFORMATION.

(a) IN GENERAL.—The sponsor of a self-insured health benefit plan shall annually prepare and make available to individuals eligible to enroll in the plan, in a uniform format, information on the plans offered by the sponsor.

(b) INFORMATION DESCRIBED.—The information required to be provided under subsection (a) shall include summary information described in section 5011(b)(2) (other than information described in subparagraph (A)(vi)).

(c) DISCLOSURE OF UTILIZATION REVIEW AND QUALITY STANDARDS.—Upon the request of any individual eligible to enroll in a self-insured health benefit plan offered by a sponsor, the sponsor shall make available information on—

(1) procedures used by the plan to control utilization of services and expenditures, and

(2) procedures used by the plan to assure quality of care.

SEC. 5111. REQUIREMENTS FOR ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.

The provisions of section 5012 shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

SEC. 5112. UTILIZATION REVIEW.

The provisions of section 5014 shall apply with respect to a utilization review program of a self-insured health benefit plan in the same manner as such provisions apply with respect to a utilization review program of an insured health benefit plan.

SEC. 5113. ACCEPTANCE OF PREMIUM CERTIFICATES.

The provisions of section 5015 shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

SEC. 5114. ADDITIONAL REQUIREMENTS FOR SELF-INSURED HEALTH BENEFIT PLANS.

The additional requirements described in section 5016 shall apply with respect to the sponsor of a self-insured health benefit plan in the same manner as such additional requirements apply with respect to a carrier providing an insured health benefit plan, except that the requirements of paragraph (2) of such section shall not apply in the case of a sponsor who is not required to participate in a State system approved under title IV.

PART 2—RESPONSIBILITIES RELATING TO FINANCING

SEC. 5121. RESERVE REQUIREMENTS.

(a) IN GENERAL.—The Secretary of Labor shall ensure that each sponsor of a self-insured health benefit plan maintains plan assets in trust as provided in section 403 of the Employee Retirement Income Security Act of 1974—

(1) without any exemption under section 403(b)(4) of such Act, and

(2) in amounts which the Secretary of Labor determines are sufficient to provide at any time for payment to health care providers of all outstanding balances owed by the plan at such time.

The requirements of the preceding sentence may be met through letters of credit, bonds, or other appropriate security to the extent provided in regulations of the Secretary of Labor.

(b) SOLVENCY REQUIREMENTS.—The Secretary of Labor shall—

(1) prescribe such additional financial reserve requirements (which may include requirements relating to the use of aggregate and specific stop-loss insurance, reinsurance, or any other insurance requirement), and

(2) establish such limits on the amount of risk such a plan may retain,

as may be appropriate to assure the solvency of a self-insured health benefit plan. The requirements and limits shall take into account the number of lives covered and other appropriate risk-related factors identified by the Secretary of Labor.

(c) DISCLOSURE.—The sponsor of a self-insured health benefit plan shall notify the Secretary of Labor at such time as the financial reserve requirements of this section are not being met. The Secretary of Labor may assess a civil money penalty of not more than $100,000 against any sponsor for any failure to provide such notification in such form and manner and within such time periods as such Secretary may prescribe by regulation.

SEC. 5122. TRUSTEESHIP OF INSOLVENT PLANS BY SECRETARY OF LABOR.

(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary of Labor determines that self-insured health benefit plan will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of such Secretary, the Secretary of Labor shall, upon notice to the plan, apply to the appropriate United States district court for appointment of such Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the enrolled individuals or health care providers or to avoid any unreasonable deterioration of the financial condition of the plan or any unreasonable increase in the liability of the Self-Insured Plan Insolvency Fund. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

(b) POWERS AS TRUSTEE.—The Secretary of Labor, upon appointment as trustee under subsection (a), shall have the power—

(1) to do any act authorized by the plan, this Act, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

(3) to invest any assets of the plan which such Secretary holds in accordance with the provisions of the plan, regulations of such Secretary, and applicable provisions of law,

(4) to do such other acts as such Secretary deems necessary to continue operation of the plan without increasing the potential liability of the Self-Insured Plan Insolvency Fund, if such acts may be done under the provisions of the plan,

(5) to require the plan sponsor, the plan administrator, any contributing employer, and any employee organization representing covered individuals to furnish any information with respect to the plan which such Secretary as trustee may reasonably need in order to administer the plan,

(6) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

(7) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

(8) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

(9) to terminate the plan and liquidate the plan assets in accordance with applicable provisions of this Act and other provisions of law, to restore the plan to the responsibility of the large group sponsor, or to continue the trusteeship,

(10) to take such steps as may be necessary to ensure the continuation of the individual's enrollment in a plan providing coverage of the guaranteed national benefit package, and

(11) to do such other acts as may be necessary to comply with this Act or the Employee Retirement Income Security Act of 1974 or any order of the court and to protect the interests of enrolled individuals and health care providers.

(c) NOTICE OF APPOINTMENT.—As soon as practicable after such Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

(1) the plan administrator,

(2) each enrolled individual,

(3) each employer who may be liable for contributions to the plan, and

(4) each employee organization which, for purposes of collective bargaining, represents enrolled individuals.

(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this Act or title I of the Employee Retirement Income Security Act of 1974, the Secretary of Labor, upon appointment as trustee under this section, shall have the same rights, powers, and duties as those of a trustee under chapters 1, 3 (other than the right to compensation under section 330), and 5, and subchapters I and II of chapter 7, of title 11, United States Code, and shall have the duties of a fiduciary for purposes of such title I.

(e) OTHER PROCEEDINGS.—An application by the Secretary of Labor under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

(f) JURISDICTION OF COURT.—

(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this subsection, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this subsection, of a court of the United States having jurisdiction over cases under title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary of Labor as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the large group sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of such Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

(2) VENUE.—An action under this subsection may be brought in the judicial district where the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

(g) PERSONNEL.—In accordance with regulations of the Secretary of Labor, such Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with such Secretary's service as trustee under this section.

SEC. 5123. PROVISION OF AMOUNTS DUE PROVIDERS FROM INSOLVENT PLANS.

(a) IN GENERAL.—To the extent that amounts are available in the Fund established under subsection (b), the Secretary of Labor shall make payment from such Fund of outstanding amounts due to providers under a self-insured health benefit plan while such plan is under such Secretary's trusteeship under section 5122.

(b) SELF-INSURED PLAN INSOLVENCY FUND.—

(1) ESTABLISHMENT.—The Secretary of Labor shall establish a Self-Insured Plan Insolvency Fund (hereinafter in this part referred to as the "Fund") from which the Secretary shall authorize payment of the amounts described in subsection (a).

(2) BORROWING AUTHORITY.—At the direction of the Secretary of Labor, the Fund may, to the extent necessary to carry out this section, issue to the Secretary of the Treasury notes or other obligations, in such forms and denominations, bearing such maturities, and subject to such terms and conditions as may be prescribed by the Secretary of the Treasury. The total balance of the Fund obligations outstanding at any time shall not exceed $500,000,000. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of such notes or other obligations by the Fund. The Secretary of the Treasury shall purchase any notes or other obligations issued by the Fund under this paragraph, and for that purpose the Secretary of the Treasury may use as a public debt transaction the proceeds from the sale of any securities issued under chapter 31 of title 31, United States Code and the purposes for which securities may be issued under such chapter are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by such Secretary under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States.

(3) PROTECTION FOR ENROLLEES.—The Secretary of Labor shall take such actions as may be necessary to assure that health care providers continue to care for eligible individuals enrolled in such a plan while the plan is under trusteeship.

SEC. 5124. IMPOSITION AND COLLECTION OF PERIODIC ASSESSMENTS ON PLAN SPONSORS.

(a) IMPOSITION OF ASSESSMENTS.—The Secretary of Labor may impose assessments under this section to enable the Fund to repay amounts borrowed by the Fund while maintaining a balance sufficient to ensure the Fund's solvency.

(b) LIMITATION ON AMOUNT OF ASSESSMENT.—The total amount assessed against a plan under this section during a year may not exceed two percent of the total amount contributed to the plan toward the enrollment of individuals under the plan during the year.

(c) PAYMENT OF ASSESSMENTS.—

(1) OBLIGATION TO PAY.—The designated payor of each plan shall pay the assessments imposed by the Secretary of Labor under this section with respect to that plan when they are due. Assessments under this section are payable at the time, and on an estimated, advance, or other basis, as determined by such Secretary. Assessments shall continue to accrue until the plan's assets are distributed pursuant to a termination procedure or such Secretary is appointed to serve as trustee of the plan under section 5122.

(2) LATE PAYMENT CHARGES AND INTEREST.—

(A) LATE PAYMENT CHARGES.—If any assessment is not paid when it is due, the Secretary of Labor may assess a late payment charge plus interest, as prescribed by such Secretary in regulations.

(B) WAIVERS.—Late payment charges and interest under subparagraph (A) shall not apply to any assessment payment made within 60 days after the date on which payment is due, if before such date, the designated payor obtains a waiver from the Secretary of Labor based upon a showing of substantial hardship arising from the timely payment of the assessment.

(d) CIVIL ACTION UPON NONPAYMENT OR LATE PAYMENT.—If any designated payor fails to pay an assessment when due, the Secretary of Labor may bring a civil action in any district court of the United States within the jurisdiction of which the plan assets are located, the plan is administered, or in which a defendant resides or is found, for the recovery of the amount of the unpaid assessment, reasonable interest, any late payment charge, and interest, and process may be served in any other district. The district courts of the United States shall have jurisdiction over actions brought under this subsection by the Secretary of Labor without regard to the amount in controversy.

(e) DESIGNATED PAYOR DEFINED.—

(1) IN GENERAL.—For purposes of this section, the term "designated payor" means—

(A) the employer or plan administrator in any case in which the eligible sponsor of the plan is described in subparagraph (A) of section 5101(b)(1); and

(B) the contributing employers or the plan administrator in any case in which the eligible sponsor of the large group sponsor is described in subparagraph (B) or (C) of section 5101(b)(1).

(2) CONTROLLED GROUPS.—If an employer is a member of a controlled group, each member of such group shall be jointly and severally liable for any assessments required to be paid by such employer. For purposes of the preceding sentence, the term "controlled group" means any group treated as a single employer under subsection (b) or (c) of section 414 of the Internal Revenue Code of 1986.

SEC. 5125. MANAGEMENT OF FUNDS; RELATIONS WITH EMPLOYEES.

(a) MANAGEMENT OF FUNDS.—The management of funds by the sponsor of a self-insured health benefit plan shall be subject to the applicable fiduciary requirements of title I of the Employee Retirement Income Security Act of 1974.

(b) MANAGEMENT OF FINANCES AND RECORDS; ACCOUNTING SYSTEM.—Each sponsor of a self-insured health benefit plan shall comply with standards relating to the management of finances and records and accounting systems as the Secretary of Labor shall specify.

Subtitle C—Standards for Supplemental Health Plans

SEC. 5201. REQUIREMENT FOR CERTIFICATION OF CARRIERS AND POLICIES.

(a) CERTIFICATION REQUIRED.—

(1) IN GENERAL.—No carrier may sell, issue, or renew a contract under a supplemental health benefit policy (as defined in section 5504(11)) with respect to any individual or group in a State, unless the carrier, in relation to the plan, and the plan have been certified as meeting the applicable standards established under section 5501 consistent with this subtitle—

(A) by a State regulatory program of the State (approved under section 5502), or

(B) in the case of a State without such an approved program, by the Secretary (in accordance with such procedures as the Secretary establishes).

(2) POLICY DISAPPROVED.—If the applicable regulatory authority determines that a carrier with respect to a supplemental health benefit policy does not meet the applicable standards of this title on or after the effective date described in subsection (d), the carrier may not provide coverage under the policy to individuals not enrolled as of the date of the determination and may not continue to provide the policy for policy years beginning after the date of such determination until the authority determines that such carrier and policy are in compliance with such standards.

(3) SPECIAL RULE FOR CARRIERS OFFERING POLICIES IN MULTI-STATE METROPOLITAN STATISTICAL AREAS.—In the case of a carrier offering or selling a supplemental health benefit policy in a portion of a State that is located in a metropolitan statistical area, the carrier may not sell, issue, or renew a contract under the policy with respect to an individual or employer in such metropolitan statistical area unless the carrier, in relation to the policy, and the policy have been certified as meeting the applicable standards established under section 5501 by the State regulatory program of each State in which the metropolitan statistical area is located. The Secretary may waive the application of this paragraph to a carrier under extraordinary circumstances.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subsection (a) shall apply to contracts under supplemental health benefit policies sold, issued, or renewed on or after January 1, 1997.

(2) EXCEPTION FOR PLANS OFFERED IN STATES REQUIRING LEGISLATION.—In the case of a supplemental health benefit policy sold, issued, or renewed in a State which the Secretary identifies, in consultation with the NAIC, as—

(A) requiring State legislation (other than legislation appropriating funds) in order for carriers and plans to meet the requirements of this subtitle, but

(B) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered, the date specified in this subsection is January 1, 1998, or, if earlier, the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1998. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 5202. STANDARDIZED BENEFITS.

(a) LIMITATION ON POLICIES PERMITTED.—An carrier may not offer or sell a supplemental health benefit policy unless the benefits covered by the policy meet the requirements for one of the standard benefit packages established by the Secretary under subsection (b).

(b) ESTABLISHMENT OF STANDARDIZED PACKAGES.—

(1) IN GENERAL.—Not later than July 1, 1995, the Secretary shall establish not more than 10 standardized benefit packages for supplemental health benefit policies under this subtitle. Of such packages—

(A) the Secretary shall designate one as a core supplemental benefit package consisting of a reasonable combination of benefits typical of such policies; and

(B) at least one shall be designed to supplement a managed care plan.

(2) CRITERIA USED IN ESTABLISHING PACKAGES.—In establishing standardized benefit packages under paragraph (1), the Secretary shall take into account State laws that mandate the inclusion of particular benefits and providers of services, and the benefits typically offered or sold by health plans that are not included in the guaranteed national benefit package.

SEC. 5203. REQUIREMENTS FOR OFFERING OF PACKAGES.

(a) REQUIRING OFFER OF CORE SUPPLEMENTAL BENEFIT PACKAGE.—An carrier may not offer or sell any supplemental health benefit policy unless the carrier offers or sells one such policy that provides only for coverage of the core supplemental benefit package described in section 5202(b)(1)(A).

(b) PROHIBITING OFFER OF MULTIPLE PACKAGES TO AN INDIVIDUAL.—An carrier may not offer or sell a supplemental health benefit policy to an individual who is covered under another such policy, unless the individual's coverage under the new policy begins only after the individual's coverage under the original policy is terminated.

SEC. 5204. NON-DISCRIMINATION REQUIREMENTS.

(a) DISCRIMINATION BASED ON HEALTH STATUS.—The provisions of section 5002(a) shall apply during the annual open enrollment period established under section 5205 with respect to a carrier offering or selling a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

(b) DISCRIMINATION BASED ON OTHER FACTORS.—The provisions of section 5002(b) shall apply with respect to a carrier offering or selling a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

SEC. 5205. OPEN ENROLLMENT.

The State shall establish an annual open enrollment period of at least 30 days during which a carrier offering or selling a supplemental health benefit policy may not refuse to enroll an individual who seeks coverage under the policy.

SEC. 5206. PROHIBITION ON PRE-EXISTING CONDITION EXCLUSIONS.

(a) DURING ANNUAL OPEN ENROLLMENT PERIOD.—A carrier offering or selling a supplemental health benefit policy may not exclude or limit coverage under the policy during the annual open enrollment period established under section 5105 with respect to services covered under the policy related to treatment of a pre-existing condition.

(b) DURING OTHER PERIODS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier offering or selling a supplemental health benefit policy may exclude coverage during any period other than the annual open enrollment period established under section 5105 with respect to services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months and shall not apply to services furnished to newborns or pregnancy-related services.

(2) CREDITING OF PREVIOUS COVERAGE.—

(A) IN GENERAL.—A carrier offering or selling a supplemental health benefit policy shall provide that if an individual covered under such a policy is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under such policy, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(B) DEFINITIONS.—As used in this paragraph:

(i) PERIOD OF CONTINUOUS COVERAGE.—The term "period of continuous coverage" means, with respect to particular services, the period beginning on the date an individual is enrolled under any plan or policy which provides benefits with respect to the same or substantially similar services (as determined in accordance with criteria established by the Secretary) and ends on the date the individual is not so enrolled for a continuous period of more than 3 months (or for a longer period with respect to individuals who lose employment and meet such other conditions as the Secretary may specify).

(ii) PREEXISTING CONDITION.—The term "preexisting condition" means a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of the individual's coverage (without regard to any waiting period).

SEC. 5207. CONTINUATION OF COVERAGE REQUIREMENT.

The provisions of section 5006 (other than subsection (b) of such section) shall apply with respect to a carrier offering or selling a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier offering an insured health benefit plan.

SEC. 5208. COMMUNITY RATING REQUIREMENTS.

(a) IN GENERAL.—The premium rate charged by a carrier for a supplemental health benefit policy consisting of a standard benefit package established by the Secretary under section 5202 in a community-rating area for a class of enrollment shall be the same for all such enrollments.

(b) REFERENCES TO COMMUNITY AND ENROLLMENT.—The "community-rating area" and "class of enrollment" applicable under subsection (a) are the community and class of enrollment applicable to the community rating of premiums for insured health benefit plans required under section 5008.

SEC. 5209. STANDARDS FOR MARKETING.

(a) RESTRICTIONS ON TIE-INS WITH HEALTH BENEFIT PLANS.—

(1) IN GENERAL.—A carrier offering or selling a supplemental health benefit policy may not condition the offer or sale of a health benefit plan to an individual on the purchase of the supplemental health benefit policy by the individual.

(2) RESTRICTION ON AUTHORITY OF MANAGED CARE PLANS TO OFFER SUPPLEMENTAL POLICIES.—A carrier providing a managed care plan which provides for coverage of the guaranteed national benefit package may not offer or sell a supplemental health benefit policy to any individual unless the individual is enrolled in such managed care plan.

(b) APPLICABILITY OF OTHER REQUIREMENTS.—The provisions of section 5010 shall apply with respect to a carrier offering or selling a supplemental health benefit policy in the same manner as such provisions apply with respect to a carrier providing an insured health benefit plan.

Subtitle D—Universal FEHBP

SEC. 5301. PURPOSE.

The purpose of this subtitle is to ensure that individuals seeking health insurance coverage in the community-rated market sector may enroll in the same range of health plans providing the same guaranteed national benefits as are provided to Members of Congress and Federal employees.

SEC. 5302. CONTRACTS WITH CARRIERS.

(a) IN GENERAL.—

(1) CARRIERS SERVING THE COMMUNITY-RATED MARKET SECTOR.—The Office of Universal FEHBP (established under section 5307(a), in this subtitle referred to as the "Office") shall enter into such contracts with carriers who, beginning on January 1, 1997, shall offer insured health benefit plans certified under this title in the community-rated market sector and who shall meet standards prescribed under subsection (c).

(2) ASSURING RANGE OF PLANS AVAILABLE.—To the maximum extent practicable, the Office shall assure with respect to each community-rating area the offering of such a range of types of health benefit plans in the area under this subtitle as is (or was) provided under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code).

(3) CONDITIONS.—The Office may enter into contracts with carriers under this subtitle under the same conditions (in relation to bidding and duration of contract) as are provided for contracts under section 8902(a) of title 5, United States Code. The Office is not required to enter into such a contract with any particular carrier. Each such contract under this subtitle shall be consistent with the provisions of this subtitle and this Act.

(b) OFFERING OF SUPPLEMENTAL POLICIES.—To the extent practicable, the Office may provide for the offering of supplemental health benefit policies that meet the applicable requirements of subtitle C of this title to individuals who are enrolled under this subtitle in an insured health benefit plan certified under this title. The Office shall take such actions as may be appropriate to permit the offering of a supplemental health benefit policy that has the same benefits as those in a maintenance of effort policy described in section 8904a of title 5, United States Code.

(c) STANDARDS FOR CARRIERS, PLANS, AND POLICIES.—The Office may prescribe reasonable standards for carriers seeking to offer insured health benefit plans under this subtitle in the community-rated market sector, including standards relating to quality, price, administration, and other matters. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

(d) INFORMATION TO THE PUBLIC.—The Office shall disseminate general information to the public (especially to individuals and employers of individuals eligible to enroll under this subtitle) on the availability of insured health benefit plans under this subtitle, enrollment and premium payment procedures, and such other related information as the Office considers appropriate. Such information shall meet the standards specified in section 5011(c)(2).

(e) RISK.—Neither the Office nor the United States Government may bear insurance risk under this subtitle, and the Office may not bear any financial, fiduciary, or other responsibility for any VA health plan in which veterans may enroll under title 38, United States Code, pursuant to an agreement under subsection (f). The Office may not collect premiums with respect to the enrollment in any such VA health plan.

(f) AGREEMENT REGARDING VA HEALTH PLANS.—The Office shall enter into an agreement with the Secretary of Veterans Affairs to provide for disseminating information and the enrollment of veterans who are eligible to be enrolled both—

(1) in an insured health benefit plan offered under this subtitle, and

(2) in a VA health plan under chapter 18 of title 38, United States Code,

in such a VA health plan certified pursuant to section 5501(c) of this title. Such a VA health plan is an experienced-rated plan whose premiums are established under section 1831(d)(2) of title 38, United States Code, and shall not be treated as part of a community-rating area for any purpose relating to risk or the establishment of premiums for the purposes of this subtitle. The Secretary of Veterans Affairs shall reimburse the Office for any expense incurred in disseminating information on the availability of VA health plans and enrolling in such a plan pursuant to such agreement.

SEC. 5303. ELIGIBILITY.

(a) IN GENERAL.—Individuals in the community-rated market sector (described in section 5003(e)(1)) are eligible to be enrolled in an insured health benefit plan certified under this title that is offered under this subtitle. The enrollment may include family members based on an appropriate class of enrollment.

(b) CERTAIN INDIVIDUALS NOT INCLUDED IN COMMUNITY-RATED MARKET SECTOR.—The following individuals are not included in the community-rated market sector:

(1) IN GENERAL.—Subject to paragraphs (2) and (3) of this subsection, any individual described in section 5003(f).

(2) CHAPTER 89 ELIGIBLES.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), an individual who is eligible to enroll in an approved health benefit plan under chapter 89 of title 5, United States Code.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply to any individual—

(i) who makes an effective election under section 8905b of such title (relating to elections of coverage during the FEHBP transition period (within the meaning of section 8903b(a)(1) of title 5, United States Code));

(ii) who is a full-time employee and is not eligible to enroll (other than as a family member) under chapter 89 of such title; or

(iii) who is a family member of an individual described in clause (ii).

(C) TERMINATION.—The previous provisions of this paragraph shall not be effective with respect to any period of coverage which begins after the end of the FEHBP transition period.

(3) FULL-TIME EMPLOYEE OF LARGE EMPLOYERS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), an individual who is a full-time employee of a large employer.

(B) EXCEPTION FOR FAMILY MEMBERS.—Subparagraph (A) shall not apply to an employee who is—

(i) a spouse of an individual who is a employee of an employer that is not a large employer, or

(ii) a dependent child.

(C) EXCEPTION FOR POSTAL WORKERS.—Subparagraph (A) shall not apply to a full-time employee of the United States Postal Service.

(c) TREATMENT OF FEDERAL GOVERNMENT.—For purposes of this section, the Government of the United States (excluding the United States Postal Service) shall not be treated as a large employer.

SEC. 5304. PREMIUMS FOR COVERAGE.

(a) AMOUNT OF PREMIUMS.—

(1) IN GENERAL.—Premiums charged individuals in a community-rating area enrolled in insured health benefit plans under this subtitle shall be the premiums established under section 5008 for the plan for the area.

(2) NEGOTIATION OF ADMINISTRATIVE DISCOUNT.—The Office may negotiate with a carrier seeking to offer an insured health benefit plan under this subtitle a dollar or percentage discount from the amount of the premiums otherwise applicable. Such a discount—

(A) shall be applied uniformly to all enrollees of the plan;

(B) may vary only by class of enrollment;

(C) shall only reflect administrative savings to such a carrier from marketing such a plan through the Office under this subtitle instead of other means of marketing such a plan; and

(D) may not relate to differences in anticipated claims, costs, or utilization.

(b) PAYMENT PROCEDURES.—The Office shall develop and implement procedures for the payment of premiums by enrolling individuals and by employers offering health coverage through insured health benefit plans under this subtitle. The procedures shall provide for the acceptance and forwarding of premium certificates issued under part A of title XXII of the Social Security Act toward payment of the premiums owed.

SEC. 5305. GENERAL ADMINISTRATIVE PROVISIONS.

(a) TERMS OF OFFERING AND ENROLLMENT.—Plans and policies shall be offered under this subtitle in a manner consistent with the requirements of this title for the offering of such plans and policies other than under this subtitle. The Office shall develop and implement procedures for the enrollment, directly or by contract, of individuals under this subtitle during an annual open enrollment period and at such other special enrollment periods as may be appropriate and consistent with the requirements of this Act based on changes in employment, family status, or otherwise.

(b) AUDIT.—Each contract entered into with a carrier under this subtitle shall contain provisions requiring the carrier to—

(1) furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this subtitle; and

(2) permit the Office and representatives of the General Accounting Office to examine records of the carriers as may be necessary to carry out the purposes of this subtitle.

(c) TREATMENT OF CERTAIN ORGANIZATIONS AS CARRIERS.—

An organization which is a bargaining representative recognized under section 1203 of title 39, United States Code, which at any time during the 24-month period ending on the date of the enactment of this Act, was under contract with the Office of Personnel Management under section 8902 of title 5, United States Code, for a health benefits plan that was self-insured, shall be treated as a carrier for purposes of this subtitle, and may provide health benefits only to full members of such organization (determined in a manner consistent with section 8903a(d) of such title 5), including annuitants (as defined in section 8901(3) of such title 5) by reason of separating from a position in such a bargaining unit.

SEC. 5306. UNIVERSAL FEHBP HEALTH BENEFITS FUND.

(a) ESTABLISHMENT.—The Secretary of the Treasury shall establish, at the request of the Office, in the Treasury of the United States, a Universal FEHBP Health Benefits Fund. The Fund shall be administered by the Office.

(b) DEPOSITS INTO FUND.—If the Fund is established, there shall be deposited into the Fund—

(1) premiums paid to the Office under this subtitle;

(2) administrative fees and such other payments as are prescribed by the Office;

(3) moneys and the proceeds from the sale of gifts, devises, and bequests of property received under subsection (f).

(c) AVAILABILITY OF AMOUNTS IN FUND.—

(1) IN GENERAL.—Amounts in the Fund shall be available—

(A) without fiscal year limitation for payments to insured health benefit plans under this subtitle; and

(B) to pay expenses for administering this subtitle within the limitations that may be specified annually by Congress.

(2) USE OF LETTER-OF-CREDIT ARRANGEMENTS.—Payments from the Fund to a plan participating in a letter-of-credit arrangement under this subtitle shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

(d) SET-ASIDE FOR ADMINISTRATIVE EXPENSES.—

(1) FUND.—If the Fund is established, a percentage (specified under paragraph (3)) of the amounts deposited into the Fund as premiums shall be regularly set aside in the Fund to pay administrative expenses described in subsection (c)(1)(B).

(2) PREMIUMS NOT PAID INTO FUND.—In the case of premiums payable to a carrier for coverage under this subtitle which are not deposited into the Fund, the Office shall assess an administrative fee against the carrier in an amount equal to a percentage (specified under paragraph (3)) of such premiums.

(3) PERCENTAGE.—For purposes of this subsection, the Office shall establish a percentage that, when applied under this subsection, is reasonably adequate to pay such administrative expenses. Beginning with the fourth full contract year under this subtitle, such percentage may not exceed 1 percent.

(e) INVESTMENT AUTHORITY.—The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations shall be added to and become a part of the Fund.

(f) GIFTS.—The Office may accept, hold, administer, and utilize gifts, devises, and bequests of property, both real and personal, made unconditionally for the purpose of carrying out this subtitle. Conditional gifts may be accepted and used in accordance with their provisions, except that no gift may be accepted which is conditioned on any expenditure not to be met therefrom or from the income thereof unless such expenditure has been approved by Act of Congress.

(g) AUTHORIZATION OF APPROPRIATION OF AMOUNT FOR START-UP EXPENSES.—There are authorized to be appropriated to the Office such sums as may be necessary for the initial implementation of this subtitle. The Office shall provide for repayments to the General Fund of the Treasury, during a period of not longer than 10 years beginning with the second full contract year during which insured health benefit plans are offered under this subtitle and from the premiums paid for coverage under such plans, of the amounts appropriated pursuant to this subsection.

SEC. 5307. ESTABLISHMENT OF OFFICE OF UNIVERSAL FEHBP.

(a) ESTABLISHMENT OF OFFICE.—There is established in the Office of Personnel Management an office to be known as the "Office of Universal FEHBP" to be headed by a Director appointed by the President.

(b) FUNCTIONS.—The Office shall be responsible for the administration of the program under this subtitle.

(c) TRANSFER.—The President shall transfer to the Office such functions, personnel, and other resources (and may transfer such authority) of the Office of Personnel Management or any other department or agency as the Office may require to carry out its responsibilities under this subtitle.

(d) DETAIL AUTHORITY.—Agencies may detail to the Office, with or without reimbursement, such personnel as the Office may require to carry out such responsibilities.

(e) REGULATIONS.—The Office may prescribe regulations necessary to carry out this subtitle.

SEC. 5308. STUDIES; ANNUAL REPORT.

(a) STUDIES.—The Office shall make a continuing study of the operation and administration of this subtitle, including surveys and reports on insured health benefit plans available to individuals eligible to enroll under this subtitle and on the experience of the plans.

(b) ANNUAL REPORT.—Not later than April 1 of each year, the Office shall transmit to Congress an annual report on the operation of this subtitle for the preceding contract year. Such report shall include an assessment of any circumstances in the universal FEHBP market that would adversely affect the operation of this subtitle. The report submitted under this subsection before the first full contract year under this subtitle shall include a description of the procedures developed and intended to be implemented for enrollment of individuals in insured health benefit plans under this subtitle.

Subtitle E—Consumer Purchasing Cooperatives

PART 1—ESTABLISHMENT BY STATES

SEC. 5401. ESTABLISHMENT OF COOPERATIVES.

(a) IN GENERAL.—For purposes of this title, a "consumer purchasing cooperative" or "cooperative" is an entity which is established by a State in accordance with this part and—

(1) which meets the governance requirements of part 2; and

(2) which carries out functions in accordance with part 3.

(b) ESTABLISHMENT OF COOPERATIVES BY UNITS OF LOCAL GOVERNMENT.—A unit of local government may establish a cooperative under this subtitle in the same manner as a State, but only if—

(1) the geographic area over which the unit has jurisdiction is included in a metropolitan statistical area with a population not less than 1,000,000; and

(2) the cooperative established by the unit covers the entire geographic area over which the unit has jurisdiction.

(c) ADMINISTRATION OF COOPERATIVE BY STATE.—A State may operate a consumer purchasing cooperative through a State agency or a unit of local government or may contract with a nonprofit organization for the operation of the cooperative.

SEC. 5402. DESIGNATION OF COOPERATIVE BOUNDARIES AND SERVICE AREA.

In establishing the boundaries of a consumer purchasing cooperative—

(1) a State may not discriminate on the basis of or otherwise take into account race, age, gender, sexual orientation, language, religion, national origin, socioeconomic status, or health status; or

(2) if a cooperative area includes any portion of a metropolitan statistical area located in the State, the State shall include the entire portion of such metropolitan statistical area located in the State in the cooperative area; and

(3) if the State establishes more than one cooperative under this subpart—

(A) no area of the State may be included in more than one cooperative area, and

(B) each area of the State shall be included in a cooperative area.

PART 2—GOVERNANCE REQUIREMENTS

SEC. 5411. BOARD OF DIRECTORS.

(a) IN GENERAL.—A consumer purchasing cooperative must be governed by a Board of Directors appointed or elected consistent with the provisions of this section. All powers vested in a consumer purchasing cooperative under this subtitle shall be vested in the Board of Directors.

(b) MEMBERSHIP; CHAIRMAN.—

(1) MEMBERSHIP.—Such a Board of Directors shall consist of 13 members as follows:

(A) REPRESENTATIVES OF EMPLOYERS.—6 members who represent employers whose employees purchase health coverage through the cooperative, including self-employed individuals who purchase such coverage.

(B) REPRESENTATIVES OF CONSUMERS.—6 members who represent individuals who purchase such coverage, including employees who purchase such coverage.

(C) CHIEF HEALTH OFFICER.—The chief health officer of the State (or such officer's designee).

The members of the Board of Directors described in subparagraphs (A) and (B) are referred to in this section as "elected" Board members.

(2) CHAIR.—The Board of Directors shall elect a member to serve as the chair of the Board.

(3) APPOINTMENT AND ELECTION.—

(A) INITIAL APPOINTMENT.—The State shall provide, in accordance with rules established by the Secretary, for the appointment of initial members to the Board of Directors.

(B) SUBSEQUENT ELECTION.—Subsequent elected members of the Board of Directors of a cooperative shall be elected by individuals enrolled in plans through the cooperative. Such elections shall occur annually for Board members whose terms expire in the following year.

(C) VACANCIES.—A vacancy of an elected Board member shall be filled through election within 30 days after the date of the vacancy. A vacancy in the Board of Directors shall not affect the ability of the remaining Board members to govern the cooperative.

(4) NOMINATION PROCESS.—

(A) IN GENERAL.—Each cooperative shall provide a process for nominating individuals to serve as members of the Board. Under the process, the individuals nominated shall be broadly representative of the interests and backgrounds (including ethnic and racial backgrounds and gender) of the cooperative members.

(B) QUALIFICATIONS OF MEMBERS NOMINATED.—No cooperative member shall be nominated unless the member—

(i) has been a member of the cooperative for at least 6 months,

(ii) has presented a petition signed by 250 cooperative members, and

(iii) has submitted a written nominating statement, pursuant to the rules of the cooperative.

(5) TERMS OF MEMBERS.—

(A) IN GENERAL.—Elected Board members shall serve for a term of 3 years, except that such members initially elected shall serve for staggered terms.

(B) REMOVAL FOR CAUSE.—Each cooperative shall establish procedures for the removal of an elected Board member for cause. Such procedure shall assure adequate due process.

(6) COMPENSATION OF MEMBERS.—No member of the Board of Directors shall receive compensation for service as a member of the Board, except that such a member may receive reimbursement for expenses incurred while performing official functions as member of the Board.

(c) REQUIREMENTS ON BOARD MEMBERS.—

(1) NO CONFLICT OF INTEREST PERMITTED.—An individual may not serve as an elected Board member (or as a member appointed under subsection (b)(3)) if the individual is one of the following (or an immediate family member of one of the following):

(A) A health care provider.

(B) An individual who is an employee or member of the board of directors of, has a substantial ownership in, or derives substantial income from, a health care provider, health plan, pharmaceutical company, or a supplier of medical equipment, devices, or services.

(C) A person who derives substantial income from the provision of health care.

(D)(i) A member or employee of an association, law firm, or other institution or organization that represents the interests of one or more health care providers, health plans or others involved in the health care field, or (ii) an individual who practices as a professional in an area involving health care.

(2) PROHIBITING DISCRIMINATION BASED ON POLITICAL AFFILIATION.—Members of the Board may not engage in any activity that constitutes discrimination on the basis of political affiliation.

(3) FIDUCIARY STANDARDS.—Members of the Board of Directors and other officers and employees of a consumer purchasing cooperative shall comply with the requirements of part 4 of title I of the Employee Retirement Income Security Act of 1974.

(4) LIMITATION ON GIFTS.—Members of the Board of Directors of a cooperative may not receive gifts (other than of nominal value, from immediate families, or under other circumstances explicitly permitted by the State) from any entity that has a financial interest in activities conducted by the Board.

(d) MEETINGS OF THE BOARD.—

(1) IN GENERAL.—Meetings of the Board of Directors shall be called by the Chairman or a majority of its members.

(2) OPEN MEETINGS.—Meetings of the Board of Directors shall be open to cooperative members and the public, except that, under rules established by the State, the Board may meet in executive session that is not open to the public.

(3) QUORUM.—A majority of the serving members of the Board of Directors shall constitute a quorum for the purposes of conducting its business, but 4 members of the Board constitute a quorum for purposes of holding hearings or gathering information.

SEC. 5412. PROVIDER ADVISORY BOARDS.

Each consumer purchasing cooperative must establish a provider and technical advisory board consisting of representatives of health care providers and professionals who provide covered items and services through plans offered in the community-rated market sector served by the cooperative and including other professionals. Such advisory board shall provide the Board of Directors of the cooperative with medical, technical, and policy advice on various issues relating to the cooperative. To the greatest extent feasible, the membership of such advisory board shall represent the various geographic regions of the area served by the cooperative and shall reflect the racial, ethnic, and gender composition of the health care providers and professionals who provide covered items and services through health plans offered by the cooperative.

PART 3—RESPONSIBILITIES AND AUTHORITIES OF COOPERATIVES

SEC. 5421. CONTRACTS WITH CARRIERS.

(a) CONTRACTS WITH CARRIERS.—Each cooperative may enter into a contract under this part with a carrier that seeks to offer an insured health benefit plan certified under this title in the community-rated market sector through the cooperative.

(b) DEVELOPMENT OF STANDARDS.—The cooperative shall develop standards for carriers seeking to offer plans through the cooperative, including standards relating to quality, price, administration, and other matters.

SEC. 5422. SERVICES FOR PARTICIPANTS.

(a) OFFERING CHOICE OF PLANS.—

(1) NO LIMITATION ON CHOICE OF PLANS OFFERED.—Each consumer purchasing cooperative shall permit each individual eligible to seek coverage in the community-rated market sector through an insured health benefit plan offered through the cooperative to seek coverage through any such plan offered through the cooperative.

(2) REQUIREMENTS FOR OFFERING CERTAIN PLANS.—The cooperative shall assure that each individual eligible to seek coverage through a plan offered through the cooperative is offered—

(A) at least one managed care plan (unless there is no such plan available in the area served by the cooperative); and

(B) at least one unlimited-choice-of-provider plan, which may be a point-of-service plan.

(b) INFORMATION.—In conjunction with the offering of plans to individuals and employers, the cooperative shall make available the information described in section 5011(c)(2) and such other information as it deems appropriate about such plans.

(c) OUTREACH.—Each cooperative shall provide for appropriate outreach programs to underserved populations.

(d) ADDITIONAL SERVICES.—Each cooperative shall carry out the following additional functions:

(1) The notification of the availability of medicare part C for certain individuals

(2) The enrollment of individuals during an annual open enrollment period and at such other special enrollment periods as may be appropriate and consistent with the requirements of this Act based on changes in employment, family status, or otherwise.

(3) In accordance with requirements of section 5414, the collection of premium contributions, the forwarding of such contributions to the plans in which the individuals are enrolled, and the acceptance and forwarding of premium certificates issued under part A of title XXII of the Social Security Act toward payment of the premiums owed.

SEC. 5423. REQUIREMENTS RELATING TO COLLECTION OF PREMIUMS AND ACCOUNTING.

(a) ADMINISTRATIVE DISCOUNT PERMITTED FOR PLANS OFFERED THROUGH COOPERATIVES.—A cooperative may negotiate with a carrier seeking to offer a plan through the cooperative a dollar or percentage discount from the amount of the premiums otherwise applicable. Such a discount—

(1) shall be applied uniformly to all enrollees of the plan;

(2) may vary only by class of enrollment;

(3) shall only reflect administrative savings to such a carrier from marketing such a plan through the cooperative instead of other means of marketing such a plan; and

(4) may not relate to differences in anticipated claims, costs, or utilization.

(b) LIABILITY FOR PAYMENTS OF PREMIUMS TO PLAN SPONSORS.—Under rules established by the State—

(1) IN GENERAL.—The cooperative has a duty—

(A) to account for the receipt of payments for premiums and premium certificates issued under part A of title XXII of the Social Security Act, and

(B) to coordinate such payments in a manner consistent with this Act.

(2) LIABILITY.—The cooperative is liable to the parties involved for breach of the duty described in paragraph (1)(A).

(c) ACCOUNTING SYSTEM.—The cooperative shall establish an accounting system that meets standards established by the Secretary of Health and Human Services (in consultation with the Secretary of Labor) for purposes of carrying out this subtitle. Such a system shall collect such information on a timely basis as may be required to ascertain the individuals (including family members) covered under plans offered through the cooperative, the applicable premium, and premium payments (including employer contributions towards enrollment and reductions in premiums owed pursuant to premium certificates issued under part A of title XXII of the Social Security Act) and to provide periodic reports on premiums imposed, amounts collected, and remaining amount owing by such individuals.

(d) COMPLIANCE WITH FIDUCIARY STANDARDS.—The cooperative shall comply with standards and duties relating to administration, management, and distribution of premium payments and other funds provided under this subtitle. The standards shall be specified by the Secretary of Labor, in consultation with the Secretary of Health and Human Services. The standards shall include at least protections of the type applicable to fiduciaries under part 4 of title I and under title V of the Employee Retirement Income Security Act of 1974.

SEC. 5424. COOPERATIVE FEE.

(a) IN GENERAL.—A consumer purchasing cooperative may require a carrier that offers a plan through the cooperative to pay a fee in an amount equal to a uniform percentage (not to exceed one percent) of the premiums paid by individuals enrolled in the plan through the cooperative.

(b) USE OF FUNDS.—A cooperative shall use the funds under subsection (a) only for activities described in this subtitle.

SEC. 5425. ANTIDISCRIMINATION.

No cooperative may discriminate, or engage (directly or through contractual arrangements) in any activity, including marketing, that has the effect of discriminating against an individual on the basis of race, national origin, sex, religion, language, socioeconomic status, age, disability, sexual orientation, health status, anticipated need for health services, or location of residence within the service area of a plan of a carrier. However, this section shall not be construed as preventing a cooperative from engaging in activities to encourage the enrollment of individuals eligible to enroll in plans through the cooperative who reside in underserved areas.

PART 4—GRANTS FOR ESTABLISHMENT AND OPERATION OF COOPERATIVES

SEC. 5431. ESTABLISHMENT OF GRANT PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a program under which the Secretary shall make grants to eligible States for the planning, development, and initial operation of consumer purchasing cooperatives.

(c) ELIGIBILITY OF STATE.—A State is eligible to receive a grant under this subpart if the State submits to the Secretary (at such time and in such form as the Secretary may require) an application containing—

(1) assurances that the State has established (or is in the process of establishing) one or more cooperatives in accordance with this subtitle);

(2) assurances that the State and each such cooperative meet the applicable requirements of this subtitle; and

(3) such other information and assurances as the Secretary may require.

(g) GRANTS TO CONTIGUOUS STATES ESTABLISHING JOINT COOPERATIVES.—In the case of contiguous States each of which is eligible to receive a grant under this part, the Secretary may make grants to the States for the establishment and operation of a consumer purchasing cooperative operated jointly by the States and serving areas in each of the States.

(f) LIMIT ON TOTAL PROVIDED TO STATE.—The total amount of funds provided to a State under this part may not exceed $5,000,000 for a 5-year period.

SEC. 5432. USE OF GRANT FOR PARTICIPATION OF COOPERATIVE IN CAPITAL REVIEW PROGRAM.

(a) IN GENERAL.—A State (or unit of local government) receiving a grant for the operation of a consumer purchasing cooperative under this subtitle may use funds provided under the grant for the participation of the cooperative in a program of the State to review and approve capital expenditures in the State (meeting the requirements of subsection (b)).

(b) REQUIREMENTS FOR PROGRAM.—A capital review program meets the requirements of this subsection if the program—

(A) is designed to assure that the needs of the State's residents for health care services are met;

(B) includes and enforces occupancy targets for inpatient hospital facilities;

(C) includes and enforces utilization targets for services subject to review under the plan;

(D) identifies where appropriate which facilities (and parts of facilities) would be consolidated in order to reach the occupancy and utilization targets for health care services; and

(E) provides an opportunity for review and comment by interested parties.

SEC. 5433. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $150,000,000 for the 5-year period beginning with fiscal year 1996 for grants under this part.

Subtitle F—General Provisions

SEC. 5501. ESTABLISHMENT OF FEDERAL STANDARDS.

(a) ESTABLISHMENT OF GENERAL STANDARDS FOR HEALTH BENEFIT PLANS.—

(1) STANDARDS FOR CARRIERS PROVIDING INSURED HEALTH BENEFIT PLANS.—Not later than July 1, 1995, the Secretary shall establish standards for carriers providing insured health benefit plans consistent with this section and the requirements described in subtitle A.

(2) STANDARDS FOR SPONSORS OF SELF-INSURED HEALTH BENEFIT PLANS.—Not later

than July 1, 1995, the Secretary of Health and Human Services (in consultation with the Secretary of Labor) shall establish and publish standards for self-insured health benefit plans and the sponsors of such plans consistent with this section and the requirements of subtitle B. Under such standards, the Secretary of Labor would annually certify (for years beginning with 1997) each self-insured health benefit plan found by the Secretary of Labor to be in compliance with such standards, based on information provided by the plans in such manner and format as the Secretary of Labor considers appropriate.

(3) STANDARDS FOR PLANS THAT SUPPLEMENT THE GUARANTEED NATIONAL BENEFIT PACKAGE.—Not later than July 1, 1995, the Secretary shall establish standards for supplemental health benefit policies in accordance with the requirements for such policies (and the entities offering such policies) consistent with this section and the requirements described in subtitle C.

(b) SPECIAL RULES FOR PROGRAMS OF THE INDIAN HEALTH SERVICE.—

(1) IN GENERAL.—The standards established under subsection (a) apply with respect to the certification of health programs of the Indian Health Service (as used in section 901 of the Indian Health Care Improvement Act), except as provided in paragraph (3).

(2) APPLICABLE REGULATORY AUTHORITY.—The applicable regulatory authority with respect to the certification of health programs of the Indian Health Service under this title shall be the Secretary. The Secretary may not delegate the responsibility for certification.

(3) EXCEPTED STANDARDS.—The Secretary shall, after consulting with Indian tribes, tribal organizations, and urban Indian organizations, promulgate regulations describing the standards or elements of standards which the Secretary finds are not appropriate to health programs of the Indian Health Service. In carrying out this subsection, the Secretary shall apply the same standards in the same manner to health programs operated directly by the Indian Health Service as the Secretary applies to health programs operated by tribes, tribal organizations, and urban Indian organizations.

(4) REPORT.—The Secretary shall submit a report to the Congress describing the standards which the Secretary finds are not appropriate and the reasons therefore.

(5) REGULATIONS.—Regulations promulgated under this section shall be promulgated no later than 3 months after the date that standards are established and published under subsection (a).

(c) SPECIAL RULES FOR PROGRAMS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The standards established under subsection (a) apply with respect to the certification of health plans of the Department of Veterans Affairs, except as provided in paragraph (3).

(2) APPLICABLE REGULATORY AUTHORITY.—The applicable regulatory authority with respect to the certification of health plans of the Department of Veterans Affairs under this title shall be the Secretary. The Secretary may not delegate the responsibility for certification.

(3) SPECIAL RULES.—The Secretary shall, after consulting with the Secretary of Veterans Affairs, promulgate regulations describing the standards or elements of standards which the Secretary finds are not appropriate to health plans of the Department of Veterans Affairs. Under such regulations, the Secretary shall assure that premium charged for enrollment in such a plan may not be less than the actuarial value of the benefits provided to enrollees under the plan.

(4) REPORT.—The Secretary shall submit a report to the Congress describing the standards which the Secretary finds are not appropriate and the reasons therefore.

(5) REGULATIONS.—Regulations promulgated under this section shall be promulgated no later than 3 months after the date that standards are established and published under subsection (a).

(d) ROLE OF NAIC IN RELATION TO SOLVENCY STANDARDS.—

(1) REQUEST.—The Secretary shall request the NAIC (in consultation with the American Society of Actuaries) within 6 months after the date of the enactment of this title—

(A) to develop model regulations that specify standards with respect to the solvency requirements described in section 5013 (consistent with paragraph (2)), and

(B) to submit such model regulations to the Secretary.

(2) SPECIFICATIONS FOR STANDARDS.—The standards specified by the model regulations under paragraph (1)(A) shall include the following:

(A) Capital requirements for carriers, based on financial analysis, appropriate for maintaining reasonable net worth for the type of carrier (and plan) involved, including a requirement for additional capital in the case of factors likely to adversely affect the carrier's financial stability and solvency as measured by the following:

(i) Projected plan enrollment.

(ii) The number of participating providers.

(iii) The extent and nature of risk-sharing with participating providers.

(iv) Prior performance of the carrier and its plans and liquidity of the carrier's assets.

(B) Procedures for financial review of carriers.

(C) Procedures for ongoing monitoring and enforcement of compliance with the standards.

(D) Standards for the oversight and regulation of financial transactions between the carrier and its parent or affiliate organizations.

(E) Criteria for determining whether a carrier is in a financially impaired condition.

(F) Standards for health plan guaranty funds described in section 5013(d), including standards with respect to premium assessments.

(3) USE OF MODEL REGULATION.—If the NAIC develops and submits model regulations on a timely basis under paragraph (1) and the Secretary determines that the model regulations incorporates such solvency requirements, the Secretary shall incorporate such model regulations within the standards established under this section.

(e) STANDARDS RELATING TO COORDINATION OF ENROLLMENT AND COVERAGE.—

(1) IN GENERAL.—In establishing standards for health benefit plans under this section, the Secretary shall establish rules concerning when changes in enrollment become effective under health benefit plans in relation to changes in the status of an individual enrolled in a health benefit plan.

(2) MONTHLY CHANGES.—Such rules shall be designed—

(A) to provide automatic coverage to newborns as of the date of birth,

(B) in the case of an individual provided coverage through employment, to provide for coverage through the end of the month in which the employment is terminated, and

(C) to prevent eligible individuals from having any periods of noncoverage when changing enrollment among health benefit plans.

(3) SPECIAL RULES FOR COORDINATION OF COVERAGE.—The Secretary shall provide for such rules as may be necessary to provide for the allocation of responsibility among certified health plans (and the medicare program and medicare part C) in the case of an inpatient hospital stay, or in the case in which a single payment amount is made for other services provided over a period of time, that begins during the period of coverage under one such health benefit plan and ends during a period of coverage under another such certified health plan or program.

SEC. 5502. ENFORCEMENT THROUGH APPROVED STATE PROGRAMS.

(a) IN GENERAL.—If the Secretary determines that a State has in effect an effective regulatory program—

(1) for the application of the standards established under section 5501(a)(1) to carriers providing insured health benefit plans (including provisions imposing penalties under the same conditions and in the same amounts as provided for under section 5503(a), and other provisions to monitor and enforce such standards), and for providing for collecting and disseminating information under section 5009, the Secretary may approve such program for purposes of certification of carriers and insured health benefit plans under subtitle A; and

(2) for the application of the standards established under section 5501(a)(3) to carriers providing supplemental health benefit policies (including provisions imposing penalties under the same conditions and in the same amounts as provided for under section 5503(a), and other provisions to monitor and enforce such standards), and for providing for collecting and disseminating information with respect to such policies under section 5106(b), the Secretary may approve such program for purposes of certification of carriers and supplemental health benefit policies under subtitle C.

(b) ANNUAL REPORTS.—As a condition for the continued approval of such a regulatory program, the State shall report to the Secretary annually such information as the Secretary may require with respect to the performance of the program. Such information shall include a list of the carriers and insured health benefit plans or supplemental health benefit policies (as the case may be) certified under the program, the compliance of such carriers and plans with the applicable standards established under section 5501, and monitoring and enforcement actions taken to ensure such compliance.

(c) PERIODIC SECRETARIAL REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary annually shall review State regulatory programs approved under subsection (a) to determine if they adequately continue to apply, monitor, and enforce the standards. If the Secretary initially determines that a State regulatory program no longer is applying and enforcing such standards, the Secretary shall provide the State an opportunity to adopt such a plan of correction that would bring such program into compliance. If the Secretary makes a final determination that the State regulatory program fails to apply and enforce such standards after such an opportunity, the Secretary shall disapprove such program and assume responsibility for certification of all carriers and insured health benefit plans or supplemental health benefit policies (as the case may be) in that State, for establishing enrollment periods under section 5003(b), and for providing for collecting and disseminating information under section 5011.

(d) GAO AUDITS.—The Comptroller General shall conduct periodic reviews on a sample of State regulatory programs approved under subsection (a) to determine their compliance with the requirements of such subsection. The Comptroller General shall report to the Secretary and Congress on the findings of such reviews.

(e) EFFECT ON SECRETARIAL RESPONSIBILITIES.—Nothing in this section may be construed to restrict the Secretary's ability to obtain such information and carry out such activities as may be necessary to impose the Federal penalties described in section 5503 or to otherwise carry out duties and responsibilities under this title in a State with an approved program under this section.

SEC. 5503. FEDERAL PENALTIES.

(a) APPLICATION OF FEDERAL CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Any person who sells or issues a health plan—

(A) that is not certified in accordance with this title is subject to a civil money penalty not to exceed $25,000 for each such violation,

(B) in violation of the requirements of part 2 of subtitle B (relating to financial requirements for self-insured health benefit plans) is subject to the civil money penalty applicable under such part, and

(C) in violation of any other requirement under subtitle A, B, or C is subject to a civil money penalty not to exceed $25,000 for each such violation.

(2) PROCEDURES FOR IMPOSITION.—Except as provided in subsection (d), the provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A of such Act.

(3) IMPOSITION OF PENALTIES BY APPROPRIATE SECRETARY.—The civil money penalties referred to in paragraph (1) shall be imposed by the Secretary of Health and Human Services (in the case of penalties relating to an insured health benefit plan or a supplemental health benefit policy) or the Secretary of Labor (in the case of penalties relating to a self-insured health benefit plan).

(4) AVAILABILITY OF INJUNCTIVE RELIEF.—The Secretary of Health and Human Services (in cases relating to an insured health benefit plan or a supplemental health benefit policy) or the Secretary of Labor (in cases relating to a self-insured health benefit plan) may obtain injunctive relief to enjoin any act or omission which may be subject to a civil money penalty under this subsection.

(5) APPLICATION OF FEDERAL PENALTIES.—A person is subject to a penalty under this section without regard to whether the applicable regulatory authority with respect to the person is the Secretary or the State.

(b) WITHHOLDING FEDERAL FINANCIAL ASSISTANCE TO STATES NOT ENFORCING ANTI-DISCRIMINATION REQUIREMENTS.—If the Secretary finds that a State has not adopted and is not enforcing the requirements described in section 5002 (relating to anti-discrimination requirements for carriers providing insured health benefit plans) with respect to insured health benefit plans in the State, the Secretary may—

(1) withhold Federal financial assistance payments to the State; and

(2) refer any findings to the Attorney General for further action pursuant to subtitle A of title IX.

(c) PENALTY FOR CERTAIN POLICIES DUPLICATING COVERAGE.—

(1) IN GENERAL.—Any person who sells or issues a health plan described in paragraph (4) that duplicates coverage of any item or service covered under the guaranteed national benefit package is subject to a civil money penalty not to exceed $25,000 for each such violation. Paragraph (2) of subsection (a) shall apply with respect to a penalty under the previous sentence in the same manner as such paragraph applies to penalties under such subsection.

(2) EXCEPTION FOR PLANS PROVIDING BENEFITS WITHOUT REGARD TO OTHER COVERAGE.—Paragraph (1) shall not apply with respect to any health plan that provides benefits to an enrollee without regard to any benefits provided to the enrollee under another plan.

(3) EXCEPTION FOR LIABILITY INSURANCE COVERAGE.—Paragraph (1) shall not apply with respect to any health plan described in clause (iv) or (v) of section 5504(15)(B) that provides benefits to an enrollee without regard to any benefits provided to the enrollee under a plan other than a plan described in such clause.

(4) PLANS DESCRIBED.—The health plans described in this paragraph are the plans described in section 5504(15)(B), but do not include a maintenance of effort policy provided under section 8904a of title 5, United States Code.

(d) PROCEDURES FOR IMPOSITION OF PENALTIES FOR VIOLATION OF FINANCIAL REQUIREMENTS FOR SELF-INSURED PLANS.—

(1) APPLICABILITY.—The procedures described in this subsection shall apply with respect to the imposition of a civil money penalty against the sponsor of a self-insured health benefit plan for violations of any requirements described in part 2 of subtitle B (relating to financial requirements).

(2) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under the procedures established under this section, the Secretary of Labor shall take into account the previous record of compliance of the person being assessed with the applicable requirements for sponsors of self-insured health benefit plans under subtitle B and the gravity of the violation.

(3) ADMINISTRATIVE REVIEW.—

(A) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an opportunity for hearing by the Secretary of Labor upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing all evidence shall be determined on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(B) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary of Labor modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under paragraph (4).

(4) JUDICIAL REVIEW.—

(A) FILING OF ACTION FOR REVIEW.—Any person against whom an order imposing a civil money penalty has been entered after an agency hearing under this subsection may obtain review by the United States district court for any district in which such person is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice be registered mail to the Secretary of Labor.

(B) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary of Labor shall promptly certify and file in such court the record upon which the penalty was imposed.

(C) STANDARD FOR REVIEW.—The findings of the Secretary of Labor shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(D) APPEAL.—Any final decision, order, or judgment of such district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28 of such Code.

(5) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(A) FAILURE TO PAY ASSESSMENT.—If any person fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary of Labor, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(B) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(6) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this subsection shall be paid to the Secretary of Labor (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(e) AVAILABILITY OF PRIVATE RIGHT OF ACTION FOR AGGRIEVED INDIVIDUALS.—

(1) IN GENERAL.—Any person aggrieved by an act or omission of an individual or entity which constitutes a failure to comply with an applicable requirement of this title may obtain from such individual or entity in any court of competent jurisdiction appropriate relief, including actual, compensatory, and punitive damages and equitable relief.

(2) EXCEPTION FOR CERTAIN VIOLATIONS.—Paragraph (1) does not apply in the case of an act or omission upon which a complaint may be filed in a complaint review office pursuant to section 9304 or for which a remedy may be sought under section 9333.

(3) ATTORNEY'S FEES AND COSTS.—In any action under paragraph (1) in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(4) EXHAUSTION OF REMEDIES.—In an action under paragraph (1), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

SEC. 5504. DEFINITIONS.

In this title:

(1) APPLICABLE REGULATORY AUTHORITY.—The term "applicable regulatory authority" means—

(A) the Secretary, or

(B) in the case of a State that has assumed responsibility for enforcement of standards under subtitle A pursuant to a State program approved under section 5502, the authority of the State that is exercising such responsibility.

(2) CARRIER.—The term 'carrier' means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of section 833(c)(2) of the Internal Revenue Code of 1986), a

health maintenance organization, or other entity licensed or certified by a State to provide health insurance or health benefits. The Secretary may issue regulations that provide for affiliated carriers to be treated as a single carrier where appropriate under this title.

(3) HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term "health benefit plan" means a health plan, other than a plan described in subparagraph (B).

(B) EXCEPTION.—The term "health benefit plan" does not include any of the following (or any combination thereof):

(i) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

(ii) Medicare supplemental health insurance.

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Worker's compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital or fixed indemnity policy.

(ix) Coverage provided exclusively to individuals who are not eligible individuals under this Act.

(4) HEALTH PLAN.—The term "health plan" means—

(A) any contract of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, that is provided by a carrier, or

(B) an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits and is funded in a manner other than through the purchase of one or more policies or contracts described in subparagraph (A).

(5) HIGH DEDUCTIBLE PLAN.—The term "high deductible plan" means an insured health benefit plan (other than a plan that provides services through a provider network) that provides for cost-sharing using the standard cost-sharing schedule under section 3013(a) for which the carrier establishes the deductible in accordance with paragraph (4) of such section.

(6) INSURED.—The term "insured" means, with respect to a plan, a plan that is provided by a carrier.

(7) MANAGED CARE PLAN.—The term "managed care plan" means a health benefit plan that provides for services included in the guaranteed national benefit package under the plan (other than services described in subsections (c) and (d) of section 5009) primarily through providers in the provider network of the plan.

(8) MARKET SECTOR.—The term "market sector" means a market sector described in section 5003(e)(2).

(9) NAIC.—The term "NAIC" means the National Association of Insurance Commissioners.

(10) POINT-OF-SERVICE PLAN.—The term "point-of-service plan" means an unlimited-choice-of-provider plan that also permits an enrollee to receive benefits through a provider network.

(11) PROVIDER NETWORK.—The term "provider network" means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services covered under the plan to individuals enrolled in the plan subject to the managed care cost-sharing schedule established under section 3014.

(12) SELF-INSURED.—The term "self-insured" means, with respect to a plan, a plan that is described in paragraph (4)(B).

(13) SPONSOR.—The term "sponsor" means, in relation to a health plan that—

(A) is insured, the carrier providing the plan, or

(B) is self-insured, the entity that sponsors the plan.

(14) STATE.—The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(15) SUPPLEMENTAL HEALTH BENEFIT POLICY.—

(A) IN GENERAL.—The term "supplemental health benefit policy" means a health insurance policy or health benefit plan which provides—

(i) coverage for items and services not included in the guaranteed national benefit package, or

(ii) coverage for items and services included in such package but not covered because of a limitation in amount, duration, or scope of benefits (including coverage for cost-sharing),

or both.

(B) EXCLUSIONS.—Such term does not include the following:

(i) Coverage only for accident, disability income, or long-term care insurance, or any combination thereof.

(ii) Medicare supplemental health insurance.

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Worker's compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital or fixed indemnity policy.

(ix) Coverage provided exclusively to individuals who are not eligible individuals under this Act.

(C) EXCEPTION FOR SERVICES COVERED UNDER CERTIFIED SELF-INSURED PLAN.—Such term does not include any self-insured health benefit plan certified by the Secretary under section 5501(a)(1)(B) as meeting the standards applicable to such a plan under subtitle B, notwithstanding that the plan provides coverage for any item or service described in subparagraph (A).

(16) TYPE OF PLAN.—Each of the following is considered to be a separate "type" of plan:

(A) A managed care plan.

(B) A point-of-service plan.

(C) A high deductible plan.

(D) An unlimited-choice-of-provider plan that is not a point-of-service plan or a high deductible plan.

(16) UNLIMITED-CHOICE-OF-PROVIDER PLAN.—

(A) IN GENERAL.—The term "unlimited-choice-of-provider plan" means a health benefit plan that, regardless of whether it permits enrollees to receive benefits through a provider network—

(i) provides coverage for all items and services included in the guaranteed national benefit package that are furnished by any lawful health care provider, subject to permissible coverage limitations (described in subparagraph (B)), and

(ii) makes payment to such a provider whether or not there is a contractual arrangement between the plan and the provider subject to cost sharing at the standard cost-sharing schedule (described in section 3013).

(B) PERMISSIBLE COVERAGE LIMITATIONS DESCRIBED.—The permissible coverage limitations are (as specified by the Secretary) the following:

(i) Utilization review.

(ii) Prior approval for specified services (not including routine prior approval for services), other than services provided for the treatment of an emergency medical condition (as defined in section 1867(e)(1) of the Social Security Act).

(iii) Exclusion of providers on the basis of poor quality of care, based on evidence obtainable by the plan.

SEC. 5505. PREEMPTION OF STATE LAW.

No State may enforce any law or regulation that is inconsistent with any standard established under this title.

SEC. 5506. CONSTRUCTION OF REFERENCES.

In this title, except as otherwise specifically provided, any references to provisions of the Social Security Act or the Employee Retirement Income Security Act of 1974 are deemed to be references to such provisions as in effect on the day after the date of the enactment of this Act, taking into account the amendments made to such provisions by this Act.

Subtitle G—Transitional Insurance Reforms

SEC. 5601. ESTABLISHMENT OF STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in consultation with the Secretary of Labor) shall establish standards to carry out the requirements of this subtitle.

(b) CERTIFICATION OF COMPLIANCE.—For each 6-month period in which this subtitle is effective, each health plan sponsor shall file a certification with the Secretary (or with a State with which the Secretary has entered into an arrangement under subsection (c)(2)) that the sponsor is in compliance with the requirements of this subtitle.

(c) ENFORCEMENT.—

(1) ISSUANCE OF REGULATIONS.—The Secretary shall issue regulations to carry out this subtitle, and is authorized to issue such regulations on an interim basis that become final on the date of publication, subject to change based on subsequent public comment. The Secretary may consult with States and the National Association of Insurance Commissioners in issuing regulations and guidelines under this subtitle.

(2) ARRANGEMENTS WITH STATES.—The Secretary may enter into arrangements with a State to enforce the requirements of this subtitle with respect to insured health benefit plans issued or sold, or established and maintained, in the State.

(d) SANCTIONS AND REMEDIES.—

(1) IN GENERAL.—Any health plan sponsor that violates a requirement of this subtitle shall be subject to a civil money penalty of not more than $25,000 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) EQUITABLE REMEDIES.—A civil action may be brought by the Secretary—

(A) to enjoin any act or practice which violates any provision of this subtitle, or

(B) to obtain other appropriate equitable relief (I) to redress such violations, or (II) to enforce any provision of this subtitle, including, in the case of a wrongful termination of (or refusal to renew) coverage, reinstating coverage effective as of the date of the violation.

(e) CONSTRUCTION.—The provisions of this subtitle shall be construed in a manner that assures, to the greatest extent practicable, continuity of health benefits under health benefit plans in effect on the effective date of this Act.

(f) SPECIAL RULES FOR ACQUISITIONS AND TRANSFERS.—The Secretary may issue regulations regarding the application of this subtitle in the case of insured health benefit plans (or groups of such plans) which are transferred from one carrier to another carrier through assumption, acquisition, or otherwise, and in the case of plans terminated pursuant to a joint marketing agreement entered into prior to January 1, 1994.

SEC. 5602. CONTINUATION OF COVERAGE.

(a) PROHIBITION OF TERMINATION.—

(1) GROUP HEALTH INSURANCE PLANS.—Each health plan sponsor that provides a group health insurance plan for a group of employees may not terminate (or fail to renew) coverage for the group, or for any covered individual, if the employer of the employees continues the plan, except in the case of—

(A) nonpayment of required premiums, or

(B) fraud or misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(2) INDIVIDUAL HEALTH INSURANCE PLANS.—Each carrier providing an individual health insurance plan may not terminate (or fail to renew) coverage for an individual covered under the plan (or a covered dependent), except in the case of—

(A) nonpayment of required premiums,

(B) fraud, or

(C) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(3) SELF-INSURED HEALTH BENEFIT PLANS.—Each sponsor of a self-insured health benefit plan may not terminate (or fail to renew) coverage for an individual covered under the plan (or a covered dependent), except in the case of—

(A) nonpayment of required premiums,

(B) fraud, or

(C) misrepresentation of a material fact relating to an application for coverage or claim for benefits.

(b) ACCEPTANCE OF NEW MEMBERS IN A GROUP HEALTH INSURANCE PLAN.—

(1) IN GENERAL.—In the case of a health plan sponsor that provides a group health insurance plan that is in effect on the effective date of this subtitle, the sponsor is required—

(A) to accept all individuals, and their eligible dependents, who become full-time employees (as defined in section 3467(b)(1) of the Internal Revenue Code of 1986) of an employer covered after such effective date;

(B) to establish and apply premium rates that are consistent with section 5605; and

(C) to limit the application of pre-existing condition restrictions in accordance with section 5603.

(2) CONSISTENT APPLICATION OF RULES RELATING TO DEPENDENTS AND WAITING PERIODS.—In this subsection, the term "eligible dependent", with respect to a group health insurance plan, has the meaning provided under the plan as of June 29, 1994, or, in the case of a plan not established as of such date, as of the date of establishment of the plan.

SEC. 5603. LIMITS ON PRE-EXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—Subject to the succeeding provisions of this section, a carrier providing an insured health benefit plan may exclude coverage with respect to services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months and such exclusion shall not apply with respect to services furnished to newborns, pregnancy-related services, or to a plan for which such exclusion did not apply as of the effective date of this subtitle.

(b) CREDITING OF PREVIOUS COVERAGE.—

(1) IN GENERAL.—A carrier providing an insured health benefit plan shall provide that if an individual covered under such a plan is in a period of continuous coverage (as defined in paragraph (2)(A)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a pre-existing condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(2) DEFINITIONS.—As used in this subsection:

(A) PERIOD OF CONTINUOUS COVERAGE.—The term "period of continuous coverage" means, with respect to particular services, the period beginning on the date an individual is enrolled under a health benefit plan, the medicare program, a State medicaid plan, or other health benefit arrangement which provides benefits with respect to the same or substantially similar services (as determined in accordance with criteria established by the Secretary) and ends on the date the individual is not so enrolled for a continuous period of more than 3 months (or for a longer period with respect to individuals who lose employment and meet such other conditions as the Secretary may specify).

(B) PRE-EXISTING CONDITION.—The term "pre-existing condition" means, with respect to coverage under a health benefit plan, a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

SEC. 5604. PREMIUM CHANGES TO REFLECT CHANGES IN GROUP OR INDIVIDUAL CHARACTERISTICS OR TERMS OF COVERAGE.

(a) APPLICATION.—The provisions of this section shall apply to changes in premiums under insured health benefit plans that reflect—

(1) changes in the number of individuals covered under such a plan;

(2) changes in the group or individual characteristics (including age, gender, family composition or geographic area but not including health status, claims experience or duration of coverage under the plan) of individuals covered under such a plan;

(3) changes in the level of benefits (including changes in cost-sharing) under the plan; and

(4) changes in any material terms and conditions of the health benefit plan (other than factors related to health status, claims experience, and duration of coverage under the plan).

(b) DIVISION OF HEALTH INSURANCE PLANS BY SECTOR.—For purposes of this section, each health plan sponsor shall divide its health insurance business into the following 3 sectors:

(1) Health insurance for groups with at least 100 covered lives (in this subsection referred to as the "large group sector")

(2) Health insurance for groups with fewer than 100 covered lives (in this subsection referred as the "small group sector").

(3) Health insurance for individuals, and not for groups (in this subsection referred to as the "individual sector").

(c) SINGLE SET OF RATE FACTORS.—

(1) IN GENERAL.—Each health plan sponsor shall develop a single set of rate factors which will be used to calculate any changes in premium within a sector described in subsection (b) that relate to the reasons described in paragraphs (1) through (4) of subsection (a).

(2) STANDARDS.—Such rate factors—

(A) shall relate to reasonable and objective differences in demographic characteristics, in the design and in levels of coverage, and in other terms and conditions of a contract,

(B) shall not relate to expected health status, claims experience, or duration of coverage of the one or more groups or individuals, and

(C) shall comply with regulations established under section 5606.

(d) COMPUTATION OF PREMIUM CHANGES.—

(1) IN GENERAL.—Changes in premium rates within a sector that relate to the reasons described in subsection (a) shall be calculated using the rate factors developed pursuant to subsection (c).

(2) APPLICATION OF FACTORS.—

(A) IN GENERAL.—The change in premium rates with respect to each health benefit plan shall reflect the rate factors specified under subsection (c) applicable to the reason as applied to the current premium charged for the plan. Such rate factors shall be applied in a manner so that the resulting adjustment, to the extent possible, reflects the premium that would have been charged under the plan if the reason for the change in premium had existed at the time that the current premium rate was calculated.

(B) NO REFLECTION OF CHANGE IN HEALTH STATUS.—In applying the rate factors under this paragraph, the adjustment shall not reflect any change in the health status, claims experience or duration of coverage with respect to any employer or individual covered under the plan.

(e) LIMITATION ON APPLICATION.—This section shall only apply—

(1) to changes in premiums occurring on or after the date of the enactment of this Act to groups and individuals covered as of such date, and

(2) with respect to groups and individuals subsequently covered, to changes in premiums subsequent to such coverage.

(f) APPLICATION TO COMMUNITY-RATED PLANS.—Nothing in this section shall require the application of rate factors related to individual or group characteristics with respect to any health benefit plan that, as of the date of the enactment of this Act, does not use such factors in the determination of premiums under the plan.

SEC. 5605. LIMITATIONS ON CHANGES IN PREMIUMS FOR PLANS IN INDIVIDUAL SECTOR AND SMALL GROUP SECTOR RELATED TO INCREASES IN HEALTH CARE COSTS AND UTILIZATION.

(a) APPLICATION.—The provisions of this section shall apply to changes in premiums for insured health benefit plans in the individual sector and the small group sector (as such terms are defined in section 5604(b)) that reflect increases in health care costs and utilization.

(b) EQUAL INCREASE FOR ALL PLANS WITHIN EACH SECTOR.—

(1) IN GENERAL.—To the extent that any increase in premiums by a health plan sponsor for insured health benefit plans reflect increases in health care costs and utilization—

(A) the annual percentage increase for plans within the individual sector shall be the same for all such plans in the sector; and

(B) the annual percentage increase for plans within the small group sector shall be the same for all such plans in the sector.

(2) GEOGRAPHIC APPLICATION.—Paragraph (1)—

(A) may be applied on a national level, or

(B) may vary based on geographic area, but only if (i) such areas are sufficiently large to provide credible data on which to calculate the variation and (ii) the variation is due to reasonable factors related to the objective differences among such areas in costs and utilization of health services.

(3) EXCEPTIONS TO ACCOMMODATE STATE RATE REFORM EFFORTS.—Paragraph (1) shall not apply, in accordance with guidelines of the Secretary, to the extent necessary to permit a State to narrow the variations in premiums among insured health benefit plans offered by health plan sponsors to similarly situated groups or individuals within a sector.

(4) OTHER REASONS SPECIFIED BY THE SECRETARY.—The Secretary may specify through regulations such other exceptions to the provisions of this subsection as the Secretary determines are required to enhance stability of the health insurance market and continued availability of coverage.

(c) EVEN APPLICATION THROUGHOUT A YEAR.—In applying the provisions of this section to an insured health benefit plan that are renewed in different months of a year, the annual percentage increase shall be applied in a consistent, even manner so that any variations in the rate of increase applied in consecutive months are even and continuous during the year.

(d) PETITION FOR EXCEPTION.—A health plan sponsor may petition the Secretary (or a State acting under a contract with the Secretary under section 5601(c)(3)) for an exception from the application of the provisions of this section. The Secretary may approve such an exception if—

(1) the sponsor demonstrates that the application of this section would threaten the financial viability of the sponsor, and

(2) the sponsor offers an alternative method for increasing premiums that is not substantially discriminatory to any sector or to any group or individual covered by an insured health benefit plan offered by the sponsor.

SEC. 5606. MORE STRINGENT STATE LAWS NOT PREEMPTED.

The requirements of this subtitle do not preempt any State law unless the State law directly conflicts with such requirements. The provision of additional protections under State law shall not be considered to directly conflict with such requirements.

SEC. 5607. LIMIT ON CHANGES IN SELF-INSURED HEALTH BENEFIT PLANS.

(a) IN GENERAL.—A sponsor of a self-insured health benefit plan may not make a modification of benefits described in subsection (b).

(b) MODIFICATION OF BENEFITS DESCRIBED.—

(1) IN GENERAL.—A modification of benefits described in this subsection is any reduction or limitation in coverage, effected on or after the effective date of this subtitle, with respect to any medical condition or course of treatment for which the anticipated cost for any individual enrollee is likely to exceed $5,000 in any 12-month period.

(2) TREATMENT OF TERMINATION.—A modification of benefits includes the termination of a plan if the sponsor, within a period (specified by the Secretary) establishes a substitute plan that reflects the reduction or limitation described in paragraph (1).

(c) REMEDY.—Any modification made in violation of this subsection shall not be effective and the sponsor of the self-insured health benefit plan shall continue to provide benefits as though the modification (described in subsection (b)) had not occurred.

SEC. 5608. DEFINITIONS.

In this subtitle:

(1) COVERED EMPLOYEE.—The term "covered employee" means an employee (or dependent of such an employee) covered under a group health insurance plan.

(2) COVERED INDIVIDUAL.—The "covered individual" means, with respect to a health plan, an individual insured, enrolled, eligible for benefits, or otherwise covered under the plan.

(3) GROUP HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—The term "group health insurance plan" means a health benefit plan offered primarily to employers for the purpose of providing health insurance to the employees (and dependents) of the employer.

(B) INCLUSION OF ASSOCIATION PLANS AND MEWAS.—Such term includes—

(i) any arrangement in which coverage for health benefits is offered to employers through an association, trust, or other arrangement, and

(ii) a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974), whether funded through insurance or otherwise.

(4) INDIVIDUAL HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—The term "individual health insurance plan" means any health benefit plan directly purchased by an individual or offered primarily to individuals (including families) for the purpose of permitting individuals (without regard to an employer contribution) to purchase health insurance coverage.

(B) INCLUSION OF ASSOCIATION PLANS.—Such term includes any arrangement in which coverage for health benefits is offered to individuals through an association, trust, list-billing arrangement, or other arrangement in which the individual purchaser is primarily responsible for the payment of any premium associated with the contract.

(C) TREATMENT OF CERTAIN ASSOCIATION PLANS.—In the case of a health benefit plan sponsored by an association, trust, or other arrangement that provides health insurance coverage both to employers and to individuals, the plan shall be treated as—

(i) a group health insurance plan with respect to such employers, and

(ii) an individual health insurance plan with respect to such individuals.

(5) STATE COMMISSIONER OF INSURANCE.—The term "State commissioner of insurance" includes a State superintendent of insurance.

SEC. 5609. EFFECTIVE DATE.

(a) INSURED HEALTH BENEFIT PLANS.—The provisions of this subtitle—

(1) shall first apply to insured health benefit plans provided in a State on or after January 1, 1995, except that section 5602 shall apply to such plans on or after the date of the enactment of this Act; and

(2) shall not apply to an insured health benefit plan provided in a State on and after the first day of the first year during which the standards established by the Secretary under section 5501 for insured health benefit plans sold to individuals and employers are in effect in the State (in accordance with such section).

(b) SELF-INSURED HEALTH BENEFIT PLANS.—The provisions of this subtitle—

(1) shall first apply to self-insured health benefit plans provided on or after January 1, 1995, except that section 5602 shall apply to such plans on or after the date of the enactment of this Act; and

(2) shall not apply as of the first day of the first year during which the standards established by the Secretary under section 5501 for self-insured health benefit plans and the sponsors of such plans are in effect.

TITLE VI—STANDBY COST CONTAINMENT IN THE PRIVATE SECTOR

Subtitle A—National Health Expenditure Estimates

SEC. 6001. NATIONAL PRIVATE SECTOR PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—For each calendar year (beginning with 1996), there is established a national private sector per capita health expenditure estimate (in this subtitle referred to as the "national private per capita estimate") determined under paragraph (2).

(2) AMOUNT.—Subject to subsection (e)—

(A) 1996.—The national private per capita estimate for 1996 is equal to the private sector per capita budget baseline for 1995 (determined under subsection (b)) multiplied by the national private sector growth factor (specified under subsection (c)) for 1996.

(B) SUBSEQUENT YEARS.—The total amount of the national private per capita estimate for each year after 1996 is equal to the national private per capita estimate determined under this paragraph for the previous year multiplied by the national private sector growth factor (specified under subsection (c)) for the year involved.

(3) PUBLICATION.—The Secretary of Health and Human Services shall publish in the Federal Register and report to the Congress—

(A) by not later than April 1 before each year, an initial estimate of the national private per capita estimate for the year; and

(B) by not later than October 1 before each year, a final determination of the national private per capita estimate for such year.

(b) PRIVATE SECTOR PER CAPITA BUDGET BASELINE.—The Secretary shall compute a private sector per capita budget baseline under this subsection for 1995 as follows:

(1) 1993 ACTUAL EXPENDITURES.—The Secretary shall determine (on the basis of the best data available) the amount of the private sector per capita expenditures (as determined under subsection (d)) for 1993.

(2) PROJECTION FOR 1995.—The Secretary shall increase such amount by the Secretary's estimate of the percentage increase in the national private per capita estimate between the midpoint of 1993 and the midpoint of 1995.

(c) NATIONAL PRIVATE SECTOR GROWTH FACTOR.—The national private sector growth factor under this subsection for each year is 1 plus the sum (expressed as a fraction) of—

(1) the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year; and

(2)(A) for 1996, 2.4 percentage points,

(B) for 1997, 0.6 percentage points, and

(C) for each year thereafter, 0 percentage points.

(d) DETERMINATION OF NATIONAL PRIVATE PER CAPITA EXPENDITURES FOR 1993.—

(1) IN GENERAL.—The Secretary shall determine for 1993 the national private per capita expenditures equal to—

(A) total covered health care expenditures (described in paragraph (2)), divided by

(B) the estimated average population in the United States of individuals in 1993 who are eligible individuals (and would be subject to the individual mandate in 1998) (other than medicare part A beneficiaries and individuals entitled to medical assistance under a State plan under title XIX of the Social Security Act) for whom such expenditures were determined.

(2) COVERED HEALTH CARE EXPENDITURES.—For purposes of paragraph (1)(A), the Secretary shall determine covered health care expenditures for 1993 as follows:

(A) DETERMINATION OF TOTAL EXPENDITURES.—

(i) IN GENERAL.—The Secretary shall first determine the amount of total payments made for items and services included in the guaranteed national benefit package (determined without regard to cost sharing) or included in any standard benefit package for supplemental health benefit policies established under subtitle C of title V (determined without regard to cost sharing) in the United States in 1993.

(ii) INCLUSION OF ALL PAYERS.—Except as provided in clause (iii), the amount of total payments described in clause (i) shall be determined without regard to the source of payment and shall include (as specified by the Secretary) direct patient expenditures and payments made by third party payers (including Government health programs and health maintenance organizations).

(iii) EXCLUSIONS.—In computing such payment amounts, there shall be excluded, as specified by the Secretary—

(I) nonoperating revenues (such as interest);

(II) receipts attributable to personal comfort and convenience items described in section 6002(a)(5);

(III) direct payments from the Federal Government, from State government, from units of local government for research to the extent unrelated (and not attributable) to the provision of health care services;

(IV) receipts attributable to the program for the provision of hospital care and medical services by the Department of Veterans' Affairs under chapter 17 of title 38, United States Code;

(V) payments made to health care facilities and providers of the Department of Defense and of the Indian Health Service; and

(VI) such other receipts unrelated to the provision of health care services as the Secretary specifies.

(B) REMOVAL OF CERTAIN EXPENDITURES NOT INCLUDED IN PRIVATE SECTOR.—The amount so determined shall be decreased by the proportion of such amount that is attributable to any of the following:

(i) Medicare beneficiaries.

(ii) Medicaid beneficiaries.

(iii) Expenditures which are paid for through workers' compensation or automobile or other liability insurance.

(iv) Expenditures which are paid for items and services excluded from classes of services under section 6002(a)(4).

(v) Expenditures by parties (including the Federal Government) that the Secretary determines will not be payable by private health plans for coverage either of the guaranteed national benefit package or under any supplemental health benefit policy under this Act.

(e) ADJUSTMENTS.—

(1) IN GENERAL.—Except as provided in this subsection, the Secretary is not authorized to adjust the national private per capita estimate for a year once it is published before October of the previous year.

(2) RECOMMENDATIONS FOR CHANGES.—Except as permitted under paragraphs (3) and (4), the Secretary may submit to Congress recommendations for changes in the national private per capita estimate, but may not implement such recommendations without the approval of Congress.

(3) CORRECTION PERMITTED FOR ESTIMATION ERRORS IN PRIVATE SECTOR PER CAPITA BUDGET BASELINE.—Insofar as the Secretary determines that the amounts used in estimating initially the private sector per capita budget baseline described in subsection (b) did not accurately reflect the actual amount described in subsection (b)(1) and the actual percentage increase described in subsection (b)(2), the Secretary shall adjust the national private per capita estimate to correct for such estimation errors.

(4) SPECIAL RULE FOR 1998.—The Secretary shall adjust the national private per capita estimate for 1998 in order to reflect the impact of universal coverage on the national private per capita estimate, including—

(A) the elimination from the private sector per capita budget baseline under subsection (b) of amounts attributable to uncompensated care or to a differential between payment rates under title XIX of the Social Security Act and payment rates in the private sector; and

(B) increased utilization of, and expenditures for, items and services covered under the guaranteed national benefit package likely to occur, as a result of coverage of individuals under certified health plans who, as of 1997 were uninsured or underinsured with respect to such package.

(5) SPECIAL RULE FOR YEARS AFTER 2002.—The Secretary shall adjust the national private per capita estimate for each year after 2002 in order to reflect the impact of establishing an annual out-of-pocket limit on cost-sharing under the guaranteed national benefit package under section 3001.

SEC. 6002. CLASSES OF HEALTH CARE SERVICES.

(a) ESTABLISHMENT OF CLASSES.—

(1) IN GENERAL.—

(A) SPECIFIED SERVICES.—

(i) IN GENERAL.—Subject to subparagraph (B)(ii), in the case of items and services specified in a subparagraph under paragraph (2), all of the items and services described in that subparagraph shall be considered to be a "separate" class of health care services.

(ii) OVERLAPPING SERVICES.—Except as the Secretary may provide, items and services specified in a subparagraph of paragraph (2) shall be considered to be excluded from the subsequent subparagraphs of that paragraph.

(B) OTHER ITEMS AND SERVICES.—

(i) IN GENERAL.—In the case of items and services included as health care services under paragraph (3), the Secretary shall group such items and services into such class or classes of health care services as may be appropriate.

(ii) INCLUSION IN CLASSES OF SPECIFIED HEALTH CARE SERVICES.—In carrying out clause (i), the Secretary may include an item or service described in paragraph (3) within a class of services established under subparagraph (A).

(iii) UNIFORM DEFINITION OF CLASSES.—The Secretary shall define classes under this section in a manner identical to the definition of classes under section 8202.

(2) SPECIFIED HEALTH CARE SERVICES.—Subject to paragraph (4), the items and services specified in this paragraph are as follows:

(A) Inpatient hospital services, other than mental health services.

(B) Outpatient hospital services and ambulatory facility services (including renal dialysis facility services), other than mental health services.

(C) Diagnostic testing services (including clinical laboratory services and x-ray services).

(D) Physicians' services and other professional medical services, other than mental health services.

(E) Home health services and hospice care.

(F) Rehabilitation services, such as physical therapy, occupational and speech therapy.

(G) Durable medical equipment and supplies.

(H) Prescription drugs and biologicals and insulin.

(I) Nursing facility services, including skilled nursing facility services and intermediate care facility services, other than mental health services.

(J) Mental health services.

(3) CLASSIFICATION OF ADDITIONAL ITEMS AND SERVICES.—Subject to paragraph (4), with respect to items and services (not described in paragraph (2)) which are included under the guaranteed national benefit package or included in any standard benefit package for supplemental health benefit policies established under subtitle C of title V, the Secretary may classify them either within a class specified in paragraph (2) or within a new class established by the Secretary for such an item or service.

(4) EXCLUSIONS.—The following items and services shall not be considered to be health care services and shall not be included in a class of services under paragraph (1) or (3):

(A) Over-the-counter medications and medical equipment and devices.

(B) Homemaker and home health aide services and personal care services, and other services described in section 1915(c)(4)(B), section 1929(a), or section 1930(a) of the Social Security Act.

(C) Inpatient mental health services of a custodial nature.

(5) EXCLUSION OF INSTITUTIONAL CHARGES FOR PERSONAL COMFORT AND CONVENIENCE ITEMS.—Payments received (and amounts charged) by a facility which are attributable to items (such as private rooms, telephones, and television rentals) provided for the personal comfort and convenience of patients shall not be counted as receipts (nor subject to limitations on amounts that may be charged) for purposes of this title.

(b) PUBLICATION.—

(1) IN GENERAL.—The Secretary shall publish—

(A) by not later than April 1, 1995, proposed regulations defining the health care services and establishing the classes of services under this section, and

(B) by not later than October 1, 1995, final regulations defining the health care services and establishing such classes.

(2) ITEMS INCLUDED IN REGULATIONS.—In such regulations, the Secretary shall define—

(A) the class or classes to be established under subsection (a)(1),

(B) the services to be included within each class, and

(C) the methods and sources of data for computing, for purposes of this title, the national private per capita estimate within the class.

(3) CHANGES.—

(A) NO CHANGES AUTHORIZED.—After the Secretary has established classes of services under paragraph (1)(B), the Secretary may not change such classes (or the services included in such classes), except in the case of services not previously classified. Any such services not previously classified shall be classified within one of the classes previously established.

(B) RECOMMENDED CHANGES.—If the Secretary determines that a change in the classification established under this section may be appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the national private per capita estimate permitted for classes of services that would be affected by the change.

(4) COMMISSION REPORTS.—

(A) INITIAL REPORTS.—With respect to the establishment of classes of services under this section, each applicable Commission (as defined in section 8202(c)), by not later than June 1, 1995, shall report to the Congress its comments concerning the classification proposed by the Secretary under paragraph (1)(A).

(B) PERIODIC REPORTS.—Each applicable Commission shall periodically report to Congress on changes in the system of classification under this section that should be made to promote the more efficient provision of medically appropriate health care services.

(c) APPLICABLE COMMISSION DEFINED.—In this title, the term "applicable Commission" has the meaning given such term in section 8202(c).

SEC. 6003. ALLOCATION OF PER CAPITA ESTIMATES BY CLASS OF SERVICE.

(a) ALLOCATION.—

(1) IN GENERAL.—The Secretary shall allocate the national private per capita estimate under section 6001 for a year among classes of services specified under section 6002.

(2) PROPORTIONAL ALLOCATION BASED ON HISTORICAL PROJECTED EXPENDITURES.—

(A) IN GENERAL.—The amount allocated to each class for a year shall be equal to the national private per capita estimate allocated for the year multiplied by the ratio (expressed as a percentage) of—

(i) the historical projected private expenditures for the class for the year (as determined under subsection (b)(2)), to

(ii) the sum of such historical projected private expenditures for all the classes for the year.

(B) NATIONAL ANNUAL RATE OF INCREASE FOR A CLASS OF SERVICES.—In this Act, the term "national annual rate of increase" means, with respect to a class of services for a year, the percentage by which—

(i) the amount determined under subparagraph (A) for the class for the year, exceeds

(ii) the amount determined under such subparagraph for the class for the preceding year.

(3) PUBLICATION.—

(A) IN GENERAL.—The Secretary shall, in conjunction with the publication of the initial estimate and final determination of the national private per capita estimate under section 6001(a)(3) for a year, publish in the Federal Register and report to the Congress the allocation of the national private per capita estimate among the classes of services under this subsection.

(B) EXCEPTION FOR 1996.—For 1996, the Secretary shall publish and report the allocation of the national private per capita estimate among the classes of services under this subsection not later than August 1, 1995.

(b) HISTORICAL PROJECTED PRIVATE EXPENDITURES.—

(1) IN GENERAL.—

(A) DETERMINATION.—For purposes of subsection (a)—

(i) FOR 1995.—The historical projected private expenditures for a class of services for 1995 is equal to the portion of the national private per capita estimate during 1993 (as determined under section 6001(b)(2)(A)) which is attributable to the class of services, multiplied by the private trend factor (described in subparagraph (B)) for the class. In computing such portion for classes, the Secretary shall take into account the allocation of expenditures by health maintenance organizations among the different classes of services.

(ii) SUBSEQUENT YEARS.—The historical projected private expenditures for a class of services for a year after 1995 is equal to the amount of the allocation for the class under subsection (a)(2)(B) for the preceding year multiplied by the trend factor (described in subparagraph (B)) for the class and multiplied by the adjustment factor described in subparagraph (C) for the year..

(B) PRIVATE TREND FACTOR.—In subparagraph (A), subject to subsection (c)(1)(B), the "private trend factor", for a class of services, is 1 plus the average annual rate of increase in per capita private expenditures for the class of services during the 5-year period ending with 1995.

(C) ADJUSTMENT FACTOR.—The adjustment factor described in this subparagraph for a year is equal to the ratio of—

(i) the national private per capita estimate for the year (as determined under section 6001(a)(2)), or, for 1995, the private sector per capita budget baseline for 1995 (as determined under section 6001(b)(2)), to

(ii) the sum of the historical projected private expenditures projected for all the classes for the year (determined under subparagraph (A) without regard to this subparagraph).

(2) PUBLICATION OF TREND FACTORS.—The Secretary shall publish, by not later than August 1, 1995, the private trend factors for the different classes of services.

(c) REVIEW AND CHANGES IN ALLOCATION.—

(1) IN GENERAL.—

(A) NO ADMINISTRATIVE AUTHORITY TO CHANGE.—Except as specifically provided in this paragraph or by law enacted after the enactment of this Act, the Secretary has no authority to change the allocation or private trend factors from the allocation and private trend factors provided under this section.

(B) ADJUSTMENT IN PRIVATE TREND FACTORS.—The Secretary shall make such adjustments in the private trend factors under subsection (b)(1)(B) as the Secretary determines to be appropriate to reflect changes in patterns of use of health care services among the different classes of services. Such adjustment shall be made by regulation published not later than August 1, 1998, and shall be effective for determining allocations for years beginning with 1999.

(C) RECOMMENDED CHANGES.—Subject to subparagraph (D), if the Secretary determines that a change in the allocation of an estimate among classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the national private per capita estimate permitted for classes of services that would be affected by the change.

(D) CORRECTION PERMITTED FOR ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the historical projected private expenditures under this subsection did not accurately reflect the actual portions described in subsection (b)(1)(A)(i) or the actual private trend factors described in subsection (b)(1)(B), the Secretary shall adjust the allocation of the national private per capita estimate among classes of services to correct for such estimation errors.

(2) COMMISSION REVIEW.—Each applicable Commission shall annually review and report to Congress, in its report submitted under section 6002(b)(4), on the effect of the private trend factors used in the allocation of the national private per capita estimate among classes of services. Such report shall include such recommendations for appropriate adjustments in the private trend factors as the applicable Commission considers appropriate to properly take into account at least—

(A) changes in health care technology,

(B) changes in the patterns and practices relating to health care delivery found to be appropriate,

(C) changes in the distribution of health care services, and

(D) the special health care needs of underserved rural and inner city populations.

SEC. 6004. NATIONAL HEALTH EXPENDITURES REPORTING SYSTEM.

(a) IN GENERAL.—The Secretary shall establish a national health expenditures reporting system (in this section referred to as the "system") for purposes of—

(1) establishing the national private per capita estimate,

(2) allocating the national private per capita estimate among classes of services,

(3) determining maximum payment rates,

(4) monitoring of any State cost containment and benefit management programs established by States pursuant to title IV, and

(5) otherwise carrying out this title.

(b) INFORMATION REPORTING.—

(1) ANNUAL REPORT BY PROVIDERS.—

(A) IN GENERAL.—Under the system, providers of health care services (including such providers within provider networks) shall submit (by not later than April 15 of each year, beginning with 1997) a report.

(B) CONTENTS.—Such a report shall include such information as the Secretary specifies relating to the provision of health care services in the previous year, including—

(i) the volume and receipts for such services,

(ii) cost and revenue data for hospitals and other institutional providers and revenue data for other providers, and

(iii) information by class of service, type of payer, and State of residence of individual provided the services.

Information on revenues for activities not related to the provision of direct patient care, such as teaching or research or for services that are explicitly excluded from the system of national health expenditures estimates, shall be reported separately.

(C) FORM.—The report shall be submitted in such form and manner (including the use of electronic transmission) as the Secretary shall specify in regulation. Such form shall permit the reporting of information by health plans on behalf of providers who are in provider networks in the plan.

(D) USE OF REPORTING MECHANISMS.—To the maximum extent practicable and appropriate, reporting under such system shall be done through reporting mechanisms (such as uniform hospital reports provided under section 9105) and using data bases otherwise in use.

(E) USE OF SURVEYS.—The Secretary may, where appropriate, provide for the collection of information under the system through surveys of a sample of health care providers or with respect to a sample of information with respect to such providers.

(2) CONFIDENTIALITY.—Information gathered pursuant to the authority provided under this section shall not be disclosed in a manner that identifies individual providers of services.

(3) TRANSITION.—Before April 15, 1997, for purposes of this title, the Secretary may use such other data collection and estimation

techniques as may be appropriate for purposes described in subsection (a).

(c) ENFORCEMENT.—If a provider of health services is required, under the system under this section, to report information and refuses, after being requested by the Secretary, to provide the information required, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

Subtitle B—State Health Expenditure Estimates

SEC. 6101. STATE PRIVATE SECTOR PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—For each calendar year (beginning with 1996), the Secretary shall establish a State private sector per capita health expenditure estimate (in this title referred to as a "State private per capita estimate") for each State under paragraph (2).

(2) AMOUNT.—Subject to subsection (e), the State private per capita estimate for a State for a year is equal to the national private per capita estimate for the year, established under section 6001, multiplied by the applicable State adjustment factor (specified under subsection (b)) for the State.

(3) PUBLICATION.—The Secretary shall publish in the Federal Register and report to the Congress and to each State—

(A) by not later than April 1 before each year, an initial estimate of the State private per capita estimate for each State for the year; and

(B) by not later than October 1 before each year, a final determination of the State private per capita estimate for each State for the year.

(4) PERIODIC COMMISSION REPORTS ON STATE ESTIMATES.—Each applicable Commission shall periodically review and report to Congress on the State private per capita estimates established under this section. Such a report shall include such recommendations as the respective Commission deems appropriate.

(b) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—The Secretary shall compute a State adjustment factor for each State consistent with this subsection.

(2) UTILIZATION AND PRICE FACTORS.—In establishing State adjustment factors, the Secretary shall take into account the following:

(A) RATIO OF STATE PRIVATE SECTOR PER CAPITA EXPENDITURES TO NATIONAL PRIVATE SECTOR PER CAPITA EXPENDITURES.—Subject to adjustments to reflect subparagraphs (B) and (C), the ratio of a State private sector per capita expenditures (that would be computed for the State under section 6001(d) if computations under such section were made for that State rather than for the United States) to the national private per capita expenditures determined under such section.

(B) HISTORIC UTILIZATION.—With respect to utilization of services, differences among the States in demographic composition and historic utilization of different services in the private sector in 1993.

(C) MAXIMUM PAYMENT RATES UNDER THIS TITLE.—With respect to the price of services, the price of such services that would be allowed in the State in 1995 if the maximum payment rates (provided under subtitle D) were to apply in the State in 1995.

(3) ADJUSTMENT TO REFLECT HEALTH CARE EXPENDITURES FOR STATE RESIDENTS.—The Secretary shall provide for an adjustment to take into account differences among States in the in-State, and out-of-State, use of services by residents and non-residents of the State, in order that the per capita amount reflects per capita health care expenditures for residents of the State for services provided anywhere in the United States.

(4) AVERAGE.—The Secretary shall establish the State adjustment factors in such a manner as assures that the population weighted average of such factors is 1.

(c) ADJUSTMENT.—

(1) IN GENERAL.—Subject to paragraph (3), the provisions of section 6001(e) shall apply to the State private per capita estimates under this section in the same manner as they apply to the national private per capita estimate.

(2) ADJUSTMENT TO CORRECT ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the State private per capita estimates did not accurately reflect the correct values for the factors used in computing State adjustments factors under subsection (b), the Secretary shall adjust the State private per capita estimates to correct for such estimation errors.

(3) ADJUSTMENT IN 1998.—In applying section 6001(e)(4) under paragraph (1), the adjustment for each State private per capita estimate shall be the same as the adjustment to the national private per capita estimate under such section.

Subtitle C—Stand-By Federal Cost Containment

SEC. 6201. APPLICATION OF MAXIMUM PAYMENT RATES IN STATES THAT FAIL TO CONTROL COSTS.

(a) DETERMINATION OF STATE PERFORMANCE.—

(1) IN GENERAL.—During each year (beginning with 1997), the Secretary shall determine for each State whether the actual State private per capita health care expenditures (determined in a manner similar to the manner in which the national private per capita expenditures is determined under section 6001(d)(2)) for the previous year exceeded the State private per capita estimate for the State for such year (as determined under subtitle B). Such determination shall be based on information submitted by providers under section 6005 and such other data as the Secretary finds appropriate.

(2) ADJUSTMENT OF ACTUAL PER CAPITA HEALTH EXPENDITURES.—

(A) IN GENERAL.—In accordance with procedures established by the Secretary, a State may apply to the Secretary to exclude from the computation of actual State per capita health expenditures under paragraph (1) in the State for a year expenditures attributable to health care needs of a sudden and temporary nature, such as epidemics or natural disasters, to the extent that health care expenditures for such or similar needs were not reflected in the State private per capita estimate.

(B) LIMITATION.—For purposes of subparagraph (A), expenditures extending over a period of longer than 6 months shall not be considered temporary.

(b) APPLICATION OF STANDBY COST CONTAINMENT UNDER SUBTITLE D.—

(1) IN GENERAL.—If the Secretary determines in a year under subsection (a) beginning after 1999 that the actual State per capita health expenditures in a State for the previous year was greater than the State private per capita estimate for the State for such year, subject to paragraph (2) the provisions of subtitle D shall apply to charges imposed (and payments made) for services furnished in the State on or after January 1 of the following year.

(2) SUBSTITUTION OF STATE APPROVED ALTERNATIVE PAYMENT SYSTEM.—

(A) ALTERNATIVE PAYMENT SYSTEM.—Subtitle D shall not apply in a State for a year to services if the Secretary determines that the State has in effect for the year an alternative payment system that meets the applicable requirements of subtitle A of title III for the services covered.

(B) BENEFITS MANAGEMENT PROGRAM.—Subtitle D shall not apply in a State for a year if the Secretary determines that the State has in effect for the year a benefits management program that meets the applicable requirements of subtitle B of title III.

Subtitle D—Maximum Payment Rates

PART 1—ESTABLISHMENT AND APPLICATION OF MAXIMUM PAYMENT RATES

SEC. 6301. PROCESS.

(a) PUBLICATION OF RATES.—

(1) IN GENERAL.—The Secretary shall cause to have published in the Federal Register—

(A) not later than April 1 of each year (or not later than September 1, 1995, in the case of rates for 1996), proposed maximum payment rates under this subtitle for the following year for public comment, and

(B) not later than October 1 of each year (or not later than December 1, 1995, in the case of rates for 1996), after such consideration of public comment on the proposed rates, the maximum payment rates under this subtitle for the following year.

(2) PAYMENT RATES ONLY ADVISORY FOR 1996 THROUGH 2000.—The maximum payment rates for 1996 through 2000 published under paragraph (1) are only advisory and shall not be applied to payment for services during such years.

(b) ITEMS INCLUDED IN PUBLICATIONS.—The Secretary shall include in the publications referred to in subsection (a)(1)—

(1) a description of the payment methodology used in the establishment of maximum payment rates; and

(2) in the case of a publication under subsection (a)(1)(B), the extent that the rates differ from the applicable Commission's recommendations under subsection (c), an explanation of the Secretary's grounds for not following such recommendations.

(c) REPORTS OF COMMISSIONS.—With respect to the establishment of maximum payment rates for services under this subtitle, the applicable Commission, not later than June 1 of each year, shall report its recommendations to the Secretary and Congress concerning such rates for the following year. Each such report may include such other recommendations relating to the operation of this subtitle as the Commission considers appropriate.

(d) PAYMENT RATE DEFINED.—In this subtitle, the term "payment rate" means, with respect to health care services for which amounts are payable under a plan or program, the rate of payment provided for under the plan or program and including cost-sharing (including deductibles, coinsurance, and extra billing amounts) applicable under the plan or program with respect to the services.

SEC. 6302. PAYMENT METHODOLOGY; RELATION TO ESTIMATE ALLOCATION.

(a) PAYMENT METHODOLOGY.—

(1) IN GENERAL.—Subject to sections 8002(c) and 8003, the Secretary shall establish maximum payment rates under this subtitle consistent with the payment rate methodology specified under part 2.

(2) TREATMENT OF SERVICES WITHIN A CLASS.—Nothing in this title shall be construed as requiring that maximum payment rates established under this subtitle for different health care services within a class of services be the same or determined under the same methodology.

(b) RELATION TO NATIONAL PRIVATE PER CAPITA ESTIMATE.—

(1) IN GENERAL.—Subject to paragraph (2), the maximum payment rates for a year shall be established under this subtitle in a manner so that, if they were to apply in the year in all the States under this title—

(A) the national average private per capita expenditures for all the services within each class subject to such rates, is equal to

(B) the percent of the national private per capita estimate allocated to the class under section 6003(a)(1) for the year.

(2) RULES FOR CERTAIN STATES.—The rates shall be established under paragraph (1) not taking into account any reductions in such rates effected under section 4004(c)(2)(A). The reductions under such section shall be applied only to the rates (as so established) in that State.

SEC. 6303. GENERAL APPLICATION AND ENFORCEMENT OF MAXIMUM PAYMENT RATES.

(a) LIMITS ON CHARGES.—

(1) IN GENERAL.—In the case of a provider that provides health care services to an individual for which a maximum payment rate is established and applied pursuant to this subtitle and subtitle C—

(A) the provider may not charge (i) an amount in excess of such rate or (ii) on a payment basis other than the payment basis established for such services under part 2;

(B) the provider may not collect for such services an amount in excess of such rate; and

(C) the individual and other entities, including a health benefit plan, are not liable collectively for payment of any amount that exceeds such rate.

(2) RELATION TO MEDICARE PROGRAMS.—This subsection shall not apply to services furnished to an individual who is entitled to benefits with respect to such services under title XVIII of the Social Security Act, medicare part C, or the program established under part B of title XXII of the Social Security Act.

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPROPER CHARGES.—If a provider imposes a charge in violation of subsection (a)(1)(A), the provider is subject to civil money penalty in an amount not to exceed $100 for each such charge.

(2) IMPROPER COLLECTION.—If a provider collects excess amounts in violation of subsection (a)(1)(B) and does not refund such excess amounts within 30 days of date on which the provider is notified (in a form and manner specified by the Secretary) that the provider collected excess amount, the provider is subject to a civil money penalty in an amount equal to three times the amount of such excess which has not been so refunded or, if greater, $500.

(3) PROCESS.—The provisions of section 1128A of the Social Security Act (other subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(4) DEPOSIT OF PENALTIES IN ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—Any civil money penalties collected under this subsection shall be paid into the All-payer Health Care Fraud and Abuse Control Account (established under section 9212).

PART 2—METHODOLOGIES FOR DETERMINING MAXIMUM PAYMENT RATES

SEC. 6311. BASIS FOR MAXIMUM PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES.

(a) PAYMENT RATES.—

(1) IN GENERAL.—Subject to subsection (e), the maximum payment rate established under this subtitle for a service within the class of services consisting of inpatient hospital services that is provided by—

(A) a hospital that is not an exempt hospital (as defined in paragraph (4)) is the payment rate specified in paragraph (2), or

(B) an exempt hospital is the payment rate specified in paragraph (3).

(2) RATE FOR GENERAL HOSPITALS.—The payment rate under this paragraph during a year shall be equal to the sum of the following:

(A) STANDARD DRG-BASED PAYMENT RATE.—The product of—

(i) the standardized amount applicable to the hospital, as established in accordance with subsection (b), adjusted under subsection (d); and

(ii) the weighting factor assigned to the service (as determined in accordance with subsection (c)).

(B) OUTLIERS.—An amount for discharges classified as outliers, in accordance with a methodology similar to the methodology used under section 1886(d)(5)(A) of the Social Security Act.

(C) DIRECT GRADUATE MEDICAL EDUCATION.—An amount for direct graduate medical education costs of the hospital, as determined in accordance with section 7024(e(1)).

(3) RATE FOR EXEMPT HOSPITALS.—The payment rate under this paragraph during a year shall be determined on a per admission basis, based on the allowable operating receipts of the hospital (determined in the manner specified in subparagraphs (A) and (B) of subsection (b)(2)).

(4) EXEMPT HOSPITAL DEFINED.—In this section, the term "exempt hospital" means—

(A) a psychiatric hospital (as defined in section 1861(f) of the Social Security Act), including a psychiatric unit of a hospital which is a distinct part of the hospital (as defined by the Secretary);

(B) a rehabilitation hospital (as defined by the Secretary), including a rehabilitation unit of a hospital which is a distinct part of the hospital (as defined by the Secretary);

(C) a hospital whose inpatients are predominantly individuals under 18 years of age;

(D) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days; or

(E) a hospital that the Secretary has classified, at any time on or before December 31, 1990, for purposes of applying exceptions and adjustments to payment amounts under section 1886(d) of such Act, as a hospital involved extensively in treatment for or research on cancer.

(5) EXCLUSION OF EXEMPT HOSPITALS IN DETERMINATIONS.—For purposes of the succeeding subsections of this section, the term "hospital" does not include an exempt hospital.

(b) ESTABLISHMENT OF STANDARDIZED AMOUNTS.—

(1) IN GENERAL.—The Secretary shall establish a standardized amount under subsection (a) for hospitals located in a large urban area and for other hospitals for a year by standardizing the hospital's average cost per discharge (based on the hospital's allowed operating receipts, as determined under paragraph (2)) in accordance with paragraph (3). For purposes of the preceding sentence, a hospital is located in a "large urban area" if the hospital is treated as being located in a large urban area under section 1886(d) of the Social Security Act for purposes of the medicare program.

(2) ALLOWED OPERATING RECEIPTS PER DISCHARGE DEFINED.—

(A) IN GENERAL.—For purposes of paragraph (1) and except as provided in subparagraph (B), a hospital's "allowed operating receipts" means the total of all receipts of the hospital (without regard to the source) attributable to routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services, as determined on an average per admission or per discharge basis (as determined by the Secretary), during 1993, increased by the Secretary's estimate of the percentage increase in such receipts between the midpoint of 1993 and the midpoint of 1995.

(B) EXCLUSIONS.—In determining a hospital's allowed operating receipts per discharge under subparagraph (A), the Secretary shall exclude receipts attributable to services for which payment was made to the hospital under the medicare program and discharges (or admissions) attributable to individuals entitled to benefits under part A of the medicare program.

(C) CERTAIN OUTPATIENT RECEIPTS INCLUDED.—In determining a hospital's allowed operating receipts under subparagraph (A), the Secretary shall include all receipts attributable to services that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to a patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).

(3) PROCESS FOR STANDARDIZING AMOUNTS.—The Secretary shall standardize the average per discharge amount for each hospital for a year, in a manner similar to the standardization process described in section 1886(d)(2)(C) of the Social Security Act, by providing for the following adjustments and exclusions:

(A) Adjusting for variations among hospitals by area in the average hospital wage level, using the area wage level applied for hospitals under the medicare program under section 1886(d)(3)(E) of the Social Security Act.

(B) Adjusting for variations in case mix among hospitals.

(C) Excluding an estimate of the additional payments to be made for outliers, using the amounts paid to hospitals for outliers under the medicare program under section 1886(d)(5)(A) of such Act (except that the Secretary may apply different amounts if the Secretary finds that such different amounts more accurately reflect outliers for services furnished to individuals who are not medicare beneficiaries).

(D) Adjusting for variations among hospitals by area in input prices other than wages and wage-related costs.;

(E) Excluding an estimate of indirect medical education costs, using the indirect medical education adjustment applied for hospitals under the medicare program under section 1886(d)(5)(B) of such Act.

(F) Excluding an estimate of the additional payments made for hospitals serving a disproportionate share of low-income individuals, determined in the same manner as payment adjustments made on behalf of such hospitals under section 1886(d)(5)(F) of such Act (as amended by this Act).

(G) Excluding an estimate of direct graduate medical education costs.

(H) Excluding an estimate of capital-related costs.

(c) ESTABLISHMENT OF DIAGNOSIS-RELATED GROUPS AND WEIGHTING FACTORS.—

(1) DIAGNOSIS-RELATED GROUPS.—For purposes of this section, the Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(2) WEIGHTING FACTORS.—For each diagnosis-related group established under paragraph (1), the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(3) USE OF MEDICARE GROUPS AND FACTORS.—In establishing diagnosis-related groups and assigning weighting factors for such groups under this paragraph, the Secretary shall use the diagnosis-related groups and weighting factors used under the medicare program under section 1886(d)(4) of the Social Security Act, except to the extent that the Secretary must establish diagnosis-related groups in addition to the groups under such program, or adjust such weighting factors, to take into account the application of payment rates under this section to inpatient hospital services furnished to individuals who are not medicare beneficiaries. In carrying out this paragraph, the Secretary shall establish separate diagnosis-related groups and weighting factors applicable to services furnished to children.

(d) ADJUSTMENTS TO STANDARDIZED AMOUNTS.—The adjustments under this subsection are as follows:

(1) WAGE ADJUSTMENT.—Adjusting for variations among hospitals by area in the average hospital wage level, using the area wage level applied for hospitals under the medicare program under section 1886(d)(3)(E) of the Social Security Act.

(2) NON-WAGE ADJUSTMENT.—Adjusting for variations among hospitals by area in input prices other than wages and wage-related costs.

(3) ADDITION OF INDIRECT MEDICAL EDUCATION.—Adding an amount for the indirect medical education costs of the hospital, in accordance with section 7024(e)(2).

(4) ADDITION OF CAPITAL.—Adding an amount for capital and capital-related costs, determined in the same manner as payment for such costs is provided under section 1886(g) of the Social Security Act.

(5) ADDITION OF DSH.—Adding an amount in the case of hospitals serving a disproportionate share of low-income individuals, determined in the same manner as payment adjustments are made on behalf of such hospitals under section 1886(d)(5)(F) of such Act (as amended by this Act).

(e) OTHER ADJUSTMENTS.—

(1) NEEDS OF CERTAIN FACILITIES.—The Secretary may adjust the maximum payment rates otherwise determined under this section for hospitals in such manner and to such extent as the Secretary considers appropriate to take into account the needs of—

(A) regional and national referral centers described in section 1886(d)(5)(C) of the Social Security Act;

(B) sole community hospitals described in section 1886(d)(5)(D) of such Act; and

(C) essential access hospitals designated by the Secretary under section 1820(i)(1) of such Act.

(2) RULES FOR TRANSFERRED PATIENTS.—The Secretary shall provide for rules for applying the maximum payment rates under this section in the case of a hospital for inpatient hospital services provided to patients transferred to (or from) the hospital, in accordance with the rules used with respect to such transfers under the medicare program.

SEC. 6312. BASIS FOR MAXIMUM PAYMENT RATES FOR CLASS OF PHYSICIANS' SERVICES AND OTHER PROFESSIONAL MEDICAL SERVICES.

(a) USE OF RELATIVE VALUE FEE SCHEDULE.—

(1) IN GENERAL.—Subject to subsection (b), the maximum payment rates established under this subtitle for a service within the class of services consisting of physicians' services and other professional medical services during a year shall be equal to the product of—

(A) the relative value for the service applied under section 1848(b) of the Social Security Act;

(B) an applicable conversion factor (determined by the Secretary in an amount consistent with the requirements of section 6302(b)); and

(C) the applicable geographic adjustment factors applied under section 1848(b) of the Social Security Act.

(b) NEW PROCEDURE CODES AND RELATIVE VALUE UNITS.—In applying subsection (a) in the case of services for which relative value units have not been established under section 1848 of the Social Security Act, the Secretary shall establish relative value units in the same manner as if payment for such services were made under the medicare program.

(c) PUBLICATION OF DEFINITIONS, RELATIVE VALUE UNITS, AND PAYMENT POLICIES.—The Secretary shall provide for publication of such definitions, relative value units (established under subsection (b)), and payment policies as may be necessary for payers to apply the maximum payment rates established under this section.

SEC. 6313. BASIS FOR OTHER MAXIMUM PAYMENT RATES FOR SERVICES USING CERTAIN MEDICARE PAYMENT METHODOLOGIES.

The maximum payment rates established under this subtitle for services for any of the following classes of services shall be determined using the applicable payment methodologies under the medicare program as follows:

(1) In the case of facility services described in section 1832(a)(2)(F) of the Social Security Act furnished in connection with a surgical procedure specified pursuant to section 1833(i)(1)(A) of such Act and furnished to an individual in an ambulatory surgical center described in such section, the methodology described in section 1833(i)(2) of such Act.

(2) For services provided by Federally qualified health centers, the methodology shall be the cost-based methodology used in determining payment amounts under the medicare programs, as amended by section 7022, and the maximum payment rates shall be the amounts determined under such programs.

(3) For the class of diagnostic testing services described in section 6002(a)(2)(C)—

(A) in the case of clinical laboratory services, the methodology described in sections 1833(a)(2)(D) and 1833(h) of such Act (including the requirement of direct billing for such services), and

(B) in the case of other diagnostic services, the applicable methodology under part B of title XVIII of the Social Security Act.

(4) In the case of an item of durable medical equipment (described in section 1834(a)(13) of the Social Security Act), the methodology described in section 1834(a)(1) of such Act.

(5) In the case of prosthetic devices and orthotics and prosthetics, the methodology described in section 1834(h)(1)(A) of the Social Security Act.

(6) In the case of psychologists and clinical social workers, the methodologies described in section 1833(a)(1)(L) and 1833(a)(1)(F) of the Social Security Act, respectively.

(7) For prescription drugs, the methodology used to determine payment limits under section 1834(d)(4) of the Social Security Act, as inserted by section 3102(a), except that—

(A) any reference in such section to "1998" or "1999" shall be deemed to be a reference to "1996" or "1997",

(B) any reference in such section to "4 12-month periods ending with June 1997" shall be deemed a reference to "2 12-month periods ending with June 1995", and

(C) any reference in such section to the uniform percentage increase determined under section 8206(a) shall be deemed a reference to national rate of increase for the class of prescription drugs established under 6003(a)(2)(B).

(8) For renal dialysis services, home dialysis supplies and equipment (as defined in section 1881(b)(8) of the Social Security Act), and self-care home dialysis support services (as defined in section 1881(b)(9) of such Act), the methodology described in section 1881(b) of such Act.

(9) For any other service within a class of services for which the amount of payment made under part B of the medicare program is determined on the basis of reasonable or prevailing charge, the methodology used for payment for such service under such part.

SEC. 6314. SERVICES PROVIDED BY MANAGED CARE ORGANIZATIONS.

(a) IN GENERAL.—The maximum payment rates established under this subtitle for capitation payments made to managed care organizations for the guaranteed national benefit package shall be determined using the applicable payment methodologies established under subsection (b).

(b) PAYMENT METHODOLOGY.—

(1) IN GENERAL.—The Secretary shall establish a system of determining payments to managed care organizations contracting to provide the guaranteed national benefit package on a capitated or risk basis.

(2) USE OF MEDICARE METHODOLOGY.—Such methodology shall be based on the methodology used under section 1876 of the Social Security Act, and the payment rates shall reflect the guaranteed national benefit package and a representative population of individuals in the private sector.

(c) PAYMENT RATES.—The maximum payment rates under this section shall be equal to 95 percent of the actuarially comparable cost of providing services to individuals not enrolled with managed care organizations, consistent with maximum payment rates established under this part.

SEC. 6315. OTHER SERVICES.

In the case of services within a class of services for which a methodology for establishing maximum payment rates is not otherwise provided pursuant to the preceding provisions of this subtitle, by January 1, 1997, the Secretary shall establish an appropriate methodology for establishing such rates, taking into account the payment methodology or methodologies in use under the medicare program or other health benefit plans, including prospective payment methodologies developed and implemented under section 8002(a).

Subtitle E—Administrative and Judicial Review

SEC. 6401. LIMITATION ON ADMINISTRATIVE AND JUDICIAL REVIEW.

There shall be no administrative or judicial review of any of the following determinations:

(1) The maximum payment rates established under subtitle D, including—

(A) relative values and relative value units and conversion factors;

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof.

(2) The national private per capita estimate and the State private per capita estimate for each State.

(3) Allocation of the national private per capita estimate or a State private per capita estimate to a class of health services.

SEC. 6402. REFERENCES TO MEDICARE PROVISIONS.

In this title, except as otherwise specifically provided, any references to provisions of title XVIII of the Social Security Act are deemed to be references to such provisions as in effect on the day after the date of the enactment of the Guaranteed Health Insurance Act of 1994, taking into account the amendments made to such title by such Act.

Subtitle F—National Health Cost Commission

SEC. 6501. NATIONAL HEALTH COST COMMISSION.

(a) ESTABLISHMENT.—By not later than January 1, 1997, the President shall establish a National Health Cost Commission (in this subtitle referred to as the "Commission").

(b) COMPOSITION.—The Commission shall consist of 9 members, appointed by the President, who shall serve at the pleasure of the President. The President shall appoint members based on their expertise and national recognition in the fields of health economics, provider reimbursement, health insurance, health benefits design, and related fields. The Commission shall include individuals from diverse geographic areas and, to the greatest extent feasible, the membership of the Commission shall reflect the racial, ethnic, and gender composition of the population of the United States. In appointing members to the Commission, the President shall seek recommendations from the Speaker and majority and minority leaders of the House of Representatives and the majority and minority leaders of the Senate.

(c) DUTIES.—

(1) ANALYSES.—

(A) IN GENERAL.—The Commission shall conduct analyses of the health care cost and revenue data reported to the Secretary under section 6004.

(B) ANALYSIS OF REGIONAL VARIATION IN PER CAPITA EXPENDITURES DUE TO PRACTICE PATTERNS.—The Commission shall conduct analyses of the variations in per capita expenditures and utilization patterns among different geographic areas (that are States or sub-State areas) due to variation in practice patterns, not due to other factors (such as health care input prices and demographic factors).

(2) ANNUAL REPORTS.—Not later than April 1 of each year, beginning in 1998, the Commission shall submit a report to Congress on health care costs in the United States. The report shall include an analysis relating to each of the following:

(A) The rate of growth in health care costs, by type of provider, by type of payer, and by State.

(B) The success or failure of the private sector in maintaining health care expenditures within the national health expenditure estimates established under subtitle A on a State-by-State basis.

(C) The impact of universal coverage on health care costs and on payment for services by private payers.

(D) The future rate of growth in health care costs, based on projections of historical trends, using the same economic assumptions used by the Congressional Budget Office.

(E) The variations in per capita expenditures described in paragraph (1)(B).

(3) RECOMMENDATIONS ON CHANGES IN STATE HEALTH EXPENDITURE ESTIMATES TO ELIMINATE INAPPROPRIATE REGIONAL VARIATION.—The annual report submitted under this subsection in 1999 shall include recommendations relating to such phased-in changes in the State private sector per capita health expenditure estimates under section 6101 as the Commission determines to be appropriate to eliminate the effect of inappropriate variations described in paragraph (1)(B). In making such recommendations, the Commission shall take into account the prior success of cost containment efforts in the States and may take into account regional variations in demographic or health status and in health care input prices.

(d) SPECIAL REPORT IN 2000.—

(1) IN GENERAL.—In the report submitted under subsection (c)(2) in 2000, the Commission shall include a specific finding regarding whether a system of cost containment should be imposed on health care services provided under private health benefit plans. The finding shall be based on the most recent data available at the time of the report's preparation.

(2) RECOMMENDATIONS.—

(A) IN GENERAL.—Such report may recommend that the system of private sector cost containment provided under subtitle C be allowed to go into effect, or may recommend an alternative system.

(B) LEGISLATIVE PROPOSAL.—Any recommendations which require legislation to implement shall include a detailed legislative proposal providing for their implementation.

(C) NO CHANGES IN GUARANTEED NATIONAL BENEFIT PACKAGE.—Such recommendations shall not include any change in the guaranteed national benefit package.

(e) ADMINISTRATION.—The President shall assure such compensation, staff, and support services for the Commission as may be necessary for the Commission to carry out its duties.

SEC. 6502. EXPEDITED CONSIDERATION OF RECOMMENDATIONS AND ALTERNATIVES.

(a) INTRODUCTION AND REFERRAL.—

(1) IN GENERAL.—If—

(A) the report under section 6501(d) contains a detailed legislative proposal, and

(B) such report is accompanied by a statement (provided by the Director of the Congressional Budget Office under subsection (i)) that the system provided in the proposal meets the cost-containment objectives set forth in this Act,

the majority leader (or the leader's designee) in each House shall introduce (by request and not later than 7 days after the date of receipt by Congress of the report) the legislative proposal as a bill. The title of that bill shall be "A bill to achieve the cost containment objectives set forth in the Guaranteed Health Insurance Act of 1994, and for other purposes.".

(2) REFERRAL.—That bill shall be referred on the date of introduction to the appropriate committee (or committees) in accordance with rules of the respective Houses.

(b) DISCHARGE DEADLINE.—If any committee to which the bill is referred does not report the bill by the end of the 45-day period beginning on the date the bill was referred to the committee, the committee shall be automatically discharged from further consideration of the bill as of the end of such period.

(c) FLOOR CONSIDERATION.—

(1) HOUSE OF REPRESENTATIVES.—For the purpose of expediting consideration and passage of a measure reported or discharged under this section, it shall be in order for the Committee on Rules of the House of Representatives to report a privileged resolution providing for the consideration of the bill. Any such resolution, if it makes in order any amendments to the bill, shall make in order an amendment consisting of the text of the Commission's recommendations.

(2) SENATE.—[LANGUAGE TO BE INSERTED LATER.]

(d) NO RECOMMITTAL.—It shall not be in order to move to recommit the bill.

(e) FINAL PASSAGE.—A vote on final passage of the bill shall be taken in a House not later than the end of the 15-day period beginning on the date on which the motion to proceed to its consideration in that House has been approved.

(f) SPECIAL RULES.—If the House of Representatives approves a bill and the Senate approves a bill the text of which is identical to the text of the bill approved by the House of Representatives, the Senate is deemed to have approved the bill approved by the House of Representatives, effective on the later of—

(1) the date of approval of a bill in the Senate, or

(2) the date the Senate receives a message from the House of Representatives announcing that the House has passed the bill.

(g) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and of the Senate, respectively, or of that House to which they specifically apply and such rules supersede other rules only to the extent that they are inconsistent therewith, and

(2) with full recognition of the constitutional right of either House to change such rules (so far as relating to such House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

(h) NOT INCLUDING CERTAIN DAYS.—Days on which a House of Congress is not in session because of an adjournment of more than 3 days shall be excluded in the computation of any number of days in a period under this section with respect to that House.

(i) CONGRESSIONAL BUDGET OFFICE DETERMINATIONS.—The Director of the Congressional Budget Office, upon request of the Commission or an appropriate committee, shall—

(1) review any bill to be proposed by the Commission or the committee to determine if the system of health care cost containment reflected in the bill would meet the cost-containment objectives set forth in this Act, and

(2) provide a written statement of such determination.

TITLE VII—PUBLIC HEALTH INITIATIVES

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PART 1—NATIONAL PLAN REGARDING PHYSICIANS AND OTHER HEALTH PROFESSIONALS

Subpart A—National Plan; General Provisions

SEC. 7001. DEVELOPMENT OF PLAN.

(a) IN GENERAL.—

(1) DEVELOPMENT OF PLAN.—The Secretary shall develop and carry out in accordance with this part a plan for the applicable period to be known as the National Health Care Workforce Plan.

(2) PURPOSE.—The purpose of the Plan shall be to establish a national goal for the United States of developing a health care workforce whose composition reflects the needs of the United States for practitioners in the various health professions, including the need for practitioners in primary health care.

(3) DEFINITIONS.—For purposes of this subtitle:

(A) The term "applicable period" means the academic years designated by the Secretary as the years to which a plan under paragraph (1) is to apply, except that the initial applicable period shall be the academic years 1998 through 2002.

(B) The term "academic year" means the 1-year period beginning on July 1. The academic year beginning July 1, 1998, is academic year 1998.

(C) The term "Plan" means the plan under paragraph (1) for the applicable period involved.

(b) PROVISIONS REGARDING HEALTH PROFESSIONALS OTHER THAN PHYSICIANS.—With respect to health professionals other than physicians, the Secretary shall in carrying out subsection (b) ensure that, for the academic years of the applicable period, the Plan—

(1) establishes recommendations for national goals regarding the number and variety of such professionals that should be trained (including goals regarding nurse practitioners and other advanced practice nurses); and

(2) provides recommendations for encouraging the training of such professionals in accordance with the goals.

(c) PROVISIONS REGARDING PHYSICIANS.—

(1) IN GENERAL.—With respect to physicians, the Secretary shall develop the Plan in accordance with subpart B.

(2) APPLICABILITY OF CERTAIN REQUIREMENTS.—Subsections (e) through (g) apply both to provisions of the Plan that relate to physicians and to provisions of the Plan that relate to other health professionals.

(d) PERIODIC REVIEW AND REVISION OF PLAN.—With respect to the discretion provided in this part to the Secretary for the development and administration of the Plan, the Secretary shall periodically review the Plan, and shall revise the Plan to the extent determined by the Secretary to be appropriate.

(e) CONSIDERATION OF PROJECTED NUMBERS OF PROFESSIONALS.—In developing and revising the Plan, the Secretary shall take into account projections of the health care needs of the United States.

(f) CONSULTATIONS.—In developing and revising the Plan, the Secretary shall consult with the advisory council established under section 7011, consumers, experts in health workforce needs, teaching physicians, physicians in private practice, nurses, representatives of health insurers (including health maintenance organizations and other managed care plans), other organizations representing physicians, organizations involved in the accreditation of residency training programs, and organizations involved in the certification of practitioners.

(g) REPORT TO CONGRESS.—Not later than June 30, 1996, the Secretary shall submit to the Congress a final report describing the contents of the initial Plan. The report shall include an analysis of the impact on teaching hospitals and other training sites of limiting support for training, consistent with the Plan. The Secretary may submit interim reports regarding any component of the Plan (regardless of whether the Secretary has prepared other components).

Subpart B—National Plan; Provisions Regarding Physicians

SEC. 7011. NATIONAL ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.

(a) In General.—There is established within the Department of Health and Human Services an advisory council to be known as the National Advisory Council on Graduate Medical Education (in this subtitle referred to as the "Council").

(b) Duties.—The Council shall provide advice to the Secretary on carrying out this subpart. In providing such advice, the Council shall develop and submit to the Secretary a proposal for the components of the Plan under section 7001 that relate to physicians (including the provisions of the Plan required in sections 7012 and 7013).

(c) Composition.—

(1) In general.—The Secretary shall appoint to the Council 15 individuals who are not officers or employees of the United States. Such individuals shall include not less than 1 individual from each of the following categories of individuals or entities:

(A) Organizations representing consumers of health care services.

(B) Physicians who are faculty members of medical schools (as defined in section 7012(f)), or who supervise approved physician training programs (as so defined).

(C) Physicians in private practice who are not physicians described in subparagraph (B).

(D) Practitioners in public health.

(E) Medical schools.

(F) Teaching hospitals.

(G) Certified health plans (as defined in section 2).

(H) The Accreditation Council on Graduate Medical Education.

(I) The American Board of Medical Specialities.

(J) The Council on Postdoctoral Training of the American Osteopathic Association.

(K) The Council on Podiatric Medical Education of the American Podiatric Medical Association.

(2) Requirements regarding representative membership.—To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States, shall reflect the racial, ethnic, and gender composition of the population of the United States, and shall be broadly representative of medical schools and teaching hospitals in the United States.

(3) Ex officio members; other federal officers or employees.—The membership of the Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary (or by other Federal officers who are appointed by the President with the advice and consent of the Senate). Individuals designated under the preceding sentence shall include each of the following officials (or a designee of the official):

(A) The Secretary of Health and Human Services.

(B) The Secretary of Veterans Affairs.

(C) The Secretary of Defense.

(d) Chair.—The Secretary shall, from among members of the Council appointed under subsection (c)(1), designate an individual to serve as the Chair of the Council.

(e) Termination.—The Council terminates December 31, 1999.

SEC. 7012. ANNUAL DESIGNATION OF AUTHORIZED PER-SPECIALTY NUMBER OF SPECIALTY POSITIONS; REQUIREMENTS REGARDING PRIMARY HEALTH CARE.

(a) Annual Authorization of Number of Positions Per Specialty.—With respect to physicians, the Secretary shall in carrying out section 7001 ensure that, for each medical specialty, the Plan designates, for each of the academic years of the applicable period, the number of individuals nationwide who are authorized to be enrolled in approved physician training programs in the specialty for the academic year involved, including a designation of the number of individuals who are authorized to enter the programs for such year. The Secretary may, under section 7001(d), change a number designated under the preceding sentence for an academic year to reflect changing needs for physicians in the various medical specialties.

(b) Primary Health Care.—

(1) Requirement across specialties.—In designating the per-specialty annual numbers of positions for all medical specialties for academic year 2002 or any subsequent academic year, the Secretary shall ensure that, of the class of training participants entering approved physician training programs for the year, the percentage that enters such programs in primary health care is not less than 55 percent, subject to the following:

(A) The Secretary, in order to provide a period of transition regarding such requirement, shall establish a lesser percentage for each of the academic years 1998 through 2001.

(B) The Secretary may change the percentage specified in the Plan for any academic year to reflect changing needs for physicians in the various medical specialties.

(2) Rules of construction.—For purposes of the requirement of paragraph (1) (relating to a percentage):

(A) The requirement applies in the aggregate to all training participants in approved physician training programs for the academic year involved, and not individually to any such program.

(B) In the case of approved physician training programs in a medical specialty participation in which is a prerequisite to participation in approved physician training programs in another medical specialty, the Secretary shall apply the requirement of paragraph (1) as follows:

(i) The Secretary shall periodically make an estimate, by specialty, of the average number of training participants in such prerequisite programs who subsequently enter the other programs.

(ii) In designating the per-specialty annual numbers of positions for such prerequisite programs, the Secretary shall consider such estimates in order to ensure that the numbers designated for the programs reasonably reflect the needs of the United States for practitioners in the medical specialities for which the programs provide training.

(3) Exclusion from determination.—Specialty positions in approved physician training programs in podiatric medicine shall be excluded from determinations under paragraph (1) (both determinations regarding the number of entering positions in specialties in primary health care and the number of entering positions in other specialities).

(c) Certain Considerations in Designating Annual Numbers.—Factors considered by the Secretary in designating a per-specialty annual number of positions for an academic year shall include the extent to which there is a need for additional practitioners in the medical specialty involved. In carrying out the preceding sentence, the Secretary shall consider, among other factors determined by the Secretary to be relevant, the incidence and prevalence (in the general population and in various other populations) of the diseases, disorders, or other health conditions with which the specialty is concerned.

(d) Definitions.—

(1) Approved program.—For purposes of this subtitle:

(A) The term "approved physician training program", with respect to the medical specialty involved, means (subject to subparagraph (C)) a residency or other postgraduate program that trains physicians and meets the conditions described in clause (i), or the conditions described in clause (ii), as follows:

(i) The conditions described in this clause are that—

(I) participation in the program may be counted toward certification in the medical specialty, as determined under the applicable standards of the American Board of Medical Specialities or the Council on Postdoctoral Training of the American Osteopathic Association; and

(II) the program is accredited by the Accreditation Council on Graduate Medical Education or approved by the Council on Postdoctoral Training of the American Osteopathic Association.

(ii) The conditions described in this clause are that—

(I) the program meets the condition described in subclause (I) of clause (i), or the condition described in subclause (II) of such clause, but not both; and

(II) the Secretary designates the program as an approved physician training program for purposes of this subtitle.

(B) The term "approved physician training program" includes any postgraduate program meeting the conditions described in clause (i) or (ii) in subparagraph (A), including such a program that provides health services in an ambulatory setting (regardless of whether the program provides inpatient hospital services).

(C) The term "approved physician training program" includes (notwithstanding subparagraphs (A) and (B)) each program that receives payments under section 1886(h) of the Social Security Act as an approved medical residency training program.

(2) Other definitions.—For purposes of this subtitle:

(A) The term "medical school" means a school of medicine (as defined in section 799 of the Public Health Service Act) or a school of osteopathic medicine (as so defined).

(B) The term "medical specialty" includes all medical, surgical, and other physician specialties and subspecialties.

(C) The term "per-specialty annual number of positions", with respect to a medical specialty, means the number designated by the Secretary under subsection (a) for approved physician training programs for the academic year involved.

(D) The term "primary health care" means the following medical specialties: Family medicine, general internal medicine, general pediatrics, geriatrics, preventive medicine, osteopathic general practice, and obstetrics and gynecology.

(E) The term "specialty position" means a position as a training participant.

(F) The term "training participant" means an individual who is enrolled in an approved physician training program.

SEC. 7013. ALLOCATIONS AMONG SPECIALITIES AND PROGRAMS.

(a) Provisions in National Plan.—

(1) In general.—With respect to physicians, the Secretary shall in carrying out

section 7001 ensure that the Plan specifies that the per-specialty annual number of positions designated under section 7012 for a medical specialty for an academic year is to be allocated among approved physician training programs in the specialty.

(2) METHODOLOGY FOR PROGRAM BY PROGRAM IMPLEMENTATION OF PLAN.—In developing the Plan, the Secretary shall develop a methodology for annually allocating among the approved physician training programs in a medical specialty the per-specialty annual number of positions that the Secretary has designated for the academic year involved. The Secretary shall include among the factors upon which the methodology is based the following:

(A) The geographic distribution of physicians.

(B) The historical distribution of specialty positions among the various geographic areas of the United States.

(C) The extent to which the approved physician training programs of a hospital directly provide health services to patients of the hospital.

(D) The extent to which a reduction in the allocation of specialty positions for such programs of a hospital will have an adverse effect on the financial capacity of the hospital to maintain a level of health services equivalent to the level the hospital would provide in the absence of the reduction.

(E) The quality of physician training programs.

(F) The need to train physicians in sites other than hospitals, as appropriate to the specialty involved.

(G) The need to encourage the training of minority physicians.

(H) The need for appropriate opportunities for training in osteopathic specialities.

(I) The extent to which graduates of an approved physician training program are practicing in underserved rural and urban areas.

(J) The extent to which an approved physician training program provides training under the program in underserved rural and urban areas, including training provided at health facilities provided for under Public Law 94-437.

(3) DEFINITION.—For purposes of this subtitle, the term "underserved", with respect to a rural or urban area, means a health professional shortage area as defined in section 332(a)(1) of the Public Health Service Act.

(b) ANNUAL ALLOCATIONS BY SECRETARY.—

(1) IN GENERAL.—For academic year 1998 and each subsequent academic year, the Secretary shall for each medical specialty make allocations among approved physician training programs of the per-specialty annual number of positions designated for the academic year involved. The preceding sentence is subject to section 7031 (relating to qualifying physician training consortia).

(2) USE OF PLAN METHODOLOGY.—In making allocations under paragraph (1), the Secretary shall use the methodology developed under subsection (a)(2), with such modifications in the methodology as the Secretary may make under section 7001(d).

(c) ADVANCE NOTICE TO PROGRAMS.—The Secretary shall notify each approved physician training program of the allocation to be made for the program under subsection (b) for an academic year not later than October 1 of the preceding academic year.

(d) EXCLUSIONS FROM ALLOCATION SYSTEM.—

(1) IN GENERAL.—The Secretary shall exclude from the applicability of this section any specialty position filled by a training participant described in paragraph (2). Such positions in an approved physician training program are in addition to specialty positions allocated to the program under subsection (b).

(2) RELEVANT TRAINING PARTICIPANTS.—For purposes of paragraph (1) and other provisions of this subtitle, a training participant described in this paragraph is such a participant who, through a program carried out jointly by a medical school and another accredited educational entity, has received both—

(A) a doctorate of medicine; and

(B) a doctorate of philosophy, or an equivalent degree.

PART 2—PAYMENTS TO TEACHING HOSPITALS

SEC. 7021. FORMULA PAYMENTS REGARDING PRIVATE-SECTOR SHARE OF COSTS OF GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—In the case of each teaching hospital that in accordance with section 7023 submits to the Secretary an application for calendar year 1996 or any subsequent calendar year (referred to in this part as an "eligible hospital" for the year involved), the Secretary shall in accordance with section 7024 make payments for such year to the hospital, and shall in accordance with such section make adjustments in maximum payment rates for the hospital. The preceding sentence is subject to section 7031 (relating to qualifying physician training consortia).

(b) DEFINITIONS.—For purposes of this subtitle, the term "teaching hospital" means any hospital that receives payments under subsection (d)(5)(B) or (h) of section 1886 of the Social Security Act (relating to graduate medical education).

SEC. 7022. AGREEMENT REGARDING COMPLIANCE WITH ALLOCATION SYSTEM.

With respect to the approved physician training programs of a teaching hospital, the Secretary may make payments under section 7021 for the programs only if the hospital agrees to ensure that the numbers of individuals enrolled in the programs is in accordance with allocations made under section 7013 for the programs.

SEC. 7023. APPLICATION FOR PAYMENTS.

(a) IN GENERAL.—For purposes of section 7021(a), an application for payments under such section for a calendar year is in accordance with this section if—

(1) the application is submitted not later than the date specified by the Secretary;

(2) the application contains the agreement required in section 7022; and

(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(b) CONSOLIDATION WITH APPLICATION UNDER PART 3.—The Secretary may establish procedures through which teaching hospitals simultaneously apply for payments under section 7021 and 7041.

SEC. 7024. ANNUAL AMOUNT OF PAYMENTS.

(a) IN GENERAL.—From amounts in the Health Care Workforce Trust Fund under section 9512 of the Internal Revenue Code of 1986, the Secretary shall, subject to section 7025, make payments under section 7021 to an eligible hospital for a calendar year as follows:

(1) Payments, made on a periodic basis, whose sum is equal to the amount determined under subsection (c) for the hospital for the year (which amount relates to the direct costs for graduate medical education attributable to certain individuals).

(2) Payments (in addition to payments under paragraph (1)), made on a periodic basis, whose sum is equal to the amount determined under subsection (d) for the hospital for the year (which amount relates to the per discharge indirect costs of the hospital for graduate medical education attributable to certain individuals).

Payments under paragraph (1) are effective for portions of cost reporting periods occurring on or after January 1, 1996. Payments under paragraph (2) are effective for patient discharges occurring on or after such date.

(b) RELATIONSHIP OF PAYMENTS TO ALLOCATION OF SPECIALTY POSITIONS.—On and after July 1, 1998, the Secretary, in making determinations under subsections (c) and (d) for the payments required in paragraphs (1) and (2) of subsection (a) for an eligible hospital, shall count only training participants who are in a specialty position that, under section 7013, has been allocated to an approved physician training program of the hospital. In the case of payments under paragraph (1) of subsection (a), the preceding sentence is effective for portions of cost reporting periods occurring on or after such date; and in the case of payments under paragraph (2) of such subsection, the sentence is effective for patient discharges occurring on or after such date.

(c) AMOUNT OF PAYMENTS; DIRECT COSTS.—

(1) IN GENERAL.—For purposes of paragraph (1) of subsection (a), the amount determined under this subsection for an eligible hospital for a calendar year is the product of—

(A) the aggregate nonmedicare training amount for the hospital, as defined in paragraph (2); and

(B) the direct-cost Fund payout percentage, as defined in paragraph (4).

(2) AGGREGATE NONMEDICARE TRAINING AMOUNT.—For purposes of this subtitle, the term "aggregate nonmedicare training amount", with respect to the eligible hospital involved, means (subject to paragraph (3)(D)) an amount equal to the product of subparagraphs (A) and (B), as follows:

(A) Subject to section 7025(b), the number of full-time-equivalent training participants in the approved physician training programs of the hospital for the academic year in which the calendar year begins (including training participants described in section 7013(d)(2)).

(B) An amount equal to the product of—

(i) the national average FTE training amount, as defined in paragraph (3); and

(ii) a percentage equal to 1 minus the medicare patient load of the hospital (determined under section 1886(h)(3)(C) of the Social Security Act) for the cost reporting period involved, except that the determination of the medicare patient load for purposes of this clause shall include (in addition to the patients included under such section) patients enrolled in the program under title XXI of such Act.

(3) NATIONAL AVERAGE FTE TRAINING AMOUNT.—

(A) IN GENERAL.—For purposes of this subtitle, the term "national average FTE training amount" means the national average of the costs per training participant for all approved physician training programs and all medical specialities, which average shall be derived from the per-resident approved FTE resident amounts in effect for hospitals under section 1886(h) of the Social Security Act for academic year 1992 (as adjusted under subparagraphs (B) and (C)). The weighting factor applied pursuant to paragraph (4)(C) of such section shall be the weighting factor in effect under such paragraph on the day before the date of the enactment of this Act.

(B) ANNUAL ADJUSTMENTS PER CONSUMER PRICE INDEX.—The national average applicable under subparagraph (A) for a calendar year for such programs is, subject to subparagraph (C), the amount determined under subparagraph (A) increased by the amount necessary to offset the effects of inflation occurring since academic year 1992, as determined through use of the consumer price index.

(C) INDIVIDUAL ADJUSTMENTS PER AREA WAGE INDEX.—The national average determined under subparagraph (A) and adjusted under subparagraph (B) for a calendar year shall, in the case of the approved physician training programs of the eligible hospital involved, be adjusted by a factor to reflect regional differences in wage and wage-related costs, as determined in accordance with the area wage index applicable (as of the beginning of such year) to hospitals in the labor-market area involved, as determined under section 1886(d)(3)(E) of the Social Security Act.

(D) ALTERNATIVE RULE FOR CERTAIN HOSPITALS.—

(i) ELECTION FOR APPLICABILITY OF RULE.—In the case of an eligible hospital for which the election under section 1861(b)(7) of the Social Security Act was in effect on July 1, 1994, and has remained in effect continuously from such date, the following applies:

(I) The hospital may, with respect to the determination under paragraph (2) of the aggregate nonmedicare training amount for the hospital, elect to have the alternative rule described in clause (ii) applied to the hospital.

(II) If the election under such section 1861(b)(7) ceases to be in effect, any election made by the hospital under subclause (I) is terminated.

(III) If the hospital has made the election under subclause (I) and subsequently requests that the election be terminated, the Secretary shall approve the request. Upon the approval of the request, the hospital may not subsequently elect to have the alternative rule applied to the hospital.

(ii) DESCRIPTION OF ALTERNATIVE RULE.—With respect to a determination under paragraph (2) of the aggregate nonmedicare training amount for an eligible hospital that has made the election under clause (i), the alternative rule described in this clause is as follows:

(I) In lieu of the applicability of the national FTE training amount (for purposes of paragraph (2)(B)(i)), the Secretary shall apply an amount equal to the approved FTE resident amount in effect for the hospital under section 1886(h)(2) of the Social Security Act.

(II) Subject to the modification applied under subclause (I), the Secretary shall determine an amount under paragraph (2).

(III) The Secretary shall determine an amount equal to the product of the percentage determined under paragraph (2)(B)(ii) and the amount of the physician costs of services recognized under section 1861(v)(1) of the Social Security Act pursuant to the election of the hospital under section 1861(b)(7) of such Act.

(IV) In lieu of the applicability of the aggregate nonmedicare training amount (for purposes of paragraph (1)(A)), the Secretary shall apply an amount equal to the sum of the amount determined under subclause (II) and the amount determined under subclause (III).

(4) DIRECT-COST FUND PAYOUT PERCENTAGE.—For purposes of this subtitle, the term "direct-cost Fund payout percentage", with respect to the calendar year involved, means a percentage equal to the ratio of—

(A) the amount available in the Health Care Workforce Trust Fund for such year (as estimated by the Secretary); to

(B) an amount equal to the sum of clauses (i) through (iv), as follows:

(i) The total amount of payments under subsection (a)(1) that would be made to eligible hospitals for such year if each hospital received, pursuant to paragraph (1), 100 percent of the aggregate nonmedicare training amount determined for the hospital.

(ii) The total of the amounts determined under subsection (d) of section 7041 for such year for teaching hospitals eligible for payments under such section.

(iii) The total of the amounts determined for such year for grants under section 848 of the Public Health Service Act (relating to graduate nursing education).

(iv) The total of the amounts determined for such year for grants under section 741 of such Act (relating to medical schools).

(d) AMOUNT OF PAYMENTS; INDIRECT COSTS.—

(1) IN GENERAL.—For purposes of paragraph (2) of subsection (a), the amount determined under this subsection for an eligible hospital for a calendar year is the product of—

(A) an amount equal to the sum of the nonmedicare per-discharge supplemental payments, as defined in paragraph (2); and

(B) the indirect-cost Fund payout percentage, as defined in paragraph (3).

(2) NONMEDICARE PER-DISCHARGE SUPPLEMENTAL PAYMENT.—

(A) IN GENERAL.—For purposes of this subtitle, the term "nonmedicare per-discharge supplemental payment", with respect to a calendar year, means a payment made to an eligible hospital for a discharge during the year of a patient described in subparagraph (B), the amount of which payment is determined in accordance with subparagraph (C).

(B) RELEVANT PATIENTS.—For purposes of subparagraph (A), a patient described in this subparagraph is a patient who is not—

(i) entitled to benefits under part A of title XVIII of the Social Security Act;

(ii) enrolled in the health insurance program under title XXI of such Act; or

(iii) eligible for medical assistance under title XIX of such Act.

(C) AMOUNT OF PER-DISCHARGE PAYMENT.—For purposes of subparagraph (A), the amount of the payment under such subparagraph for the discharge of a patient described in subparagraph (B) is the product of—

(i) an amount equal to the maximum payment rate determined for the discharge under subsection (a)(2)(A) of section 6311, except that for purposes of this clause, the determination under such subsection shall be made without the adjustments described in paragraphs (3) through (5) of subsection (d) of such section; and

(ii) the percentage applicable to the hospital under section 1886(d)(5)(B)(ii) of the Social Security Act.

(3) INDIRECT-COST FUND PAYOUT PERCENTAGE.—For purposes of this subtitle, the term "indirect-cost Fund payout percentage", with respect the calendar year involved, means a percentage equal to the ratio of—

(A) the amount available in the Health Care Workforce Trust Fund for such year remaining after payments for the year have been made under subsection (a)(1), under section 7041, and under sections 848 and 741 of the Public Health Service Act (as such amount is estimated by the Secretary); to

(B) the total amount of payments under subsection (a)(2) that would be made to eligible hospitals for such year if each hospital received, pursuant to paragraph (1), 100 percent of an amount equal to the sum of the nonmedicare per-discharge supplemental payments determined for the hospital.

(e) OFFSET REGARDING SHORTFALL IN FUND PAYMENTS; INCREASE IN MAXIMUM PAYMENT RATES UNDER TITLE VI.—

(1) SHORTFALL IN DIRECT-COST PAYMENTS.—

(A) IN GENERAL.—In the case of an eligible hospital, for any calendar year for which the direct-cost Fund payout percentage is less than 100 percent, the Secretary shall increase, by the amount determined under subparagraph (B), the maximum payment rate otherwise applicable to a discharge under subtitle D of title VI for inpatient services furnished by the hospital. The amount so determined shall be applied uniformly to each discharge from the hospital. This paragraph is subject to paragraph (3).

(B) AMOUNT OF INCREASE.—For purposes of subparagraph (A), the amount of the increase per discharge for a calendar year for an eligible hospital is the product of—

(i) a percentage equal to 1 minus the direct-cost Fund payout percentage; and

(ii) the applicable per discharge training amount for the hospital, as defined in subparagraph (C).

(C) APPLICABLE PER DISCHARGE TRAINING AMOUNT.—For purposes of this subtitle, the term "applicable per discharge training amount", with respect to the eligible hospital involved and the calendar year involved, means an amount equal to the quotient of—

(i) the aggregate nonmedicare training amount for the hospital, as determined under subsection (c)(1)(A); divided by

(ii) the average annual number of discharges of patients described in subsection (d)(2)(B) during the most recent 3-year period (as determined by the Secretary on the basis of the most recent data available to the Secretary).

(2) SHORTFALL IN INDIRECT-COST PAYMENTS.—

(A) IN GENERAL.—In the case of an eligible hospital, for any calendar year for which the indirect-cost Fund payout percentage is less than 100 percent, the Secretary shall increase, by the amount determined under subparagraph (B), the maximum payment rate per discharge otherwise established under section 6311 with respect to the discharge. The preceding sentence is subject to paragraph (3).

(B) AMOUNT OF INCREASE.—For purposes of subparagraph (A), the amount of the per discharge increase for an eligible hospital for a calendar year is the product of—

(i) a percentage equal to 1 minus the indirect-cost Fund payout percentage; and

(ii) an amount equal to the amount applicable under subsection (d)(2)(C)(i) to the discharge multiplied by the percentage applicable to the hospital under section 1886(d)(5)(B)(ii) of the Social Security Act.

(3) RELATIONSHIP OF RATE INCREASES TO ALLOCATIONS OF SPECIALTY POSITIONS.—Effective for patient discharges occurring on or after July 1, 1998, the Secretary, in making determinations under paragraphs (1) and (2) of increases in amounts, shall count only training participants who are in a specialty position that, under section 7013, has been allocated to an approved physician training program.

(f) PUBLICATION OF FUND PAYOUT PERCENTAGES AND ADJUSTMENTS IN MAXIMUM PAYMENT RATES.—The Secretary shall include in the publication of the final maximum payment rates for a calendar year under section 6301(a)—

(1) the direct-cost Fund payout percentage;

(2) the indirect-cost Fund payout percentage; and

(3) the hospital-specific adjustments in such rates determined under paragraph (1) or (2) of subsection (e).

(g) DEFINITIONS.—For purposes of this subtitle, the term "full-time-equivalent training participant" means a full-time equivalent resident of the hospital as determined under section 1886(h)(4) of the Social Security Act for the cost reporting period involved.

SEC. 7025. TRANSITIONAL PROVISIONS REGARDING DIRECT-COST PAYMENTS.

(a) PAYMENT BLEND.—For each of the calendar years 1996 through 1998, in the case of an eligible hospital (other than an eligible hospital making the election under section 7024(c)(3)(D)), the amount required in section 7024(a)(1) to be paid to the hospital is the sum of paragraphs (1) and (2), as follows (as applicable to the calendar year involved):

(1) An amount determined in accordance with section 7024(c) except that, in lieu of applying the national FTE training amount (for purposes of paragraph (2)(B)(i) of such section), the Secretary shall apply the following:

(A) For calendar year 1996, an amount equal to 75 percent of the approved FTE resident amount in effect for the hospital under section 1886(h)(2) of the Social Security Act.

(B) For calendar year 1997, an amount equal to 50 percent of such resident amount.

(C) For calendar year 1998, an amount equal to 25 percent of such resident amount.

(2) An amount determined in accordance with section 7024(c) except that, in lieu of applying 100 percent of the national FTE training amount (for purposes of paragraph (2)(B)(i) of such section), the Secretary shall apply the following:

(A) For calendar year 1996, an amount equal to 25 percent of such training amount.

(B) For calendar year 1997, an amount equal to 50 percent of such training amount.

(C) For calendar year 1998, an amount equal to 75 percent of such training amount.

(b) TRANSITIONAL LIMIT ON NUMBER OF FTES.—In determining the number of full-time-equivalent training participants under section 7024(c)(2)(A) for a hospital, for the period beginning on January 1, 1996 and ending on June 30, 1998, such number may not exceed the number of full-time equivalent residents determined with respect to the hospital under section 1886(h)(4) of the Social Security Act for portions of cost-reporting periods during the academic year 1994.

SEC. 7026. RULE OF CONSTRUCTION REGARDING MEDICARE AMENDMENTS.

Except as otherwise provided in this subtitle:

(1) A reference in this title to title XVIII of the Social Security Act shall be considered to be a reference to such title as in effect on the day after the date of the enactment of this Act, without regard to any amendment subsequently made to such title XVIII.

(2) For purposes of paragraph (1), an amendment to such title XVIII that is made by this Act as of the day referred to in such paragraph applies to this title upon the amendment taking effect, without regard to whether the date on which the amendment takes effect is after the day referred to in such paragraph.

PART 3—QUALIFYING PHYSICIAN TRAINING CONSORTIA

SEC. 7031. SPECIAL RULES REGARDING ALLOCATION OF SPECIALTY POSITIONS AND RECEIPT OF DIRECT-COST PAYMENTS.

(a) IN GENERAL.—In the case of a qualifying physician training consortium (as defined in subsection (b))—

(1) the Secretary may make allocations under section 7013 to the consortium in the aggregate in lieu of making the allocations individually to the approved physician training programs of the consortium; and

(2) if the Secretary makes allocations to the consortium pursuant to paragraph (1)—

(A) the Secretary shall make payments under sections 7024(a)(1) and 7041 to the consortium in the aggregate in lieu of making the payments individually to the teaching hospitals of the consortium; and

(B) the payments shall be made on the basis of the amount of the payments that otherwise would have been made to the hospitals, adjusted through averaging the criteria that under sections 7024(a)(1) and 7041 do not apply uniformly to teaching hospitals and through weighting such averages according to the extent to which the data that form the basis of such criteria apply to the hospitals of the consortium.

(b) DEFINITION.—For purposes of this subtitle, the term "qualifying physician training consortium" means a group of teaching hospitals meeting the following conditions:

(1) The hospitals of the group have entered into an agreement under which a consortium is established, and the purposes of the consortium include the purposes specified in subsection (c).

(2) The hospitals of the consortium include not less than 2 teaching hospitals, and—

(A) with respect to allocations under section 7013, all of the approved physician training programs of the hospitals participate in the consortium; and

(B) with respect to any entity (other than an entity that is part of any of the hospitals of the consortium) at whose facilities any of the hospitals conducts a significant amount of training under such programs, each of such entities participates in the consortium.

(3) For the academic year preceding the academic year for which the allocations are to be made pursuant to subsection (a), or for academic year 1994, the aggregate number of training participants of the consortium who were entering their first approved physician training program was not less than 50.

(4) The consortium submits to the Secretary an application in accordance with subsection (d) for designation as a qualifying physician training consortium, and the Secretary approves the application.

(c) PURPOSES OF CONSORTIUM.—The purposes referred to in subsection (b)(1) regarding a consortium are as follows:

(1) The approved physician training programs of the consortium collaborate in the provision of training under the programs.

(2) With respect to an aggregate allocation for a medical specialty that is made to the consortium pursuant to subsection (a)(1), the consortium designates the number of specialty positions to be received by each of the approved physician training programs of the consortium in the specialty.

(3) With respect to aggregate payments that are made to the consortium pursuant to subsection (a)(2), the consortium allocates the payments among each of the teaching hospitals of the consortium.

(4) Such other purposes as the Secretary determines to be appropriate.

(d) APPLICATION FOR CONSORTIUM STATUS.—

(1) IN GENERAL.—For purposes of subsection (b)(4), an application under this subsection for designation as a qualifying physician training consortium for a calendar year is in accordance with this subsection if—

(A) the application is submitted not later than the date specified by the Secretary;

(B) the application demonstrates that the teaching hospitals involved meet the conditions described in paragraphs (1) through (3) of subsection (b);

(C) the application contains an agreement described in section 7022 from each of the teaching hospitals; and

(D) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(2) RELATION TO REQUIREMENT OF INDIVIDUAL APPLICATIONS.—If a group of teaching hospitals submits to the Secretary an application in accordance with paragraph (1) for a calendar year, and the Secretary approves the application, each of the hospitals shall be considered to have submitted an application in accordance with section 7023 (and accordingly, each of the hospitals is an eligible hospital for the year for purposes of part 2).

PART 4—TRANSITIONAL PAYMENTS FOR TEACHING HOSPITALS LOSING SPECIALTY POSITIONS

SEC. 7041. TRANSITIONAL PAYMENTS TO TEACHING HOSPITALS.

(a) PAYMENTS REGARDING EFFECTS OF ALLOCATION OF SPECIALTY POSITIONS.—In the case of each hospital that in accordance with subsection (c) submits to the Secretary an application for calendar year 1998 or any subsequent calendar year (in this section referred to as an 'eligible hospital' for the year involved), the Secretary shall make payments for the year to the hospital in an amount determined in accordance with subsection (d). Such payments shall be made from amounts in the Health Care Workforce Trust Fund under section 9512 of the Internal Revenue Code of 1986.

(b) HOSPITALS LOSING SPECIALTY POSITIONS; OTHER CONDITIONS.—

(1) HOSPITALS LOSING SPECIALTY POSITIONS.—

(A) IN GENERAL.—The Secretary may make payments under subsection (a) to a teaching hospital for a calendar year only if, as a result of allocations under 7013, the aggregate number of full-time-equivalent specialty positions for the hospital for the academic year in which the calendar year begins (as estimated by the Secretary) is below the aggregate number of such positions for the hospital for academic year 1993.

(B) AGGREGATE NUMBER OF SPECIALTY POSITIONS LOST.—For purposes of this section:

(i) The term "aggregate number of specialty positions lost", with respect to a teaching hospital and an academic year, means the difference between the 2 aggregate numbers determined by the Secretary under subparagraph (A) for the hospital.

(ii) The term "lost position", with respect to an academic year, means a full-time-equivalent specialty position counted in the determination under clause (i) of the aggregate number of specialty positions lost for the year.

(2) COMPLIANCE WITH ALLOCATION SYSTEM.—With respect to the approved physician training programs of a teaching hospital, the Secretary may make payments under subsection (a) only if the hospital agrees to ensure that the numbers of individuals enrolled

in the programs is in accordance with allocations made under section 7013 for the programs.

(c) APPLICATION FOR PAYMENTS.—For purposes of subsection (a), an application for payments under such subsection for a teaching hospital is in accordance with this subsection if—

(1) the hospital submits the application not later than the date specified by the Secretary;

(2) the application demonstrates that the hospital meets the condition described in subsection (b)(1)(A);

(3) the application contains each agreement required in this section; and

(4) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary.

(d) AMOUNT OF PAYMENTS.—The amount of payments required in subsection (a) to be made to an eligible hospital for a calendar year is an amount equal to the product of paragraphs (1) and (2), as follows:

(1) An amount equal to the product of—

(A) the aggregate lost position amount, as defined in subsection (e) for the academic year; and

(B) 1 minus the medicare patient load of the hospital (determined under section 1886(h)(3)(C) of the Social Security Act) for the cost reporting period involved, except that the determination of the medicare patient load for purposes of this subparagraph shall include (in addition to the patients included under such section) patients enrolled in the program under title XXI of such Act.

(2) The direct-cost Fund payout percentage under section 7024(c)(4).

(e) AGGREGATE LOST POSITION AMOUNT.—

(1) FIRST YEAR OF RECEIVING PAYMENTS.—For purposes of subsection (d)(1)(A), the term "aggregate lost position amount", with respect to the first calendar year for which an eligible hospital receives payments under subsection (a), means an amount equal to the product of—

(A) the aggregate number of specialty positions lost (as defined in subsection (b)(1)(B)); and

(B) an amount equal to 100 percent of the national average FTE training amount in effect for the year under section 7024(c)(3) (or, as the case may be, 100 percent of the alternative amount that applies to the hospital under section 7024(c)(3)(D) or section 7025).

(2) SUBSEQUENT YEARS OF PAYMENT.—For purposes of subsection (d)(1)(A), the term "aggregate lost position amount", with respect to the second or subsequent calendar year for which an eligible hospital receives payments under subsection (a), means an amount equal to the sum of subparagraphs (A) through (D), as follows:

(A) An amount equal to the product of—

(i) the aggregate number of specialty positions lost, less an amount equal to the sum of—

(I) the number of lost positions for which payments are being made for the calendar year pursuant to subparagraphs (B) through (D); and

(II) the total number of lost positions for which, in determinations under this subsection for the hospital for prior calendar years, the percentage applicable to the national average or alternative amount referred to in paragraph (1)(B) was 25 percent; and

(ii) 100 percent of such national average or alternative amount applicable for the year involved.

(B) An amount equal to the product of—

(i) the number of lost positions for which, in the determination under this subsection for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 100 percent, subject to paragraph (3) (relating to decreases in aggregate numbers); and

(ii) 75 percent of the national average or alternative amount applicable for the year involved.

(C) An amount equal to the product of—

(i) the number of lost positions for which, in the determination under this subsection for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 75 percent, subject to paragraph (3); and

(ii) 50 percent of the national average or alternative amount applicable for the year involved.

(D) An amount equal to the product of—

(i) the number of lost positions for which, in the determination under this subsection for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 50 percent, subject to paragraph (3); and

(ii) 25 percent of the national average or alternative amount applicable for the year involved.

(3) RULE REGARDING DECREASE IN AGGREGATE NUMBER OF SPECIALTY POSITIONS LOST.—With respect to payments under subsection (a) for an eligible hospital for a calendar year, if the aggregate number of specialty positions lost for the academic year involved is less than such number for the preceding academic year (which difference between the 2 aggregate numbers is referred to in this paragraph as the "decrease in the number of lost positions"), the following applies:

(A) The Secretary shall identify the number of lost positions for which, as determined under paragraph (2) without regard to this paragraph, the percentage applicable to payments for the calendar year is 75 percent, the number of such positions for which such percentage is 50 percent, and the number of such positions for which such percentage is 25 percent.

(B) In the case of the lost positions so identified, the Secretary shall apply the decrease in the number of lost positions as follows:

(i) First, as a reduction in the number of positions for which the percentage applicable is 75 percent.

(ii) Second (for any remaining portions of the decrease after compliance with clause (i)), as a reduction in the number of positions for which such percentage is 50 percent.

(iii) Third (for any remaining portions of the decrease after compliance with clause (ii)), as a reduction in the number of positions for which such percentage is 25 percent.

PART 5—OTHER HEALTH PROFESSIONS PROGRAMS

Subpart A—Graduate Nursing Education

SEC. 7051. FEDERAL PAYMENTS FOR GRADUATE NURSING EDUCATION.

(a) IN GENERAL.—Part B of title VIII of the Public Health Service Act (42 U.S.C. 297 et seq.) is amended by adding at the end the following subpart:

"Subpart IV—Grants Under Health Care Workforce Trust Fund

"FORMULA GRANTS FOR GRADUATE NURSE EDUCATION PROGRAMS

"SEC. 848. (a) GRANTS UNDER HEALTH CARE WORKFORCE TRUST FUND.—

"(1) IN GENERAL.—In the case of each graduate nurse education program that in accordance with subsection (c) submits to the Secretary an application for calendar year 1996 or any subsequent calendar year (in this section referred to as an 'eligible program' for the year involved), the Secretary shall make a grant for the year to the program for the purposes specified in subsection (b). The grant shall consist of the allotment determined for the program under subsection (d).

"(2) TRUST FUND.—Grants under paragraph (1) shall be made from amounts in the Health Care Workforce Trust Fund under section 9512 of the Internal Revenue Code of 1986. Of the amounts in such Fund, the amount available for carrying out this section for a calendar year is the product of—

"(i) $150,000,000; and

"(ii) the direct-cost Fund payout percentage for the year, as determined under section 7024(c)(4) of the Guaranteed Health Insurance Act of 1994.

"(3) RESERVATION OF AMOUNTS.—Of the amount available under paragraph (2) for carrying out this section for a calendar year, the Secretary may reserve not more than 10 percent for carrying out section 849.

"(b) PURPOSE OF PAYMENTS.—

"(1) IN GENERAL.—The Secretary may make a grant under subsection (a) only if the graduate nurse education program involved agrees that the payments will be expended only for the following purposes:

"(A) Increasing nursing education opportunities for individuals from disadvantaged backgrounds (including members of racial or ethnic minority groups) through the activities authorized in section 827(a).

"(B) Expanding enrollment, including individuals who are not described in subparagraph (A).

"(C) Providing scholarships to students in financial need with preference given to those who agree to practice in health professional shortage areas.

"(D) Developing and supporting programs to provide students with experience in providing primary health care services in noninstitutional settings.

"(E) Developing innovative approaches to delivering services in the cultural context and language most appropriate for the individuals to whom the services are provided.

"(F) Developing programs or otherwise providing for education and training in the identification, treatment, and referral of cases of domestic violence.

"(G) Such other purposes as the Secretary determines to be appropriate.

"(2) ALLOCATION.—The Secretary may make a grant under subsection (a) only if the graduate nurse education program involved agrees that the program will expend not less than 20 percent of the grant to carry out the purpose described in paragraph (1)(A).

"(c) APPLICATION FOR PAYMENTS.—For purposes of subsection (a)(1), an application for a grant under such subsection for a calendar year is in accordance with this subsection if—

"(1) the application is submitted not later than the date specified by the Secretary;

"(2) the application contains the agreements required in this section; and

"(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(d) AMOUNT OF PAYMENTS.—

"(1) IN GENERAL.—For purposes of subsection (a), the allotment determined under this subsection for an eligible program for a calendar year is the product of—

"(A) the percentage determined for the program under the formula established by the Secretary under paragraph (2); and

"(B) the amount available under subsection (a)(2) for the year, less any amount the Secretary reserves under subsection (a)(3).

"(2) DEVELOPMENT OF FORMULA.—The Secretary shall establish a formula for purposes of paragraph (1)(A). The formula shall be established by the Secretary on the basis of the following factors (which factors shall be given equal weight):

"(A) The percentage constituted by the ratio of—

"(i) the number of individuals enrolled (or accepted for enrollment) in the eligible program involved; to

"(ii) the sum of the respective numbers determined under clause (i) for each eligible program.

"(B) A factor developed by the Secretary to reflect the operational costs of the program relative to the operational costs of other eligible programs.

"(C) A factor developed by the Secretary to reflect the extent of the need for the nursing professionals involved in medically underserved communities.

"(e) DEFINITION OF GRADUATE NURSE EDUCATION PROGRAM.—For purposes of this section, the term 'graduate nurse education programs' means programs for advanced nurse education, including programs for education as nurse practitioners, programs for education as nurse midwives, programs for education as nurse anesthetists, programs for advanced training in occupational health nursing, other programs for training in clinical nurse specialties determined by the Secretary to require advanced education, and programs in nursing administration.

"(f) REPORT TO CONGRESS.—

"(1) IN GENERAL.—The Secretary shall conduct a study for the purpose of determining the cost incurred in the operation of graduate nurse education programs. In conducting the study, the Secretary shall evaluate the program carried out under subsection (a) and may develop recommendations for improving the program.

"(2) DATE CERTAIN FOR COMPLETION.—Not later than February 1, 1998, the Secretary shall complete the study required in paragraph (1) and submit to the Congress the findings made in the study, including any recommendations developed in the study.

"CATEGORICAL GRANTS REGARDING BASIC NURSE EDUCATION

"SEC. 849. (a) IN GENERAL.—The Secretary may make grants to public and nonprofit schools of nursing for the purpose of improving the capacity of such schools to provide for basic nurse education and practice.

"(b) FUNDING.—Grants under subsection (a) shall be made from such amounts as the Secretary may reserve under section 848(a)(3).".

(b) OTHER MODIFICATIONS REGARDING TITLE VIII.—

(1) IN GENERAL.—Section 851 of the Public Health Service Act (42 U.S.C. 298) is amended—

(A) by striking "(a) There is" and all that follows and inserting the following: "(a) IN GENERAL.—There is established within the Department of Health and Human Services an advisory council to be known as the National Advisory Council on Nurse Education (in this section referred to as the "Council").

"(b) DUTIES.—

"(1) IN GENERAL.—The Council shall provide advice to the Secretary on carrying out this title, including advice on—

"(A) the need for educating additional individuals as advanced practice nurses; and

"(B) matters relating to the program under section 848.

"(2) CERTAIN ACTIVITIES.—The Council may collect and analyze data for purposes of carrying out the duties of the Council under paragraph (1), including data on the number of advanced practice nurses and other health professionals in the various geographic areas of the United States.

"(c) COMPOSITION.—

"(1) IN GENERAL.—The membership of the Council shall include individuals who are appointed to the Council from among individuals who are not officers or employees of the United States. Such individuals shall be appointed by the Secretary, and shall include individuals from each of the following categories:

"(A) Nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists.

"(B) Schools of nursing, teaching hospitals or other entities that provide health services, and other experts in health care financing, in the delivery of health services, and in education in the health professions.

"(2) REPRESENTATIVE MEMBERSHIP.—To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States, and shall reflect the racial, ethnic, and gender composition of the population of the United States.

"(3) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary (or by other Federal officers who are appointed by the President with the advice and consent of the Senate). Individuals designated under the preceding sentence shall include each of the following officials (or a designee of the official):

"(A) The Secretary of Health and Human Services.

"(B) The Secretary of Veterans Affairs.

"(C) The Secretary of Defense.

"(d) CHAIR.—The Secretary shall, from among members of the National Council appointed under subsection (c)(1), designate an individual to serve as the Chair of the Council."; and

(B) in the heading for the section, by striking "PRACTICE;" and all that follows and inserting "PRACTICE".

(2) RULE OF CONSTRUCTION.—With respect to the advisory council in effect under section 851 of the Public Health Service Act on the day before the date of the enactment of this Act, individuals who were serving as members of the council may serve as members of the Council established under the amendment made by subsection (a), except as inconsistent with the amendment.

Subpart B—Medical Schools

SEC. 7061. FEDERAL PAYMENTS FOR MEDICAL SCHOOLS.

Part B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.) is amended by adding at the end the following section:

"SEC. 741. FORMULA GRANTS FOR MEDICAL SCHOOLS.

"(a) GRANTS UNDER HEALTH CARE WORKFORCE TRUST FUND.—

"(1) IN GENERAL.—In the case of each school of medicine or osteopathic medicine that in accordance with subsection (c) submits to the Secretary an application for calendar year 1996 or any subsequent calendar year (in this section referred to as an 'eligible school' for the year involved), the Secretary shall make a grant for the year to the school for the purposes specified in subsection (b). The grant shall consist of the allotment determined for the school under subsection (d).

"(2) TRUST FUND.—Grants under paragraph (1) shall be made from amounts in the Health Care Workforce Trust Fund under section 9512 of the Internal Revenue Code of 1986. Of the amounts in such Fund, the amount available for carrying out this section for a calendar year is the product of—

"(i) $50,000,000; and

"(ii) the direct-cost Fund payout percentage for the year, as determined under section 7024(c)(4) of the Guaranteed Health Insurance Act of 1994.

"(b) EXPENDITURES OF GRANT.—

"(1) IN GENERAL.—The Secretary may make a grant under subsection (a) only if the school involved agrees to expend the grant in accordance with the following purposes:

"(A) The school will carry out a program to recruit and retain minority and disadvantaged individuals (including members of racial or ethnic minority groups).

"(B) The school will carry out a program to encourage students of the school to enter a field in primary health care.

"(C) The school will provide for education and training in the identification, treatment, and referral of cases of domestic violence.

"(D) The school will establish goals for the programs described in subparagraphs (A) through (C) and will monitor the programs to determine the extent to which progress is being made toward achieving the goals.

"(2) CERTAIN AUTHORITIES REGARDING MINORITY AND DISADVANTAGED INDIVIDUALS.—With respect to the program for minority and disadvantaged individuals that is carried out by a school of medicine or osteopathic medicine receiving a grant under subsection (a), the Secretary may authorize the school to expend the grant for the following purposes:

"(A) Identifying, recruiting, and selecting minority and disadvantaged individuals for the program.

"(B) Facilitating the entry of such individuals into the school.

"(C) Providing counseling or other services designed to assist such individuals in successfully completing the educational programs involved.

"(D) Providing, for a period prior to the entry of such individuals into the regular course of education of the school, preliminary education designed to assist the individuals in successfully completing such regular course of education at the school, or referring the individuals to hospitals providing such preliminary education.

"(E) Publicizing existing sources of financial aid available to the individuals for attendance at the school.

"(F) Paying such scholarships as the Secretary may determine for such attendance.

"(G) Paying such stipends as the Secretary may approve for such individuals for any period of education in student-enhancement programs (other than regular courses) at the school, except that such a stipend may not be provided to an individual for more than 12 months, and such a stipend shall be in an amount of $40 per day (notwithstanding any other provision of law regarding the amount of stipends).

"(3) ALLOCATION.—The Secretary may make a grant under subsection (a) only if the school involved agrees that the school will expend not less than 20 percent of the grant to carry out the purposes described in paragraph (2).

"(c) APPLICATION FOR PAYMENTS.—For purposes of subsection (a)(1), an application for a grant under such subsection for a calendar year is in accordance with this subsection if—

"(1) the application is submitted not later than the date specified by the Secretary;

"(2) the application contains the agreements required in this section; and

"(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(d) AMOUNT OF PAYMENTS.—

"(1) IN GENERAL.—For purposes of subsection (a), the allotment determined under this subsection for an eligible school for a calendar year is the product of—

"(A) the percentage determined for the school under the formula established by the Secretary under paragraph (2); and

"(B) the amount determined under subsection (a)(2) for the year.

"(2) DEVELOPMENT OF FORMULA.—The Secretary shall establish a formula for purposes of paragraph (1)(A). Subject to paragraph (3), the formula shall be established by the Secretary on the basis of the following factors (which factors shall be given equal weight):

"(A) The number of minority and disadvantaged individuals enrolled (or accepted for enrollment) in the entering class of the eligible school involved for the academic year in which the calendar year begins, plus the number of minority and disadvantaged individuals to whom the contingency described in subsection (e) applies (subject to not counting any individual more than once for purposes of this subparagraph).

"(B) Of the individuals graduating from the school for the academic year that is 6 years prior to the academic year involved, the number of individuals who have entered a postgraduate residency training program in a field of primary health care.

"(3) MINIMUM FORMULA AMOUNT FOR CERTAIN SCHOOLS.—If for the year involved an eligible school is a grantee under section 740, the Secretary shall ensure that the amount determined pursuant to paragraph (1)(A) for the school is not less than the amount of the grant made under section 740 to the school for fiscal year 1994, or fiscal year 1995, whichever is greater, subject to the school agreeing to expend the grant under subsection (a) to reach the goals established for the school under section 740 regarding the recruitment and retention of minority and disadvantaged individuals. The Secretary shall waive the requirement of such agreement if the Secretary determines that the goal for the school has been reached.

"(e) PAYMENTS BY MEDICAL SCHOOLS FOR OFF-SCHOOL EDUCATION.—The Secretary may make a grant under subsection (a) for a calendar year only if the school involved agrees that if, for the academic year beginning in such calendar year, 1 or more students is enrolled (or accepted for enrollment) in the school on the contingency of successfully completing for the academic year a substantial number of hours in medical education through an educational institution that does not operate a school of medicine or osteopathic medicine, and if the school provides credit toward a doctorate in medicine for the hours successfully completed at such other institution, then the school will pay to the other institution for such calendar year an amount equal to the product of—

"(1) the amount of the grant under subsection (a) for the calendar year; and

"(2) the percentage constituted by the ratio of—

"(A) the number of such students attending the other institution for the academic year; to

"(B) the total number of individuals enrolled (or accepted for enrollment) in the eligible school involved for the academic year in which the calendar year begins, plus the number of individuals to whom the contingency described in this subsection applies (subject to not counting any individual more than once for purposes of this subparagraph).".

PART 6—MISCELLANEOUS PROVISIONS

SEC. 7071. STUDY OF FUNDING NEEDS OF HEALTH PROFESSIONS SCHOOLS.

(a) IN GENERAL.—The Secretary shall conduct a study for the purpose of determining the funding needs of health professions schools, including schools of medicine and osteopathic medicine, and schools of dentistry.

(b) CONSIDERATION OF CERTAIN COSTS.—In conducting the study under subsection (a), the Secretary shall also consider the following costs regarding the funding needs of health professions schools:

(1) Uncompensated costs incurred in providing health care.

(2) Costs resulting from reduced productivity due to teaching responsibilities.

(3) Increased costs of caring for the health needs of patients with severe medical complications.

(4) Uncompensated costs incurred in conducting clinical research.

(5) The impact of competitive health plans on payments for professional services delivered by faculty.

(6) The costs associated with changes in medical education from hospital inpatient to ambulatory, nonhospital sites.

(c) CONSIDERATIONS REGARDING ADDITIONAL FUNDING.—In conducting the study under subsection (a), the Secretary shall determine the following:

(1) Whether the health professions schools involved have a significant need for an increase in the amount of funds available to the schools.

(2) If there is such a need—

(A) recommendations regarding the sources of funds to provide the increase; and

(B) recommendations for a methodology for determining the amount that should be provided to the schools involved.

(d) REPORT TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Congress a report describing the findings and recommendations made in the study.

SEC. 7072. ADDITIONAL STUDIES.

(a) PAYMENT AMOUNTS REGARDING GRADUATE MEDICAL EDUCATION.—

(1) IN GENERAL.—The Secretary shall conduct a study to determine whether the program of payments under section 7021 should be modified (relating to payments to approved physician training programs). Factors considered in the study shall include the following factors:

(A) The effect on educational costs of hospital size, faculty salary levels, and geographic region (including location in urban areas and area wage rates).

(B) Variations in costs associated with training in ambulatory settings, including community health centers, managed care organizations, and hospital outpatient clinics.

(C) Variations in costs associated with the operation of approved physician training programs in different medical specialties.

(D) Whether payments to training participants should vary according to which year of training the participant is in.

(E) Whether additional factors should be included under section 7024(c)(3) regarding adjustments in the amount of payments.

(F) Whether, for purposes of section 7024(c), approved physician training programs in podiatric medicine should receive payments on the basis of a national average FTE training amount that is specific to podiatric medicine.

(2) INDEX REGARDING COST VARIATIONS.—The Secretary shall conduct a study for the purpose of developing an index, for use in the program under section 7021, to reflect variations by geographic area in the costs incurred in operating approved physician training programs.

(b) RETRAINING OF PHYSICIANS REGARDING PRACTICING IN PRIMARY HEALTH CARE.—With respect to physicians who do not practice in primary health care, the Secretary shall conduct a study to determine the feasibility of retraining the physicians as practitioners in such care.

(c) DATE CERTAIN FOR COMPLETION.— Not later than February 1, 1997, the Secretary shall complete the studies required in subsections (a) and (b) and submit to the Congress reports describing the findings made in the studies.

PART 7—GENERAL PROVISIONS

SEC. 7081. DEFINITIONS.

For purposes of this subtitle:

(1) The term "academic year" has the meaning given such term in section 7001(a)(3).

(2) The term "aggregate lost position amount" has the meaning given such term in section 7041(e).

(3) The term "aggregate nonmedicare training amount" has the meaning given such term in section 7024(c)(2).

(4) The term "aggregate number of specialty positions lost" has the meaning given such term in section 7041(b)(1)(B).

(5) The term "applicable per discharge training amount" has the meaning given such term in section 7024(e)(1)(C).

(6) The term "applicable period" has the meaning given such term in section 7001(a)(3).

(7) The term "approved physician training program" has the meaning given such term in section 7012(d).

(8) The term "Council" has the meaning given such term in section 7011(a).

(9) The term "direct-cost Fund payout percentage" has the meaning given such term in section 7024(c)(4).

(10) The term "full-time-equivalent training participant" has the meaning given such term in section 7024(g)(2).

(11) The term "indirect-cost Fund payout percentage" has the meaning given such term in section 7024(d)(3).

(12) The term "lost position" has the meaning given such term in section 7041(b)(1)(B).

(13) The term "medical school" has the meaning given such term in section 7012(d).

(14) The term "medical specialty" has the meaning given such term in section 7012(d).

(15) The term "national average FTE training amount" has the meaning given such term in section 7024(c)(3).

(16) The term "nonmedicare per-discharge supplemental payment" has the meaning given such term in section 7024(d)(2).

(17) The term "per-specialty annual number of positions" has the meaning given such term in section 7012(d).

(18) The term "Plan" has the meaning given such term in section 7001(a)(3).

(19) The term "primary health care" has the meaning given such term in section 7012(d).

(20) The term "qualifying physician training consortium" has the meaning given such term in section 7031(b).

(21) The term "specialty position" has the meaning given such term in section 7012(d).

(22) The term "teaching hospital" has the meaning given such term in section 7021(b).

(23) The term "training participant" has the meaning given such term in section 7012(d).

(24) The term "underserved" has the meaning given such term in section 7013(a)(3).

Subtitle B—Certain Direct Spending Programs of Public Health Service

PART 1—BIOMEDICAL RESEARCH

SEC. 7101. ADDITIONAL FUNDING.

(a) ADMINISTRATOR OF ADDITIONAL FUNDS.—Section 402(a) of the Public Health Service Act (42 U.S.C. 282(a)) is amended by striking the first sentence and inserting the following: "There shall be within the Department of Health and Human Services an Assistant Secretary for Scientific Affairs, who shall be appointed by the President by and with the advice and consent of the Senate. Such Assistant Secretary shall serve as the head of the National Institutes of Health, in a position to be known as the Director of the National Institutes of Health (in this title referred to as the 'Director of NIH').".

(b) EXPENDITURE OF FUNDS.—Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following part:

"PART C—HEALTH RESEARCH PROGRAM OF ASSISTANT SECRETARY FOR SCIENTIFIC AFFAIRS

"HEALTH RESEARCH PROGRAM

"SEC. 261. (a) IN GENERAL.—With respect to the amounts appropriated in subsection (b), the Secretary, acting through the Assistant Secretary for Scientific Affairs and in consultation with the interagency advisory board established under subsection (d), shall in accordance with subsection (c) carry out a program for the expenditure of such amounts.

"(b) DIRECT SPENDING.—For carrying out the program under subsection (c), there are hereby appropriated, out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

"(1) For fiscal year 1996, $325,000,000.

"(2) For fiscal year 1997, $500,000,000.

"(3) For fiscal year 1998, $550,000,000.

"(4) For fiscal year 1999, $575,000,000.

"(5) For fiscal year 2000, $600,000,000.

"(6) For fiscal year 2001, $650,000,000.

"(7) For fiscal year 2002, $675,000,000.

"(8) For fiscal year 2003, $725,000,000.

"(9) For fiscal year 2004, $775,000,000.

"(10) For fiscal year 2005, the amount specified in paragraph (9) multiplied by an amount equal to the product of—

"(A) 1 plus the national medicare growth factor (as defined in section 8201(c) of the Guaranteed Health Insurance Act of 1994); and

"(B) 1 plus the annual percentage increase projected by the Assistant Secretary to occur during such year in the population of the States.

"(11) For fiscal year 2006 and each subsequent fiscal year, the amount determined under this subsection for the preceding fiscal year multiplied by an amount equal to the product of subparagraphs (A) and (B) of paragraph (10) (as such subparagraphs are applied for the fiscal year involved).

"(c) PROGRAM FOR MAKING EXPENDITURES.—The Assistant Secretary may expend the amounts appropriated in subsection (b) for biomedical and behavioral research and demonstration projects authorized in this Act, and for health services research and demonstration projects authorized in this Act. In conducting and supporting such projects under the preceding sentence, the Assistant Secretary shall provide for projects to develop and evaluate effective methods for the delivery of health services in rural areas.

"(d) INTERAGENCY ADVISORY BOARD.—

"(1) IN GENERAL.—There is established an advisory board to be known as the Interagency Advisory Board on Scientific Affairs (in this subsection referred to as the 'Board'), consisting of the following officials.

"(A) The Director of the Centers for Disease Control and Prevention.

"(B) The Commissioner of Food and Drugs.

"(C) The Administrator for Health Care Policy and Research.

"(D) The Administrator of the Health Resources and Services Administration.

"(E) The Director of the Indian Health Service.

"(2) DUTIES.—The Board shall provide advice to the Assistant Secretary on carrying out the program under subsection (c). Such advice shall include advice on priorities in the expenditure of the amounts appropriated in subsection (b), a description of which priorities shall be made available to the public. Such priorities shall include priorities for —

"(A) basic research and applied research;

"(B) research on significant public health problems; and

"(C) research on the development and application of cost-effective and improved medical technologies.

"(e) DEFINITIONS.—For purposes of this section, the term 'Assistant Secretary' means the Assistant Secretary for Scientific Affairs (appointed under section 402(a)(1)).".

PART 2—CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS

SEC. 7111. TABLE OF CONTENTS REGARDING REVISED PROVISIONS OF TITLE XIX OF PUBLIC HEALTH SERVICE ACT.

A table describing the contents of part A of title XIX of the Public Health Service Act, as added by section 7112 of this Act, is as follows:

PART A—PUBLIC HEALTH PROGRAMS

SUBPART I—BLOCK GRANTS FOR CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS

Sec. 1901. Formula grants to States.
Sec. 1902. Purposes of grant.
Sec. 1903. State contributions toward purposes.
Sec. 1904. Submission of information.
Sec. 1905. Reports.
Sec. 1906. Application for grant.
Sec. 1907. Amount of allotment.

SUBPART II—NATIONAL PUBLIC HEALTH EMERGENCY FUND

Sec. 1910. National emergency fund.

SEC. 7112. CAPPED ENTITLEMENT REGARDING FORMULA GRANTS TO STATES.

Title XIX of the Public Health Service Act (42 U.S.C. 300w et seq.) is amended by striking part A and inserting the following:

"PART A—PUBLIC HEALTH PROGRAMS

"Subpart I—Block Grants for Core Functions of Public Health Programs

"SEC. 1901. FORMULA GRANTS TO STATES.

"(a) FORMULA GRANTS.—In the case of each State that submits to the Secretary an application in accordance with section 1906 for a fiscal year (in this part referred to as an 'eligible State' for the year), the Secretary shall make a grant to the State for the year for the purposes specified in section 1902. The grant shall consist of the allotment made for the State under section 1907. For the purpose of carrying out this part for fiscal year 1995, there are authorized to be appropriated such sums as may be necessary.

"(b) DIRECT SPENDING.—For the purpose of carrying out this part, there are hereby appropriated, out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved), effective October 1 of the fiscal year involved:

"(1) For each of the fiscal years 1996 through 2004, an amount equal to the amount appropriated for fiscal year 1994 for carrying out this part (as in effect for such year), plus the following additional amount, as applicable to the fiscal year involved:

"(A) For fiscal year 1996, $325,000,000.

"(B) For fiscal year 1997, $500,000,000.

"(C) For fiscal year 1998, $550,000,000.

"(D) For fiscal year 1999, $575,000,000.

"(E) For fiscal year 2000, $600,000,000.

"(F) For fiscal year 2001, $650,000,000.

"(G) For fiscal year 2002, $675,000,000.

"(H) For fiscal year 2003, $725,000,000.

"(I) For fiscal year 2004, $775,000,000.

"(2) For fiscal year 2005, the aggregate amount specified in paragraph (1) for fiscal year 2004 multiplied by an amount equal to the product of—

"(A) 1 plus the national medicare growth factor (as defined in section 8201(c) of the Guaranteed Health Insurance Act of 1994); and

"(B) 1 plus the annual percentage increase projected by the Secretary to occur during such year in the populations of the States.

"(3) For fiscal year 2006 and each subsequent fiscal year, the amount determined under this subsection for the preceding fiscal year multiplied by an amount equal to the product of subparagraphs (A) and (B) of paragraph (2) (as such subparagraphs are applied for the fiscal year involved).

"(c) ENTITLEMENT STATUS OF GRANTS.—

"(1) CAPPED ENTITLEMENT.—Effective on and after October 1, 1995, in the case of an eligible State, the requirement established in subsection (a) for the Secretary (relating to making a grant)—

"(A) is an entitlement in the State on behalf of the population of the State (but is not an entitlement in any member of the population or in any other entity); and

"(B) represents the obligation of the Federal Government, subject to subsection (c)—

"(i) to make grants under subsection (a) from the amounts appropriated in subsection (b); and

"(ii) to apply the formula under section 1907 (as in effect for the fiscal year involved) to such amounts for the year in order to determine the amount of the grant for the State for the year.

"(2) NATURE OF ENTITLEMENT.—With respect to the purposes for which a grant under subsection (a) is authorized to be expended, modifications in such purposes enacted after the date of the enactment of the Guaranteed Health Insurance Act of 1994 do not affect the amount of budget authority provided in subsection (b) for any fiscal year.

"(c) ALLOCATIONS FOR NATIONAL PUBLIC HEALTH EMERGENCY FUND.—Of the amounts appropriated in subsection (b) for a fiscal year, 10 percent is hereby transferred to the account established in section 1910, effective October 1 of the year.

"(d) ADMINISTRATOR OF PROGRAMS.—The Secretary shall carry out this part acting through the Director of the Centers for Disease Control and Prevention.

"SEC. 1902. PURPOSES OF GRANT.

"(a) IN GENERAL.—A funding agreement for a grant under section 1901 is that the State involved will expend the grant only for carrying out the following activities:

"(1) To monitor and protect the health of communities against communicable diseases and exposure to toxic environmental pollutants and occupational hazards.

"(2) To identify and control outbreaks of infectious disease and patterns of chronic disease and injury.

"(3) To inform and educate health care consumers and providers about their roles in preventing and controlling disease and the appropriate use of medical services.

"(4) To collect, analyze, and disseminate data regarding the activities carried out under paragraphs (1) through (3).

"(5) To develop and test new prevention and public health control interventions.

"(6) To provide for health laboratory services.

"(b) PROGRESS IN IMPROVING PUBLIC HEALTH STATUS.—For fiscal year 1998 and each subsequent fiscal year, if the Secretary determines that, relative to October 1, 1994, a State has not made reasonable progress in improving the public health status of the State (as determined under the Healthy People 2000 Objectives, as defined in section 1904(b)), the Secretary shall designate the particular activities under this section to be carried out by the State with the grant under section 1901. For any such fiscal year for which the Secretary makes such a determination, a funding agreement for a grant under section 1901 for the fiscal year is that the State will expend the grant in accordance with the designations made by the Secretary under the preceding sentence.

"SEC. 1903. STATE CONTRIBUTIONS TOWARD PURPOSES.

"(a) MATCHING FUNDS.—

"(1) IN GENERAL.—With respect to the costs of carrying out the purposes specified in section 1902, a funding agreement for a grant under section 1901 is that the State involved will make available (directly or through donations from public or private entities) non-Federal contributions in cash toward such costs in an amount that is not less than $1 for each $2 of Federal funds provided in the grant.

"(2) DETERMINATION OF AMOUNT CONTRIBUTED; RELATIONSHIP TO MAINTENANCE OF EFFORT.—In making a determination of the amount of non-Federal contributions provided by a State under paragraph (1), the Secretary may only include non-Federal contributions in excess of amounts expended by the State in compliance with subsection (b).

"(b) MAINTENANCE OF EFFORT.—

"(1) IN GENERAL.—With respect to the costs of carrying out the purposes specified in section 1902, a funding agreement for a grant under section 1901 is that the State involved will maintain expenditures of non-Federal amounts for such purposes at a level that is not less than the level of such expenditures maintained by the State for the 2-year period preceding October 1, 1994.

"(2) WAIVER.—The Secretary may, upon the request of a State, waive the requirement established in paragraph (1) for a fiscal year if the Secretary determines that extraordinary economic conditions in the State justify the waiver. If the Secretary provides a waiver under the preceding sentence for a State for a fiscal year, the Secretary may make a grant under section 1901 to the State for the following fiscal year only if the Secretary reviews the circumstances involved to determine whether the waiver should remain in effect.

"(3) NONCOMPLIANCE BY STATE.—

"(A) In making a grant under section 1901 to a State for a fiscal year, the Secretary shall make a determination of whether, for the previous fiscal year, the State maintained material compliance with the agreement under paragraph (1). If the Secretary determines that a State has failed to maintain such compliance, the Secretary shall reduce the amount of the allotment under section 1907 for the State for the fiscal year for which the grant is being made by an amount equal to the amount constituting such failure for the previous fiscal year.

"(B) The Secretary may make a grant under section 1901 for a fiscal year only if the State involved submits to the Secretary information sufficient for the Secretary to make the determination required in subparagraph (A).

"SEC. 1904. SUBMISSION OF INFORMATION.

"(a) IN GENERAL.—The Secretary may make a grant under section 1901 only if the State involved submits to the Secretary the following information (expressed in relation to standards, objectives, and goals of the Healthy People 2000 Objectives, as defined in subsection (b)):

"(1) A description of existing deficiencies in the public health system of the State (at the State level and the local level).

"(2) A description of public health status measures to be improved within the State (at the State level and the local level) through expanding the extent to which activities authorized in section 1902 are carried out.

"(3) Information regarding each such activity, which—

"(A) identifies the amount of State and local funding expended on each such activity for the fiscal year preceding the fiscal year for which the grant is sought; and

"(B) provides a detailed description of how additional Federal funding will improve each such activity by both the State and local public health agencies.

"(4) A description of such activities to be carried out at the local level, and a specification for each such activity of—

"(A) the communities in which the activity will be carried out; and

"(B) the amount of the grant to be expended for the activity in each community so specified.

"(b) HEALTHY PEOPLE 2000 OBJECTIVES.—For purposes of this part, the term 'Healthy People 2000 Objectives' means—

"(1) in the case of the fiscal years 1996 through 2000, the objectives established by the Secretary toward the goals of increasing the span of healthy life, reducing health disparities among various populations, and providing access to preventive services, which objectives apply to the health status of the population of the United States for the year 2000; and

"(2) in the case of fiscal year 2001 and subsequent fiscal years, any successor goals and objectives established by the Secretary regarding the health status of such population for a year.

"SEC. 1905. REPORTS.

"A funding agreement for a grant under section 1901 is that the States involved will, not later than the date specified by the Secretary, submit to the Secretary a report, for the fiscal year for which the grant was provided, describing—

"(1) the purposes for which the grant was expended; and

"(2) the extent of progress made by the State in achieving the public health status measures identified under section 1904(a)(2).

"SEC. 1906. APPLICATION FOR GRANT.

"For purposes of section 1901, an application for a grant under such section for a fiscal year is in accordance with this section if—

"(1) the State involved submits the application not later than the date specified by the Secretary;

"(2) the application contains each funding agreement that is described in this subpart;

"(3) the application contains an agreement by the State that each provision of subpart III of part B applies to the grant to the same extent and in the same manner as such subpart applies to grants under subpart I or II of part B;

"(4) the agreements are made through certification from the chief executive officer of the State; and

"(5) the application is otherwise in such form, is made in such manner, and contains such agreements as the Secretary determines to be necessary to carry out this subpart.

"SEC. 1907. AMOUNT OF ALLOTMENT.

"For purposes of section 1901, the allotment for a State for a fiscal year is the sum of paragraphs (1) through (3) as follows:

"(1) An amount equal to the product of—

"(A) an amount equal to ⅓ of the portion of the amount appropriated in subsection (b) of section 1901 for the fiscal year that remains after the transfer under subsection (c) of such section for the year (except that, for fiscal year 1995, the amount under this subparagraph is ⅓ of the amounts that are appropriated under subsection (a) of such section and available for allotment under this section); and

"(B) the percentage constituted by the ratio of—

"(i) a number determined by the Secretary on the basis of population of the State; to

"(ii) the sum of the respective amounts determined under clause (i) for eligible States for the fiscal year.

"(2) An amount equal to the product of—

"(A) an amount equal to ⅓ of the portion referred to in paragraph (1)(A) (except that, for fiscal year 1995, the amount under this subparagraph is ⅓ of the amount specified in paragraph (1)(A) with respect to such fiscal year); and

"(B) the percentage constituted by the ratio of—

"(i) a number determined by the Secretary on the basis of the extent of poverty in the State; to

"(ii) the sum of the respective amounts determined under clause (i) for eligible States for the fiscal year.

"(3) An amount equal to the product of—

"(A) an amount equal to ⅓ of the portion referred to in paragraph (1)(A) (except that, for fiscal year 1995, the amount under this subparagraph is ⅓ of the amount specified in paragraph (1)(A) with respect to such fiscal year); and

"(B) the percentage constituted by the ratio of—

"(i) a number determined by the Secretary on the basis of the years of potential life lost by individuals in the State; to

"(ii) the sum of the respective amounts determined under clause (i) for eligible States for the fiscal year.

"Subpart II—NATIONAL PUBLIC HEALTH EMERGENCY ACCOUNT

"SEC. 1910. NATIONAL EMERGENCY ACCOUNT.

"(a) ESTABLISHMENT OF ACCOUNT.—There is established an account to be known as the National Public Health Emergency Account (in this section referred to as the 'Account').

The Account shall consist of the amounts transferred under section 1901(c).

"(b) EXPENDITURES FROM ACCOUNT.—

"(1) IN GENERAL.—Subject to paragraph (2), upon the Secretary submitting to the Congress a written declaration that a public health emergency exists, amounts in the Account are available to the Secretary for the purpose of responding to the emergency.

"(2) CERTAIN CONDITIONS.—With respect to the availability to the Secretary of amounts in the Account, a declaration under paragraph (1) is effective only if in the declaration the Secretary provides that the Secretary has determined that—

"(A) the emergency involved poses a significant threat to the health of individuals in the community involved;

"(B) the resources of the State involved (including Federal funds provided to the State) that are otherwise available to the State for responding to the emergency are insufficient; and

"(C) the circumstances constituting the emergency are other than chronic conditions.

"(c) ALLOCATION TO STATES OF UNOBLIGATED AMOUNTS.—With respect to amounts that are transferred under 1901(c) for a fiscal year and that are unobligated as of September 30 of the fiscal year (referred to in this subsection as the 'unobligated balance'), the Secretary shall pay to a State, from the unobligated balance, an amount equal to the product of such balance and the percentage constituted by the ratio of the amount of the grant under section 1901 to the State for the fiscal year to the total amount of such grants for the year. The amount paid to a State under the preceding sentence shall be considered by the Secretary to be part of the grant made to the State under section 1901 for such fiscal year.

PART 3—HEALTH CENTERS FOR POPULATIONS LACKING ACCESS TO SERVICES

SEC. 7121. PURPOSE OF PROGRAM.

The purpose of the program under title XXVII of the Public Health Service Act (added by section 7123 of this Act) is to achieve the goal that federally qualified health centers in operation as of the date of the enactment of this Act, and such centers developed and placed into operation pursuant to such title XXVII, will have sufficient capacity to provide the required services of the centers to all rural and urban medically underserved populations that, as of December 31, 1995, were designated by the Secretary as such a population.

SEC. 7122. TABLE OF CONTENTS REGARDING NEW TITLE XXVII OF PUBLIC HEALTH SERVICE ACT.

A table describing the contents of title XXVII of the Public Health Service Act, as added by section 7123 of this Act, is as follows:

TITLE XXVII—FEDERALLY QUALIFIED HEALTH CENTERS

Subtitle A—Unfunded Portion of Operational Costs of Rural and Urban Centers

PART 1—GRANTS REGARDING UNFUNDED PORTION OF OPERATIONAL COSTS

Sec. 2701. Capped entitlement regarding unfunded portion of operational costs.

PART 2—SERVICES AND STRUCTURE OF CENTERS; OTHER CONDITIONS REGARDING CURRENT STATUS

Sec. 2711. Required services of centers; additional services.
Sec. 2712. Activities for special populations.
Sec. 2713. Governing board.
Sec. 2714. Schedule of fees and discounts.
Sec. 2715. Additional conditions.
Sec. 2716. Application for grant.

PART 3—REQUIRED AGREEMENTS

Sec. 2721. Expenditure of grant; operational costs.
Sec. 2722. Additional services.
Sec. 2723. Certain public entities with modified governing boards; matching funds.
Sec. 2724. Certain provisions regarding capital costs.
Sec. 2725. Development by centers of health plans and community provider networks.
Sec. 2726. Additional agreements.
Sec. 2727. Reports.

PART 4—GENERAL PROVISIONS

Sec. 2741. Amount of grant; unfunded portion of operational costs.
Sec. 2742. Expenditure of certain funds.
Sec. 2743. Designation of service area.
Sec. 2744. Miscellaneous provisions.

Subtitle B—Development of Additional Rural and Urban Centers

Sec. 2751. Development of centers.
Sec. 2752. Requirement regarding presence of certain medically underserved populations.
Sec. 2753. Authority regarding modified governing boards.
Sec. 2754. Certain requirements.
Sec. 2755. Application for grant.
Sec. 2756. General provisions.

Subtitle C—General Provisions

Sec. 2791. Miscellaneous provisions.
Sec. 2792. Definitions.

SEC. 7123. DIRECT SPENDING REGARDING FEDERALLY QUALIFIED HEALTH CENTERS; TEMPORARY PROGRAM FOR DEVELOPMENT OF ADDITIONAL CENTERS.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following title:

"TITLE XXVII—FEDERALLY QUALIFIED HEALTH CENTERS

"Subtitle A—Unfunded Portion of Operational Costs of Rural and Urban Centers

"PART 1—GRANTS REGARDING UNFUNDED PORTION OF OPERATIONAL COSTS

"SEC. 2701. CAPPED ENTITLEMENT REGARDING UNFUNDED PORTION OF OPERATIONAL COSTS.

"(a) IN GENERAL.—In the case of any public or nonprofit private entity that in accordance with section 2716 submits to the Secretary an application for a fiscal year demonstrating that the entity is a federally qualified health center, the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make a grant to the entity for such year for the purposes determined under section 2721. The grant shall be made in an amount determined under section 2741, subject to subsections (b) through (e). Grants under this subsection may only be made for fiscal year 1996 and subsequent fiscal years.

"(b) DIRECT SPENDING.—For carrying out this title, there are hereby appropriated, out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

"(1) For fiscal year 1996, $1,325,000,000.
"(2) For fiscal year 1997, $1,630,000,000.
"(3) For fiscal year 1998, $1,750,000,000.
"(4) For fiscal year 1999, $1,750,000,000.
"(5) For fiscal year 2000, $1,800,000,000.
"(6) For fiscal year 2001, $1,850,000,000.
"(7) For fiscal year 2002, $1,950,000,000.
"(8) For fiscal year 2003, $1,850,000,000.
"(9) For fiscal year 2004, $1,950,000,000.

"(10) For fiscal year 2005, the amount specified in paragraph (9) multiplied by an amount equal to the product of—

"(A) 1 plus the national medicare growth factor (as defined in section 8201(c) of the Guaranteed Health Insurance Act of 1994); and

"(B) 1 plus the annual percentage increase projected by the Secretary to occur during such year in the populations served by federally qualified health centers.

"(11) For fiscal year 2006 and each subsequent fiscal year, the amount determined under this subsection for the preceding fiscal year multiplied by an amount equal to the product of subparagraphs (A) and (B) of paragraph (10) (as such subparagraphs are applied for the fiscal year involved).

"(c) ENTITLEMENT STATUS OF GRANTS.—

"(1) IN GENERAL.—Effective on and after October 1, 1995, in the case of a federally qualified health center, the requirement established in subsection (a) for the Secretary (relating to making a grant)—

"(A) is an entitlement in the center on behalf of individuals served by the center (but is not an entitlement in any such individual); and

"(B) represents the obligation of the Federal Government, subject to paragraph (2), to make a grant under subsection (a) to the center in the amount determined for the center under section 2741.

"(2) CAPPED ENTITLEMENT.—With respect to making grants under subsection (a) to federally qualified health centers in the amounts determined under section 2741, the entitlement established in paragraph (1) for such centers is subject to the extent of the amount appropriated in subsection (b) for the fiscal year and to allocations under subsections (d) and (e).

"(3) PRO RATA REDUCTIONS UNDER CAP AMOUNT.—With respect to making grants under subsection (a) for a fiscal year to federally qualified health centers in the amounts determined under section 2741, if the Secretary determines that the budget authority provided in subsection (b) is insufficient to both provide the amounts under section 2741 and make the allocations under subsections (d) and (e), the Secretary shall first make the allocation under subsection (e) and then reduce each amount determined under section 2741 for such year on a pro rata basis to the extent necessary for the grants under subsection (a) to be provided in an aggregate amount equal to the balance of the budget authority.

"(4) NATURE OF ENTITLEMENT.—With respect to the purposes for which a grant under subsection (a) is authorized to be expended, modifications in such purposes enacted after the date of the enactment of the Guaranteed Health Insurance Act of 1994 do not affect the amount of budget authority provided in subsection (b) for any fiscal year.

"(d) ALLOCATIONS REGARDING DEVELOPMENT OF ADDITIONAL CENTERS.—Of the budget authority provided in subsection (b) for a fiscal year, the Secretary shall, for the purpose of making grants under section 2751 (relating to the development of federally qualified health centers), reserve the following amount, as applicable to the fiscal year involved:

"(1) For fiscal year 1996, $75,000,000.
"(2) For fiscal year 1997, $80,000,000.
"(3) For fiscal year 1998, $100,000,000.
"(4) For fiscal year 1999, $100,000,000.
"(5) For fiscal year 2000, $100,000,000.

"(6) For fiscal year 2001, $100,000,000.

"(7) For fiscal year 2002, $150,000,000.

"(e) ALLOCATIONS FOR UNANTICIPATED NEEDS.—

"(1) IN GENERAL.—Of the budget authority provided in subsection (b) for a fiscal year, the Secretary shall reserve 2 percent for—

"(A) making grants to any federally qualified health center that, in the determination of the Secretary, has a need for such a grant to assist the center in responding to unanticipated needs for required services or additional services that have arisen in the service area of the center, or in responding to other unanticipated circumstances that have arisen in the provision by the center of required services or additional services; and

"(B) making grants to any grantee under section 2751 that, in the determination of the Secretary, has a need for a such a grant to assist the grantee in responding to unanticipated circumstances that have arisen in carrying out the project under such section.

"(2) ALLOCATION TO GRANTEES OF UNOBLIGATED AMOUNTS.—With respect to amounts that are reserved under paragraph (1) for a fiscal year and that are unobligated as of September 30 of the fiscal year (referred to in this subsection as the 'unobligated balance'), the Secretary shall pay to each federally qualified health center and to each grantee under section 2751, from the unobligated balance, an amount equal to the product of such balance and the percentage constituted by the ratio of the amount of the grant for the fiscal year for such center or grantee (made under subsection (a) or section 2751, respectively) to the sum of the total amount of grants under subsection (a) for the year and the total amount of grants under section 2751 for the year. The amount paid to such center or grantee under the preceding sentence shall be considered by the Secretary to be part of the grant made for such fiscal year to the center or grantee under subsection (a) or section 2751, respectively.

"(f) DEFINITION OF FEDERALLY QUALIFIED HEALTH CENTER.—

"(1) IN GENERAL.—For purposes of this title, the term 'federally qualified health center' means a public or nonprofit private entity that is described in paragraph (2) or (3), and that operates a health center that—

"(A) serves any medically underserved populations (as defined in section 2752(b)) in the service area designated for the center under section 2743;

"(B) meets each of the conditions described in part 2 (relating to current status);

"(C) meets each of the conditions described in part 3 (relating to agreements on future status); and

"(D) meets each of the conditions described in sections 2741 and 2742 of part 4 (relating to general provisions).

"(2) RELATIONSHIP TO STATUS IN FISCAL YEAR 1995.—For purposes of paragraph (1), an entity described in this paragraph is an entity that met one or more of the following conditions for fiscal year 1995:

"(A) The entity received a grant under section 329, 330, 340, or 340A, as in effect for such year.

"(B) The entity applied for such a grant and was approved by the Secretary as meeting the requirements for such a grant, but the entity did not receive a grant because the amount of funding available to the Secretary for such grants was insufficient to make a grant to all entities so approved.

"(C) The entity was certified by the Secretary as a Federally-qualified health center under section 1905(l)(2)(B) of the Social Security Act.

"(3) RELATIONSHIP TO DEVELOPMENT GRANTS.—For purposes of paragraph (1), an entity described in this paragraph is an entity that, for fiscal year 1996 or any subsequent fiscal year, received a grant under section 2751 of subtitle B (relating to the development of centers).

"PART 2—SERVICES AND STRUCTURE OF CENTERS; OTHER CONDITIONS REGARDING CURRENT STATUS

"SEC. 2711. REQUIRED SERVICES OF CENTERS; ADDITIONAL SERVICES.

"(a) SERVICES GENERALLY; AVAILABILITY.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is as follows:

"(1) The center involved (directly or through contracts or cooperative agreements with public or private entities)—

"(A) provides the required services (as defined in subsection (b)); and

"(B) provides any additional service (as defined in section 2722) that is included for the center in the plan in effect for the center under section 2721(d).

"(2) The center makes the required and additional services available to all individuals (subject to the extent of the capacity of the center), unless the Secretary provides a waiver for the entity under which the center provides the services principally to migratory or seasonal agricultural workers and related individuals, or principally to Indians. The Secretary shall provide such a waiver upon request of the center regarding the individuals involved if, for fiscal year 1995, the center principally served such individuals. Before making a grant under section 2701 for a fiscal year to a center for which such a waiver was in effect for the previous fiscal year, the Secretary shall review the circumstances involved to determine whether the waiver should remain in effect.

"(b) REQUIRED SERVICES.—

"(1) IN GENERAL.—For purposes of this title, the term 'required services' means the following:

"(A) Basic health services.

"(B) Referrals to providers of medical services and other health-related services.

"(C) Patient case management services.

"(D) Required enabling services, subject to subsection (c).

"(2) BASIC HEALTH SERVICES.—For purposes of this title, the term 'basic health services' means the following:

"(A) Services of health professionals.

"(B) Diagnostic laboratory and radiologic services.

"(C) Preventive health services.

"(D) Emergency medical services.

"(E) Preventive dental services, subject to subsection (c).

"(F) Pharmaceutical services, subject to subsection (c).

"(3) PREVENTIVE HEALTH SERVICES.—With respect to the definition of the term 'preventive health services' for purposes of this title—

"(A) for each of the fiscal years 1996 through 1998, such term includes prenatal and perinatal services; screening for breast and cervical cancer (including mammography); well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, for communicable diseases, and for cholesterol; pediatric eye and ear examinations to determine the need for vision and hearing correction; and voluntary family planning services; and

"(B) for fiscal year 1999 and subsequent fiscal years, such term means services specified in subparagraph (A), and in addition, any preventive or screening service included in the guaranteed national benefit package under subtitle A of title III of the Guaranteed Health Insurance Act of 1994.

"(4) PATIENT CASE MANAGEMENT SERVICES.—For purposes of this title, the term 'patient case management services' means services that will assist patients of a center in gaining access to needed medical, social, educational, and other services.

"(5) REQUIRED ENABLING SERVICES.—

"(A) For purposes of this title, the term 'required enabling services' means services specified in subparagraph (B) that are provided for the purpose of enabling individuals to utilize the services of the center involved.

"(B) The services referred to in subparagraph (A) are (as necessary in the service area of the center involved) transportation, community and patient outreach, patient education, and translation services.

"(c) APPLICABILITY OF CERTAIN REQUIREMENTS.—

"(1) IN GENERAL.—If, for fiscal year 1995, a center did not provide a service specified in paragraph (2), the requirement under subsection (a) to provide the service is effective for fiscal year 1999 and subsequent fiscal years, except as provided in subparagraph (B). With respect to the fiscal years 1996 through 1998, the following applies to the center:

"(A) If, for such a fiscal year, the center (at the option of the center) includes the service in the proposed plan submitted under 2721(a)(1), the Secretary shall include the service in the plan in effect for the center under 2721(d) for the year.

"(B) Upon the service being so included in the plan, the center is subject to the requirement under subsection (a) to provide the service each fiscal year.

"(2) RELEVANT SERVICES.—A service referred to in paragraph (1) is any required enabling service, any preventive dental service, and any pharmaceutical service.

"(d) OTHER DEFINITIONS.—For purposes of this title:

"(1) The term 'Indian' means an individual who, under section 4 of the Indian Health Care Improvement Act, is an Indian or an urban Indian.

"(2)(A) The term 'migratory or seasonal agricultural worker, or related individual' means each of the following:

"(i) A migratory agricultural worker.

"(ii) A seasonal agricultural worker.

"(iii) A member of the family of a migratory or seasonal agricultural worker.

"(iv) An individual who previously was such a worker, but who no longer meets the definition under subparagraph (B) or (C) because of age or disability.

"(v) A member of the family of an individual described in clause (iv).

"(B) The term 'migratory agricultural worker' means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.

"(C) The term 'seasonal agricultural worker' means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

"(D) The term 'agriculture' means farming in all its branches, including—

"(i) cultivation and tillage of the soil;

"(ii) the production, cultivation, growing, and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on, the land; and "(iii) any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described in clause (i).

"SEC. 2712. ACTIVITIES FOR SPECIAL POPULATIONS.

"(a) DEFINITION OF SPECIAL POPULATIONS.—For purposes of this title, the term 'special population' means each of the following populations:

"(1) Homeless individuals.

"(2) Residents of public housing.

"(3) Individuals with HIV disease, tuberculosis, or other communicable diseases.

"(4) Such other populations as the Secretary may identify as having significant particularized difficulties in obtaining the services of federally qualified health centers.

"(b) RULE OF CONSTRUCTION.—The activities carried out under subsection (c) for special populations are in addition to the services carried out for such populations under section 340 and 340A.

"(c) REQUIRED ACTIVITIES.—Effective for fiscal year 1996 and subsequent fiscal years, a condition under section 2701(f) for status as a federally qualified health center is that the center involved carries out for each special population activities to overcome the particularized difficulties experienced by the population in obtaining the services of the center.

"(d) DEFINITIONS.—For purposes of this title:

"(1) The term 'homeless individual' means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

"(2) The term 'resident of public housing' means a resident of housing that is public housing as defined in section 3(b)(1) of the United States Housing Act of 1937.

"SEC. 2713. GOVERNING BOARD.

"(a) REQUIREMENTS.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved has established a governing board meeting the following requirements:

"(1) Except as provided in subsection (b), such board is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center.

"(2) The board establishes general policies for the center, except as provided in subsection (c).

"(3) The board reviews the application to be submitted by the center under section 2716, including the proposed plan for the center developed under section 2721(a)(1), and approves or disapproves the application.

"(4) The board approves the selection of a director for the center.

"(5) The board meets at least once quarterly.

"(b) INDIAN TRIBES AND ORGANIZATIONS.—The requirement of subsection (a)(1) does not apply to the governing board of a center if the center is operated by an Indian tribe or tribal organization under the Indian Self-Determination Act.

"(c) CENTERS OF CERTAIN PUBLIC ENTITIES; MODIFIED BOARDS.—

"(1) IN GENERAL.—In the case of a center operated by a public entity, the requirement of subsection (a)(2) does not apply to the personnel policies of the center, or the fiscal policies of the center (subject to paragraph (2)), if—

"(A) the center is operated by an entity described in section 2701(f)(2), and for fiscal year 1994 was not required to permit the governing board of the center to establish personnel or fiscal policies for the center; or

"(B) for fiscal year 1996 or any subsequent fiscal year, the center received a grant under subtitle B (relating to the development of centers) and, under section 2753, was not so required.

"(2) RULE OF CONSTRUCTION.—The requirements of subsection (a)(3), including with respect to the proposed plan under section 2721, apply to a center notwithstanding the provisions of paragraph (1) regarding fiscal policies.

"SEC. 2714. SCHEDULE OF FEES AND DISCOUNTS.

"A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved is in compliance with the following:

"(1) The center has maintained and is maintaining a schedule of fees for the provision of the services of the center, and the schedule has been and is consistent with locally prevailing rates or charges.

"(2) In the case of any portion of a fee for which a patient of the center has the responsibility of making payment (including amounts owed pursuant to requirements of health plans regarding copayments and deductibles), the center has maintained and is maintaining a schedule of discounts to be applied to the payment of such portion, and the discounts have been and are being adjusted in accordance with section 303(f) of part 51c of title 42, Code of Federal Regulations (42 CFR 51c.303(f)), as in effect for fiscal year 1994.

"(3) With respect to the schedule of fees under paragraph (1) and the schedule of discounts under paragraph (2), the center has made and is making every reasonable effort to secure in accordance with the schedules payments from patients, subject to paragraph (4).

"(4) In the case of an individual seeking a service of the center, the center has not conditioned and is not conditioning the provision of the service on payment for the service, and the center has provided and is providing the service without regard to whether the individual has paid the portions of fees imposed by the center for which the individual has the responsibility of making payments (including amounts owed pursuant to requirements of health plans regarding copayments and deductibles).

"SEC. 2715. ADDITIONAL CONDITIONS.

"A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved is in compliance with the following:

"(1) The services of the center have been and are available and accessible in the service area of the center promptly, as appropriate, and in a manner that assures continuity.

"(2) The center has maintained and is maintaining organizational arrangements that provide for—

"(A) an ongoing quality assurance program regarding the services of the center; and

"(B) procedures to maintain the confidentiality of patient records.

"(3) The center has maintained and is maintaining an ongoing referral relationship with one or more hospitals.

"(4) The center has maintained and is maintaining compliance with applicable Federal law on accounting procedures, including such requirements on accounting procedures as the Secretary may establish specifically for the expenditure of a grant under section 2701.

"(5) The center has provided and is providing the services of the center in the language and cultural context that is most appropriate for the patients involved.

"SEC. 2716. APPLICATION FOR GRANT.

"(a) IN GENERAL.—For purposes of section 2701(a), an application for a grant under such section for a fiscal year for a center is in accordance with this section if the application—

"(1) is submitted not later than the date specified by the Secretary;

"(2) contains the proposed plan required in section 2721(a)(1);

"(3) demonstrates that the application, including such plan, has been approved by the governing board of the center;

"(4) contains the agreements required in this subtitle, and otherwise demonstrates that the center meets the conditions established in this subtitle regarding status as a federally qualified health center; and

"(5) is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subtitle.

"(b) AGREEMENT REGARDING CONTINUANCE OF CURRENT STATUS.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved agree to continue serving any medically underserved populations in the service area of the center, and to continue meeting each of the conditions described in this part.

"PART 3—REQUIRED AGREEMENTS

"SEC. 2721. EXPENDITURE OF GRANT; OPERATIONAL COSTS.

"(a) IN GENERAL.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is as follows:

"(1) The center involved submits to the Secretary, in accordance with subsection (d), a proposed plan for the expenditure by the center of a grant under section 2701 for the fiscal year.

"(2) The center agrees to expend the grant only for costs that are specified in subsection (b) and only in accordance with the plan in effect for the center for the year under subsection (d).

"(b) OPERATIONAL COSTS.—

"(1) IN GENERAL.—For purposes of subsection (a)(2), the costs specified in this subsection regarding the expenditure by a federally qualified health center of a grant under section 2701 are the costs of providing the required services; the costs of providing any additional services (as defined in section 2722) that are included for the center in the plan in effect under subsection (d); and the costs of otherwise operating the center involved in accordance with the conditions established in this subtitle.

"(2) REQUIRED ALLOWANCE OF CERTAIN COSTS.—The Secretary shall under paragraph (1) authorize each federally qualified health center to expend a grant under section 2701 for the following costs:

"(A) The costs of providing the required services and the additional services involved.

"(B) The costs of recruiting, training, and compensating the staff of the center.

"(C) The costs of administering the center, including the costs of participating as a provider in one or more health plans.

"(D) The costs of carrying out offsite activities with respect to the required and additional services.

"(3) DISCRETIONARY ALLOWANCE OF CERTAIN COSTS.—In the case of the center involved, the Secretary may under paragraph (1) authorize the expenditure of a grant under section 2701 for any or all of the following costs (in addition to expenditures authorized under paragraph (2)):

"(A) The developmental costs of expanding the capacity of the center to provide required and additional services (including the provision of additional services not previously provided by the center; the provision of services to an increased number of individuals; and the provision of services through school-based clinics, mobile clinics, satellite clinics, and other offsite locations).

"(B) Capital costs, subject to section 2724. Such costs include the purchase of equipment; the acquisition, expansion, or modernization of existing facilities; and the construction of new facilities.

"(C) The costs of carrying out activities in areas beyond the service area of the center for the purpose of improving or maintaining the health of individuals within the service area.

"(D) The costs of planning and developing a health plan in accordance with section 2725(a).

"(E) The costs of planning and developing a network of health care providers in accordance with section 2725(b) (relating to community providers).

"(F) Such other costs as the Secretary may allow with respect to the provision of required services and additional services.

"(c) Criteria for Determining Authorized Expenditures.—

"(1) In general.—With respect to an expenditure by a federally qualified health center, the Secretary shall establish criteria for determining—

"(A) whether the expenditure is for a cost for which a grant under section 2701 may be expended; and

"(B) whether any limitation applies to the expenditure with respect to being considered as such a cost.

"(2) Certain requirements.—Criteria under paragraph (1) regarding the expenditure of a grant under section 2701 shall provide for the reasonable and efficient administration of federally qualified health centers, and shall appropriately reflect the costs of operating such centers under the following circumstances (as applicable to the center involved):

"(A) With respect to recruiting and retaining individuals as professional staff for the center (including health professionals), difficulties arising from substantial disparities between the rate of compensation provided by a center for a professional and the rate of compensation for such a professional prevailing in the geographic area involved.

"(B) With respect to a center located in a rural area, the increased costs that the center incurs, relative to other centers, as a result of serving fewer patients or as a result of difficulties in recruiting or retaining professional staff.

"(C) With respect to the population of patients served by a center, the increased costs that the center incurs, relative to other centers, as a result of the population having a higher incidence or prevalence of a health condition, or a greater number of severe or chronic health conditions.

"(D) With respect to a center at which a health professions training program is carried out, the increased costs that the center incurs, relative to other centers, as a result of the training program.

"(3) Relationship to former criteria.—

"(A) In establishing criteria under paragraph (1), the Secretary shall, subject to subparagraph (B), ensure that the expenditures that are authorized for grants under section 2701 include all expenditures that were authorized for fiscal year 1994 for purposes of part 413 of title 42, Code of Federal Regulations (42 CFR 413 et seq.; relating to payments under title XVIII of the Social Security Act), except to the extent that such part 413 relates to services that are not required services or additional services for purposes of this subtitle.

"(B) With respect to the relationship between criteria under paragraph (1) and criteria under part 413 of title 42, Code of Federal Regulations, subparagraph (A) does not for purposes of this subsection establish any limitation regarding the maximum amount of expenditures. Such limitations described in the Federal Register in volume 57 at any of pages 24961 through 24974 (June 12, 1992; file code BPD-728-FC) (relating to a final rule under Public Law 101-508) do not apply to criteria under paragraph (1), and otherwise shall not have any legal effect.

"(d) Plan Regarding Expenditure of Grant.—For purposes of subsection (a), the following applies to the plan of a center for a fiscal year:

"(1) The proposed plan submitted by the center is in accordance with this subsection if the proposal describes the purposes for which the center intends to expend the grant under section 2701, including the following:

"(A) The activities to be carried out in providing the required services and the amounts to be expended for the activities.

"(B) The requests of the center regarding additional services, and the activities to be carried out in providing the services and the amounts to be expended for the activities.

"(2) If the center meets the conditions established in this subtitle regarding status as a federally qualified health center, the Secretary shall negotiate with the center to approve a plan for the fiscal year for the expenditure by the center of a grant under section 2701 for the costs described in subsection (b).

"(3) The Secretary shall ensure that the plan negotiated and approved under paragraph (2) for the fiscal year includes a specification of each of the following:

"(A) The total amount of costs that are projected to be incurred by the center for the fiscal year in carrying out the plan.

"(B) The total amount, exclusive of the grant under section 2701, that is projected to be received by the center for the fiscal year as payments for the provision of the required services and the additional services of the center.

"(4) In negotiating a plan under paragraph (2), the Secretary shall provide to the center written findings explaining the basis of the decisions of the Secretary, including decisions regarding the following:

"(A) Types of expenditures.

"(B) Limitations on expenditures.

"(C) Any denial by the Secretary of a request by the center regarding the provision of a service. The written findings regarding such a denial shall include an explanation of whether the service is needed by the individuals served by the center.

"(5) With the consent of a federally qualified health center, the Secretary may modify the plan in effect under this subsection for the center for the fiscal year involved. If a center submits to the Secretary a written request for a modification to the plan of the center, the Secretary shall approve or deny the request not later than 30 days after the request is received by the Secretary.

"SEC. 2722. ADDITIONAL SERVICES.

"For purposes of this title, the term 'additional service' means each of the following (if not a required service under this title):

"(1) Any item or service covered in the guaranteed national benefit package under subtitle A of title III of the Guaranteed Health Insurance Act of 1994, except for the following (as defined in such title): Hospital services; extended care services; residential mental health treatment services; residential substance abuse treatment services; and ambulance services.

"(2) Any item or service available under title XVIII or XIX of the Social Security Act, except for the following (as defined in such titles): Nursing facility services; inpatient hospital services; outpatient hospital services; services in an intermediate care facility for the mentally retarded; and inpatient psychiatric hospital services.

"(3) Ambulance services in rural areas (notwithstanding paragraph (1)).

"(4) Environmental health services (including the detection and alleviation of unhealthful conditions associated with water supply, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health).

"(5) Services that are in addition to the services specified in section 2711(b)(5)(B) and that are provided for the purpose of enabling individuals to utilize the services of the center involved.

"SEC. 2723. CERTAIN PUBLIC ENTITIES WITH MODIFIED GOVERNING BOARDS; MATCHING FUNDS.

"(a) In General.—In the case of a center to which section 2713(c)(1)(B) applies, a condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the public entity involved agrees to make available (directly or through donations from public or private entities) non-Federal contributions in cash toward the operational costs of the center in an amount that is not less than 50 percent of such costs.

"(b) Maintenance of Effort; Relationship to Matching Funds.—In making a determination of the amount of non-Federal contributions provided by a public entity under subsection (a), the Secretary may only include non-Federal contributions in excess of the average amount of non-Federal contributions made by the entity toward the operational costs of the center involved for the 2-year period preceding October 1, 1994.

"SEC. 2724. CERTAIN PROVISIONS REGARDING CAPITAL COSTS.

"(a) Certain Costs.—With respect to authorizing capital costs as permissible expenditures under section 2721(b)(3)(B), the costs that the Secretary may authorize include the costs of amortizing the principal of, and paying interest on, loans; and the costs of repaying loan guarantees and interest subsidies.

"(b) Wages of Laborers and Mechanics.—

"(1) Agreement.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved agree that, in the performance of work on any expansion, modernization, or construction of buildings carried out with a grant under section 2701, all laborers and mechanics employed by contractors or subcontractors will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a-5, known as the Davis-Bacon Act).

"(2) AUTHORITY OF SECRETARY OF LABOR.—The Secretary of Labor shall have with respect to the labor standards referred to in paragraph (1) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

"(c) RESTRICTIONS REGARDING CONSTRUCTION.—The Secretary may authorize as a permissible expenditure under section 2721(b)(3)(B) the construction of new buildings only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, or expanding existing buildings and that the center involved has made reasonable efforts to secure from other sources funds in lieu of the grant under section 2701 to construct such facilities.

"(d) APPLICABILITY OF CERTAIN PROVISIONS.—With respect to the use and disposition of real property, and the transfer of title to such property, a condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved agree that expenditures of a grant under section 2701 for capital costs regarding such property are subject to the provisions of section 134 of part 74 of title 45, Code of Federal Regulations (45 CFR 74.134) (or any successor provision).

"(e) SUBORDINATION; WAIVERS.—In the case of any Federal interest that may be derived by virtue of the expenditure of a grant under section 2701 for the capital costs of a center, the Secretary may subordinate or waive Federal rights if the Secretary determines that the subordination or waiver will further the objectives of this subtitle.

"SEC. 2725. DEVELOPMENT BY CENTERS OF HEALTH PLANS AND COMMUNITY PROVIDER NETWORKS.

"(a) HEALTH PLANS.—With respect to authorizing the costs of developing a health plan as permissible expenditures under section 2721(b)(3)(D), a federally qualified health center has developed a plan in accordance with this subsection if the plan meets the following conditions:

"(1) The plan is an insured health benefits plan meeting the requirements of subtitle A of title V of the Guaranteed Health Insurance Act of 1994.

"(2) The plan is a public or nonprofit private entity governed by the center (or by the center in collaboration with other public or nonprofit private entities).

"(3) The center is a provider of health services through the plan.

"(b) COMMUNITY PROVIDER NETWORK.—With respect to authorizing the costs of developing a network of health care providers as permissible expenditures under section 2721(b)(3)(E), a federally qualified health center has developed a network in accordance with this subsection if the network meets the following conditions:

"(1) The network is a public or nonprofit private entity governed by the center (or by the center in collaboration with other public or nonprofit private entities).

"(2) The network maintains written agreements with each of the health care providers participating in the network, and the agreements provide as follows:

"(A) Each member agrees to provide appropriate emergency and medical support services to other members.

"(B) Each member agrees to accept referrals from other members.

"(C) Each hospital member has arrangements to provide staff privileges to physicians providing care for other members.

"(D) Each member has in effect (or is in the process of establishing) agreements with other members to share in the member's communication system, including (where appropriate) the electronic sharing of patient data, medical records, and billing services.

"(3) The network includes the center as a provider of health services in the network.

"(4) The network participates as a provider of health care in one or more health plans that are either insured health benefits plan under subtitle A of title V of the Guaranteed Health Insurance Act of 1994, or self-insured health benefit plans under subtitle B of such title.

"(5) The network is composed principally of essential community providers (as defined in subsection (d)).

"(6) The network provides health services within a defined geographic area (in this title referred to as the 'network service area'), which area includes the service area of each of the federally qualified health centers participating in the network.

"(7) The network serves any medically underserved populations in the network service area.

"(8) In the case of federally qualified health centers in the network service area—

"(A) the network permits each such center to participate in the network, subject to the center entering into the agreement under paragraph (2) for such participation;

"(B) the terms and conditions of the agreement for the participation of the center are at least as favorable as the terms and conditions of the agreement for the participation of other entities; and

"(C) the network provides a written notification to each federally qualified health center in the network service area informing the center of the opportunity to participate in the network.

"(c) ANTIDISCRIMINATION REGARDING NETWORKS.—Section 9333 of the Guaranteed Health Insurance Act of 1994 applies to networks under subsection (b) to the same extent and in the same manner as such section applies to health plans under such section 9333.

"(d) DEFINITIONS.—For purposes of this title, the term 'essential community provider' means entities that are essential community providers under section 5012(c) of the Guaranteed Health Insurance Act of 1994.

"SEC. 2726. ADDITIONAL AGREEMENTS.

"(a) THIRD-PARTY REIMBURSEMENTS.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved agree as follows:

"(1) The center will participate as a provider of health services in the program under title XVIII of the Social Security Act; the program under title XIX of such Act; other Federal or State programs that make payment for the provision of health services to individuals in the State involved, and in private health plans.

"(2) The center, in providing health services, will make every reasonable effort—

"(A) to collect appropriate reimbursement from the programs and plans referred to in paragraph (1); and

"(B) to collect the reimbursements on the basis of the full amount of fees applicable under the schedule in effect pursuant to paragraph (1) of section 2714, which reimbursements shall be made on the basis of such fees without regard to discounts that are applied by the center pursuant to paragraph (2) of such section.

"(b) MAINTENANCE OF EFFORT REGARDING PUBLIC ENTITIES.—In the case of a center operated by a public entity, a condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the entity will maintain expenditures of non-Federal amounts for the center at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the center is applying to receive a grant under section 2701. The preceding sentence is subject to section 2723(b).

"SEC. 2727. REPORTS.

"(a) IN GENERAL.—A condition under section 2701(f) for status as a federally qualified health center for a fiscal year is that the center involved agree as follows:

"(1) The center will prepare a report regarding the activities of the center for the fiscal year, and will submit the report to the Secretary during the following fiscal year by not later than the date specified under subsection (b).

"(2) The report will include information on the following:

"(A) Expenditures of the center for operational costs included in the plan in effect for the center under 2721(d).

"(B) The patterns of use of the services of the center, including the patterns of use of each of the special populations in the service area of the center.

"(C) The availability and accessibility of such services.

"(D) Expenditures made from any amount the center retained under section 2743(b).

"(E) Such other matters relating to operations of the center as the Secretary may require.

"(b) DATE FOR SUBMISSION OF REPORT.—With respect to reports under subsection (a) for a fiscal year, the Secretary shall specify a date in the following fiscal year by which the reports are to be submitted to the Secretary.

"PART 4—GENERAL PROVISIONS

"SEC. 2741. AMOUNT OF GRANT; UNFUNDED PORTION OF OPERATIONAL COSTS.

"(a) IN GENERAL.—For purposes of section 2701(a), the amount determined under this section for a grant for a federally qualified health center for a fiscal year is the difference between—

"(1) the total amount of costs that are projected to be incurred by the center for the fiscal year in carrying out the plan in effect for the year under section 2721(d), as such total amount is specified under paragraph (3)(A) of such section; and

"(2) the total amount, exclusive of the grant under section 2701 for the fiscal year, that is projected to be received by the center for the year as payments for the provision under the plan of required services and additional services, as such total amount is specified under paragraph (3)(B) of section 2721(d).

"(b) GRANT PAYMENTS.—Payments under a grant under section 2701 shall be made in advance, and in such installments as the Secretary finds necessary. Adjustments in such payments may be made for overpayments or underpayments, subject to section 2742(b).

"SEC. 2742. EXPENDITURE OF CERTAIN FUNDS.

"(a) EXPENDITURE OF NONGRANT FUNDS.—

"(1) IN GENERAL.—

"(A) Subject to paragraph (2), the Secretary may not under this subtitle restrict the purposes for which a federally qualified health center expends the nongrant funds of the center, including restricting expenditures pursuant to criteria under section 2721(c)(1) or pursuant to other Federal cost principles.

"(B) For purposes of this section, the term 'nongrant funds' means funds of a center other than the grant under section 2701.

"(2) COMPLIANCE WITH CENTER CONDITIONS.—The Secretary may require, as a condition under section 2701(f) for status as a federally qualified health center for a fiscal year, that the center involved agree that the nongrant funds of the entity will be expended for purposes that are consistent with the purposes specified in this subtitle.

"(b) EXPENDITURE OF EXCESS OPERATING REVENUES.—If, for a fiscal year, the sum of the amount of the grant under section 2701 to a federally qualified health center and the amount of the nongrant funds of the center exceeds the costs of the center in carrying out the plan in effect for the center under section 2721(d), the center is entitled to retain such excess operating revenues (without any offsetting reduction in grants under section 2701) if the center agrees, as a condition under section 2701 for status as such a center, to expend such revenues only for purposes authorized in this subtitle. Such purposes include the following:

"(1) Expanding and improving services.

"(2) Increasing the number of individuals served.

"(3) Purchasing equipment; acquiring, modernizing, and expanding facilities; and constructing facilities.

"(4) Improving the administration of the center.

"(5) Establishing financial reserves, including reserves required for the furnishing of services on a prepaid basis or as needed to cover unanticipated expenses.

"(6) Carrying out health professions training programs.

"(7) Developing health plans and community provider networks in accordance with section 2725.

"(c) RULE OF CONSTRUCTION.—With respect to amounts that are nongrant funds under subsection (a), or excess operating revenues under subsection (b), this section may not be construed as limiting the authority of the Secretary to require the submission of such plans, budgets, and other information as may be necessary to ensure that the funds and revenues are expended in accordance with subsections (a) and (b), respectively.

"SEC. 2743. DESIGNATION OF SERVICE AREA.

"(a) IN GENERAL.—In determining whether a center meets the conditions under section 2701(f) for status as a federally qualified health center for a fiscal year, the Secretary shall designate the geographic area that the center is to serve. In designating a service area under the preceding sentence, the Secretary shall ensure that the following requirements are met:

"(1) The size of the area is a size that ensures that the services of the center (including services provided at any satellite clinic or offsite location) are available and accessible to individuals in the area promptly and as appropriate.

"(2) The boundaries of the area, to the extent practicable, conform to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs.

"(3) The boundaries of the area, to the extent practicable, eliminate barriers to access to the services of the center, including barriers resulting from the physical characteristics of the area, the residential patterns of the area, the economic and social grouping of the area, and available transportation.

"(b) OVERLAP IN AREAS.—In designating service areas under subsection (a), the Secretary may provide for the operation of more than one federally qualified health center in a service area in any case in which the Secretary determines that there is a population group in such area that otherwise will have a shortage of personal health services. The preceding sentence may not be construed as requiring that, in such a case, the service areas of the centers involved be identical.

"(c) DEFINITION.—For purposes of this title, the term 'service area', with respect to a center, means the area designated under subsection (a) for the center.

"SEC. 2744. MISCELLANEOUS PROVISIONS.

"(a) OPPORTUNITY TO CORRECT MATERIAL FAILURE REGARDING GRANT CONDITIONS.—

"(1) IN GENERAL.—Notwithstanding the provisions of this subtitle, if a center materially fails to meet a condition of this subtitle regarding status as a federally qualified health center for a fiscal year, the Secretary shall provide the center an opportunity to comply with the condition, subject to paragraph (2).

"(2) LIMITATIONS.—The provision of an opportunity under paragraph (1) is subject to the following:

"(A) The opportunity may not be provided with respect to a material failure to comply with any applicable condition of section 2713 or 2723 (relating to governing boards).

"(B) In the case of any other condition, the opportunity shall be provided for a period determined by the Secretary, which may not exceed one year.

"(C) Such period begins on the date on which the Secretary provides a written notification to the center informing the center of the material failure of the center, and of the opportunity to comply with the condition involved.

"(b) AGENCY REVIEW OF DECISIONS.—

"(1) PROCEDURES OF DEPARTMENTAL GRANTS APPEALS BOARD.—Through the applicable procedures in effect under parts 16, 74, and 75 of title 45, Code of Federal Regulations (or any successor provisions), the Secretary, upon request of the center involved, shall (subject to paragraph (3)) permit the center to appeal a decision of the Secretary under this subtitle and obtain from the Secretary a fair, impartial review of the decision.

"(2) ALTERNATIVE PROCEDURES REGARDING CERTAIN DECISIONS.—

"(A) Subject to paragraph (3), if the Secretary makes a decision under this subtitle that is described in subparagraph (B), the Secretary, upon request of the center involved, shall permit the center to appeal the decision and obtain from the Secretary a review of the decision on the record.

"(B) The decisions referred to in subparagraph (A) regarding a center are as follows:

"(i) The Secretary, having provided to the center a period of opportunity under subsection (a) to comply with a condition, finds that the center continues to be in material failure regarding the condition.

"(ii) The Secretary modifies the service area of the center.

"(iii) The Secretary terminates the designation as a medically underserved population of a population within the service area of the center.

"(iv) The amount of the grant determined under section 2741 for the fiscal year involved is less than the amount so determined for the center for the preceding fiscal year, and the difference between such amounts results or will result in a significant reduction in the availability from the center of required services and additional services.

"(3) EXCEPTION REGARDING PRO RATA REDUCTIONS.—The requirements under paragraphs (1) and (2) for the Secretary to review a decision do not apply if the decision is made in response to pro rata reductions under section 2701(b)(3) (except that review may be obtained to the extent necessary to determine whether the decision was so made).

"(4) ELECTION OF PROCEDURES.—In the case of a decision described in paragraph (2)(B), the center involved may elect for appeal and review of the decision under paragraph (1) or under paragraph (2), but not both.

"(c) RULE OF CONSTRUCTION.—With respect to compliance with the conditions of this subtitle for status as a federally qualified health center for a fiscal year, the circumstances constituting the material failure of a center to be in such compliance include expending a grant under section 2701 for a cost that the Secretary disallows. Subsections (a) and (b) apply to such a material failure.

"Subtitle B—Development of Additional Rural and Urban Centers

"SEC. 2751. DEVELOPMENT OF CENTERS.

"(a) IN GENERAL.—From amounts reserved under section 2701(d), the Secretary shall make grants to public and nonprofit private entities for carrying out projects to plan and develop centers whose services, structure, programs, capabilities, and other characteristics will, once the project is completed, meet the conditions for the entitlement under subtitle A (relating to the operational costs of federally qualified health centers). Grants under this subsection may only be made for fiscal year 1996 and subsequent fiscal years.

"(b) ALLOCATIONS REGARDING RURAL AREAS.—Of the amounts reserved under section 2701(c)—

"(1) the Secretary shall reserve ⅔ for projects under paragraph (1) in rural areas;

"(2) the Secretary shall reserve ⅓ for projects under paragraph (1) in urban areas.

"(c) PREFERENCES IN CERTAIN GRANTS.—In making grants under subsection (a) from amounts reserved under subsection (b)(2), the Secretary shall give preference to grantees under section 340 or 340A to assist the grantees in meeting the standards referred to in subsection (a) with respect to becoming a federally qualified health center. The requirement of preference applies only to grantees under section 340 or 340A who meet the requirements of this subtitle for receiving a grant under section 2751.

"SEC. 2752. REQUIREMENTS REGARDING PRESENCE OF CERTAIN MEDICALLY UNDERSERVED POPULATIONS.

"(a) IN GENERAL.—The Secretary may make a grant under section 2751 only if the Secretary determines that, in the geographic area for which the project under such section is to be carried out, there is a medically underserved population (as defined in subsection (b)).

"(b) DEFINITION OF MEDICALLY UNDERSERVED POPULATION.—For purposes of this title, the term 'medically underserved population' means the population of a rural or urban area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

"(c) CRITERIA REGARDING DEFINITION.—

"(1) IN GENERAL.—For purposes of subsection (b), the Secretary shall establish criteria for determining the specific shortages of personal health services of an area or population group. Such criteria shall—

"(A) take into account comments received by the Secretary from the chief executive officer of a State and local officials in a State and from affected persons; and

"(B) include factors indicative of the health status of a population group or individuals in an area (including the rate of infant mortality), the ability of the residents of an area or of a population group to pay for health services and their accessibility to them, and the availability of health professionals to residents of an area or to a population group.

"(2) MODIFICATION OF CRITERIA.—The Secretary may modify the criteria established under paragraph (1) only after affording public notice and an opportunity for comment on any such proposed modifications.

"(d) NOTICE AND COMMENT REGARDING DESIGNATIONS.—The Secretary may not designate a medically underserved population in a State or terminate the designation of such a population unless, prior to such designation or termination, the Secretary provides reasonable notice to and opportunity for comment by—

"(1) the chief executive officer of such State;

"(2) local officials in such State;

"(3) members of the medically underserved population involved; and

"(4) representatives of the health center involved.

"SEC. 2753. AUTHORITY REGARDING MODIFIED GOVERNING BOARDS.

"(a) IN GENERAL.—Subject to the subsequent provisions of this section, in the case of a public entity that submits an application for a grant under section 2751, the Secretary may provide that, in meeting the requirement under such section to plan and develop a governing board (in accordance with section 2713), the entity is authorized to develop and operate a board that does not establish the personnel policies of the center, or the fiscal policies of the center (subject to section 2713(c)(2)).

"(b) MATCHING FUNDS.—With respect to the costs of carrying out a project under section 2751, the Secretary may provide an authorization under subsection (a) only if the public entity involved agrees to make available (directly or through donations from public or private entities) non-Federal contributions in cash toward such costs in an amount that is not less than 50 percent of such costs.

"(c) RESTRICTION REGARDING FUNDING.—Of the budget authority provided in section 2751(b) for a fiscal year, the Secretary may not obligate more than 5 percent for projects under such section with respect to which an authorization under subsection (a) has been (or is to be) provided.

"SEC. 2754. CERTAIN REQUIREMENTS.

"(a) SUBMISSION OF INFORMATION.—The Secretary may make a grant under section 2751 only if the applicant for the grant submits to the Secretary, in the application under section 2755, the following information:

"(1) An assessment of the need in the geographic area involved for the required services.

"(2) The design for the federally qualified health center involved, and the services of the center, based on such assessment.

"(3) Information demonstrating that the center developed with the grant will, by the date on which funding under section 2751 is terminated for the center (pursuant to section 2756(c)), meet the conditions for the entitlement under subtitle A.

"(b) COMMUNITY INVOLVEMENT.—The Secretary may make a grant under section 2751 only if the applicant for the grant agrees that, in developing the federally qualified health center involved, the applicant will provide for the involvement of the individuals to be served by the center.

"SEC. 2755. APPLICATION.

"The Secretary may make a grant under section 2751 only if an application for the grant is submitted to the Secretary, the application is submitted by the date specified by the Secretary, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subtitle.

"SEC. 2756. GENERAL PROVISIONS.

"(a) LOCATION OF CENTER WITHIN SERVICE AREA.—In making a grant under section 2751 for a center, the Secretary shall ensure that the center is located so that the center provides services to the greatest number of individuals residing in the service area that (in accordance with section 2743) is designated under section 2751 for the center.

"(b) EXPENDITURES.—The purposes for which a grant under section 2751 may be expended include the capital costs of developing the center involved (including the costs specified in sections 2721(b)(3))(B) and 2724), and such other costs of carrying out a project under such section as the Secretary may authorize.

"(c) AMOUNT AND NUMBER OF GRANTS.—The amount of a grant under section 2751 for a project shall be determined by the Secretary. A center may not receive more than 2 years of funding under such section.

"Subtitle C—General Provisions

"SEC. 2791. MISCELLANEOUS PROVISIONS.

"(a) TECHNICAL ASSISTANCE.—The Secretary may provide (either through the Department of Health and Human Services, or through grant or contract) all necessary technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management)—

"(1) to any public or nonprofit private entity to assist the entity in operating as a federally qualified health center under subtitle A or in developing such a center under subtitle B;

"(2) to assist federally qualified health centers in developing health plans and community provider networks pursuant to subparagraphs (D) and (E) of section 2721(b)(3); and

"(3) to any public or nonprofit private entity to assist the entity in meeting the requirements for applications to receive grants under section 2701 and section 2751.

"(b) AUTHORITY REGARDING JOINT-PURCHASING ARRANGEMENTS FOR REDUCED COSTS.—With respect to the costs of providing the supplies and services needed for the operation of federally qualified health centers, the Secretary, directly or through grants or contracts, may carry out projects to establish and administer arrangements under which such costs are reduced through collaborative efforts of the centers, through making purchases that apply to multiple centers, or through such other methods as the Secretary determines to be appropriate. Amounts under this subsection may not be expended for the purchase of supplies or services.

"(c) ADMINISTRATION OF PROGRAMS.—The Secretary may delegate the authority to administer the programs authorized by this title to any office within the Public Health Service, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts may be delegated only within the central office of the Health Resources and Services Administration.

"SEC. 2792. DEFINITIONS.

"For purposes of this title:

"(1) The term 'additional services', with respect to federally qualified health centers, has the meaning given such term in section 2722.

"(2) The term 'agriculture' has the meaning given such term in section 2712(e).

"(3) The term 'basic health services' has the meaning given such term in section 2711(b).

"(4) The term 'essential community provider' has the meaning given such term in section 2725(d).

"(5) The term 'federally qualified health center' has the meaning given such term in section 2701(f).

"(6) The term 'HIV disease' means infection with the human immunodeficiency virus, and includes any condition arising from acquired immune deficiency syndrome.

"(7) The term 'homeless individual' has the meaning given such term in section 2712(d).

"(8) The term 'human immunodeficiency virus' means the etiologic agent for acquired immune deficiency syndrome.

"(9) The term 'Indian' has the meaning given such term in section 2711(d).

"(10) The term 'migratory agricultural worker' has the meaning given such term in section 2711(d).

"(11) The term 'migratory or seasonal agricultural worker, or related individual' has the meaning given such term in section 2711(d).

"(12) The term 'network service area', with respect to an essential community provider network, has the meaning indicated for such term in section 2725(b)(6).

"(13) The term 'preventive health services' has the meaning given such term in section 2711(b).

"(14) The term 'required enabling services' has the meaning given such term in section 2711(b).

"(15) The term 'required services' has the meaning given such term in section 2711(b).

"(16) The term 'resident of public housing' has the meaning given such term in section 2712(d).

"(17) The term 'seasonal agricultural worker' has the meaning given such term in section 2711(d).

"(18) The term 'service area' has the meaning given such term in section 2743(c).

"(19) The term 'special population' has the meaning given such term in section 2712(a).".

SEC. 7124. CONFORMING AMENDMENTS.

Effective October 1, 1995, the Public Health Service Act (42 U.S.C. 201 et seq.) is amended by striking sections 329 and 330.

PART 4—NATIONAL HEALTH SERVICE CORPS

SEC. 7131. PURPOSE OF PROGRAM.

The purpose of the programs carried out pursuant to section 7132 is to achieve the goal that the number of members of the National Health Service Corps who are practicing in health professional shortage areas, together with the number of students attending health professions schools under the Scholarship Program of the Corps, will be sufficient (once such students begin practicing in such areas) to provide primary health services to all rural and urban health professional shortage areas that, as of December 31, 1995, were designated under section 332 of the Public Health Service Act as such an area.

SEC. 7132. DIRECT SPENDING REGARDING GENERAL PROGRAM AND SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

Section 331(a) of the Public Health Service Act (42 U.S.C. 254d(a)) is amended by adding at the end the following paragraph:

"(4) For the purpose of carrying out this subpart and sections 338A through 338H of subpart III, there are hereby appropriated the following amounts, as applicable to the fiscal year involved:

"(A) For fiscal year 1995, $200,000,000.

"(B) For fiscal year 1996, $200,000,000.

"(C) For fiscal year 1997, $250,000,000.

"(D) For fiscal year 1998, $250,000,000.

"(E) For fiscal year 1999, $300,000,000.

"(F) For fiscal year 2000, $300,000,000.

"(G) For fiscal year 2001, $350,000,000.

"(H) For fiscal year 2002, $350,000,000.

"(I) For fiscal year 2003, $400,000,000.

"(J) For fiscal year 2004, $400,000,000.

"(K) For fiscal year 2005, the amount specified in subparagraph (J) multiplied by an amount equal to the product of—

"(i) 1 plus the national medicare growth factor (as defined in section 8201(c) of the Guaranteed Health Insurance Act of 1994); and

"(ii) 1 plus the annual percentage increase projected by the Secretary to occur during such year in the populations served by the Corps.

"(L) For fiscal year 2006 and each subsequent fiscal year, the amount determined under this paragraph for the preceding fiscal year multiplied by an amount equal to the product of clauses (i) and (ii) of subparagraph (K) (as such clauses are applied for the fiscal year involved).".

PART 5—CONSUMER RESOURCES REGARDING HEALTH PLANS

SEC. 7141. CONSUMER RESOURCES.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following part:

"PART O—CONSUMER RESOURCES REGARDING HEALTH PLANS

"FUNDING FOR CERTAIN GRANT PROGRAMS

"SEC. 399P. (a) DIRECT SPENDING FOR GRANTS FOR CONSUMER HEALTH ADVOCACY OFFICES.—For carrying out the program under section 399Q, there are hereby appropriated, out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

"(1) For fiscal year 1999, $40,000,000.

"(2) For fiscal year 2000, the amount specified in paragraph (1) multiplied by an amount equal to the product of—

"(A) 1 plus the national medicare growth factor (as defined in section 8201(c) of the Guaranteed Health Insurance Act of 1994); and

"(B) 1 plus the annual percentage increase projected by the Secretary to occur during such year in the population of the States.

"(3) For fiscal year 2001 and each subsequent fiscal year, the amount determined under this subsection for the preceding fiscal year multiplied by an amount equal to the product of subparagraphs (A) and (B) of paragraph (2) (as such subparagraphs are applied for the fiscal year involved).

"(b) DIRECT SPENDING FOR GRANTS FOR NATIONAL CONSUMER HEALTH RESOURCE CENTER.—For carrying out the program under section 399R, there are hereby appropriated, out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

"(1) For fiscal year 1996, $5,000,000.

"(2) For fiscal year 1997, $5,000,000.

"(3) For fiscal year 1998, $7,500,000.

"(4) For fiscal year 1999, $10,000,000.

"(5) For fiscal year 2000, $10,000,000.

"(6) For fiscal year 2001, the amount specified in paragraph (5) multiplied by an amount equal to 1 plus the consumer price index for all urban consumers (U.S. city average).

"(7) For fiscal year 2002 and each subsequent fiscal year, the amount determined under this subsection for the preceding fiscal year multiplied by an amount equal to 1 plus such index (as such index is applied for the fiscal year involved).

"GRANTS FOR CONSUMER HEALTH ADVOCACY OFFICES

"SEC. 399Q. (a) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor, shall make grants under this section to private nonprofit entities for the establishment and operation of offices to perform the functions described in subsection (b) for consumers in a State (or a multi-State area described in subsection (d)). Each such office shall be known as a 'Consumer Health Advocacy Office' (in this part referred to as an 'Office'). For any grant term under subsection (c), the Secretary may not make a grant under this section to more than one entity with respect to any State or multi-State area.

"(b) FUNCTIONS.—An entity that receives a grant under this section shall use the grant to establish and operate an Office to perform the following functions in a State or multi-State area:

"(1) Assist, in person and by toll-free telephone access, individuals eligible to seek coverage in the community-rated market sector with enrollment in insured health benefit plans (as described in title V of the Guaranteed Health Insurance Act of 1994) by referring them to an appropriate enrollment assistance program established under section 5011(b) of such Act.

"(2) Assist, in person and by toll-free telephone access, individuals in applying for enrollment in the medicare part C program under title XXI of the Social Security Act, a premium certificate under part A of title XXII of such Act, or wrap-around benefits under part B of such title, by referring them to an appropriate local office used by the Social Security Administration.

"(3) Collect and provide to the public—

"(A) annual information on insured health benefit plans provided in the State or area that is required to be prepared under section 5011(c) of the Guaranteed Health Insurance Act of 1994; and

"(B) performance reports prepared under section 9003(g) of the such Act by the State or States in the area.

"(4) Provide, in person and by toll-free telephone access, information to individuals regarding the remedies available under subtitle D of title IX of such Act.

"(5) Address systemic problems affecting consumers in health benefit plans provided in the State or area (as described in title V of such Act), but refer individual complaints relating to denials of items and services and requests for reimbursement under such plans to an appropriate complaint review office established under part 1 of subtitle D of title IX of such Act.

"(6) Respond, in person and by toll-free telephone access, to general inquiries from consumers concerning such plans.

"(7) Provide outreach and education relating to consumer rights and responsibilities under this Act to consumers, including underserved populations.

"(8) Annually report to the National Consumer Health Resource Center concerning the activities carried out by the Office during the year.

"(9) Perform such other functions as the Secretary may specify.

"(c) TERM OF GRANT AND RENEWABILITY.—A grant under this section shall be awarded under a competitive selection process for a term of 3 years.

"(d) MULTI-STATE AREAS.—A multi-State area under this section may only be comprised of multiple contiguous States.

"(e) APPLICATIONS.—

"(1) SUBMISSION.—To apply for a grant under this section, an entity shall submit an application to the Secretary in accordance with the procedures established by the Secretary and in a form prescribed by the Secretary.

"(2) CRITERIA FOR APPROVAL.—The Secretary may not approve an application submitted by an entity under paragraph (1) unless the application includes assurances satisfactory to the Secretary that—

"(A) funds received under this section will be used for the purpose described in subsection (b);

"(B) the applicant has demonstrated expertise in the fields of—

"(i) provision of consumer information; and

"(ii) advocacy on behalf of consumers;

"(C) the applicant has the ability to serve an entire State or, with respect to an application submitted for a multi-State area, the entire area;

"(D) the applicant will establish and maintain local offices to the extent necessary effectively to carry out the functions described in paragraphs (1) through (9) of subsection (b) in the area for which the application is submitted; and

"(E) the applicant is not subject to a conflict of interest, including a conflict of interest arising from an affiliation (through ownership or common control) with—

"(i) a certified health benefit plan sponsor (as defined in section 9300(2) of the Guaranteed Health Insurance Act of 1994); or

"(ii) a health provider (as defined in section 9109(7) of such Act).

"(3) PETITIONS FOR RECONSIDERATION AND REAPPLICATIONS.—

"(A) IN GENERAL.—With respect to an application submitted under paragraph (1) that is disapproved under this subsection, the applicant may submit to the Secretary—

"(i) a petition for reconsideration of the application; and

"(ii) an application that conforms to the requirements of this subsection.

"(B) DEADLINES.—The Secretary shall establish a deadline for the submission of petitions for reconsideration and reapplications under this paragraph. The Secretary shall approve or disapprove each such petition and reapplication before the termination of the 60-day period beginning on the date of such submission.

"GRANTS FOR NATIONAL CONSUMER HEALTH RESOURCE CENTER

"SEC. 399R. (a) IN GENERAL.—The Secretary shall make grants under this section to private nonprofit entities for the establishment and operation of a national center to perform the functions described in subsection (b). The center shall be known as the 'National Consumer Health Resource Center' (in this part referred to as the 'Center'). For any grant term under subsection (c), the Secretary may not make a grant under this section to more than one entity.

"(b) FUNCTIONS.—An entity that receives a grant under this section shall use the grant to perform the following functions through the Center:

"(1) Coordinate and oversee the activities of the Offices under section 399Q .

"(2) Provide technical assistance to the Offices.

"(3) Consolidate the annual reports prepared by the Offices under section 399Q of such Act into a national annual report and submit the national report to the Secretary.

"(4) Make recommendations to the Secretary on issues affecting consumers of health care items and services.

"(5) Perform such other functions as the Secretary may specify.

"(c) TERM OF GRANT AND RENEWABILITY.—A grant under this section shall be awarded under a competitive selection process for a term of 3 years.

"(d) APPLICATIONS.—

"(1) SUBMISSION.—To apply for a grant under this section, an entity shall submit an application to the Secretary in accordance with the procedures established by the Secretary and in a form prescribed by the Secretary.

"(2) CRITERIA FOR APPROVAL.—The Secretary may not approve an application submitted by an entity under paragraph (1) unless the application includes assurances satisfactory to the Secretary that—

"(A) funds received under this section will be used for the purpose described in subsection (b);

"(B) the applicant has demonstrated expertise in the fields of—

"(i) provision of consumer information; and

"(ii) advocacy on behalf of consumers; and

"(C) the applicant is not subject to a conflict of interest, including a conflict of interest arising from an affiliation (through ownership or common control) with—

"(i) a certified health benefit plan sponsor (as defined in section 9300(2) of the Guaranteed Health Insurance Act of 1994); or

"(ii) a health provider (as defined in section 9109(7) of such Act).

"(3) PETITIONS FOR RECONSIDERATION AND REAPPLICATIONS.—

"(A) IN GENERAL.—With respect to an application submitted under paragraph (1) that is disapproved under this subsection, the applicant may submit to the Secretary—

"(i) a petition for reconsideration of the application; and

"(ii) an application that conforms to the requirements of this subsection.

"(B) DEADLINES.—The Secretary shall establish a deadline for the submission of petitions for reconsideration and reapplications under this paragraph. The Secretary shall approve or disapprove each such petition and reapplication before the termination of the 60-day period beginning on the date of such submission.

"REVIEW AND SANCTIONS

"SEC. 399S. The Secretary shall review at least annually the compliance of an entity receiving a grant under a section of this part with the provisions of such section. The Secretary shall establish a procedure for determining whether an entity receiving a grant under a section of this part has failed to comply substantially within the provisions of such section and the sanctions to be imposed for any such noncompliance.

"ANNUAL REPORTS

"SEC. 399T. The Secretary shall transmit annually to the Congress a report containing a detailed statement of the activities carried out under this part by the Secretary, the Offices, and the Center in the year that is the subject of the report.

"REGULATIONS

"SEC. 399U. The Secretary may issue any regulations necessary to carry out this part.".

PART 6—SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS REGARDING SERVICE IN PUBLIC HEALTH POSITIONS

SEC. 7151. ESTABLISHMENT OF SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

Section 761 of the Public Health Service Act (42 U.S.C. 294d) is amended to read as follows:

"SEC. 761. SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS REGARDING SERVICE IN PUBLIC HEALTH POSITIONS.

"(a) DIRECT SPENDING FOR PROGRAMS.—For carrying out this section, there are hereby appropriated, out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

"(1) For fiscal year 1999, $25,000,000.

"(2) For fiscal year 2000, the amount specified in paragraph (1) multiplied by an amount equal to 1 plus the consumer price index for all urban consumers (U.S. city average).

"(3) For fiscal year 2001 and each subsequent fiscal year, the amount determined under this subsection for the preceding fiscal year multiplied by an amount equal to 1 plus such index (as such index is applied for the fiscal year involved).

Amounts appropriated in this subsection are in addition to amounts appropriated in section 765 that are available for carrying out this section.

"(b) SCHOLARSHIP PROGRAM.

"(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall carry out a program under which the Secretary awards scholarships to individuals described in paragraph (2) for the purpose of assisting the individuals with the costs of attending public and nonprofit private schools of public health (or other public or nonprofit private institutions providing graduate or specialized training in public health).

"(2) ELIGIBLE INDIVIDUALS.—An individual referred to in paragraph (1) is any individual meeting the following conditions:

"(A) The individual is enrolled (or accepted for enrollment) at a school or other institution referred to in paragraph (1) as a full-time or part-time student in a program providing training in a health profession in a field of public health (including the fields of epidemiology, biostatistics, environmental health, health administration and planning, behavioral sciences, maternal and child health, occupational safety, public health nursing, nutrition, and toxicology).

"(B) The individual enters into the contract required pursuant to subsection (d) as a condition of receiving the scholarship (relating to an agreement to provide services in approved public health positions, as defined in subsection (d).

"(3) ELIGIBLE SCHOOLS.—For fiscal year 1997 and subsequent fiscal years, the Secretary may make an award of a scholarship under paragraph (1) only if the Secretary determines that—

"(A) the school or other institution with respect to which the award is to be provided has coordinated the activities of the school or institution with relevant activities of the Health Resources and Services Administration and the Centers for Disease Control and Prevention; and

"(B) not fewer than 60 percent of the graduates of the school or institution are in public health positions determined by the Secretary to be consistent with the needs of the United States regarding such professionals.

"(4) APPLICABILITY OF CERTAIN PROVISIONS.—Except as inconsistent with this subsection or subsection (d), the provisions of subpart III of part D of title III (relating to the Scholarship and Loan Repayment Programs of the National Health Service Corps) apply to an award of a scholarship under paragraph (1) to the same extent and in the same manner as such provisions apply to an award of a scholarship under section 338A.

"(c) LOAN REPAYMENT PROGRAM.—

"(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall carry out a program under which the Federal Government enters into agreements to repay all or part of the educational loans of individuals meeting the following conditions:

"(A) The individual involved is a graduate of a school or other institution described in subsection (b)(1).

"(B) The individual meets the applicable legal requirements to provide services as a public health professional (including a professional in any of the fields specified in subsection (b)(2)(A)).

"(C) The individual enters into the contract required pursuant to subsection (b) as a condition of the Federal Government repaying such loans (relating to an agreement to provide services in approved public health positions, as defined in subsection (d)).

"(2) APPLICABILITY OF CERTAIN PROVISIONS.—Except as inconsistent with this subsection or subsection (d), the provisions of subpart III of part D of title III (relating to the Scholarship and Loan Repayment Programs of the National Health Service Corps) apply to an agreement regarding repayment under paragraph (1) to the same extent and in the same manner as such provisions apply to an agreement regarding repayment under section 338B.

"(3) AMOUNT OF REPAYMENTS.—For each year for which an individual contracts to serve in an approved public health position pursuant to paragraph (2), the Secretary may repay not more than $20,000 of the principal and interest of the educational loans of the individual.

"(d) APPROVED PUBLIC HEALTH POSITIONS.—

"(1) POSITION REGARDING POPULATIONS WITH SIGNIFICANT NEED FOR SERVICES.—

"(A) With respect to the programs under this section, the obligated service of a program participant pursuant to subsections (b)(4) and (c)(2) shall be provided through an assignment, to an entity described in paragraph (2), for a position in which the participant provides services as a public health professional to a population determined by the Secretary to have a significant unmet need for the services of such a professional.

"(B) For purposes of subsection (b)(4) and (c)(2), the period of obligated service is the following, as applicable to the program participant involved:

"(i) In the case of scholarships under subsection (b) for full-time students, the greater of—

"(I) 1 year for each year for which such a scholarship is provided; or

"(II) 2 years.

"(ii) In the case of scholarships under subsection (b) for part-time students, a period determined by the Secretary on the basis of the number of hours of education or training received under the scholarship, considering the percentage constituted by the ratio of such number to the number of hours for a full-time student in the program involved.

"(iii) In the case of the loan repayments under subsection (c), such period as the Secretary and the participant may agree, except that the period may not be less than 2 years.

"(2) APPROVAL OF ENTITIES FOR ASSIGNMENT OF PROGRAM PARTICIPANTS.—The entities referred to in paragraph (1)(A) are public and nonprofit private entities approved by the Secretary as meeting such requirements for the assignment of a program participant as the Secretary may establish. The entities that the Secretary may so approve include State and local departments of health, public hospitals, community and neighborhood health clinics, migrant health clinics, community-based health-related organizations, certified regional poison control centers, purchasing cooperatives regarding health insurance, and any other public or nonprofit private entity.

"(3) DEFINITIONS.—For purposes of this section:

"(1) The term 'approved public health position', with respect to a program participant, means a position to which the participant is assigned pursuant to paragraph (1).

"(B) The term 'program participant' means an individual who enters into a contract pursuant to subsection (b)(2)(B) or subsection (c)(1)(C).

"(e) ALLOCATION OF FUNDS; SPECIAL CONSIDERATIONS.—

"(1) ALLOCATIONS REGARDING NEW PARTICIPANTS IN SCHOLARSHIP PROGRAM.—Of the amounts appropriated in subsection (a) for a fiscal year, the Secretary shall obligate not less than 30 percent for the purpose of providing awards for scholarships under subsection (b) to individuals who have not previously received such scholarships.

"(2) SPECIAL CONSIDERATION FOR CERTAIN INDIVIDUALS.—In making awards of scholarships under subsection (b) and making repayments under subsection (c), the Secretary shall give special consideration to individuals who are in the armed forces of the United States or who are veterans of the armed forces.

"(3) SCHOOL HEALTH EDUCATION PROGRAMS.—The Secretary shall ensure that the approved public health positions to which the Secretary assigns program participants under this part include positions in programs that provide education on the promotion of health and the prevention of diseases and that are carried out on the premises of public or nonprofit private elementary and secondary schools.".

Subtitle C—Assistance for Capital Costs of Safety-Net Hospitals

SEC. 7201. TABLE OF CONTENTS REGARDING NEW TITLE XXVIII OF PUBLIC HEALTH SERVICE ACT.

A table describing the contents of title XXVIII of the Public Health Service Act, as added by section 7202 of this Act, is as follows:

TITLE XXVIII—ASSISTANCE FOR CAPITAL COSTS OF CERTAIN ENTITIES

Subtitle A—Safety-Net Hospitals

PART 1—GENERAL PROVISIONS

Sec. 2801. Financial assistance for qualifying hospitals.
Sec. 2802. Funding.
Sec. 2803. Certain requirements for assistance.
Sec. 2804. Application for assistance.

PART 2—QUALIFYING HOSPITALS; SAFETY-NET HOSPITALS

SUBPART A—GENERAL PROVISIONS

Sec. 2811. Definition of qualifying hospitals.
Sec. 2812. Priorities in award of assistance.

SUBPART B—REQUIREMENTS FOR LOAN GUARANTEES

Sec. 2821. Loan guarantees.
Sec. 2822. Funding.
Sec. 2823. Terms and conditions of loan guarantees.
Sec. 2824. Premiums for loan guarantees.
Sec. 2825. Procedures regarding loan default.

SUBPART C—REQUIREMENTS FOR INTEREST RATE SUBSIDIES

Sec. 2831. Grants as interest rate subsidies.
Sec. 2832. Eligible loans.
Sec. 2833. Amount of subsidy; allocation of funds.
Sec. 2834. Terms and conditions for subsidies.
Sec. 2835. Subsidies for loan refinancing.

SUBPART D—REQUIREMENTS FOR DIRECT MATCHING LOANS

Sec. 2841. Provision of matching loans.
Sec. 2842. Eligible projects.
Sec. 2843. Funding.
Sec. 2844. Terms and conditions of loans.
Sec. 2845. Use of loans for refinancing.
Sec. 2846. Creation of revolving fund.
Sec. 2847. Loan default.

SUBPART E—REQUIREMENTS FOR GRANTS FOR URGENT CAPITAL NEEDS

Sec. 2851. Provision of grants.
Sec. 2852. Eligible projects.

PART 3—QUALIFYING HOSPITALS; ACADEMIC HEALTH CENTERS

Sec. 2871. Transitional assistance; provision of interest rate subsidies.
Sec. 2872. Eligible financing.
Sec. 2873. Eligible projects.
Sec. 2874. Allotment of subsidies.

Subtitle B—Emergency Medical Equipment for Rural Areas

Sec. 2881. Grants regarding emergency medical services.

Subtitle C—Facilities of Indian Health Service

Sec. 2891. Financial assistance for facilities of Service.

SEC. 7202. DIRECT SPENDING REGARDING CERTAIN HOSPITALS.

The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 7123 of this Act, is amended by adding at the end the following title:

"TITLE XXVIII—ASSISTANCE FOR CAPITAL COSTS OF CERTAIN ENTITIES

"Subtitle A—Safety-Net Hospitals

"PART 1—GENERAL PROVISIONS

"SEC. 2801. FINANCIAL ASSISTANCE FOR QUALIFYING HOSPITALS.

"(a) IN GENERAL.—For the fiscal years 1996 through 1999, the Secretary, acting through the Administrator of the Health Resources and Services Administration, may in accordance with this subtitle provide financial assistance for qualifying hospitals for projects for—

"(1) the construction, acquisition, modernization, and renovation of facilities for the hospitals; and

"(2) the purchase of equipment.

"(b) QUALIFYING HOSPITAL.—For purposes of this subtitle, the term 'qualifying hospital'—

"(1) in the case of financial assistance authorized in part 2, has the meaning given such term in section 2811(a); and

"(2) in the case of financial assistance authorized in part 3, has the meaning given such term in section 2871(b).

"(c) FORMS OF ASSISTANCE.—The forms of financial assistance that may be provided under this subtitle are loan guarantees, direct loans, and grants, subject to being authorized in part 2 or part 3.

"SEC. 2802. FUNDING.

"(a) DIRECT SPENDING.—For carrying out this title, there are hereby appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the calendar year involved):

"(1) For fiscal year 1996, $980,000,000.

"(2) For fiscal year 1997, $975,000,000.

"(3) For fiscal year 1998, $955,000,000.

"(4) For fiscal year 1999, $955,000,000.

"(b) ALLOCATIONS.—Of the amounts appropriated in subsection (a) for a fiscal year, the Secretary—

"(1) shall reserve $29,400,000 for carrying out subtitle C;

"(2) shall reserve $75,000,000 for carrying out part 3 of this subtitle; and

"(3) may reserve not more than $35,000,000 for carrying out subtitle B.

"SEC. 2803. CERTAIN REQUIREMENTS FOR ASSISTANCE.

"(a) COMMUNITY SERVICE.—The Secretary may provide financial assistance under this subtitle only if the qualifying hospital involved—

"(1) provides services to individuals without regard to their ability to pay for such services (in accordance with standards established by the Secretary); and

"(2) effective January 1, 1999, is a participating provider under medicare part C (established under title XXI of the Social Security Act).

"(b) PROTECTION OF FEDERAL FINANCIAL INTERESTS.—The Secretary shall establish criteria to ensure that the financial interests of the United States in projects described in section 2801 are protected, including ensuring that qualifying hospitals have the capacity to meet any financial obligations established under this subtitle for the hospital. The Secretary may provide financial assistance under this subtitle only if the qualifying hospital involved agrees to comply with the criteria.

"(c) TWENTY-YEAR OBLIGATION; RIGHT OF RECOVERY.—

"(1) IN GENERAL.—The Secretary may provide financial assistance under this subtitle only if the qualifying hospital involved agrees as follows:

"(A) The hospital is liable to the United States, for an amount determined pursuant to subparagraph (B), if at any time during the 20-year period beginning on the date of completion of the activities for which the assistance is provided, the hospital—

"(i) ceases to be a hospital meeting 1 or more of the conditions described in section 2811(a)(3) (relating to ownership status); or

"(ii) is sold or transferred to any entity other than an entity that is—

"(I) a hospital described in clause (i); and

"(II) approved by the Secretary as a purchaser or transferee of the hospital.

"(B) The provisions of section 1622 (relating to the amount of liability, the waiver of recovery rights, and other matters) apply to the hospital regarding the liability of the hospital under subparagraph (A) to the same extent and the same manner as such provisions apply to the liability of an entity under section 1622(a).

"(2) OTHER PARTIES.—The Secretary may recover the amount of liability under paragraph (1) from the qualifying hospital involved or from any transferee (or, in the case of a hospital that has ceased to be public or nonprofit private entity, from the owners thereof).

"(d) WAGES OF LABORERS AND MECHANICS.—

"(1) AGREEMENT.—The Secretary may provide financial assistance under section 2801 only if the qualifying hospital involved agrees that, in carrying out the capital activities for which the assistance is provided, all laborers and mechanics employed by contractors or subcontractors will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a-5, known as the Davis-Bacon Act).

"(2) AUTHORITY OF SECRETARY OF LABOR.—The Secretary of Labor shall have with respect to the labor standards referred to in paragraph (1) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

"SEC. 2804. APPLICATION FOR ASSISTANCE.

"The Secretary may provide financial assistance under this subtitle only if the qualifying hospital involved—

"(1) submits to the Secretary an application for the assistance;

"(2) the application contains the agreements required in this subtitle for the receipt of the assistance; and

"(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subtitle.

"PART 2—QUALIFYING HOSPITALS; SAFETY-NET HOSPITALS

"Subpart A—General Provisions

"SEC. 2811. DEFINITION OF QUALIFYING HOSPITALS.

"(a) DEFINITION.—

"(1) IN GENERAL.—For purposes of this part, the term 'qualifying hospital' means a hospital that—

"(A) meets 1 or more of the conditions described in paragraph (2); and

"(B) meets 1 or more of the conditions described in paragraph (3).

"(2) MEDICARE STATUS.—For purposes of paragraph (1), the conditions described in this paragraph regarding a hospital are as follows:

"(A) The hospital is designated as an essential access community hospital by the Secretary under section 1820(i)(1) of the Social Security Act.

"(B) The hospital is designated as a rural primary care hospital by the Secretary under section 1820(i)(2) of such Act.

"(C) The hospital has a disproportionate patient percentage (as described in section 1886(d)(5)(F)(vi) of such Act) equal to or greater than 40 percent.

"(3) OWNERSHIP STATUS.—For purposes of paragraph (1), the conditions described in this paragraph regarding a hospital are as follows:

"(A) The hospital is owned or operated by a unit of State or local government.

"(B) The hospital is a quasi-public corporation, defined as a private, nonprofit corporation or public benefit corporation which is formally granted one or more governmental powers by legislative action through (or is otherwise partially funded by) the State legislature, city or county council.

"(C) The hospital is a private nonprofit hospital.

"(4) CERTAIN HOSPITALS.—For purposes of this part, the term 'qualifying hospital' includes each of the following: George W. Hubbard Hospital of the Meharry Medical College (in Nashville, in the State of Tennessee); Howard University Hospital (in the District of Columbia); Newport News General Hospital (in Newport News, in the State of Virginia); Norfolk Community Hospital (in Norfolk, in the State of Virginia); Richmond Community Hospital (in Richmond, in the State of Virginia); Riverside General Hospital (in Houston, in the State of Texas); Bethany Hospital (in Chicago, in the State of Illinois); Jackson Park Hospital (in Chicago, in the State of Illinois); North General Hospital (in New York, in the State of New York); Roseland Community Hospital (in Chicago, in the State of Illinois); Southwest Hospital and Medical Center (in Atlanta, in the State of Georgia); and St. Bernard Hospital (in Chicago, in the State of Illinois).

"(b) RULE OF CONSTRUCTION REGARDING MEDICARE AMENDMENTS.—Except as otherwise provided in this subtitle:

"(1) A reference in this subtitle to title XVIII of the Social Security Act shall be considered to be a reference to such title as in effect on the day after the date of the enactment of the Guaranteed Health Insurance Act of 1994, without regard to any amendment subsequently made to such title XVIII.

"(2) For purposes of paragraph (1), an amendment to such title XVIII that is made by the Guaranteed Health Insurance Act of 1994 as of the day referred to in such paragraph applies to this subtitle upon the amendment taking effect, without regard to whether the date on which the amendment takes effect is after the day referred to in such paragraph.

"SEC. 2812. PRIORITIES IN AWARD OF ASSISTANCE.

"In the case of qualifying hospitals that meet the requirements of this part for receiving financial assistance, the Secretary shall give priority to hospitals meeting the conditions of each of paragraphs (1) and (2), as follows:

"(1) The project to be carried out with the assistance meets 1 or more of the following conditions:

"(A) The project is necessary to bring the hospital into compliance with accreditation standards or fire and life safety, seismic, or other related Federal, State or local regulatory standards.

"(B) The project will improve the provision of essential services (such as emergency medical and trauma services; services regarding acquired immune deficiency syndrome and infectious diseases; perinatal services; services for burned individuals; primary care; and such other services as the Secretary may designate).

"(C) The project will result in the provision of access to essential health services to indigent and other needy individuals within the service area of the hospital, which services would otherwise be unavailable.

"(2) The hospital provides to the Secretary (in the application under section 2804) specific anticipated State or local governmental or other non-Federal assurances of financial support.

"Subpart B—Requirements for Loan Guarantees

"SEC. 2821. LOAN GUARANTEES.

"(a) PURPOSE.—The Secretary may provide loan guarantees for loans to qualifying hospitals for projects described in section 2801. The program under this subpart shall be designed by the Secretary with the goal of rebuilding and maintaining the essential health services of qualifying hospitals eligible for such guarantees.

"(b) GUARANTEE AS ESSENTIAL ELEMENT IN FINANCING.—The Secretary may provide a loan guarantee under subsection (a) for a qualifying hospital only if the guarantee is essential for the hospital to obtain financing for the project involved from a non-Federal lender at a reasonably affordable rate of interest.

"(c) PREFERENCES IN PROVIDING GUARANTEES.—In providing loan guarantees under subsection (a), the Secretary shall give preference to projects in which State or local governmental entities participate in the form of first guarantees of part or all of the total loan value.

"(d) LIMITATION REGARDING RATE OF INTEREST.—The Secretary shall ensure that, with respect to a loan guarantee under subsection (a), the rate of interest does not exceed such annual percentage on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States.

"SEC. 2822. FUNDING.

"(a) IN GENERAL.—Of the amounts available under section 2802 for a fiscal year after compliance with subsection (b) of such section, the Secretary may reserve not more than $150,000,000 for providing loan guarantees under section 2821.

"(b) ALLOCATIONS FOR RURAL HOSPITALS.—Of the amounts available for a fiscal year pursuant to subsection (a), the Secretary shall reserve not less than 10 percent for loan guarantees for qualifying hospitals in rural areas, subject to a sufficient number of such hospitals meeting the requirements for such guarantees.

"(c) LIMITATION REGARDING REFINANCING LOANS.—Of the amounts available for a fiscal year pursuant to subsection (a), the Secretary may not obligate more than 20 percent to guarantee refinancing loans.

"SEC. 2823. TERMS AND CONDITIONS OF LOAN GUARANTEES.

"(a) IN GENERAL.—The principle amount of a loan guaranteed under section 2821, when added to any Federal grant assistance made under this subtitle, may not exceed 95 percent of the total value of the project, including land.

"(b) MAINTENANCE OF EFFORT.—Loan guarantees under section 2821 may not be used to supplant other forms of State or local support.

"(c) RIGHT TO RECOVER FUNDS.—The United States shall be entitled to recover from any applicant the amount of payments made pursuant to any loan guarantee under this part, unless the Secretary for good cause waives its right of recovery, and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipients of the payments with respect to which the guarantee was made.

"(d) INCONTESTABILITY OF TERMS ABSENT FRAUD OR MISREPRESENTATION.—Any loan guarantee made by the Secretary under section 2821 shall be incontestable in the hands of an applicant on whose behalf such guarantee is made, and as to any person who makes or contracts to make a loan to such applicant in reliance thereon, except for fraud or misrepresentation on the part of such applicant or other person.

"SEC. 2824. PREMIUMS FOR LOAN GUARANTEES.

"(a) IN GENERAL.—The Secretary shall determine a reasonable loan insurance premium which shall be charged for loan guarantees under section 2821, taking into account the availability of the reserves created under section 2822. Premium charges shall be payable in cash to the Secretary (either in full upon issuance or annually in advance). In addition to such charge, the Secretary may charge and collect such amount as the Secretary considers reasonable for the appraisal of a property or project offered for insurance and for the inspection of such property or project.

"(b) PAYMENT IN ADVANCE.—In the event that the principal obligation of any loan accepted for a guarantee under section 2821 is paid in full prior to the maturity date, the Secretary may, in the discretion of the Secretary, require the payment by the borrower of an adjusted premium charge in such amount as the Secretary determines to be equitable, but not in excess of the aggregate amount of the premium charges that the qualifying hospital involved would otherwise have been required to pay if the loan had continued to be guaranteed until maturity date.

"(c) WAIVER OF PREMIUMS.—The Secretary may, in the discretion of the Secretary, partially or totally waive premiums charged for loan guarantees under section 2821 for qualifying hospitals that are financially distressed (as described by the Secretary).

"SEC. 2825. PROCEDURES REGARDING LOAN DEFAULT.

"(a) PAYMENT OF INSURANCE AFTER DEFAULT.—

"(1) TRANSFER OF RIGHTS AND INTERESTS.—The failure of a qualifying hospital to make the payment due under or provided by the terms of a loan guaranteed under section 2821 shall be considered in default under such loan and, if such default continues for a period of 30 days, the lender shall be entitled to receive the benefits of the guarantee as provided in this part, upon assignment, transfer, and delivery to the Secretary, within a period and in accordance with rules and regulations to be prescribed by the Secretary of—

"(A) all rights and interests arising under the loan in default;

"(B) all claims of the lender against the qualifying hospital or others, arising out of the loan transactions;

"(C) all policies of title or other insurance or surety bonds or other guarantees and any and all claims thereunder;

"(D) any balance of the loan not advanced to the borrower;

"(E) any cash or assets held by the lender, or to which it is entitled, as deposits made for the account of the borrower and which have not been applied in reduction of the principal of the loan indebtedness; and

"(F) all records, documents, books, papers, and accounts relating to the mortgage transaction.

"(2) PAYMENTS BY SECRETARY.—Upon an assignment, transfer, and delivery described in paragraph (1), the obligation of a qualifying hospital to pay the premium charges for the loan guarantee shall cease, and the Secretary shall, subject to the cash adjustment provided for in subsection (d), issue to the lender a certificate of claim as provided in subsection (b), and debentures having total face value equal to the original principal face amount of the loan plus such amount as the borrower may have paid for taxes, special assessments, and water rates, which are liens prior to the mortgage; insurance on the assets; and reasonable expenses for the completion and preservation of the assets and any loan insurance premiums paid after default, less the sum of—

"(A) that part of the amount of the principal obligation that has been repaid by the borrower,

"(B) an amount equivalent to 1 percent of the unpaid amount of such principal obligation, and

"(C) any net income received by the lender from the assets.

"(3) OPTION TO FORECLOSE.—

"(A) IN GENERAL.—In the event of a default under the loan the lender may, at its option and in accordance with the regulations of, and in a period of time to be determined by the Secretary, proceed to foreclose on and obtain possession of or otherwise acquire such assets from the borrower after default, and receive the benefits of the insurance as herein provided, upon—

"(i) the prompt conveyance to the Secretary of title to the assets which meets the requirements of the rules and regulations of the Secretary in force at the time the loan was insured and which is evidenced in the manner prescribed by such rules and regulations; and

"(ii) the assignment to the Secretary of all claims of the lender against the borrower or others, arising out of the loan transaction or foreclosure proceedings, except such claims that may have been released with the consent of the Secretary.

"(B) REPEAL OF OBLIGATION TO PAY PREMIUM.—Upon such conveyance and assignment, the obligation of the qualifying hospital to pay the premium charges for the loan guarantee shall cease and the hospital shall be entitled to receive the benefits of the guarantee as provided in this subsection, except that in such event the 1 percent deduction set out above shall not apply.

"(b) CERTIFICATE OF CLAIM; DIVISION OF EXCESS PROCEEDS.—

"(1) VALUE OF CERTIFICATE.—The certificate of claim issued under this section shall be for an amount which the Secretary determines to be sufficient, when added to the face value of the debentures issued and the cash adjustment paid to the lender, to equal the amount which the lender would have received if, on the date of the assignment, transfer and delivery to the Secretary provided for in subsection (a) of this section, the mortgagor had extinguished the mortgage indebtedness by payment in full of all obligations under the loan and a reasonable amount for necessary expenses incurred by the lender in connection with the default proceedings, or the acquisition of the mortgaged assets otherwise, and the conveyance thereof to the Secretary. Each such certificate of claim shall provide that there shall accrue to the holder of such certificate with respect to the face amount of such certificate, an increment at the rate of 3 percent per annum which shall not be compounded.

"(2) TREATMENT OF EXCESS.—If the net amount realized from the mortgage, and all claims in connection therewith, so assigned, transferred, and delivered, and from the assets covered by such mortgage and all claims in connection with such assets, after deducting all expenses incurred by the Secretary in handling, dealing with, acquiring title to, and disposing of such mortgage and assets and in collecting such claims, exceeds the face value of the debentures issued and the case adjustment paid to the mortgagee plus all interest paid on such debentures, such excess shall be divided as follows:

"(A) If such excess is greater than the total amount payable under the certificate of claim issued in connection with such assets, the Secretary shall pay to the holder of such certificate the full amount so payable, and any excess remaining thereafter shall be retained by the Secretary and credited to the loan insurance program of the Secretary.

"(B) If such excess is equal to or less than the total amount payable under such certificate of claim, the Secretary shall pay to the holder of such certificate the full amount of such excess.

"(c) ACQUISITION OF ASSETS BY CONVEYANCE OR FORECLOSURE.—

"(1) IN GENERAL.—The Secretary is authorized to—

"(A) acquire possession of and title to any assets, covered by a mortgage insured under this section and assigned to it, by voluntary conveyance in extinguishment of the mortgage indebtedness, or

"(B) institute proceeding for foreclosure on the assets covered by any such insured mortgage and prosecute such proceedings to conclusion.

"(2) BIDDING PROCEDURES AT FORECLOSURE.—The Secretary at any sale under foreclosure may, in its discretion, for the protection of the Secretary, bid any sum up to but not in excess of the total unpaid indebtedness secured by the mortgage plus taxes, insurance, foreclosure costs, fees, and other expenses, and may become the purchaser of the assets at such sale. In determining the amount to be bid, the Secretary shall act consistently with its duties.

"(3) PAYMENT OF EXPENSES.—The Secretary is authorized to pay from the Secretary such sums as may be necessary to defray such taxes, insurance, costs, fees, and other expenses in connection with the acquisition or foreclosure of assets under this section.

"(4) EXERCISE OF RIGHTS PENDING ACQUISITION.—Pending such acquisition by voluntary conveyance or by foreclosure, the Secretary is authorized, with respect to any mortgage assigned to it under the provisions of subsection (a), to exercise all the rights of a mortgagee under such mortgage, including the right to sell such a mortgage, and to take such action and advance such sums as may be necessary to preserve or protect the lien of such mortgage.

"(d) HANDLING AND DISPOSAL OF ASSETS; SETTLEMENT OF CLAIMS.—

"(1) PAYMENT FOR CERTAIN EXPENSES.—Notwithstanding any other provisions of law relating to the acquisition, handling, or disposal of real and other property by the United States, the Secretary shall also have power, for the protection of the interests of the Secretary, to pay out of the Secretary all expenses or charges in connection with, and to deal with, complete, reconstruct, rent, renovate, modernize, insure, make contracts for the management of, or establish suitable agencies for the management of, or sell for cash or credit or lease in its discretion, any assets acquired by it under this section.

"(2) SETTLEMENT OF CLAIMS.—Notwithstanding any other provision of law, the Secretary shall also have the power to pursue to final collection by way of compromise or otherwise all claims assigned and transferred to it in connection with the assignment, transfer, and delivery provided for in this section, and at any time, upon default, to foreclose or refrain from foreclosing on any assets secured by any mortgage assigned and transferred to or held by it.

"(3) LIMITATIONS ON AUTHORITY.—Subsections (a) and (b) shall not be construed to apply to any contract for hazard insurance, or to any purchase or contract for services or supplies on account of such assets if the amount thereof does not exceed $1,000.

"Subpart C—Requirements for Interest Rate Subsidies

"SEC. 2831. GRANTS AS INTEREST RATE SUBSIDIES.

"(a) IN GENERAL.—The Secretary shall make grants as interest subsidies to reduce the costs of qualifying hospitals in financing projects described in section 2801.

"(b) PURPOSES.—The interest subsidy program under subsection (a) shall provide a partial Federal subsidy of debt service payment for financing replacement (whether by construction or acquisition), modernization, and renovation projects or capital equipment acquisitions.

"(c) INTEREST SUBSIDIES AS ESSENTIAL ELEMENT IN FINANCING.—The Secretary may make a grant under subsection (a) for a qualifying hospital only if the grant is essential for the hospital as financing for the project involved.

"SEC. 2832. ELIGIBLE LOANS.

"(a) IN GENERAL.—Qualifying hospitals shall have issued or plan to issue bonds, or shall have secured or plan to secure loans, for capital projects or be responsible for paying debt service on general obligation or revenue bonds issued or loans made on the qualifying hospital's behalf. To be eligible, bonds must have been issued after December 31, 1992.

"(b) NON-FEDERAL PARTICIPATION REQUIREMENT.—The Secretary may provide interest subsidies under section 2831 for a qualifying hospital only if the hospital receives assistance from non-Federal sources in an amount not less than the amount of such subsidies.

"SEC. 2833. AMOUNT OF SUBSIDY; ALLOCATION OF FUNDS.

"(a) IN GENERAL.—Interest subsidy grants under section 2831 shall be made in the amount of 3 percentage points for qualifying non-Federal loans.

"(b) QUALIFYING FEDERAL LOANS UNDER PART 2.—Interest subsidy grants under section 2831 in an amount of up to 5 percentage points shall be made for qualifying Federal loans made under this part if it is determined by the Secretary that the project would not be otherwise financially feasible.

"(c) RESERVE FOR RURAL HOSPITALS AND FACILITIES.—Of the amounts available for a fiscal year pursuant to subsection (e), the Secretary shall reserve not less than 10 percent for grants under section 2831 to qualifying hospitals in rural areas, subject to there being a sufficient number of qualified applicants.

"(d) LIMITATION ON AMOUNT OF SUBSIDIES AWARDED PER STATE.—The aggregate value of interest subsidies made under section 2831 to qualifying hospitals in any State for a fiscal year shall not exceed 25 percent of the amounts available under subsection (e) for the year.

"(e) AMOUNT ALLOCATED FROM SECRETARY.—Of the amounts available under section 2802 for a fiscal year after compliance with subsection (b) of such section, the Secretary shall reserve $220,000,000 for interest subsidies under section 2831.

"SEC. 2834. TERMS AND CONDITIONS FOR SUBSIDIES.

"(a) STATE OR LOCAL PARTICIPATION.—State or local participation in an amount equal to not less than the Federal subsidy shall be required.

"(b) ISSUANCE OF FEDERAL COMMITMENTS.—If the Secretary approves an application for interest subsidies under section 2831, the qualifying hospital involved shall receive a Federal commitment of a grant for the subsidies. Applicants shall then have 12 months to finalize financing arrangements before unobligated funds are returned to the subsidy program. A commitment, when issued, shall be valid for as long as the qualifying hospital continues to meet the eligibility qualifications of this subtitle.

"SEC. 2835. SUBSIDIES FOR LOAN REFINANCING.

"In addition to providing interest rate subsidies for new loans, the Secretary may provide subsidies to assist in refinancing if the qualifying hospital involved presently lacks permanent financing at an affordable current market rate.

"Subpart D—Requirements for Direct Matching Loans

"SEC. 2841. PROVISION OF MATCHING LOANS.

"(a) IN GENERAL.—The Secretary may provide direct loans to qualifying hospitals for projects described in section 2801 if the hospitals are unable otherwise to obtain essential financing for the projects.

"(b) PRIORITY FOR CERTAIN PROJECTS.—In making direct loans under subsection (a) to qualifying hospitals, the Secretary shall give priority to smaller projects where the transaction costs of securing financing from other sources may be disproportionately onerous in relationship to the amounts financed.

"SEC. 2842. ELIGIBLE PROJECTS.

"(a) IN GENERAL.—Qualifying hospitals may seek a direct loan under section 2841 for a project of up to $50,000,000. Not more than 75 percent of the cost of the project may come from Federal sources.

"(b) EXCEPTION FOR FINANCIALLY DISTRESSED APPLICANTS.—The Secretary shall have the discretion to waive the 25 percent match requirement under subsection (a) for financially distressed hospitals and facilities (as described by the Secretary).

"SEC. 2843. FUNDING.

"(a) IN GENERAL.—Of the amounts available under section 2802 for a fiscal year after compliance with subsection (b) of such section, the Secretary shall reserve for direct loans under section 2841 $114,500,000 for fiscal year 1996, $109,500,000 for fiscal year 1997, and $89,500,000 for fiscal year 1998. Funded projects shall be divided between projects designed to achieve compliance with accreditation standards, life safety code, and other certification standards, and those related to the provision of new services.

"(b) RESERVE FOR RURAL HOSPITALS AND FACILITIES.—Of the amounts available for a fiscal year pursuant to subsection (a), the Secretary shall reserve not less than 10 percent for direct loans under section 2841 to qualifying hospitals in rural areas, subject to there being a sufficient number of qualified applicants.

"SEC. 2844. TERMS AND CONDITIONS OF LOANS.

"(a) GENERAL TERM.—Direct loans under section 2841 shall be made for a period equal to the construction period of the project involved plus up to 39 years amortization.

"(b) INTEREST RATE.—The interest rate for a direct loan under section 2841 shall be a market rate determined by the Secretary to be the most recent applicable index for revenue bonds, as the Secretary finds appropriate.

"SEC. 2845. USE OF LOANS FOR REFINANCING.

"In addition to making direct loans under section 2841 for new projects, the Secretary may make such loans to refinance existing loans if the qualifying hospital involved has been unable to secure permanent financing at an affordable current market rate, except that the amount of such loans made for a fiscal year for refinancing existing loans may not exceed 20 percent of the total amount made available for such loans for the year.

"SEC. 2846. CREATION OF REVOLVING FUND.

"In addition to the new amounts made available under section 2843 for a fiscal year, all loan repayments under section 2841 made by qualifying hospitals shall be held in a revolving fund that may be used for additional loans under section 2841.

"SEC. 2847. LOAN DEFAULT.

"(a) IN GENERAL.—The failure of a qualifying hospital to make payment due under or provided by the terms of a direct loan made under section 2841 shall be considered a default under such loan and, if such default continues for a period of 30 days, the Secretary shall have the right to begin collection proceedings against the hospital.

"(b) PRIORITY OF FEDERAL INTEREST.—In the case of default, the United States shall be paid prior to State or local bonds.

"(c) SETTLEMENT OF CLAIMS.—Notwithstanding any other provision of law, the Secretary shall have the power to pursue to final collection by way of compromise or otherwise all claims assigned and transferred to the Secretary in connection with an assignment, transfer, and delivery and at any time, upon default, to foreclose or refrain from foreclosing on any assets secured by any defaulted loan held by the Secretary.

"Subpart E—Requirements for Grants for Urgent Capital Needs

"SEC. 2851. PROVISION OF GRANTS.

"(a) IN GENERAL.—The Secretary shall make grants to qualifying hospitals with urgent capital needs for carrying out a project under section 2801.

"(b) PURPOSES.—Grants made under subsection (a) shall be available to qualifying hospitals for 3 types of projects:

"(1) Emergency certification and licensure grants shall be available to such hospitals that are threatened with closure or loss of accreditation or certification of a facility or of essential services as a result of life or safety code violations or similar facility or equipment failures. Such grants shall provide limited funding for repair and renovation or capital equipment acquisition where failure to fund would disrupt the provision of essential public health services such as emergency care.

"(2) Emergency grants shall be available for capital renovation, expansion, or replacement (whether by construction or acquisition) necessary to the maintenance or expansion of essential safety and health services such as obstetrics, perinatal, emergency and trauma, primary care and preventive health services.

"(3) Planning grants shall be available to qualified hospitals and facilities requiring pre-approval assistance related to management and finance in order to apply for loans, loan guarantees, and interest subsidies under this part.

"(c) PRIORITY TO FINANCIALLY DISTRESSED PROVIDERS.—In making grants pursuant to subsection (a), the Secretary shall give priority to qualifying hospitals that are financially distressed (as described by the Secretary).

"(d) APPLICATION PROCESS.—The Secretary shall create an expedited application process for grants under subsection (a).

"(e) AMOUNT ALLOCATED FROM SECRETARY.—Of the amounts available under section 2802 for a fiscal year after compliance with subsection (b) of such section, the Secretary shall reserve $356,100,000 for making grants under subsection (a).

"SEC. 2852. ELIGIBLE PROJECTS.

"(a) MATCHING GRANTS.—

"(1) LIMITATION ON AMOUNT.—Grants under section 2851 shall be limited to $25,000,000.

"(2) MATCHING REQUIREMENT.—The Secretary shall require that qualifying hospitals receiving grants under section 2851 receive at least 50 percent of their funding from State or local sources.

"(3) RESERVATION FOR RURAL APPLICANTS.—Of the amounts available pursuant to section 2851(e) for a fiscal year, the Secretary shall reserve not less than 10 percent for grants under section 2851 for qualifying hospitals in rural areas, subject to there being a sufficient number of qualified applicants.

"(b) PLANNING GRANTS.—

"(1) IN GENERAL.—In making grants under section 2851, the Secretary may make a grant to a qualifying hospital of up to $200,000 to assist in implementation of key budgetary and financial systems as well as management and governance restructuring.

"(2) LIMIT ON TOTAL AMOUNTS PROVIDED.—The total amount of assistance provided pursuant to section 2851 in the form of planning grants described in this subsection shall not exceed $10,000,000.

"PART 3—QUALIFYING HOSPITALS; ACADEMIC HEALTH CENTERS

"SEC. 2871. TRANSITIONAL ASSISTANCE; PROVISION OF INTEREST RATE SUBSIDIES.

"(a) IN GENERAL.—From the amounts reserved under section 2802(b)(2) for a fiscal year, the Secretary may make grants as interest subsidies to reduce the capital costs of qualifying hospitals in carrying out projects described in section 2801 that meet the conditions described in section 2873.

"(b) DEFINITION OF QUALIFYING HOSPITAL.—For purposes of this part, the term 'qualifying hospital' means a hospital that—

"(1) is eligible to receive payment for the direct costs of graduate medical education under section 1886(h) of the Social Security Act;

"(2) on June 1, 1994, was eligible to receive a payment adjustment under section 1886(d)(5)(F) of such Act in an amount determined in accordance with section 1886(d)(5)(f)(vii)(I) of such Act; and

"(3) is a public or nonprofit private hospital.

"SEC. 2872. ELIGIBLE FINANCING.

"(a) IN GENERAL.—An interest subsidy is available under section 2871 with respect to any financing obtained by the hospital involved if the financing meets the requirements of subsections (b) through (d), without regard to whether such financing is subject to refunding, advance refunding, or refinancing.

"(b) PROPORTION OF AGGREGATE FINANCING USED FOR PROJECT.—An interest subsidy is available under section 2871 with respect to any financing obtained for a project only if not less than 80 percent of all financing for which a subsidy is provided under such section with respect to the project is used for such project.

"(c) LIMIT ON TOTAL AMOUNT OF FINANCING ELIGIBLE FOR SUBSIDY.—The total amount of financing for which a subsidy is provided under section 2871 with respect to a project may not exceed the lesser of—

"(1) 65 percent of the total cost of the project, as specified by the governing board of the hospital prior to June 1, 1994;

"(2) the total amount of borrowing authorized by the governing board of the hospital with respect to the project prior to June 1, 1994; or

"(3) the Secretary's estimate of the reasonable cost of such financing, as determined in accordance with the methodology described in section 1861(v).

"(d) PROHIBITION AGAINST USE OF SUBSIDY FOR RETROACTIVE DEBT SERVICE PAYMENTS.—The Secretary may not provide any interest subsidy under section 2871 with respect to any debt service payment made by a hospital prior to the date on which the subsidy is initially provided to the hospital under such section.

"SEC. 2873. ELIGIBLE PROJECTS.

"(a) IN GENERAL.—The Secretary may make a grant under section 2871 to a qualifying hospital for a project under section 2801 only if—

"(1) prior to June 1, 1994, the project has been approved by a State under a capital review program or, in the case of a project in a State without such a program, by the governing board of the hospital;

"(2) the hospital demonstrates that the replacement facility will be available for providing services to patients not later than December 31, 2002 and was not available for providing services to patients prior to January 1, 1987; and

"(3) the total cost of the project is not less than $200,000,000.

"(b) TOTAL PROJECT COST.—For purposes of subsection (a)(3), the term 'total cost of the project' means the total amount of project-related costs, including the following: Construction; land; air rights; equipment; construction contingency; planning; legal, architectural, engineering, and design services; interest during construction; borrowings for the purpose of refinancing previously incurred debt in order to meet requirements of a new lender; and other expenses generally recognized as costs of development, financing, and construction of such projects.

"SEC. 2874. ALLOTMENT OF SUBSIDIES.

"(a) IN GENERAL.—Interest subsidy grants to a hospital under section 2871 shall be made in an amount not exceeding 3 percentage points, except that the amount of such a grant may not exceed the interest portion of the eligible financing involved. The amount applicable under the preceding sentence as the maximum amount for such a grant shall be reduced by the Secretary by the amount of any financial assistance provided for the project involved under part 2.

"(b) AMOUNT ALLOCATED BY SECRETARY.—If the amount reserved under section 2802(b)(2) for a fiscal year is insufficient to provide interest subsidies to all qualifying hospitals that apply for and are eligible for such subsidies, the amount of the subsidy provided to each recipient shall be reduced on a pro rata basis.

"Subtitle B—Emergency Medical Equipment for Rural Areas

"SEC. 2881. GRANTS REGARDING EMERGENCY MEDICAL SERVICES.

"(a) IN GENERAL.—From amounts reserved under section 2802(b)(3), the Secretary, acting through the Director of the Office of Rural Health Policy, may make grants to public and nonprofit private entities for the purpose of purchasing equipment and vehicles for the provision of emergency medical services in rural areas.

"(b) REQUIREMENT REGARDING COMMUNITY SERVICE.—Section 2803(a) applies to a grant under subsection (a) to the same extent and in the same manner as such section applies to financial assistance under section 2801.

"(c) USE OF EQUIPMENT AND VEHICLES.—The Secretary may make a grant under subsection (a) only if the applicant agrees that the equipment and vehicles purchased pursuant to subsection (a) will be owned, operated, and maintained by the applicant.

"(d) MATCHING FUNDS.—

"(1) IN GENERAL.—With respect to the costs of the program to be carried out under subsection (a) by an applicant, the Secretary may make a grant under such subsection only if the applicant agrees to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 50 percent of such costs.

"(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(e) APPLICATION FOR GRANT.—The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"Subtitle C—Facilities of Indian Health Service

"SEC. 2891. FINANCIAL ASSISTANCE FOR FACILITIES OF SERVICE.

"(a) IN GENERAL.—From the amounts reserved under section 2802(b)(1), the Secretary shall provide financial assistance in the form of loan guarantees, direct loans, and grants to facilities of health programs of the Service (as defined in section 901 of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) for the purposes specified in subparagraphs (A) and (B) of section 2801(a)(1).

"(b) TERMS AND CONDITIONS.—Section 2803 applies to financial assistance under subsection (a) to the same extent and in the same manner as such section applies to financial assistance under section 2801. Such assistance shall be subject to such other terms and conditions as the Secretary determines appropriate to carry out this subtitle with respect to such facilities of health programs of the Service.

"(c) EQUAL TREATMENT OF IHS AND TRIBAL FACILITIES.—In carrying out this section, the Secretary shall—

"(1) treat facilities operated directly by the Indian Health Service and facilities operated by Indian tribes, tribal organizations, and urban Indian organizations through a contract or compact with the Indian Health Service equitably; and

"(2) apply the same terms and conditions in the same manner with respect to facilities operated directly by the Indian Health Service as the Secretary applies to facilities operated by tribes, tribal organizations, and urban Indian organizations through a contract or compact with the Indian Health Service.".

Subtitle D—Other Programs in Public Health Service Act

SEC. 7301. SCHOOL-BASED HEALTH CLINICS.

(a) IN GENERAL.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following section:

"SCHOOL-BASED HEALTH CLINICS

"SEC. 340E. (a) IN GENERAL.—

"(1) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for the purpose of making available to school children the health services described in subsection (c) at sites that are on or in close proximity to the premises of a school (or at such other sites as the Secretary determines to be appropriate to provide school children with access to the services).

"(2) SCHOOL CHILDREN.—For purposes of this section, the term "school children" means an individual between the ages of 3 and 21 (inclusive).

"(b) MINIMUM QUALIFICATIONS; STATUS REGARDING FEDERAL HEALTH PROGRAMS.—

"(1) IN GENERAL.—For fiscal year 1996 and subsequent fiscal years, the Secretary may make a grant under subsection (a) only if, subject to paragraph (2), the applicant involved is in compliance with the following, as applicable to the fiscal year involved:

"(A) For each of the fiscal years 1996 through 1998, and for the first quarter of fiscal year 1999, the applicant is a provider of services under the State plan approved for the State involved under title XIX of the Social Security Act.

"(B) For the remaining quarters of fiscal year 1999 and for each subsequent fiscal year, the applicant is a participating provider under medicare part C (established under title XXI of the Social Security Act).

"(2) WAIVER.—The requirements established in paragraph (1) do not apply to an applicant that provides health services without charge and does not receive reimbursement for the services from any third-party payors.

"(c) REQUIRED CONSULTATIONS REGARDING PARENTS AND TEACHERS.—The Secretary may make a grant under paragraph (1) only if the applicant involved, in preparing the application under subsection (k), has consulted with parents in the community in which services under the grant are to be provided, with teachers at schools in the community, and with the local educational agency with jurisdiction over such schools.

"(d) PREFERENCES IN MAKING GRANTS.—In making grants under subsection (a), the Secretary shall give preference to—

"(1) qualified applicants that are experienced in delivering health care services to medically underserved populations (as defined in section 2752(b)) or in areas in which a significant number of children are at risk for health problems; and

"(2) qualified applicants that are affiliated with community provider networks operated pursuant to section 2721(b)(3)(E).

"(e) AUTHORIZED SERVICES.—

"(1) IN GENERAL.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that services made available under the grant will include each of the following (as medically appropriate for the child involved):

"(A) Comprehensive health examinations.

"(B) Health education and prevention services, including prenatal care.

"(C) Follow-up care for routine health problems.

"(D) Referrals for dental, vision, and hearing services and for mental health services.

"(E) Screenings and follow-up treatment for sexually-transmitted diseases or other communicable diseases.

"(2) OPTION REGARDING FAMILY PLANNING SERVICES.—A grantee under subsection (a) may, at the option of the grantee, expend the grant under such subsection to provide voluntary family planning services. The Secretary may not require as a condition of the receipt of a grant under subsection (a) that an applicant for the grant agree to provide such services.

"(3) OTHER SERVICES.—In addition to services specified in paragraphs (1) and (2), the Secretary may authorize a grantee under subsection (a) to expend the grant for such additional health or health-related services for school children as the Secretary determines to be appropriate.

"(4) AVAILABILITY THROUGHOUT YEAR.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that services under the grant will be available throughout the year (including any portion of the year during which the school does not hold classes).

"(f) CULTURAL CONTEXT OF SERVICES.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that services under the grant will be provided in the language and cultural context most appropriate for the individuals to whom the services are provided.

"(g) LIMITATION ON IMPOSITION OF FEES FOR SERVICES.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that, if a fee is imposed for the provision of services under the grant, such fee—

"(1) will be made according to a schedule of fees that is made available to the public;

"(2) will be adjusted to reflect the income and resources of the school-children involved; and

"(3) will not be imposed on any school child with an income of less than 100 percent of the applicable official poverty line (established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981).'

"(h) MATCHING FUNDS.—

"(1) IN GENERAL.—With respect to the costs of the program to be carried out under subsection (a) by an applicant, the Secretary, subject to paragraph (3), may make a grant under such subsection only if the applicant agrees to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is—

"(A) for the first fiscal year for which the applicant receives such a grant, 10 percent of such costs;

"(B) for any second such fiscal year, 25 percent of such costs; and

"(C) for any subsequent such fiscal year, 50 percent of such costs.

"(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(3) WAIVER.—The Secretary may for an applicant waive the requirement of paragraph (1) for a fiscal year if the Secretary determines that the applicant will be unable to carry out a program under subsection (a) otherwise. If the Secretary provides a waiver under the preceding sentence for a grantee under subsection (a) for a fiscal year, the Secretary may make a grant to the applicant for the following fiscal year only if the Secretary reviews the waiver to determine whether the waiver should remain in effect.

"(i) ADDITIONAL AGREEMENTS.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees as follows:

"(1) The applicant will maintain the confidentiality of patient records.

"(2) The applicant will establish an ongoing quality assurance program regarding services provided under the grant.

"(3) The applicant will not expend more than 10 percent of the grant for administrative expenses regarding the grant.

"(j) REPORTS TO SECRETARY.—The Secretary may make a grant under subsection (a) only if the applicant agrees that, not later than February 1 of the fiscal year following the fiscal year for which the grant is to be made, the applicant will submit to the Secretary a report describing the program carried out by the applicant under the grant, including provisions on the utilization, cost, and outcome of services provided under the grant.

"(k) APPLICATION FOR GRANT; PLAN.—The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary; the application contains a plan describing the proposal of the applicant for a program under subsection (a); and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(l) EVALUATION OF PROGRAMS.—The Secretary, directly or through grants or contracts, shall provide for evaluations of programs carried out under subsection (a), including the cost-effectiveness and health-effectiveness of the programs.

"(m) REPORTS TO CONGRESS.—Not later than May 31 of each fiscal year, the Secretary shall submit to the Congress a report on the programs carried out under subsection (a). The report shall include a summary of the evaluations carried out under subsection (l) for the preceding fiscal year.

"(n) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $100,000,000 for each of the fiscal year 1996, $275,000,000 for fiscal year 1997, $350,000,000 for fiscal year 1998, and $400,000,000 for each of the fiscal years 1999 and 2000.".

(b) CONFORMING AMENDMENT.—Part D of title III of the Public Health Service Act (42 U.S.C 254b et seq.), as amended by section 104 of Public Law 103–183 (107 Stat. 2230), is amended in the heading for subpart VIII by striking "Bulk" and all that follows and inserting the following: "Miscellaneous Provisions Regarding Primary Health Care".

(c) RULE OF CONSTRUCTION.—For fiscal year 1995, references in section 340E of the Public Health Service Act (as added by subsection (a) of this section) to section 2752(b) of such Act are deemed to be references to section 330(a) of such Act.

SEC. 7302. RURAL AND URBAN MANAGED CARE PROGRAM.

(a) IN GENERAL.—The Public Health Service Act, as amended by section 7201 of the this Act, is amended by adding at the end the following title:

"TITLE XXIX—ADDITIONAL PROGRAMS OF PUBLIC HEALTH SERVICE

"SEC. 2901. RURAL AND URBAN MANAGED CARE PROGRAM.

"(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for the purpose of carrying out projects for the following:

"(1) To develop rural community-operated health plans, as defined in subsection (b).

"(2) To develop community health networks, as defined in subsection (c).

"(3) To promote the establishment of managed care plans in underserved areas.

"(b) RURAL COMMUNITY-OPERATED HEALTH PLAN.—For purposes of this section, the term 'rural community-operated health plan' means health plan meeting the following conditions:

"(1) The health plan is a public or nonprofit private entity that provides services exclusively in a rural or frontier area.

"(2) The plan is developed in consultation with the local governments of the geographic area to be served by the plan, with individuals who reside in the area, and with a reasonable number and variety of health professionals who provide services in the area.

"(3) The principal legal authority over the operation of the plan is vested in individuals who reside in such geographic area.

"(4) The plan provides a full continuum of services.

"(c) COMMUNITY HEALTH NETWORK.—

"(1) IN GENERAL.—For purposes of this section, the term 'community health network' means a public or nonprofit entity meeting the following requirements:

"(A) The entity provides primary care services and acute care services, including health promotion, health maintenance, and disease prevention, either directly through its members or through contracts with other entities (under such limited circumstances as the Secretary may permit in regulations) in an area—

"(i) designated by the Secretary as a health professional shortage area under section 332(a)(1)(A); or

"(ii) with a significant number of individuals who are members of a medically underserved population designated by the Secretary under section 2752(b).

"(B) The entity consists of—

"(i) at least one hospital that

"(I) is a sole community hospital described in section 1886(d)(5)(D) of the Social Security Act;

"(II) is a rural referral center described in section 1886(d)(5)(C) of such Act; or

"(III) is described in section 1886(d)(5)(F) of such Act, or would be described in such section if the hospital were a subsection (d) hospital as defined in section 1886(d)(1)(B) of such Act;

"(ii) at least 3 primary care centers, as described in paragraph (2); and

"(iii) at the election of the entity's members, any other entities that provide primary care or other health care services.

"(C) The members of the entity have entered into an agreement under which—

"(i) each member agrees to provide appropriate emergency and medical support services to other members;

"(ii) each member agrees to accept referrals from other members;

"(iii) each hospital member has arrangements to provide staff privileges to physicians providing care for other members; and

"(iv) each member has in effect (or is in the process of establishing) agreements with other members to share in the member's communication system, including (where appropriate) the electronic sharing of patient data, medical records, and billing services.

"(2) PRIMARY CARE CENTERS.—For purposes of this section, the term 'primary care center' means—

"(A) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

"(B) a Federally-qualified health center certified by the Secretary under section 1905(l)(2)(B) of such Act; or

"(C) a facility that would be a Federally-qualified health center but for its failure to meet the requirement described in section 2713(a)(1) (relating to the composition of the facility's governing board), but only if the facility provides assurances to the State or unit of local government that consumers have significant input into the governance of the facility.

"(3) RULE OF CONSTRUCTION REGARDING MEDICARE AMENDMENTS.—Except as otherwise provided in this section:

"(A) A reference in this section to title XVIII of the Social Security Act shall be considered to be a reference to such title as in effect on the day after the date of the enactment of the Guaranteed Health Insurance Act of 1994, without regard to any amendment subsequently made to such title XVIII.

"(B) For purposes of subparagraph (A), an amendment to such title XVIII that is made by the Guaranteed Health Insurance Act of 1994 as of the day referred to in such subparagraph applies to this section upon the amendment taking effect, without regard to whether the date on which the amendment takes effect is after the day referred to in such subparagraph.

"(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $85,000,000 for each of the fiscal years 1995 through 1999.".

(b) RULE OF CONSTRUCTION.—For fiscal year 1995, references in section 2901 of the Public Health Service Act (as added by subsection (a) of this section) to section 2752(b) of such Act are deemed to be references to section 330(a) of such Act, and references to section 2713(a)(1) of such Act are deemed to be references to section 329(e)(2)(G)(i) of such Act, or section 330(e)(3)(G)(i) of such Act, as applicable to the entity involved.

SEC. 7303. EMERGENCY MEDICAL SERVICES IN RURAL AREAS.

(a) USE OF CERTAIN FORMULA GRANTS FOR TRAINING OF PERSONNEL.—Part B of title XII of the Public Health Service Act (42 U.S.C. 300d-11 et seq.) is amended—

(1) in section 1211(b), by inserting before the period the following: ", and for training personnel in accordance with section 1213(e)"; and

(2) in section 1213, by adding at the end the following subsection:

"(e) TRAINING OF PERSONNEL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees that 25 percent of the payments will be expended to train personnel in the provision of trauma care.".

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 1232(a) of the Public Health Service Act (42 U.S.C. 300d-32(a)) is amended—

(1) by striking "and such sums" and inserting ", such sums"; and

(2) by inserting before the period the following: ", and $100,000,000 for each of the fiscal years 1995 through 1997".

SEC. 7304. ALLIED HEALTH PROFESSIONS.

(a) CAPITAL COSTS.—Subpart II of part D of title VII of the Public Health Service Act (42 U.S.C. 294d et seq.) is amended by adding at the end the following section:

"SEC. 768. CAPITAL COSTS OF SCHOOLS OF ALLIED HEALTH IN INCREASING CAPACITY FOR TRAINING.

"(a) IN GENERAL.—The Secretary may make loans to, and guarantee the payment of principal and interest to Federal and non-Federal lenders on behalf of, schools of allied health for the capital costs of increasing the capacity of the schools to train students in the allied health professions.

"(b) PREFERENCES REGARDING UNDERSERVED AREAS.—In providing loans and guarantees under subsection (a), the Secretary shall give preference to qualified applicants that agree to make capital expenditures under subsection (a) that the Secretary determines will assist underserved rural and urban areas.

"(c) TERMS AND CONDITIONS.—The Secretary shall establish terms and conditions (and such other criteria as the Secretary considers necessary) regarding loans and loan guarantees under subsection (a), including provisions regarding defaults by borrowers and including such provisions as may be necessary to protect the financial interests of the United States. The Secretary may provide a loan or loan guarantee under subsection (a) only if the applicant involved agrees to comply with such terms and conditions (and other criteria).

"(d) TWENTY-YEAR OBLIGATION; RIGHT OF RECOVERY.—

"(1) IN GENERAL.—With respect to a facility for which a loan or loan guarantee is to be made under subsection (a), the Secretary may provide the loan or loan guarantee only if the applicant involved agrees that the applicant will be liable to the United States for the amount of the loan or loan guarantee, together with an amount representing interest, if at any time during the 20-year period beginning on the date of completion of the activities involved, the facility—

"(A) ceases to be a facility utilized for the purpose specified in subsection (a) (or another purpose approved by the Secretary for education and training in the health professions); or

"(B) is sold or transferred to any entity other than an entity that is—

"(i) qualified to carry out a purpose referred to in subparagraph (A); and

"(ii) approved by the Secretary as a purchaser or transferee regarding the facility.

"(2) SUBORDINATION; WAIVERS.—The Secretary may subordinate or waive the right of recovery under paragraph (1), and any other Federal interest that may be derived by virtue of a loan or loan guarantee under subsection (a), if the Secretary determines that subordination or waiver will further the objectives of this section.

"(e) WAIVER.—The Secretary may, under a waiver of the requirement under subsection (a) regarding status as a school of allied health, make not more than 1 grant under such subsection each fiscal year to a public or nonprofit private institution that does not meet each of the conditions described in section 799(4) if the entity operates a program that provides training in the allied health professions.

"(f) FUNDING.—

"(1) CREDIT AUTHORITY.—Credit authority for making loans and loan guarantees under subsection (a) for a fiscal year is available only to the extent of amounts provided in appropriations Acts.

"(2) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1995 through 1997.".

(b) PROJECT GRANTS AND CONTRACTS.—Section 767(d) of the Public Health Service Act (42 U.S.C. 294e(d)) is amended—

(1) by striking "there is" and inserting "there are"; and

(2) by striking "through 1995" and inserting the following: "and 1994, and $9,000,000 for each of the fiscal years 1995 through 1997".

SEC. 7305. COMMUNITY HEALTH ADVISORS.

Title XXIX of the Public Health Service Act, as added by section 7302 of this Act, is amended by adding at the end the following section.

"SEC. 2902. FORMULA GRANTS REGARDING COMMUNITY HEALTH ADVISOR PROGRAMS.

"(a) IN GENERAL.—

"(1) FORMULA GRANTS.—In the case of each State (or entity designated by a State under paragraph (4) that submits to the Secretary an application in accordance with subsection (d) for a fiscal year, the Secretary, acting through the Director of the Centers for Disease Control and Prevention and in coordination with the heads of the agencies specified in paragraph (2), shall make an award of financial assistance to the State or entity for the development and operation of community health advisor programs under section subsection (b)(2). The award shall consist of the allotment determined under subsection (e) with respect to the State, subject to subsection (j).

"(2) COORDINATION WITH OTHER AGENCIES.—The agencies referred to in paragraph (1) regarding coordination are the Health Resources and Services Administration, the National Institutes of Health, the Substance

Abuse and Mental Health Services Administration, the Agency for Health Care Policy and Research, and the Indian Health Service.

"(3) PRIORITY FOR MEDICALLY UNDERSERVED COMMUNITIES.—A funding agreement for an award under paragraph (1) is that the applicant involved will give priority to developing and operating community health advisor programs for medically underserved communities.

"(4) DESIGNATED ENTITIES.—With respect to the State involved, an entity other than the State may receive an award under paragraph (1) only if the entity—

"(A) is a public or nonprofit private entity; and

"(B) has been designated by the State to carry out the purpose described in such paragraph in the State and to receive amounts under such paragraph in lieu of the State.

"(5) ROLE OF STATE AGENCY FOR PUBLIC HEALTH.—A funding agreement for an award under subsection (a) is that—

"(A) if the applicant is a State, the award will be administered by the State agency with the principal responsibility for carrying out public health programs; and

"(B) if the applicant is an entity designated under paragraph (3), the award will be administered in consultation with such State agency.

"(5) STATEWIDE RESPONSIBILITIES; LIMITATION ON EXPENDITURES.—

"(A) A funding agreement for an award under paragraph (1) is that the applicant involved will—

"(i) operate a clearinghouse to maintain and disseminate information on community health advisor programs (and similar programs) in the State, including information on developing and operating such programs, on training individuals to participate in the programs, and on evaluation of the programs;

"(ii) provide to community health advisor programs in the State technical assistance in training community health advisors under subsection (c)(7)(A);

"(iii) coordinate the activities carried out in the State under the award, including coordination between the various community health advisor programs and coordination between such programs and related activities of the State and of other public or private entities.

"(B) A funding agreement for an award under paragraph (1) is that the applicant involved will not expend more than 15 percent of the award in the aggregate for carrying out subparagraph (A) and for the expenses of administering the award with respect to the State involved, including the process of receiving payments from the Secretary under the award, allocating the payments among the entities that are to develop and operate the community health advisor programs involved, and monitoring compliance with the funding agreements made under this section by the applicant.

"(b) REQUIREMENTS REGARDING COMMUNITY HEALTH ADVISOR PROGRAMS.

"(1) PURPOSE OF AWARD; HEALTHY PEOPLE 2000 OBJECTIVES.—

"(A) Subject to subparagraph (B), a funding agreement for an award under subsection (a) for an applicant is that the purpose of the award is, through community health advisor programs under paragraph (2), to assist the State involved in attaining the Healthy People 2000 Objectives (as defined in paragraph (4)).

"(B) With respect to compliance with the agreement made under subparagraph (A), an applicant receiving an award under subsection (a) may, from among the various Healthy People 2000 Objectives, select one or more Objectives to be given priority in the operation of a community health advisor program of the applicant, subject to the applicant selecting such priorities in consultation with the entity that is to carry out the program.

"(2) REQUIREMENTS FOR PROGRAMS.—A funding agreement for an award under subsection (a) for an applicant is that, in expending the award, the purpose described in subsection (a)(1) will be carried out in accordance with the following:

"(A) For each community for which the purpose is to be carried out, the applicant will establish a program in accordance with this subsection.

"(B) The program will be carried out in a community only if the applicant has, under subsection (c)(1), identified the community as having a significant need for the program.

"(C) The program will be operated by a public or nonprofit private entity with experience in providing health or health-related social services to individuals who are underserved with respect to such services.

"(D) The services of the program, as specified in paragraph (3), will be provided principally by community health advisors (as defined in paragraph (5)).

"(3) AUTHORIZED PROGRAM SERVICES.—For purposes of paragraph (2)(D), the services specified in this paragraph for a program are as follows:

"(A) The program will collaborate with health care providers and related entities in order to facilitate the provision of health services and health-related social services (including collaborating with local health departments, community health centers, migrant health centers, rural health clinics, hospitals, physicians and nurses, providers of health education, and providers of social services).

"(B) The program will provide public education on health promotion and disease prevention and facilitate the use of available health services and health-related social services.

"(C) The program will provide health-related counseling.

"(D) The program will provide referrals for available health services and health-related social services.

"(E) For the purpose of increasing the capacity of individuals to utilize health services and health-related social services under Federal, State, and local programs, the following conditions will be met:

"(i) The program will assist individuals in establishing eligibility under the programs and in receiving the services or other benefits of the programs.

"(ii) The program will provide such other services as the Secretary determines to be appropriate, which services may include (but are not limited to) transportation and translation services.

"(F) The program will provide outreach services to inform the community of the availability of the services of the program.

"(c) ADDITIONAL AGREEMENTS.—

"(1) IDENTIFICATION OF COMMUNITY NEEDS.—A funding agreement for an award under subsection (a) is that the applicant involved will—

"(A) identify the needs of the community involved for the authorized program services;

"(B) in identifying such needs, consult with members of the community, with individuals and programs that provide health services in the community, and with individuals and programs that provide health-related social services in the community; and

"(C) consider such needs in carrying out a community health advisor program for the community.

"(2) MATCHING FUNDS.—

"(A) IN GENERAL.—With respect to the cost of carrying out a community health advisor program, a funding agreement for an award under subsection (a) is that the applicant involved will make available (directly or through donations from public or private entities) non-Federal contributions toward such cost in an amount that is not less than 25 percent of such cost.

"(B) DETERMINATION OF AMOUNT CONTRIBUTED.—

"(i) Non-Federal contributions required in subparagraph (A) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(ii) With respect to the State in which the community health advisor program involved is to be carried out, amounts provided by the State in compliance with paragraph (3) shall be included in determining the amount of non-Federal contributions under subparagraph (A).

"(3) MAINTENANCE OF EFFORT.—

"(A) With respect to the purposes for which an award under subsection (a) is authorized in this section to be expended, the Secretary may make such an award only if the State involved agrees to maintain expenditures of non-Federal amounts for such purposes at a level that is not less than the level of such expenditures maintained by the State for the fiscal year preceding the first fiscal year for which such an award is made with respect to the State.

"(B)(i) In making an award under subsection (a) for a fiscal year, the Secretary shall make a determination of whether, for the previous fiscal year, the State involved maintained material compliance with the agreement made under subparagraph (A). If the Secretary determines that a State has failed to maintain such compliance, the Secretary shall reduce the amount of the grant under subsection (a) for the fiscal year for which the grant is being made by an amount equal to the amount constituting such failure for the previous fiscal year.

"(ii) The Secretary may make a grant under subsection (a) for a fiscal year only if the State involved submits to the Secretary information sufficient for the Secretary to make the determination required in clause (i).

"(4) CULTURAL CONTEXT OF SERVICES.—A funding agreement for an award under subsection (a) for an applicant is that the services of the community health advisor program involved will be provided in the language and cultural context most appropriate for the individuals served by the program.

"(5) NUMBER OF PROGRAMS PER AWARD; PROGRAMS FOR URBAN AND RURAL AREAS.—A funding agreement for an award under subsection (a) for an applicant is that the number of community health advisor programs operated in the State with the award will be determined by the Secretary, except that (subject to subsection (a)(3)) such a program will be carried out in not less than one urban area of the State, and in not less than one rural area of the State.

"(6) ONGOING SUPERVISION OF ADVISORS.—A funding agreement for an award under subsection (a) is that the applicant involved will ensure that each community health advisor program operated with the award provides for the ongoing supervision of the community health advisors of the program.

"(7) CERTAIN EXPENDITURES.—

"(A) Funding agreements for an award under subsection (a) include the following:

"(i) The applicant involved will ensure that, for each community health advisor program operated with the award, a program is carried out to train community health advisors to provide the authorized program services, including practical experiences in providing services for health promotion and disease prevention.

"(ii) The program of training will provide for the continuing education of the community health advisors.

"(iii) Not more than 15 percent of the award will be expended for the program of training.

"(B) With respect to compliance with the agreements made under this section, the purposes for which an award under subsection (a) may be expended include providing compensation for the services of community health advisors.

"(8) REPORTS TO SECRETARY; ASSESSMENT OF EFFECTIVENESS.—Funding agreements for an award under subsection (a) for an applicant include the following:

"(A) The applicant will ensure that, for each fiscal year for which a community health advisor program receives amounts from the award, the program will prepare a report describing the activities of the program for such year, including—

"(i) a specification of the number of individuals served by the program;

"(ii) a specification of the entities with which the program has collaborated in carrying out the purpose described in subsection (a)(1); and

"(iii) an assessment of the extent of the effectiveness of the program in carrying out such purpose.

"(B) Such reports will include such additional information regarding the applicant and the programs as the Secretary may require.

"(C) The applicant will prepare the reports as a single document and will submit the document to the Secretary not later than February 1 of the fiscal year following the fiscal year for which the reports were prepared.

"(d) APPLICATION FOR ASSISTANCE; STATE PLAN.—For purposes of subsection (a), an application is in accordance with this section if the application is submitted not later than the date specified by the Secretary; the application contains each funding agreement described in this section; the application contains a State plan describing the purposes for which the award is to be expended in the State (including a description of the manner in which the applicant will comply with each such funding agreement); and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(e) DETERMINATION OF AMOUNT OF ALLOTMENT.—

"(1) IN GENERAL.—For purposes of subsection (a), the allotment under this subsection with respect to a State for a fiscal year is the greater of—

"(A) the sum of the respective amounts determined for the State under paragraph (2) and paragraph (3); and

"(B) $500,000.

"(2) AMOUNT RELATING TO POPULATION.—For purposes of subsection (a), the amount determined under this paragraph is the product of—

"(A) an amount equal to 50 percent of the amount appropriated under subsection (j) for the fiscal year and available for awards under subsection (a); and

"(B) the percentage constituted by the ratio of—

"(i) the number of individuals residing in the State involved; to

"(ii) the sum of the respective amounts determined for each State under clause (i).

"(3) AMOUNT RELATING TO POVERTY LEVEL.—For purposes of subsection (a), the amount determined under this paragraph is the product of—

"(A) the amount determined under paragraph (2)(A); and

"(B) the percentage constituted by the ratio of—

"(i) the number of individuals residing in the State whose income is at or below an amount equal to 200 percent of the official poverty line; to

"(ii) the sum of the respective amounts determined for each State under clause (i).

"(f) QUALITY ASSURANCE; COST-EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of community health advisor programs (including quality in the training of community health advisors) and for assuring the cost-effectiveness of the programs. A funding agreement for an award under subsection (a) is that the applicant involved will carry out such programs in accordance with the guidelines.

"(g) EVALUATIONS; TECHNICAL ASSISTANCE.—

"(1) EVALUATIONS.—The Secretary shall conduct evaluations of community health advisor programs, and may disseminate information developed as a result of the evaluations. In conducting such evaluations, the Secretary shall determine whether the programs are in compliance with the guidelines established under subsection (f).

"(2) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to recipients of awards under subsection (a) with respect to the planning, development, and operation of community health advisor programs.

"(3) GRANTS AND CONTRACTS.—The Secretary may carry out this subsection directly or through grants, cooperative agreements, or contracts.

"(4) LIMITATION ON EXPENDITURES.—Of the amounts appropriated under subsection (j) for a fiscal year, the Secretary may reserve not more than 10 percent for carrying out this subsection.

"(h) RULE OF CONSTRUCTION REGARDING PROGRAMS OF INDIAN HEALTH SERVICE.—This section may not be construed as requiring the Secretary to modify or terminate the program carried out by the Director of the Indian Health Service and designated by such Director as the Community Health Representative Program. The Secretary shall ensure that support for such Program is not supplanted by awards under subsection (a). In communities in which both such Program and a community health advisor program are being carried out, the Secretary shall ensure that the community health advisor program works in cooperation with, and as a complement to, the Community Health Representative Program.

"(i) DEFINITIONS.—For purposes of this section:

"(1) The term "authorized program services", with respect to a community health advisor program, means the services specified in subsection (b)(3).

"(2) The term "community health advisor" means an individual—

"(A) who has demonstrated the capacity to carry out one or more of the authorized program services;

"(B) who, for not less than 1 year, has been a resident of the community in which the community health advisor program involved is to be operated; and

"(C) is a member of a socioeconomic group to be served by the program.

"(3) The term "community health advisor program" means a program carried out under subsection (b)(2).

"(4) The term "financial assistance", with respect to an award under subsection (a), means a grant, cooperative agreement, or a contract.

"(5) The term "funding agreement" means an agreement required as a condition of receiving an award under subsection (a).

"(6) The term "Healthy People 2000 Objectives" means the objectives established by the Secretary toward the goals of increasing the span of healthy life, reducing health disparities among various populations, and providing access to preventive services, which objectives apply to the health status of the population of the United States for the year 2000.

"(7) The term "medically underserved community" has the meaning given such term in section 799.

"(8) The term "official poverty line" means the official poverty line established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981, which poverty line is applicable to the size of the family involved.

"(9) The term "State involved", with respect to an applicant for an award under subsection (a), means the State in which the applicant is to carry out a community health advisor program.

"(j) FUNDING.—

"(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1995 through 2000.

"(2) EFFECT OF INSUFFICIENT APPROPRIATIONS FOR MINIMUM ALLOTMENTS.—

"(A) If the amounts made available under paragraph (1) for a fiscal year are insufficient for providing each State (or entity designated by the State pursuant to subsection (a), as the case may be) with an award under subsection (a) in an amount equal to or greater than the amount specified in subsection (e)(1)(B), the Secretary shall, from such amounts as are made available under paragraph (1), make such awards on a discretionary basis.

"(B) For purposes of subparagraph (A), awards under subsection (a) are made on a discretionary basis if the Secretary determines which States (or entities designated by States pursuant to such subsection, as the case may be) are to receive such awards, subject to meeting the requirements of this section for such an award, and the Secretary determines the amount of such awards.".

SEC. 7306. TRAINING OF HEALTH PROFESSIONALS FOR RURAL AREAS.

Section 778(f) of the Public Health Service Act (42 U.S.C. 294p(f)) is amended by striking "there is" and all that follows and inserting the following: "there is authorized to be appropriated $400,000,000 for each of the fiscal years 1995 through 2003.".

SEC. 7307. REGIONAL POISION CONTROL CENTERS.

Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended by adding at the end the following part:

"PART G—REGIONAL POISON CONTROL CENTERS

"SEC. 1271. GRANTS FOR REGIONAL CENTERS.

"(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for centers to carry out activities regarding—

"(1) the prevention and treatment of poisoning; and

"(2) such other activities regarding the control of poisons as the Secretary determines to be appropriate.

"(b) REGIONAL CONSIDERATIONS.—In making grants under subsection (a), the Secretary shall determine the need in each of the principal geographic regions of the United States for a center under such subsection, and shall make the grants according to priorities established by the Secretary on the basis of the extent of such need in each of the regions. In carrying out the preceding sentence, the Secretary shall ensure that no two centers receive grants for the same geographic service area.

"(c) MATCHING FUNDS.—

"(1) IN GENERAL.—With respect to the costs of an entity in providing for centers under subsection (a), the Secretary may make a grant under such subsection only if the State in which the center is to operate, or other public entities in the State, agree to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount determined by the Secretary.

"(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"SEC. 1272. REQUIREMENTS REGARDING CERTIFICATION.

"(a) IN GENERAL.—Subject to subsection (b), the Secretary may make a grant under section 1271 only if the center involved has been certified by a professional organization in the field of poison control, and the Secretary has approved the organization as having in effect standards for certification that reasonably provide for the protection of the public health with respect to poisoning. In carrying out the preceding sentence, the Secretary shall consider the standards established by the American Association of Poison Control Centers.

"(b) TEMPORARY WAIVER.—The Secretary may waive the requirement of subsection (a) for a center for a period not exceeding 1 year.

"SEC. 1273. GENERAL PROVISIONS.

"(a) DURATION OF GRANT.—The period during which payments are made under a grant under section 1271 may not exceed 3 years. The provision of such payments is subject to annual approval by the Secretary of the payments and subject to the availability of appropriations for the fiscal year involved to make the payments. The preceding sentence may not be construed as establishing a limitation on the number of such grants that may be made to an entity.

"(b) STUDY REGARDING NEED FOR CENTERS.—

"(1) IN GENERAL.—The Secretary shall conduct a study of each of the centers for which a grant under section 1271 has been provided. The purpose of the study shall be to determine the effectiveness of the centers in carrying out the activities described in such section and the extent to which the activities have been carried out in a cost-effective manner.

"(2) ALTERNATIVES TO CENTERS.—In carrying out the study under paragraph (1), the Secretary shall determine the extent to which the activities described in section 1271 can be effectively carried out through means other than centers under such section. The alternative means considered by the Secretary under the preceding sentence shall include the alternative of requiring public and private health plans to carry out such activities.

"(3) DATE CERTAIN FOR COMPLETION.—Not later than November 1, 1996, the Secretary shall submit to the Congress a report describing the findings made in the study under paragraph (1).

"(4) NOTICE TO CENTERS.—Not later than February 1, 1997, the Secretary shall notify each grantee under section 1271 whether the Secretary considers the continued operation of the center involved to be necessary in meeting the needs of the geographic region involved for the activities described in such section.

"SEC. 1274. AUTHORIZATIONS OF APPROPRIATIONS FROM FUND.

"For the purpose of carrying out this part, there is authorized to be appropriated $50,000,000 for each of the fiscal years 1995 through 1997.".

SEC. 7308. COBRA CONTINUATION COVERAGE; TRANSITIONAL COVERAGE REQUIREMENT FOR GROUP HEALTH PLANS.

Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2) is amended by adding at the end the following new sentence: "In the case of an individual whose period of coverage under this paragraph would (but for this sentence) end after the date of the enactment of the Guaranteed Health Insurance Act of 1994 and before January 1, 1999, such period shall in no event terminate by reason of this paragraph before January 1, 1999.".

Subtitle E—Mental Health

SEC. 7401. STATE COMPREHENSIVE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM.

Title XIX of the Public Health Service Act (42 U.S.C. 300w et seq.) is amended by adding at the end the following part:

"PART D—STATE COMPREHENSIVE MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS

"SEC. 1981. AUTHORITY FOR ESTABLISHMENT OF PROGRAMS.

"(a) OPTIONAL ESTABLISHMENT OF PROGRAMS BY STATES.—

"(1) IN GENERAL.—A State with an application approved by the Secretary under subsection (b) may establish a comprehensive managed mental health and substance abuse program (in this section referred to as the 'Program') under which, during a year the Program is in effect—

"(A) the State shall provide (or arrange for the provision of) mental health and substance abuse services through the Program for qualified individuals residing in the State who choose to receive such services through the Program during such year; and

"(B) such individuals shall receive such services through the Program and not through a certified health plan, through the medicare program, or through medicare part C providing the guaranteed national benefit package.

"(2) PERMITTING OPERATION OF PROGRAM THROUGH PLANS.—A State may operate the Program by entering into agreements with certified health plans, the medicare program, or medicare part C, under which the State shall reimburse such plans or programs for providing services under the Program under this section to qualified individuals who are enrolled in such certified health plans or programs.

"(3) EFFECT ON OTHER MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—Nothing in this section shall be construed to affect the provision of services in a State that are not covered under the guaranteed national benefit package.

"(4) APPLICABILITY TO INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—

"(A) IN GENERAL.—An Indian tribe or tribal organization may establish a program under this section in the same manner and under the same terms and conditions as a State (other than the condition described in subsection (b)(8)).

"(B) DEFINITION.—In subparagraph (A), the terms 'Indian tribe' and 'tribal organization' have the meaning given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

"(b) ELIGIBILITY REQUIREMENTS FOR STATES.—A State is eligible to establish a Program under this section if the State submits an application to the Secretary (at such time and in such form as the Secretary may require) containing information and assurances that the State and the Program meets the following requirements:

"(1) COVERAGE OF SERVICES WITHOUT DAY LIMITS.—The Program provides for coverage of the mental health and substance abuse services described in the guaranteed national benefit package without the imposition of any limits applicable under the package on the number of days for which the services may be provided and (at the option of the State) at a lower coinsurance rate than the rate applicable under the package.

"(2) COVERAGE OF ALL QUALIFIED INDIVIDUALS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the Program provides for coverage for all qualified individuals in the State (as described in subsection (c)) during the year.

"(B) INITIAL COVERAGE OF ONE GROUP OF QUALIFIED INDIVIDUALS ONLY.—During any of the first 3 years in which the Program is in operation, the Program may provide for coverage for only the group of qualified individuals described in paragraph (1) of subsection (c) or only the group of qualified individuals described in paragraph (2) of such subsection, except that the Program may not discontinue coverage of any group for which coverage is provided.

"(3) DEVELOPMENT OF INTEGRATED DELIVERY SYSTEMS.—The Program promotes the development of integrated delivery systems for the management of mental health and substance abuse services for individuals enrolled in the Program.

"(4) ACCESS TO PROVIDERS.—The State assures that individuals enrolled in the Program have access to the full range of qualified providers necessary to furnish services covered under the Program in accordance with such requirements as the State may impose, except that any individual or entity to whom payment may be made for the provision of mental health and substance abuse services under medicare part C shall be deemed to be a qualified provider under the Program.

"(5) MECHANISM FOR ENROLLMENT OF ADULTS NOT MEETING INCOME ELIGIBILITY REQUIREMENT.—

"(A) OPTION DESCRIBED.—A State operating a Program may elect to permit certified health plans in the State, the medicare program, and medicare part C to enroll in the Program any individual covered under the certified health plan, the medicare program, or medicare part C who wishes to enroll in the Program and who would be a qualified individual described in subsection (c)(2) but for the individual's failure to meet the requirement described in subparagraph (E) of such subsection (relating to income).

"(B) REQUIRING ENROLLMENT AND BUY-IN MECHANISM.—If a State elects to permit plans or programs to enroll individuals in the Program under subparagraph (A), the State shall establish an effective mechanism to enroll such individuals and impose an appropriate premium with respect to such enrollment.

"(6) STANDARDS FOR PROVIDERS.—The State establishes and enforces standards for the eligibility of individuals and entities to furnish services under the Program.

"(7) SUBMISSION OF PLAN.—The State shall submit to the Secretary (and regularly update) a plan describing the operation of the Program, including information on the following:

"(A) The management, access and referral structure which the State would use to promote and achieve integration of the services the State intends to integrate under the Program.

"(B) The steps to be taken under the Program to ensure the integration of services under the Program with services of other agencies and providers that serve the needs of adults with serious mental illness or substance abuse, or children with serious emotional disturbance or substance abuse (including agencies and providers involved with child welfare, education, juvenile justice, corrections, vocational rehabilitation, crime prevention, health care, mental health, and substance abuse prevention and treatment).

"(C) The detailed specifications for the program which will assure that individuals enrolled in the Program have access to each service covered under the Program.

"(D) The criteria used by the State to determine whether an individual is a qualified individual under subsection (c).

"(E) The involvement of the families of individuals to whom services are provided under the Program (with the approval of the individual where possible) in the planning of treatment, the delivery of services, and the evaluation of these interventions.

"(F) In the case of substance abuse treatment services, the application of uniform patient placement criteria (as established by the Secretary in consultation with the States) for determining the placement of individuals enrolled in the Program in treatment programs .

"(G) The proposed system for the development and implementation of individualized treatment plans through multi-disciplinary or multi-agency teams.

"(H) The description of how the State will provide for public input in the development and ongoing assessment of the Program.

"(I) The description of the grievance procedure that will be available to eligible individuals dissatisfied with the Program.

"(J) The method and components of Program review, including assessments of clinical outcomes, residential stability, vocational and academic achievement, and management of costs.

"(K) The sources of any funds that the State proposes to integrate in order to finance the Program (including funds expended by or provided to the State under title IV of the Social Security Act, title XIX of such Act, and the Individuals With Disabilities Education Act, and State general revenue), except that nothing in this section may be construed to permit the State from reducing the level of financial assistance it provides under any other program as a result of receiving funds provided under this Act or amendments made by this Act for the operation of the Program.

"(L)(i) Assurances that, prior to implementing the Program, negotiations will be commenced with labor organizations representing the employees of any hospitals or other facilities that may be affected by the Program. Such negotiations shall address the following:

"(I) The impact of the proposed Program upon the workforce.

"(II) Methods to redeploy workers to positions in the Program or other private or public settings, in the case of workers affected by the proposed Program.

"(ii) Evidence of compliance with clause (i).

"(8) CONSULTATION WITH INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The State consults with Indian tribes and tribal organizations in the State regarding the establishment of the Program and the ability of individuals who receive services from the tribes and tribal organizations to enroll in the State Program.

"(c) QUALIFIED INDIVIDUALS DESCRIBED.—In this section, a 'qualified individual' is either of the following:

"(1) The individual—

"(A) is an eligible individual (as defined in section 2);

"(B) is under 19 years of age;

"(C) has a serious mental illness or emotional disturbance or substance abuse disorder (as determined in accordance with standards established by the Secretary consistent with subsection (d)); and

"(D) has such an illness, disturbance, or disorder that is expected to last for not less than 1 year.

"(2) The individual—

"(A) is an eligible individual;

"(B) is 19 years of age or older;

"(C) has a serious mental illness or emotional disturbance or substance abuse disorder (as determined in accordance with standards established by the Secretary consistent with subsection (d));

"(D) has such an illness, disturbance, or disorder that is expected to last for not less than 1 year; and

"(E) has family income not greater than 200 percent of the official poverty line.

"(d) CRITERIA FOR STANDARDS FOR QUALIFIED INDIVIDUALS.—In establishing standards for purposes of subsection (c), the Secretary shall assure that Programs under this section focus services on adults with serious mental illness, children with serious emotional disturbance, and individuals with substance abuse disorder, as evidenced by a need for multiple services (either a past history, or prediction of future needs), and who have a disorder which is expected to last at least one year.

"(e) DEFINITIONS.—

"(1) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—In this section, the term "mental health and substance abuse services" has the meaning given such term under section 1893(c) of the Social Security Act (as in effect on the date of the enactment of the Guaranteed Health Insurance Act of 1994).

"(2) OTHER DEFINITIONS.—In this section, the terms 'guaranteed national benefit package', 'medicare part C', 'medicare program', and 'certified health plan' have the meaning given such terms in the Guaranteed Health Insurance Act of 1994.

"SEC. 1982. GRANTS FOR DEVELOPMENT OF PROGRAMS.

"(a) IN GENERAL.—The Secretary may make grants to States for the initial operation of State programs under section 1981.

"(b) LIMITATION ON PERIOD OF GRANT.—A State may not receive funding from a grant awarded under this section for a period exceeding 5 years.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for grants under this section $100,000,000 for each of the fiscal years 1996 through 1999.".

SEC. 7402. COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES.

Section 565(f)(1) of the Public Health Service Act (42 U.S.C. 290ff–4(f)(1)) is amended by striking "for fiscal year 1994" and inserting "for each of the fiscal years 1994 through 1997".

Subtitle F—United States-Mexico Border Health Commission

SEC. 7501. AGREEMENT TO ESTABLISH BINATIONAL COMMISSION.

The President is authorized and encouraged to conclude an agreement with Mexico to establish a binational commission to be known as the United States-Mexico Border Health Commission.

SEC. 7502. DUTIES.

It should be the duty of the Commission—

(1) to conduct a comprehensive needs assessment in the United States-Mexico border area for the purposes of identifying, evaluating, preventing, and resolving health problems that affect the general population of the area;

(2) to implement the actions recommended by the needs assessment by—

(A) assisting in the coordination of the efforts of public and private entities to prevent and resolve such health problems; and

(B) assisting in the coordination of the efforts of public and private entities to educate such population concerning such health problems; and

(3) to formulate recommendations to the Governments of the United States and Mexico concerning a fair and reasonable method by which the government of one country would reimburse a public or private entity in the other country for the cost of a health care service that the entity furnishes to a citizen of the first country who is unable, through insurance or otherwise, to pay for the service.

SEC. 7503. OTHER AUTHORIZED FUNCTIONS.

In addition to the duties described in section 7502, the Commission should be authorized to perform the following additional functions as the Commission determines to be appropriate:

(1) To conduct or sponsor investigations, research, or studies designed to identify, study, and monitor health problems that affect the general population in the United States-Mexico border area.

(2) To provide financial, technical, or administrative assistance to public or private entities who act to prevent, resolve, or educate such population concerning such health problems.

SEC. 7504. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT OF UNITED STATES SECTION.—The United States section of the Commission should be composed of 13 members. The section should consist of the following members:

(1) The Secretary of Health and Human Services or such individual's delegate.

(2) The commissioners of health from the States of Texas, New Mexico, California, and Arizona or such individuals' delegates.

(3) 2 individuals from each of the States of Texas, New Mexico, California, and Arizona who are nominated by the chief executive officer of one of such States, and are appointed by the President from among individuals who have demonstrated ties to community-based organizations and have a demonstrated interest in health issues of the United States-Mexico border area.

(b) COMMISSIONER.—The Commissioner of the United States section of the Commission should be the Secretary of Health and Human Services or such individual's delegate to the Commission. The Commissioner should be the leader of the section.

SEC. 7505. REGIONAL OFFICES.

The Commission should establish no fewer than 2 regional border offices in locations selected by the Commission.

SEC. 7506. REPORTS.

Not later than February 1 of each year that occurs more than 1 year after the date of the establishment of the Commission, the Commission should submit an annual report to both the United States Government and the Government of Mexico regarding all activities of the Commission during the preceding calendar year.

SEC. 7507. DEFINITIONS.

For purposes of this subtitle:

(1) COMMISSION.—The term "Commission" means the United States-Mexico Border Health Commission authorized in section 7501.

(2) HEALTH PROBLEM.—The term "health problem" means a disease or medical ailment or an environmental condition that poses the risk of disease or medical ailment. The term includes diseases, ailments, or risks of disease or ailment caused by or related to environmental factors, control of animals and rabies, control of insect and rodent vectors, disposal of solid and hazardous waste, and control and monitoring of air and water quality.

(3) UNITED STATES-MEXICO BORDER AREA.—The term "United States-Mexico border area" means the area located in the United States and Mexico within 100 kilometers of the border between the United States and Mexico.

Subtitle G—Comprehensive School Health Education

PART 1—GENERAL PROVISIONS

SEC. 7601. PURPOSES.

Subject to the subsequent provisions of this subtitle, the purposes of this subtitle are as follows:

(1) To support the provision in kindergarten through grade 12 of sequential, age-appropriate, comprehensive health education programs that address locally-determined priorities developed with the active participation of parents, families, community organizations, and other appropriate entities.

(2) To establish a national framework within which State educational agencies, educational service agencies, and local education agencies can create comprehensive school health education programs that—

(A) target the health risk behaviors accounting for the majority of the morbidity and mortality among youth and adults, including the following: Alcohol and other drug abuse; sexual behaviors resulting in infection with the human immunodeficiency virus, in other sexually transmitted diseases or in unintended pregnancy; child abuse and neglect; behaviors resulting in intentional and unintentional injuries; dietary patterns resulting in disease; work hazards associated with preventable diseases and injuries and sedentary lifestyles; and

(B) are integrated with plans and programs in the State, if any, under title III of the Goals 2000: Educate America Act or any other State education reform plan and those targeting health promotion and disease prevention goals related to the national health objectives set forth in Healthy People 2000.

(3) To pay the initial costs of developing statewide comprehensive school health education programs that will be implemented and maintained with local, State, and other Federal resources.

(4) To support Federal activities such as research and demonstrations, evaluations, and training and technical assistance regarding comprehensive school health education.

(5) To motivate youth, especially low-achieving youth, to stay in school, avoid teen pregnancy, and strive for success by providing intensive, high-quality comprehensive health education programs that include peer-teaching, family, and community involvement.

(6) To improve the knowledge and skills of children and youth by integrating academic and experiential learning in comprehensive health education with other elements of a comprehensive school health program.

(7) To further the National Education Goals set forth in title I of the Goals 2000: Educate America Act and the national health objectives set forth in Healthy People 2000.

SEC. 7602. DEFINITIONS.

(a) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—For purposes of this subtitle, the term "comprehensive school health education program" means a program that addresses locally determined priorities and is developed with the active involvement of parents, families, community organizations, and other appropriate entities, and that meets the following conditions:

(1) The program is sequential, and age and developmentally appropriate.

(2) The program is provided, in the area served by the program, every year for all students from kindergarten through grade 12.

(3) The program provides comprehensive health education, which covers a full range of topics relevant to human health, such as the following:

(A) Community health.

(B) Environmental health.

(C) Personal health (including physical fitness).

(D) Family life (including parenting and child development).

(E) Growth and development.

(F) Nutritional health.

(G) Emotional and mental health.

(H) Prevention and control of disease and disorders and such heath-risk behaviors as child abuse and neglect.

(I) Safety and prevention of injuries.

(J) Alcohol and drug abuse.

(K) Consumer health, including education to ensure that students understand the benefits and appropriate use of medical services, including immunizations and other clinical preventive services.

(4) The program is based upon current scientific knowledge of human health, fitness, and nutrition and does not provide medically false information.

(5) The program promotes personal responsibility for a healthy lifestyle and provides the knowledge and skills necessary to adopt a healthy lifestyle, including teaching the legal, social, mental, and health consequences of behaviors that pose health risks.

(6) To the extent practicable, the program is sensitive to cultural, gender, and ethnic issues in the content of instructional materials and approaches and addresses the needs of children with disabilities.

(7) The program includes activities that support instruction.

(8) The program includes activities to promote involvement by parents, families, community organizations, and other appropriate entities.

(9) The program is coordinated with other Federal, State, and local health education and prevention programs and with other Federal, State and local education programs, including those carried out under the Elementary and Secondary Education Act of 1965 (including the Drug-Free Schools and Communities Act of 1986) and the Individuals with Disabilities Education Act.

(10) The program focuses on the particular health concerns of the students, parents, and families in the State, school district, or school, as the case may be.

(11) The program utilizes existing professional resources and pupil services programs to prevent duplication and waste and to increase efficiency and coordination among education and prevention programs.

(b) OTHER DEFINITIONS.—For purposes of this subtitle:

(1) The term "educational service agency" means regional public multiservice agencies authorized by State statute to develop, manage, and provide services and programs to local educational agencies.

(2) The term "local educational agency" has the meaning given such term in section 1471(12) of the Elementary and Secondary Education Act of 1965.

(3) The term "parent" includes a legal guardian or other person standing in loco parentis.

(4) The term "Secretary" means the Secretary of Health and Human Services, except as otherwise provided.

(5) The term "State educational agency" has the meaning given such term in section 1471(23) of the Elementary and Secondary Education Act of 1965.

SEC. 7603. PROHIBITION AGAINST FEDERAL CONTROL OF EDUCATION.

Nothing in this subtitle shall be construed to authorized any department, agency, officer, or employee of the United States to exercise any direction, supervision, or control over the curriculum, program of instruction, administration, or personnel of any educational institution, school, or school system, or over the selection of library resources, textbooks, or other printed or published instructional materials by any educational institution or school system.

SEC. 7604. PROHIBITION AGAINST DISTRIBUTION OF OBSCENE MATERIALS.

No entity receiving assistance under this subtitle may use such assistance to support the distribution of obscene materials to minors on school grounds.

PART 2—SCHOOL HEALTH EDUCATION; GENERAL PROVISIONS

SEC. 7611. AUTHORIZATIONS OF APPROPRIATIONS.

(a) FUNDING FOR SCHOOL HEALTH EDUCATION.—For the purpose of carrying out part 3, there are authorized to be appropriated $50,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 through 2000.

(b) ALLOCATIONS.—Of the amounts appropriated under subsection (a) for a fiscal year—

(1) the Secretary may reserve not more than $5,000,000 to support national leadership activities, such as research and demonstration, evaluation, and training and technical assistance in comprehensive school health education; and

(2) the Secretary may reserve not more than 5 percent for administrative expenses regarding part 3.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

SEC. 7612. WAIVERS OF STATUTORY AND REGULATORY REQUIREMENTS.

(a) IN GENERAL.—

(1) WAIVERS.—Except as provided in subsection (c), upon the request of an entity receiving funds under part 3 and under a program specified in paragraph (2), the Secretary of Education, upon the request of the Secretary of Health and Human Services, may grant to the entity a waiver of any requirement of such program regarding the use of funds, or of the regulations issued for the program by the Secretary of Education, if the following conditions are met with respect to such program:

(A) The Secretaries determine that the requirement of such program impedes the ability of the State educational agency or other recipient to achieve more effectively the purposes of part 3.

(B) The Secretaries determine that, with respect to the use of funds under such program, the requested use of the funds by the entity would be consistent with the purposes of part 3.

(C) In the case of a request for a waiver submitted by a State educational agency, the State educational agency—

(i) provides all interested local educational agencies in the State with notice and an opportunity to comment on the proposal; and

(ii) submits the comments to the Secretary.

(D) In the case of a request for a waiver submitted by a local educational agency or other agency, institution, or organization that receives funds under part 3 from the State educational agency, such request has been reviewed by the State educational agency and is accompanied by the comments, if any, of such agency.

(2) RELEVANT PROGRAMS.—For purposes of paragraph (1), the programs specified in this paragraph are any program carried out under part B of the Drug-Free Schools and Communities Act of 1986.

(b) WAIVER PERIOD.—

(1) IN GENERAL.—A waiver under this section shall be for a period not to exceed three years.

(2) EXTENSIONS.—The Secretaries involved under subsection (a) may extend such period if the Secretaries determines that—

(A) the waiver has been effective in enabling the State or affected recipients to carry out the activities for which it was requested and has contributed to improved performance; and

(B) such extension is in the public interest.

(c) WAIVERS NOT AUTHORIZED.—The Secretaries involved under subsection (a) may not waive, under this section, any statutory or regulatory requirement relating to—

(1) comparability of services;

(2) maintenance of effort;

(3) the equitable participation of students attending private schools;

(4) parental participation and involvement;

(5) the distribution of funds to States or to local educational agencies or other recipients of funds under the programs specified in subsection (a)(2);

(6) maintenance of records;

(7) applicable civil rights requirements; or

(8) the requirements of sections 444 and 445 of the General Education Provisions Act.

(d) TERMINATION OF WAIVER.—The Secretaries involved under subsection (a) shall terminate a waiver under this section if the Secretary determines that the performance of the State or other recipient affected by the waiver has been inadequate to justify a continuation of the waiver or if it is no longer necessary to achieve its original purposes.

PART 3—SCHOOL HEALTH EDUCATION; GRANTS TO STATE EDUCATION AGENCIES

SEC. 7621. APPLICATION FOR GRANT.

(a) IN GENERAL.—Any State educational agency that wishes to receive a grant under this part shall submit an application to the Secretary of Health and Human Services and the Secretary of Education, at such time and in such manner as the Secretaries may require.

(b) APPLICATION; DEVELOPMENT; CONTENTS.—An application under subsection (a) shall be developed by the State educational agency in consultation with the State health agencies of the State involved, and shall describe the following:

(1) The State's need for comprehensive school health education based on an assessment, using goals that are established by the Department of Health and Human Services and the Department of Education and that are integrated with the State's school improvement plan, if any, under title III of Goals 2000: Educate America Act or other State education reform plan.

(2) The State educational agency's goals and objectives for comprehensive school health education.

(3) How the State educational agency will collaborate with the State health agency in the planning and development of a comprehensive school health education and pupil services program in the State, including coordination of existing health education and pupil services programs and resources.

(4) A plan for evaluating the effectiveness of comprehensive school health education activities.

(5) How the State will allocate funds to local educational agencies in accordance with section 7625.

(6) How the State will coordinate programs under this part with other local, State and Federal health education and nutrition education programs.

(7) How comprehensive school health education programs will be coordinated and integrated with other local, State and Federal education programs, such as programs under the Elementary and Secondary Education Act of 1965 and the Individuals with Disabilities Education Act, with the State's school improvement plan, if any, under title III of the Goals 2000: Educate America Act, and with any similar programs.

(8) How the State will work with local education agencies, educational service agencies, and State and local health agencies to reduce barriers to implementing comprehensive school health education programs.

(9) How the State will monitor the implementation of such programs by local educational agencies.

(10) How the State will build capacity for professional development of school personnel.

(11) How the State will provide staff development (including curricula models and materials) and technical assistance to local educational agencies, including through the use of educational service agencies where such agencies exist.

(12) The respective roles of the State educational agency, local educational agencies, educational service agencies, the State health agency, and the local health agencies in developing and implementing such comprehensive school health education programs.

(13) How such school health education programs will be tailored, to the extent practicable, to be sensitive to gender, cultural, and linguistic differences and responsive to the various needs of the students served, including individuals with disabilities, and individuals from disadvantaged backgrounds (including racial and ethnic minorities).

(14) Such other information and assurances as the Secretary may reasonably require.

SEC. 7622. SELECTION OF GRANTEES.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary of Education, shall establish criteria for the competitive selection of grantees under this part.

(b) EQUITABLE DISTRIBUTION.—The Secretary shall seek to ensure that assistance under this part is equitably distributed among the geographic regions of the United States, including both urban and rural areas.

SEC. 7623. AMOUNT OF GRANT.

(a) IN GENERAL.—For any fiscal year, the minimum grant to any State under this part is an amount determined by the Secretary to be necessary to enable the State to carry out the activities under this part.

(b) CRITERIA.—In determining the amount of any such grant, the Secretary may consider such factors as the number of children enrolled in schools in the State, the number or percentage of school-aged children living in poverty in the State, and the scope and quality of the State's plan.

SEC. 7624. AUTHORIZED ACTIVITIES; LIMITATION ON ADMINISTRATIVE COSTS.

(a) SUBGRANTS TO LOCAL EDUCATIONAL AGENCIES.—Each State that receives funds under this part for any fiscal year shall retain not more than 20 percent of those funds in the first year, and 10 percent of those funds in each succeeding year. Those funds not retained by the State shall be used to make grants to local educational agencies or educational service agencies in accordance with section 7625.

(b) STATE-LEVEL ACTIVITIES.—Each State shall use retained funds for any fiscal year for the following purposes:

(1) To conduct statewide or sub-State regional coordination and collaboration activities.

(2) To develop and provide technical assistance for the implementation of student learning objectives, instructional materials, and assessment instruments.

(3) To adapt, validate, or disseminate program models or strategies for comprehensive school health education.

(4) To build capacity to deliver staff development and technical assistance services to local educational agencies, and State and local health agencies.

(5) To promote program activities involving families and coordinating program activities with community groups and other public and private nonprofit agencies.

(6) To evaluate and report to the Secretary on the activities carried out with assistance under this part.

(7) To conduct such other activities to achieve the objectives of this part as the Secretary may by regulation authorize.

(c) STATE ADMINISTRATION.—Of the amounts received by a State for a fiscal year under this part and remaining after any grants to local educational agencies made from such amounts, the State may use up to 5 percent for the costs of administering such amounts, including monitoring the performance of local educational agencies.

SEC. 7625. SUBGRANTS TO LOCAL EDUCATIONAL AGENCIES.

(a) APPLICATION FOR GRANT.—Any local educational agency or educational service agency that wishes to receive a grant under this part shall submit an application to the State, containing such information and assurances as the State may require, including a description of the following:

(1) The local educational agency's goals and objectives for comprehensive school health education programs.

(2) How the local educational agency will concentrate funds in schools with the greatest need for comprehensive health education and provide sufficient funds to such schools to ensure the implementation of comprehensive programs.

(3) How the local educational agency will monitor the implementation of these programs.

(4) How the local educational agency will ensure that comprehensive school health education programs are tailored, to the extent practicable, to be sensitive to gender, cultural, and linguistic differences and responsive to the various needs of the students served, including individuals with disabilities, and individuals from disadvantaged backgrounds (including racial and ethnic minorities).

(5) How the local educational agency, in consultation with the local health agency, will evaluate and report on its progress toward attaining the goals and objectives described in paragraph (1).

(6) How the local educational agency, in consultation with the local health agency, will involve parents, teachers, school health and pupil services personnel, and other education and health professionals in the design, instructional content, development, and implementation of the program.

(b) SELECTION OF SUBGRANTEES.—

(1) IN GENERAL.—Each State shall give priority to applications from local educational agencies serving areas with high needs, as indicated by objective, needs-based criteria developed by the State, using readily available public health and other data, which shall include, but need not be limited to, high rates of any of the following:

(A) Poverty among school-aged youth.

(B) Birth to adolescents.

(C) Sexually transmitted diseases among school-aged youth.

(D) Drug and alcohol use among school-aged youth.

(E) Violence among school-aged youth.

(F) Poor daily school attendance.

(2) EQUITABLE DISTRIBUTION.—Each State shall ensure that assistance under this part is equitably distributed among the geographic regions of the State, including both urban and rural areas.

(c) AUTHORIZED ACTIVITIES.—Each local educational agency that receives a grant under this part shall use the grant funds to implement comprehensive school health education programs, as defined in section 7602.

SEC. 7701. OCCUPATIONAL INJURY AND ILLNESS PREVENTION.

(a) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Labor shall collaborate to develop and implement a comprehensive program to expand and coordinate initiatives to prevent occupational injuries and illnesses.

(b) SECRETARY OF LABOR.—The Secretary of Labor, after consultation with the Secretary of Health and Human Services, shall directly or by grants or contracts—

(1) provided for training and education programs for employees and employers in the recognition and control of workplace hazards and methods and measures to prevent occupational injuries and illnesses;

(2) develop model educational materials for training and educating employees and employers on the recognition and control of workplace hazards, including a core curriculum for general safety and health training and materials related to specific safety and health hazards; and

(3) provide programs and services for technical assistance to employers and employees on the recognition and control of workplace safety and health hazards including programs for onsite consultation.

Nothing in this Act shall be construed to require adoption or implementation by any employer of materials or curricula funded by the Secretary of Labor pursuant to paragraph (2). Technical assistance and consultative services under paragraph (3) shall be provided in a manner that is separate from the enforcement programs conducted by the Secretary of Labor.

(c) SECRETARY OF HEALTH AND HUMAN SERVICES.—The Secretary of Health and Human Services, acting through the Director of the National Institute for Occupational Safety and Health and after consultation with the Secretary of Labor, shall directly or by grants or contracts—

(1) provide education programs for training occupational safety and health professionals including professionals in the fields of occupational medicine, occupational health nursing, industrial hygiene, safety engineering, toxicology, and epidemiology;

(2) provide education programs for other health professionals and health care providers and the public to improve the recognition, treatment, and prevention of occupationally related injuries and illnesses;

(3) conduct surveillance programs to identify patterns and to determine the prevalence of occupational illnesses, injuries and deaths related to exposure to particular safety and health hazards;

(4) conduct investigations and evaluations to determine if workplace exposures to toxic chemicals, harmful physical agents or potentially hazardous conditions pose a risk to exposed employees; and

(5) conduct research, demonstrations, and experiments relating to occupational safety and health to identify the causes of and major factors contributing to occupational illnesses and injuries.

In any case in which the Secretary of Health and Human Services conducts any activity under paragraph (3), (4), or (5) which includes a cohort study involving current or past employees of an employer, the Secretary shall provide prior notice to the employer and the employees (or employee representatives of the employees) in advance of the major steps of such activity, and shall provide the employer and the employees (or employee representatives) an opportunity to review the study and submit analysis or other comments prior to making the study publicly available.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $150,000,000 for each of the fiscal years 1995 through 2000.

Subtitle I—Miscellaneous Provisions

SEC. 7801. IDENTIFYING STRATEGIES FOR ASSESSING IMPACT OF HEALTH CARE REFORM.

(a) IN GENERAL.—Within 90 days after the date of the enactment of this Act, the Secretary shall seek to enter into an agreement with the Institute of Medicine of the National Academy of Sciences (or another nonprofit, nongovernmental organization or consortium of institutions) to study and report on the impact of this Act at the national, regional, and State levels.

(b) PURPOSE.—The purpose of the study under this section is to develop a detailed framework, using a prospective, longitudinal study design, to assess the impact of this Act on national goals, such as the goals of assuring security of coverage, promoting simplicity of administration, achieving health care savings, encouraging individual responsibility, improving quality of care, promoting choice, and improving health status.

(c) REPORT.—The Secretary shall require the organization conducting the study under this section to submit to the Secretary and the Congress a report within 18 months after the date of the enactment of this Act. The report shall include recommendations regarding each of the following:

(1) The appropriate indicators of national progress towards meeting the national goals referred to in subsection (b).

(2) The appropriate study designs that would assess the impact of this Act on these indicators and that could take into account different approaches to health care reform that may be used in different States and regions (or by different Federal agencies), as well as by foreign countries.

(3) The data elements and public and private sources of information for measuring such indicators, including—

(A) the special requirements or authorities needed to permit access to confidential data (and to assure continued confidentiality of such data) needed to measure such indicators;

(B) the methods for obtaining the elements that are not currently in use;

(C) approaches to establishing a core set of primary data as part of a national collection effort that could overlap with the evaluation of this Act; and

(D) the relationship between Federal, State, and local agencies in the gathering, reporting, and sharing of information on this Act and its assessment.

(4) The nature, scope, and frequency of reports that would best serve the Secretary and the Congress in the evaluation of this Act.

(5) The overall cost estimates associated with obtaining and evaluating information on the impact of this Act.

(6) The ways in which the findings contained in the report could be used by various groups, such as patients, providers, insurers, employers, taxpayers, and various government agencies.

SEC. 7802. STUDY OF WORKSITE WELLNESS PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services, after consultation with the Secretary of Labor, shall conduct a study evaluating the effectiveness of health promotion programs in the worksite and analyzing the feasibility and desirability of providing incentives (including health plan premium discounts) to encourage employers to adopt such programs. In conducting the study, the Secretary shall assess the effect of programs of various size, scope, and type on health status, medical risk factors, life style, disability, morbidity, mortality, and productivity.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), and shall include in the report—

(1) information on the cost effectiveness, type, and amount of financial incentives (if any) provided under the programs studied; and

(2) such recommendations as the Secretary considers appropriate for providing incentives to encourage employers to adopt health promotion programs in the worksite.

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SEC. 8000. REFERENCES IN TITLE.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) REFERENCES TO OBRA.—In this title, the terms "OBRA–1986", "OBRA–1987", "OBRA–1989", "OBRA–1990", and "OBRA–1993" refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

Subtitle A—Medicare Part C Program

SEC. 8001. ESTABLISHMENT OF MEDICARE PART C PROGRAM.

The Social Security Act is amended by adding after title XX the following new title:

"TITLE XXI—MEDICARE PART C

"SEC. 2100. ESTABLISHMENT OF PROGRAM.

"Not later than January 1, 1999, the Secretary shall establish and operate a Medicare Part C Program under this title to provide coverage for the guaranteed national benefit package for eligible individuals.

"PART A—ELIGIBILITY AND ENROLLMENT

"SEC. 2101. ELIGIBILITY.

"(a) ELIGIBILITY TO ENROLL FOR HEALTH INSURANCE BENEFITS.—Each medicare part C eligible individual (as defined in subsection (b)) is eligible to enroll in the program under this title.

"(b) MEDICARE PART C ELIGIBLE INDIVIDUAL DEFINED.—In this title, subject to subsection (c), the term 'medicare part C eligible individual' means any eligible individual (as defined in section 1001(c) of the Guaranteed Health Insurance Act of 1994) who meets any of the following requirements:

"(1) CERTAIN PART-TIME, TEMPORARY, AND SEASONAL EMPLOYEES.—The individual is an employee described in section 1102(c) of the Guaranteed Health Insurance Act of 1994 or a member of the family of such an individual (as defined in section 3 of such Act).

"(2) FULL-TIME EMPLOYEES OF SMALL EMPLOYERS.—The individual is a full-time employee (as defined in section 1106(a) of the Guaranteed Health Insurance Act of 1994) of an employer that is not a large employer (as defined in section 1106(b) of such Act) and the employee is not a qualified employer-covered employee of the employer (as defined in section 1104 of such Act), or a member of the family of such an individual (as defined in section 3 of such Act).

"(3) NON-WORKERS.—The individual is not an employee, or is a member of the family of an individual who is not an employee.

"(4) AFDC AND SSI RECIPIENTS.—The individual is an AFDC or SSI recipient.

"(5) EMPLOYED INDIVIDUALS WITH INCOME BELOW SPECIFIED PERCENTAGE OF INCOME THRESHOLD.—

"(A) IN GENERAL.—The individual—

"(i) is an employee of a small employer (as defined in section 1106(b) of the Guaranteed Health Insurance Act of 1994), and

"(ii) is determined, under part D of title XXII in the manner described in section 2251, to have projected modified adjusted gross income that is less than the applicable percentage (specified in subparagraph (B)) of the threshold amount (as defined in section 2122(c)(3)) applicable to the taxpayer involved.

"(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the 'applicable percentage', for taxable years ending with or within—

"(i) 1999, 2000, or 2001, is 200 percent,

"(ii) 2002 or 2003, is 220 percent, and

"(iii) a year thereafter, is 240 percent.

"(c) INELIGIBLE INDIVIDUAL.—

"(1) IN GENERAL.—

"(A) IN GENERAL.—The term 'medicare part C eligible individual' does not include an eligible individual (as defined in section 1001 of the Guaranteed Health Insurance Act of 1994)—

"(i) who is covered under a certified health plan,

"(ii) subject to paragraph (2), who is entitled to benefits under part A of title XVIII,

"(iii) whose principal place of abode is in Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, unless (and only so long as) such possession meets the requirements of paragraph (3)(A), or

"(iv) who is covered under a State single-payer system or a State managed competition program under subtitle A or B of title IV of the Guaranteed Health Insurance Act of 1994.

"(B) CONSTRUCTION.—Nothing in subparagraph (A)(i) shall prevent an individual described in such subparagraph from disenrolling from a plan in order to become a medicare part C eligible individual.

"(2) EXCEPTION FOR MEDICARE SECONDARY PAYER SITUATIONS.—Paragraph (1)(A)(ii) shall not apply to an individual to whom section 1862(b)(2) applies, if the program under this title would otherwise constitute the primary plan (as defined in section 1862(b)(2)(A)).

"(3) RULES RELATING TO POSSESSIONS.—

"(A) REQUIREMENTS.—The requirements of this subparagraph with respect to a possession are that an agreement is in effect between the United States and such possession pursuant to which—

"(i) the laws of such possession impose a qualified medicare part C premium individual share tax (as defined in subparagraph (B));

"(ii) nothing in any provision of law, including the law of such possession, permits such possession to reduce or remit in any way, directly or indirectly, any liability to such possession by reason of such individual share tax;

"(iii) any amount received in the Treasury of such possession by reason of such individual share tax shall be paid (at such time and in such manner as the Secretary of the Treasury shall prescribe) to the Treasury of the United States for credit to the Medicare Part C Trust Fund;

"(iv) such individual share tax is coordinated with the tax imposed by section 59B of the Internal Revenue Code of 1986 such that, for any period, an individual would be required to pay (in the aggregate under both such taxes) not more than the appropriate applicable medicare part C premium for such period; and

"(v) the possession complies with such other requirements as may be prescribed by the Secretary and the Secretary of the Treasury to carry out the purposes of this paragraph, including requirements prescribing the information individuals to whom such individual share tax may apply shall furnish to the Secretary and the Secretary of the Treasury.

"(B) QUALIFIED MEDICARE PART C PREMIUM INDIVIDUAL SHARE TAX.—In subparagraph (A), the term 'qualified medicare part C premium individual share tax' means a tax imposed and collected by such a possession that is—

"(i) equivalent to the tax imposed under section 59B of the Internal Revenue Code of 1986 (and any tax subsequently enacted for the purpose of collecting the individual share of premiums for benefits under this title); and

"(ii) imposed on all individuals who are medicare part C eligible individuals (as determined without regard to paragraph (1)(A)(iii)) and who are bona fide residents of the possession, to the extent such individuals have not paid the tax imposed under such section 59B to the United States by reason of subsection (f)(4) of such section or otherwise paid the qualified medicare part C premium individual share tax imposed by another possession under this paragraph.

"SEC. 2102. ENROLLMENT PROCESS.

"(a) IN GENERAL.—The Secretary, through the Health Care Financing Administration, the Social Security Administration, and other appropriate agencies, shall establish a process in coordination with section 2184 for—

"(1) determining whether individuals are medicare part C eligible individuals,

"(2) enrolling medicare part C eligible individuals under this title if they seek such enrollment or are otherwise required to be enrolled or covered under this title, and

"(3) enrolling medicare part C eligible individuals described in section 2101(b)(2) whose employers do not enroll such individuals in a certified health plan.

"(b) PERIOD OF CONTINUOUS OPEN ENROLLMENT.—Any medicare part C eligible individual may enroll under this title at any time beginning July 1, 1998.

"(c) APPLICATION PROCESS.—

"(1) IN GENERAL.—The filing of an application for enrollment under this title shall (except as the Secretary may provide) constitute enrollment under this title. Such an application may be filed with the Secretary by mail or at such locations as the Secretary may specify.

"(2) AVAILABILITY OF APPLICATIONS.—The Secretary shall make applications for enrollment under this title available—

"(A) at local offices of the Social Security Administration,

"(B) at out-reach sites (such as provider and practitioner locations described in section 2103(c)), and

"(C) at other locations (including post offices) accessible to a broad cross-section of medicare part C eligible individuals.

"(3) COORDINATION WITH APPLICATION FOR PREMIUM SUBSIDIES AND WRAP-AROUND BENEFITS.—An application for enrollment under this title may (but need not) be accompanied by an application for wrap-around benefits under part B of title XXII.

"(c) CERTAIN INDIVIDUALS DEEMED ENROLLED.—Consistent with standards established under section 5501 of the Guaranteed Health Insurance Act of 1994—

"(1) TERMINATION OF ENROLLMENT UNDER CERTIFIED HEALTH PLAN.—The Secretary shall provide a process under which an eligible individual whose coverage under a certified health plan is terminated and who fails to establish continuous coverage under another certified health plan or the medicare program shall be deemed to be enrolled under this title as of the date of termination of such coverage.

"(2) COVERAGE AT BIRTH.—The Secretary shall provide that in the case of an individual born in the United States and who is not enrolled or otherwise covered under a certified health plan at the time of birth, the individual shall be deemed to have been enrolled under this title at the time of birth.

"(d) ISSUANCE OF HEALTH SECURITY CARD.—At the time an individual enrolls in the program under this title, the Secretary shall issue a health security card to the individual in accordance with the standards applicable to the issuance of such cards under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994.

"SEC. 2103. FACILITATION OF ENROLLMENT.

"(a) IN GENERAL.—The Secretary shall establish procedures that facilitate enrollment under this title.

"(b) COORDINATION.—The Secretary shall coordinate with existing programs and agencies to streamline the enrollment process.

"(c) USE OF CERTAIN PROVIDERS.—

"(1) IN GENERAL.—In accordance with regulations promulgated by the Secretary, hospitals, rural primary care hospitals, federally qualified health centers, rural health clinics, and any essential community provider (as described in section 5012(c) of the Guaranteed Health Insurance Act of 1994) receiving Federal funds, shall—

"(A) assist in enrolling under this title individuals who (i) appear to be medicare part C eligible individuals, (ii) are provided services covered under the guaranteed national benefit package, and (iii) do not present a valid health security card, and

"(B) report to the Secretary such information as the Secretary may require to assist in the enrollment of such individuals.

"(2) ACCESS TO INFORMATION.—Such hospitals, centers, clinics, and providers shall have access to information, pertaining to the certified health plans (or the medicare program or medicare part C) in which individuals are enrolled, through the national enrollment verification system established under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994.

"(d) OUTREACH.—The Secretary shall develop and implement outreach programs to ensure enrollment of all medicare part C eligible individuals (who are not enrolled in a certified health plan or the medicare program) under this title.

"SEC. 2104. COVERAGE PERIOD; TERMINATION OF ENROLLMENT.

"(a) BEGINNING OF COVERAGE.—In the case of an individual enrolled under this title, the benefits under this title shall first become available for services furnished beginning—

"(1) in the case of an individual who enrolls on or before January 1, 1999, on January 1, 1999; or

"(2) in the case of an individual who enrolls after such date, on the date of enrollment or such other date as the Secretary may specify, consistent with preventing eligible individuals from having any periods of noncoverage and consistent with rules established under section 5501 of the Guaranteed Health Insurance Act of 1994.

"(b) LIMITING TERMINATION OF ENROLLMENT.—An individual enrolled under this title may not terminate such enrollment unless—

"(A) the individual is no longer a medicare part C eligible individual because of a change of family, employment, or other relevant status; or

"(B) the individual demonstrates to the satisfaction of the Secretary that if the individual is an eligible individual the individual is enrolled under a certified health plan, is entitled to benefits under part A of title XVIII, is a noncovered, noncontributing individual (as defined in section 1004(b) of the Guaranteed Health Insurance Act of 1994), or is described in section 59B(g)(2)(A)(ii) of the Internal Revenue Code of 1986.

"PART B—BENEFITS AND PAYMENTS

"SEC. 2111. COVERAGE OF BENEFITS UNDER GUARANTEED NATIONAL BENEFIT PACKAGE.

"(a) IN GENERAL.—Subject to subsection (b), the health insurance benefits provided to an individual covered under this title shall consist of entitlement to the benefits (including cost-sharing) contained in the guaranteed national benefit package described in subtitle A of title III of the Guaranteed Health Insurance Act of 1994. Except in the case of enrollment with an organization under section 2132, the cost-sharing schedule shall be the standard cost-sharing schedule described in section 3013 of the Guaranteed Health Insurance Act of 1994 (determined without regard to subsection (a)(4) thereof).

"(b) Requiring Covered Services To Be Furnished by Medicare-Eligible Providers.—No benefits are payable under this title with respect to an individual or entity that provides items and services (other than services described in section 3002(d) of the Guaranteed Health Insurance Act of 1994) unless the individual or entity qualifies for payment with respect to such items or services under title XVIII (for individuals entitled to benefits under such title).

"SEC. 2112. PAYMENTS FOR HEALTH INSURANCE BENEFITS.

"(a) Use of Medicare Payment Rules.—

"(1) In general.—Except as otherwise provided in this title, consistent with sections 5501(c)(3) and 8002(c) of the Guaranteed Health Insurance Act of 1994 and consistent with the cost-sharing described in section 2111(a)—

"(A) payment of health insurance benefits under this title with respect to services shall be made, subject to adjustment in payment rates under section 2113, in the same amounts and on the same basis as payment may be made with respect to such services under title XVIII (including pursuant to waiver authority), and

"(B) the provisions of sections 1814, 1815, 1833, 1834, 1835, 1842, 1848, 1850, 1886, 1887, and 1893 shall apply to payment of benefits (and provision of services and charges thereon) under this title in the same manner as they apply to benefits, services, and charges under title XVIII.

"(2) Establishment of comparable payment methods for new services.—In the case of any service for which there is not a payment basis established under title XVIII, the Secretary shall establish payment rules that are similar to the payment rules for similar services under such title, in consultation with the Prospective Payment Assessment Commission, Physician Payment Review Commission, and the Prescription Drug Payment Review Commission.

"(3) Limitations on administrative or judicial review.—Administrative or judicial review of the payment rates or rules under this section (including adjustments made under section 2113) shall be available only to the extent such a review would be available with respect to such rates or rules (or similar rates or rules) under title XVIII.

"(4) Use of trust fund.—In applying the provisions described in paragraph (a)(1)(B) in carrying out this section, any reference in title XVIII to a trust fund shall be treated as a reference to the Medicare Part C Trust Fund established under section 2124.

"(b) Payments to Providers for Certain Emergency Care Services for Ineligible Aliens.—

"(1) In general.—In addition to amounts otherwise payable under this title, the Secretary shall make payments for care and services that are necessary for the treatment of an emergency medical condition (as defined in section 1903(v)(3)) of an alien who is not an eligible individual.

"(2) Payment amount.—Notwithstanding any other provisions of this title, the amount of such payments—

"(A) shall not take into account any cost-sharing that may otherwise be imposed under this title, but

"(B) shall be reduced by the amount of any payment otherwise made (or that through the exercise of reasonable collection policies, would have been paid) with respect to such care and services.

"(3) Effective date.—This subsection shall not apply to care and services furnished before January 1, 2002.

"SEC. 2113. ADJUSTMENTS TO MEDICARE RATES AND METHODOLOGIES.

"(a) Adjustment of Medicare Payment Rates for Inpatient Hospital Services.—

"(1) For pps hospitals.—For purposes of payment for inpatient hospital services for hospitals receiving payment under section 1886(d), the Secretary, by regulation and in accordance with this section—

"(A) shall adjust the standardized amounts otherwise established under title XVIII to reflect differences in the average cost of providing inpatient hospital services (included in the guaranteed national benefit package) between the program under part A of title XVIII and under this title, and

"(B) may develop separate diagnosis-related groups and weighting factors for such groups to reflect resource needs of individuals enrolled under this title and shall develop separate groups and factors for children.

"(2) Report by prospective payment assessment commission.—The Prospective Payment Assessment Commission, in its report to Congress under section 1886(e)(3)(A) in 1998, shall include its recommendations on the adjustments that should be made under paragraph (1) in the payment methodology for inpatient hospital services and data that should be collected in order to establish appropriate weighting factors for diagnosis-related groups used under this section. The Commission shall include, in its subsequent reports under such section, such recommendations with respect to payment for inpatient hospital services under this title as it deems appropriate.

"(3) Secretarial publications.—The Secretary shall provide for the publication, in the manner and time specified under section 1886(e)(5), of adjustments proposed to be made (and to be made) under this subsection for each fiscal year.

"(b) New Procedure Codes and Relative Value Units for Physicians' Services.—

"(1) New procedure codes and relative value units.—In applying section 2112 in the case of services for which relative value units have not been established under section 1848, the Secretary shall establish relative value units in the same manner as if payment for such services were made under part B of title XVIII.

"(2) Report by physician payment review commission.—The Physician Payment Review Commission, in its recommendations to Congress under section 1845(b) in the year before the first year in which this title is effective, shall include recommendations on adjustments to the relative value units that should be applied (under paragraph (1)) with respect to physicians' services furnished under this title. The Commission shall include, in its subsequent recommendations under such section, such recommendations with respect to the payment for physicians' services under this title as it deems appropriate.

"(3) Secretarial publication.—The Secretary shall cause to be published in the Federal Register—

"(A) before June 1 of the year before the first year in which this title is effective, the relative value units proposed to be applied during such first year under this title, and

"(B) after consideration of public comments submitted pursuant to such proposal and before October 1 before such first year, the relative value units to be applied during such first year under this title.

"(4) Secretarial review and revision.—The Secretary shall provide for the periodic review and adjustment of the relative value units to be applied under this title in the same manner and frequency as provided under section 1848(c)(2)(B), except that such review shall first be conducted each year during the first 3 years in which this title is in effect and not less often than every 5 years thereafter.

"(c) Adjustment to Average Per Capita Rates for Health Maintenance Organizations.—For purposes of establishing per capita rates of payment for classes of individuals enrolled with an eligible organization under a risk-sharing contract under section 2132, the Secretary, by regulation and in accordance with this subsection, shall adjust the adjusted average per capita cost otherwise established under section 1876(a)(4) to take into account differences between the population served under title XVIII and the population receiving health insurance benefits under this title.

"SEC. 2114. EXCLUSIONS; COORDINATION.

"(a) Exclusions.—

"(1) In general.—Section 1862 shall apply to expenses incurred for items and services provided under this title in the same manner as such section applies to items and services provided under title XVIII.

"(2) Use of same national coverage decision review process.—The provisions of section 1869(b)(3) shall apply under this title in the same manner as they apply under title XVIII. Any determination under such title that, under paragraph (1), applies under this title shall not be subject to review under this paragraph.

"(b) Treatment as Large Group Health Plan for Purposes of Medicare Secondary Payer.—For purposes of section 1862(b), this title shall be treated as a large group health plan (described in such section).

"Part C—Premiums; Medicare Part C Trust Fund

"SEC. 2121. COMPUTATION OF APPLICABLE MEDICARE PART C PREMIUM.

"(a) In General.—The applicable medicare part C premium under this title, for health insurance benefits for any individual in a class of enrollment (as defined in section 3(b) of the Guaranteed Health Insurance Act of 1994) in a State (or outside the United States) for a month in a year, is equal to the product of—

"(1) the monthly national actuarial rate established under subsection (b) with respect to such class for months in the year, and

"(2) a State actuarial adjustment factor established under subsection (c) with respect to the State (or outside the United States).

The Secretary shall publish, for purposes of this title, sections 59B(c)(3)(D) and 3455(c)(4)(A) of the Internal Revenue Code of 1986, and part A of title XXII, tables of the monthly applicable medicare part C premium computed under this subsection.

"(b) Monthly National Actuarial Rates.—

"(1) Initial rate.—Subject to the succeeding provisions of this subsection, the national monthly actuarial rates under this subsection for months in 1999 are as follows (expressed in 1994 dollars):

"(A) Individual enrollment.—$178.25 for the individual class of enrollment.

"(B) Single parent enrollment.—$347.50 for the single parent class of enrollment.

"(C) FAMILY ENROLLMENT.—$472.60 for the family class of enrollment.

"(2) DETERMINATION OF RATES.—

"(A) ANNUAL DETERMINATION.—In September of each year (beginning with 1998) the Secretary shall determine and publish a national monthly actuarial rate for each class of enrollment for health insurance benefits under this title in the following year. Such rates for—

"(i) 1999 shall be the rates specified under paragraph (1), subject to adjustment under subparagraph (C), or

"(ii) a subsequent year, shall be the monthly actuarial rates estimated under paragraph (3).

"(B) PUBLIC STATEMENT.—Whenever the Secretary publishes monthly actuarial rates under this section, the Secretary shall, at the time of such publication, include a public statement setting forth the actuarial assumptions and bases employed in arriving at the amount of the actuarial rates.

"(C) RELATION TO SPECIFIED RATES.—If the Secretary finds that the rates specified under paragraph (1) are greater or less than the respective monthly actuarial rates estimated under paragraph (3), the Secretary shall adjust the specified rates to reflect such estimated actuarial rates and the national monthly actuarial rates under this subsection shall be treated for all purposes as the rates as so adjusted.

"(3) BASIS FOR MONTHLY ACTUARIAL RATES.—

"(A) IN GENERAL.—Subject to subparagraph (C), each such monthly actuarial rate established for a class of enrollment shall be an amount the Secretary estimates to be necessary so that, if payments were made on the basis of such rates for all individuals enrolled under this title in such class, the aggregate amount for the calendar year would equal the total of the benefits and administrative costs which the Secretary estimates will be payable from the Medicare Part C Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rates, the Secretary shall include an appropriate amount for a contingency margin.

"(B) ASSUMPTIONS FOR PREMIUM CALCULATION.—In determining actuarial rates under subparagraph (A)—

"(i) the Secretary shall not take into account any expenditures (including related administrative expenses) attributable to—

"(I) individuals enrolled for health insurance benefits under this title who are SSI recipients who have been determined to be disabled for purposes of the supplemental security income program (under title XVI); or

"(II) the operation of part B of this title; or

"(III) payments made pursuant to section 2112(b); and

"(ii) for months in 1999, 2000, 2001, and 2002, the Secretary shall assume that ¾ of individuals who are medicare part C eligible individuals are enrolled under this title.

"(c) STATE ACTUARIAL ADJUSTMENT FACTORS.—

"(1) IN GENERAL.—The Secretary shall establish for each State a State actuarial adjustment factor. Such factor shall vary among the States based on the variation in the average level of costs for covered benefits and administration, described in subsection (b)(3)(B) and determined on a per capita basis, among such States.

"(2) CONDITIONS.—State actuarial adjustment factors shall be computed for each year in a manner so that the application of such adjustment factors shall not change the weighted average of the national monthly payment rates computed under this subsection.

"(3) SPECIAL RULE FOR INDIVIDUALS RESIDING OUTSIDE THE UNITED STATES.—In the case of an eligible individual who has a principal place of abode outside the United States, the State actuarial adjustment factor under this subsection is 1.

"(d) APPLICATION TO FAMILIES.—In the case of individuals enrolled under this title in a class of enrollment other than the individual class of enrollment, the premium rate established under this section applies collectively to all family members included within the class of enrollment.

"SEC. 2122. MEDICARE PART C PREMIUM LIABILITY.

"(a) IN GENERAL.—An individual's share of the medicare part C premium is the amount determined under section 59B of the Internal Revenue Code of 1986.

"(b) DESCRIPTION OF FACTORS TAKEN INTO ACCOUNT.—The amount of such individual share under such section—

"(1) is based on the sum of monthly premiums based on class of enrollment;

"(2) is fully or partially reduced for low-income individuals, as described in subsection (c); and

"(3) may be reduced by any employer payments.

"(c) REDUCTION FOR LOW-INCOME INDIVIDUALS.—

"(1) IN GENERAL.—An individual whose modified adjusted gross income (as defined in paragraph (4)) does not exceed the threshold amount (as defined in paragraph (3)) is not liable for payment of the individual share of the medicare part C premium.

"(2) PHASE-IN OF PREMIUM LIABILITY.—

"(A) IN GENERAL.—If the modified adjusted gross income of an individual for a taxable year exceeds the threshold amount by less than the phase-in amount (described in subparagraph (C)), the amount of the premium liability under subsection (a) for the year shall be the phase-in percentage (specified in subparagraph (B)) of the medicare part C premium liability of such individual for the taxable year.

"(B) PHASE-IN PERCENTAGE.—For purposes of subparagraph (A), the phase-in percentage shall be determined under tables prescribed by the Secretary of the Treasury under section 59B(b)(2)(B) of the Internal Revenue Code of 1986, which tables—

"(i) have income brackets of not more than $50, and

"(ii) provide for a ratable increase in the amount of premium imposed by subsection (a) for modified adjusted gross incomes between the threshold amount and the sum of the threshold amount and the phase-in amount.

"(C) PHASE-IN AMOUNT.—For purposes of subparagraphs (A) and (B), the phase-in amount is the amount equal to the applicable percentage (determined in accordance with the following table) of the threshold amount.

"In the case of taxable years ending with or within—	The applicable percentage is—
1999, 2000, or 2001	100 percent
2002 or 2003	120 percent
2004 or thereafter	140 percent.

"(3) THRESHOLD AMOUNT DEFINED.—For purposes of this subsection—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'threshold amount' means—

"(i) $7,400 in the case of a return with respect to which 1 personal exemption is allowable under section 151 of the Internal Revenue Code of 1986,

"(ii) $11,500 in the case of a return with respect to which 2 or 3 personal exemptions are allowable under such section, and

"(iii) $16,000 in the case of a return with respect to which 4 or more personal exemptions are allowable under such section.

"(B) CERTAIN SEPARATE RETURNS.—The threshold amount shall be zero in the case of a taxpayer who—

"(i) is married as of the close of the taxable year but does not file a joint return for such taxable year, and

"(ii) does not live apart from his spouse at all times during the last 6 months of the taxable year.

"(C) INFLATION ADJUSTMENTS.—In the case of a taxable year beginning in a calendar year after 1998, each dollar amount contained in subparagraph (A) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) of the Internal Revenue Code of 1986 for the calendar year in which the taxable year begins, by substituting 'calendar year 1994' for 'calendar year 1992' in subparagraph (B) thereof.

"(4) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this subsection, and pursuant to section 59B(e)(1) of the Internal Revenue Code of 1986, the term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 911, 931, and 933 of the Internal Revenue Code of 1986, and

"(B) increased by the amount of interest received or accrued by the individual during the taxable year which is exempt from tax. The determination under the preceding sentence shall be made without regard to any carryover or carryback.

"SEC. 2123. COLLECTION OF PREMIUMS.

"(a) IN GENERAL.—Except as provided in subsection (b), the amounts under section 2122 are payable pursuant to section 59B of the Internal Revenue Code of 1986.

"(b) DIRECT PAYMENT PROCESS.—

"(1) IN GENERAL.—The Secretary shall establish a process whereby individuals who are liable for payments under section 2122 (or section 59B of the Internal Revenue Code of 1986) may make such payments directly to the Secretary (or the Secretary's designee) in a manner specified by the Secretary.

"(2) INFORMATION.—Under the process, the Secretary shall provide such information return or other documentation that may be used to establish, for purposes of the Internal Revenue Code of 1986 or otherwise, the amounts paid on behalf of each individual under this subsection and the period in which the individual was enrolled under this title.

"(3) DEPOSIT.—Amounts received under this subsection shall be deposited to the credit of the Medicare Part C Trust Fund (established under section 2124).

"SEC. 2124. MEDICARE PART C TRUST FUND.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Part C Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided pursuant to section 201(h) and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this part.

"(2) DEPOSIT OF PREMIUM AMOUNTS AND CONTRIBUTIONS.—There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of—

"(A) the amounts received in the Treasury under section 59B and chapter 25 of the Internal Revenue Code of 1986 and section 2132,

"(B) the amount of payments made by States to the Secretary under sections 8111, 8121, and 8131 of the Guaranteed Health Insurance Act of 1994, and

"(C) amounts paid to the Treasury pursuant to agreements under section 2101(c)(3)(A).

The amounts appropriated by clauses (A) and (C) of the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the amounts paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts specified in such clauses.

"(3) APPROPRIATIONS TO COVER BALANCE OF EXPENDITURES.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Medicare Part C Trust Fund a Government contribution equal to the amount by which the expenditures from the Trust Fund (including the payment of administrative expenses in accordance with section 201(g)(1)) exceed the other receipts of the Trust Fund.

"(b) INCORPORATION OF PROVISIONS.—

"(1) IN GENERAL.—Subject to paragraph (2), the provisions of subsections (b) through (e), (h), and (i) of section 1817 shall apply to the Trust Fund and this title in the same manner as they apply to the Federal Hospital Insurance Trust Fund and part A of title XVIII.

"(2) EXCEPTIONS.—In applying paragraph (1)—

"(A) the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Hospital Insurance Trust Fund; and

"(B) any reference in section 1817 to the Federal Hospital Insurance Trust Fund or to title XVIII (or part A thereof) is deemed a reference to the Trust Fund under this section and this title, respectively.

"(c) PAYMENTS FROM TRUST FUND.—

"(1) PAYMENTS FOR PART C PROGRAM.—Pursuant to authority described in section 1817(h) (as incorporated under subsection (b)(1)), the Managing Trustee of the Trust Fund shall pay from time to time from the Trust Fund such amounts as the Secretary certifies are necessary to carry out the medicare part C program under this title.

"(2) CERTAIN TRANSFERS.—The Managing Trustee of the Trust Fund shall also pay from time to time from the Trust Fund—

"(A) such amounts to the General Treasury as the Secretary certifies to be necessary to carry out parts A, B, and C of title XXII (including amounts for payments to States under subsections (a)(1)(B), (a)(2)(B), and (b)(2) of section 4004 of the Guaranteed Health Insurance Act of 1994).

"(B) such amounts to the General Treasury as the Secretary of the Treasury certifies to be payments for credits under section 3461 and 3462 of the Internal Revenue Code of 1986 that are not an offset to a liability in amounts otherwise payable under chapter 25 of such Code;

"(C) such amounts to the Secretary of Health and Human Services as are appropriated to the Trust Fund under subsection (a)(2)(B);

"(D) amounts equivalent to the amounts received in the Trust Fund by reason of section 3455(e) of the Internal Revenue Code of 1986 to the Indian Health Service to augment the appropriation for health programs of such Service; and

"(E) amounts equivalent to the amounts received in the Trust Fund by reason of section 3455(f) of the Internal Revenue Code of 1986 to the Secretary of Veterans Affairs to augment the appropriation for health programs of the Department of Veterans Affairs.

Amounts paid by a small employer (as defined in section 1106(b) of the Guaranteed Health Insurance Act of 1994) shall be taken into account under subparagraph (E) only if such employer offers coverage under a certified health plan.

"PART D—ADMINISTRATIVE PROVISIONS

"SEC. 2131. AGREEMENTS WITH HOSPITALS; PARTICIPATING PHYSICIANS; TREATMENT OF INDIAN HEALTH SERVICE FACILITIES.

"(a) REQUIREMENT.—Any hospital shall be qualified to participate under this title and shall be eligible for payments under this title if—

"(1) it has in effect a participation agreement under section 1866(a)(1), and

"(2) it files with the Secretary a participation agreement meeting the requirements of subsection (b).

"(b) ELEMENTS OF AGREEMENT.—

"(1) IN GENERAL.—Except as provided in this subsection, a participation agreement under this subsection shall provide terms, specified by the Secretary, that are the same terms as those required of hospital participation agreements under section 1866(a)(1).

"(2) MODIFIED COPAYMENTS.—Instead of the limitation on charges specified under paragraphs (1)(A) and (2) of section 1866(a), the agreement shall not permit the hospital to charge more than the applicable deductible and coinsurance permitted under this title.

"(c) PHYSICIAN PARTICIPATION AGREEMENTS.—The Secretary shall provide for participating physician agreements under this title in the same manner as such agreements are provided for under part B of title XVIII pursuant to section 1842(h).

"(d) INDIAN HEALTH SERVICE FACILITIES.—The provisions of section 1880 (relating to Indian health service facilities) shall apply to this title in the same manner as they apply under title XVIII.

"SEC. 2132. HEALTH MAINTENANCE ORGANIZATIONS.

"(a) IN GENERAL.—Except as provided in this section, section 1876 shall apply to individuals enrolled under this title in the same manner as such section applies to individuals entitled to benefits under part A, and enrolled under part B, of title XVIII.

"(b) APPLICATION.—In applying section 1876 under subsection (a)—

"(1) individuals who are enrolled in a class of enrollment under this title may enroll with an eligible organization only based on the same class of enrollment;

"(2) if an eligible organization imposes an additional premium for additional benefits, such a premium shall be adjusted to reflect the class of enrollment with the eligible organization;

"(3) the appropriate classes of members described in section 1876(a)(1)(B) applied under this section may be different from the classes applied for purposes of title XVIII;

"(4) the provisions of such section relating only to individuals enrolled under part B of title XVIII shall not apply;

"(5) any reference to a Trust Fund established under title XVIII and to benefits with respect to any services under such title is deemed a reference to the Medicare Part C Trust Fund and to the guaranteed national benefit package with respect to required health services under this title;

"(6) the adjusted average per capita cost shall be determined on the basis of benefits under this title;

"(7) subsection (h) shall not apply; and

"(8) in the case of a risk-sharing contract, the eligible organization may not require an enrollee to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

"SEC. 2133. USE OF FISCAL AGENTS.

"(a) USE OF FISCAL AGENTS.—

"(1) IN GENERAL.—Except as provided in this section, the Secretary shall provide for the administration of this title through the use of fiscal agents in the same manner as title XVIII is carried out through the use of fiscal intermediaries and carriers.

"(2) SEPARATE CONTRACTS.—Contracts with fiscal agents entered into pursuant to this subsection for an area need not be with the same fiscal intermediary or carrier with an agreement under section 1816 or a contract under section 1842 for the area. However, nothing in this section shall be construed as preventing such an organization with such an agreement or contract under such respective section from entering into a contract under this section.

"SEC. 2134. COMPLIANCE WITH INFORMATION STANDARDS; APPLICATION OF MEDICARE QUALITY ASSURANCE AND SURVEY AND CERTIFICATION REQUIREMENTS.

"(a) IN GENERAL.—The Secretary, with respect to the program under this title, shall comply with the applicable provisions of subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 (relating to information systems and administrative simplification).

"(b) SURVEY AND CERTIFICATION; QUALITY ASSURANCE.—In accordance with rules of the Secretary, the survey and certification requirements of title XVIII, and the quality assurance provisions of such title and part B of title XI (relating to professional review organizations), insofar as they relate to providers of services and other health care providers under title XVIII, shall apply to such providers under this title in the same manner as they apply to providers under title XVIII.

"SEC. 2135. PROGRAM INTEGRITY.

Sections 1124, 1124A, 1126, 1128 through 1128B (relating to fraud and abuse), 1145 (relating to restrictions on the disclosure of health information), and section 1877 (relating to limitation on certain physician referrals) shall apply to this title in the same manner as they apply to title XVIII.

"SEC. 2136. GENERAL ADMINISTRATION; MISCELLANEOUS PROVISIONS.

"(a) HEALTH SECURITY ADMINISTRATION.—

"(1) IN GENERAL.—Except as otherwise provided in this title, this title shall be administered by the Health Security Administration.

"(2) RENAMING HEALTH CARE FINANCING ADMINISTRATION AS HEALTH SECURITY ADMINISTRATION.—Any reference in law to the 'Health Care Financing Administration' is hereby deemed a reference to the 'Health Security Administration'.

"(b) REGULATIONS; TITLE II PROVISIONS; ADMINISTRATION.—The provisions of sections 1871, 1872, and 1874 (relating to regulations, application of certain provisions of title II, and administration) shall apply to this title in the same manner as they apply to title XVIII.

"(c) DETERMINATIONS; APPEALS; PROVIDER REIMBURSEMENT REVIEW BOARD.—

"(1) IN GENERAL.—The determination of whether an individual is entitled to benefits under this title, the determination of the amount of benefits under this title, and appeals from such determinations shall be made in accordance with the same procedures applicable to determinations under title XVIII.

"(2) PROVIDER REIMBURSEMENT REVIEW BOARD.—The provisions of section 1878 (relating to the Provider Reimbursement Review Board) shall apply under this title in the same manner as they apply under title XVIII.

"(d) REPORTING OF INFORMATION TO SECRETARY OF TREASURY.—The Secretary shall submit to the Secretary of the Treasury such information on individuals enrolled under this title as the Secretary of the Treasury may require for purposes of carrying out section 59B and chapter 25, and related provisions, of the Internal Revenue Code of 1986.

"PART E—DEFINITIONS AND MISCELLANEOUS

"SEC. 2161. DEFINITIONS.

"In this title—

"(1) the definitions contained in section 1861 apply for purposes of this title in the same manner as they apply for purposes of title XVIII;

"(2) the definitions contained in sections 2 and 3 (relating to general definitions and definitions relating to families) of the Guaranteed Health Insurance Act of 1994 apply for purposes of this title in the same manner as they apply for purposes of such Act.

"SEC. 2162. REFERENCES TO MEDICARE PROVISIONS.

"In this title, except as otherwise specifically provided, any references to provisions of title XVIII of the Social Security Act are deemed to be references to such provisions as in effect on the day after the date of the enactment of the Guaranteed Health Insurance Act of 1994, taking into account the amendments made to such title by such Act.".

SEC. 8002. CONFORMING AMENDMENTS.

(a) IN GENERAL.—Effective January 1, 1999, section 1876(f) (42 U.S.C. 1395mm(f)) is amended by striking "under a State plan approved under title XIX" and inserting "under title XXI" each place it appears.

(b) RENAMING OF HEALTH CARE FINANCING ADMINISTRATION.—Section 1117 (42 U.S.C. 1317) is amended—

(1) in the heading, by striking "HEALTH CARE FINANCING ADMINISTRATION" and inserting "HEALTH SECURITY ADMINISTRATION", and

(2) by striking "Health Care Financing Administration" and inserting "Health Security Administration".

(c) ADMINISTRATIVE EXPENSES.—Section 201 (42 U.S.C. 401) is amended—

(1) in subsection (g)(1)(A), by inserting "and the Medicare Part C Trust Fund established by title XXI" after "title XVIII" in the matter before clause (i);

(2) in subsection (g)(1), by striking "and XVIII" and "and title XVIII" each place either appears and inserting "XVIII, and XXI" and "title XVIII, and title XXI", respectively; and

(3) in subsection (h), by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting "the Federal Supplementary Medical Insurance Trust Fund, and the Medicare Part C Trust Fund".

(d) DEFINITION OF STATE.—Section 1101(a)(1) (42 U.S.C. 1301(a)(1)) is amended by inserting "or title XXI" after "Such term when used in title XX".

SEC. 8003. EFFECTIVE DATE.

Title XXI of the Social Security Act, as added by section 8001, shall take effect on the date of the enactment of this Act, except that no benefits shall be provided under such title for services furnished before January 1, 1999.

Subtitle B—Benefits for Low-Income Individuals; State Maintenance of Effort

Subtitle C—Cost Containment in the Medicare Programs

PART 1—MEDICARE HEALTH EXPENDITURE ESTIMATES

Sec. 8201. National medicare per capita health expenditure estimate.
Sec. 8202. Classes of health care services.
Sec. 8203. Allocation of per capita estimates by class of service for medicare A/B.
Sec. 8204. Allocation of per capita estimates by class of service for medicare C.
Sec. 8205. Combined medicare per capita allocations for classes of services.
Sec. 8206. Computation of medicare annual combined rate of increase for classes of services; application to medicare payment rates.
Sec. 8207. National health expenditures reporting system.

PART 2—STATE HEALTH EXPENDITURE ESTIMATES

Sec. 8211. State medicare per capita health expenditure estimate.

PART 3—ADMINISTRATIVE AND JUDICIAL REVIEW

Sec. 8221. Limitation on administrative and judicial review.

PART 1—BENEFITS FOR LOW-INCOME INDIVIDUALS

SEC. 8101. ESTABLISHMENT OF BENEFITS.

The Social Security Act, as amended by section 8001, is amended by adding after title XXI the following new title:

"TITLE XXII—ASSISTANCE FOR LOW-INCOME INDIVIDUALS

"SEC. 2200. ESTABLISHMENT OF PROGRAMS.

"(a) IN GENERAL.—Not later than January 1, 1999, the Secretary shall establish and operate the following programs under this title:

"(1) A program of premium subsidies under part A for certain low-income individuals covered under a certified health plan (as defined in section 2 of the Guaranteed Health Insurance Act of 1994).

"(2) A program of wrap-around benefits under part B for certain low-income individuals.

"(3) A program of payment of medicare cost-sharing under part C for qualified medicare beneficiaries.

"(b) DIRECT SPENDING FOR PROGRAMS.—

"(1) IN GENERAL.—There are hereby appropriated to the Secretary such amount as the Secretary determines is necessary to enable the Secretary to make all required expenditures under this title.

"(2) DIRECT SPENDING.—Amounts appropriated pursuant to this subsection are available each fiscal year to the Secretary for carrying out this title.

"PART A—PREMIUM CERTIFICATE PROGRAM

"Subpart 1—Certificates for Low-Income Individuals Covered Under Certified Health Plans

"SEC. 2201. ELIGIBILITY.

"(a) IN GENERAL.—Each premium certificate eligible individual is entitled to be issued a premium certificate in accordance with this part.

"(b) PREMIUM CERTIFICATE ELIGIBLE INDIVIDUAL.—

"(1) IN GENERAL.—In this part, the term 'premium certificate eligible individual' means an eligible individual who—

"(A) with respect to premiums for a taxable year ending in a year, is determined, in the manner described in section 2251, to have projected modified adjusted gross income that is less than the applicable percentage (specified in section 2101(b)(5)(B)) of the threshold amount (as defined in section 2122(c)(3)) applicable to the taxpayer involved; or

"(B) with respect to a premium for a month, is an AFDC or SSI recipient (as defined in section 2 of the Guaranteed Health Insurance Act of 1994) in the month.

"(2) EXCEPTION.—

"(A) IN GENERAL.—Such term does not include an individual—

"(i) who is enrolled under the medicare part C program under title XXI;

"(ii) who is entitled to benefits under part A of title XVIII;

"(iii) subject to subparagraph (B), who is covered under a State single-payer system approved under subtitle A of title IV of the Guaranteed Health Insurance Act of 1994 or a State managed competition system approved under subtitle B of title IV of such Act; or

"(iv) whose only enrollment in a certified health plan is in a plan that is a high deductible plan (as defined in section 5504(5)).

"(B) CONTINUED APPLICATION IN CASE OF CERTAIN ELECTION.—Subparagraph (A)(iii) shall not apply in the case of a State which has made the election described in section 4104(a)(1)(A)(ii) of the Guaranteed Health Insurance Act of 1994.

"SEC. 2202. VALUE OF PREMIUM CERTIFICATE.

"The value of the premium certificate issued under this part to an individual is equal to—

"(1) the amount of the reduction that would occur in the medicare part C premium liability under section 2122(c) for the individual if the individual were a medicare part C covered individual; or

"(2) if less in the case of an individual who is an employee and who is covered under a certified health plan of the employer, the employee's premium obligation under such certified health plan.

"SEC. 2203. ADMINISTRATION OF PROGRAM.

"(a) IN GENERAL.—The Secretary shall establish a program to provide for the issuance of premium certificates, in the amount described in section 2202, to premium certificate eligible individuals. Under the program the Secretary shall—

"(1) determine if individuals are premium certificate eligible individuals, and

"(2) provide for issuance of premium certificates to individuals determined to be premium certificate eligible individuals.

"(b) APPLICATION FOR CERTIFICATE.—

"(1) IN GENERAL.—Any eligible individual may apply for a premium certificate under this part by filing an application with the Secretary (either in person or by mail) through a local office of the Social Security Administration. An eligible Indian under section 902(a) of the Indian Health Care Improvement Act may apply for a certificate through the Indian Health Service in the same manner as an individual applying through a local office of the Social Security Administration.

"(2) ATTACHMENTS.—The Secretary shall require attachments to the application of such documentation (such as prior year tax forms and pay stubs) as may be needed to determine the individual's eligibility and the value of any premium certificate.

"(c) DETERMINATIONS.—

"(1) IN GENERAL.—The Secretary shall provide for—

"(A) prompt determination, on each application made under subsection (b), of eligibility of an applicant and the value of any premium certificate for the applicant, and

"(B) prompt notification of the applicant of such determinations (including an explanation of the reasons for the determination)

"(2) CONDITION OF CERTIFICATE.—Each certificate issued to an individual under this section is conditioned upon the individual reporting to the Secretary (in a form and manner specified by the Secretary) any change in status that would affect the individual's eligibility for such a certificate or the amount of the certificate.

"(3) HEARINGS; APPEALS.—The provisions of section 2136(c) shall apply with respect to determinations of eligibility for and the value of a premium certificate under this part in the same manner as such provisions apply to determinations of entitlement to and the amount of benefits under title XXI.

"(d) ISSUANCE AND USE OF CERTIFICATES.—

"(1) ISSUANCE.—The Secretary shall issue a premium certificate to each individual determined to be a premium certificate eligible individual under this section.

"(2) TREATMENT OF EMPLOYEES.—

"(A) IN GENERAL.—If an individual who is entitled to a premium certificate under this part is an employee and eligible to be enrolled under a certified health plan offered by an employer of the individual, the premium certificate may only be applied against the premiums for a certified health plan offered by the employer.

"(B) SUBMISSION TO SECRETARY AND REMISSION OF VALUE TO EMPLOYER.—The Secretary shall make payments (in a manner specified by the Secretary) to each employer who tenders such a certificate to the Secretary in the value of the certificate so tendered.

"(3) TREATMENT OF OTHER INDIVIDUALS.—

"(A) IN GENERAL.—If an individual who is entitled to a premium certificate under this part is not described in paragraph (2)(A)—

"(i) the premium certificate may be applied against the premiums for the certified health plan in which the individual is enrolled, and

"(ii) upon the tender of such certificate by the individual to the applicable carrier, the carrier is required to reduce the amount of premiums required to be paid by the individual.

"(B) APPLICABLE CARRIER DESCRIBED.—In subparagraph (A), the term 'applicable carrier' means, with respect to an individual enrolled in a certified health plan,—

"(i) the Office of Universal FEHBP, in the case of an individual who pays premiums through such office;

"(ii) the consumer purchasing cooperative under subtitle E of title V of the Guaranteed Health Insurance Act of 1994, in the case of an individual who pays premiums through the cooperative);

"(iii) the program of the Indian Health Service (as used in section 901 of the Indian Health Care Improvement Act), in the case of an individual enrolled in a health program of the Indian Health Service; or

"(iv) the Secretary of Veterans Affairs, in the case of an individual enrolled in a health program of the Department of Veterans Affairs.

"(4) DIRECT PAYMENT OF CERTAIN ASSISTANCE.—The Secretary shall provide for a payment directly to an individual whose application is approved of an amount equal to the amount of the reduction in premium that would have been provided with respect to the individual for the month in which the application was filed if the certificate had been issued (and tendered to the individual's employer or plan, as the case may be) on the first day of such month.

"(e) VERIFICATION.—

"(1) IN GENERAL.—The Secretary shall periodically verify information reported on applications under this section, using any or all of the following:

"(A) The national enrollment verification system established under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994.

"(B) Information reported pursuant to section 1137.

"(C) Other information deemed to be necessary.

"(2) RECONCILIATION.—

"(A) EXCESS PAYMENTS.—If the Secretary determines, based upon information described in paragraph (1), that the value of a certificate issued exceeded the correct value of the certificate or that an individual who was issued a certificate was not a premium certificate eligible individual, the Secretary shall—

"(i) adjust the value of the certificate to recoup, over a reasonable period of time, the amount of the overpayment, or

"(ii) if the individual is no longer a premium certificate eligible individual, bill the individual for the amount of the excess value and for interest on any amount so billed that is not repaid on a timely basis.

"(B) DEFICIT PAYMENTS.—If the Secretary determines, based upon the information described in paragraph (1), that the value of a certificate issued was less than the correct value of the certificate, the Secretary shall—

"(i) pay directly to the individual the amount of the underpayment, or

"(ii) if the individual continues to be a premium certificate eligible individual, adjust the value of the certificate, as appropriate.

"(f) PENALTIES FOR MISREPRESENTATION.—Any individual who knowingly makes a material misrepresentation of information in an application for a premium certificate under this section would be liable for excess payments made based upon such misrepresentation and interest on such excess payments, at a rate specified by the Secretary. In addition, such individuals would be subject to a civil monetary penalty of $1,000, or, if greater, three times the amount of excess payments made based on such misrepresentations. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A(a).

"Subpart 2—Premium Assistance for Qualified Retirees

"SEC. 2211. ELIGIBILITY FOR PREMIUM CERTIFICATE FOR CERTAIN RETIREES.

"(a) IN GENERAL.—A qualified retiree (or qualified spouse or child of such a retiree) is eligible for a premium certificate in accordance with this subpart if—

"(1) the total amount paid by the individual for premiums for enrollment in a health benefit plan during months in a year, exceeds

"(2) the product of (A) the individual's projected modified adjusted gross income for the year, and (B) the applicable percentage established under section 2212(c).

"(b) HEALTH BENEFIT PLAN DEFINED.—In subsection (a), the term 'health benefit plan' has the meaning given such term in section 5504(3) of the Guaranteed Health Insurance Act of 1994.

"SEC. 2212. ELIGIBILITY.

"(a) QUALIFIED RETIREE AND QUALIFIED SPOUSE OR CHILD DEFINED.—For purposes of this subpart—

"(1) QUALIFIED RETIREE DEFINED.—The term 'qualified retiree' means, with respect to a month in a calendar year, an eligible individual who meets the income requirements specified in subsection (b) for the year and who as of the first day of the month—

"(A) has attained age 55 but not age 65 (as of January 1, 1994),

"(B) is not a full-time employee, and

"(C) is not entitled to benefits under part A of title XVIII.

"(2) QUALIFIED SPOUSE OR CHILD DEFINED.—The term 'qualified spouse or child' means, in relation to a qualified retiree, an eligible individual who meets the income requirements specified in subsection (b) for the year and with respect to whom the requirements in one of the following clauses is met (with respect to the first day of a month):

"(A) The individual (i) is under 65 years of age, is not a full-time employee, and is (and has been for a period of at least one year) married to a qualified retiree or (ii) is a young dependent (as described in section 1003(b)(1)(B) of the Guaranteed Health Insurance Act of 1994) of the qualified retiree.

"(B) In the case of a person who was a qualified retiree at the time of the person's death—

"(i) the individual was (and had for a period of at least one year been) married to the retiree at the time of the person's death,

"(ii) the individual is under 65 years of age,

"(iii) the individual is not a full-time employee,

"(iv) the individual is not remarried, and

"(v) the deceased spouse would still be a qualified retiree if such spouse had not died.

"(C) The individual is a young dependent (as described in section 1003(b)(1)(B) of the Guaranteed Health Insurance Act of 1994) of an individual described in subparagraph (B).

"(b) MAXIMUM AMOUNT OF INCOME.—

"(1) IN GENERAL.—An individual meets the income requirements of this subsection if (for a calendar year ending in 1994)—

"(A) in the case of a married individual whose spouse is a qualified retiree or qualified spouse or child under subsection (a), the combined income of the individual and the individual's spouse for the year does not exceed $40,000, or

"(B) in the case of any other individual, the individual's income for the year does not exceed $30,000.

"(2) INFLATION ADJUSTMENTS.—In the case of a year after 1997, each dollar amount contained in paragraph (1) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the previous calendar year.

"(c) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage specified in this paragraph for a year is determined in accordance with the following table:

"In the case of calendar years ending with or within—	The applicable percentage is—
1997	7 percent
1998	7 percent
1999	6 percent
2000	5 percent
2001 or thereafter	4 percent.

"(d) PRORATION.—In the case of an individual described in subsection (a) who is not a qualified retiree or qualified spouse or child for all months in the calendar year, the amount of any premium certificate under subsection (a) shall be prorated to reflect the ratio of the number of months in the year in which the individual is a qualified retiree or qualified spouse or child to 12 months.

"SEC. 2213. VALUE OF PREMIUM CERTIFICATE.

"(a) IN GENERAL.—The amount of the premium certificate provided to an individual under this subpart for a year is equal to the amount by which—

"(1) the total amount paid by the individual for premiums for enrollment in a health benefit plan during months in the year; exceeds

"(2) the product of (A) the individual's projected modified adjusted gross income for the year, and (B) the applicable percentage established under section 2212(c).

"(b) LIMITATION FOR YEARS AFTER 1998.—With respect to years beginning with 1999, the amount of the premium certificate provided to an individual under this subpart for the year is equal to the lesser of—

"(1) the amount determined in accordance with subsection (a); or

"(2) an amount equal to the amount by which—

"(A) the total amount that would have been paid by the individual for premiums during the year if the individual had been enrolled in medicare part C during the year, exceeds

"(B) the amount described in subsection (a)(2).

"SEC. 2214. ADMINISTRATION OF PREMIUM CERTIFICATES FOR RETIREES.

"The provisions of section 2203 shall apply to this subpart in the same manner as they apply to subpart 1.

"Subpart 3—Maintenance of Effort Offset for Retiree Premium Contributions

"SEC. 2221. OFFSET OF PREMIUM OBLIGATIONS FOR RETIREES.

"The Secretary shall make a per capita payment to each employer who meets the requirements of section 1113 of the Guaranteed Health Insurance Act of 1994 (relating to maintenance of effort for premiums for certain retirees, spouses, and dependents) during a year in the amount determined under section 2222 with respect to each eligible individual for whom the employer meets such requirement.

"SEC. 2222. AMOUNT OF OFFSET.

"The amount of the payment made to an employer with respect to an individual for a year is equal to 50 percent of the employer's share of the premium that would be applicable to the individual based on the individual's class of enrollment during the year if the individual were enrolled in medicare part C during the year.

"SEC. 2223. PROCEDURES FOR OBTAINING OFFSET.

"The Secretary shall establish procedures under which employers may submit information necessary for the Secretary to make payment to the employer under this subpart.

"PART B—WRAP-AROUND BENEFITS FOR LOW-INCOME INDIVIDUALS

"SEC. 2231. ELIGIBILITY.

"(a) IN GENERAL.—Subject to subsection (c), each individual who applies for benefits under this part and is determined under this part to be a wrap around eligible individual described in subsection (b) is entitled to wrap-around benefits in accordance with this part, without regard to whether the individual is enrolled under medicare part C under title XXI.

"(b) WRAP AROUND ELIGIBLE INDIVIDUAL.—

"(1) IN GENERAL.—In this part, the term 'wrap around eligible individual' means any of the following individuals:

"(A) INDIVIDUALS WITH INCOME BELOW POVERTY LEVEL.—An individual who is determined under this part to have projected modified adjusted gross income that is less than the threshold amount (as defined in section 2122(c)(3)) applicable to the individual involved.

"(B) AFDC AND SSI RECIPIENTS.—An AFDC recipient or SSI recipient.

"(C) CHILDREN AND PREGNANT WOMEN WITH INCOME BELOW 200 PERCENT OF POVERTY LEVEL.—Any of the following individuals if the individual is determined under this part to have projected modified adjusted gross income that is less than twice the threshold amount (as defined in section 2122(c)(3)) applicable to the individual involved:

"(i) A child under 19 years of age.

"(ii) A pregnant woman.

For purposes of clause (ii), a woman shall be deemed to be a pregnant woman during the period ending on the first day of the first month that begins more than 60 days after the date of the termination of the pregnancy.

"(2) EXCEPTIONS.—

"(A) IN GENERAL.—Such term does not include an individual—

"(i) who is entitled to benefits under part A of title XVIII,

"(ii) subject to subparagraph (B), who is covered under a State single-payer system approved under subtitle A of title IV of the Guaranteed Health Insurance Act of 1994 or a State managed competition system approved under subtitle B of title IV of such Act, or

"(iii) whose only enrollment in a certified health plan is in a plan that is a high deductible plan (as defined in section 5504(5)).

"(B) SPECIAL RULE.—Subparagraph (A)(ii) shall not apply in the case of a State which has made the election described in section 4104(b)(1)(B) of the Guaranteed Health Insurance Act of 1994.

"(c) SPECIAL RULES FOR CASH ASSISTANCE RECIPIENTS.—

"(1) IN GENERAL.—An individual who is an AFDC recipient or SSI recipient is deemed to be entitled to benefits under this part, without the need to file an application under this part, for items and services furnished during the period in which the individual is receiving assistance.

"(2) COORDINATION.—The Secretary shall provide for a method under which individuals who are determined to be AFDC recipients or SSI recipients are notified of the benefits to which they are entitled under this part and any applicable procedures for obtaining evidence of their entitlement.

"(d) PERIOD OF ENTITLEMENT.—

"(1) BEGINNING OF BENEFITS.—Benefits under this part shall be available with respect to expenses incurred for items and services furnished after the date the individual is determined to be a wrap around eligible individual.

"(2) TERMINATION OF PERIOD.—

"(A) IN GENERAL.—Subject to subparagraph (C) and section 2251(c), an individual who is determined to be entitled to benefits under this part shall remain so entitled for a period of 12 months beginning on the date on which the determination takes effect. Such period may be extended upon the filing of an application under this part before the end of the 12-month period.

"(B) NOTICE OF REQUIREMENT.—The Secretary shall provide for appropriate written notice of the requirement of subparagraph (A) (relating to reapplying annually in order to continue to be entitled to benefits under this part) to each family a member of which is entitled to benefits under this part at least 60 days before the expiration of the 12-month period described in such subparagraph.

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply with respect to an individual whose entitlement to benefits under this part is based solely on the grounds that the individual is an AFDC recipient or an SSI recipient.

"(e) AFDC RECIPIENT AND SSI RECIPIENT DEFINED.—In this part, the terms 'AFDC recipient' and 'SSI recipient' have the meanings given such terms in section 2 of the Guaranteed Health Insurance Act of 1994.

"SEC. 2232. WRAP-AROUND BENEFITS.

"(a) BENEFITS.—The benefits provided to a wrap around eligible individual under this part consist of the following (subject to subsection (e)):

"(1) WAIVER OF COST-SHARING.—The payment for any cost sharing (described in part B of title XXI) otherwise applicable to items and services covered under the guaranteed national benefit package (described in subtitle A of title III of the Guaranteed Health Insurance Act of 1994).

"(2) EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES.—For individuals under 19 years of age, payment for those early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r)) that are not covered under the guaranteed national benefit package.

"(3) VISION AND HEARING CARE.—For individuals 19 years of age or older, payment for vision and hearing care of the same scope as provided under paragraph (2), including eyeglasses and hearing aids, that are not covered under the guaranteed national benefit package.

"(b) PAYMENT AMOUNTS.—

"(1) COST-SHARING.—Payments for cost-sharing under subsection (a)(1) for an item or service shall be based upon the cost-sharing amounts that would apply to the item or service if the individual were enrolled under medicare part C under title XXI, without regard to whether the individual is enrolled under such part.

"(2) ADDITIONAL SERVICES.—Payments for items and services described in paragraph (2) or (3) of subsection (a)—

"(A) for which there are payment amounts established under title XXI shall be based on the payment amounts established under such title; or

"(B) for which there are not such payment amounts established, shall be based on payment amounts established by the Secretary, in consultation with the Prospective Payment Assessment Commission and the Physician Payment Review Commission, taking into account the payment rules established for similar items and services under part A of title XVIII.

"(c) SECONDARY PAYER TO CERTIFIED HEALTH PLANS.—Section 1862(b) shall apply to expenses incurred for items and services provided under this part in the same manner as such section applies to items and services provided under title XVIII.

"(d) USE OF MEDICARE PART C CLAIMS PROCESS.—

"(1) COST-SHARING FOR INDIVIDUALS ENROLLED UNDER MEDICARE PART C.—In the case of individuals entitled to benefits under this part and enrolled under title XXI, the benefits for cost-sharing under subsection (a)(1) with respect to an item or service shall be provided simultaneous with the payment of benefits with respect to such item or service under such part.

"(2) OTHER BENEFITS.—Except as provided in paragraph (1), claims for payment for benefits under this part shall be made and processed in the same manner as claims for payment for benefits under title XXI.

"(3) EXTENSION OF AGREEMENTS WITH FISCAL AGENTS.—The Secretary may provide for the administration of this part through agreements with fiscal agents meeting the requirements applicable to such agents under title XXI.

"(e) SPECIAL RULES FOR INDIVIDUALS ENROLLED IN MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS.—

"(1) COVERAGE OF SERVICES THROUGH THE PROGRAM.—In the case of a wrap around eligible individual who is enrolled in a managed mental health and substance abuse program of a State or an Indian tribe or tribal organization approved under section 1981 of the Public Health Service Act for a month—

"(A) the individual is considered to have waived the right to benefits described in paragraph (3) under this part in consideration of receipt of benefits for mental health and substance abuse services through such program;

"(B) the Secretary shall make a per capita payment to the State or Indian tribe or tribal organization, in the amount specified in paragraph (2), on behalf of the individual; and

"(C) no other payment may be made under this part with respect to such services furnished to the individual during the month.

Payments under subparagraph (B) shall be made not less frequently than monthly.

"(2) CAPITATED PAYMENTS AMOUNTS.—The amount of the per capita payment provided under paragraph (1)(B) shall be an amount determined in accordance with a methodology established by the Secretary (similar to the methodology used under section 1893(b) to determine capitated payments to States or Indian tribes or tribal organizations on behalf of medicare beneficiaries enrolled in such programs) that reflects the costs associated with the benefits described in paragraph (3) that would be provided to the individual under this part if the individual were not enrolled in the managed mental health and substance abuse program.

"(3) MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS DESCRIBED.—The benefits described in this paragraph are as follows:

"(A) MENTAL HEALTH AND SUBSTANCE ABUSE COST SHARING.—Payment of cost sharing described in subsection (a)(1) with respect to mental health and substance abuse services (as defined in section 1893(c)) covered under the guaranteed national benefit package.

"(B) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES INCLUDED IN EPSDT.—Benefits under subsection (a)(2) with respect to such mental health and substance abuse services.

"SEC. 2233. APPLICATION FOR BENEFITS.

"(a) FORM.—

"(1) IN GENERAL.—An application for benefits under this part shall be made in such form and manner as the Secretary shall specify consistent with this section.

"(2) INFORMATION.—The application shall require—

"(A) the provision of information necessary to determine eligibility for benefits under this part, and

"(B) the provision of information respecting whether the individual is enrolled under medicare part C and the certified health plan (if any) in which the individual is enrolled.

"(b) AVAILABILITY OF APPLICATIONS.—The Secretary shall make applications for benefits under this part available in the same manner as the Secretary makes available applications for enrollment under title XXI.

"(c) COORDINATION WITH PART C AND PREMIUM CERTIFICATE ENROLLMENT APPLICATION.—An application for benefits under this part may (but need not) be accompanied by an application for enrollment under medicare part C or for a premium certificate under part A on the basis of being a low-income individual.

"(d) FACILITATION OF APPLICATIONS FOR BENEFITS.—The provisions of section 2103 shall apply to wrap around eligible individuals and applications for benefits under this part in the same manner as such provisions apply to medicare part C eligible individuals and applications for enrollment under title XXI.

"(e) TIMING OF APPLICATION.—An application for benefits under this part may be filed at any time during the year.

"SEC. 2234. REFERENCES TO MEDICARE PROVISIONS.

"In this part, except as otherwise specifically provided, any references to provisions of title XVIII of the Social Security Act are deemed to be references to such provisions as in effect on the day after the date of the enactment of the Guaranteed Health Insurance Act of 1994, taking into account the amendments made to such title by such Act.

"PART C—PAYMENT OF MEDICARE COST-SHARING FOR CERTAIN LOW-INCOME INDIVIDUALS

"SEC. 2241. PAYMENT OF COST-SHARING FOR CERTAIN INDIVIDUALS.

"Subject to section 2242, the Secretary shall make payments as follows:

"(1) QUALIFIED MEDICARE BENEFICIARIES WITH INCOME BELOW 100 PERCENT OF POVERTY LEVEL.—In the case of an individual who is determined by the Secretary to be a qualified medicare beneficiary (as defined in section 2243(a)), the Secretary shall make payment for all medicare cost-sharing described in section 2242(a).

"(2) QUALIFIED MEDICARE BENEFICIARIES WITH INCOME BELOW 120 PERCENT OF POVERTY LEVEL.—In the case of an individual who would be such a qualified medicare beneficiary but for the fact the individual's family income exceeds 100 percent, but is less than 120 percent, of the official poverty line (as described in section 2243(d)), the Secretary shall make payment for the medicare cost-sharing described in section 2242(a)(1)(B).

"(3) QUALIFIED DISABLED AND WORKING INDIVIDUALS.—In the case of an individual who is determined by the Secretary to be a qualified disabled and working individual (as defined in section 2243(d)(2)), the Secretary shall make payment for the medicare cost-sharing described in section 2242(a)(1)(A).

"SEC. 2242. MEDICARE COST-SHARING DEFINED.

"(a) IN GENERAL.—In this section, the term 'medicare cost-sharing' means the following costs incurred with respect to a qualified medicare beneficiary or a qualified disabled and working individual:

"(1)(A) Premiums under section 1818 or 1818A, and

"(B) premiums under section 1839.

"(2) Coinsurance under title XVIII (including coinsurance described in section 1813).

"(3) Deductibles established under title XVIII (including those described in section 1813, 1833(b), and 1834(b)).

"(4) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'.

"(b) ENROLLMENT WITH ELIGIBLE ORGANIZATIONS.—Under rules established by the Secretary for an individual described in section 2241(1), 'medicare cost-sharing' under this section may include premiums for the enrollment of the individual with an eligible organization under section 1876.

"SEC. 2243. INDIVIDUALS DEFINED.

"(a) QUALIFIED MEDICARE BENEFICIARY.—In this part, the term 'qualified medicare beneficiary' means an individual—

"(1) who is entitled to benefits under part A of title XVIII (other than an individual entitled to such benefits only pursuant to an enrollment under section 1818A);

"(2) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (c)) does not exceed 100 percent of the official poverty line applicable to a family of the size involved; and

"(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

"(b) QUALIFIED DISABLED AND WORKING INDIVIDUAL.—The term 'qualified disabled and working individual' means an individual—

"(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A;

"(2) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (c)) does not exceed 200 percent of the official poverty line applicable to a family of the size involved;

"(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits under that program; and

"(4) who is not eligible for medical assistance under the State plan for medical assistance under title XIX for the State in which the individual resides.

"(c) EXCLUSION OF CERTAIN TRANSITION INCOME.—In determining under this section the income of an individual who is entitled to monthly insurance benefits under title II for a transition month in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year. In the previous sentence, the term 'transition month' means each month in a year through the month following the month in which the annual revision of the official poverty line (as described in subsection (d)) is published.

"(d) OFFICIAL POVERTY LINE DESCRIBED.—In this section, the 'official poverty line' is the line defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

"(e) USE OF ALTERNATIVE METHODOLOGIES.—

"(1) IN GENERAL.—The methodology to be employed in determining income and resource eligibility under this section may be less restrictive, and shall be no more restrictive, than the methodology—

"(A) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

"(B) in the case of other groups, under the State plan most closely categorically related.

"(2) MORE RESTRICTIVE METHODOLOGY DESCRIBED.—For purposes of this subsection, a methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for treatment as qualified medicare beneficiaries or qualified disabled and working individuals and no individuals who are otherwise eligible to be so treated are made ineligible for such treatment.

"SEC. 2244. TIMING.

"If an individual is determined to be a qualified medicare beneficiary or a qualified disabled and working individual under this part, such determination shall apply to items and services furnished after the end of the month in which the determination first occurs.

"PART D—ADMINISTRATIVE PROVISIONS

"SEC. 2251. DETERMINATION OF ELIGIBILITY; APPEALS.

"(a) PROCESS.—The Secretary, through the Social Security Administration and other appropriate agencies, shall establish a process for determining whether individuals are eligible for benefits under this title. Such process shall be coordinated with the enrollment process described in section 2102.

"(b) DETERMINATION OF PROJECTED INCOME FOR PURPOSES OF MEDICARE PART C AND WRAP-AROUND.—

"(1) IN GENERAL.—In determining the amount of an individual's projected modified adjusted gross income for purposes of part A or part B, the income for a year shall be projected on an annual basis based on evidence of the current (and projected) modified adjusted gross income over a period of at least 3 months, as determined under a uniform, national methodology established by the Secretary.

"(2) MODIFIED ADJUSTED GROSS INCOME DEFINED.—In this title, the term 'modified adjusted gross income' has the meaning given such term in section 59B(e)(2) of the Internal Revenue Code of 1986 (as in effect on the date of the enactment of the Guaranteed Health Insurance Act of 1994). The parenthetical in the preceding sentence shall not apply to the determination of adjusted gross income.

"(c) REQUIREMENT TO PROVIDE NOTICE OF MATERIAL CHANGE AFFECTING ELIGIBILITY FOR BENEFITS.—

"(1) IN GENERAL.—Each individual who has been determined to be entitled to benefits under this title (including under section 2231(c)) shall notify the Secretary (in a form and manner specified by the Secretary) of any material change in status that would affect the individual's eligibility for benefits under this title.

"(2) CONSTRUCTION.—Nothing in this section shall be construed as authorizing reconciliation of benefits provided with respect to deductibles and coinsurance.

"(d) NOTICE AND APPEALS.—

"(1) NOTICE.—If the Secretary determines that an individual is not entitled to benefits under this title, the Secretary shall notify the individual of the determination (and an explanation of the reasons for the determination).

"(2) APPEALS.—The provisions of section 2136(c) shall apply with respect to determinations of entitlement to and the amount of benefits under this title in the same manner as such provisions apply to determinations of entitlement to and the amount of benefits under title XXI.

"SEC. 2252. VERIFICATION OF ELIGIBILITY.

"(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall provide for such verification of eligibility, including verification of income, as the Secretary deems appropriate. Such verification may be based upon information provided under the national enrollment verification system established under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 and information provided under section 1137, and may be made on a sample or other basis.

"(b) MONITORING CHANGES IN STATUS.—

"(1) IN GENERAL.—The Secretary periodically shall verify, using the national enrollment verification system established under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 and other means, the status of individuals who are receiving benefits under this title in order to identify changes of employment or other status that may affect their eligibility for such benefits.

"(2) INFORMATION ON CASH ASSISTANCE RECIPIENTS.—In order to carry out paragraph (1), the Secretary shall require States administering plans under parts A or E of title IV and the entity responsible for administering the supplemental security income program under title XVI to report to the Secretary, on a semiannual basis, such information as may be necessary to verify an individual's status as an AFDC or SSI recipient.

"SEC. 2253. PENALTIES FOR MISREPRESENTATION.

"Any individual that knowingly misrepresents income or family status for the purpose of obtaining benefits under this title to which the individual is not entitled is subject to a civil money penalty not to exceed $1,000 for each such misrepresentation, or, if greater, three times the amount of the benefits obtained as a result of the misrepresentation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this section in the same manner as they apply to a penalty or proceeding under section 1128A(a).".

SEC. 8102. EFFECTIVE DATES.

(a) PREMIUM CERTIFICATES.—No premium certificate or other assistance under title XXII of the Social Security Act (as added by subsection (a)) shall be made available—

(1) under subpart 1 or subpart 3 of part A of such title for premiums or assistance for months before January 1999; or

(2) under subpart 2 of part A of such title for premiums for months before January 1997.

(b) WRAP-AROUND BENEFITS.—No wrap-around benefits are available under part B of title XXII of the Social Security Act, added by subsection (a), with respect to any items or services furnished before January 1, 1999.

(c) MEDICARE COST-SHARING.—No medicare cost-sharing is available under part C of title XXII of the Social Security Act (as added by section 8001) with respect to items or services furnished in a State before January 1999.

PART 2—STATE MAINTENANCE OF EFFORT

Subpart A—Payments for Cash Assistance Recipients

SEC. 8111. STATE RESPONSIBILITY FOR PAYMENTS.

(a) IN GENERAL.—Subject to section 8133, each State shall provide in each year (beginning with 1999) for payment to the Secretary, to the credit of the Medicare Part C Trust Fund, of an amount equal to the State medical assistance percentage (as defined in subsection (b)) of the State maintenance of effort percentage (as defined in section 8134) for the year of the sum of the following products:

(1) AFDC PORTION.—The product of—

(A) the sum of—

(i) the AFDC, non-DSH per capita amount for the State for the year (determined under section 8112(a)(1)), and

(ii) the AFDC, DSH per capita amount for the State for the year (determined under section 8112(a)(2)); and

(B) the number of AFDC recipients residing in the State in the year (as determined under section 8114).

(2) SSI PORTION.—The product of—

(A) the sum of—

(i) the SSI, non-DSH per capita amount for the State for the year (determined under section 8113), and

(ii) the SSI, DSH per capita amount for the State for the year (determined under section 8113); and

(B) the number of SSI recipients residing in the State in the year (as determined under section 8114).

(b) STATE MEDICAL ASSISTANCE PERCENTAGE DEFINED.—In subsection (a), the term "State medical assistance percentage" means, for a State for a quarter in a fiscal year, 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) for the State for the fiscal year.

(c) BENEFIT PACKAGE FOR LOW-INCOME INDIVIDUALS.—In this subtitle, the term "benefit package for low-income individuals" means the benefits, including the guaranteed national benefit package and the wrap-around benefits made available for low-income individuals under part A and subpart 2 of part B of title XXI of the Social Security Act, as added by the previous provisions of this title.

SEC. 8112. DETERMINATION OF AFDC PER CAPITA AMOUNTS FOR STATES.

(a) DETERMINATIONS.—

(1) IN GENERAL.—For each State for each year, the Secretary shall determine an AFDC, non-DSH per capita amount in accordance with paragraph (2) and an AFDC, DSH per capita amount in accordance with paragraph (3).

(2) AFDC, NON-DSH PER CAPITA AMOUNT.—The AFDC, non-DSH per capita amount is equal to the per capita, non-DSH State medicaid expenditures (under subsection (b)(1)) for the benefit package for low-income individuals (as defined in section 8111(c)) for AFDC recipients for the State for the year (as determined under subsection (b)(1)).

(3) AFDC, DSH PER CAPITA AMOUNT.—The AFDC, DSH per capita amount is equal to the per capita DSH State medicaid expenditures (under subsection (b)(2)) for the benefit package for low-income individuals (as defined in section 8111(c)) for AFDC recipients for the State for the year (as determined under subsection (b)(2)).

(b) PER CAPITA STATE MEDICAID EXPENDITURES DEFINED.—For purposes of subsection (a)—

(1) PER CAPITA NON-DSH STATE MEDICAID EXPENDITURES.—The "per capita non-DSH State medicaid expenditures" for the benefit package for low-income individuals for a State for a year is equal to the base per capita non-DSH expenditures (described in subsection (c)(1)), updated to the year involved under subsection (d)).

(2) PER CAPITA DSH STATE MEDICAID EXPENDITURES.—The "per capita DSH State medicaid expenditures" for the benefit package for low-income individuals for a State for a year is equal to the base per capita DSH expenditures (described in subsection (c)(2)), updated to the year involved under subsection (d)).

(c) MEDICAID EXPENDITURES.—

(1) BASE PER CAPITA NON-DSH EXPENDITURES.—The "base per capita non-DSH expenditures" described in this paragraph, for a State for a year, is—

(A) the baseline non-DSH medicaid expenditures (as defined in subsection (e)(1)(A)) for the State, divided by

(B) the number of AFDC recipients enrolled in the State medicaid plan in fiscal year 1993, as determined under section 8114(a).

(2) BASE PER CAPITA DSH EXPENDITURES.—The "base per capita DSH expenditures" described in this paragraph, for a State for a year, is—

(A) the baseline DSH medicaid expenditures (as defined in subsection (e)(1)(B)) for the State; divided by

(B) the number of AFDC recipients enrolled in the State medicaid plan in fiscal year 1993, as determined under section 8114(a).

(d) UPDATING.—

(1) INITIAL UPDATE THROUGH 1998.—

(A) IN GENERAL.—

(i) BASE PER CAPITA NON-DSH EXPENDITURES.—The Secretary shall update the base per capita non-DSH expenditures described in subsection (c)(1) for each State from fiscal year 1993 through 1998, by 57.6 percent.

(ii) BASE PER CAPITA DSH EXPENDITURES.—The Secretary shall update the base per capita DSH expenditures described in subsection (c)(2) for each State from fiscal year 1993 through 1998, by 39.7 percent.

(B) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—In determining the update under paragraph (1), the Secretary may provide for an adjustment in a manner similar to the adjustment permitted under section 8122(b)(3).

(2) UPDATE FOR SUBSEQUENT YEARS.—For each State for 1999 and for each subsequent year the Secretary shall update the base per capita non-DSH expenditures described in subsection (c)(1) (as previously updated under this subsection) and the base per capita DSH expenditures described in subsection (c)(2) (as previously updated under this subsection) by a factor equal to the national medicare growth factor (under section 8201(c) for the year.

(e) DETERMINATION OF BASELINE MEDICAID EXPENDITURES.—

(1) IN GENERAL.—

(A) BASELINE NON-DSH MEDICAID EXPENDITURES.—For purposes of subsection (c)(1)(A), the "baseline non-DSH medicaid expenditures" for a State is the gross amount of payments under the State medicaid plan with respect to medical assistance furnished, for items and services included in the benefit package for low-income individuals, for AFDC recipients for calendar quarters in fiscal year 1993, but does not include such expenditures for which no Federal financial participation is provided under such plan and does not include any payments made under section 1923 of the Social Security Act (relating to DSH payments).

(B) BASELINE DSH MEDICAID EXPENDITURES.—For purposes of subsection (c)(2)(A), the term "baseline DSH medicaid expenditures" for a State is payments made under section 1923 of the Social Security Act in fiscal year 1993 multiplied by the proportion of payments for medical assistance for hospital services (including psychiatric hospital services) under the State medicaid plan in fiscal year 1993 that is attributable to AFDC recipients.

(2) TREATMENT OF DISALLOWANCES.—The amount determined under this subsection shall take into account amounts (or an estimate of amounts) disallowed.

(f) APPLICATION TO PARTICULAR ITEMS AND SERVICES IN BENEFIT PACKAGE FOR LOW-INCOME INDIVIDUALS.—For purposes of this section, in determining the per capita State non-DSH medicaid expenditures and the per capita State DSH medicaid expenditures for a category of items and services (within the benefit package for low-income individuals) furnished in a State, there shall be counted only that proportion of such expenditures (determined only with respect to medical assistance furnished to AFDC recipients) that were attributable to items and services included in the benefit package for low-income individuals (taking into account any limitation on amount, duration, or scope of items and services included in such package).

SEC. 8113. DETERMINATION OF SSI PER CAPITA AMOUNT FOR STATES.

For State for each year, the Secretary shall determine an SSI per capita amount in accordance with this section. Such amount shall be determined in the same manner as the AFDC per capita amount for the State is determined under section 8112 except that, for purposes of this section—

(1) any reference in such section (or in sections referred to in such section) to an "AFDC recipient" is deemed a reference to an "SSI recipient"; and

(2)(A) 25.8 percent shall be substituted for 57.6 percent in section 8112(d)(1)(A)(i), and

(B) 11.5 percent shall be substituted for 39.7 percent in section 8112(d)(1)(A)(ii).

SEC. 8114. DETERMINATION OF NUMBER OF AFDC AND SSI RECIPIENTS.

(a) BASELINE.—For purposes of section 8112 and section 8113, the number of AFDC recipients and SSI recipients for a State for fiscal year 1993 shall be determined based on actual reports submitted by the State to the Secretary. In the case of individuals who were not recipients for the entire fiscal year, the number shall take into account only the portion of the year in which they were such recipients. The Secretary may audit such reports.

(b) SUBSEQUENT YEARS.—For purposes of section 8111(a), the number of AFDC and SSI recipients residing in a State shall be determined on a monthly basis based on the actual number of such recipients.

Subpart B—Payments for Non-Cash Assistance Recipients

SEC. 8121. STATE RESPONSIBILITY FOR PAYMENTS.

(a) PAYMENT.—Each State shall provide for each year (beginning with 1999) for payment to the Secretary, to the credit of the Medicare Part C Trust Fund, of the amounts specified in subsection (b).

(b) AMOUNT.—Subject to section 8133, the total amount of such payment for a year shall be equal to the State maintenance of effort percentage (as defined in section 8134) for the year of the sum of—

(1) the State non-cash, non-DSH baseline amount for the State, determined under section 8122(a)(1) and updated to the year involved under section 8123, and

(2) the State non-cash, DSH baseline amount for the State, determined under section 8122(a)(2) and updated to the year involved under section 8123.

SEC. 8122. DETERMINATION OF BASELINE AMOUNTS.

(a) BASELINE AMOUNTS.—

(1) NON-DSH AMOUNT.—The Secretary shall determine for each State a non-cash, non-DSH baseline amount which is equal to the aggregate State medicaid expenditures in fiscal year 1993 (as defined in subsection (c)(1)) for the benefit package for low-income individuals for non-cash assistance recipients (as defined in subsection (b)).

(2) DSH AMOUNT.—The Secretary shall determine for each State a non-cash, DSH baseline amount which is equal to the DSH expenditures in fiscal year 1993 (as defined in subsection (c)(2)) multiplied by proportion of payments for medical assistance for hospital services (including psychiatric hospital services) under the State medicaid plan in fiscal year 1993 that is attributable to non-cash assistance recipients.

(b) NON-CASH ASSISTANCE RECIPIENT.—In this part, the term "non-cash assistance recipient" means an eligible individual who is not an AFDC or SSI recipient or a medicare part A beneficiary.

(c) STATE MEDICAID EXPENDITURES AND DSH EXPENDITURES DEFINED.—

(1) AGGREGATE STATE MEDICAID EXPENDITURES.—

(A) IN GENERAL.—In this section, the term "aggregate State medicaid expenditures" means, with respect to a State in fiscal year 1993, the amount of payments under the State medicaid plan with respect to medical assistance furnished for non-cash assistance recipients for calendar quarters in fiscal year 1993, less the amount of Federal financial participation paid to the State with respect to such assistance, and not including any DSH expenditures (as defined in paragraph (2)).

(B) LIMITED TO PAYMENTS FOR SERVICES.—In applying subparagraph (A), payments under the State medicaid plan shall not be included unless Federal financial participation is provided with respect to such payments under section 1903(a)(1) of the Social Security Act and such payments shall not include payments for medicare cost-sharing (as defined in section 1905(p)(3) of the Social Security Act).

(2) DSH EXPENDITURES.—In this section, the term "DSH expenditures" means payments made under section 1923 of the Social Security Act in fiscal year 1993.

(3) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—If the Secretary finds that a State took an action that had the effect of shifting the timing of medical assistance payments under the State medicaid plan between quarters or fiscal years in a manner so that the payments made in fiscal year 1993 do not accurately reflect the value of the medical assistance provided with respect to items and services furnished in that fiscal year, the Secretary may provide for such adjustment in the amounts computed under this subsection as may be necessary so that the non-cash, non-DSH baseline amount and the non-cash, DSH baseline amount determined under this section accurately reflect such value.

(4) TREATMENT OF DISALLOWANCES.—The amounts determined under this subsection shall take into account amounts (or an estimate of amounts) disallowed.

(d) APPLICATION TO PARTICULAR ITEMS AND SERVICES IN THE BENEFIT PACKAGE FOR LOW-INCOME INDIVIDUALS.—For purposes of subsection (a), in determining the aggregate State medicaid expenditures for a category of items and services (within the benefit package for low-income individuals) furnished in a State, there shall be counted only that proportion of such expenditures that were attributable to items and services included in such package (taking into account any limitation on amount, duration, or scope of items and services included in such package).

SEC. 8123. UPDATING OF BASELINE AMOUNT.

(a) UPDATE FOR YEARS THROUGH 1998.—

(1) NON-CASH, NON-DSH BASELINE AMOUNT.—The Secretary shall update the non-cash, non-DSH baseline amount determined under section 8122(a)(1) for each State for years from fiscal year 1993 through 1998 by 66.2 percent.

(2) NON-CASH, DSH BASELINE AMOUNT.—The Secretary shall update the non-cash, DSH baseline amount determined under section 8122(a)(2) for each State for years from fiscal year 1993 through 1998 by 47.3 percent.

(3) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—In determining the updates under paragraph (1), the Secretary may provide for an adjustment in a manner similar to the adjustment permitted under section 8122(b)(3).

(b) UPDATE FOR SUBSEQUENT YEARS.—For each State for each year after 1998, the Secretary shall update the non-cash, non-DSH baseline amount (as previously updated under this section) and the non-cash, DSH baseline amount (as previously updated under this section) by the product of—

(1) 1 plus the national medicare growth factor (under section 8201(c)) for the year, and

(2) 1 plus the annual percentage increase in the population of the United States of individuals who are under 65 years of age (as estimated by the Secretary based on projections made by the Bureau of Labor Statistics of the Department of Labor) for the year.

Subpart C—General and Miscellaneous Provisions

SEC. 8131. TIMING AND MANNER OF PAYMENTS.

(a) IN GENERAL.—Amounts required to be paid under this part shall be paid on a periodic basis specified by the Secretary, taking into account the benefits provided under part B of title XXI of the Social Security Act and taking into account the manner in which States provide for payments under agreements under section 1843 of such Act.

(b) PERIODIC PROVISION OF INFORMATION.—Each State shall periodically transmit to the Secretary such information as the Secretary may require to verify the amounts payable.

(c) RECONCILIATION.—

(1) PRELIMINARY.—At such time after the end of each year as the Secretary shall specify, the State shall submit to the Secretary such information as the Secretary may require to do a preliminary reconciliation of the amounts paid under this part and the amounts due.

(2) FINAL.—No later than June 30 of each year, the Secretary shall provide for a final reconciliation for such payments for quarters in the previous year. Amounts subsequently payable are subject to adjustment to reflect the results of such reconciliation.

(3) AUDIT.—Payments under this part are subject to audits by the Secretary in accordance with rules established by the Secretary.

SEC. 8132. SPECIAL RULES FOR PUERTO RICO AND OTHER TERRITORIES.

(a) COMPUTATION OF BASELINES AS IF COMMONWEALTHS AND TERRITORIES WERE STATES.—

(1) IN GENERAL.—For purposes of determining payment amounts by the Commonwealths and territories under subpart A and subpart B of this part, subject to paragraph (2), the Secretary, in consultation with such Commonwealths and territories and using data on expenditures reported to the Secretary by the Commonwealths and territories, shall compute—

(A) the base per capita non-DSH expenditures and base per capita DSH expenditures, under section 8112(c), and

(B) the non-cash, non-DSH baseline amount and the non-cash, DSH baseline amount, under section 8122(a),

in the same manner as if the Commonwealths and territories had been one of the 50 States of the United States.

(2) REDUCTION OF MAINTENANCE OF EFFORT PAYMENTS BY AMOUNT OF TOBACCO TAXES IN PUERTO RICO.—The payment amounts otherwise payable under subparts A and B of this part by each of the Commonwealths and territories for a year shall be ratably reduced by ratio of—

(A) the amount of additional revenues in the year which the Secretary of the Treasury estimates to be attributable to section 5701(h) of the Internal Revenue Code of 1986 (as added by section 11101(h) of this Act), to

(B) the total payment amounts otherwise payable under such subparts by all of the Commonwealths and territories for the year.

(b) TREATMENT OF CERTAIN SSI RECIPIENTS.—With respect to the Commonwealths and territories insofar as they are not covered under the supplementary security income program, in this part, the term "SSI recipient" includes an individual receiving aid under a territorial program for the aged, blind, or disabled under the Social Security Act.

(c) COMMONWEALTHS AND TERRITORIES.—In this section, the term "Commonwealths and territories" means Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 8133. SANCTIONS FOR FAILURE TO MAKE TIMELY PAYMENTS.

(a) REDUCTION OF FEDERAL MATCHING PAYMENTS.—To the extent that a State that fails to make the payments required under this part in a timely manner, the Secretary shall, in addition to withholding payments pursuant to section 1903(x) of the Social Security Act (as added by section 8502(b)), withhold the required amounts from Federal matching payments that would otherwise be paid to the State for the following programs:

(1) The program under part A of title IV of the Social Security Act.

(2) The program under title XVI of such Act.

(3) The program under title XX of such Act.

(b) CONSTRUCTION.—Nothing in this section shall be construed as affecting payments made directly to individuals, whether or not such payments are administered by a State agency.

SEC. 8134. STATE MAINTENANCE OF EFFORT PERCENTAGE.

For purposes of sections 8111(a) and 8121(b), the term "State maintenance of effort percentage" means—

(1) 100 percent for 1999, 2000, and 2001

(2) 96 percent for 2002 and 2003, and

(3) 86 percent for each year thereafter.

PART 3—ANALYSIS OF IMPACT OF ACT ON FEDERAL EXPENDITURES AND STATES

SEC. 8141. IMPACT OF HEALTH CARE REFORM ON FEDERAL BUDGET.

(a) STUDY.—The Director of the Congressional Budget Office shall conduct a study of the impact of this Act on the budget of the Federal Government (including the impact on receipts, spending, and other obligations) with respect to each fiscal year (beginning with fiscal year 1996).

(b) REPORT.—Not later than March 1 of each year (beginning with 1997), the Director shall submit a report to Congress on the study conducted under subsection (a) for the previous fiscal year, and shall include in the report—

(1) a comparison of the actual impact of this Act on the Federal budget with the projected impact of this Act on Federal receipts, spending, and obligations, as first estimated by the Director after the date of the enactment of this Act; and

(2) to the extent that the actual impact of this Act on the Federal budget is not in accordance with the Director's estimate, an explanation for the differences.

SEC. 8142. IMPACT OF HEALTH CARE REFORM ON STATES.

(a) STUDY.—The Director of the Congressional Budget Office shall conduct a State-by-State study for each fiscal year (beginning with fiscal year 1996) of the impact of this Act on State spending for health care services and the overall economy of the State during the fiscal year. Such study shall include an analysis of the impact of this Act on the following:

(1) The number of individuals in the State with health insurance coverage.

(2) Health-related expenditures by the State, including—

(A) maintenance of effort paid under part 2;

(B) payments under the State plan under title XIX of the Social Security Act;

(C) support for uninsured and low-income individuals (including undocumented aliens);

(D) payments for medical education and other public health programs;

(E) payments for health insurance coverage for State and local government employees.

(3) Health-related payments by the Federal government to individuals and providers in the State, including—

(A) premium certificates under part A of title XXII of the Social Security Act and other premium assistance for low-income individuals;

(B) credits for small employers and retirees;

(C) payments to providers under the medicare program and medicare part C; and

(D) other Federal assistance to providers and programs (including capital assistance, payments under the Public Health Service Act, and payments for graduate medical education) under this Act and other Federal laws.

(b) REPORT.—Not later than March 1 of each year (beginning with 1997), the Director shall submit a report to Congress on the study conducted under subsection (a) for the previous fiscal year.

(c) RECOMMENDATIONS TO ASSIST ADVERSELY AFFECTED STATES.—If, with respect to a State for a fiscal year, the Director finds that this Act resulted in an adverse impact on State revenues and the overall State economy during the year, the Director shall report such information to the Secretary. The Secretary shall submit recommendations to Congress for a legislative proposal to assure that the State is held harmless as a result of this Act (including recommendations relating to adjustments in the State maintenance of effort payments required under part 2, other revenues contained in this Act, and other provisions).

Subtitle C—Cost Containment in the Medicare Programs

PART 1—MEDICARE HEALTH EXPENDITURE ESTIMATES

SEC. 8201. NATIONAL MEDICARE PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—For each calendar year (beginning with 1996), there is established a national medicare per capita health expenditure estimate (in this subtitle referred to as the "national medicare per capita estimate") determined under paragraph (2).

(2) AMOUNT.—Subject to subsection (e)—

(A) NATIONAL MEDICARE PER CAPITA ESTIMATE.—

(i) 1996, 1997, AND 1998.—The national medicare per capita estimate for 1996, 1997, and 1998 is equal to the national medicare A/B per capita estimate for the respective year.

(ii) SUBSEQUENT YEARS.—The national medicare per capita estimate for a year after 1998 is equal to the average, weighted by the estimated number of enrollees in the respective programs, of the national medicare A/B per capita estimate and the national medicare C per capita estimate for the year.

(B) NATIONAL MEDICARE A/B PER CAPITA AMOUNT.—

(i) 1996.—Subject to the special rule provided under subsection (e)(4), the national medicare A/B per capita estimate for 1996 is equal to the medicare per capita budget baseline for 1995 (as determined under subsection (b)) multiplied by the sum of 1 plus the national medicare growth factor (specified under subsection (c)) for 1996.

(ii) SUBSEQUENT YEARS.—Subject to the special rule provided under subsection (e)(4), the total amount of the national medicare A/B per capita estimate for each year after 1996 is equal to the national medicare A/B per capita estimate determined under this subparagraph for the previous year multiplied by the national medicare growth factor (specified under subsection (c)) for the year involved.

(C) NATIONAL MEDICARE C PER CAPITA AMOUNT.—

(i) 1999.—The Secretary shall estimate the national medicare C per capita estimate for 1999 by using the payment rates under the medicare part C program in 1999 and taking into account the average characteristics of the population expected to be enrolled in such program and their projected use of covered services (including wrap around services covered under subpart 2 of part B of title XXIII of the Social Security Act).

(ii) SUBSEQUENT YEARS.—The total amount of the national medicare C per capita estimate for each year after 1999 is equal to the national medicare C per capita estimate determined under this subparagraph for the previous year multiplied by the sum of 1 plus the national medicare growth factor (specified under subsection (c)) for the year involved.

(3) PUBLICATION.—The Secretary of Health and Human Services shall publish in the Federal Register and report to the Congress—

(A) by not later than April 1 before each year, an initial estimate of the per capita estimates under this subsection for the year; and

(B) by not later than October 1 before each year, a final determination of such per capita estimates for such year.

COM008 (b) MEDICARE PER CAPITA BUDGET BASELINE.—The Secretary shall compute a medicare per capita budget baseline under this subsection for 1995 as follows:

(1) 1993 ACTUAL EXPENDITURES.—The Secretary shall determine (on the basis of the best data available) the amount of the medicare per capita expenditures (as determined under subsection (d)) for 1993.

(2) PROJECTION FOR 1995.—The Secretary shall increase such amount by the Secretary's estimate of the percentage increase in the national medicare per capita estimate between the midpoint of 1993 and the midpoint of 1995.

(c) NATIONAL MEDICARE GROWTH FACTOR.—The national medicare growth factor under this subsection for each year is the sum (expressed as a fraction) of—

(1) the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year; and

(2)(A) for 1996, 1.8 percentage points,

(B) for 1997, 1.4 percentage points,

(C) for 1998, 0.5 percentage points,

(D) for 1999, 0.1 percentage points, and

(E) for each year thereafter, 0 percentage points.

(d) DETERMINATION OF NATIONAL MEDICARE PER CAPITA EXPENDITURES FOR 1993.—

(1) IN GENERAL.—The Secretary shall determine for 1993 the national medicare per capita expenditures equal to—

(A) total covered health care expenditures (described in paragraph (2)), divided by

(B) the estimated average number of medicare beneficiaries in 1993 for whom such expenditures were determined.

(2) COVERED HEALTH CARE EXPENDITURES.—For purposes of paragraph (1)(A), the Secretary shall determine covered health care expenditures for 1993 as follows:

(A) DETERMINATION OF TOTAL EXPENDITURES.—The Secretary shall first determine the amount of total payments made for items and services under title XVIII of the Social Security Act (determined without regard to cost sharing) in 1993.

(B) REMOVAL OF CERTAIN EXPENDITURES NOT INCLUDED IN MEDICARE.—The amount so determined shall be decreased by the proportion of such amount that is attributable to expenditures which are paid for items and services excluded from classes of services under section 8202(a)(4).

(e) ADJUSTMENTS.—

(1) IN GENERAL.—Except as provided in this subsection, the Secretary is not authorized to adjust the medicare A/B per capita estimate or the medicare C per capita estimate under this section for a year once they are published before October of the previous year.

(2) RECOMMENDATIONS FOR CHANGES.—Except as permitted under paragraphs (3) and (4), the Secretary may submit to Congress recommendations for changes in the medicare A/B per capita estimate or the medicare C per capita estimate, but may not implement such recommendations without the approval of Congress.

(3) CORRECTION PERMITTED FOR ESTIMATION ERRORS IN MEDICARE PER CAPITA BUDGET BASELINE.—Insofar as the Secretary determines that the amounts used in estimating initially the medicare per capita budget baseline described in subsection (b) did not accurately reflect the actual amount described in subsection (b)(1) and the actual percentage increase described in subsection (b)(2), the Secretary shall adjust the national medicare per capita estimate to correct for such estimation errors.

(4) SPECIAL RULES.—

(A) MEDICARE A/B PER CAPITA ESTIMATE.—The Secretary shall adjust the national medicare A/B per capita estimate for each year (beginning with 1996) in order to reflect the changes in expenditures under parts A and B of the medicare program attributable to amendments made by subtitle B of title III or subtitle D of this title, including the addition of an outpatient prescription drug benefit.

(B) MEDICARE C PER CAPITA ESTIMATE.—The Secretary shall adjust the national medicare C per capita estimate for each year (beginning with 1999) in order to reflect the changes in expenditures under medicare part C attributable to the addition of benefits not included in the previous year.

SEC. 8202. CLASSES OF HEALTH CARE SERVICES.

(a) ESTABLISHMENT OF CLASSES.—

(1) IN GENERAL.—

(A) SPECIFIED SERVICES.—

(i) IN GENERAL.—Subject to subparagraph (B)(ii), in the case of items and services specified in a subparagraph under paragraph (2), all of the items and services described in that subparagraph shall be considered to be a "separate" class of health care services.

(ii) OVERLAPPING SERVICES.—Except as the Secretary may provide, items and services specified in a subparagraph of paragraph (2) shall be considered to be excluded from the subsequent subparagraphs of that paragraph.

(B) OTHER ITEMS AND SERVICES.—

(i) IN GENERAL.—In the case of items and services included as health care services under paragraph (3), the Secretary shall group such items and services into such class or classes of health care services as may be appropriate.

(ii) INCLUSION IN CLASSES OF SPECIFIED HEALTH CARE SERVICES.—In carrying out clause (i), the Secretary may include an item or service described in paragraph (3) within a class of services established under subparagraph (A).

(2) SPECIFIED HEALTH CARE SERVICES.—Subject to paragraph (4), the items and services specified in this paragraph are as follows:

(A) Inpatient hospital services, other than mental health services.

(B) Outpatient hospital services and ambulatory facility services (including renal dialysis facility services), other than mental health services.

(C) Diagnostic testing services (including clinical laboratory services and x-ray services).

(D) Physicians' services and other professional medical services, other than mental health services.

(E) Home health services and hospice care.

(F) Rehabilitation services, such as physical therapy, occupational and speech therapy.

(G) Durable medical equipment and supplies.

(H) Prescription drugs and biologicals and insulin.

(I) Nursing facility services, including skilled nursing facility services and intermediate care facility services, other than mental health services.

(J) Mental health services.

(3) CLASSIFICATION OF ADDITIONAL ITEMS AND SERVICES.—Subject to paragraph (4), with respect to items and services (not described in paragraph (2)) which are included under the medicare program (including wrap around benefits under subpart 2 of part B of title XXIII of the Social Security Act), the Secretary may classify them either within a class specified in paragraph (2) or within a new class established by the Secretary for such an item or service.

(4) EXCLUSIONS.—The following items and services shall not be considered to be health care services and shall not be included in a

class of services under paragraph (1) or (3), except as provided in paragraph (5):

(A) Over-the-counter medications and medical equipment and devices.

(B) Homemaker and home health aide services and personal care services, and other services described in section 1915(c)(4)(B), section 1929(a), or section 1930(a) of the Social Security Act.

(C) Inpatient mental health services of a custodial nature.

(5) INCLUSION OF MEDICARE SERVICES.—Paragraph (4) shall not apply to items and services covered under the medicare program.

(b) PUBLICATION.—

(1) IN GENERAL.—The Secretary shall publish—

(A) by not later than April 1, 1995, proposed regulations defining the health care services and establishing the classes of services under this section, and

(B) by not later than October 1, 1995, final regulations defining the health care services and establishing such classes.

(2) ITEMS INCLUDED IN REGULATIONS.—In such regulations, the Secretary shall define—

(A) the class or classes to be established under subsection (a)(1),

(B) the services to be included within each class, and

(C) the methods and sources of data for computing, for purposes of this subtitle, the national medicare per capita estimate within the class.

(3) CHANGES.—

(A) NO CHANGES AUTHORIZED.—After the Secretary has established classes of services under paragraph (1)(B), the Secretary may not change such classes (or the services included in such classes), except in the case of services not previously classified. Any such services not previously classified shall be classified within one of the classes previously established.

(B) RECOMMENDED CHANGES.—If the Secretary determines that a change in the classification established under this section may be appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the per capita estimates under this part and on medicare expenditures permitted for classes of services that would be affected by the change.

(4) COMMISSION REPORTS.—

(A) INITIAL REPORTS.—With respect to the establishment of classes of services under this section, each applicable Commission (as defined in subsection (c)), by not later than June 1, 1995, shall report to the Congress its comments concerning the classification proposed by the Secretary under paragraph (1)(A).

(B) PERIODIC REPORTS.—Each applicable Commission shall periodically report to Congress on changes in the system of classification under this section that should be made to promote the more efficient provision of medically appropriate health care services.

(c) APPLICABLE COMMISSION DEFINED.—In this subtitle, the term "applicable Commission" means—

(1) with respect to services included in a class of services furnished by a hospital, other institutional provider, or home health provider, the Prospective Payment Assessment Commission (established under section 1886(e)(2) of the Social Security Act);

(2) with respect to prescription drugs, biologicals, and insulin, the Prescription Drug Payment Review Commission (provided for under section 1847 of the Social Security Act, as added by section 3104 of this Act),

(3) with respect to physicians' services, the Physician Payment Review Commission (provided for under section 1845 of the Social Security Act), and

(4) with respect to mental health and substance abuse services, the Advisory Commission on Mental Health and Substance Abuse Services (provided for under section 3025(a)).

SEC. 8203. ALLOCATION OF PER CAPITA ESTIMATES BY CLASS OF SERVICE FOR MEDICARE A/B.

(a) ALLOCATION.—

(1) IN GENERAL.—The Secretary shall allocate the medicare A/B per capita estimate under section 8201 for a year among classes of services specified under section 8202.

(2) PROPORTIONAL ALLOCATION BASED ON PROJECTED EXPENDITURES.—The amount allocated to each class for a year shall be equal to the medicare A/B per capita estimate for the year multiplied by the ratio (expressed as a percentage) of—

(A) the projected medicare A/B expenditures for the class for the year (as determined under subsection (b)(2)), to

(B) the sum of such projected medicare A/B expenditures for all the classes for the year.

(3) PUBLICATION.—

(A) IN GENERAL.—The Secretary shall, in conjunction with the publication of the initial estimate and final determination of the per capita estimates under section 8201(a)(3) for a year, publish in the Federal Register and report to the Congress the allocation of the per capita estimates among the classes of services under this subsection.

(B) EXCEPTION FOR 1996.—For 1996, the Secretary shall publish and report the allocation of the medicare A/B per capita estimate among the classes of services under this subsection not later than August 1, 1995.

(b) PROJECTED MEDICARE A/B EXPENDITURES.—

(1) IN GENERAL.—

(A) DETERMINATION.—For purposes of subsection (a)—

(i) FOR 1995.—The projected medicare A/B expenditures for a class of services for 1995 is equal to the portion of the national medicare per capita expenditures during 1993 (as determined under section 8201(d)) which is attributable to the class of services, multiplied twice by the medicare A/B trend factor (described in subparagraph (B)) for the class and multiplied by the adjustment factor described in subparagraph (C) for 1995. In computing such portion for classes, the Secretary shall take into account the allocation of expenditures by health maintenance organizations among the different classes of services.

(ii) SUBSEQUENT YEARS.—The projected medicare A/B expenditures for a class of services for a year after 1995 is equal to the amount of the allocation for the class under clause (i) for the preceding year multiplied by the medicare A/B trend factor (described in subparagraph (B)) for the class and multiplied by the adjustment factor described in subparagraph (C) for the year.

(B) MEDICARE A/B TREND FACTOR.—In subparagraph (A), subject to subparagraph (D), the "medicare A/B trend factor", is 1 plus the following amount for the class of services involved:

(i) INPATIENT HOSPITAL SERVICES.—For the class described in section 8202(a)(2)(A), 8.6 percent.

(ii) OUTPATIENT HOSPITAL SERVICES.—For the class described in section 8202(a)(2)(B), 15.7 percent.

(iii) DIAGNOSTIC TESTING SERVICES.—For the class described in section 8202(a)(2)(C), 12.2 percent.

(iv) PHYSICIANS' SERVICES.—For the class described in section 8202(a)(2)(D), 9.1 percent.

(v) HOME HEALTH AND HOSPICE.—For the class described in section 8202(a)(2)(E), 13.9 percent.

(vi) REHABILITATION SERVICES.—For the class described in section 8202(a)(2)(F), 12.3 percent.

(vii) DURABLE MEDICAL EQUIPMENT.—For the class described in section 8202(a)(2)(G), 10.2 percent.

(viii) PRESCRIPTION DRUGS.—For the class described in section 8202(a)(2)(H), 8.2 percent.

(ix) NURSING FACILITY SERVICES.—For the class described in section 8202(a)(2)(I), 11.5 percent.

(x) MENTAL HEALTH SERVICES.—For the class described in section 8202(a)(2)(J), 15.7 percent.

(C) ADJUSTMENT FACTOR (NORMALIZATION).—The adjustment factor described in this subparagraph for a year is equal to the ratio of—

(i) the national medicare A/B per capita estimate for the year (as determined under section 8201(a)(2)(B)) or, for 1995, the medicare per capita budget baseline for 1995 (as determined under section 8201(b)(2)), to

(ii) the sum of the projected medicare A/B expenditures projected for all the classes for the year (determined under subparagraph (A) without regard to this subparagraph).

(D) SPECIAL RULE.—The Secretary shall adjust the projected medicare A/B expenditures for each year (beginning with 1996) in order to reflect the changes in expenditures under parts A and B of the medicare program attributable to amendments made by subtitle B of title III or subtitle D of this title, including the addition of an outpatient prescription drug benefit. Such adjustment shall be consistent with the adjustment described in section 8201(e)(4)(A).

(2) PUBLICATION OF TREND FACTORS.—The Secretary shall publish, by not later than August 1, 1995, the medicare A/B trend factors for the different classes of services.

(c) REVIEW AND CHANGES IN ALLOCATION.—

(1) IN GENERAL.—

(A) NO ADMINISTRATIVE AUTHORITY TO CHANGE.—Except as specifically provided in this paragraph, the Secretary has no authority to change the allocation or medicare A/B trend factors from the allocation and medicare A/B trend factors provided under this section.

(B) RECOMMENDED CHANGES.—Subject to subparagraph (C), if the Secretary determines that a change in the allocation of an estimate among classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the per capita estimates permitted for classes of services that would be affected by the change.

(C) CORRECTION PERMITTED FOR ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the projected medicare A/B expenditures under this subsection did not accurately reflect the actual portions described in subsection (b)(1)(A)(i), the Secretary shall adjust the allocation of the medicare A/B per capita estimate among classes of services to correct for such estimation errors.

(2) COMMISSION REVIEW.—Each applicable Commission shall annually review and report

to Congress, in its report submitted under section 8202(b)(4), on the effect of the medicare trend factors used in the allocation of the medicare A/B per capita estimate among classes of services. Such report shall include such recommendations for appropriate adjustments in the medicare trend factors as the applicable Commission considers appropriate to properly take into account at least—

(A) changes in health care technology,

(B) changes in the patterns and practices relating to health care delivery found to be appropriate,

(C) changes in the distribution of health care services, and

(D) the special health care needs of underserved rural and inner city populations.

SEC. 8204. ALLOCATION OF PER CAPITA ESTIMATES BY CLASS OF SERVICE FOR MEDICARE C.

(a) Allocation.—

(1) In general.—The Secretary shall allocate the medicare C per capita estimate under section 8201 for a year among classes of services specified under section 8202.

(2) Proportional allocation based on projected expenditures.—The amount allocated to each class for a year shall be equal to the medicare C per capita estimate allocated for the year multiplied by the ratio (expressed as a percentage) of—

(A) the projected medicare C expenditures for the class for the year (as determined under subsection (b)(2)), to

(B) the sum of such projected medicare C expenditures for all the classes for the year.

(3) Publication.—The Secretary shall, in conjunction with the publication of the initial estimate and final determination of the per capita estimates under section 8201(a)(3) for a year, publish in the Federal Register and report to the Congress the allocation of the per capita estimates among the classes of services under this subsection.

(b) Projected Medicare Part C Expenditures.—

(1) In general.—

(A) Determination.—For purposes of subsection (a)—

(i) For 1999.—The projected medicare part C expenditures for a class of services for 1999 is equal to the portion of the national medicare C per capita estimate during 1999 (as determined under section 8201(a)(2)(C)) which is attributable to each class of services, as estimated by the Secretary based upon the best data available, consistent with data used in determining the applicable medicare part C premiums under section 2121 of the Social Security Act.

(ii) Subsequent years.—The projected medicare C expenditures for a class of services for a year after 1999 is equal to the amount of the allocation for the class under clause (i) for the preceding year multiplied by the medicare C trend factor (described in subparagraph (B)) for the class for the year involved and multiplied by the adjustment factor described in subparagraph (C) for the year.

(B) Medicare c trend factor.—

(i) In general.—In subparagraph (A), subject to clause (ii), the "medicare C trend factor", for a class of services, the private trend factor for the class of services, as determined under section 6003(b)(1)(B).

(ii) Modification.—Based upon data from the medicaid program and such other data as the Secretary determines to be appropriate, the Secretary may modify the trend factors described in clause (i) to reflect the rate of growth in services for the classes under medicare part C.

(C) Adjustment factor (normalization).—The adjustment factor described in this subparagraph for a year is equal to the ratio of—

(i) the national medicare C per capita estimate for the year (as determined under section 8201(a)(2)(C)), to

(ii) the sum of the projected medicare C expenditures projected for all the classes for the year (determined under subparagraph (A) without regard to this subparagraph).

(D) Special rule.—The Secretary shall adjust the projected medicare C expenditures for each year (beginning with 2000) in order to reflect the changes in expenditures under medicare part C to reflect the changes in expenditures under medicare part C attributable to the addition of benefits not included in the previous year. Such adjustment shall be consistent with the adjustment described in section 8201(e)(4)(B).

(2) Publication of trend factors.—The Secretary shall publish, by not later than April 1, 1998, the medicare C trend factors for the different classes of services.

(c) Review and Changes in Allocation.—

(1) In general.—

(A) No administrative authority to change.—Except as specifically provided in this paragraph, subsection (b)(1)(B)(ii), and sections 8201(e)(4)(B) and 8203(b)(1)(D), the Secretary has no authority to change the allocation or medicare C trend factors from the allocation and medicare C trend factors provided under this section.

(B) Recommended changes.—If the Secretary determines that a change in the allocation of an estimate among classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the per capita estimates permitted for classes of services that would be affected by the change.

(2) Commission review.—Each applicable Commission shall annually review and report to Congress, in its report submitted under section 8202(b)(4), on the effect of the medicare trend factors used in the allocation of the medicare C per capita estimate among classes of services. Such report shall include such recommendations for appropriate adjustments in the medicare trend factors as the applicable Commission considers appropriate to properly take into account at least—

(A) changes in health care technology,

(B) changes in the patterns and practices relating to health care delivery found to be appropriate,

(C) changes in the distribution of health care services, and

(D) the special health care needs of underserved rural and inner city populations.

SEC. 8205. COMBINED MEDICARE PER CAPITA ALLOCATIONS FOR CLASSES OF SERVICES.

(a) For 1996, 1997, and 1998.—For 1996, 1997, and 1998, the Secretary shall compute a combined medicare per capita allocation for each class of services equal to the per capita amount allocated to the class for medicare A/B for the year under section 8203.

(b) Subsequent Years.—For each year after 1998, the Secretary shall compute a combined medicare per capita allocation for each class of services equal to the average of—

(1) the per capita amount allocated to the class for medicare A/B for the year under section 8203, and

(2) the per capita amount allocated to the class for medicare C for the year under section 8204,

weighted to reflect the relative average number of enrollees in the medicare program and in medicare part C, respectively, for the year.

SEC. 8206. COMPUTATION OF MEDICARE ANNUAL COMBINED RATE OF INCREASE FOR CLASSES OF SERVICES; APPLICATION TO MEDICARE PAYMENT RATES.

(a) Combined Rates.—

(1) Determination.—For each year (beginning with 1996) for services within each class of services, the Secretary shall determine a uniform percentage increase. The uniform percentage increase shall be such an increase as the Secretary determines will result in aggregate expenditures under the medicare program and medicare part C consistent with the combined medicare per capita allocation for such class for such year, as determined under section 8205.

(2) Application to medicare payment rates.—Notwithstanding any provision of title XVIII or title XXIII of the Social Security Act, subject to section 4004(c)(1)(B), the amount of payment under such titles for items and services included in a class of services for a year (after 1995) shall be based on the amount of payment for such items and services under such titles in the previous year increased by the uniform percentage increase determined under paragraph (1) for such class of services for the year.

(b) Percentage Increase in Combined Allocation for Class of Prescription Drugs.—For each year beginning after 1997, for purposes of sections 1834(d) of the Social Security Act and sections 3012(d) and 3013(a), the Secretary shall compute the percentage by which—

(1) the combined medicare per capita allocation for the class of services that includes prescription drugs for the year, exceeds

(2) the combined medicare per capita allocation for such class of services for the preceding year.

SEC. 8207. NATIONAL HEALTH EXPENDITURES REPORTING SYSTEM.

(a) In General.—The Secretary shall establish a national health expenditures reporting system (in this section referred to as the "system") for purposes of—

(1) establishing per capita estimates,

(2) allocating the medicare per capita estimates among classes of services,

(3) determining medicare payment rates,

(4) monitoring of any State cost containment and benefit management programs established by States pursuant to title IV, and

(5) otherwise carrying out this subtitle.

(b) Information Reporting.—

(1) Annual report by providers.—

(A) In general.—Under the system, providers of health care services (including such providers within provider networks) shall submit (by not later than April 15 of each year, beginning with 1997) a report.

(B) Contents.—Such a report shall include such information as the Secretary specifies relating to the provision of health care services in the previous year, including—

(i) the volume and receipts for such services,

(ii) cost and revenue data for hospitals and other institutional providers and revenue data for other providers, and

(iii) information by class of service, type of payer, and State of residence of individual provided the services.

Information on revenues for activities not related to the provision of direct patient care, such as teaching or research or for services that are explicitly excluded from the system of national health expenditures estimates, shall be reported separately.

(C) FORM.—The report shall be submitted in such form and manner (including the use of electronic transmission) as the Secretary shall specify in regulation. Such form shall permit the reporting of information by health plans on behalf of providers who are in provider networks in the plan.

(D) USE OF REPORTING MECHANISMS.—To the maximum extent practicable and appropriate, reporting under such system shall be done through reporting mechanisms (such as uniform hospital reports provided under section 9105) and using data bases otherwise in use.

(E) USE OF SURVEYS.—The Secretary may, where appropriate, provide for the collection of information under the system through surveys of a sample of health care providers or with respect to a sample of information with respect to such providers.

(2) CONFIDENTIALITY.—Information gathered pursuant to the authority provided under this section shall not be disclosed in a manner that identifies individual providers of services.

(3) TRANSITION.—Before April 15, 1997, for purposes of this subtitle, the Secretary may use such other data collection and estimation techniques as may be appropriate for purposes described in subsection (a).

(c) ENFORCEMENT.—If a provider of health services is required, under the system under this section, to report information and refuses, after being requested by the Secretary, to provide the information required, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

PART 2—STATE HEALTH EXPENDITURE ESTIMATES

SEC. 8211. STATE MEDICARE PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—For each calendar year (beginning with 1996), the Secretary shall establish a State medicare per capita health expenditure estimate (in this subtitle referred to as a "State medicare per capita estimate") for each State under paragraph (2).

(2) AMOUNT.—Subject to subsection (e), the State medicare per capita estimate for a State for a year is equal to the national medicare per capita estimate for the year, established under section 8201, multiplied by the applicable State adjustment factor (specified under subsection (b)) for the State.

(3) PUBLICATION.—The Secretary shall publish in the Federal Register and report to the Congress and to each State—

(A) by not later than April 1 before each year, an initial estimate of the State medicare per capita estimate for each State for the year; and

(B) by not later than October 1 before each year, a final determination of the State medicare per capita estimate for each State for the year.

(4) PERIODIC COMMISSION REPORTS ON STATE ESTIMATES.—Each applicable Commission shall periodically review and report to Congress on the State medicare per capita estimates established under this section. Such a report shall include such recommendations as the respective Commission deems appropriate.

(b) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—The Secretary shall compute a State adjustment factor for each State consistent with this subsection.

(2) BASIS FOR COMPUTATION.—Subject to adjustment under paragraphs (3) and (4), the State adjustment factor for a State shall be equal to the ratio of the State's medicare per capita expenditures (that would be computed for the State under section 8201(d) if computations under such section were made for that State rather than for the United States) to the national medicare per capita expenditures determined under such section.

(3) ADJUSTMENT TO REFLECT HEALTH CARE EXPENDITURES FOR STATE RESIDENTS.—The Secretary shall provide for an adjustment to take into account differences among States in the in-State, and out-of-State, use of services by residents and non-residents of the State, in order that the per capita amount reflects the medicare per capita health care expenditures for residents of the State for services provided anywhere in the United States.

(4) AVERAGE.—The Secretary shall establish the State adjustment factors in such a manner as assures that the population weighted average of such factors is 1.

(c) ADJUSTMENT.—

(1) IN GENERAL.—Subject to paragraph (3), the provisions of section 8201(e) shall apply to the State medicare per capita estimates under this section in the same manner as they apply to the national medicare per capita estimate.

(2) ADJUSTMENT TO CORRECT ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the State medicare per capita estimates did not accurately reflect the correct values for the factors used in computing State adjustments factors under subsection (b), the Secretary shall adjust the State medicare per capita estimates to correct for such estimation errors.

(3) ADJUSTMENTS IN 1996 AND SUBSEQUENT YEARS.—

(A) ADJUSTMENT FOR CHANGES IN BENEFITS IN 1996.—In applying section 8201(e)(4) under paragraph (1), the adjustment for each State medicare per capita estimate shall be the same as the adjustment to the national medicare per capita estimate under such section.

(B) ADJUSTMENT FOR IMPLEMENTATION OF MEDICARE PART C.—The Secretary shall adjust the State medicare per capita estimates for each State for each year (beginning with 1999) to reflect variations among States in the estimated number of residents of the State who are enrolled in medicare part C for the year.

PART 3—ADMINISTRATIVE AND JUDICIAL REVIEW

SEC. 8221. LIMITATION ON ADMINISTRATIVE AND JUDICIAL REVIEW.

There shall be no administrative or judicial review of any of the following determinations:

(1) The national medicare per capita estimate and the State medicare per capita estimate for each State.

(2) Allocation of the national medicare per capita estimate or a State medicare per capita estimate to a class of health services.

Subtitle D—Revisions to Medicare Part A and Part B

PART 1—ADDITIONAL MEDICARE SAVINGS

SEC. 8301. REDUCTION IN PAYMENTS FOR INDIRECT COSTS OF MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

"(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c * (((1+r) to the nth power) - 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring on or after—

"(I) May 1, 1986, and before January 1, 1999, 'c' is equal to 1.89;

"(II) January 1, 1999, and before October 1, 1999, 'c' is equal to 1.68;

"(III) October 1, 1999, and before October 1, 2000, 'c' is equal to 1.48; and

"(IV) October 1, 2000, 'c' is equal to 1.28.".

(b) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking "of 1985" and inserting "of 1985, but not taking into account the amendments made by section 8301(a) of the Guaranteed Health Insurance Act of 1994".

SEC. 8302. REDUCTIONS IN DISPROPORTIONATE SHARE ADJUSTMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking "The amount" and inserting "Subject to clause (ix), the amount"; and

(2) by adding at the end the following new clause:

"(ix) Notwithstanding any other provision of this subparagraph, the Secretary shall reduce the amount of any additional payment made to a hospital under this subparagraph—

"(I) for discharges occurring on or after January 1, 1999, and before October 1, 2000, by 25 percent (or, in the case of an urban hospital that has more than 100 beds and a disproportionate patient percentage equal to or greater than 30 percent or a hospital described in the second sentence of clause (v), by 10 percent); and

"(II) for discharges occurring on or after October 1, 2000 by 50 percent (or, in the case of an urban hospital that has more than 100 beds and a disproportionate patient percentage equal to or greater than 30 percent or a hospital described in the second sentence of clause (v), by 25 percent).".

(b) RECOMMENDATIONS ON ADJUSTMENTS TO FORMULA.—

(1) RECOMMENDATIONS OF SECRETARY.—Not later than October 1, 1995, the Secretary shall submit recommendation to Congress on methods to adjust the definition of disproportionate patient percentage used to determine the amount of payment adjustments made under section 1886(d)(5)(F) of the Social Security Act to hospitals serving a significantly disproportionate number of low-income patients to take into account the provisions of this Act, including the establishment under the health insurance benefit program under part A of title XXIII of the Social Security Act and the repeal of coverage of inpatient hospital services under State plans for medical assistance under title XIX of such Act.

(2) REPORT BY PROPAC.—The Prospective Payment Assessment Commission shall review the Secretary's report under paragraph (2) and include recommendations relating to the report in the report submitted pursuant

to section 1886(e)(3) of the Social Security Act on March 1, 1996.

SEC. 8303. REDUCTIONS IN PAYMENTS FOR CAPITAL-RELATED COSTS OF INPATIENT HOSPITAL SERVICES FOR PPS HOSPITALS.

Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: "In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Guaranteed Health Insurance Act of 1994) and shall reduce by 10.41 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the Guaranteed Health Insurance Act of 1994).".

SEC. 8304. LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS.

(a) IN GENERAL.—

(1) LIMITATIONS DESCRIBED.—Part B of title XVIII, as amended by [*Review:* section 3103(a)], is amended by inserting after section 1848 the following new section:

"LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS

"SEC. 1849. (a) SERVICES SUBJECT TO REDUCTION.—

"(1) DETERMINATION OF HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1997), the Secretary shall determine for each hospital—

"(A) the hospital-specific per admission relative value under subsection (b)(2) for the following year; and

"(B) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to the hospital for the following year under subsection (b)(1).

"(2) REDUCTION FOR SERVICES AT HOSPITALS EXCEEDING ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value for a year (beginning with 1998) is projected to exceed the allowable average per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection (c)) the amount of payment otherwise determined under this part for each physician's service furnished during the year to an inpatient of the hospital by an individual who is a member of the hospital's medical staff.

"(3) TIMING OF DETERMINATION; NOTICE TO HOSPITALS AND CARRIERS.—Not later than October 1 of each year (beginning with 1997), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the determinations made with respect to the medical staff under paragraph (1).

"(b) DETERMINATION OF ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUES.—

"(1) ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—

"(A) URBAN HOSPITALS.—In the case of a hospital located in an urban area, the allowable average per admission relative value established under this subsection for a year is equal to 125 percent (or 120 percent for years after 1999) of the median of 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(B) RURAL HOSPITALS.—In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1998 and each succeeding year, is equal to 140 percent of the median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(2) HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—

"(A) IN GENERAL.—The hospital-specific per admission relative value projected for a hospital (other than a teaching hospital) for a calendar year, shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under subparagraph (C)).

"(B) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a calendar year shall be equal to the sum of—

"(i) the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year; and

"(ii) the equivalent per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding such calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall determine such equivalent relative value unit per admission for interns and residents based on the best available data for teaching hospitals and may make such adjustment in the aggregate.

"(C) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5). The adjustment for teaching status or disproportionate share shall not be less than zero.

"(c) AMOUNT OF REDUCTION.—The amount of payment otherwise made under this part for a physician's service that is subject to a reduction under subsection (a) during a year shall be reduced 15 percent, in the case of a service furnished by a member of the medical staff of the hospital for which the Secretary determines under subsection (a)(1) that the hospital medical staff's projected relative value per admission exceeds the allowable average per admission relative value.

"(d) RECONCILIATION OF REDUCTIONS BASED ON HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION WITH ACTUAL RELATIVE VALUES.—

"(1) DETERMINATION OF ACTUAL AVERAGE PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1999), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians' services furnished by members of a hospital's medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Secretary under subsection (b)(2)(C)). Notwithstanding any other provision of this title, no payment may be made under this part for any physician's service furnished by a member of a hospital's medical staff to an inpatient of the hospital during a year unless the hospital submits a claim to the Secretary for payment for such service not later than 90 days after the last day of the year.

"(2) RECONCILIATION WITH REDUCTIONS TAKEN.—In the case of a hospital for which the payment amounts for physicians' services furnished by members of the hospital's medical staff to inpatients of the hospital were reduced under this section for a year—

"(A) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under subsection (c), including interest at an appropriate rate determined by the Secretary;

"(B) if the actual average per admission relative value for such hospital's medical staff during the year is less than 15 percentage points above the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff, as a percent of the total allowed charges for physicians' services performed in such hospital (prior to the withhold), the difference between 15 percentage points and the actual number of percentage points that the staff exceeds the limit allowable average per admission relative value, including interest at an appropriate rate determined by the Secretary; and

"(C) if the actual average per admission relative value for such hospital's medical staff during the year exceeded the allowable average per admission relative value applicable to the hospital's medical staff by 15 percentage points or more, none of the withhold is paid to the fiduciary agent for the medical staff.

"(3) MEDICAL EXECUTIVE COMMITTEE OF A HOSPITAL.—Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have one year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate withhold amount made by the carrier.

"(4) ALTERNATIVE REIMBURSEMENT TO MEMBERS OF STAFF.—At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement described in paragraph (2)(B) for excess reductions in payments during a year, the Secretary shall make such reimbursement to the members of the hospital's medical staff, on a pro-rata basis according to the proportion of physicians' services furnished to inpatients of the hospital during the year that were furnished by each member of the medical staff.

"(e) DEFINITIONS.—In this section, the following definitions apply:

"(1) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

"(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

"(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities;

"(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body; and

"(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

"(B) if such physician provides at least one service to a medicare beneficiary in such hospital.

"(2) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given such terms under section 1886(d)(2)(D).

"(3) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6).".

(2) CONFORMING AMENDMENTS.—(A) Section 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting "(subject to reduction under section 1849)" after "1848(a)(1)".

(B) Section 1848(a)(1)(B) (42 U.S.C. 1395w-4(a)(1)(B)) is amended by striking "this subsection," and inserting "this subsection and section 1849,".

(b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL AT WHICH SERVICE FURNISHED.—Section 1848(g)(4)(A)(i) (42 U.S.C. 1395w-4(g)(4)(A)(i)) is amended by striking "beneficiary," and inserting "beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form),".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 8305. MEDICARE SECONDARY PAYER.

(a) EXTENSION OF DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) REPEAL OF SUNSET ON APPLICATION TO DISABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended—

(1) in the heading, by striking "SUNSET" and inserting "EFFECTIVE DATE"; and

(2) by striking ", and before October 1, 1998".

(c) PROVISIONS RELATING TO END STAGE RENAL DISEASE BENEFICIARIES.—

(1) EXTENSION OF PERIOD.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended in the second sentence by striking "and on or before October 1, 1998,".

(2) CLARIFICATION OF SECONDARY PAYER FOR BENEFICIARIES COVERED UNDER GROUP HEALTH PLANS.—Effective as if included in the enactment of OBRA–1993, section 1862(b)(1)(C)(i) (42 U.S.C. 1395y(b)(1)(C)(i)) is amended—

(A) by inserting "(or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer" after "an individual"; and

(B) by inserting "solely" after "this title".

(d) PENALTY FOR LATE PAYMENT.—Section 1862(b)(2)(B)(i) (42 U.S.C. 1395y(b)(2)(B)(i)) is amended by adding at the end the following: "If a primary plan fails to make such reimbursement during the 60-day period that begins on the date such notice or other information is received, the amount required to be reimbursed shall be increased by 1 percent for each month occurring after the expiration of such period and prior to the month in which the primary plans makes the reimbursement.".

SEC. 8306. IMPOSITION OF 20 PERCENT COINSURANCE ON HOME HEALTH SERVICES UNDER MEDICARE.

(a) PART A.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

"(5) The amount payable for a home health service furnished to an individual under this part shall be reduced by a copayment amount equal to 20 percent of the average of all the per visit costs for such service furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year).".

(b) PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)), as amended by section 2106(c)(1), is amended—

(1) in subparagraph (A), by striking "to home health services," and by striking the comma after "opinion)";

(2) in subparagraph (E), by striking "and" at the end;

(3) in subparagraph (F), by striking the semicolon at the end and inserting "; and"; and

(4) by adding at the end the following new subparagraph:

"(G) with respect to any home health service—

"(i) the lesser of —

"(I) the reasonable cost of such service, as determined under section 1861(v), or

"(II) the customary charges with respect to such service,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), or

"(ii) if such service is furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2),

less a copayment amount equal to 20 percent of the average of all per visit costs for such service furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year);".

(c) PROVIDER CHARGES.—Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(1) by striking "deduction or coinsurance" and inserting "deduction, coinsurance, or copayment"; and

(2) by striking "or (a)(4)" and inserting "(a)(4), or (a)(5)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 8307. HOME HEALTH COST LIMITS.

(a) REDUCTION IN UPDATE TO ROUTINE COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) in subclause (II), by striking "or" at the end;

(2) in subclause (III), by striking "112 percent," and inserting "and before July 1, 1996, 112 percent, or"; and

(3) by inserting after subclause (III) the following new subclause:

"(IV) July 1, 1996, 100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13564(a)(1) of the Omnibus Budget Reconciliation Act of 1993),".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after July 1, 1996.

PART 2—PROVISIONS RELATING TO PAYMENTS FOR MEDICAL EDUCATION

SEC. 8311. LIMITING MEDICARE MEDICAL EDUCATION PAYMENTS TO APPROVED RESIDENCY POSITIONS.

(a) PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

"(F) REQUIRING RESIDENTS TO MEET APPROVAL UNDER WORKFORCE PROGRAM.—Such rules shall provide that, with respect to a resident whose initial residency period begins on or after July 1, 1998—

"(i) an individual shall be counted only if the individual is in a residency position that, under section 7013 of the Guaranteed Health Insurance Act of 1994, has been allocated to an approved medical residency training program; and

"(ii) the Secretary may not make any payments under this subsection to a hospital unless the number of residents in each of the approved medical residency training programs of the hospital is in accordance with allocations under such section 7013.".

(b) PAYMENT FOR INDIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

"(v) On and after July 1, 1998—

"(I) the Secretary, in determining such adjustment, may count a resident in the calculation of a hospital's ratio of full-time equivalent interns and residents to beds only if the resident is in a residency position that, under section 7013 of the Guaranteed Health Insurance Act of 1994, has been allocated to an approved medical residency training program; and

"(II) the Secretary may not make any payments under this subparagraph to the hospital unless the number of residents in each of the approved medical residency training programs of the hospital is in accordance with allocations under such section 7013.".

SEC. 8312. DETERMINATION OF NUMBER OF FULL-TIME EQUIVALENT RESIDENTS.

(a) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS DURING INITIAL RESIDENCY PERIOD.—

(1) EMPHASIS ON PRIMARY CARE.—Paragraph (4)(C)(ii) of section 1886(h) (42 U.S.C. 1395ww(h)) is amended by striking "is 1.00," and inserting the following: "is—

"(I) 1.1, in the case of a resident who is a primary care resident (as defined in paragraph (5)(H)),

"(II) .8, in the case of a resident not described in subclause (I),".

(2) TREATING OBSTETRICS AND GYNECOLOGY RESIDENTS AS PRIMARY CARE RESIDENTS.—Paragraph (5) of such section is amended—

(A) by striking "or"; and

(B) by striking the period and inserting ", or obstetrics and gynecology.".

(b) Effective Date.—The amendments made by subsection (a) shall apply to portions of cost reporting periods beginning on or after January 1, 1996.

SEC. 8313. PAYMENTS FOR HOSPITALS LOSING SPECIALTY POSITIONS.

Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following subsection:

"(j) Payments for Hospitals Losing Specialty Positions Under Allocation System.—

"(1) In general.—

"(A) Payments.—In the case of each hospital that in accordance with paragraph (3) submits to the Secretary an application for calendar year 1998 or any subsequent calendar year (in this subsection referred to as an 'eligible hospital' for the year involved), the Secretary shall make payments for the year to the hospital in an amount determined in accordance with paragraph (4).

"(B) Source of funds for payments.—Payments under paragraph (1) shall be made from amounts in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, and from amounts in the Medicare Part C Trust Fund under title XXI (in the proportions described in subsection (h)(1), taking into account the proportions of direct medical education costs associated with the provision of services under title XXI).

"(2) Hospitals losing specialty positions; other conditions.—

"(A) Loss of positions.—

"(i) In general.—The Secretary may make payments under paragraph (1) to a hospital for a calendar year only if, as a result of allocations under 7013 of the Guaranteed Health Insurance Act of 1994, the aggregate number of full-time-equivalent specialty positions for the hospital for the academic year in which the calendar year begins (as estimated by the Secretary) is below the aggregate number of such positions for the hospital for academic year 1993.

"(ii) Aggregate number of specialty positions lost.—For purposes of this subsection:

"(I) The term 'aggregate number of specialty positions lost', with respect to a hospital and an academic year, means the difference between the 2 aggregate numbers determined by the Secretary under clause (i) for the hospital.

"(II) The term 'lost position', with respect to an academic year, means a full-time-equivalent specialty position counted in the determination under subclause (I) of the aggregate number of specialty positions lost for the year.

"(B) Compliance with allocation system.—With respect to the approved physician training programs of a hospital, the Secretary may make payments under paragraph (1) only if the hospital agrees to ensure that the numbers of individuals enrolled in the programs is in accordance with allocations made under section 7013 of the Guaranteed Health Insurance Act of 1994 for the programs.

"(3) Application for payments.—For purposes of paragraph (1), an application for payments under such paragraph for a hospital is in accordance with this paragraph if—

"(A) the hospital submits the application not later than the date specified by the Secretary;

"(B) the application demonstrates that the hospital meets the condition described in paragraph (2)(A)(i);

"(C) the application contains each agreement required in this subsection; and

"(D) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary.

"(4) Amount of payments.—The amount of payments required in paragraph (1) to be made to an eligible hospital for a calendar year is an amount equal to the product of—

"(A) the aggregate lost position amount, as defined in paragraph (5) or (6) for the year, as applicable; and

"(B) the medicare patient load of the hospital under subsection (h)(3)(C) for the cost reporting period involved, except that the determination of the medicare patient load for purposes of this subparagraph shall include (in addition to the patients included under such subsection) patients enrolled in the medicare part C program under part A of title XXI.

"(5) Aggregate lost position amount; first year of payments.—For purposes of paragraph (4)(A), the term 'aggregate lost position amount', with respect to the first calendar year for which an eligible hospital receives payments under paragraph (1), means an amount equal to the product of—

"(A) the aggregate number of specialty positions lost (as defined in paragraph (2)(A)(ii)(I)); and

"(B) an amount equal to 100 percent of the national average FTE training amount in effect for the year under section 7024(c)(3) of the Guaranteed Health Insurance Act of 1994 (or, as the case may be, 100 percent of the alternative amount that applies to the hospital under section 7024(c)(3)(D) or section 7025 of such Act).

"(6) Aggregate lost position amount; subsequent years of payments.—For purposes of paragraph (4)(A), the term 'aggregate lost position amount', with respect to the second or subsequent calendar year for which an eligible hospital receives payments under paragraph (1), means an amount equal to the sum of subparagraphs (A) through (D), as follows:

"(A) An amount equal to the product of—

"(i) the aggregate number of specialty positions lost, less an amount equal to the sum of—

"(I) the number of lost positions for which payments are being made for the calendar year pursuant to subparagraphs (B) through (D); and

"(II) the total number of lost positions for which, in determinations under this paragraph for the hospital for prior calendar years, the percentage applicable to the national average or alternative amount referred to in paragraph (5)(B) was 25 percent; and

"(ii) 100 percent of such national average or alternative amount applicable for the year involved.

"(B) An amount equal to the product of—

"(i) the number of lost positions for which, in the determination under this paragraph for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 100 percent, subject to paragraph (7) (relating to decreases in aggregate numbers); and

"(ii) 75 percent of the national average or alternative amount applicable for the year involved.

"(C) An amount equal to the product of—

"(i) the number of lost positions for which, in the determination under this paragraph for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 75 percent, subject to paragraph (7); and

"(ii) 50 percent of the national average or alternative amount applicable for the year involved.

"(D) An amount equal to the product of—

"(i) the number of lost positions for which, in the determination under this paragraph for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 50 percent, subject to paragraph (7); and

"(ii) 25 percent of the national average or alternative amount applicable for the year involved.

"(7) Rule regarding decrease in aggregate number of specialty positions lost.—With respect to payments under paragraph (1) for an eligible hospital for a calendar year, if the aggregate number of specialty positions lost for the academic year involved is less than such number for the preceding academic year (which difference between the 2 aggregate numbers is referred to in this paragraph as the "decrease in the number of lost positions"), the following applies:

"(A) The Secretary shall identify the number of lost positions for which, as determined under paragraph (6) without regard to this paragraph, the percentage applicable to payments for the calendar year is 75 percent, the number of such positions for which such percentage is 50 percent, and the number of such positions for which such percentage is 25 percent.

"(B) In the case of the lost positions so identified, the Secretary shall apply the decrease in the number of lost positions as follows:

"(i) First, as a reduction in the number of positions for which the percentage applicable is 75 percent.

"(ii) Second (for any remaining portions of the decrease after compliance with clause (i)), as a reduction in the number of positions for which such percentage is 50 percent.

"(iii) Third (for any remaining portions of the decrease after compliance with clause (ii)), as a reduction in the number of positions for which such percentage is 25 percent.

"(8) Definitions.—For purposes of this subsection, the terms 'academic year', 'approved physician training program', 'full-time-equivalent specialty position', and 'specialty position', each has the meaning given the term under section 7081 of the Guaranteed Health Insurance Act of 1994.".

SEC. 8314. MEDICARE DEMONSTRATION REGARDING CONSORTIA OF HOSPITALS.

(a) In General.—The Secretary shall establish and conduct not more than 10 demonstration projects to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice under which the Secretary shall make payments in accordance with subsection (c) to participating health care training consortia.

(b) Applications.—Each consortium desiring to participate in a demonstration project under this section shall prepare and submit to the Secretary an application at such time and in such manner as the Secretary may require, and containing—

(1) assurances that not less than 55 percent of all residents participating in approved residency training programs conducted by members of the consortium are primary care residents (as defined in section 1886(h)(5)(H) of the Social Security Act); and

(2) such other information and assurances as the Secretary may require.

(c) Payments to Participants.—

(1) In general.—Notwithstanding any provision of title XVIII of the Social Security Act—

(A) in the case of a consortium participating in a demonstration project under this subtitle, the Secretary shall make payments under such title for the direct and indirect costs of graduate medical education of members of the consortium to the consortium (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium), except that the amount paid to the consortium shall be based on the designations described in paragraph (2); and

(B) the Secretary may not make any payment under such title to a member of a consortium for the direct and indirect costs of graduate medical education during the period of the consortium's participation in the demonstration project.

(2) DESIGNATION OF RESIDENTS BY CONSORTIUM.—Each consortium participating in a demonstration project shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the amount paid to the consortium under paragraph (1)(A). Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

(3) LIMIT ON PAYMENT.—The amount paid to a consortium under paragraph (1)(A) during a year may not exceed the Secretary's estimate of the sum of the payments that would have been made under title XVIII to each member of the consortium during the year but for the application of this section, determined as if such payments were based on—

(A) the number of full-time-equivalent residents in approved medical residency training programs of the member calculated under section 1886(h)(4) of the Social Security Act during the academic year beginning July 1, 1993; and

(B) the ratio of the member's full-time equivalent interns and residents to beds applicable under section 1886(d)(5)(B)(ii) of such Act for discharges occurring during the 12-month cost reporting period beginning or after July 1, 1993.

(d) DURATION.—A demonstration project under this section shall be conducted for a period not to exceed 10 years. The Secretary may terminate a project if the Secretary determines that the consortium participating in the project is not in substantial compliance with the terms of the application approved by the Secretary.

(e) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—Each consortium participating in a demonstration project shall submit to the Secretary a final evaluation within 360 days of the termination of the consortium's participation and such interim evaluations as the Secretary may require.

(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this section begins, and annually thereafter for each year in which such a project is conducted, the Secretary shall submit a report to Congress which evaluates the effectiveness of the consortium activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(f) DEFINITIONS.—In this section:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term "approved medical residency training program" has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act.

(2) HEALTH CARE TRAINING CONSORTIUM.—The term "health care training consortium" means a State, regional, or local entity consisting of at least 2 hospitals operating approved medical residency training programs.

(3) RESIDENT.—The term "resident" has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

SEC. 8315. STUDY OF PAYMENTS FOR MEDICAL EDUCATION AT SITES OTHER THAN HOSPITALS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the feasibility and desirability of making payments to facilities, from sources including the Health Care Workforce Trust Fund under title VII and the Trust Funds established under title XVIII of the Social Security Act, that are not hospitals for the direct and indirect costs of graduate medical education attributable to residents trained at such facilities. In conducting the study, the Secretary shall evaluate new payment methodologies—

(1) under which each entity which incurs costs of graduate medical education shall receive reimbursement for such costs; and

(2) which would encourage the training of primary care physicians.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress a report on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate.

PART 3—ASSISTANCE FOR PROVIDERS SERVING LOW-INCOME AND UNDERSERVED POPULATIONS

SEC. 8321. INCREASE IN PAYMENTS FOR FEDERALLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting after "1861(v)(1)(A)," the following: "and, in the case of services described in subparagraph (D)(ii) of such section, which include any costs associated with participation in an approved medical residency training program (as defined in section 1886(h)(5)(A)) as determined based on the portion of time spent by a resident or intern at the center and adjusted by a factor reflecting the relative indirect and direct costs of such participation,".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to costs incurred on or after January 1, 1996.

SEC. 8322. CHANGES IN UNDERSERVED AREA BONUS PAYMENTS.

(a) INCREASE IN AMOUNT OF PAYMENT FOR PRIMARY CARE SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

(A) by striking "10 percent" and inserting "a percent",

(B) by striking "service" the last place it appears and inserting "services", and

(C) by adding the following new sentence: "The percent referred to in the previous sentence is 20 percent in the case of primary care services, as defined in section 1842(i)(4), and 10 percent for services other than primary care services furnished in health professional shortage areas located in rural areas as defined in section 1886(d)(2)(D).".

(b) EXTENSION TO SERVICES FURNISHED IN AREAS LOSING DESIGNATION.—Section 1833(m) of such Act (42 U.S.C. 1395l(m)) is amended by striking "area," and inserting "area (or was designated as such an area at any time during the 36-month period ending on the date the services are furnished),".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to services furnished on or after January 1, 1998.

SEC. 8323. ESSENTIAL ACCESS COMMUNITY HOSPITALS.

(a) INCREASING NUMBER OF PARTICIPATING STATES.—Section 1820(a)(1) of the Social Security Act (42 U.S.C. 1395i-4(a)(1)) is amended by striking "not more than 7".

(b) TREATMENT OF INPATIENT HOSPITAL SERVICES PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

(1) IN GENERAL.—Section 1820(f)(1)(F) of such Act (42 U.S.C. 1395i-4(f)(1)(F)) is amended to read as follows:

"(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care to patients requiring stabilization before discharge or transfer to a hospital, except that the facility may not provide any inpatient hospital services—

"(i) to any patient whose attending physician does not certify that the patient may reasonably be expected to be discharged or transferred to a hospital within 72 hours of admission to the facility; or

"(ii) consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A)), unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.".

(2) LIMITATION ON AVERAGE LENGTH OF STAY.—Section 1820(f) of such Act (42 U.S.C. 1395i-4(f)) is amended by adding at the end the following new paragraph:

"(4) LIMITATION ON AVERAGE LENGTH OF INPATIENT STAYS.—The Secretary may terminate a designation of a rural primary care hospital under paragraph (1) if the Secretary finds that the average length of stay for inpatients at the facility during the previous year in which the designation was in effect exceeded 72 hours. In determining the compliance of a facility with the requirement of the previous sentence, there shall not be taken into account periods of stay of inpatients in excess of 72 hours to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.".

(3) CONFORMING AMENDMENT.—Section 1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is amended by striking "such services" and all that follows and inserting "the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital.".

(4) GAO REPORTS.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit reports to Congress on—

(A) the application of the requirements under section 1820(f) of the Social Security Act (as amended by this subsection) that rural primary care hospitals provide inpatient care only to those individuals whose attending physicians certify may reasonably be expected to be discharged within 72 hours after admission and maintain an average length of inpatient stay during a year that does not exceed 72 hours; and

(B) the extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited the ability of such hospitals to provide needed services.

(c) DESIGNATION OF HOSPITALS.—

(1) PERMITTING DESIGNATION OF HOSPITALS LOCATED IN URBAN AREAS.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i-4) is amended—

(i) by amending paragraph (1) of subsection (e) to read as follows:

"(1) is participating in a rural health network that includes at least one rural primary care hospital designated by the State under subsection (f);";

(ii) in subsection (e)(2)(A)—

(I) by striking "is located" and inserting "except in the case of a hospital located in an urban area, is located",

(II) by striking ", (ii)" and inserting "or (ii)", and

(III) by striking "or (iii)" and all that follows through "section,"; and

(iii) in subsection (i)(1)(B), by striking "paragraph (3)" and inserting "paragraph (2)".

(B) NO CHANGE IN MEDICARE PROSPECTIVE PAYMENT.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(i) in clause (iii)(III), by inserting "located in a rural area and" after "that is", and

(ii) in clause (v), by inserting "located in a rural area and" after "in the case of a hospital".

(2) PERMITTING HOSPITALS LOCATED IN ADJOINING STATES TO PARTICIPATE IN STATE PROGRAM.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i-4) is amended—

(i) by redesignating subsection (k) as subsection (l); and

(ii) by inserting after subsection (j) the following new subsection:

"(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN PARTICIPATING STATES.—Notwithstanding any other provision of this section—

"(1) for purposes of including a hospital or facility as a member institution of a rural health network, a State may designate a hospital or facility that is not located in the State as an essential access community hospital or a rural primary care hospital if the hospital or facility is located in an adjoining State and is otherwise eligible for designation as such a hospital;

"(2) the Secretary may designate a hospital or facility that is not located in a State receiving a grant under subsection (a)(1) as an essential access community hospital or a rural primary care hospital if the hospital or facility is a member institution of a rural health network of a State receiving a grant under such subsection; and

"(3) a hospital or facility designated pursuant to this subsection shall be eligible to receive a grant under subsection (a)(2).".

(B) CONFORMING AMENDMENTS.—(i) Section 1820(c)(1) of such Act (42 U.S.C. 1395i-4(c)(1)) is amended by striking "paragraph (3)" and inserting "paragraph (3) or subsection (k)".

(ii) Paragraphs (1)(A) and (2)(A) of section 1820(i) of such Act (42 U.S.C. 1395i-4(i)) are each amended—

(I) in clause (i), by striking "(a)(1)" and inserting "(a)(1) (except as provided in subsection (k))", and

(II) in clause (ii), by striking "subparagraph (B)" and inserting "subparagraph (B) or subsection (k)".

[*New*] (3) ELIGIBILITY OF INDIAN HEALTH SERVICE FACILITIES FOR DESIGNATION AS RURAL PRIMARY CARE HOSPITALS.—Section 1820(i)(2) (42 U.S.C. 1395i@4(i)(2)) is amended by adding at the end the following new subparagraph:

"(D) The Secretary may designate a [facility of the Indian Health Service] as a rural primary care hospital under this section if the facility meets the requirements applicable to a hospital described in subparagraph (C) and elects to be treated as such a hospital under this title. No facility designated by the Secretary under this subparagraph shall be taken into account under subparagraph (C) in determining the number of hospitals designated by the Secretary under this paragraph.".

(d) SKILLED NURSING SERVICES IN RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(3) (42 U.S.C. 1395i-4(f)(3)) is amended by striking "because the facility" and all that follows and inserting the following: "because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital.".

(e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—Section 1814(l)(2) of such Act (42 U.S.C. 1395f(l)(2)) is amended by striking "January 1, 1993" and inserting "January 1, 1996".

(f) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in paragraph (1), by striking "during a year before 1993" and inserting "during a year before the prospective payment system described in paragraph (2) is in effect"; and

(B) in paragraph (2), by striking "January 1, 1993," and inserting "January 1, 1996,".

(2) NO USE OF CUSTOMARY CHARGE IN DETERMINING PAYMENT.—Section 1834(g)(1) of such Act (42 U.S.C. 1395m(g)(1)) is amended by adding at the end the following new flush sentence:

"The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.".

(g) REQUIREMENTS RELATING TO RURAL HEALTH CARE PLAN.—

(1) IN GENERAL.—Section 1820(b)(1)(A) of such Act (42 U.S.C. 1395i-4(b)(1)(A)) is amended—

(A) by striking "and" at the end of clause (iii);

(B) by striking the semicolon at the end of clause (iv) and inserting ", and"; and

(C) by adding at the end the following new clause:

"(v) meets such other requirements as the Secretary may establish regarding the quality and effectiveness of such plans;".

(2) TECHNICAL ASSISTANCE.—At the request of a State submitting an application for a grant under section 1820 of the Social Security Act, the Secretary of Health and Human Services shall provide technical assistance to the State for the development of the State's rural health care plan described in section 1820(b)(1) of such Act.

(h) SERVICE AREA OF FACILITIES INCLUDED IN RURAL HEALTH NETWORKS.—Section 1820(g) of such Act (42 U.S.C. 1395i-4(g)) is amended—

(1) by striking "and" at the end of paragraph (1);

(2) by striking the period at the end of paragraph (2) and inserting ", and"; and

(3) by adding at the end the following new paragraph:

"(3) the members of which provide services in the same general geographic area (in accordance with criteria established by the Secretary).".

(i) PAYMENT FOR SERVICES OF ESSENTIAL ACCESS COMMUNITY HOSPITALS.—

(1) REPEAL OF CATEGORICAL TREATMENT AS SOLE COMMUNITY HOSPITAL.—Section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii)) is amended—

(A) by adding "or" at the end of subclause (I);

(B) by striking "or" at the end of subclause (II); and

(C) by striking subclause (III).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1996.

(3) REPORT ON APPROPRIATE PAYMENT METHODOLOGY.—Not later than September 1, 1995, the Prospective Payment Assessment Commission shall submit a report to Congress recommending appropriate adjustments in the methodology used to determine the amounts paid to essential access community hospitals for the operating costs of inpatient hospital services under part A of the medicare program to take into account the special needs of such hospitals.

(j) CLARIFICATION OF PHYSICIAN STAFFING REQUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(1)(H) of such Act (42 U.S.C. 1395i-4(f)(1)(H)) is amended by striking the period and inserting the following: ", except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).".

(k) TECHNICAL AMENDMENTS RELATING TO PART A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILLNESS.—(1) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)) is amended—

(A) by striking "inpatient hospital services" the first place it appears and inserting "inpatient hospital services or inpatient rural primary care hospital services";

(B) by striking "inpatient hospital services" the second place it appears and inserting "such services"; and

(C) by striking "and inpatient rural primary care hospital services".

(2) Sections 1813(a) and 1813(b)(3)(A) of such Act (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking "inpatient hospital services" each place it appears and inserting "inpatient hospital services or inpatient rural primary care hospital services".

(3) Section 1813(b)(3)(B) of such Act (42 U.S.C. 1395e(b)(3)(B)) is amended by striking "inpatient hospital services" and inserting "inpatient hospital services, inpatient rural primary care hospital services".

(4) Section 1861(a) of such Act (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by striking "inpatient hospital services" and inserting "inpatient hospital services, inpatient rural primary care hospital services"; and

(B) in paragraph (2), by striking "hospital" and inserting "hospital or rural primary care hospital".

(l) AUTHORIZATION OF APPROPRIATIONS.—Section 1820(l) of such Act (42 U.S.C. 1395i-4(l)), as redesignated by subsection (c)(2)(A), is amended by striking "Trust Fund" and all that follows and inserting the following: "Trust Fund—

"(1) for each of the fiscal years 1990 through 1994—

"(A) $10,000,000 for grants to States under subsection (a)(1), and

"(B) $15,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2); and

"(2) for each of the fiscal years 1995 through 1999—

"(A) $50,000,000 for grants to States under subsection (a)(1), and

"(B) $40,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2).".

(m) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 8324. MEDICARE TELEMEDICINE PILOT PROJECTS.

(a) ESTABLISHMENT OF PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish not more than 10 pilot projects to investigate over a 3-year period the effectiveness of the use of rural health care provider telemedicine networks to provide coverage of physician consultative services provided with respect to the provision of other services under part B of the medicare program in rural areas.

(2) NETWORKS DEFINED.—In this section, the term "rural health care provider telemedicine network" (hereafter referred to as a "network") means a network of providers that meets the following requirements:

(A) The network serves physicians, clinics (including rural health clinics described in section 1861(aa)(2) of the Social Security Act), and other non-tertiary care providers in a rural area who have entered into agreements with a multi-specialty tertiary care provider who has agreed to provide physician consultative services (without regard to whether or not such tertiary care provider is in the rural area) regarding patient referral and transfer, the use of joint communications systems, and the provision of emergency and non-emergency transportation among the network members.

(B) The area in which the network operates is a rural area designated as a health professional shortage area (under section 332(a) of the Public Health Service Act) or is an underserved rural area in accordance with such other criteria as the Secretary may specify.

(b) MEDICARE PAYMENT FOR PARTICIPANTS.—

(1) IN GENERAL.—Under the projects established under this section, the Secretary shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act in accordance with the methodology described in paragraph (2) for physicians' consultation services provided by the tertiary care services consisting of a professional consultation to an individual or entity in the network furnishing a service for which payment may be made under such part to a medicare beneficiary in a rural area, notwithstanding that the individual providing the professional consultation is not at the same location as the individual furnishing the service to the medicare beneficiary.

(2) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the amount of funds available for payments under the project, the Secretary shall establish a methodology for determining the amount of payments made under paragraph (1), and shall include in the methodology a method for making payment for reasonable costs incurred in the usage of signal transmission facilities suitable for the conduct of physician consultative services.

(c) ELIGIBILITY OF NETWORKS.—

(1) IN GENERAL.—A network is eligible to participate in a pilot project under this section if—

(A) the network submits to the Secretary (at such time and in such form as the Secretary may require) an application containing—

(i) information and assurances that the members of the network have entered into such agreements as are necessary to operate the network,

(ii) information and assurances that the network has available the appropriate technology for providing remote consultations, and

(iii) such other information and assurances as the Secretary may require; and

(B) the network agrees to submit to the Secretary such information as the Secretary may require to determine the amount of payments described in subsection (b)(2), to prepare reports under subsection (e), and to otherwise carry out the project.

(2) RURAL AREA DEFINED.—In this section, the term "rural area" has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

(d) CRITERIA FOR SELECTING PARTICIPANTS.—

(1) TECHNOLOGY APPLIED.—In selecting among eligible networks for participation in pilot projects under this section, the Secretary shall give priority to networks that provide for consultations between patients and medical specialists involving transmission of detailed data on the patient in a manner that serves as a reasonable substitute for in-person interaction between the patients and the specialists.

(2) PERMITTING EXISTING NETWORKS TO PARTICIPATE.—Nothing in this section may be construed to prohibit the Secretary from selecting a network operating at the time of the establishment of the pilot projects for participation in the project.

(e) REPORTS.—

(1) INTERIM REPORT ON PARTICIPATING SITES.—Not later than 24 months after the Secretary first makes payment under subsection (b) for services under a pilot project, the Secretary shall submit a report to Congress describing the projects and the networks participating in the projects under this section, including a description of the amounts expended and the number of patients served under the projects;

(2) FINAL.—Not later than 1 year after the termination of the projects, the Secretary shall submit a final report to Congress describing the operation of the projects and containing—

(A) the Secretary's analysis of the projects' cost-effectiveness and success in promoting the access of providers of health care services in rural areas to consultation services of specialist physicians;

(B) the Secretary's analysis of the impact of the projects on the ability of patients to obtain a higher quality and greater range of care; and

(C) such recommendations as the Secretary considers appropriate for changes in the medicare program relating to telemedicine, including estimates of the costs associated with any such changes.

(f) LIMITATION ON AMOUNT EXPENDED UNDER PROJECTS.—The total amount expended from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act for services under the demonstration project under this section may not exceed $25,000,000.

SEC. 8325. TREATMENT OF OTHER INDIAN FACILITIES AS INDIAN HEALTH SERVICE FACILITIES.

(a) IN GENERAL.—Section 1880(a) (42 U.S.C. 1395qq(a)) is amended by striking "facility of the Indian Health Service, whether operated by such service" and inserting "facility operated by the Indian Health Service".

(b) CLARIFICATION OF COVERAGE OF HOSPITAL OUTPATIENT SERVICES.—Section 1880(a) (42 U.S.C. 1395qq(a)) is amended by inserting "(including payments for services described in section 1832(a)(2)(B))" after "under this title".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to portions of cost reporting periods beginning on or after January 1, 1999.

PART 4—APPLICATION OF QUALITY MANAGEMENT AND ADMINISTRATIVE REFORM UNDER GUARANTEED HEALTH INSURANCE ACT OF 1994

SEC. 8331. INTEGRATION OF MEDICARE INTO NATIONAL QUALITY MANAGEMENT PROGRAM.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a detailed proposal for legislation to provide for the integration of the medicare program into the National Quality Management Program through—

(1) the incorporation of information provided by medicare beneficiaries into the consumer surveys described in section 9002;

(2) the incorporation of information on the quality of services provided under the medicare program, as measured by the national measures of quality performance established under section 9003, into the performance reports described in section 9003(g);

(3) the transfer to approved quality improvement organizations, on a State-by-State basis over a 5-year period, of functions being performed by both approved quality improvement organizations and utilization and quality control peer review organizations entering into contracts with the Secretary under part B of title XI of the Social Security Act (without regard to whether the organizations with contracts under such part perform such functions on a multi-State basis); and

(4) the retention by such peer review organizations of functions the organizations are required to perform under such Act that do not overlap with functions that are required to be performed by approved quality improvement organizations under this part.

SEC. 8332. COORDINATION OF MEDICARE CARDS WITH HEALTH SECURITY CARDS.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

"COORDINATION OF CARDS

"SEC. 1805. In issuing identification cards for individuals entitled to benefits under this title, the Secretary shall assure that such cards conform to the standards established for health security cards under section 9101(c) of the Guaranteed Health Insurance Act of 1994.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect January 1, 1997.

SEC. 8333. ELIMINATION OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

Effective upon full implementation of the national enrollment verification system under section 9102—

(1) no employer is required to make any reports under section 1144(c) of the Social Security Act; and

(2) information and functions previously in or performed by the Medicare and Medicaid

Coverage Data Bank under section 1144 of such Act shall be subsumed by the enrollment verification system.

SEC. 8334. REQUIREMENT FOR UNIFORM HOSPITAL COST REPORTING.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (P), by striking "and" at the end;

(2) by striking the period at the end of subparagraph (Q) and inserting ", and"; and

(3) by inserting after subparagraph (Q) the following:

"(R) in the case of a hospital or a rural primary care hospital, to report information in a uniform manner consistent with standards established by the Secretary to carry out section 4007(c) of the Omnibus Budget Reconciliation Act of 1987 and in an electronic form, consistent with standards established by the Secretary.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after October 1, 1994.

SEC. 8335. APPLICATION OF HEALTH INFORMATION AND INFORMATION TRANSACTION REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.

(a) FISCAL INTERMEDIARIES UNDER PART A.—Section 1816(f) (42 U.S.C. 1395h(f)) is amended by adding at the end the following new paragraph:

"(3) The standards and criteria under paragraph (1) shall include requirements that the agency or organization meet the following requirements applicable under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 to a sponsor of an administered health plan:

"(A) Health information standards under section 9103 of such Act.

"(B) Standards relating to transactions and information under section 9104 of such Act.

"(C) Standards relating to the acceptance of claims and attachments and limitations on other transactions under section 9105 of such Act.".

(b) CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(4) Each contract under this section shall include requirements that the carrier meet the following requirements applicable under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 to a sponsor of an administered health plan:

"(A) Health information standards under section 9103 of such Act.

"(B) Standards relating to transactions and information under section 9104 of such Act.

"(C) Standards relating to the acceptance of claims and attachments and limitations on other transactions under section 9105 of such Act.".

SEC. 8336. APPLICATION OF RESTRICTIONS ON DISCLOSURE AND USE OF HEALTH INFORMATION.

Part A of title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

"RESTRICTIONS ON DISCLOSURE OF HEALTH INFORMATION

"SEC. 1145. The provisions of subtitle C of title IX of the Guaranteed Health Insurance Act of 1994 shall apply with respect to health information relating to individuals entitled to benefits under part A of title XVIII in the same manner as such provisions apply with respect to health information relating to other individuals under such subtitle.".

PART 5—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS

SEC. 8341. ANTI-KICKBACK STATUTORY PROVISIONS.

(a) REVISION TO PENALTIES.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking "or" at the end of paragraphs (1) and (2);

(B) by striking the semicolon at the end of paragraph (3) and inserting "; or"; and

(C) by inserting after paragraph (3) the following new paragraph:

"(4) carries out any activity in violation of paragraph (1) or (2) of section 1128B(b);".

(2) DESCRIPTION OF CIVIL MONETARY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking "given)." at the end of the first sentence and inserting the following: "given or, in cases under paragraph (4), $50,000 for each such violation)."; and

(B) by striking "claim." at the end of the second sentence and inserting the following: "claim (or, in cases under paragraph (4), damages of not more than three times the total amount of remuneration offered, paid, solicited, or received).".

(3) INCREASE IN CRIMINAL PENALTY.—Paragraphs (1) and (2) of section 1128B(b) (42 U.S.C. 1320a–7b(b)) are each amended—

(A) by striking "$25,000" and inserting "$50,000"; and

(B) by striking the period at the end and inserting the following: ", and shall be subject to damages of not more than three times the total remuneration offered, paid, solicited, or received.".

(b) REVISIONS TO EXCEPTIONS.—

(1) EXCEPTION FOR DISCOUNTS.—Section 1128B(b)(3)(A) (42 U.S.C. 1320a–7b(b)(3)(A)) is amended by striking "program;" and inserting "program and is not in the form of a cash payment;".

(2) EXCEPTION FOR PAYMENTS TO EMPLOYEES.—Section 1128B(b)(3)(B) (42 U.S.C. 1320a–7b(b)(3)(B)) is amended by inserting at the end "if the amount of remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals, except that such employee can be paid remuneration in the form of a productivity bonus based on services personally performed by the employee.".

(3) EXCEPTION FOR WAIVER OF COINSURANCE BY CERTAIN PROVIDERS.—Section 1128B(b)(3)(D) (42 U.S.C. 1320a–7b(b)(3)(D)) is amended to read as follows:

"(D) a waiver or reduction of any coinsurance or other copayment if—

"(i) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

"(ii) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

"(iii) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

"(iv) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

"(v) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan under title XXII; and".

(4) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(C) by adding at the end the following new subparagraphs:

"(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under any of the following:

"(i) A health plan which is furnishing items or services under a risk-sharing contract under section 1876 or section 1903(m).

"(ii) A health plan receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972; and

"(G) any amounts paid to a provider for an item or service furnished to an individual or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under a health plan under which the provider furnishing the item or service is paid by the health plan for furnishing the item or service only on a capitated basis pursuant to a written arrangement between the plan and the provider in which the provider assumes financial risk for furnishing the item or service.".

(c) AUTHORIZATION FOR THE SECRETARY TO ISSUE REGULATIONS.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

"(4) The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions described in paragraph (3).".

(d) CLARIFICATION OF OTHER ELEMENTS OF OFFENSE.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended—

(1) in paragraph (1)(A), by striking "in return for referring" and inserting "to refer";

(2) in paragraph (1)(B), by striking "in return for purchasing, leasing, ordering, or arranging for or recommending" and inserting "to purchase, lease, order, or arrange for or recommend"; and

(3) by adding at the end of paragraphs (1) and (2) the following sentence: "A violation exists under this paragraph if one or more purposes of the remuneration is unlawful under this paragraph.".

SEC. 8342. CIVIL MONEY PENALTIES.

(a) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by section 8341(a)(1), is amended—

(A) by striking "; or" at the end of paragraph (3) and inserting a semicolon;

(B) by striking the semicolon at the end of paragraph (4) and inserting "; or"; and

(C) by inserting after paragraph (4) the following new paragraph:

"(5) offers, pays, or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program, other than to influence an individual enrolled in a managed care plan or a point-of-service plan (as defined in section 2204) to receive benefits under the plan in accordance with established practice patterns for the delivery of medically necessary services;".

(2) REMUNERATION DEFINED.—Section 1128A(i) of such Act (42 U.S.C. 1320a-7a(i)) is amended by adding at the end the following new paragraph:

"(6) The term 'remuneration' includes the waiver or reduction of coinsurance amounts, and transfers of items or services for free or for other than fair market value, except that such term does not include the waiver or reduction of coinsurance amounts by a person or entity, if—

"(A) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

"(B) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

"(C) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

"(D) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

"(E) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan under title XXII.".

(b) ADDITIONAL OFFENSES.—Section 1128A(a) of such Act, as amended by section 8341(a)(1) and subsection (a)(1), is further amended—

(1) by striking "or" at the end of paragraph (4);

(2) by striking the semicolon at the end of paragraph (5) and inserting "; or"; and

(3) by inserting after paragraph (5) the following new paragraphs:

"(6) engages in a practice which has the effect of limiting or discouraging (as compared to other plan enrollees) the utilization of medically necessary health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

"(7) substantially fails to cooperate with a quality assurance program or a utilization review activity;

"(8) engaging in a pattern of failing substantially to provide or authorize medically necessary items and services that are required to be provided to an individual covered under a health plan under the Guaranteed Health Insurance Act of 1994 or public program for the delivery of or payment for health care items or services, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individual; or

"(9) submits false or fraudulent statements, data or information on claims to the Secretary, a State health care agency, or any other Federal, State or local agency charged with implementation or oversight of a health plan or a public program that the person knows or should know is fraudulent;".

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)), as amended by section 8341(a), subsection (a)(1), and subsection (b), is amended in the matter following paragraph (9)—

(1) by striking "$2,000" and inserting "$10,000";

(2) by inserting after "under paragraph (4), $50,000 for each such violation" the following: "; in cases under paragraph (5), $10,000 for each such offer, payment, or transfer; in cases under paragraphs (6) through (9), an amount not to exceed $10,000 for each such determination by the Secretary"; and

(3) by striking "twice the amount" and inserting "three times the amount".

(d) INTEREST ON PENALTIES.—Section 1128A(f) (42 U.S.C. 1320a-7a(f)) is amended by adding after the first sentence the following: "Interest shall accrue on the penalties and assessments imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where the penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of penalties and assessments owed to cover the costs of collection.".

(e) AUTHORIZATION TO ACT.—

(1) IN GENERAL.—The first sentence of section 1128A(c)(1) (42 U.S.C. 1320a-7a(c)(1)) is amended by striking all that follows "(b)" and inserting the following: "unless, within one year after the date the Secretary presents a case to the Attorney General for consideration, the Attorney General brings an action in a district court of the United States.".

(2) EFFECTIVE DATE.—The amendment made by this paragraph (1) shall apply to cases presented by the Secretary of Health and Human Services for consideration on or after the date of the enactment of this Act.

(f) DEPOSIT OF PENALTIES COLLECTED INTO ALL-PAYER ACCOUNT.—Section 1128A(f)(3) (42 U.S.C. 1320a-7a(f)(3)) is amended by striking "as miscellaneous receipts of the Treasury of the United States" and inserting "in the All-Payer Health Care Fraud and Abuse Control Account established under section [9212] of Guaranteed Health Insurance Act of 1994".

(g) CLARIFICATION OF PENALTY IMPOSED ON EXCLUDED PROVIDER FURNISHING SERVICES.—Section 1128A(a)(1)(D) (42 U.S.C. 1320a-7a(a)(1)(D)) is amended by inserting "who furnished the service" after "in which the person".

SEC. 8343. AMENDMENTS TO EXCLUSIONARY PROVISIONS IN FRAUD AND ABUSE PROGRAM.

(a) MANDATORY EXCLUSION OF INDIVIDUAL CONVICTED OF CRIMINAL OFFENSE RELATED TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a-7(a)) is amended by adding at the end the following new paragraph:

"(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted under Federal or State law, in connection with the delivery of a health care item or service on or after January 1, 1996, or with respect to any act or omission on or after such date in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) (42 U.S.C. 1320a-7(b)(1)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.—

(1) IN GENERAL.—Section 1128(c)(3) (42 U.S.C. 1320a-7(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraphs (1), (2), or (3) of subsection (b), the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that an alternative period is appropriate because of aggravating or mitigating circumstances.

"(E) In the case of an exclusion of an individual or entity under paragraph (4) or (5) of subsection (b), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

"(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.".

(2) CONFORMING AMENDMENT.—Section 1128(c)(3)(A) (42 U.S.C. 1320a-7(c)(3)(A)) is amended by striking "subsection (b)(12)" and inserting "paragraph (1), (2), (3), (4), (6)(B), or (12) of subsection (b)".

(c) FAILURE TO PROVIDE INFORMATION AS GROUNDS FOR PERMISSIVE EXCLUSION UNDER MEDICARE AND MEDICAID.—Section 1128(b)(9) (42 U.S.C. 1320a-7(b)(9)) is amended by striking the period at the end and inserting ", or provide any information requested by the Attorney General or the Inspector General of the Department of Health and Human Services to carry out the All-Payer Health Care Fraud and Abuse Control Program established under section [9211] of the Guaranteed Health Insurance Act of 1994.";

SEC. 8344. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS RELATING TO QUALITY OF CARE.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is

amended by striking "may prescribe)" and inserting "may prescribe, except that such period may not be less than one year)".

(2) Conforming Amendment.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking "shall remain" and inserting "shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain".

(b) Amount of Civil Money Penalty.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3)) is amended by striking "the actual or estimated cost" and inserting the following: "$10,000 for each instance".

(c) Repeal of "Unwilling or Unable" Condition for Imposition of Sanction.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking "and determines" and all that follows through "such obligations," and

(2) by striking the third sentence.

SEC. 8345. REVISIONS TO CRIMINAL PENALTIES.

(a) Treble Damages for Criminal Sanctions.—Section 1128B (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

"(f) In addition to the fines that may be imposed under subsection (a) or (c) any individual found to have violated the provisions of any of such subsections may be subject to treble damages.".

(b) Identification of Community Service Opportunities.—Section 1128B (42 U.S.C. 1320a–7b), as amended by subsection (a), is further amended by adding at the end the following new subsection:

"(g) The Secretary shall—

"(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

"(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.".

SEC. 8346. EFFECTIVE DATE.

The amendments made by this part shall take effect January 1, [1996].

PART 6—REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRALS

SEC. 8351. APPLICATION OF BAN ON SELF-REFERRALS TO CLAIMS SUBMITTED BY PHYSICIANS.

Section 1877(a)(1)(B) (42 U.S.C. 1395nn(a)(1)(B)) is amended to read as follows:

"(B) no physician or entity may present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).".

SEC. 8352. EXPANSION OF SELF-REFERRAL BAN TO ADDITIONAL SERVICES.

Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)) is amended—

(1) in subparagraph (D), by striking "or other diagnostic"; and

(2) by adding at the end the following new subparagraphs:

"(L) Home infusion drug therapy services (other than services consisting of the furnishing of infusion pumps).

"(M) Any other item or service not rendered by the physician personally or by a person under the physician's direct supervision.".

SEC. 8353. EXCEPTIONS FOR BOTH OWNERSHIP AND COMPENSATION ARRANGEMENTS.

(a) Repeal of Exception for Physicians' Services.—Section 1877(b) (42 U.S.C. 1395nn(b)) is amended by striking paragraph (1).

(b) Revision to In-Office Ancillary Services Exception.—

(1) In general.—Section 1877(b) (42 U.S.C. 1395nn(b)(1)), as amended by subsection (a), is amended by striking "Subsection (a)(1) shall not apply in the following cases" and all that follows through paragraph (2) and inserting the following:

"(1) In-office ancillary services of sole practitioners.—Subsection (a)(1) shall not apply in the case of designated health services—

"(A) that are furnished—

"(i) personally by the referring physician or personally by individuals who are directly supervised by the physician,

"(ii) in an office location in which the referring physician furnishes physicians' services unrelated to the furnishing of designated health services, and

"(iii) using equipment that is wholly owned or leased exclusively by the referring physician; and

"(B) that are billed by the physician performing or supervising the services or by an entity that is wholly owned by such physician,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"(2) In-office ancillary services of physicians in group practice.—Subject to subsection (h)(4)(C), subsection (a)(1) shall not apply in the case of designated health services—

"(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by any physician who is a member of such group practice;

"(B) that are furnished in a building in which a physician who is a member of the group practice furnishes physicians' services unrelated to the furnishing of designated health services;

"(C) that are furnished using equipment that is owned or leased exclusively by the physician group; and

"(D) that are billed by the group practice of which the physician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by such group practice,

unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse.".

(2) Requirements for group practice.—Section 1877(h)(4) (42 U.S.C. 1395nn(h)(4)) is amended by adding at the end the following new subparagraph:

"(C) Requirements for group practice.—For purposes of subsection (b)(2), a group practice meets the requirements of this subparagraph only if—

"(i) no member of the group is permitted to personally employ any individual to participate in the furnishing of services to patients of the group;

"(ii) no member of the group is permitted to enter separately on the member's own behalf into arrangements with any type of managed care entity (including health maintenance organizations and preferred provider organizations), third party payer, or other health benefit plan for the provision of services to patients of the group, except that nothing in this clause may be construed to prohibit the group from entering into an arrangement with a managed care entity that does not apply to services furnished by all the members of the group; and

"(iii) the group has a governing body or persons with responsibility for the conduct of the group practice, including making decisions relating to retention of all physician and nonphysician personnel, promulgating and enforcing personnel policies which apply to all employees of the group, developing salary, bonus, and benefits applicable to physicians and nonphysician personnel, and establishing fees for all services furnished by the group, except that nothing in this clause may be construed to prohibit the delegation of authority within a group practice or to require the personnel policies to be documented in writing.".

(c) New Exception for Capitated Payments.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2) the following new paragraph:

"(3) Other capitated payments.—Subsection (a)(1) shall not apply in the case of a designated health service, if the designated health service is included in the services for which a physician or physician group is paid only on a capitated basis by a health plan or insurer pursuant to a written arrangement between the plan or insurer and the physician or physician group in which the physician or physician group assumes financial risk for the furnishing of the service.".

(d) New Exception for Shared Facility Services.—

(1) In general.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by subsections (a) and (c), is amended—

(A) by redesignating paragraph (4) as paragraph (3); and

(B) by inserting after paragraph (3) the following new paragraph:

"(4) Shared facility services.—

"(A) In general.—Subsection (a)(1) shall not apply in the case of a designated health service consisting of a shared facility service of a shared facility—

"(i) that is furnished—

"(I) personally by the referring physician who is a shared facility physician or personally by an individual directly employed by such a physician,

"(II) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

"(III) to a patient of a shared facility physician; and

"(ii) that is billed by the referring physician.

"(B) Shared facility related definitions.—

"(i) Shared facility service.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

"(ii) Shared facility.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

"(iii) Shared facility physician.—The term 'shared facility physician' means, with respect to a shared facility, a physician who has a financial relationship under a shared facility arrangement with the facility.

"(iv) Shared facility arrangement.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

"(I) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

"(II) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

"(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.".

SEC. 8354. EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT.

(a) REVISION TO PUBLICLY TRADED SECURITIES EXCEPTION.—Section 1877(c)(1) (42 U.S.C. 1395nn(c)(1)) is amended by inserting "at the time acquired by the physician" after "which may be purchased on terms generally available to the public".

(b) REVISION TO RURAL PROVIDER EXCEPTION.—Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2)) is amended by striking "substantially all" and inserting "not less than 75 percent (as determined in accordance with regulations of the Secretary)".

SEC. 8355. REPEAL OF EXCEPTION FOR REMUNERATION UNRELATED TO PROVISION OF DESIGNATED HEALTH SERVICES.

Section 1877(e) (42 U.S.C. 1395nn(e)) is amended—

(1) by striking paragraph (4); and

(2) by redesignating paragraphs (5), (6), (7), and (8) as paragraphs (4), (5), (6), and (7).

SEC. 8356. REFERRING PHYSICIANS.

Section 1877(h)(5)(C) (42 U.S.C. 1395nn(H)(5)(C)) is amended—

(1) by striking "and a request" and inserting "a request";

(2) by inserting after "radiation therapy," the following: "and a request by a nephrologist for items or services related to renal dialysis,"; and

(3) by striking "or radiation oncologist" and inserting "radiation oncologist, or nephrologist".

SEC. 8357. MISCELLANEOUS AND TECHNICAL PROVISIONS.

(a) CLARIFICATION OF COVERAGE OF INDIRECTLY HELD FINANCIAL INTERESTS.—The last sentence of section 1877(a)(2) (42 U.S.C. 1395nn(a)(2)) is amended by striking "an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service" and inserting the following: "an interest held indirectly through means such as (but not limited to) holding a legal or beneficial interest in another entity (such as a trust) that holds such investment interest".

(b) CLARIFICATION OF EXCEPTION FOR PAYMENTS BY A PHYSICIAN.—Section 1877(e)(7) (42 U.S.C. 1395nn(e)(7)), as redesignated by section 9305, is amended to read as follows:

"(7) PAYMENTS BY A PHYSICIAN FOR ITEMS AND SERVICES.—Payments made by a physician to an individual or entity as compensation for items or services if the items or services are furnished at a price that is consistent with fair market value.".

(c) REPORTING REQUIREMENTS.—Section 1877(f) (42 U.S.C. 1395nn) is amended—

(1) in the matter before paragraph (1), by inserting ", investment, and compensation" after "ownership";

(2) in paragraph (2), by inserting ", or with a compensation arrangement (as described in subsection (a)(2)(B))," after "investment interest (as described in subsection (a)(2)(A))";

(3) in paragraph (2), by inserting "interest or who have such a compensation relationship with the entity" before the period at the end;

(4) in the fourth sentence, by striking "covered items and" and inserting "designated health"; and

(5) by striking the third and fifth sentences.

(d) REVISION OF EFFECTIVE DATE EXCEPTION PROVISION.—Section 13562(b)(2) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking subparagraphs (A) and (B) and inserting the following:

"(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

"(B) section 1877(b)(4) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply;

"(C) the requirements of section 1877(c)(2) of the Social Security Act (as amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(D) section 1877(e)(3) of the Social Security Act (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of the Social Security Act (as amended by this Act) shall not apply; and

"(F) section 1877(h)(4)(B) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act).".

(e) CLARIFICATION OF SANCTION AUTHORITY.—Section 1877(g)(4) (42 U.S.C. 1395nn(g)(4)) is amended by striking "Any physician" and all that follows through "to such entity," and inserting the following: "Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement or an arrangement with multiple leases overlapping in time for the same or similar rental space or equipment) which the physician or entity knows or should know has a principal purpose of inducing referrals to another entity, which referrals, if made directly by the physician or entity to such other entity,".

(f) AUTHORIZATION FOR SECRETARY TO ISSUE REGULATIONS.—Section 1877 (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

"(i) ADDITIONAL REQUIREMENTS.—The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions under this section.".

SEC. 8358. EFFECTIVE DATE.

The amendments made by this part shall apply to referrals made on or after January 1, 1996, except that the amendments made by section 8356(2) and section 8357(d) shall apply as if included in the enactment of OBRA–1993.

PART 7—OTHER MEDICARE PROVISIONS

SEC. 8361. TREATMENT OF BENEFICIARIES RESIDING IN STATES WITH APPROVED SINGLE-PAYER SYSTEMS.

Title XVIII, as amended by section 3116(f), is further amended by adding at the end the following new section:

"TREATMENT OF BENEFICIARIES UNDER STATE SINGLE-PAYER SYSTEMS

"SEC. 1894. (a) IN GENERAL.—In the case of individual entitled to benefits under this title who is covered under a State single-payer system approved under subtitle A of title IV of the Guaranteed Health Insurance Act of 1994—

"(1) the benefits covered under such system shall be instead of the payments which would otherwise be made to the individual or on the individual's behalf under this title; and

"(2) the Secretary shall make a payment to the State in the amount specified under subsection (b), on such periodic basis that will permit the State to make timely payment for items and services furnished under the State single-payer system to such individuals.

"(b) AMOUNT OF PAYMENTS TO STATES.—

"(1) IN GENERAL.—The amount specified in this subsection with respect to a State is the Secretary's estimate of the sum of the following products:

"(A) The product of—

"(i) the part A per enrollee payment described in paragraph (2) for the month; and

"(ii) the number of individuals who are entitled to benefits under part A during the month and (as estimated prior to the month based on information provided by the State) who are covered under the State system described in subsection (a).

"(B) The product of—

"(i) the part B per enrollee payment described in paragraph (2) for the month; and

"(ii) the number of individuals who are enrolled under part B during the month and (as estimated prior to the month based on information provided by the State) who are covered under the State system described in subsection (a).

"(2) PER ENROLLEE PAYMENTS.—In paragraph (1)—

"(A) the 'part A per enrollee payment' for a month is an amount equal to the Secretary's estimate of the amount of payment which would be made under part A for the month on behalf of individuals covered under the State system described in subsection (a) during the month if the individuals were not covered under the State system during the month; and

"(B) the 'part B per enrollee payment' for a month is an amount equal to the Secretary's estimate of the amount of payment which would be made under part B for the month on behalf of individuals covered under the State system described in subsection (a) during the month if the individuals were not covered under the State system during the month.

"(3) ADJUSTMENTS.—The Secretary shall adjust the amount of payment otherwise made to a State under this subsection for a month to take into account overpayments or underpayments made under this subsection in previous months.

"(c) PAYMENTS FROM TRUST FUNDS.—Of the total amount of payment made to a State under subsection (b)—

"(1) the portion attributable to the amount described in subsection (b)(1)(A) shall be paid from the Federal Hospital Insurance Trust Fund; and

"(2) the portion attributable to the amount described in subsection (b)(1)(B) shall be paid from the Federal Supplementary Medical Insurance Trust Fund.".

SEC. 8362. DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT METHODOLOGIES.

(a) In General.—Subject to subsection (b), the Secretary shall, not later than January 1, 1997, develop and implement prospective payment methodologies for setting payment rates for services for which a prospective payment methodology is not used under the medicare program. In developing such methodologies, the Secretary shall ensure that the amount of payments under such methodologies under the medicare program would not exceed the amount of payments that would be paid under the methodologies otherwise applicable.

(b) Payment Methodologies for PPS-Exempt Hospitals.—The Secretary shall develop and implement such a payment methodology for services of classes of hospitals (including children's hospitals) that are not subsection (d) hospitals (within the meaning of section 1886(d)(1)(B) of the Social Security Act) where appropriate. Any such payment methodology shall provide for hospital-specific payment rates based on resource requirements of such hospitals, determined using data specific to the different classes of such hospitals.

(c) Application of Methodologies.—In the case of any service within a class of services for which a prospective payment methodology is implemented under subsection (a), notwithstanding any other provision of law, such methodology shall be applied under the medicare program and medicare part C and under subtitle D of title VI instead of the methodology otherwise provided.

(d) Development of Methodology for Establishing Limits on Payments for Services Provided in Hospital Outpatient Departments.—The Secretary shall revise the payment methodology established under the medicare program for payment for services provided in hospital outpatient departments in order to provide for a hospital-specific limit on the rate of growth in payments for such services. Such revision shall first be applied to payments to hospitals for portions of cost reporting periods occurring on or after January 1, 1997.

SEC. 8363. MEDICARE SUPPLEMENTAL INSURANCE POLICY AMENDMENTS.

(a) Conforming Changes in Medicare Benefits.—Not later than July 1, 1995, the Secretary shall, in accordance with section 1882(p)(1) of the Social Security Act, promulgate standards for medicare supplemental policies to reflect the changes in benefits provided under parts A and B of title XVIII of such Act for purposes of the NAIC or Federal Standards applicable under such section. The provisions of section 1882(p)(1) of the Social Security Act shall apply to such standards in the same manner as such provisions apply to "Federal standards" described in subparagraph (B) of such section, except that any reference in such section to "the date specified in subparagraph" shall be deemed to be a reference to "January 1, 1998".

(b) Requiring Open Enrollment.—

(1) In general.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(A) in paragraph (3), by striking "paragraphs (1) and (2)" and inserting "paragraphs (1), (2), and (3)";

(B) by redesignating paragraph (3) as paragraph (4); and

(C) by inserting after paragraph (2) the following new paragraph:

"(3) Notwithstanding paragraph (2), the issuer of a medicare supplemental policy may not deny the issuance of a medicare supplemental policy during an annual open enrollment period of at least 30 days established by the Secretary for medicare supplemental policies.".

(2) Issuance of regulations.—Not later than July 1, 1995, the Secretary shall issue regulations to carry out the amendments made by paragraph (1).

(c) Effective Date.—

(1) Conforming changes.—The changes in the NAIC or Federal standards made pursuant to subsection (a) shall apply to medicare supplemental policies issued on or after January 1, 1998.

(2) Open enrollment.—(A) Except as provided in subparagraph (B), the amendments made by subsection (b) shall apply to medicare supplemental policies issued on or after January 1, 1997.

(B) In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the amendments made by subsection (b), but

(ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered, the amendment made by subsection (b) shall apply to medicare supplemental policies issued in the State on or after the earlier of January 1, 1998, or the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 8364. REQUIRING HOSPITALS TO PARTICIPATE IN MEDICARE PART C.

(a) In General.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)), as amended by section 8334(a), is amended—

(1) in subparagraph (Q), by striking "and" at the end;

(2) by striking the period at the end of subparagraph (R) and inserting ", and"; and

(3) by inserting after subparagraph (R) the following:

"(S) in the case of a hospital or a rural primary care hospital, to file a participation agreement with respect to the medicare part C program (in accordance with [section 2131]).".

(b) Effective Date.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 1999.

SEC. 8365. CONFORMING AMENDMENTS RELATING TO PROGRAM OF COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.

(a) In General.—(1) Section 1818(g)(1) (42 U.S.C. 1395i-2(g)(1)) is amended by striking "1905(p)(1)" and inserting "2223(a)".

(2) Section 1843(h) (42 U.S.C. 1395v(h)) is amended by striking "1905(p)(1)" each place it appears in paragraph (1)(B) and paragraph (2) and inserting "2223(a)"

(3) Section 1848(g)(3)(A) (42 U.S.C. 1395w-4(g)(3)) is amended—

(A) by striking "(including as a qualified medicare beneficiary, as described in section 1905(p)(1))", and

(B) by inserting "or who is eligible for benefits under part C of title XXII" after "title XIX".

(b) Effective Date.—The amendments made by this section shall apply with respect to items or services furnished in a State on or after January 1, 1999.

SEC. 8366. ADJUSTING CAPITAL PAYMENTS FOR AMOUNTS RECEIVED UNDER CAPITAL FINANCING ASSISTANCE PROGRAM.

Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended—

(1) by striking "and" at the end of clause (iii);

(2) by striking the period at the end of clause (iv) and inserting ", and"; and

(3) by adding at the end the following new clause:

"(v) shall provide for adjustments to assure that payment is not made to a hospital for capital-related costs to the extent that such costs were reduced or eliminated as a result of the receipt of financial assistance under title XXVIII of the Public Health Service Act.".

SEC. 8367. STUDY OF PHYSICIAN SUPERVISION OF NURSE ANESTHETIST SERVICES.

(a) Study.—The Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration, shall conduct a study to determine the appropriate requirements for and amount of—

(1) payments under part B of the medicare program for services of a certified registered nurse anesthetist who does not provide such services under the medical supervision or medical direction of a physician, and

(2) payments under such part for the medical direction of such certified registered nurse anesthetist by a physician.

(b) Report.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate.

PART 8—EXPANSION OF FRAIL ELDERLY DEMONSTRATIONS

SEC. 8371. EXPANSION OF NUMBER OF SITES FOR DEMONSTRATION PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).

Section 9412(b)(1) of OBRA–1986 is amended by striking "not more than 15" and inserting "not more than 50".

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PART 1—PROVISIONS RELATING TO PART A

SEC. 8401. PROVISIONS RELATING TO ADJUSTMENTS TO STANDARDIZED AMOUNTS FOR WAGES AND WAGE-RELATED COSTS.

(a) USE OF OCCUPATIONAL MIX IN GUIDELINES FOR DETERMINATION OF AREA WAGE INDEX.—

(1) IN GENERAL.—Section 1886(d)(10)(D)(i)(I) (42 U.S.C. 1395ww(d)(10)(D)(i)(I)) is amended by inserting "(to the extent the Secretary determines appropriate)" after "taking into account".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of OBRA–1989.

(b) CONFORMING AMENDMENTS RELATING TO GEOGRAPHIC AREA USED TO DETERMINE WAGE INDEX APPLICABLE TO HOSPITAL.—(1) Section 1886(d)(8)(C) (42 U.S.C. 1395ww(d)(8)(C)), as amended by section 13501(b)(1) of OBRA–1993, is amended—

(A) in clause (iv), by striking "paragraph (1)" and inserting "paragraph (10)"; and

(B) by adding at the end the following new clause:

"(v) This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.".

(2) Section 1886(d)(10) (42 U.S.C. 1395ww(d)(10)) is amended—

(A) in subparagraph (C)(i)(II), by striking "the area wage index applicable" and inserting "the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies"; and

(B) in subparagraph (D)—

(i) by redesignating clause (ii) as clause (iii), and

(ii) by inserting after clause (i) the following new clause:

"(ii) Notwithstanding clause (i), if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) that is not based on the use of Metropolitan Statistical Area classifications, the Secretary may revise the guidelines published under clause (i) to the extent such guidelines are used to determine the appropriateness of the geographic area in which the hospital is determined to be located for purposes of making such adjustments.".

(c) ADJUSTMENT OF LABOR AND NON-LABOR PORTIONS OF STANDARDIZED AMOUNTS.—Section 1886(d)(3)(A)(iii) (42 U.S.C. 1395ww(d)(3)(A)(iii)) is amended by adding at the end the following: "For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.".

SEC. 8402. PROVISIONS RELATING TO RURAL HEALTH TRANSITION GRANT PROGRAM.

(a) ELIGIBILITY OF RURAL PRIMARY CARE HOSPITALS FOR GRANTS.—

(1) IN GENERAL.—Section 4005(e)(2) of OBRA–1987 is amended in the matter preceding subparagraph (A) by inserting "any rural primary care hospital designated by the Secretary under section 1820(i)(2) of the Social Security Act, or" after "means".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to grants made on or after October 1, 1993.

(b) EXTENSION OF AUTHORIZATION OF APPROPRIATIONS.—Section 4005(e)(9) of OBRA–1987 is amended—

(1) by striking "1989 and" and inserting "1989,"; and

(2) by striking "1992" and inserting "1992 and $30,000,000 for each of fiscal years 1993 through 1997".

(c) FREQUENCY OF REQUIRED REPORTS.—Section 4008(e)(8)(B) of OBRA–1987 is amended by striking "every 6 months" and inserting "every 12 months".

(d) USE OF GRANTS FOR TELECOMMUNICATIONS PROJECTS.—

(1) IN GENERAL.—Section 4005(e)(7) of OBRA–1987 is amended by adding at the end the following new subparagraph:

"(E) A hospital may use a grant received under this subsection to participate in a project established by the Secretary to establish telecommunications linkages between the hospital and other medical facilities in order to permit the hospital to use the medical expertise or equipment of the other facility through telecommunications techniques. In awarding grants to hospitals for this purpose, the Secretary shall take into account the need to demonstrate alternative telecommunications techniques for rural hospitals, including interactive video telecommunications, static video imaging transmitted through the telephone system, and facsimile reproductions transmitted through the telephone system.".

(2) SET-ASIDE OF AUTHORIZATION.—Section 4005(e)(9) of OBRA–1987 is amended by adding at the end the following: "Of the amounts authorized to be appropriated during each of the fiscal years 1996 and 1997, $2,000,000 shall be available solely for projects described in paragraph (7)(E).".

SEC. 8403. PSYCHOLOGY SERVICES IN HOSPITALS.

Section 1861(e)(4) (42 U.S.C. 1395x(e)(4)) is amended by striking "physician;" and inserting "physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;".

SEC. 8404. SKILLED NURSING FACILITIES.

(a) CONSTRUCTION OF WAGE INDEX.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall begin to collect data on employee compensation and paid hours of employment in skilled nursing facilities for the purpose of constructing a skilled nursing facility wage index adjustment to the routine service cost limits required under section 1888(a)(4) of the Social Security Act.

(b) CLARIFICATION OF REPEAL OF UTILIZATION REVIEW REQUIREMENTS.—

(1) IN GENERAL.—(A) Section 1814(a)(5) (42 U.S.C. 1395f(a)(5)) is amended—

(i) by striking "and with respect" and all that follows through "regulations";

(ii) by striking "or skilled nursing facility, as the case may be"; and

(iii) by striking "or facility".

(B) Section 1866(d) (42 U.S.C. 1395cc(d)) is amended—

(i) by striking "or skilled nursing facility";

(ii) by striking "or facility" each place it appears;

(iii) by striking "or for post-hospital" and all that follows through "the case may be"; and

(iv) by striking ", or (in the case of" and all that follows through "transfer agreement,".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of OBRA–1987.

(c) REIMBURSEMENT FOR ATYPICAL SERVICES.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

(1) by striking "(c)" and inserting "(c)(1)"; and

(2) by adding at the end the following new paragraph:

"(2) The Secretary shall establish an expedited review process under which the Secretary shall respond to the request of a skilled nursing facility received on or after October 1, 1994, for an adjustment under this subsection based on the furnishing of atypical services by the facility during any cost reporting period (including the furnishing of atypical services based on the facility's case mix) not later than 30 days after receiving the facility's request. If the Secretary approves a facility's request under the process, the Secretary shall adjust the amount of the payments made under this title (on a timely basis) with respect to routine service costs of extended care services furnished by the facility for each cost reporting period for which the facility demonstrates that it furnishes (or will furnish) such atypical services.".

(d) PAYMENT FOR SERVICES OF INDEPENDENT LABORATORIES FURNISHED TO RESIDENTS.—

(1) INCLUSION AS ROUTINE SERVICE COSTS OF EXTENDED CARE SERVICES.—Section 1861(h)(6) (42 U.S.C. 1395x(h)(6)) is amended by inserting "or an independent clinical laboratory" after "by a hospital".

(2) REQUIRING FACILITIES TO FURNISH LABORATORY SERVICES.—Section 1819(b)(4)(A) (42 U.S.C. 1395i–3(b)(4)(A)) is amended—

(A) by striking "and" at the end of clause (vi);

(B) by striking the period at the end of clause (vii) and inserting "; and"; and

(C) by inserting after clause (vii) the following new clause:

"(viii) clinical laboratory services necessary to meet the needs of each resident.".

(e) CONFORMING AMENDMENTS TO NURSING HOME REFORM.—

(1) SUSPENSION OF DECERTIFICATION OF NURSES AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS BASED ON EXTENDED SURVEYS.—

(A) IN GENERAL.—Section 1819(f)(2)(B)(iii)(I)(b) (42 U.S.C. 1395i–3(f)(2)(B)(iii)(I)(b)) is amended by striking the semicolon and inserting the following: ", unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section;".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect as if included in the enactment of OBRA–1990.

(2) REQUIREMENTS FOR CONSULTANTS CONDUCTING REVIEWS ON USE OF DRUGS.—

(A) IN GENERAL.—Section 1819(c)(1)(D) (42 U.S.C. 1395i–3(c)(1)(D)) is amended by adding at the end the following sentence: "In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this title to have access to the services of such a consultant on a timely basis.".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect as if included in the enactment of OBRA–1987.

(3) INCREASE IN MINIMUM AMOUNT REQUIRED FOR SEPARATE DEPOSIT OF PERSONAL FUNDS.—

(A) IN GENERAL.—Section 1819(c)(6)(B)(i) (42 U.S.C. 1395i–3(c)(6)(B)(i)) is amended by striking "$50" and inserting "$100".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect January 1, 1995.

(4) DUE PROCESS PROTECTIONS FOR NURSE AIDES.—

(A) PROHIBITING STATE FROM INCLUDING UNDOCUMENTED ALLEGATIONS IN NURSES AIDE REGISTRY.—Section 1819(e)(2)(B) (42 U.S.C. 1395i–3(e)(2)(B)) is amended by striking the period at the end of the first sentence and inserting the following: ", but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection.".

(B) DUE PROCESS REQUIREMENTS FOR REBUTTING ALLEGATIONS.—Section 1819(g)(1)(C) (42 U.S.C. 1395i–3(g)(1)(C)) is amended by striking the second sentence and inserting the following: "The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to rebut the allegations) and the opportunity for a hearing on the record, make a written finding as to the accuracy of the allegations.".

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect January 1, 1995.

(f) CORRECTIONS RELATING TO SECTION 4008.—

(1) Section 1819(b)(5)(D) (42 U.S.C. 1395i–3(b)(5)(D)), as amended by section 4008(h)(1)(D) of OBRA–1990, is amended by striking the comma before "or a new competency evaluation program.".

(2) Section 1819(b)(5)(G) (42 U.S.C. 1395i–3(b)(5)(G)) is amended by striking "or licensed or certified social worker" and inserting "licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician".

(3) Section 1819(f)(2)(B)(i) (42 U.S.C. 1395i–3(f)(2)(B)(i)) is amended by striking "facilities," and inserting "facilities (subject to clause (iii)),".

(4) Section 1819(f)(2)(B)(iii)(I)(c) (42 U.S.C. 1395i–3(f)(2)(B)(iii)(I)(c)) is amended by striking "clauses" each place it appears and inserting "clause".

(5) Section 1819(g)(5)(B) (42 U.S.C. 1395i–3(g)(5)(B)) is amended by striking "paragraphs" and inserting "paragraph".

(6) Section 4008(h)(1)(F)(ii) of OBRA–1990 is amended—

(A) by striking "The amendments" and inserting "(I) The amendments";

(B) by striking "nursing facility" each place it appears and inserting "skilled nursing facility";

(C) by redesignating subclauses (I) through (V) as items (aa) through (ee); and

(D) by adding at the end the following new subclause:

"(II) Notwithstanding subclause (I) and subject to section 1819(f)(2)(B)(iii)(I) of the Social Security Act (as amended by clause (i)), a State may approve a training and competency evaluation program or a competency evaluation program offered by or in a skilled nursing facility described in subclause (I) if, during the previous 2 years, item (aa), (bb), (cc), (dd), or (ee) of subclause (I) did not apply to the facility.".

(7) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the enactment of OBRA–1990.

SEC. 8405. NOTIFICATION OF AVAILABILITY OF HOSPICE BENEFIT.

(a) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended by inserting ", including hospice services," after "post-hospital services".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the first day of the first month beginning more than one year after the date of the enactment of this Act.

SEC. 8406. CLARIFYING EXPERTISE OF INDIVIDUALS TO SERVE ON THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

Section 1886(e)(6)(B) (42 U.S.C. 1395ww(e)(6)(B)) is amended by striking "hospital reimbursement, hospital financial management" and inserting "health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities".

SEC. 8407. AUTHORITY FOR BUDGET NEUTRAL ADJUSTMENTS FOR CHANGES IN PAYMENT AMOUNTS FOR TRANSFER CASES.

Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)) is amended—

(1) by inserting "(i)" after "(I)"; and

(2) by adding at the end the following new clause:

"(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater or lesser than those that would have otherwise been made in such fiscal year.".

SEC. 8408. HEMOPHILIA PASS-THROUGH EXTENSION.

Effective as if included in the enactment of OBRA–1993, section 6011(d) of OBRA–1989 (as amended by section 13505 of OBRA–1993) is amended by striking "September 30, 1994" and inserting "September 30, 1999".

SEC. 8409. SUB-ACUTE CARE SERVICES DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project during fiscal years 1996 and 1997 on the provision of sub-acute care services under part A of the medicare program in freestanding skilled nursing facilities and hospitals.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 for each of the fiscal years 1996 and 1997 to conduct the demonstration project under paragraph (1).

(b) REPORT.—Not later than 6 months after the conclusion of the demonstration project conducted under subsection (a), the Secretary shall submit a report to Congress on the demonstration project, and shall include in the report an evaluation of the demonstration project together with any recommendations considered appropriate by the Secretary for changes to title XVIII of the Social Security Act relating to the provision of sub-acute care services under part A of the medicare program.

SEC. 8410. CLARIFICATION OF DRG PAYMENT WINDOW EXPANSION; MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) CLARIFICATION OF DRG PAYMENT WINDOW EXPANSION.—The first sentence of section 1886(a)(4) (42 U.S.C. 1395ww(a)(4)) is amended by inserting "(or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day)" after "3 days".

(b) TECHNICAL CORRECTION RELATING TO RESIDENT ASSESSMENT IN NURSING HOMES.—Section 1819(b)(3)(C)(i)(I) (42 U.S.C. 1395i–3(b)(3)(C)(i)(I)) is amended by striking "not later than" before "14 days".

(c) Technical Correction Relating to Applicable Adjustment Factor for Indirect Medical Education Adjustment.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended by striking "May 1, 1986," and inserting "October 1, 1988,".

(d) Medicare-Dependent, Small Rural Hospitals and Sole Community Hospitals.—

(1) Medicare dependent, small rural hospitals.—

(A) Clarification of additional payment.—Section 1886(d)(5)(G)(ii)(I) (42 U.S.C. 1395ww(d)(5)(G)(ii)(I)), as amended by section 13501(e)(1) of OBRA–1993, is amended by striking "the first 3 12-month cost reporting periods that begin" and inserting "the 36-month period beginning with the first day of the cost reporting period that begins".

(B) Conforming target amounts to extension of additional payments.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended in the matter preceding clause (i) by striking "March 31, 1993" and inserting "September 30, 1994".

(2) Clarification of updates.—Section 1886(b)(3)(B)(iv)(II) (42 U.S.C. 1395ww(b)(3)(B)(iv)(II)), as added by section 13501(a)(2) of OBRA–1993, is amended by striking "(taking into account" and all that follows through "1994)" and inserting "(adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I))".

(e) Clerical Corrections.—(1) Section 1814(i)(1)(C)(i) (42 U.S.C. 1395f(i)(1)(C)(i)) is amended by striking "1990" and inserting "1990,".

(2) Section 1816(f)(2)(A)(ii) (42 U.S.C. 1395h(f)(2)(A)(ii)) is amended by striking "such agency" and inserting "such agency's".

PART 2—PROVISIONS RELATING TO PART B

Subpart A—Physicians' Services

SEC. 8411. DEVELOPMENT AND IMPLEMENTATION OF RESOURCE-BASED METHODOLOGY FOR PRACTICE EXPENSES.

(a) Development.—

(1) In general.—The Secretary of Health and Human Services shall develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physicians' service. The methodology utilized shall recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.

(2) Report.—The Secretary shall transmit a report by July 1, 1995, on the methodology developed under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data utilized in developing the methodology and an explanation of the methodology.

(b) Implementation.—

(1) In general.—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w–4(c)(2)(C)(ii)) is amended—

(A) by inserting "for the service for years before 1997" before "equal to",

(B) by striking the period at the end of subclause (II) and inserting a comma, and

(C) by adding after and below subclause (II) the following:

"and for years beginning with 1997 based on the relative practice expense resources involved in furnishing the service (in accordance with the transition provided in subparagraph (G)).".

(2) Transition.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

"(G) Transition to resource-based practice expense relative value units.—With respect to physicians' services furnished in years beginning with 1997, the number of practice expense relative value units applicable under subparagraph (C)(ii) shall be equal to the following:

"(i) For services furnished in 1997, the sum of—

"(I) 75 percent of the units determined under the methodology applicable under such subparagraph for years prior to 1997; and

"(II) 25 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Guaranteed Health Insurance Act of 1994.

"(ii) For services furnished in 1998, the sum of—

"(I) 50 percent of the units determined under the methodology applicable under such subparagraph for years prior to 1997; and

"(II) 50 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Guaranteed Health Insurance Act of 1994.

"(iii) For services furnished in 1999, the sum of—

"(I) 25 percent of the units determined under the methodology applicable under such subparagraph for years prior to 1997; and

"(II) 75 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Guaranteed Health Insurance Act of 1994.

"(iv) For services furnished in years beginning with 2000, 100 percent of the units determined under the methodology developed by the Secretary under section 8411(a)(1) of the Guaranteed Health Insurance Act of 1994.".

(3) Conforming amendment.—Section 1848(c)(3)(C)(ii) (42 U.S.C. 1395w–4(c)(3)(C)(ii)) is amended by striking "The practice" and inserting "For years before 2000, the practice".

(4) Application of certain provisions.—In implementing the amendment made by paragraph (1)(C), the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.

SEC. 8412. GEOGRAPHIC COST OF PRACTICE INDEX REFINEMENTS.

(a) Requiring Consultation With Representatives of Physicians in Reviewing Geographic Adjustment Factors.—Section 1848(e)(1)(C) (42 U.S.C. 1395w–4(e)(1)(C)) is amended by striking "shall review" and inserting "shall, in consultation with appropriate representatives of physicians, review".

(b) Use of Most Recent Data in Geographic Adjustment.—Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended by adding at the end the following new subparagraph:

"(D) Use of recent data.—In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.".

(c) Report on Review Process.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall study and report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives on—

(1) the data necessary to review and revise the indices established under section 1848(e)(1)(A) of the Social Security Act, including—

(A) the shares allocated to physicians' work effort, practice expenses (other than malpractice expenses), and malpractice expenses;

(B) the weights assigned to the input components of such shares; and

(C) the index values assigned to such components;

(2) any limitations on the availability of data necessary to review and revise such indices at least every three years;

(3) ways of addressing such limitations, with particular attention to the development of alternative data sources for input components for which current index values are based on data collected less frequently than every three years; and

(4) the costs of developing more accurate and timely data.

SEC. 8413. EXTRA-BILLING LIMITS.

(a) Enforcement of Limits.—Section 1848(g) (42 U.S.C. 1395w–4(g)), as amended by section 13517(a) of OBRA–1993, is amended—

(1) by amending paragraph (1) to read as follows:

"(1) Limitation on actual charges.—

"(A) In general.—In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1842(i)(2)) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply:

"(i) Application of limiting charge.—No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

"(ii) No liability for excess charges.—No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

"(iii) Correction of excess charges.—If such a physician, supplier, or other person bills, but does not collect, an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed for the service to an amount not to exceed the limiting charge for the service.

"(iv) Refund of excess collections.—If such a physician, supplier, or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in the amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

"(B) Sanctions.—If a physician, supplier, or other person—

"(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

"(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the Secretary may apply sanctions against the physician, supplier, or other person in accordance with paragraph (2) of section 1842(j). In applying this subparagraph, paragraph (4) of such section applies in the same manner as such paragraph applies to such section and any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.

"(C) TIMELY BASIS.—For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided 'on a timely basis', if the reduction or refund is made not later than 30 days after the date the physician, supplier, or other person is notified by the carrier under this part of such violation and of the requirements of subparagraph (A)."; and

(2) in paragraph (3)(B)—

(A) by inserting after the first sentence the following: "No person is liable for payment of any amounts billed for such a service in violation of the previous sentence.", and

(B) in the last sentence, by striking "previous sentence" and inserting "first sentence".

(b) CLARIFICATION OF MANDATORY ASSIGNMENT RULES FOR CERTAIN PRACTITIONERS.—

(1) IN GENERAL.—Section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 8416(e), is amended by adding at the end the following new paragraph:

"(18)(A) Payment for any service furnished by a practitioner described in subparagraph (C) and for which payment may be made under this part on a reasonable charge or fee schedule basis may only be made under this part on an assignment-related basis.

"(B) A practitioner described in subparagraph (C) or other person may not bill (or collect any amount from) the individual or another person for any service described in subparagraph (A), except for deductible and coinsurance amounts applicable under this part. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a practitioner or other person knowingly and willfully bills (or collects an amount) for such a service in violation of such sentence, the Secretary may apply sanctions against the practitioner or other person in the same manner as the Secretary may apply sanctions against a physician in accordance with subsection (j)(2) in the same manner as such section applies with respect to a physician. Paragraph (4) of subsection (j) shall apply in this subparagraph in the same manner as such paragraph applies to such section.

"(C) A practitioner described in this subparagraph is any of the following:

"(i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)).

"(ii) A certified registered nurse anesthetist (as defined in section 1861(bb)(2)).

"(iii) A certified nurse-midwife (as defined in section 1861(gg)(2)).

"(iv) A clinical social worker (as defined in section 1861(hh)(1)).

"(v) A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)).

"(D) For purposes of this paragraph, a service furnished by a practitioner described in subparagraph (C) includes any services and supplies furnished as incident to the service as would otherwise be covered under this part if furnished by a physician or as incident to a physician's service.".

(2) CONFORMING AMENDMENTS.—

(A) Section 1833 (42 U.S.C. 1395l) is amended—

(i) in subsection (l)(5), by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B);

(ii) by striking subsection (p); and

(iii) in subsection (r), by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

(B) Section 1842(b)(12) (42 U.S.C. 1395u(b)(12)) is amended by striking subparagraph (C).

(c) INFORMATION ON EXTRA-BILLING LIMITS.—

(1) PART OF EXPLANATION OF MEDICARE BENEFITS.—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

(A) by striking "and" at the end of subparagraph (B),

(B) in subparagraph (C), by striking "shall include",

(C) in subparagraph (C), by striking the period at the end and inserting ", and", and

(D) by adding at the end the following new subparagraph:

"(D) in the case of services for which the billed amount exceeds the limiting charge imposed under section 1848(g), information regarding such applicable limiting charge (including information concerning the right to a refund under section 1848(g)(1)(A)(iv)).".

(2) DETERMINATIONS BY CARRIERS.—Subparagraph (G) of section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended to read as follows:

"(G) will, for a service that is furnished with respect to an individual enrolled under this part, that is not paid on an assignment-related basis, and that is subject to a limiting charge under section 1848(g)—

"(i) determine, prior to making payment, whether the amount billed for such service exceeds the limiting charge applicable under section 1848(g)(2);

"(ii) notify the physician, supplier, or other person periodically (but not less often than once every 30 days) of determinations that amounts billed exceeded such applicable limiting charges; and

"(iii) provide for prompt response to inquiries of physicians, suppliers, and other persons concerning the accuracy of such limiting charges for their services;".

(d) REPORT ON CHARGES IN EXCESS OF LIMITING CHARGE.—Section 1848(g)(6)(B) (42 U.S.C. 1395w-4(g)(6)(B)) is amended by inserting "information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information" after "report to the Congress".

(e) MISCELLANEOUS AND TECHNICAL AMENDMENTS.—Section 1833(h)(5)(D) (42 U.S.C. 1395l(h)(5)(D)) is amended—

(1) by striking "paragraphs (2) and (3)" and by inserting "paragraph (2)"; and

(2) by adding at the end the following: "Paragraph (4) of such section shall apply in this subparagraph in the same manner as such paragraph applies to such section.".

(f) EFFECTIVE DATES.—

(1) ENFORCEMENT; MISCELLANEOUS AND TECHNICAL AMENDMENTS.—The amendments made by subsections (a) and (e) shall apply to services furnished on or after the date of the enactment of this Act; except that the amendments made by subsection (a) shall not apply to services of a nonparticipating supplier or other person furnished before January 1, 1995.

(2) PRACTITIONERS.—The amendments made by subsection (b) shall apply to services furnished on or after January 1, 1995.

(3) EOMBs.—The amendments made by subsection (c)(1) shall apply to explanations of benefits provided on or after January 1, 1995.

(4) CARRIER DETERMINATIONS.—The amendments made by subsection (c)(2) shall apply to contracts as of January 1, 1995.

(5) REPORT.—The amendment made by subsection (d) shall apply to reports for years beginning with 1995.

SEC. 8414. RELATIVE VALUES FOR PEDIATRIC SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall fully develop, by not later than January 1, 1995, relative values for the full range of pediatric physicians' services which are consistent with the relative values developed for other physicians' services under section 1848(c) of the Social Security Act. In developing such values, the Secretary shall conduct such refinements as may be necessary to produce appropriate estimates for such relative values.

(b) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study of the relative values for pediatric and other services to determine whether there are significant variations in the resources used in providing similar services to different populations. In conducting such study, the Secretary shall consult with appropriate organizations representing pediatricians and other physicians and physical and occupational therapists.

(2) REPORT.—Not later than July 1, 1995, the Secretary shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include any appropriate recommendations regarding needed changes in coding or other payment policies to ensure that payments for pediatric services appropriately reflect the resources required to provide these services.

SEC. 8415. ADMINISTRATION OF CLAIMS RELATING TO PHYSICIANS' SERVICES.

(a) LIMITATION ON CARRIER USER FEES.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(4) Neither a carrier nor the Secretary may impose a fee under this title—

"(A) for the filing of claims related to physicians' services,

"(B) for an error in filing a claim relating to physicians' services or for such a claim which is denied,

"(C) for any appeal under this title with respect to physicians' services,

"(D) for applying for (or obtaining) a unique identifier under subsection (r), or

"(E) for responding to inquiries respecting physicians' services or for providing information with respect to medical review of such services.".

(b) CLARIFICATION OF PERMISSIBLE SUBSTITUTE BILLING ARRANGEMENTS.—

(1) IN GENERAL.—Clause (D) of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended to read as follows: "(D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act.

SEC. 8416. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) Overvalued Procedures.—(1) Section 1842(b)(16)(B)(iii) (42 U.S.C. 1395u(b)(16)(B)(iii)) is amended—

(A) by striking ", simple and subcutaneous",

(B) by striking "; small" and inserting "and small",

(C) by striking "treatments;" the first place it appears and inserting "and",

(D) by striking "lobectomy;",

(E) by striking "enterectomy; colectomy; cholecystectomy;",

(F) by striking "; transurerethral resection" and inserting "and resection", and

(G) by striking "sacral laminectomy;".

(2) Section 4101(b)(2) of OBRA–1990 is amended—

(A) in the matter before subparagraph (A), by striking "1842(b)(16)" and inserting "1842(b)(16)(B)", and

(B) in subparagraph (B)—

(i) by striking ", simple and subcutaneous",

(ii) by striking "(HCPCS codes 19160 and 19162)" and inserting "(HCPCS code 19160)", and

(iii) by striking all that follows "(HCPCS codes 92250" and inserting "and 92260).".

(b) Radiology Services.—(1) Section 1834(b)(4) (42 U.S.C. 1395m(b)(4)) is amended by redesignating the subparagraphs (E) and (F) redesignated by section 4102(a)(1) of OBRA–1990 as subparagraphs (F) and (G), respectively.

(2) Section 1834(b)(4)(D) (42 U.S.C. 1395m(b)(4)(D)) is amended—

(A) in the matter before clause (i), by striking "shall be determined as follows:" and inserting "shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:",

(B) in clause (iv), by striking "Local Adjustment.—Subject to clause (vii), the conversion factor to be applied to" and inserting "Adjusted conversion factor.—The adjusted conversion factor for",

(C) in clause (vii), by striking "under this subparagraph", and

(D) in clause (vii), by inserting "reduced under this subparagraph by" after "shall not be".

(3) Section 4102(c)(2) of OBRA–1990 is amended by striking "radiology services" and all that follows and inserting "nuclear medicine services.".

(4) Section 4102(d) of OBRA–1990 is amended by striking "new paragraph" and inserting "new subparagraph".

(5) Section 1834(b)(4)(E) (42 U.S.C. 1395m(b)(4)(E)) is amended by inserting "Rule for certain scanning services.—" after "(E)".

(6) Section 1848(a)(2)(D)(iii) (42 U.S.C. 1395w–4(a)(2)(D)(iii)) is amended by striking "that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989" and by striking "provided under such section" and inserting "provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989".

(c) Anesthesia Services.—(1) Section 4103(a) of OBRA–1990 is amended by striking "Reduction in Fee Schedule" and inserting "Reduction in Prevailing Charges".

(2) Section 1842(q)(1)(B) (42 U.S.C. 1395u(q)(1)(B)) is amended—

(A) in the matter before clause (i), by striking "shall be determined as follows:" and inserting "shall, subject to clause (iv), be reduced to the adjusted prevailing charge conversion factor for the locality determined as follows:", and

(B) in clause (iii), by striking "Subject to clause (iv), the prevailing charge conversion factor to be applied in" and inserting "The adjusted prevailing charge conversion factor for".

(d) Assistants at Surgery.—(1) Section 4107(c) of OBRA–1990 is amended by inserting "(a)(1)" after "subsection".

(2) Section 4107(a)(2) of OBRA–1990 is amended by adding at the end the following: "In applying section 1848(g)(2)(D) of the Social Security Act for services of an assistant-at-surgery furnished during 1991, the recognized payment amount shall not exceed the maximum amount specified under section 1848(i)(2)(A) of such Act (as applied under this paragraph in such year).".

(e) Technical Components of Diagnostic Services.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by redesignating paragraph (18), as added by section 4108(a) of OBRA–1990, as paragraph (17) and, in such paragraph, by inserting ", tests specified in paragraph (14)(C)(i)," after "diagnostic laboratory tests".

(f) Statewide Fee Schedules.—Section 4117 of OBRA–1990 is amended—

(1) in subsection (a)—

(A) by striking "(a) In General.—", and

(B) by striking ", if the" and all that follows through "1991,"; and

(2) by striking subsections (b), (c), and (d).

(g) Study of Aggregation Rule for Claims of Similar Physician Services.—Section 4113 of OBRA–1990 is amended—

(1) by inserting "of the Social Security Act" after "1869(b)(2)"; and

(2) by striking "December 31, 1992" and inserting "December 31, 1993".

(h) Other Miscellaneous and Technical Amendments.—(1) The heading of section 1834(f) (42 U.S.C. 1395m(f)) is amended by striking "Fiscal Year".

(2)(A) Section 4105(b) of OBRA–1990 is amended—

(i) in paragraph (2), by striking "amendments" and inserting "amendment", and

(ii) in paragraph (3), by striking "amendments made by paragraphs (1) and (2)" and inserting "amendment made by paragraph (1)".

(B) Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended by inserting "Performance standard rates of increase for fiscal year 1991.—" after "(C)".

(C) Section 4105(d) of OBRA–1990 is amended by inserting "Publication of Performance Standard Rates.—" after "(d)".

(3) Section 4106(c) of OBRA–1990 is amended by inserting "of the Social Security Act" after "1848(d)(1)(B)".

(4) Section 4114 of OBRA–1990 is amended by striking "patients" the second place it appears.

(5) Section 1848(e)(1)(C) (42 U.S.C. 1395w–4(e)(1)(C)) is amended by inserting "date of the" after "since the".

(6) Section 4118(f)(1)(D) of OBRA–1990 is amended by striking "is amended".

(7) Section 4118(f)(1)(N)(ii) of OBRA–1990 is amended by striking "subsection (f)(5)(A)" and inserting "subsection (f)(5)(A))".

(8) Section 1845(e) (42 U.S.C. 1395w–1(e)) is amended—

(A) by striking paragraph (2); and

(B) by redesignating paragraphs (3), (4), and (5) as paragraphs (2), (3), and (4).

(9) Section 4118(j)(2) of OBRA–1990 is amended by striking "In section" and inserting "Section".

(10)(A) Section 1848(i)(3) (42 U.S.C. 1395w–4(i)(3)) is amended by striking the space before the period at the end.

(B) Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(i) by striking "apply to" and inserting "would otherwise apply to", and

(ii) by inserting before the period at the end "but for the application of section 1848(i)(3)".

(i) Other Corrections.—(1) Effective on the date of the enactment of this Act, section 6102(d)(4) of OBRA–1989 is amended by striking all that follows the first sentence.

(2) Effective for payments for fiscal years beginning with fiscal year 1994, section 1842(c)(1) (42 U.S.C. 1395u(c)(1)) is amended—

(A) in subparagraph (A), by striking "(A) Any contract" and inserting "Any contract"; and

(B) by striking subparagraph (B).

(j) Effective Date.—Except as provided in subsection (i), the amendments made by this section and the provisions of this section shall take effect as if included in the enactment of OBRA–1990.

Subpart B—Durable Medical Equipment

SEC. 8421. CERTIFICATION OF SUPPLIERS.

(a) Requirements.—

(1) In general.—Section 1834 (42 U.S.C. 1395m), as amended by section 13544(b)(1) of OBRA–1993, is amended by adding at the end the following new subsection:

"(j) Requirements for Suppliers of Medical Equipment and Supplies.—

"(1) Issuance and renewal of supplier number.—

"(A) Payment.—Except as provided in subparagraph (C), no payment may be made under this part after the expiration of the 60-day period that begins on the date of the enactment of the Guaranteed Health Insurance Act of 1994, for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number.

"(B) Standards for possessing a supplier number.—A supplier may not obtain a supplier number unless—

"(i) for medical equipment and supplies furnished on or after the expiration of the 60-day period that begins on the date of the enactment of the Guaranteed Health Insurance Act of 1994, and before January 1, 1996, the supplier meets standards prescribed by the Secretary in regulations issued on June 18, 1992; and

"(ii) for medical equipment and supplies furnished on or after January 1, 1996, the supplier meets revised standards prescribed by the Secretary (in consultation with representatives of suppliers of medical equipment and supplies, carriers, and consumers) that shall include requirements that the supplier—

"(I) comply with all applicable State and Federal licensure and regulatory requirements;

"(II) maintain a physical facility on an appropriate site;

"(III) have proof of appropriate liability insurance; and

"(IV) meet such other requirements as the Secretary may specify.

"(C) Exception for items furnished as incident to a physician's service.—Subparagraph (A) shall not apply with respect to medical equipment and supplies furnished incident to a physician's service.

"(D) Prohibition against multiple supplier numbers.—The Secretary may not issue more than one supplier number to any supplier of medical equipment and supplies unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

"(E) Prohibition against delegation of supplier determinations.—The Secretary may not delegate (other than by contract under section 1842) the responsibility to determine whether suppliers meet the standards necessary to obtain a supplier number.

"(2) Certificates of medical necessity.—

"(A) Limitation on information provided by suppliers on certificates of medical necessity.—

"(i) In general.—Effective upon the expiration of the 60-day period that begins on the date of the enactment of the Guaranteed Health Insurance Act of 1994, a supplier of medical equipment and supplies may distribute to physicians, or to individuals entitled to benefits under this part, a certificate of medical necessity for commercial purposes which contains no more than the following information completed by the supplier:

"(I) An identification of the supplier and the beneficiary to whom such medical equipment and supplies are furnished.

"(II) A description of such medical equipment and supplies.

"(III) Any product code identifying such medical equipment and supplies.

"(IV) Any other administrative information (other than information relating to the beneficiary's medical condition) identified by the Secretary.

"(ii) Information on payment amount and charges.—If a supplier distributes a certificate of medical necessity containing any of the information permitted to be supplied under clause (i), the supplier shall also list on the certificate of medical necessity the fee schedule amount and the supplier's charge for the medical equipment or supplies being furnished prior to distribution of such certificate to the physician.

"(iii) Penalty.—Any supplier of medical equipment and supplies who knowingly and willfully distributes a certificate of medical necessity in violation of clause (i) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed $1,000 for each such certificate of medical necessity so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

"(B) Definition.—For purposes of this paragraph, the term 'certificate of medical necessity' means a form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

"(3) Definition.—The term 'medical equipment and supplies' means—

"(A) durable medical equipment (as defined in section 1861(n));

"(B) prosthetic devices (as described in section 1861(s)(8));

"(C) orthotics and prosthetics (as described in section 1861(s)(9));

"(D) surgical dressings (as described in section 1861(s)(5));

"(E) such other items as the Secretary may determine; and

"(F) for purposes of paragraph (1)—

"(i) home dialysis supplies and equipment (as described in section 1861(s)(2)(F)),

"(ii) immunosuppressive drugs (as described in section 1861(s)(2)(J)),

"(iii) therapeutic shoes for diabetics (as described in section 1861(s)(12)),

"(iv) oral drugs prescribed for use as an anticancer therapeutic agent (as described in section 1861(s)(2)(Q)), and

"(v) self-administered erythropoetin (as described in section 1861(s)(2)(P)).".

(2) Conforming amendment.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by striking paragraph (16).

(b) Use of Covered Items by Disabled Beneficiaries.—

(1) In general.—The Secretary of Health and Human Services, in consultation with representatives of suppliers of durable medical equipment under part B of the medicare program and individuals entitled to benefits under such program on the basis of disability, shall conduct a study of the effects of the methodology for determining payments for items of such equipment under such part on the ability of such individuals to obtain items of such equipment, including customized items.

(2) Report.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate to assure that disabled medicare beneficiaries have access to items of durable medical equipment.

(c) Criteria for Treatment of Items as Prosthetic Devices or Orthotics and Prosthetics.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate describing prosthetic devices or orthotics and prosthetics covered under part B of the medicare program that do not require individualized or custom fitting and adjustment to be used by a patient. Such report shall include recommendations for an appropriate methodology for determining the amount of payment for such items under such program.

SEC. 8422. RESTRICTIONS ON CERTAIN MARKETING AND SALES ACTIVITIES.

(a) Prohibiting Unsolicited Telephone Contacts From Suppliers of Durable Medical Equipment to Medicare Beneficiaries.—

(1) In general.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraph:

"(17) Prohibition against unsolicited telephone contacts by suppliers.—

"(A) In general.—A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual unless 1 of the following applies:

"(i) The individual has given written permission to the supplier to make contact by telephone regarding the furnishing of a covered item.

"(ii) The supplier has furnished a covered item to the individual and the supplier is contacting the individual only regarding the furnishing of such covered item.

"(iii) If the contact is regarding the furnishing of a covered item other than a covered item already furnished to the individual, the supplier has furnished at least 1 covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

"(B) Prohibiting payment for items furnished subsequent to unsolicited contacts.—If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

"(C) Exclusion from program for suppliers engaging in pattern of unsolicited contacts.—If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier's conduct establishes a pattern of contacts in violation of such subparagraph, the Secretary shall exclude the supplier from participation in the programs under this Act, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1128.".

(2) Requiring refund of amounts collected for disallowed items.—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

"(18) Refund of amounts collected for certain disallowed items.—

"(A) In general.—If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B), the supplier shall refund on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

"(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B), or

"(ii) before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item.

"(B) Sanctions.—If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1842(j)(2).

"(C) Notice.—Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

"(D) Timely basis defined.—A refund under subparagraph (A) is considered to be on a timely basis only if—

"(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

"(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.".

(b) Conforming Amendment.—Section 1834(h)(3) (42 U.S.C. 1395m(h)(3)) is amended by striking "Paragraph (12)" and inserting "Paragraphs (12) and (17)".

(c) Effective Date.—The amendments made by subsections (a) and (b) shall apply to items furnished after the expiration of the 60-day period that begins on the date of the enactment of this Act.

SEC. 8423. BENEFICIARY LIABILITY FOR NONCOVERED SERVICES.

(a) Unassigned Claims.—Section 1834(j) (42 U.S.C. 1395m(i)), as added by section 8421(a)(1), is amended—

(A) by redesignating paragraph (3) as paragraph (4), and

(B) by inserting after paragraph (2) the following new paragraph:

"(3) Limitation on patient liability.—If a supplier of medical equipment and supplies (as defined in paragraph (4))—

"(A) furnishes an item or service to a beneficiary for which no payment may be made by reason of paragraph (1);

"(B) furnishes an item or service to a beneficiary for which payment is denied in advance under subsection (a)(15); or

"(C) furnishes an item or service to a beneficiary for which payment is denied under section 1862(a)(1);

any expenses incurred for items and services furnished to an individual by such a supplier not on an assigned basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of subsection (a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such subsection.".

(b) Assigned Claims.—Section 1879 (42 U.S.C. 1395pp) is amended by adding at the end the following new subsection:

"(h) If a supplier of medical equipment and supplies (as defined in section 1834(j)(4))—

"(1) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1834(j)(1);

"(2) furnishes an item or service to a beneficiary for which payment is denied in advance under section 1834(a)(15); or

"(3) furnishes an item or service to a beneficiary for which no payment may be made by reason of section 1834(a)(17)(B),

any expenses incurred for items and services furnished to an individual by such a supplier on an assignment-related basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of section 1834(a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such section.".

(c) Effective Date.—The amendments made by this section shall apply to items or services furnished on or after the expiration of the 60-day period that begins on the date of the enactment of this Act.

SEC. 8424. ADJUSTMENTS FOR INHERENT REASONABLENESS.

(a) Adjustments Made to Final Payment Amounts.—

(1) In general.—Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended by adding at the end the following: "In applying such provisions to payments for an item under this subsection, the Secretary shall make adjustments to the payment basis for the item described in paragraph (1)(B) if the Secretary determines (in accordance with such provisions and on the basis of prices and costs applicable at the time the item is furnished) that such payment basis is not inherently reasonable.".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(b) Adjustment Required for Certain Items.—

(1) In general.—In accordance with section 1834(a)(10)(B) of the Social Security Act (as amended by subsection (a)), the Secretary of Health and Human Services shall determine whether the payment amounts for the items described in paragraph (2) are not inherently reasonable, and shall adjust such amounts in accordance with such section if the amounts are not inherently reasonable.

(2) Items described.—The items referred to in paragraph (1) are decubitus care equipment, transcutaneous electrical nerve stimulators, and any other items considered appropriate by the Secretary.

SEC. 8425. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) Updates to Payment Amounts.—(1) Subparagraph (A) of section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended to read as follows:

"(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point; and".

(2) The amendment made by paragraph (1) shall be effective on the date of the enactment of this Act.

(b) Advance Determinations of Coverage.—(1) Effective on the expiration of the 60-day period that begins on date of the enactment of this Act, section 1834(a)(15) (42 U.S.C. 1395m(a)(15)) is amended to read as follows:

"(15) Advance determinations of coverage for certain items.—

"(A) Development of lists of items by Secretary.—The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area.

"(B) Development of lists of suppliers by Secretary.—The Secretary may develop and periodically update a list of suppliers of items for which payment may be made under this subsection with respect to whom—

"(i) the Secretary has found that a substantial number of claims for payment under this part for items furnished by the supplier have been denied on the basis of the application of section 1862(a)(1); or

"(ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

"(C) Determinations of coverage in advance.—A carrier shall determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered or because of the application of section 1862(a)(1) if—

"(i) the item is included on the list developed by the Secretary under subparagraph (A);

"(ii) the item is furnished by a supplier included on the list developed by the Secretary under subparagraph (B); or

"(iii) the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests that such advance determination be made.".

(2) Effective for standards applied for contract years beginning after the date of the enactment of this Act, section 1842(c) (42 U.S.C. 1395u(c)), as amended by section 8415(a), is amended by adding at the end the following new paragraph:

"(5) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier to meet criteria developed by the Secretary to measure the timeliness of carrier responses to requests for payment of items described in section 1834(a)(15)(C).".

(3) Effective on the date of the enactment of this Act, section 1834(h)(3) (42 U.S.C. 1395m(h)(3)), as amended by section 8423(b), is amended by striking "(12) and (17)" and inserting "(12), (15), and (17)".

(c) Study of Variations in Durable Medical Equipment Supplier Costs.—

(1) Collection and analysis of supplier cost data.—The Administrator of the Health Care Financing Administration shall, in consultation with appropriate organizations, collect data on supplier costs of durable medical equipment for which payment may be made under part B of the medicare program, and shall analyze such data to determine the proportions of such costs attributable to the service and product components of furnishing such equipment and the extent to which such proportions vary by type of equipment and by the geographic region in which the supplier is located.

(2) Development of geographic adjustment index; reports.—Not later than 6 months after collecting and analyzing the data described in paragraph (1)—

(A) the Administrator shall submit a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the data collected and the analysis conducted under paragraph (1), and shall include in such report the Administrator's recommendations for a geographic cost adjustment index for suppliers of durable medical equipment under the medicare program and an analysis of the impact of such proposed index on payments under the medicare program; and

(B) the Comptroller General shall submit a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate analyzing on a geographic basis the supplier costs of durable medical equipment under the medicare program.

(d) Oxygen Retesting.—(1) Section 1834(a)(5)(E) (42 U.S.C. 1395m(a)(5)(E)) is amended by striking "55" and inserting "56".

(2) The amendment made by paragraph (1) shall be effective on the date of the enactment of this Act.

(e) Other Miscellaneous and Technical Amendments.—(1) Section 4152(a)(3) of OBRA–1990 is amended by striking "amendment made by subsection (a)" and inserting "amendments made by this subsection".

(2) Section 4152(c)(2) of OBRA–1990 is amended by striking "1395m(a)(7)(A)" and inserting "1395m(a)(7)".

(3) Section 1834(a)(7)(A)(iii)(II) (42 U.S.C. 1395m(a)(7)(A)(iii)(II)) is amended by striking "clause (v)" and inserting "clause (vi)".

(4) Section 1834(a)(7)(C)(i) (42 U.S.C. 1395m(a)(7)(C)(i)) is amended by striking "or paragraph (3)".

(5) Section 1834(a)(3) (42 U.S.C. 1395m(a)(3)) is amended by striking subparagraph (D).

(6) Section 4153(c)(1) of OBRA–1990 is amended by striking "1834(a)" and inserting "1834(h)".

(7) Section 4153(d)(2) of OBRA–1990 is amended by striking "Reconiliation" and inserting "Reconciliation".

(8) The amendments made by this subsection shall take effect as if included in the enactment of OBRA–1990.

Subpart C—Other Items and Services

SEC. 8431. AMBULATORY SURGICAL CENTER SERVICES.

(a) Payment Amounts for Services Furnished in Ambulatory Surgical Centers.—

(1) Use of survey to determine incurred costs.—Section 1833(i)(2)(A)(i) (42 U.S.C. 1395l(i)(2)(A)(i)) is amended by striking the comma at the end and inserting the following: ", as determined in accordance with a survey (based upon a representative sample of procedures and facilities) taken not later

than January 1, 1995, and every 5 years thereafter, of the actual audited costs incurred by such centers in providing such services,".

(2) AUTOMATIC APPLICATION OF INFLATION ADJUSTMENT.—Section 1833(i)(2) (42 U.S.C. 1395l(i)(2)) is amended—

(A) in the second sentence of subparagraph (A) and the second sentence of subparagraph (B), by striking "and may be adjusted by the Secretary, when appropriate,"; and

(B) by adding at the end the following new subparagraph:

"(C) Notwithstanding the second sentence of subparagraph (A) or the second sentence of subparagraph (B), if the Secretary has not updated amounts established under such subparagraphs with respect to facility services furnished during a fiscal year (beginning with fiscal year 1996), such amounts shall be increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.".

(3) CONSULTATION REQUIREMENT.—The second sentence of section 1833(i)(1) (42 U.S.C. 1395l(i)(1)) is amended by striking the period and inserting the following: ", in consultation with appropriate trade and professional organizations.".

(b) ADJUSTMENTS TO PAYMENT AMOUNTS FOR NEW TECHNOLOGY INTRAOCULAR LENSES.—

(1) ESTABLISHMENT OF PROCESS FOR REVIEW OF AMOUNTS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall develop and implement a process under which interested parties may request review by the Secretary of the appropriateness of the reimbursement amount provided under section 1833(i)(2)(A)(iii) of the Social Security Act with respect to a class of new technology intraocular lenses. For purposes of the preceding sentence, an intraocular lens may not be treated as a new technology lens unless it has been approved by the Food and Drug Administration.

(2) FACTORS CONSIDERED.—In determining whether to provide an adjustment of payment with respect to a particular lens under paragraph (1), the Secretary shall take into account whether use of the lens is likely to result in reduced risk of intraoperative or postoperative complication or trauma, accelerated postoperative recovery, reduced induced astigmatism, improved postoperative visual acuity, more stable postoperative vision, or other comparable clinical advantages.

(3) NOTICE AND COMMENT.—The Secretary shall publish notice in the Federal Register from time to time (but no less often than once each year) of a list of the requests that the Secretary has received for review under this subsection, and shall provide for a 30-day comment period on the lenses that are the subjects of the requests contained in such notice. The Secretary shall publish a notice of the Secretary's determinations with respect to intraocular lenses listed in the notice within 90 days after the close of the comment period.

(4) EFFECTIVE DATE OF ADJUSTMENT.—Any adjustment of a payment amount (or payment limit) made under this subsection shall become effective not later than 30 days after the date on which the notice with respect to the adjustment is published under paragraph (3).

(c) TECHNICAL CORRECTION RELATING TO BLEND AMOUNTS FOR AMBULATORY SURGICAL CENTER PAYMENTS.—

(1) IN GENERAL.—Subclauses (I) and (II) of section 1833(i)(3)(B)(ii) (42 U.S.C. 1395l(i)(3)(B)(ii)) are each amended—

(A) by striking "for reporting" and inserting "for portions of cost reporting"; and

(B) by striking "and on or before" and inserting "and ending on or before".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the enactment of OBRA-1990.

(d) TECHNICAL CORRECTION RELATED TO CATARACT SURGERY.—Effective as if included in the enactment of OBRA-1990, section 4151(c)(3) of such Act is amended by striking "for the insertion of an intraocular lens" and inserting "for an intraocular lens inserted".

SEC. 8432. STUDY OF MEDICARE COVERAGE OF PATIENT CARE COSTS ASSOCIATED WITH CLINICAL TRIALS OF NEW CANCER THERAPIES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the effects of expressly covering under the medicare program the patient care costs for beneficiaries enrolled in clinical trials of new cancer therapies, where the protocol for the trial has been approved by the National Cancer Institute or meets similar scientific and ethical standards, including approval by an institutional review board. The study shall include—

(1) an estimate of the cost of such coverage, taking into account the extent to which medicare currently pays for such patient care costs in practice;

(2) an assessment of the extent to which such clinical trials represent the best available treatment for the patients involved and of the effects of participation in the trials on the health of such patients;

(3) an assessment of whether progress in developing new anticancer therapies would be assisted by medicare coverage of such patient care costs; and

(4) an evaluation of whether there should be special criteria for the admission of medicare beneficiaries (on account of their age or physical condition) to clinical trials for which medicare would pay the patient care costs.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report on the study conducted under subsection (a) to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. Such report shall include recommendations as to the coverage under the medicare program of patient care costs of beneficiaries enrolled in clinical trials of new cancer therapies.

SEC. 8433. STUDY OF ANNUAL CAP ON AMOUNT OF MEDICARE PAYMENT FOR OUTPATIENT PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the appropriateness of continuing an annual limitation on the amount of payment for outpatient services of independently practicing physical and occupational therapists under the medicare program.

(b) REPORT.—By not later than January 1, 1996, the Secretary shall submit to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the study conducted under subsection (a). Such report shall include such recommendations for changes in such annual limitation as the Secretary finds appropriate.

SEC. 8434. PAYMENT OF PART B PREMIUM LATE ENROLLMENT PENALTIES BY STATES.

Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

"(g)(1) Upon the request of a State, the Secretary may enter into an agreement with the State under which the State agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)).

"(2) No part B late enrollment premium increase shall apply to an eligible individual for premiums for months for which the amount of such an increase is payable under an agreement under paragraph (1).

"(3) In this subsection:

"(A) The term 'eligible individual' means an individual who is enrolled under this part B and who is within a class of individuals specified in the agreement under paragraph (1).

"(B) The term 'part B late enrollment premium increase' means any increase in a premium as a result of the application of subsection (b).".

SEC. 8435. TREATMENT OF INPATIENTS AND PROVISION OF DIAGNOSTIC X-RAY SERVICES BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.

(a) TREATMENT OF INPATIENTS.—Section 1861(aa) (42 U.S.C. 1395x(aa)) is amended—

(1) in paragraph (1), in the matter following subparagraph (C), by striking "as an outpatient" and inserting "as a patient";

(2) in paragraph (2)(A), by striking "furnishing to outpatients" and inserting "furnishing to patients"; and

(3) in paragraph (3), in the matter following subparagraph (B), by striking "as an outpatient" and inserting "as a patient".

(b) TREATMENT OF DIAGNOSTIC X-RAY SERVICES.—Section 1861(aa) (42 U.S.C. 1395x(aa)) is further amended—

(1) in paragraph (1)(A), by inserting "(i)" after "(A)" and by adding at the end the following: "and (ii) diagnostic x-ray services,", and

(2) in paragraph (2)(A), by striking "(A)" and inserting "(A)(i)".

(c) CONFORMING AMENDMENT.—Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking "and services of a certified registered nurse anesthetist" and inserting "services of a certified registered nurse anesthetist, rural health clinic services, and Federally-qualified health center services".

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1995, and shall apply to services furnished on or after such date.

SEC. 8436. APPLICATION OF MAMMOGRAPHY CERTIFICATION REQUIREMENTS.

(a) SCREENING MAMMOGRAPHY.—Section 1834(c) (42 U.S.C. 1395m(c)) is amended—

(1) in paragraph (1)(B), by striking "meets the quality standards established under paragraph (3)" and inserting "is conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act";

(2) in paragraph (1)(C)(iii), by striking "paragraph (4)" and inserting "paragraph (3)";

(3) by striking paragraph (3); and

(4) by redesignating paragraphs (4) and (5) as paragraphs (3) and (4).

(b) DIAGNOSTIC MAMMOGRAPHY.—Section 1861(s)(3) (42 U.S.C. 1395x(s)(3)) is amended by inserting "and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act" after "necessary".

(c) CONFORMING AMENDMENTS.—(1) Section 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended by striking "or which does not meet the standards established under section 1834(c)(3)" and inserting "or which is not conducted by a facility described in section 1834(c)(1)(B)".

(2) Section 1863 (42 U.S.C. 1395z) is amended by striking "or whether screening mammography meets the standards established under section 1834(c)(3),".

(3) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by striking ", or whether screening mammography meets the standards established under section 1834(c)(3)".

(4) The third sentence of section 1865(a) (42 U.S.C. 1395bb(a)) is amended by striking "1834(c)(3),".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to mammography furnished by a facility on and after the first date that the certificate requirements of section 354(b) of the Public Health Service Act apply to such mammography conducted by such facility.

SEC. 8437. COVERAGE OF SERVICES OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS.

(a) SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by section 8438(f)(6)(E), is amended by inserting after subsection (kk) the following new subsection:

"Speech-Language Pathology Services; Audiology Services

"(ll)(1) The term 'speech-language pathology services' means such speech, language, and related function assessment and rehabilitation services furnished by a qualified speech-language pathologist as the speech-language pathologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician.

"(2) The term 'audiology services' means such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician.

"(3) In this subsection:

"(A) The term 'qualified speech-language pathologist' means an individual with a master's or doctoral degree in speech-language pathology who—

"(i) is licensed as a speech-language pathologist by the State in which the individual furnishes such services, or

"(ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 1 month of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.

"(B) The term 'qualified audiologist' means an individual with a master's or doctoral degree in audiology who—

"(i) is licensed as a speech-language pathologist by the State in which the individual furnishes such services, or

"(ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 1 month of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.".

(b) CONFORMING AMENDMENTS RELATING TO MEDICARE TREATMENT OF SPEECH AND LANGUAGE SERVICES.—

(1) EXTENDED CARE SERVICES.—Section 1861(h)(3) (42 U.S.C. 1395x(h)(3)) is amended by striking ", occupational, or speech therapy" and inserting "or occupational therapy or speech-language pathology services".

(2) HOME HEALTH SERVICES.—Section 1861(m)(2) (42 U.S.C. 1395x(m)(2)) is amended by striking ", occupational, or speech therapy" and inserting "or occupational therapy or speech-language pathology services".

(3) OUTPATIENT PHYSICAL THERAPY SERVICES.—The fourth sentence of section 1861(p) (42 U.S.C. 1395x(p)) is amended by striking "speech pathology services" and inserting "speech-language pathology services".

(4) COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES.—Section 1861(cc)(1)(B) (42 U.S.C. 1395x(cc)(1)(B)) is amended by striking "speech pathology services" and inserting "speech-language pathology services".

(5) HOSPICE CARE.—Section 1861(dd)(1)(B) (42 U.S.C. 1395x(dd)(1)(B)) is amended by striking "therapy or speech-language pathology" and inserting "therapy, or speech-language pathology services".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 8438. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) REVISION OF INFORMATION ON PART B CLAIMS FORMS.—Section 1833(q)(1) (42 U.S.C. 1395l(q)(1)) is amended—

(1) by striking "provider number" and inserting "unique physician identification number"; and

(2) by striking "and indicate whether or not the referring physician is an interested investor (within the meaning of section 1877(h)(5))".

(b) CONSULTATION FOR SOCIAL WORKERS.—Effective with respect to services furnished on or after January 1, 1991, section 6113(c) of OBRA–1989 is amended—

(1) by inserting "and clinical social worker services" after "psychologist services"; and

(2) by striking "psychologist" the second and third place it appears and inserting "psychologist or clinical social worker".

(c) REPORTS ON HOSPITAL OUTPATIENT PAYMENT.—(1) OBRA–1989 is amended by striking section 6137.

(2) Section 1135(d) (42 U.S.C. 1320b-5(d)) is amended—

(A) by striking paragraph (6); and

(B) in paragraph (7)—

(i) by striking "systems" each place it appears and inserting "system"; and

(ii) by striking "paragraphs (1) and (6)" and inserting "paragraph (1)".

(d) RADIOLOGY AND DIAGNOSTIC SERVICES PROVIDED IN HOSPITAL OUTPATIENT DEPARTMENTS.—(1) Effective as if included in the enactment of OBRA–1989, section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(A) by inserting "and for services described in subsection (a)(2)(E)(ii) furnished on or after January 1, 1992" after "1989"; and

(B) by striking "1842(b)" and inserting "1842(b) (or, in the case of services furnished on or after January 1, 1992, under section 1848)".

(2) Effective as if included in the enactment of OBRA–1989, section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended by striking "January 1, 1989" and inserting "April 1, 1989".

(e) PAYMENTS TO NURSE PRACTITIONERS IN RURAL AREAS (SECTION 4155 OF OBRA–1990).—(1) Section 1861(s)(2)(K)(iii) (42 U.S.C. 1395x(s)(2)(K)(iii)) is amended—

(A) by striking "subsection (aa)(3)" and inserting "subsection (aa)(5)"; and

(B) by striking "subsection (aa)(4)" and inserting "subsection (aa)(6)".

(2) Section 1833(r)(1) (42 U.S.C. 1395l(r)(1)) is amended—

(A) by striking "ambulatory" each place it appears and inserting "or ambulatory"; and

(B) by striking "center," and inserting "center".

(3) Section 1833(r)(2)(A) (42 U.S.C. 1395l(r)(2)(A)) is amended by striking "subsection (a)(1)(M)" and inserting "subsection (a)(1)(O)".

(4) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking "subsection (s)(2)(K)(i)" and inserting "clauses (i) or (iii) of subsection (s)(2)(K)".

(5) Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended by striking "this Act" and inserting "this title".

(6) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking "1861(s)(2)(K)(i)" and inserting "1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)".

(7) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking "1861(s)(2)(K)(i)" and inserting "1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)".

(f) OTHER MISCELLANEOUS AND TECHNICAL AMENDMENTS.—

(1) IMMEDIATE ENROLLMENT IN PART B BY INDIVIDUALS COVERED BY AN EMPLOYMENT-BASED PLAN.—(A) Subparagraphs (A) and (B) of section 1837(i)(3) (42 U.S.C. 1395p(i)(3)) are each amended—

(i) by striking "beginning with the first day of the first month in which the individual is no longer enrolled" and inserting "including each month during any part of which the individual is enrolled"; and

(ii) by striking "and ending seven months later" and inserting "ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled".

(B) Paragraphs (1) and (2) of section 1838(e) (42 U.S.C. 1395q(e)) are amended to read as follows:

"(1) in any month of the special enrollment period in which the individual is at any time enrolled in a plan (specified in subparagraph (A) or (B), as applicable, of section 1837(i)(3)) or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

"(2) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.".

(C) The amendments made by subparagraphs (A) and (B) shall take effect on the first day of the first month that begins after the expiration of the 120-day period that begins on the date of the enactment of this Act.

(2) CLINICAL DIAGNOSTIC LABORATORY TESTS.—Section 4154(e)(5) of OBRA–1990 is amended by striking "(1)(A)" and inserting "(1)(A),".

(3) SEPARATE PAYMENT UNDER PART B FOR CERTAIN SERVICES.—Section 4157(a) of OBRA–1990 is amended by striking "(a) SERVICES OF" and all that follows through "Section" and inserting "(a) TREATMENT OF SERVICES OF CERTAIN HEALTH PRACTITIONERS.—Section".

(4) COMMUNITY HEALTH CENTERS AND RURAL HEALTH CLINICS.—(A) The fourth sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended—

(i) by striking "certification" the first place it appears and inserting "approval"; and

(ii) by striking "the Secretary's approval or disapproval of the certification" and inserting "Secretary's approval or disapproval".

(B) Section 4161(a)(7)(B) of OBRA–1990 is amended by inserting "and to the Committee on Finance of the Senate" after "Representatives".

(5) SCREENING MAMMOGRAPHY.—Section 4163 of OBRA–1990 is amended—

(A) by adding at the end of subsection (d) the following new paragraph:

"(3) The amendment made by paragraph (2)(A)(iv) shall apply to screening pap smears performed on or after July 1, 1990."; and

(B) in subsection (e), by striking "The amendments" and inserting "Except as provided in subsection (d)(3), the amendments".

(6) INJECTABLE DRUGS FOR TREATMENT OF OSTEOPOROSIS.—

(A) CLARIFICATION OF DRUGS COVERED.—The section 1861(jj) (42 U.S.C. 1395x(jj)) inserted by section 4156(a)(2) of OBRA–1990 is amended—

(i) in the matter preceding paragraph (1), by striking "a bone fracture related to"; and

(ii) in paragraph (1), by striking "patient" and inserting "individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual".

(B) LIMITING COVERAGE TO DRUGS PROVIDED BY HOME HEALTH AGENCIES.—(i) The section 1861(jj) (42 U.S.C. 1395x(jj)) inserted by section 4156(a)(2) of OBRA–1990 is amended by striking "if" and inserting "by a home health agency if".

(ii) Section 1861(m)(5) (42 U.S.C. 1395x(m)(5)) is amended by striking "but excluding" and inserting "and a covered osteoporosis drug (as defined in subsection (kk), but excluding other".

(iii) Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(I) by adding "and" at the end of subparagraph (N), and

(II) by striking subparagraph (O) and redesignating subparagraph (P) as subparagraph (O).

(C) PAYMENT BASED ON REASONABLE COST.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (A), by striking "health services" and inserting "health services (other than a covered osteoporosis drug (as defined in section 1861(kk)))";

(ii) by striking "and" at the end of subparagraph (D);

(iii) by striking the semicolon at the end of subparagraph (E) and inserting "; and"; and

(iv) by adding at the end the following new subparagraph:

"(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v);".

(D) APPLICATION OF PART B DEDUCTIBLE.—Section 1833(b)(2) (42 U.S.C. 1395l(b)(2)) is amended by striking "services" and inserting "services (other than a covered osteoporosis drug (as defined in section 1861(kk)))".

(E) COVERED OSTEOPOROSIS DRUG (SECTION 4156 OF OBRA–1990).—Section 1861 (42 U.S.C. 1395x) is amended, in the subsection (jj) inserted by section 4156(a)(2) of OBRA–1990, by striking "(jj) The term" and inserting "(kk) The term".

(7) OTHER MISCELLANEOUS AND TECHNICAL CORRECTIONS.—

(A) OWNERSHIP DISCLOSURE REQUIREMENTS.—(i) Section 1124A(a)(2)(A) (42 U.S.C. 1320a–3a(a)(2)(A)) is amended by striking "of the Social Security Act".

(ii) Section 4164(b)(4) of OBRA–1990 is amended by striking "paragraph" and inserting "paragraphs".

(B) DIRECTORY OF UNIQUE PHYSICIAN IDENTIFIER NUMBERS.—Section 4164(c) of OBRA–1990 is amended by striking "publish" and inserting "publish, and shall periodically update,".

(g) EFFECTIVE DATE.—Except as otherwise provided in this section, the amendments made by this section shall take effect as if included in the enactment of OBRA–1990.

PART 3—PROVISIONS RELATING TO PARTS A AND B

Subpart A—Medicare Secondary Payer

SEC. 8441. MEDICARE SECONDARY PAYER REFORMS.

(a) IMPROVING IDENTIFICATION OF MEDICARE SECONDARY PAYER SITUATIONS.—

(1) SURVEY OF BENEFICIARIES.—

(A) IN GENERAL.—Section 1862(b)(5) (42 U.S.C. 1395y(b)(5)) is amended by adding at the end the following new subparagraph:

"(D) OBTAINING INFORMATION FROM BENEFICIARIES.—Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.".

(B) DISTRIBUTION OF QUESTIONNAIRE BY CONTRACTOR.—The Secretary of Health and Human Services shall enter into an agreement with an entity not later than the expiration of the 60-day period that begins on the date of the enactment of this Act, to distribute the questionnaire described in section 1862(b)(5)(D) of the Social Security Act (as added by subparagraph (A)).

(C) NO MEDICARE SECONDARY PAYER DENIAL BASED ON FAILURE TO COMPLETE QUESTIONNAIRE.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended by adding at the end the following new subparagraph:

"(C) TREATMENT OF QUESTIONNAIRES.—The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.".

(2) MANDATORY SCREENING BY PROVIDERS AND SUPPLIERS UNDER PART B.—

(A) IN GENERAL.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraph:

"(6) SCREENING REQUIREMENTS FOR PROVIDERS AND SUPPLIERS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

"(B) PENALTIES.—An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply with respect to items and services furnished on or after the expiration of the 120-day period that begins on the date of the enactment of this Act.

(b) IMPROVEMENTS IN RECOVERY OF PAYMENTS FROM PRIMARY PAYERS.—

(1) SUBMISSION OF REPORTS ON EFFORTS TO RECOVER ERRONEOUS PAYMENTS.—

(A) FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1396h) is amended by adding at the end the following new subsection:

"(k) An agreement with an agency or organization under this section shall require that such agency or organization submit an annual report to the Secretary describing the steps taken to recover payments made for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).".

(B) CARRIERS UNDER PART B.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(i) by striking "and" at the end of subparagraph (G);

(ii) by striking "and" at the end of subparagraph (H); and

(iii) by inserting after subparagraph (H) the following new subparagraph:

"(I) will submit annual reports to the Secretary describing the steps taken to recover payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)); and".

(2) REQUIREMENTS UNDER CARRIER PERFORMANCE EVALUATION PROGRAM.—

(A) FISCAL INTERMEDIARIES UNDER PART A.—Section 1816(f)(1)(A) (42 U.S.C. 1396h(f)(1)(A)) is amended by striking "processing" and inserting "processing (including the agency's or organization's success in recovering payments made under this title for services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)))".

(B) CARRIERS UNDER PART B.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following new subparagraph:

"(D) In addition to any other standards and criteria established by the Secretary for evaluating carrier performance under this paragraph relating to avoiding erroneous payments, the carrier shall be subject to standards and criteria relating to the carrier's success in recovering payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).".

(3) DEADLINE FOR REIMBURSEMENT BY PRIMARY PLANS.—

(A) IN GENERAL.—Section 1862(b)(2)(B)(i) (42 U.S.C. 1395y(b)(2)(B)(i)) is amended by adding at the end the following sentence: "If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).".

(B) CONFORMING AMENDMENT.—The heading of clause (i) of section 1862(b)(2)(B) is amended to read as follows: "REPAYMENT REQUIRED.—".

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to payments for items and services furnished on or after the date of the enactment of this Act.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to contracts with fiscal intermediaries and carriers under title XVIII of the Social Security Act for contract years beginning on or after the date of the enactment of this Act.

(c) MISCELLANEOUS AND TECHNICAL CORRECTIONS.—

(1) Effective as if included in the enactment of OBRA–1993, section 1862(b)(1)(A) (42 U.S.C. 1395y(b)(1)(A)), as amended by section 13561(e)(1) of OBRA–1993, is amended—

(A) in clause (i)(II), by striking "over (and the individual's spouse age 65 or older) who is covered under the plan by virtue of the individual's current employment status with an employer" and inserting "older (and the spouse age 65 or older of any individual) who has current employment status with an employer"; and

(B) in clause (ii), by striking "or employee organization that has 20 or more individuals in current employment status" and inserting "that has 20 or more employees".

(2) Effective as if included in the enactment of OBRA–1993, section 1837(i) (42 U.S.C. 1395p(i)) is amended—

(A) by striking "as an active individual (as those terms are defined in section 1862(b)(1)(B)(iv))" each place it appears in the second sentence of paragraph (1), and the second sentence of paragraph (2) and inserting "(as that term is defined in section 1862(b)(1)(B)(iv)) by reason of the individual's current employment status (or the current employment status of a family member of the individual)";

(B) in paragraph (3)(B), by striking "as an active individual in a large group health plan (as such terms are defined in section 1862(b)(1)(B)(iv))" and inserting "in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iv)) by reason of the individual's current employment status (or the current employment status of a family member of the individual)";

(C) in the second sentence of paragraph (2) (as amended by subparagraph (A)), by striking "as an active individual" and inserting "by reason of the individual's current employment status (or the current employment status of a family member of the individual)"; and

(D) by inserting "status" after "current employment" each place it appears in paragraphs (1)(A), (2)(B), (2)(C), and (3)(A).

(3) Effective as if included in the enactment of OBRA–1993, the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) is amended—

(A) by inserting "status" after "current employment", and

(B) by striking "as an active individual (as those terms are defined in section 1862(b)(1)(B)(iv))" and inserting "(as that term is defined in section 1862(b)(1)(B)(iv)) by reason of the individual's current employment status (or the current employment status of a family member of the individual)".

(4) Effective as if included in the enactment of OBRA–1990, the sentence in section 1862(b)(1)(C) added by section 4203(c)(1)(B) of OBRA–1990 is amended by striking "clauses (i) and (ii)" and inserting "this subparagraph".

(5) Effective as if included in the enactment of OBRA–1989, section 1862(b)(1)(C) is amended in the matter after clause (ii), by striking "taking into account that" and inserting "paying benefits secondary to this title when".

(6) Effective as if included in the enactment of OBRA–1989, section 1862(b)(5)(C)(i) (42 U.S.C. 1395y(b)(5)(C)(i)) is amended by striking "6103(l)(12)(D)(iii)" and inserting "6103(l)(12)(E)(iii)".

(7) Effective as if included in the enactment of OBRA–1990, section 4203(c)(2) of such Act is amended—

(A) by striking "the application of clause (iii)" and inserting "the second sentence";

(B) by striking "on individuals" and all that follows through "section 226A of such Act";

(C) in clause (ii), by striking "clause" and inserting "sentence";

(D) in clause (v), by adding "and" at the end; and

(E) in clause (vi)—

(i) by inserting "of such Act" after "1862(b)(1)(C)", and

(ii) by striking the period at the end and inserting the following: ", without regard to the number of employees covered by such plans.".

(8) Effective as if included in the enactment of OBRA–1990, section 4203(d) of OBRA–1990 is amended by striking "this subsection" and inserting "this section".

(9) Effective as if included in the enactment of OBRA–1993, section 13561(e)(1)(D) of OBRA–1993 is amended—

(A) by inserting "effective as if included in the enactment of OBRA–1989," after "(D)", and

(B) by striking "of each subparagraph".

(10) The amendment made by section 13561(e)(1)(G) of OBRA–1993, to the extent it relates to the definition of large group health plan, shall be effective as if included in the enactment of OBRA–1989.

Subpart B—Other Items and Services Relating to Parts A and B

SEC. 8451. DEFINITION OF FMGEMS EXAMINATION FOR PAYMENT OF DIRECT GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1886(h)(5)(E) (42 U.S.C. 1395ww(h)(5)(E)) is amended by inserting "or any successor examination" after "Medical Sciences".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

SEC. 8452. QUALIFIED MEDICARE BENEFICIARY OUTREACH.

Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish and implement a method for obtaining information from newly eligible medicare beneficiaries that may be used to determine whether such beneficiaries may be eligible for medical assistance for medicare cost-sharing under State medicaid plans as qualified medicare beneficiaries, and for transmitting such information to the State in which such a beneficiary resides.

SEC. 8453. HOSPITAL AGREEMENTS WITH ORGAN PROCUREMENT ORGANIZATIONS.

(a) HOSPITAL AGREEMENTS.—

(1) IN GENERAL.—

(A) IDENTIFICATION OF ORGAN DONORS.—Section 1138(a)(1)(A)(iii) (42 U.S.C. 1320b–8(a)(1)(A)(iii)) is amended to read as follows:

"(iii) require that such hospital's designated organ procurement agency (as defined in paragraph (3)(B)) is notified of potential organ donors;".

(B) AGREEMENTS WITH DESIGNATED ORGAN PROCUREMENT AGENCIES.—Section 1138(a)(1) (42 U.S.C. 1320b–8(a)(1)) is amended—

(i) by striking the period at the end of subparagraph (B) and inserting "; and"; and

(ii) by adding at the end the following new subparagraph:

"(C) the hospital or rural primary care hospital has an agreement (as defined in paragraph (3)(A)) only with such hospital's designated organ procurement agency.".

(C) WAIVER OF REQUIREMENTS RELATED TO AGREEMENTS.—Section 1138(a) (42 U.S.C. 1320b–8(a)) is amended—

(i) by redesignating paragraph (2) as paragraph (3); and

(ii) by inserting after paragraph (1) the following new paragraph:

"(2)(A) The Secretary shall grant a waiver of the requirements under subparagraphs (A)(iii) and (C) of paragraph (1) to a hospital or rural primary care hospital desiring to enter into an agreement with an organ procurement agency other than such hospital's designated organ procurement agency if the Secretary determines that—

"(i) the waiver is expected to increase organ donation; and

"(ii) the waiver will assure equitable treatment of patients referred for transplants within the service area served by such hospital's designated organ procurement agency and within the service area served by the organ procurement agency with which the hospital seeks to enter into an agreement under the waiver.

"(B) In making a determination under subparagraph (A), the Secretary may consider factors that would include, but not be limited to—

"(i) cost effectiveness;

"(ii) improvements in quality;

"(iii) whether there has been any change in a hospital's designated organ procurement agency due to a change made on or after December 28, 1992, in the definitions for metropolitan statistical areas (as established by the Office of Management and Budget); and

"(iv) the length and continuity of a hospital's relationship with an organ procurement agency other than the hospital's designated organ procurement agency;

except that nothing in this subparagraph shall be construed to permit the Secretary to grant a waiver that does not meet the requirements of subparagraph (A).

"(C) Any hospital or rural primary care hospital seeking a waiver under subparagraph (A) shall submit an application to the Secretary containing such information as the Secretary determines appropriate.

"(D) The Secretary shall—

"(i) publish a public notice of any waiver application received from a hospital or rural primary care hospital under this paragraph within 30 days of receiving such application; and

"(ii) prior to making a final determination on such application under subparagraph (A), offer interested parties the opportunity to submit written comments to the Secretary during the 60-day period beginning on the date such notice is published.".

(D) DEFINITIONS.—Section 1138(a)(3) (42 U.S.C. 1320b–8(a)(3)), as redesignated by subparagraph (C), is amended to read as follows:

"(3) For purposes of this subsection—

"(A) the term 'agreement' means an agreement described in section 371(b)(3)(A) of the Public Health Service Act;

"(B) the term 'designated organ procurement agency' means, with respect to a hospital or rural primary care hospital, the organ procurement agency designated pursuant to subsection (b) for the service area in which such hospital is located; and

"(C) the term 'organ' means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.".

(2) EXISTING AGREEMENTS.—Any hospital or rural primary care hospital which has an agreement (as defined in section 1138(a)(3)(A) of the Social Security Act) with an organ procurement agency other than such hospital's designated organ procurement agency (as defined in section 1138(a)(3)(B) of such Act) on the date of the enactment of this section shall, if such hospital desires to continue such agreement on and after the effective date of the amendments made by paragraph (1), submit an application to the Secretary for a waiver under section 1138(a)(2) of such Act not later than January 1, 1995, and such agreement may continue in effect pending the Secretary's determination with respect to such application.

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to hospitals and rural primary care hospitals participating in the programs under titles XVIII and XIX of the Social Security Act beginning January 1, 1995.

(b) STUDY ON HOSPITAL AGREEMENTS WITH ORGAN PROCUREMENT AGENCIES.—

(1) IN GENERAL.—The Office of Technology Assessment (referred to in this section as the "OTA") shall, pursuant to the approval of the Technology Assessment Board of the OTA, conduct a study to determine the efficacy and fairness of requiring a hospital to enter into an agreement under section 371(b)(3)(A) of the Public Health Service Act with the organ procurement agency designated pursuant to section 1138(b) of the Social Security Act for the service area in which such hospital is located and the impact of such requirement on the efficacy and fairness of organ procurement and distribution.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the OTA shall complete the study required under paragraph (1) and prepare and submit to the Committee on Finance and the Committee on Labor and Human Resources of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings of such study and the implications of such findings with respect to policies affecting organ procurement and distribution.

SEC. 8454. PEER REVIEW ORGANIZATIONS.

(a) REPEAL OF PRO PRECERTIFICATION REQUIREMENT FOR CERTAIN SURGICAL PROCEDURES.—

(1) IN GENERAL.—Section 1164 (42 U.S.C. 1320c–13) is repealed.

(2) CONFORMING AMENDMENTS.—

(A) Section 1154 (42 U.S.C. 1320c–3) is amended—

(i) in subsection (a), by striking paragraph (12), and

(ii) in subsection (d), by striking "(and except as provided in section 1164)".

(B) Section 1833 (42 U.S.C. 1395l) is amended—

(i) in subsection (a)(1)(D)(i), by striking ", or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)";

(ii) in subsection (a)(1), by striking subparagraph (G);

(iii) in subsection (a)(2)(A), by striking ", to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),";

(iv) in subsection (a)(2)(D)(i)—

(I) by striking "basis," and inserting "basis or", and

(II) by striking ", or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)";

(v) in subsection (a)(3), by striking "and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion"; and

(vi) in the first sentence of subsection (b), by striking "(4)" and all that follows through "and (5)" and inserting "and (4)".

(C) Section 1834(g)(1)(B) (42 U.S.C. 1395m(g)(1)(B)) is amended by striking "and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion".

(D) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(i) by adding "or" at the end of paragraph (14),

(ii) by striking "; or" at the end of paragraph (15) and inserting a period, and

(iii) by striking paragraph (16).

(E) The third sentence of section 1866(a)(2)(A) (42 U.S.C. 1395w(a)(2)(A)) is amended by striking ", with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services provided on or after the date of the enactment of this Act.

(b) MISCELLANEOUS AND TECHNICAL CORRECTIONS.—(1) The third sentence of section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended by striking "whehter" and inserting "whether".

(2)(A) Section 1154(a)(9)(B) (42 U.S.C. 1320c–3(a)(9)(B)) is amended to read as follows:

"(B) If the organization finds, after reasonable notice to and opportunity for discussion with the physician or practitioner concerned, that the physician or practitioner has furnished services in violation of section 1156(a) and the organization determines that the physician or practitioner should enter into a corrective action plan under section 1156(b)(1), the organization shall notify the State board or boards responsible for the licensing or disciplining of the physician or practitioner of its finding and of any action taken as a result of the finding.".

(B) Subparagraph (D) of section 1160(b)(1) (42 U.S.C. 1320c–9(b)(1)) is amended to read as follows:

"(D) to provide notice in accordance with section 1154(a)(9)(B);".

(3) Section 4205(d)(2)(B) of OBRA–1990 is amended by striking "amendments" and inserting "amendment".

(4) Section 1160(d) (42 U.S.C. 1320c–9(d)) is amended by striking "subpena" and inserting "subpoena".

(5) Section 4205(e)(2) of OBRA–1990 is amended by striking "amendments" and inserting "amendment" and by striking "all".

(6)(A) Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if included in the enactment of OBRA–1990.

(B) The amendments made by paragraph (2) (relating to the requirement on reporting of information to State boards) shall take effect on the date of the enactment of this Act.

SEC. 8455. HEALTH MAINTENANCE ORGANIZATIONS.

(a) ADJUSTMENT IN MEDICARE CAPITATION PAYMENTS TO TAKE INTO ACCOUNT SECONDARY PAYER STATUS.—

(1) IN GENERAL.—In defining the classes to be used in determining the annual per capita rate of payment under section 1876(a)(1)(B) of the Social Security Act to an eligible organization with a risk-sharing contract under such section (for contract years beginning on or after October 1, 1994), the Secretary of Health and Human Services shall treat as a separate class individuals entitled to benefits under title XVIII of such Act with respect to whom there is a group health plan that is a primary plan (within the meaning of section 1862(b)(2)(A) of such Act).

(2) DEADLINE FOR ANNOUNCEMENT OF RATES.—Not later than September 1, 1994, the Secretary shall announce annual per capita rates of payment for eligible organizations described in paragraph (1) that take into account the separate treatment of individuals with respect to whom there is a group health plan that is a primary plan.

(b) REVISIONS IN THE PAYMENT METHODOLOGY FOR RISK CONTRACTORS.—Section 4204(b) of OBRA–1990 is amended to read as follows:

"(b) REVISIONS IN THE PAYMENT METHODOLOGY FOR RISK CONTRACTORS.—(1)(A) Not later than October 1, 1995, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall submit a proposal to the Congress that provides for revisions to the payment method to be applied in years beginning with 1996 for organizations with a risk-sharing contract under section 1876(g) of the Social Security Act.

"(B) In proposing the revisions required under subparagraph (A), the Secretary shall consider—

"(i) the difference in costs associated with medicare beneficiaries with differing health status and demographic characteristics; and

"(ii) the effects of using alternative geographic classifications on the determinations of costs associated with beneficiaries residing in different areas.

"(2) Not later than 3 months after the date of submittal of the proposal under paragraph (1), the Comptroller General shall review the proposal and shall report to Congress on the appropriateness of the proposed modifications.".

(c) MISCELLANEOUS AND TECHNICAL CORRECTIONS.—(1) Section 1876(a)(3) (42 U.S.C. 1395mm(a)(3)) is amended by striking "subsection (c)(7)" and inserting "subsections (c)(2)(B)(ii) and (c)(7)".

(2) Section 4204(c)(3) of OBRA–1990 is amended by striking "for 1991" and inserting "for years beginning with 1991".

(3) Section 4204(d)(2) of OBRA–1990 is amended by striking "amendment" and inserting "amendments".

(4) Section 1876(a)(1)(E)(ii)(I) (42 U.S.C. 1395mm(a)(1)(E)(ii)(I)) is amended by striking the comma after "contributed to".

(5) Section 4204(e)(2) of OBRA–1990 is amended by striking "(which has a risk-sharing contract under section 1876 of the Social Security Act)".

(6) Section 4204(f)(4) of OBRA–1990 is amended by striking "final".

(7) Section 1862(b)(3)(C) (42 U.S.C. 1395y(b)(3)(C)) is amended—

(A) in the heading, by striking "PLAN" and inserting "PLAN OR A LARGE GROUP HEALTH PLAN";

(B) by striking "group health plan" and inserting "group health plan or a large group health plan";

(C) by striking ", unless such incentive is also offered to all individuals who are eligible for coverage under the plan"; and

(D) by striking "the first sentence of subsection (a) and other than subsection (b)" and inserting "subsections (a) and (b)".

(8) The amendments made by this subsection shall take effect as if included in the enactment of OBRA–1990.

SEC. 8456. HOME HEALTH AGENCIES.

(a) Use of Most Current Data in Determining Wage Index.—

(1) In general.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking "as of such date to" and inserting "and determined using the survey of the most recent available wages and wage-related costs of".

(2) Effective date.—The amendment made by paragraph (1) shall apply with respect to cost reporting periods beginning on or after July 1, 1996.

(b) Clarification of Extension of Waiver of Liability.—

(1) In general.—The second sentence of section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking "November 1, 1990" and inserting "December 31, 1995".

(2) Effective date.—The amendment made by paragraph (1) shall take effect as if included in the enactment of OBRA–1990.

SEC. 8457. PERMANENT EXTENSION OF AUTHORITY TO CONTRACT WITH FISCAL INTERMEDIARIES AND CARRIERS ON OTHER THAN A COST BASIS.

(a) In General.—Section 2326(a) of the Deficit Reduction Act of 1984, as amended by section 6215 of OBRA–1989, is amended in the third sentence by striking "during such period" and inserting "beginning with fiscal year 1990 and any subsequent fiscal year".

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 8458. TRANSPORTATION DEMONSTRATION PROJECT.

(a) In General.—The Secretary of Health and Human Services shall conduct a demonstration project at 2 sites to—

(1) examine methods to reduce the cost of non-emergency medical transportation and regularly scheduled medical transportation by coordinating the timing of the provision of non-emergency medical services with the availability of public transportation; and

(2) examine methods to reduce the cost of emergency medical transportation and emergency room treatment through the supervised use of ambulance emergency medical technicians.

(b) Selection of Sites.—Of the 2 sites selected for the demonstration project under subsection (a), one shall be in an urban area and one shall be in a rural area.

SEC. 8459. DIABETES TREATMENT DEMONSTRATION PROJECT.

The Secretary of Health and Human Services shall conduct a demonstration project at sites in urban and rural areas under which the Secretary shall provide for coverage under the medicare program of comprehensive diabetes treatment, management, and education services (including services necessary to provide intensive metabolic management found effective by the Diabetes Control and Complications Trial of the National Institutes of Health) to determine whether the manner in which payment is made for the treatment of diabetes under the medicare program should be modified.

SEC. 8460. EXPANSION OF NUMBER OF SITES FOR DEMONSTRATION PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).

Section 9412(b)(1) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "not more than 15" and inserting "not more than 30".

SEC. 8460A. MISCELLANEOUS AND TECHNICAL CORRECTIONS.

(a) Survey and Certification Requirements.—(1) Section 1864 (42 U.S.C. 1395aa) is amended—

(A) in subsection (e), by striking "title" and inserting "title (other than any fee relating to section 353 of the Public Health Service Act)"; and

(B) in the first sentence of subsection (a), by striking "1861(s) or" and all that follows through "Service Act," and inserting "1861(s),".

(2) An agreement made by the Secretary of Health and Human Services with a State under section 1864(a) of the Social Security Act may include an agreement that the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by the Secretary for the purpose of determining whether a laboratory meets the requirements of section 353 of the Public Health Service Act.

(b) Home Dialysis Demonstration Technical Corrections.—Section 4202 of OBRA–1990 is amended—

(1) in subsection (b)(1)(A), by striking "home hemodialysis staff assistant" and inserting "qualified home hemodialysis staff assistant (as described in subsection (d))";

(2) in subsection (b)(2)(B)(ii)(I), by striking "(as adjusted to reflect differences in area wage levels)";

(3) in subsection (c)(1)(A), by striking "skilled"; and

(4) in subsection (c)(1)(E), by striking "(b)(4)" and inserting "(b)(2)".

(c) Technical Correction to Revisions of Coverage for Immunosuppressive Drug Therapy.—The Secretary of Health and Human Services may administer section 1861(s)(2)(J) of the Social Security Act in a manner such that the months of coverage of drugs described in such section are provided consecutively, so long as the total number of months of coverage provided is the same as the number described in such section.

(d) Other Miscellaneous and Technical Provisions.—(1) Section 1833 (42 U.S.C. 1395l) is amended by redesignating the subsection (r) added by section 4206(b)(2) of OBRA–1990 as subsection (s).

(2) Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is amended by striking "1833(r)" and inserting "1833(s)".

(3) Section 4201(d)(2) of OBRA–1990 is amended by striking "(B) by striking", "(C) by striking", and "(3) by adding" and inserting "(1) by striking", "(ii) by striking", and "(B) by adding", respectively.

(4) The section following section 4206 of OBRA–1990 is amended by striking "Sec. 4027." and inserting "Sec. 4207.", and in this subtitle is referred to as section 4207 of OBRA–1990.

(5)(A) Section 4207(a)(1) of OBRA–1990 is amended by adding closing quotation marks and a period after "such review.".

(B) Section 4207(a)(4) of OBRA–1990 is amended by striking "this subsection" and inserting "paragraphs (2) and (3)".

(C) Section 4207(b)(1) of OBRA–1990 is amended by striking "section 3(7)" and inserting "section 601(a)(1)".

(6) Section 2355(b)(1)(B) of the Deficit Reduction Act of 1984, as amended by section 4207(b)(4)(B)(ii) of OBRA–1990, is amended—

(A) by striking "12907(c)(4)(A)" and inserting "4207(b)(4)(B)(i)", and

(B) by striking "feasibilitly" and inserting "feasibility".

(7) Section 4207(b)(4)(B)(iii)(III) of OBRA–1990 is amended by striking the period at the end and inserting a semicolon.

(8) Subsections (c)(3) and (e) of section 2355 of the Deficit Reduction Act of 1984, as amended by section 4207(b)(4)(B) of OBRA–1990, are each amended by striking "12907(c)(4)(A)" each place it appears and inserting "4207(b)(4)(B)".

(9) Section 4207(c)(2) of OBRA–1990 is amended by striking "the Committee on Ways and Means" each place it appears and inserting "the Committees on Ways and Means and Energy and Commerce".

(10) Section 4207(d) of OBRA–1990 is amended by redesignating the second paragraph (3) (relating to effective date) as paragraph (4).

(11) Section 4207(i)(2) of OBRA–1990 is amended—

(A) by striking the period at the end of clause (iii) and inserting a semicolon, and

(B) in clause (v), by striking "residents" and inserting "patients".

(12) Section 4207(j) of OBRA–1990 is amended by striking "title" each place it appears and inserting "subtitle".

PART 4—PROVISIONS RELATING TO MEDICARE SUPPLEMENTAL INSURANCE POLICIES

SEC. 8461. STANDARDS FOR MEDICARE SUPPLEMENTAL INSURANCE POLICIES.

(a) Simplification of Medicare Supplemental Policies.—

(1) Section 4351 of OBRA–1990 is amended by striking "(a) In General.—".

(2) Section 1882(p) (42 U.S.C. 1395ss(p)) is amended—

(A) in paragraph (1)(A)—

(i) by striking "promulgates" and inserting "changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate",

(ii) by striking "(such limitations, language, definitions, format, and standards referred to collectively in this subsection as 'NAIC standards'),", and

(iii) by striking "included a reference to the NAIC standards" and inserting "were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '1991 NAIC Model Regulation')";

(B) in paragraph (1)(B)—

(i) by striking "promulgate NAIC standards" and inserting "make the changes in the revised NAIC Model Regulation",

(ii) by striking "limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as 'Federal standards')" and inserting "a regulation", and

(iii) by striking "included a reference to the Federal standards" and inserting "were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '1991 Federal Regulation')";

(C) in paragraph (1)(C)(i), by striking "NAIC standards or the Federal standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation";

(D) in paragraphs (1)(C)(ii)(I), (1)(E), (2), and (9)(B), by striking "NAIC or Federal standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation";

(E) in paragraph (2)(C), by striking "(5)(B)" and inserting "(4)(B)";

(F) in paragraph (4)(A)(i), by inserting "or paragraph (6)" after "(B)";

(G) in paragraph (4), by striking "applicable standards" each place it appears and inserting "applicable 1991 NAIC Model Regulation or 1991 Federal Regulation";

(H) in paragraph (6), by striking "in regard to the limitation of benefits described in paragraph (4)" and inserting "described in clauses (i) through (iii) of paragraph (1)(A)";

(I) in paragraph (7), by striking "policyholder" and inserting "policyholders";

(J) in paragraph (8), by striking "after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection" and inserting "on and after the effective date specified in paragraph (1)(C) (but subject to paragraph (10)), in violation of the applicable 1991 NAIC Model Regulation or 1991 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clause (i), (ii), or (iii) of paragraph (1)(A)";

(K) in paragraph (9), by adding at the end the following new subparagraph:

"(D) Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C)."; and

(L) in paragraph (10), by striking "this subsection" and inserting "paragraph (1)(A)(i)".

(b) GUARANTEED RENEWABILITY.—Section 1882(q) (42 U.S.C. 1395ss(q)) is amended—

(1) in paragraph (2), by striking "paragraph (2)" and inserting "paragraph (4)", and

(2) in paragraph (4), by striking "the succeeding issuer" and inserting "issuer of the replacement policy".

(c) ENFORCEMENT OF STANDARDS.—

(1) Section 1882(a)(2) (42 U.S.C. 1395ss(a)(2)) is amended—

(A) in subparagraph (A), by striking "NAIC standards or the Federal standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation", and

(B) by striking "after the effective date of the NAIC or Federal standards with respect to the policy" and inserting "on and after the effective date specified in subsection (p)(1)(C)".

(2) The sentence in section 1882(b)(1) added by section 4353(c)(5) of OBRA–1990 is amended—

(A) by striking "The report" and inserting "Each report",

(B) by inserting "and requirements" after "standards",

(C) by striking "and" after "compliance,", and

(D) by striking the comma after "Commissioners".

(3) Section 1882(g)(2)(B) (42 U.S.C. 1395ss(g)(2)(B)) is amended by striking "Panel" and inserting "Secretary".

(4) Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is amended by striking "the the Secretary" and inserting "the Secretary".

(d) PREVENTING DUPLICATION.—

(1) Section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(A) by amending the first sentence to read as follows:

"(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title—

"(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

"(II) a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

"(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.";

(B) by designating the second sentence as clause (ii) and, in such clause, by striking "the previous sentence" and inserting "clause (i)";

(C) by designating the third sentence as clause (iii) and, in such clause—

(i) by striking "the previous sentence" and inserting "clause (i) with respect to the sale of a medicare supplemental policy", and

(ii) by striking "and the statement" and all that follows up to the period at the end; and

(D) by striking the last sentence.

(2) Section 1882(d)(3)(B) (42 U.S.C. 1395ss(d)(3)(B)) is amended—

(A) in clause (ii)(II), by striking "65 years of age or older",

(B) in clause (iii)(I), by striking "another medicare" and inserting "a medicare",

(C) in clause (iii)(I), by striking "such a policy" and inserting "a medicare supplemental policy",

(D) in clause (iii)(II), by striking "another policy" and inserting "a medicare supplemental policy", and

(E) by amending subclause (III) of clause (iii) to read as follows:

"(III) If the statement required by clause (i) is obtained and indicates that the individual is entitled to any medical assistance under title XIX, the sale of the policy is not in violation of clause (i) (insofar as such clause relates to such medical assistance), if (aa) a State medicaid plan under such title pays the premiums for the policy, (bb) in the case of a qualified medicare beneficiary described in section 1905(p)(1), the policy provides for coverage of outpatient prescription drugs, or (cc) the only medical assistance to which the individual is entitled under the State plan is medicare cost sharing described in section 1905(p)(3)(A)(ii).".

(3)(A) Section 1882(d)(3)(C) (42 U.S.C. 1395ss(d)(3)(C)) is amended—

(i) by striking "the selling" and inserting "(i) the sale or issuance", and

(ii) by inserting before the period at the end the following: ", (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under title XIX) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 60 days after the date the statements are published or promulgated under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this title and (in the case of a policy that is not a health plan described in section 2203(c)(2) and does not provide coverage for benefits regardless of other coverage), to the extent considered appropriate by the Secretary, benefits under the guaranteed national benefit package under title XXI or under a standardized benefit package for supplemental health benefit policies established under part D of title XXII, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual".

(B) Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended by adding at the end the following:

"(D)(i) If—

"(I) within the 90-day period beginning on the date of the enactment of this subparagraph, the National Association of Insurance Commissioners develops (after consultation with consumer and insurance industry representatives) and submits to the Secretary a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and

"(II) the Secretary approves all the statements submitted as meeting the requirements of subclause (I),

each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved. The Secretary shall review and approve (or disapprove) all the statements submitted under subclause (I) within 30 days after the date of their submittal. Upon approval of such statements, the Secretary shall publish such statements.

"(ii) If the Secretary does not approve the statements under clause (i) or the statements are not submitted within the 90-day period specified in such clause, the Secretary shall promulgate (after consultation with consumer and insurance industry representatives and not later than 90 days after the date of disapproval or the end of such 90-day period (as the case may be)) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved.".

(C) The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act shall not apply to an application made for a policy or plan before 60 days after the date the Secretary of Health and Human Services publishes or promulgates all the statements under section 1882(d)(3)(D) of such Act.

(4) Subparagraphs (A) and (B) of section 1882(q)(5) are amended by striking "of the Social Security Act".

(e) Loss Ratios and Refunds of Premiums.—

(1) Section 1882(r) (42 U.S.C. 1395ss(r)) is amended—

(A) in paragraph (1), by striking "or sold" and inserting "or renewed (or otherwise provide coverage after the date described in subsection (p)(1)(C))";

(B) in paragraph (1)(A), by inserting "for periods after the effective date of these provisions" after "the policy can be expected";

(C) in paragraph (1)(A), by striking "Commissioners," and inserting "Commissioners)";

(D) in paragraph (1)(B), by inserting before the period at the end the following: ", treating policies of the same type as a single policy for each standard package";

(E) by adding at the end of paragraph (1) the following: "For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the date specified in subsection (p)(1)(C), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after the date specified in section 8461(m)(4) of the Guaranteed Health Insurance Act of 1994.";

(F) in the first sentence of paragraph (2)(A), by striking "by policy number" and inserting "by standard package";

(G) by striking the second sentence of paragraph (2)(A) and inserting the following: "Paragraph (1)(B) shall not apply to a policy until 12 months following issue.";

(H) in the last sentence of paragraph (2)(A), by striking "in order" and all that follows through "are effective";

(I) by adding at the end of paragraph (2)(A), the following new sentence: "In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 8461(m)(4) of the Guaranteed Health Insurance Act of 1994.";

(J) in paragraph (2), by striking "policy year" each place it appears and inserting "calendar year";

(K) in paragraph (4), by striking "February", "disllowance", "loss-ratios" each place it appears, and "loss-ratio" and inserting "October", "disallowance", "loss ratios", and "loss ratio", respectively;

(L) in paragraph (6)(A), by striking "issues a policy in violation of the loss ratio requirements of this subsection" and "such violation" and inserting "fails to provide refunds or credits as required in paragraph (1)(B)" and "policy issued for which such failure occurred", respectively; and

(M) in paragraph (6)(B), by striking "to policyholders" and inserting "to the policyholder or, in the case of a group policy, to the certificate holder".

(2) Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is amended, in the matter after subparagraph (H), by striking "subsection (F)" and inserting "subparagraph (F)".

(3) Section 4355(d) of OBRA–1990 is amended by striking "sold or issued" and all that follows and inserting "issued or renewed (or otherwise providing coverage after the date described in section 1882(p)(1)(C) of the Social Security Act) on or after the date specified in section 1882(p)(1)(C) of the Social Security Act.".

(f) Treatment of HMO's.—

(1) Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by striking "a health maintenance organization or other direct service organization" and all that follows through "1833" and inserting "an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A)".

(2) Section 4356(b) of OBRA–1990 is amended by striking "on the date of the enactment of this Act" and inserting "on the date specified in section 1882(p)(1)(C) of the Social Security Act".

(g) Pre-existing Condition Limitations.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (2)(A), by striking "for which an application is submitted" and inserting "in the case of an individual for whom an application is submitted prior to or",

(2) in paragraph (2)(A), by striking "in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B" and inserting "as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B", and

(3) in paragraph (2)(B), by striking "before it" and inserting "before the policy".

(h) Medicare Select Policies.—

(1) Section 1882(t) (42 U.S.C. 1395ss(t)) is amended—

(A) in paragraph (1), by inserting "medicare supplemental" after "If a",

(B) in paragraph (1), by striking "NAIC Model Standards" and inserting "1991 NAIC Model Regulation or 1991 Federal Regulation",

(C) in paragraph (1)(A), by inserting "or agreements" after "contracts",

(D) in subparagraphs (E)(i) and (F) of paragraph (1), by striking "NAIC standards" and inserting "standards in the 1991 NAIC Model Regulation or 1991 Federal Regulation", and

(E) in paragraph (2), by inserting "the issuer" before "is subject to a civil money penalty".

(2) Section 1154(a)(4)(B) (42 U.S.C. 1320c–3(a)(4)(B)) is amended—

(A) by inserting "that is" after "(or", and

(B) by striking "1882(t)" and inserting "1882(t)(3)".

(i) Health Insurance Counseling.—Section 4360 of OBRA–1990 is amended—

(1) in subsection (b)(2)(A)(ii), by striking "Act" and inserting "Act)";

(2) in subsection (b)(2)(D), by striking "services" and inserting "counseling";

(3) in subsection (b)(2)(I), by striking "assistance" and inserting "referrals";

(4) in subsection (c)(1), by striking "and that such activities will continue to be maintained at such level";

(5) in subsection (d)(3), by striking "to the rural areas" and inserting "eligible individuals residing in rural areas";

(6) in subsection (e)—

(A) by striking "subsection (c) or (d)" and inserting "this section",

(B) by striking "and annually thereafter, issue an annual report" and inserting "and annually thereafter during the period of the grant, issue a report", and

(C) in paragraph (1), by striking "Statewide";

(7) in subsection (f), by striking paragraph (2) and by redesignating paragraphs (3) through (5) as paragraphs (2) through (4), respectively; and

(8) in the second subsection (f) (relating to authorization of appropriations for grants)—

(A) by striking "and 1993" and inserting "1993, 1994, 1995, and 1996"; and

(B) by redesignating such subsection as subsection (g).

(j) Telephone Information System.—

(1) Section 1804 (42 U.S.C. 1395b–2) is amended—

(A) by adding at the end of the heading the following: "; MEDICARE AND MEDIGAP INFORMATION",

(B) by inserting "(a)" after "1804.", and

(C) by adding at the end the following new subsection:

"(b) The Secretary shall provide information via a toll-free telephone number on the programs under this title.".

(2) Section 1882(f) (42 U.S.C. 1395ss(f)) is amended by adding at the end the following new paragraph:

"(3) The Secretary shall provide information via a toll-free telephone number on medicare supplemental policies (including the relationship of State programs under title XIX to such policies).".

(3) Section 1889 is repealed.

(k) Mailing of Policies.—Section 1882(d)(4) (42 U.S.C. 1395ss(d)(4)) is amended—

(1) in subparagraph (D), by striking ", if such policy" and all that follows up to the period at the end, and

(2) by adding at the end the following new subparagraph:

"(E) Subparagraph (A) shall not apply in the case of an issuer who mails or causes to be mailed a policy, certificate, or other matter solely to comply with the requirements of subsection (q).".

(l) Effective Date.—The amendments made by this section shall be effective as if included in the enactment of OBRA–1990; except that—

(1) the amendments made by subsection (d)(1) shall take effect on the date of the enactment of this Act, but no penalty shall be imposed under section 1882(d)(3)(A) of the Social Security Act (for an action occurring after the effective date of the amendments made by section 4354 of OBRA–1990 and before the date of the enactment of this Act) with respect to the sale or issuance of a policy which is not unlawful under section 1882(d)(3)(A)(i)(II) of the Social Security Act (as amended by this section);

(2) the amendments made by subsection (d)(2)(A) and by subparagraphs (A), (B), and (E) of subsection (e)(1) shall be effective on the date specified in subsection (m)(4); and

(3) the amendment made by subsection (g)(2) shall take effect on January 1, 1995, and shall apply to individuals who attain 65 years of age or older on or after the effective date of section 1882(s)(2) of the Social Security Act (and, in the case of individuals who attained 65 years of age after such effective date and before January 1, 1995, and who were not covered under such section before January 1, 1995, the 6-month period specified in that section shall begin January 1, 1995).

(m) Transition Provisions.—

(1) In general.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such

change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the "NAIC") modifies its 1991 NAIC Model Regulation (adopted in July 1991) to conform to the amendments made by this section and to delete from section 15C the exception which begins with "unless", such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle F—Provisions Relating to the Medicaid Program

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PART 1—CONFORMING MEDICAID TO GUARANTEED HEALTH INSURANCE ACT OF 1994

SEC. 8501. CONFORMING MEDICAID AMENDMENTS RELATING TO GUARANTEED NATIONAL BENEFIT PACKAGE.

(a) LIMITING COVERAGE UNDER MEDICAID.—

(1) IN GENERAL.—Title XIX is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

"LIMITATION ON COVERAGE OF SERVICES UNDER GUARANTEED NATIONAL BENEFIT PACKAGE

"SEC. 1931. (a) IN GENERAL.—Subject to subsection (b), a State plan under this title is not required to provide medical assistance on or after January 1, 1999, consisting of payment for any item or service which is included in the guaranteed national benefit package under title III of the Guaranteed Health Insurance Act of 1994.

"(b) EXCEPTIONS.—Subsection (a) shall not apply to—

"(1) emergency care and services described in section 1903(v)(2) furnished before January 1, 2002, or

"(2) inpatient mental health services provided to individuals who are entitled to benefits under part A of title XVIII.

"(c) NO FFP FOR STATE MAINTENANCE-OF-EFFORT.—Payment of amounts under part 2 of subtitle B of title VIII of the Guaranteed Health Insurance Act of 1994 shall not be construed to constitute medical assistance for purposes of section 1903(a).".

(2) CONFORMING AMENDMENT TO STATE PLAN REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended in the matter preceding paragraph (1) by striking "A State" and inserting "Subject to section 1931, a State".

(3) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking "or" at the end of paragraph (14),

(B) by striking the period at the end of paragraph (15) and inserting "; or", and

(C) by inserting after paragraph (15) the following new paragraphs:

"(16) with respect to medical assistance consisting of payment for items or services furnished to an individual on or after January 1, 1999, to the extent that payment may be made for the item or service under the guaranteed national benefit package under title III of the Guaranteed Health Insurance Act of 1994; or

"(17) with respect to any medical assistance furnished on or after January 1, 1999, to an individual entitled to benefits under part A of title XVIII other than long-term care services described in section 1905(t).".

(4) LONG-TERM CARE SERVICES DEFINED.—Section 1905 (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(t) The term 'long-term care services' means the following items and services:

"(1) Nursing facility services and intermediate care facility services for the mentally retarded (including items and services that may be included in such services pursuant to regulations in effect as of October 26, 1993).

"(2) Personal care services.

"(3) Home or community-based services provided under a waiver granted under subsection (c), (d), or (e) of section 1915.

"(4) Home and community care provided to functionally disabled elderly individuals under section 1929.

"(5) Community supported living arrangements services provided under section 1930.

"(6) Home health care services, case-management services, clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in paragraphs (1) through (5).".

(5) CONFORMING AMENDMENTS RELATING TO SECONDARY PAYER.—(A) Section 1902(a)(25)(A) (42 U.S.C. 1396a(a)(25)(A)) is amended by inserting "certified health plans (as defined in section 2 of the Guaranteed Health Insurance Act of 1994 and including medicare part C)," after "of 1974),".

(B) Section 1903(o) (42 U.S.C. 1396b(o)) is amended by inserting "and a certified health plan (as defined in section 2 of the Guaranteed Health Insurance Act of 1994 and including medicare part C)" after "of 1974)".

(c) OTHER MEDICAID CONFORMING AMENDMENTS.—Section 1902(a)(9)(C) (42 U.S.C. 1396a(a)(9)(C)) and section 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1396n(a)(1)(B)(ii)(I)) are each amended by striking "paragraphs (15) and (16) of section 1861(s)" and inserting "subsections (a) and (b) of section 1890".

SEC. 8502. ENFORCEMENT OF MAINTENANCE-OF-EFFORT REQUIREMENTS THROUGH MEDICAID.

(a) STATE PLAN REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking "and" at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting "; and"; and

(3) by inserting after paragraph (62) the following new paragraphs:

"(63) provide assurances that the State is making payments required under part 2 of subtitle B of title VIII of the Guaranteed Health Insurance Act of 1994.".

(b) WITHHOLDING AMOUNTS UNPAID.—Section 1903 (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

"(x) Notwithstanding any other provision of this section, the Secretary shall reduce the amount of payment made to a State under this section for quarters in any fiscal year to the extent that the State fails to make the payments required for the fiscal year under part 2 of subtitle B of title VIII of the Guaranteed Health Insurance Act of 1994 in a timely manner.".

SEC. 8503. CONFORMING MEDICAID AMENDMENTS RELATING TO QUALITY AND CONSUMER PROTECTION.

(a) STATE PLAN REQUIREMENTS.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 8502(a), is amended—

(1) by striking "and" at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting "; and"; and

(3) by inserting after paragraph (62) the following new paragraphs:

"(63) provide that the identification cards issued under the State plan conform with the requirements of section 9101(c) of the Guaranteed Health Insurance Act of 1994;

"(64) provide that the claims process applicable under the State plan conforms with the requirements of section 9103(c) of the Guaranteed Health Insurance Act of 1994; and

"(65) provide that the State plan meets the requirements of section 9104(c)(4) of the Guaranteed Health Insurance Act of 1994.".

(b) DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR IMPROPERLY SUBMITTED CLAIMS.—Section 1903(i) (42 U.S.C. 1396b(i)), as amended by section 8501(a)(3), is amended—

(A) by striking "or" at the end of paragraph (16),

(B) by striking the period at the end of paragraph (17) and inserting "; or", and

(C) by inserting after paragraph (17) the following new paragraph:

"(18) with respect to medical assistance consisting of payment for items and services for which the claim was not submitted in a form and manner consistent with the standards established under section 9103(c) of the Guaranteed Health Insurance Act of 1994.".

SEC. 8504. CONFORMING AMENDMENTS RELATING TO COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Title XIX is amended as follows:

(1) Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended—

(A) in subparagraph (C) in the matter preceding clause (i), by striking "or (E)",

(B) by adding "and" at the end of subparagraph (D);

(C) by striking subparagraph (E) and redesignating subparagraph (F) as subparagraph (E); and

(D) in the matter following subparagraph (E) (as so redesignated), by striking clause (VIII).

(2) Section 1902(e) (42 U.S.C. 1396a(e)) is amended by striking paragraph (8).

(3) The first sentence of section 1902(f) (42 U.S.C. 1396a(f)) is amended by striking "qualified disabled" and all that follows through "medicare beneficiaries".

(3) Section 1902(m)(4) (42 U.S.C. 1396a(m)(4)) is amended—

(A) in the matter preceding subparagraph (A), by striking "1905(p)(1)" and inserting "1894(e)(1)"; and

(B) in subparagraph (A), by striking "1905(p)(1)(B)" and inserting "1894(e)(1)(B)".

(4) Section 1902(u)(2) (42 U.S.C. 1396a(u)(2)) is amended by striking "(a)(10)(F)" and inserting "(a)(10)(E)".

(5) Section 1903(f)(4) (42 U.S.C. 1396b(f)(4)) is amended in the matter preceding subparagraph (A) by striking "1902(a)(10)(A)(ii)(X), or 1905(p)(1)" and inserting "or 1902(a)(10)(A)(ii)(X)".

(6) Section 1905(a) (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1) by striking "or, in the case of medicare cost-sharing" and all that follows through "such a beneficiary".

(7) Section 1905 (42 U.S.C. 1396d) is amended by striking subsections (p) and (s).

(8) Section 1916 (42 U.S.C. 1396o) is amended—

(A) in subsection (a) in the matter preceding paragraph (1), by striking "or (E)(i)";

(B) in subsection (b) in the matter preceding paragraph (1), by striking "or (E)"; and

(C) by striking subsection (d).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to items or services furnished in a State on or after January 1, 1999.

SEC. 8505. TREATMENT OF CERTAIN FACILITIES AS FEDERALLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Section 1905(l)(2)(B) (42 U.S.C. 1396d(l)(2)(B)) is amended—

(1) by striking "or 340A" each place it appears in clause (i) and clause (ii)(I) and inserting "340A, or 508";

(2) by striking "or" at the end of clause (iii);

(3) by striking the semicolon at the end of clause (iv) and inserting a comma; and

(4) by inserting after clause (iv) the following new clauses:

"(v) is a Native Hawaiian Health Center (as defined in section 8(4) of the Native Hawaiian Health Care Act of 1988), or

"(vi) is a community clinic organized as a nonprofit, public benefit corporation under California Health and Safety Code §1204(a) that does not charge patients directly for services rendered;".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to quarters beginning on or after July 1, 1995.

SEC. 8506. WAIVERS FACILITATING STATE HEALTH SECURITY PROGRAMS.

(a) IN GENERAL.—Section 1115(a) (42 U.S.C. 1315(a)) is amended by adding at the end the following: "The Secretary may not waive compliance with any of the requirements of section 1902 under this subsection with respect to a State for a year except to the extent necessary to enable the State to operate an approved State single-payer system under subtitle A of title IV of the Guaranteed Health Insurance Act of 1994 or an approved State managed competition system under subtitle B of title IV.".

(b) EFFECTIVE DATE.—The amendment made by subsection shall take effect—

(1) on January 1, 1999, in the case of a State with a waiver approved under section 1115(a) of the Social Security Act for which a formal, written, and completed application was received by the Secretary of Health and Human Services under such section on or before August 1, 1994; or

(2) on August 1, 1994, in the case of any other State.

SEC. 8507. CONFORMING REQUIREMENTS FOR REBATE AGREEMENTS FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Section 1927(a)(1) (42 U.S.C. 1396r–8(a)(1)) is amended by striking "manufacturer)," and inserting "manufacturer) and a rebate agreement with the Secretary under section 1850,".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to covered outpatient drugs furnished during quarters beginning on or after January 1, 1999.

SEC. 8508. CONSTRUCTION OF GUARANTEED HEALTH INSURANCE ACT OF 1994 REFERENCES.

Section 1932 (42 U.S.C. 1396s), as redesignated by section 8501(a), is amended by adding at the end the following new subsection:

"(c) REFERENCES GUARANTEED HEALTH INSURANCE ACT OF 1994.—In this title, except as otherwise specifically provided, any references to provisions of the Guaranteed Health Insurance Act of 1994 are deemed to be references to such provisions as in effect on the day after the date of the enactment of such Act.".

PART 2—LONG-TERM CARE

SEC. 8511. COORDINATION OF OPTIONAL HOME AND COMMUNITY BASED SERVICES UNDER MEDICAID WITH LONG-TERM CARE UNDER GUARANTEED HEALTH INSURANCE ACT OF 1994.

(a) PERSONAL CARE SERVICES.—Section 1905(a)(24) (42 U.S.C. 1396d(a)(24)) is amended—

(1) by striking "and (C)" and inserting "(C)"; and

(2) by striking "location;" and inserting "location, and (D) for quarters beginning on or after October 1, 1999, in compliance with the standards applicable to personal assistance services under the long-term care program for home and community-based services under subtitle A of title X of the Guaranteed Health Insurance Act of 1994;".

(b) SERVICES UNDER HOME AND COMMUNITY-BASED WAIVERS.—(1) Section 1915(c)(2) (42 U.S.C. 1396n(c)(2)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(F) effective October 1, 1997, the services furnished under the waiver meet the applicable standards for home and community-based services furnished under the long-term care program for home and community-based services under subtitle A of title X of the Guaranteed Health Insurance Act of 1994.".

(2) Section 1915(d)(2) (42 U.S.C. 1396n(d)(2)) is amended—

(1) by striking "and" at the end of subparagraph (B);

(2) by striking the period at the end of subparagraph (C) and inserting "; and"; and

(3) by inserting after subparagraph (C) the following new subparagraph:

"(D) effective October 1, 1997, the services furnished under the waiver meet the applicable standards for home and community-based services furnished under the long-term care program for home and community-based services under subtitle A of title X of the Guaranteed Health Insurance Act of 1994.".

SEC. 8512. NURSING HOME PASS-THROUGH.

Section 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)) is amended by—

(1) inserting "incurred by facilities in making required contributions towards enrolling employees in health plans under the Guaranteed Health Insurance Act of 1994 and" before "the costs of services"; and

(2) by striking "nursing care, and which" and inserting "nursing care, and which, in the case of intermediate care facilities for the mentally retarded, take into account the costs incurred by facilities in making required contributions towards enrolling employees in health plans under the Guaranteed Health Insurance Act of 1994, and which".

SEC. 8513. CONTINUATION OF TEXAS FRAIL ELDERLY DEMONSTRATION.

A State that is described in section 1929(b)(2)(B) of the Social Security Act and is receiving Federal financial participation under section 1903(a) of such Act as of the date of the enactment of this Act with respect to medical assistance consisting of home and community care for functionally disabled elderly individuals that meets the requirements for such care described in section 1929 of the Social Security Act may continue to receive participation with respect to such medical assistance under the same terms and conditions during quarters ending on or before September 30, 1997.

PART 3—HEALTH MAINTENANCE ORGANIZATIONS

SEC. 8521. PERMITTING GARDEN STATE HEALTH PLAN TO PARTICIPATE IN MANAGED CARE WAIVER.

Section 1903(m)(6)(D) (42 U.S.C. 1396b(m)(6)(D)) is amended to read as follows:

"(D) The undertaking described in subparagraph (A) shall be eligible to participate in a waiver under section 1915(b) if the State provides individuals subject to the waiver with the option to enroll in at least 3 plans in addition to the plan offered through the undertaking.".

SEC. 8522. EXTENSION OF PERIOD OF APPLICABILITY OF ENROLLMENT MIX REQUIREMENT TO DAYTON AREA HEALTH PLAN.

Section 2 of Public Law 102–276 is amended by striking "December 31, 1995" and inserting "December 31, 1999".

SEC. 8523. CLARIFICATION OF APPLICABILITY OF RESTRICTIONS ON FEDERAL FINANCIAL PARTICIPATION.

Section 1903(i) (42 U.S.C. 1396b(i)) is amended in the matter preceding paragraph (1) by striking "the preceding provisions of this section" and inserting "this section (including subsection (m))".

PART 4—VACCINES FOR CHILDREN

SEC. 8531. STATE MANDATE FOR INSURERS TO OFFER COVERAGE OF IMMUNIZATIONS AND WELL-CHILD SERVICES.

(a) Requirement for Pediatric Immunization Program.—Section 1928(f) (42 U.S.C. 1396s(f)) is amended to read as follows:

"(f) State Insurance Requirements.—

"(1) Maintenance of immunization laws for certain states.—In the case of a State that had in effect as of May 1, 1993, a law that requires some or all health insurance policies or plans to provide some coverage with respect to a pediatric vaccine, a State program under this section does not comply with the requirements of this section unless the State certifies to the Secretary that the State has not modified or repealed such law in a manner that reduces the amount of coverage so required.

"(2) Requirement for coverage of immunizations and well-child services.—A State program under this section does not comply with the requirements of this section unless the State certifies to the Secretary that State has in effect a law that requires (and allows enforcement through private rights of action) health insurance policies or plans issued or renewed on or after January 1, 1995, to provide coverage for the following services without deductible, coinsurance, or any other form of cost-sharing:

"(A) All vaccines on the list described in subsection (e).

"(B) Well-child services (including the administration of vaccines referred to in subparagraph (A)) for children 6 years of age or younger, as determined by the Secretary after consultation with recognized medical organizations involved in child health care.".

(b) Effective Date.—(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to calendar quarters beginning on or after January 1, 1995.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 8532. LIMITATION ON STATE ABILITY TO PURCHASE VACCINES AT FEDERAL PRICE.

(a) In General.—Section 1928(d)(4)(B) (42 U.S.C. 1396s(d)(4)(B)) is amended by striking "each State" and inserting "each eligible State (as described in paragraph (8))".

(b) States Eligible to Purchase at Federal Price Described.—Section 1928(d) (42 U.S.C. 1396s(d)) is amended by adding at the end the following new paragraph:

"(8) States eligible to purchase at federal price described.—

"(A) In general.—A State is eligible for purposes of paragraph (4)(B) if the State—

"(i)(I) is a universal purchase State (as defined in subparagraph (B)), or

"(II) the State agrees that the vaccines obtained under such paragraph will be used to provide immunizations only for children who do not have private insurance coverage for all the vaccines on the list described in subsection (e) without deductible, coinsurance, or any other form of cost-sharing; and

"(ii) does not have in operation a trust fund or similar mechanism consisting of contributions from private entities that provide health care or offer or sell health plans from which amounts are used to purchase vaccines pursuant to contracts of the Centers for Disease Control and Prevention with vaccine manufacturers (unless such trust fund was in operation as of July 1, 1994).

"(B) Universal purchase state defined.—

"(i) In general.—In paragraph (4)(B), the term 'universal purchase state' means any of the following:

"(I) A State which has in effect as of July 1, 1994, a vaccine purchase program designed to assure immunization of all children in the State with the vaccines specified in subparagraph (C) without charge.

"(II) A State which advises the Centers for Disease Control and Prevention as of July 20, 1994, of its intent to provide the vaccines specified in subparagraph (C), and, by October 1, 1994, provides the vaccines in volumes necessary to assure immunization of all children in the State, pursuant to contracts of the Centers for Disease Control and Prevention with vaccine manufacturers with effective dates on or before October 1, 1994.

"(III) A State which manufacturers any of the vaccines specified in clause (ii).

"(C) Vaccines specified.—The vaccines specified in this subparagraph are as follows: diphtheria, pertussis, tetanus, oral polio, measles, mumps, and rubella.".

(c) Effective Date.—The amendments made by this section shall apply to quarters beginning on or after January 1, 1995.

PART 5—TREATMENT OF INDIANS AND INDIAN HEALTH SERVICE PROVIDERS

SEC. 8541. NONDISCRIMINATION IN PARTICIPATION PROVIDERS.

Section 1911(a) (42 U.S.C. 1396j(a)) is amended by striking the period at the end and inserting the following: ", without regard to whether or not the facility furnishes all medical assistance covered under the State plan.".

SEC. 8542. REQUIRING INDIVIDUALS SUBJECT TO WAIVERS TO HAVE OPTION TO ENROLL IN INDIAN HEALTH SERVICE PLANS.

(a) 1115 Waivers.—Section 1115 (42 U.S.C. 1315) is amended by adding at the end the following new subsection:

"(e)(1) A State with a waiver granted under subsection (a) with respect to title XIX may not prohibit any individual eligible under the State plan under such title from receiving services pursuant to the waiver at a facility described in paragraph (2), and may not refuse to make payment under the State plan for medical assistance provided to such an individual at such a facility.

"(2) A facility described in this paragraph is a facility described in section 1911(a), or an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.".

(b) 1915 Waivers.—Section 1915(c) (42 U.S.C. 1396n(c)) is amended by adding at the end the following: "No waiver under this subsection may prohibit any individual from receiving services pursuant to the waiver at a facility described in section 1911(a), or an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.".

SEC. 8543. TREATMENT OF OUTPATIENT FACILITIES AS FEDERALLY QUALIFIED HEALTH CENTERS.

(a) In General.—Section 1905(l)(2)(B) (42 U.S.C. 1396d(l)(2)(B)) is amended in the matter following clause (iv) by inserting "the Indian Health Service or" after "operated by".

(b) Effective Date.—The amendment made by subsection (a) shall apply to quarters beginning on or after July 1, 1995.

PART 6—EFFECTIVE DATE OF AMENDMENTS

SEC. 8551. AMENDMENTS EFFECTIVE WITHOUT REGARD TO ISSUANCE OF REGULATIONS.

(a) In General.—Except as otherwise provided, the amendments made by this subtitle shall take effect on the date of the enactment of this Act.

(b) Issuance of Regulations Not Required.—Each amendment made by this subtitle shall take effect on the effective date provided for such amendment, without regard to whether or not final regulations to carry out the amendment have been issued by such effective date.

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PART 1—SUBSTANTIVE PROVISIONS

Subpart A—Managed Care Provisions

SEC. 8601. MEDICAID MANAGED CARE ANTI-FRAUD PROVISIONS.

(a) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—

(1) IN GENERAL.—Section 1903(m) (42 U.S.C. 1396b(m)) is amended—

(A) in paragraph (2)(A)—

(i) by striking "and" at the end of clause (x),

(ii) by striking the period at the end of clause (xi) and inserting "; and", and

(iii) by adding at the end the following new clause:

"(xii) the entity complies with the requirements of paragraph (3) (relating to certain protections against fraud and abuse).";

(B) in paragraph (2)(B), as amended by section 8649, by striking "clause (ix)" and inserting "clauses (ix) and (xii)"; and

(C) by inserting after paragraph (2) the following new paragraph:

"(3)(A)(i) An entity with a contract under this subsection may not have a person described in clause (iv) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity.

"(ii) An entity with a contract under this subsection may not have an employment, consulting, or other agreement with a person described in clause (iv) for the provision of goods and services that are significant and material to the entity's obligations under its contract with the State described in paragraph (2)(A)(iii).

"(iii) If an entity with a contract under this subsection is not in compliance with clause (i) or (ii)—

"(I) a State may continue an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

"(II) a State may not renew or otherwise extend the duration of an existing agreement with the entity unless the State provides a written statement to the Secretary describing compelling reasons that exist for renewing or extending the agreement and the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) approves such statement.

"(iv) A person described in this clause is a person that—

"(I) is debarred or suspended by the Federal Government, pursuant to the Federal acquisition regulation, from Government contracting and subcontracting, or

"(II) is an affiliate (within the meaning of the Federal acquisition regulation) of a person described in subclause (I).".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to agreements between a State and an entity under section 1903(m) of the Social Security Act entered into or renewed on or after January 1, 1994, without regard to whether regulations to carry out such amendments are promulgated by such date.

(b) REQUIREMENT FOR STATE CONFLICT-OF-INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—

(1) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)), as amended by subsection (a)(1)(A), is amended—

(A) by striking "and" at the end of clause (xi),

(B) by striking the period at the end of clause (xii) and inserting "; and", and

(C) by adding at the end the following new clause:

"(xiii) the State certifies to the Secretary and the Secretary finds that the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State who have responsibilities with respect to contracts with organizations under this subsection that are at least as effective as the Federal conflicts-of-interest safeguards provided under section 27 of the Office of Federal Procurement Policy Act that apply with respect to Federal procurement officials who have comparable responsibilities with respect to such contracts.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply as of July 1, 1994, without regard to whether regulations to carry out such amendments are promulgated by such date.

(c) REQUIRING DISCLOSURE OF FINANCIAL INFORMATION.—

(1) IN GENERAL.—Section 1903(m)(3), as inserted by subsection (a)(1)(C), is amended by adding at the end the following new subparagraph:

"(B) The contract between the State and an entity referred to in paragraph (2)(A)(iii) shall provide that—

"(i) the entity agrees to report to the State such financial information as the Secretary or the State may require to demonstrate that the entity has a fiscally sound operation; and

"(ii) the entity agrees to make available to its enrollees upon reasonable request—

"(I) the information reported under clause (i),

"(II) the information required to be disclosed under sections 1124 and 1126, and

"(III) a description of each transaction, described in subparagraphs (A) through (C) of section 1318(a)(3) of the Public Health Service Act, between the entity and a party in interest (as defined in section 1318(b) of such Act).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contract years beginning on or after April 1, 1994, without regard to whether regulations to carry out such amendments are promulgated by such date, with respect to information reported or required to be disclosed, or transactions occurring, before, on, or after such date.

(d) PROHIBITING MARKETING FRAUD.—

(1) IN GENERAL.—Section 1903(m)(3), as inserted by subsection (a)(1) and as amended by subsection (c)(1), is amended by adding at the end the following new subparagraph:

"(C) The contract between the State and an entity referred to in paragraph (2)(A)(iii) shall provide that the entity agrees to comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled or reenrolled with the entity, the individual is provided accurate and sufficient information to make an informed decision whether or not to enroll or reenroll.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contract years that begin on or after April 1, 1994.

(e) REQUIRING ADEQUATE PROVISION AGAINST RISK OF INSOLVENCY.—

(1) IN GENERAL.—Section 1903(m)(1)(A)(ii) (42 U.S.C. 1396b(m)(1)(A)(ii)) is amended by inserting ", which meets such standards as the Secretary shall prescribe," after "satisfactory to the State".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contract years beginning on or after January 1, 1995.

(f) REQUIRING REPORT ON NET EARNINGS AND ADDITIONAL BENEFITS.—

(1) IN GENERAL.—Section 1903(m)(3), as inserted by subsection (a)(1) and as amended by subsections (c)(1) and (d)(1) is amended by adding at the end the following new subparagraph:

"(D) The contract between the State and an entity referred to in paragraph (2)(A)(iii) shall provide that the entity shall submit a report to the State and the Secretary not later than 12 months after the close of a contract year containing—

"(i) a financial statement of the entity's net earnings under the contract during the contract year, which statement has been audited using generally accepted auditing standards;

"(ii) a description of any benefits that are in addition to the benefits required to be provided under the contract that were provided during the contract year to members enrolled with the entity and entitled to medical assistance under the plan; and

"(iii) such other information as the Secretary may prescribe.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contract years beginning on or after January 1, 1994.

SEC. 8602. EXTENSION OF MEDICAID WAIVER FOR TENNESSEE PRIMARY CARE NETWORK.

Section 6411(f) of OBRA–1989, as amended by section 1 of Public Law 102–317, is amended by striking "January 31, 1994" and inserting "December 31, 1995".

SEC. 8603. WAIVER OF APPLICATION OF MEDICAID ENROLLMENT MIX REQUIREMENT TO DISTRICT OF COLUMBIA CHARTERED HEALTH PLAN, INC.

(a) IN GENERAL.—The Secretary of Health and Human Services shall waive the application of the requirement described in section 1903(m)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(ii)) to the entity known as the District of Columbia Chartered Health Plan, Inc., for the period described in subsection (b), if the Secretary determines that the entity is making continuous efforts and progress toward achieving compliance with such requirement.

(b) PERIOD OF APPLICABILITY.—The period referred to in subsection (a) is the period that begins on October 1, 1992, and ends on December 31, 1995.

SEC. 8604. WAIVER OF APPLICATION OF MEDICAID ENROLLMENT MIX REQUIREMENT TO MANAGED HEALTH SERVICES INSURANCE CORPORATION OF MILWAUKEE, WISCONSIN.

The Secretary of Health and Human Services shall waive the application of the requirement described in section 1903(m)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(ii)) to the entity known as the Managed Health Services Insurance Corporation of Milwaukee, Wisconsin until December 31, 1995, if the Secretary determines that the entity is making continuous efforts and progress toward achieving compliance with such requirement.

SEC. 8605. EXTENSION OF MINNESOTA PREPAID MEDICAID DEMONSTRATION PROJECT.

(a) IN GENERAL.—Section 507 of the Family Support Act of 1988 (Public Law 100–485), as amended by section 6411(j) of OBRA–1989 and by section 4733 of OBRA–1990, is amended by striking "1996" and inserting "1998".

(b) AUTHORITY TO IMPOSE PREMIUM.—

(1) IN GENERAL.—Notwithstanding section 1916 of the Social Security Act and subject to paragraph (2), the State of Minnesota may impose a premium on individuals receiving medical assistance under the Minnesota Prepaid Demonstration Project operated under a waiver granted by the Secretary of Health and Human Services under section 1115(a) of the Social Security Act and other individuals eligible under the State's plan for medical assistance under title XIX of such Act.

(2) LIMITATION ON AMOUNT OF PREMIUM.—In no case may the amount of any premium imposed on an individual receiving medical assistance under the State plan or under the Demonstration Project described in paragraph (1) exceed 10 percent of the amount by which the family income (less expenses for the care of a dependent child) of the individual exceeds 110 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

Subpart B—Home and Community-Based Services Waiver Provisions

SEC. 8611. ELIMINATION OF REQUIREMENT OF PRIOR INSTITUTIONALIZATION WITH RESPECT TO HABILITATION SERVICES FURNISHED UNDER A WAIVER FOR HOME OR COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C. 1396n(c)(5)) is amended in the matter preceding subparagraph (A) by striking ", with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1994.

SEC. 8612. RELIEF FROM THIRD PARTY LIABILITY REQUIREMENTS WHEN COST-EFFECTIVE.

(a) IN GENERAL.—Section 1902(a)(25)(B) (42 U.S.C. 1396a(a)(25)(B)) is amended to read as follows—

"(B) that in any case where such a legal liability is found to exist after medical assistance has been made available, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability, unless—

"(i) the amount of reimbursement the State can reasonably expect to recover for medical assistance furnished to an individual does not exceed the costs of such recovery, or

"(ii) with respect to case management services (as defined in section 1915(g)(2)), the State demonstrates to the satisfaction of the Secretary that it is not cost-effective in the aggregate to seek such recovery with respect to such services furnished to individuals covered under the State plan, using methods specified by the Secretary which may include a demonstration that such services are not generally covered by health insurers in the State;".

(b) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 1994.

SEC. 8613. STATE EXPENDITURES FOR MEDICAL ASSISTANCE WITH RESPECT TO HOME AND COMMUNITY-BASED SERVICES PROVIDED UNDER A WAIVER.

(a) IN GENERAL.—Section 1915(d)(5)(B) (42 U.S.C. 1396n(d)(5)(B)) is amended—

(1) in clause (i), by striking "times the number of years" and inserting "compounded annually for years";

(2) in clause (ii), by striking "times the number of years" and inserting "compounded annually for years"; and

(3) in clause (iv), by striking "December 22, 1987" and inserting "the date of the enactment of the Omnibus Budget Reconciliation Act of 1986".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of OBRA–1987.

Subpart C—Other Provisions

SEC. 8621. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN.

(a) QUALIFIED PROVIDER.—Section 1920(b)(2) (42 U.S.C. 1396r–1(b)(2)) is amended to read as follows:

"(2) the term 'qualified provider' means—

"(A) any provider that—

"(i) is eligible for payments under a State plan approved under this title;

"(ii) provides services of the type described in subparagraph (A) or (B) of section 1905(a)(2) or in section 1905(a)(9);

"(iii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A); and

"(iv)(I) receives funds under section 329, 330, 340, or 340A of the Public Health Service Act, title V of this Act, or title V of the Indian Health Care Improvement Act;

"(II) participates in a program established under section 17 of the Child Nutrition Act of 1966 or section 4(a) of the Agriculture and Consumer Protection Act of 1973;

"(III) participates in a State perinatal program; or

"(IV) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638); and

"(B) at the option of the State, any individual who is employed by the State and who is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1994.

SEC. 8622. CRITERIA FOR DETERMINING THE AMOUNT OF DISALLOWANCES.

(a) IN GENERAL.—

(1) CRITERIA FOR INITIAL DETERMINATIONS.—Section 1903 (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

"(x) If the Secretary determines that a disallowance of Federal financial participation should be made under this title with respect to any item or class of items, the Secretary shall, in making a determination with respect to the amount of such disallowance, take into account (to the extent the State makes a showing) factors which shall include—

"(1) whether the amount of the disallowance is reasonably related to the act or omission by the State which is the basis for the disallowance; and

"(2) whether the act or omission by the State which is the basis for the disallowance was based on a reasonable interpretation of Federal statutes, Federal regulations, or any written guidance provided by the Secretary.".

(2) CRITERIA FOR REDETERMINATIONS.—Section 1116(d) (42 U.S.C. 1316(d)) is amended—

(A) by striking "(d)" and inserting "(d)(1)"; and

(B) by adding at the end the following new paragraph:

"(2) In conducting any reconsideration of a disallowance of Federal financial participation by the Secretary under title XIX, the Departmental Appeals Board of the Department of Health and Human Services (or another entity designated by the Secretary), shall, if such Board or entity upholds the basis for the disallowance, determine whether the amount of the disallowance properly takes into account the factors listed in section 1903(x). If the amount of the disallowance does not properly take into account such factors, the Board shall adjust such amount in accordance with such factors.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to disallowances made after the date of the enactment of this Act and shall take effect without regard to the promulgation of implementing regulations.

SEC. 8623. INTERMEDIATE SANCTIONS FOR KICKBACK VIOLATIONS.

(a) PENALTY FOR KICKBACK VIOLATIONS.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

(1) by striking "or" at the end of paragraphs (1) and (2);

(2) by adding "or" at the end of paragraph (3);

(3) by inserting after paragraph (3) the following new paragraph:

"(4) carries out any activity in violation of paragraph (1) or (2) of section 1128B(b) with respect to remuneration relating to a State health care program;";

(4) by striking "given)." at the end of the first sentence and inserting "given or, in cases under paragraph (4), $10,000 for each such violation).";

(5) in the second sentence, by inserting "in cases under paragraphs (1), (2), and (3)," after "In addition,"; and

(6) by inserting after the second sentence the following new sentence: "In cases under paragraph (4), such a person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b), determined without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose.".

(b) AUTHORIZATION TO ACT.—The first sentence of section 1128A(c)(1) (42 U.S.C. 1320a-7a(c)(1)) is amended by striking the period at the end and inserting ", except that with respect to a proceeding relating to a State health program, the Secretary may initiate such a proceeding at such time and under such procedures as the Secretary determines appropriate unless, within 1 year after the date the Secretary presents a case to the Attorney General for consideration, the Attorney General brings an action in a district court of the United States.".

(c) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to remuneration offered, paid, solicited, or received before, on, or after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall apply to cases presented by the Secretary of Health and Human Services for consideration on or after the date of the enactment of this Act.

SEC. 8624. TECHNICAL AMENDMENT RELATED TO TAXES ON CERTAIN HEALTH CARE ITEMS AND SERVICES.

(a) IN GENERAL.—Section 1903(w)(7)(A)(viii) (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking the period at the end and inserting "not otherwise subject to a tax described in this subsection.".

(b) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective January 1, 1994.

(2) In the case of a State which the Secretary of Health and Human Services determines requires State legislation in order to avoid a reduction in Federal financial participation under section 1903(a) of the Social Security Act as a result of the amendment made by subsection (a), the State shall not be subject to such a reduction before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 8625. APPLICATION OF MAMMOGRAPHY CERTIFICATION REQUIREMENTS UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1902(a)(9) (42 U.S.C. 1396a(a)(9)) is amended—

(1) by striking "and" at the end of subparagraph (B),

(2) by striking the semicolon at the end of subparagraph (C) and inserting ", and", and

(3) by adding at the end the following new subparagraph:

"(D) that any mammography paid for under such plan must be conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act;".

(b) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by subsection (a) shall apply to mammography furnished by a facility during calendar quarters beginning on or after the first date that the certificate requirements of section 354(b) of the Public Health Service Act apply to such mammography conducted by such facility, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by subsection (a)(3), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 8626. NURSING HOME REFORM.

(a) SUSPENSION OF DECERTIFICATION OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS BASED ON EXTENDED SURVEYS.—

(1) IN GENERAL.—Section 1919(f)(2)(B)(iii)(I)(b) (42 U.S.C. 1396r(f)(2)(B)(iii)(I)(b)) is amended by striking the semicolon and inserting the following: ", unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section;".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of OBRA-1990.

(b) REQUIREMENTS FOR CONSULTANTS CONDUCTING REVIEWS ON USE OF DRUGS.—

(1) IN GENERAL.—Section 1919(c)(1)(D) (42 U.S.C. 1396r(c)(1)(D)) is amended by adding at the end the following sentence: "In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this title to have access to the services of such a consultant on a timely basis.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of OBRA-1987.

(c) INCREASE IN MINIMUM AMOUNT REQUIRED FOR SEPARATE DEPOSIT OF PERSONAL FUNDS.—

(1) IN GENERAL.—Section 1919(c)(6)(B)(i) (42 U.S.C. 1396r(c)(6)(B)(i)) is amended by striking "$50" and inserting "$100".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect January 1, 1994.

(d) DUE PROCESS PROTECTIONS FOR NURSE AIDES.—

(1) PROHIBITING STATE FROM INCLUDING UNDOCUMENTED ALLEGATIONS IN NURSE AIDE REGISTRY.—Section 1919(e)(2)(B) (42 U.S.C. 1396r(e)(2)(B)) is amended by striking the period at the end of the first sentence and inserting the following: ", but shall not include any allegations of resident abuse or neglect or misappropriation of resident property that are not specifically documented by the State under such subsection.".

(2) DUE PROCESS REQUIREMENTS FOR REBUTTING ALLEGATIONS.—Section 1919(g)(1)(C) (42 U.S.C. 1396r(g)(1)(C)) is amended by striking the second sentence and inserting the following: "The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to

rebut the allegations) and the opportunity for a hearing on the record, make a written finding as to the accuracy of the allegations.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect January 1, 1994.

SEC. 8627. INCREASE IN AUTHORIZATION OF APPROPRIATIONS FOR THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT PROGRAM.

Section 501(a) (42 U.S.C. 701(a)) is amended by striking "$686,000,000 for fiscal year 1990" and inserting "$705,000,000 for fiscal year 1994".

PART 2—MISCELLANEOUS AND TECHNICAL CORRECTIONS RELATING TO OBRA–1990

SEC. 8641. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this part shall take effect as if included in the enactment of OBRA–1990.

SEC. 8642. CORRECTIONS RELATING TO SECTION 4401 (DRUG REBATE PROGRAM).

(a) SECTION 1927.—(1) Section 1927(a) (42 U.S.C. 1396r–8(a)), as inserted by section 4401(a)(3) of OBRA–1990, is amended—

(A) in paragraph (1)—

(i) by amending the second sentence to read as follows: "Any such agreement entered into prior to May 1, 1991, shall be deemed to have been entered into on January 1, 1991, and the amount of the rebate to be paid by the manufacturer under such agreement shall be calculated as if the agreement had been entered into on January 1, 1991.", and

(ii) in the third sentence, by striking "March" and inserting "May";

(B) in paragraph (2)—

(i) by striking "first", and

(ii) by striking the period at the end and inserting the following: ", except that such paragraph (and section 1903(i)(10)(A)) shall not apply to drugs dispensed before May 1, 1991, if the Secretary determines that there were extenuating circumstances with respect to the first calendar quarter of 1991.";

(C) by amending paragraph (3) to read as follows:

"(3) AUTHORIZING PAYMENT FOR DRUGS NOT COVERED UNDER REBATE AGREEMENTS.—Paragraph (1) and section 1903(i)(10) shall not apply to the dispensing of a covered outpatient drug if—

"(A) the State has made a determination that the availability of such drug is essential to the health of beneficiaries under the State plan;

"(B) the drug has been given a rating of 1–A or 1–P by the Food and Drug Administration; and

"(C)(i) the physician has obtained approval for the use of the drug in advance of dispensing such drug in accordance with a prior authorization program described in subsection (d)(5), or

"(ii) the Secretary has reviewed and approved the State's determination under subparagraph (A)."; and

(D) in paragraph (4)—

(i) by striking "In the case" and inserting "(A) In the case",

(ii) by striking "in compliance with" and inserting "in effect under",

(iii) by striking "such agreement provides for a minimum aggregate rebate of 10 percent of the State's total expenditures under the State plan for coverage of the manufacturer's drugs under this title" and inserting "such agreement provides for a minimum aggregate rebate of 10 percent of the sum of the amounts determined under subparagraph (B) for all of the manufacturer's drugs paid for by the State under the agreement", and

(iv) by adding at the end the following new subparagraph:

"(B) The amount determined under this subparagraph with respect to a manufacturer's drug paid for by a State under an agreement described in the first sentence of subparagraph (A) is an amount equal to the product of—

"(i) the average manufacturer's price for such drug; and

"(ii) the number of dosage units of such drug paid for by the State under such agreement.".

(2) Section 1927(b) (42 U.S.C. 1396r–8(b)), as inserted by section 4401(a)(3) of OBRA–1990, is amended—

(A) in paragraph (2)(A), by striking "during" and inserting "for";

(B) in paragraph (3)(A)—

(i) in clause (i), by striking the open parenthesis before "for" and the close parenthesis after "drugs",

(ii) in clause (i), by striking "subsection (c)(2)(B)) for covered outpatient drugs" and inserting "subsection (c)(1)(C)) for each covered outpatient drug", and

(iii) in clause (ii), by inserting a comma after "this section" and after "1990";

(C) in paragraph (3)(B)—

(i) by striking "$100,000" and inserting "$10,000",

(ii) by striking "about charges or prices", and

(iii) by striking "or knowingly provides false information";

(D) in paragraph (3)(C)—

(i) in clause (i)—

(I) by striking "increased by", and

(II) by striking ", and, if" and inserting ". If",

(ii) in clause (ii), by striking "under this section" and inserting "under this section, or a wholesaler or direct seller,",

(iii) in clause (ii), by inserting "under subparagraph (A) or (B)" after "provides false information", and

(iv) in clause (ii), by striking "Such civil money penalties are" and inserting "Any such civil money penalty shall be";

(E) in paragraph (3)(D), by striking "wholesaler," the first time it appears and inserting "wholesaler or the"; and

(F) in paragraph (4)(B)(i), by adding at the end the following new sentence: "Failure of a State to provide any advance notice of such a termination as required by regulation shall not affect the State's right to terminate coverage of the drugs affected by such termination as of the effective date of such termination.".

(3) Section 1927(d)(3) (42 U.S.C. 1396r–8(d)(3)), as inserted by section 4401(a)(3) of OBRA–1990 and as amended by section 13602 of OBRA–1993, is amended to read as follows:

"(3) ADDITIONS TO DRUG LISTINGS.—The Secretary shall, by regulation, periodically update the list of drugs or classes of drugs described in paragraph (2), or their medical uses, which the Secretary has determined to be subject to clinical abuse or inappropriate use.".

(4) Section 1927(g) (42 U.S.C. 1396r–8(g)) is amended—

(A) by amending paragraph (1) to read as follows:

"(1) REQUIREMENT FOR DRUG USE REVIEW PROGRAM.—Each State shall provide, by not later than January 1, 1993, for a drug use review program for covered outpatient drugs (other than drugs dispensed to residents of nursing facilities) consistent with standards established by the Secretary that—

"(i) meets the requirements of paragraph (2), and

"(ii) is intended to assure that prescriptions for such drugs are appropriate, medically necessary, and not likely to lead to adverse medical results.";

(B) in paragraph (2)—

(i) by amending the matter before subparagraph (A) to read as follows:

"(2) REQUIREMENTS.—",

(ii) by amending subparagraph (A) to read as follows:

"(A) PROSPECTIVE DRUG USE REVIEW.—Each drug use review program shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this title (including counseling by pharmacists under standards established under applicable State law). Nothing in this paragraph shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this title or caregiver of such individual refuses such consultation.",

(iii) in subparagraph (C)—

(I) by striking "APPLICATION OF STANDARDS.—" and inserting "STANDARDS.—(i)",

(II) by striking "and literature referred to in subsection (1)(B)" and inserting "described in clause (ii)",

(III) by striking "including but not limited to" and inserting ". Such assessment shall include",

(IV) by striking "abuse/misuse and, as necessary, introduce remedial strategies," and inserting "abuse or misuse and introduce remedial strategies", and

(V) by adding at the end the following new clause:

"(ii) The compendia described in this clause are the American Hospital Formulary Service Drug Information, the United States Pharmacopeia-Drug Information, and the American Medical Association Drug Evaluations.", and

(iv) by amending subparagraph (D) to read as follows:

"(D) EDUCATIONAL PROGRAM.—The program shall educate (directly or by contract) pharmacists, physicians, and other individuals prescribing or dispensing covered outpatient drugs under the State plan on common drug therapy problems in order to improve prescribing or dispensing practices.";

(C) in paragraph (3)—

(i) in subparagraph (A), by striking "(hereinafter" and all that follows and inserting "(in this paragraph referred to as the 'DUR Board').",

(ii) in subparagraph (B), by striking "51 percent" and all that follows and inserting "50 percent licensed and actively practicing physicians and at least 1/3 but not more than 50 percent licensed and actively practicing pharmacists.",

(iii) by amending subparagraph (C) to read as follows:

"(C) RESPONSIBILITIES.—The responsibilities of the DUR Board shall include the following:

"(i) Carrying out retrospective drug use review pursuant to paragraph (2)(B).

"(ii) Establishing and applying standards for drug use review described in paragraph (2)(C).

"(iii) Implementing educational programs described in paragraph (2)(D).

"(iv) Conducting ongoing evaluations of the effectiveness of its programs and activities in improving the quality and safety of drug therapy for individuals receiving benefits under the State plan."; and

(D) by amending subparagraph (D) to read as follows:

"(4) ANNUAL REPORT.—Each State shall submit a report each year to the Secretary on the nature and scope of the drug use review program under this subsection. Such report shall include an estimate of cost savings resulting from operation of such program.''.

(5) Section 1927(h) (42 U.S.C. 1396r–8(h)) is amended to read as follows:

''(h) Encouraging Electronic Claims Management.—The Secretary shall encourage each single State agency under this title to establish, as its principal means of processing claims for covered outpatient drugs, a point-of-sale electronic claims management system for the purpose of verifying eligibility, transmitting data on claims, and assisting pharmacists and other authorized persons in applying for and receiving payment under the State plan.''.

(6) Section 1927(i) (42 U.S.C. 1396r–8(i)) is amended to read as follows:

''(i) Annual Report on Rebate Program.—Not later than May 1 of each year, the Secretary shall submit to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committee on Aging of the Senate a report on the operation of the rebate agreements required for covered outpatient drugs under this section in the preceding fiscal year, and shall include in the report such information in addition to the information required to be reported under section 601(d) of the Veterans Health Care Act of 1992 as the Secretary considers appropriate.''.

(7) Section 1927(j) (42 U.S.C. 1396r–8(j)), as inserted by section 4401(a)(3) of OBRA–1990, is amended to read as follows:

''(j) Exemption for Certain Health Maintenance Organizations and Hospitals.—

''(1) In general.—Except as provided in paragraph (2), the requirements of this section shall not apply with respect to covered outpatient drugs dispensed by—

''(A) a health maintenance organization; or

''(B) a hospital that dispenses covered outpatient drugs using a drug formulary system and bills the State no more than the hospital's purchasing costs for covered outpatient drugs.

''(2) Construction in determining best price.—Nothing in paragraph (1) shall be construed as excluding amounts paid by the entities described in such paragraph for covered outpatient drugs from the determination of the best price (as defined in subsection (c)(1)(C)) for such drugs.''.

(8) Section 1927(k) (42 U.S.C. 1396r–8(k)), as inserted by section 4401(a)(3) of OBRA–1990, is amended—

(A) in paragraph (2)—

(i) in the matter preceding clause (i) of subparagraph (A), by striking ''paragraph (5)'' and inserting ''subparagraph (D)'';

(ii) in subparagraph (A)—

(I) in clause (i), by striking ''for safety and effectiveness'' and by striking ''or which is approved under section 505(j) of such Act''; and

(II) by striking ''and'' at the end;

(iii) in subparagraph (B)—

(I) in clause (i), by striking ''prescription,'' and inserting ''prescription;'';

(II) in clause (ii), by striking '', and'' and inserting ''; and''; and

(III) by striking ''and'' at the end;

(iv) by striking the period at the end of subparagraph (C) and inserting ''; and''; and

(v) by adding at the end the following new subparagraph:

''(D) a drug which may be sold without a prescription (commonly referred to as an 'over-the-counter drug'), if the drug is prescribed by a physician (or other person authorized to prescribe under State law).'';

(B) in subparagraph (H) of paragraph (3), by inserting ''services'' after ''dialysis'';

(C) by striking paragraph (4) and redesignating paragraphs (5), (6), (7), (8), and (9) as paragraphs (4), (5), (6), (7), and (8), respectively;

(D) by amending paragraph (4), as so redesignated, to read as follows:

''(4) Manufacturer.—The term 'manufacturer' means, with respect to a covered outpatient drug, the entity holding legal title to or possession of the National Drug Code number for such drug.''; and

(E) in paragraph (6), as so redesignated—

(i) in subparagraph (A)(i), by striking ''paragraph (5)'' and inserting ''paragraph (2)(D)'',

(ii) in subparagraph (A)(ii), by inserting ''or product licensing application'' after ''application'',

(iii) in subparagraph (A)(iv), by inserting ''or product licensing application'' after ''application'',

(iv) in subparagraph (A)(iv), by striking ''distributers'' and inserting ''distributors'',

(v) in subparagraph (C)(i), by striking ''pharmaceuutically'' and inserting ''pharmaceutically'', and

(vi) in subparagraph (C)(iii), by striking '', provided that'' and inserting ''if''.

(b) Section 1903.—

(1) Enhanced match.—Section 1903(a) (42 U.S.C. 1396b(a)) is amended—

(A) by striking the period at the end of paragraph (7) and inserting ''; plus''; and

(B) by adding at the end the following new paragraph:

''(8) 75 per centum of so much of the sums expended under the State plan during calendar years 1991 through 1993 as the Secretary determines attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1927(g).''.

(2) Conforming amendments.—Section 1903(a)(3) (42 U.S.C. 1396b(a)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (C) and inserting ''plus''; and

(B) by striking subparagraph (D).

(c) Funding.—Section 4401(b)(2) of OBRA–1990 is amended by striking the semicolon and all that follows and inserting a period.

(d) Demonstration Projects.—Section 4401(c)(1) of OBRA–1990 is amended—

(1) in subparagraph (A), by striking ''1992'' and inserting ''1993'';

(2) in subparagraph (A), by striking ''10'' and inserting ''5'';

(3) in subparagraph (C), by striking ''regiment'' and inserting ''regimen''; and

(4) in subparagraph (D), by striking ''1994'' and inserting ''1995''.

(e) Studies.—Section 4401(d) of OBRA–1990 is amended—

(1) in paragraph (1)(A), by striking ''other institutional facilities,'' and inserting ''nursing facilities, intermediate care facilities for the mentally retarded,'';

(2) in paragraph (1)(B), by striking ''under this subsection'' and inserting ''under this paragraph'';

(3) in paragraph (1)(B)(i), by striking ''under this section'' and inserting ''under section 1927 of the Social Security Act'';

(4) in paragraph (1)(B)(ii)—

(A) by striking ''drug use review'' the second time it appears and inserting ''the type of drug use review that is''; and

(B) by striking ''under this section'' and inserting ''under such section'';

(5) in paragraph (1)(B)(iii), by striking ''under this title'' and inserting ''under title XIX of the Social Security Act'';

(6) in paragraph (1)(C)—

(A) by striking ''May 1, 1991'' and inserting ''May 1, 1992'', and

(B) by striking ''Committees on Aging of the Senate and the House of Representatives'' and inserting ''Committee on Aging of the Senate'';

(7) in paragraph (2)—

(A) by striking ''By not later than May 1 of each year, the Comptroller'' and inserting ''The Comptroller'';

(B) by striking ''Committees on Aging of the Senate and House of Representatives'' and inserting ''Committee on Aging of the Senate'';

(C) by striking ''an annual report'' and inserting ''a report''; and

(D) by striking ''retail and'';

(8) in paragraph (3)—

(A) in subparagraph (A), by striking '', acting in consultation with the Comptroller General,'',

(B) by indenting subparagraph (B) an additional 2 ems;

(C) in subparagraph (B), by striking ''December 31, 1991, the Secretary and the Comptroller General'' and inserting ''June 1, 1993, the Secretary''; and

(D) by striking ''Committees on Aging of the Senate and the House of Representatives'' and inserting ''Committee on Aging of the Senate'';

(9) in paragraph (4)—

(A) in subparagraph (A), by striking ''each'' and by striking the semicolon and inserting a comma;

(B) in subparagraph (B), by striking ''December 31, 1991'' and inserting ''January 1, 1993''; and

(C) in subparagraph (B), by striking ''Committees on Aging of the Senate and the House of Representatives'' and inserting ''Committee on Aging of the Senate'';

(10) in paragraph (5)—

(A) by striking ''Secretary of Health and Human Services'' and inserting ''Comptroller General'',

(B) by striking ''under this title'' and inserting ''under State medicaid programs'', and

(C) by striking the second sentence and inserting the following new sentence: ''The Comptroller General shall report to the Congress on the study not later than January 1, 1993.''; and

(11) by striking paragraph (6).

SEC. 8643. CORRECTIONS RELATING TO SECTION 4402 (ENROLLMENT UNDER GROUP HEALTH PLANS).

Section 4402(b) of OBRA–1990 is amended by striking ''1903(u)(1)(C)(iv) (42 U.S.C. 1396b(u)(1)(C)(iv))'' and inserting ''1903(u)(1)(D)(iv) (42 U.S.C. 1396b(u)(1)(D)(iv))''.

SEC. 8644. CORRECTIONS RELATING TO SECTION 4501 (LOW-INCOME MEDICARE BENEFICIARIES).

(a) Section 1902(a)(10)(E)(iii) (42 U.S.C. 1396a(a)(10)(E)(iii)), as added by section 4501(b)(3) of OBRA–1990, is amended by striking ''cost sharing'' and inserting ''cost-sharing''.

(b) Section 1905(p)(4)(B) (42 U.S.C. 1396d(p)(4)(B)), as amended by section 4501(c)(1) of OBRA–1990, is amended by striking ''1902(a)(10)(E)(iii)'' and inserting ''section 1902(a)(10)(E)(iii)''.

SEC. 8645. CORRECTIONS RELATING TO SECTION 4601 (CHILD HEALTH).

(a) Section 1902(a)(10)(A)(i)(VII) (42 U.S.C. 1396a(a)(10)(A)(i)(VII)), as added by section 4601(a)(10)(A)(iii) of OBRA–1990, is amended by striking ''family;'' and inserting ''family; and''.

(b) Section 1902(l) (42 U.S.C. 1396a(l)), as amended by section 4601(a)(1)(C) of OBRA–1990, is amended—

(1) in paragraph (1)(C), by striking "children" after "(C)";

(2) in paragraph (3), by striking "(a)(10)(A)(i)(VII),," and inserting "(a)(10)(A)(i)(VII),"; and

(3) in paragraph (4)(B), by inserting a comma before "(a)(10)(A)(i)(VI),".

(c) Section 1925 (42 U.S.C. 1396r–6), as amended by section 4601(a) of OBRA–1990, is amended—

(1) in subsection (a)(3)(C), by striking "(i)(VI)" and inserting "(i)(VI),", and

(2) in subsection (b)(3)(C)(i), by striking "(i)(IV) (i)(VI) (i)(VII), ," and inserting "(i)(IV), (i)(VI), (i)(VII),".

SEC. 8646. CORRECTIONS RELATING TO SECTION 4602 (OUTREACH LOCATIONS).

(a) Section 1902(a)(55) (42 U.S.C. 1396a(a)(55)), as added by section 4602(a)(3) of OBRA–1990, is amended—

(1) in the matter preceding subparagraph (A)—

(A) by striking "subsection" and inserting "paragraph", and

(B) by striking "(a)" each place it appears; and

(2) in subparagraph (A), by striking "1905(1)(2)(B)" and inserting "1905(l)(2)(B)".

(b) Section 1902(l)(1) (42 U.S.C. 1396a(l)(1)) is amended by striking "who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and".

SEC. 8647. CORRECTIONS RELATING TO SECTION 4604 (PAYMENT FOR HOSPITAL SERVICES FOR CHILDREN UNDER 6 YEARS OF AGE).

(a) Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended in clause (X) in the matter following subparagraph (F) by striking "under one year of age" and inserting "under 6 years of age".

(b) Section 1902(s) (42 U.S.C. 1396a(s)), as added by section 4604(a) of OBRA–1990, is amended to read as follows:

"(s) In order to meet the requirements of subsection (a)(56), the State plan must provide that payments to hospitals under the plan for inpatient services furnished to infants who have not attained the age of 1 year (or, in the case of such an individual who is an inpatient on his first birthday, until such individual is discharged) shall—

"(1) if made on a prospective basis (whether per diem, per case, or otherwise), provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay;

"(2) not be limited by the imposition of day limits; and

"(3) not be limited by the imposition of dollar limits (other than dollar limits resulting from prospective payments as adjusted pursuant to paragraph (1)).".

(c) Section 1923(a)(2)(C) (42 U.S.C. 1396r–4(a)(2)(C)) is amended by striking "provided on or after July 1, 1989," and all that follows and inserting the following: "involving exceptionally high costs or exceptionally long lengths of stay—

"(i) for individuals under 1 year of age, in the case of services provided on or after July 1, 1989, and on or before June 30, 1991; and

"(ii) for individuals under 6 years of age, in the case of services provided on or after July 1, 1991.".

SEC. 8648. CORRECTIONS RELATING TO SECTION 4703 (PAYMENT ADJUSTMENTS FOR DISPROPORTIONATE SHARE HOSPITALS).

(a) Section 1923(c) (42 U.S.C. 1396r–4(c)) is amended—

(1) in paragraph (2), by striking "paragraph (b)(3)" and inserting "subsection (b)(3)";

(2) by striking the period at the end of paragraph (3)(B) and inserting a comma; and

(3) in the third sentence, by striking "the payment adjustment described in paragraph (2)" and inserting "a payment adjustment described in paragraph (2) or (3)".

(b) Effective December 22, 1987, section 1923(d)(2)(A)(ii) (42 U.S.C. 1396r–4(d)(2)(A)(ii)) is amended by striking "the date of the enactment of this Act" and inserting "December 22, 1987".

(c) Section 4703(d) of OBRA–1990 is amended by striking "412(a)(2)" and inserting "4112(a)(2)".

SEC. 8649. CORRECTIONS RELATING TO SECTION 4704 (FEDERALLY-QUALIFIED HEALTH CENTERS).

(a) Clause (ix) of section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)), as added by section 4704(b)(1)(C) of OBRA–1990, is amended—

(1) by striking "of such center" the first place it appears;

(2) by striking "federally qualified" and inserting "Federally-qualified";

(3) by inserting "section" before "1905(a)(2)(C)"; and

(4) by moving such clause 2 ems to the left.

(b) Section 1903(m)(2)(B) (42 U.S.C. 1396b(m)(2)(B)), as amended by section 4704(b)(2) of OBRA–1990, is amended in the matter preceding clause (i) by striking "except with respect to clause (ix) of subparagraph (A)," and inserting "(except with respect to clause (ix) of such subparagraph)".

(c) Section 1905(l)(2) (42 U.S.C. 1396d(l)(2)), as amended by section 4704(c) of OBRA–1990 and sections 13606(a) and 13631(f)(2)(B) of OBRA–1993, is amended—

(1) in subparagraph (A)—

(A) by striking "Federally-qualififed" and inserting "Federally-qualified", and

(B) by striking "an patient" and inserting "a patient", and

(2) in subparagraph (B)—

(A) in the matter preceding clause (i), by striking "a entity" and inserting "an entity",

(B) by striking "or" at the end of clause (iii),

(C) by striking the semicolon at the end of clause (iv) and inserting ", or", and

(D) by striking "and includes an outpatient health program" and all that follows through "for good cause shown." and inserting the following:

"(v) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.

In applying clause (ii), the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.".

SEC. 8650. CORRECTIONS RELATING TO SECTION 4708 (SUBSTITUTE PHYSICIANS).

(a) Section 1902(a)(32) (42 U.S.C. 1396a(a)(32)), as added by section 4708(a)(3) of OBRA–1990 and as amended by section 13631(e)(1) of OBRA–1993, is amended—

(1) in the matter preceding subparagraph (A), by striking "except that" and inserting "except that (subject to section 1903(i)(12))"; and

(2) by amending subparagraph (C) to read as follows:

"(C) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the State for such services includes the second physician's unique identifier (provided under the system established under subsection (x)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician; and".

(b) The amendments made by subsection (a) shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act.

SEC. 8651. CORRECTIONS RELATING TO SECTION 4711 (HOME AND COMMUNITY CARE FOR FRAIL ELDERLY).

(a) Section 1929 (42 U.S.C. 1396t), as added by section 4711(b) of OBRA–1990, is amended—

(1) in subsection (c)(2)(F), by moving the second sentence 2 ems to the right;

(2) in subsection (d)(2)(F)(ii), by striking "they manage" and inserting "it manages";

(3) in subsection (d)(2)(F)(iii), by inserting "the agency or organization" after "(iii)";

(4) in subsection (e)(2)(B), by striking "fiscal year 1989" and inserting "fiscal year 1990";

(5) in subsection (f)(1), by striking "Community care" and inserting "community care";

(6) in subsection (g)(1)—

(A) by striking "SETTINGS" and inserting "SETTING"; and

(B) in subparagraph (B), by striking "setting." and inserting "setting in which home and community care under this section is provided.";

(7) in subsection (g)(2), by striking "community care" the second, third, and fourth place it appears and inserting "home and community care";

(8) in subsection (h)(1)—

(A) by amending subparagraph (A) to read as follows:

"(A) a nonresidential setting that serves 8 or more individuals; or"; and

(B) in subparagraph (B)—

(i) by striking "more than 8" and inserting "8 or more"; and

(ii) by inserting "(other than merely board)" after "personal services";

(9) in subsection (h)(2), by striking "community care" the second and third place it appears and inserting "home and community care";

(10) in the first sentence of subsection (j)(1)(A), by striking "the State may terminate the provider's participation under the State plan and may provide in addition for a civil money penalty" and inserting "the State may provide for a civil money penalty and, in addition, may terminate the provider's participation under the State plan";

(11) in the first sentence of subsection (j)(2)(B), by striking "the Secretary may terminate the provider's participation under the State plan and may provide, in addition, for a civil money penalty under subparagraph (C)" and inserting "the Secretary may provide for a civil money penalty under subparagraph (C) and, in addition, terminate the provider's participation under the State plan";

(12) in subsection (k)(1)(A)(i)—

(A) by striking "(d)(2)(E)" and inserting "(d)(2)", and

(B) by striking "settings," and inserting "settings),";

(13) in subsection (l), by striking "State wideness" and inserting "Statewideness";

(14) in paragraph (2) of subsection (m) by striking "Individual Community Care Plan" and inserting "individual community care plan"; and

(15) by adding at the end the following new subsection:

"(n) COMMUNITY CARE SETTING DEFINED.—In this section, the term 'community care setting' means a small community care setting (as defined in subsection (g)(1)) or a large community care setting (as defined in subsection (h)(1)).".

(b) Section 1905(r)(5) (42 U.S.C. 1396d(r)(5)) is amended by striking "section 1905(a)" and inserting "subsection (a) (other than services described in paragraph (22) or (23) of such subsection)".

(c) Section 4711(f) of OBRA–1990 is amended by striking "Act" each place it appears and inserting "section".

SEC. 8652. CORRECTIONS RELATING TO SECTION 4712 (COMMUNITY SUPPORTED LIVING ARRANGEMENTS).

(a) Section 1930 (42 U.S.C. 1396u), as added by section 4712(b)(2) of OBRA–1990, is amended—

(1) in subsection (b)—

(A) by striking "title the term," and inserting "title, the term",

(B) by striking "guardian" and inserting "guardian or", and

(C) by striking "3 other" and inserting "3";

(2) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking "program," and inserting "program", and

(B) in the second sentence, by striking "plan" each place it appears and inserting "program"; and

(3) in subsection (i), by striking "FUNDS" and inserting "FUNDS".

(b) Section 4712(c) of OBRA–1990 is amended—

(1) in paragraph (1), by inserting "of section 1930 of the Social Security Act" after "subsection (h)"; and

(2) in paragraph (2), by striking "this section" and inserting "such section".

SEC. 8653. CORRECTION RELATING TO SECTION 4713 (COBRA CONTINUATION COVERAGE).

(a) Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (F) by striking "COBRA continuation premiums" and inserting "COBRA premiums".

(b) Section 1902(u)(3) (42 U.S.C. 1396a(u)(3)), as added by section 4713(a)(2) of OBRA–1990, is amended by striking "title VI" and inserting "part 6 of subtitle B of title I".

SEC. 8654. CORRECTION RELATING TO SECTION 4716 (MEDICAID TRANSITION FOR FAMILY ASSISTANCE).

Section 4716(a) of OBRA–1990 is amended by striking "AMENDMENTS.—Subsection (f) of section" and inserting "IN GENERAL.—Section".

SEC. 8655. CORRECTIONS RELATING TO SECTION 4718 (MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES).

Section 4718(b) of OBRA–1990 is amended by striking "June 1, 1989" and inserting "July 1, 1989".

SEC. 8656. CORRECTIONS RELATING TO SECTION 4723 (MEDICAID SPEND-DOWN OPTION).

Section 1903(f)(2) (42 U.S.C. 1396b(f)(2)), as amended by section 4723(a) of OBRA–1990, is amended by striking "to the State, provided that" and inserting "to the State if".

SEC. 8657. CORRECTIONS RELATING TO SECTION 4724 (OPTIONAL STATE DISABILITY DETERMINATIONS).

Section 1902(v) (42 U.S.C. 1396a(v)), as added by section 4724 of OBRA–1990, is amended—

(1) by striking "(v)(1)" and inserting "(v)"; and

(2) by striking "of the Social Security Act".

SEC. 8658. CORRECTION RELATING TO SECTION 4732 (SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS).

Section 1903(m)(2)(F)(i) (42 U.S.C. 1396b(m)(2)(F)(i)), as amended by section 4732(b)(2)(B) of OBRA–1990, is amended by striking "or" before "with an eligible organization".

SEC. 8659. CORRECTIONS RELATING TO SECTION 4747 (COVERAGE OF HIV-POSITIVE INDIVIDUALS).

Section 4747 of OBRA–1990 is amended—

(1) in subsection (a)—

(A) by striking "services described in subsection (c)" and inserting "services described in subsection (b)(1) (and may provide coverage for services described in subsection (b)(2))", and

(B) by striking "to individuals" and inserting "to individuals who are not otherwise eligible for medical assistance under such title,";

(2) by amending subsection (b) to read as follows:

"(b) SERVICES AVAILABLE UNDER A DEMONSTRATION PROJECT.—

"(1) REQUIRED SERVICES.—

"(A) IN GENERAL.—Services described in this paragraph are the following:

"(i) General and preventive medical care services, including outpatient care, physician visits, and clinic visits.

"(ii) Other laboratory and X-ray services.

"(iii) Prescription drugs (including costs associated with the intravenous administration of prescription drugs).

"(iv) Case management services.

"(B) SCOPE OF SERVICES.—The services described in subparagraph (A) may be limited under a demonstration project only on the basis of medical necessity or the appropriateness of such services.

"(2) OPTIONAL SERVICES.—

"(A) IN GENERAL.—Services described in this paragraph are the following:

"(i) Counseling and social services.

"(ii) Substance abuse treatment.

"(iii) Health education services.

"(iv) Dental services.

"(B) SCOPE OF SERVICES.—A demonstration project may limit the amount, duration, or scope of services described in subparagraph (A).";

(3) in subsection (c)—

(A) in paragraph (1)—

(i) by striking "with a hospital" and all that follows through "other entity have" and inserting "with an entity which has", and

(ii) by striking "and have access" and all that follows through the end and inserting "and has access to data on comparable patients who have so tested and who are not participating in the demonstration project.", and

(B) by striking paragraphs (2) and (3) and redesignating paragraph (4) as paragraph (2);

(4) in subsection (d), by striking "paragraph (3)" and "paragraph (1)" and inserting "subsection (b)" and "subsection (a)", respectively; and

(5) in subsection (f), by adding at the end the following new sentence: "Such sums as may be available under the limitation set forth in this paragraph for fiscal year 1993 shall be available until expended.".

SEC. 8660. CORRECTION RELATING TO SECTION 4751 (ADVANCED DIRECTIVES).

Section 1903(m)(1)(A) (42 U.S.C. 1396b(m)(1)(A)), as amended by section 4751(b)(1) of OBRA–1990, is amended—

(1) by striking "1902(w)" and inserting "1902(w) and"; and

(2) by striking "1902(a)" and inserting "1902(w)".

SEC. 8661. CORRECTIONS RELATING TO SECTION 4752 (PHYSICIANS' SERVICES).

(a) Paragraph (59) of section 1902(a) (42 U.S.C. 1396a(a)), as added by section 4752(c)(1)(C) of OBRA–1990 and as redesignated by section 13623(a)(6) of OBRA–1993, is amended by striking "subsection (v)" and inserting "subsection (x)".

(b) Section 1903(i)(12) (42 U.S.C. 1396b(i)(12)), as inserted by section 4752(e) of OBRA–1990 and as redesignated by section 13631(c)(3) of OBRA–1993, is amended—

(1) by amending clause (i) of subparagraph (A) to read as follows:

"(i) is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or is certified in family practice or pediatrics by the medical specialty boards recognized by the American Osteopathic Association,";

(2) by amending clause (i) of subparagraph (B) to read as follows:

"(i) is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics or is certified in family practice or obstetrics by the medical specialty boards recognized by the American Osteopathic Association,"; and

(3) in subparagraphs (A) and (B)—

(A) by striking "or" at the end of clause (v);

(B) by redesignating clause (vi) as clause (vii); and

(C) by inserting after clause (v) the following new clause:

"(vi) delivers such services in the emergency department of a hospital participating in the State plan approved under this title, or".

SEC. 8662. CORRECTIONS RELATING TO SECTION 4801 (NURSING HOME REFORM).

(a) Section 1919(b)(3)(C)(i)(I) (42 U.S.C. 1396r(b)(3)(C)(i)(I)), as amended by section 4801(e)(3) of OBRA–1990, is amended by striking "not to exceed" before "14 days".

(b) Section 1919(b)(5)(D) (42 U.S.C. 1396r(b)(5)(D)), as amended by section 4801(a)(4) of OBRA–1990, is amended by striking the comma before "or a new competency evaluation program.".

(c) Section 1919(b)(5)(G) (42 U.S.C. 1396r(b)(5)(G)) is amended by striking "or licensed or certified social worker" and inserting "licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician".

(d) Section 1919(f)(2)(B)(i) (42 U.S.C. 1396r(f)(2)(B)(i)) is amended by striking "facilities," and inserting "facilities (subject to clause (iii)),".

(e) Section 1919(f)(2)(B)(iii)(I)(c) (42 U.S.C. 1396r(f)(2)(B)(iii)(I)(c)) is amended by striking "clauses" each place it appears and inserting "clause".

(f) Section 1919(g)(5)(B) (42 U.S.C. 1396r(g)(5)(B)) is amended by striking "paragraphs" and inserting "paragraph".

(g) Section 4801(a)(6)(B) of OBRA–1990 is amended—

(1) by striking "The amendments" and inserting "(i) The amendments";

(2) by redesignating clauses (i) through (v) as subclauses (I) through (V); and

(3) by adding at the end the following new clause:

"(ii) Notwithstanding clause (i) and subject to section 1919(f)(2)(B)(iii)(I) of the Social Security Act (as amended by subparagraph (A)), a State may approve a training and competency evaluation program or a competency evaluation program offered by or in a nursing facility described in clause (i) if, during the previous 2 years, none of the subclauses of clause (i) applied to the facility.".

SEC. 8663. OTHER TECHNICAL CORRECTIONS.

(a) Section 1905(o)(1)(A) (42 U.S.C. 1396d(o)(1)(A)) is amended—

(1) in the first sentence, by striking "intermediate care facility services" and inserting "for nursing facility services or intermediate care facility services for the mentally retarded"; and

(2) in the second sentence, by striking "or intermediate care facility" and inserting "(for purposes of title XVIII), a nursing facility, or an intermediate care facility for the mentally retarded".

(b) Section 1915(d) (42 U.S.C. 1396n(d)) is amended—

(1) by striking "skilled nursing facility or intermediate care facility" each place it appears in paragraphs (1), (2)(B), and (2)(C) and inserting "nursing facility";

(2) in paragraph (2)(B)(i), by striking "skilled nursing or intermediate care facility" and inserting "nursing facility";

(3) in paragraph (5)(A), by striking "under" the second place it appears and inserting "(or, in the case of waiver years beginning on or after October 1, 1990, with respect to nursing facility services and home and community-based services) under"; and

(4) in paragraph (5)(B)—

(A) in clause (i), by striking "furnished" and inserting "(or, with respect to waiver years beginning on or after October 1, 1990, for nursing facility services) furnished"; and

(B) in clause (iii)(I), by striking "(regardless" and inserting "(or, with respect to waiver years beginning on or after October 1, 1990, which comprise nursing facility services) (regardless".

(c)(1) Section 1924(h)(1)(A) (42 U.S.C. 1396r-5(h)(1)(A)) is amended to read as follows:

"(A)(i) is in a medical institution or nursing facility; or

"(ii) is described in section 1902(a)(10)(A)(ii)(VI) (except that for purposes of subsection (d), such term shall include such individual only if the State elects to apply such subsection to the individual); and".

(2) The amendments made by this subsection shall apply to home or community-based services furnished on or after January 1, 1994.

PART 3—MISCELLANEOUS AND TECHNICAL CORRECTIONS RELATING TO OBRA-1993

SEC. 8671. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this part shall take effect as if included in the enactment of OBRA-1993.

SEC. 8672. CORRECTIONS RELATING TO SECTION 13601 (PERSONAL CARE SERVICES).

Section 13601(a)(3) of OBRA-1993 is amended by striking "comma" and inserting "period".

SEC. 8673. CORRECTIONS RELATING TO SECTION 13604 (EMERGENCY SERVICES FOR ALIENS).

Section 13604(b)(2) of OBRA-1993 is amended to read as follows:

"(2) The Secretary of Health and Human Services shall not disallow expenditures made under section 1903(v)(2) of the Social Security Act for care and services relating to organ transplant procedures furnished before the date of the enactment of this Act.".

SEC. 8674. CORRECTIONS RELATING TO SECTION 13611 (TRANSFERS OF ASSETS; TREATMENT OF CERTAIN TRUSTS).

(a) EXEMPTION FROM ASSET TRANSFER RESTRICTIONS.—Section 1917(c)(2)(B) (42 U.S.C. 1396p(c)(2)(B)), as amended by section 13611(a)(2) of OBRA-1993, is amended—

(1) by striking "or" at the end of clause (iii);

(2) by striking the semicolon at the end of clause (iv) and inserting ", or"; and

(3) by adding at the end the following new clause:

"(iv) were transferred to a trust described in subsection (d)(4)(B) or subsection (d)(4)(C).".

(b) RESTRICTION ON ABILITY OF TRUSTEE TO DISTRIBUTE CORPUS.—Section 1917(d)(4)(B) (42 U.S.C. 1396p(d)(4)(B)), as added by section 13611(b) of OBRA-1993, is amended—

(1) by striking "and" at the end of clause (ii);

(2) by striking the period at the end of clause (iii) and inserting ", and"; and

(3) by adding at the end the following new clause:

"(iv) no payment may be made from any portion of the corpus of the trust to any person other than the individual.".

(c) INCOME PLACED INTO TRUST NOT COUNTED FOR PURPOSES OF ELIGIBILITY.—Section 1917(d) (42 U.S.C. 1396p(d)), as added by section 13611(b) of OBRA-1993, is amended—

(1) by striking the closing quotation mark and the second period at the end of paragraph (5);

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following new paragraph:

"(6) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title, any income placed into a trust described in paragraph (4)(B) that is established for the benefit of the individual shall not be considered income of the individual.".

(d) OTHER TECHNICAL AMENDMENTS.—(1) Section 1917(c)(2)(C)(iii) (42 U.S.C. 1396p(c)(2)(C)(iii)), as added by section 13611(a)(2)(C)(iv) of OBRA-1993, is amended by striking "all".

(2) Section 1917(c)(4) (42 U.S.C. 1396p(c)(4)), as amended by section 13611(a)(2)(F), is amended by striking "resources" and inserting "assets".

(3) Section 13611(e)(3) of OBRA-1993 is amended—

(A) by striking "amendment made by subsection (b)" and inserting "amendments made by subsections (a) and (b)"; and

(B) by striking "such amendment" and inserting "such amendments".

SEC. 8675. CORRECTIONS RELATING TO SECTION 13612 (MEDICAID ESTATE RECOVERIES).

(a) CLARIFICATION OF DISREGARD OF ASSET RULES.—Section 1902(r)(2) (42 U.S.C. 1396a(r)(2)) is amended by adding at the end the following:

"(C)(i) Notwithstanding subparagraph (A), except as provided in clause (ii), a State plan may not provide pursuant to this paragraph for disregarding any assets—

"(I) to the extent that payments are made under a long-term care insurance policy; or

"(II) because an individual has received (or is entitled to receive) benefits for a specified period of time under a long-term care insurance policy.

"(ii) Clause (i) shall not apply to State plan provisions that are approved as of August 1, 1994.".

(b) ESTATE RECOVERIES.—Section 1917(b)(1) (42 U.S.C 1396p(b)(1)), as amended by section 13612(a) of OBRA-1993, is amended—

(1) by amending the matter preceding subparagraph (A) to read as follows:

"(b)(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall comply with the following:";

(2) by amending subparagraph (A) to read as follows:

"(A) In the case of an individual described in subsection (a)(1)(B), the State—

"(i) shall seek adjustment or recovery upon the sale of property subject to a lien imposed on account of medical assistance paid on behalf of the individual, and

"(ii) may seek adjustment or recovery from the individual's estate.";

(3) in subparagraph (B)—

(A) in clause (i), by striking "or" at the end and inserting "and"; and

(B) in clause (ii), by inserting "additional" after "any"; and

(4) in subparagraph (C), by striking the period at the end and inserting the following: ", and shall notify any individual who seeks to purchase such a policy (or who has purchased such a policy as of the date of the enactment of the Guaranteed Health Insurance Act of 1994) of the State's obligation to seek adjustment or recovery under this clause.".

SEC. 8676. CORRECTIONS RELATING TO SECTION 13622 (LIABILITY OF THIRD PARTIES TO PAY FOR CARE AND SERVICES).

(a) Section 1902(a)(25)(A) (42 U.S.C. 1396a(a)(25)(A)), as amended by section 13622(a) of OBRA-1993, is amended by striking "(as defined in section 607(1)" and inserting "(including any such plan meeting the definition of section 607(1)".

(b) Section 1902(a)(25)(I) (42 U.S.C. 1396a(a)(25)(I)), as added by section 13622(c) of OBRA-1993, is amended to read as follows:

"(I) assurances satisfactory to the Secretary that the State has in effect laws providing that, to the extent that payment has been made under the State plan of that or any other State for medical assistance for health care items or services furnished to an individual, the State paying such medical assistance is considered to have acquired the rights of such individual to payment by any third party legally liable to pay for such items or services;".

SEC. 8677. CORRECTIONS RELATING TO SECTION 13623 (MEDICAL CHILD SUPPORT).

(a)(1) Title XIX (42 U.S.C. 1396 et seq.) is amended by redesignating section 1908, as added by section 13623(b) of OBRA-1993, as section 1909.

(2) Paragraph (60) of section 1902(a) (42 U.S.C. 1396a(a)), as added by section 13623(a) of OBRA-1993, is amended by striking "section 1908" and inserting "section 1909".

(b) Subsection (b) of section 1909, as redesignated by subsection (a), is amended by striking "as defined in section 607(1)" and inserting "including any such plan meeting the definition of section 607(1)".

SEC. 8678. CORRECTIONS RELATING TO SECTION 13624 (PHYSICIAN REFERRALS).

Section 13624(b) of OBRA-1993 is amended by striking "on or".

SEC. 8679. CORRECTIONS RELATING TO SECTION 13631 (MEDICAID PEDIATRIC IMMUNIZATION PROVISIONS).

(a) Section 1902(a)(32)(D) (42 U.S.C. 1396(a)(32)(D)), as added by section 13631(e)(1) of OBRA-1993, is amended by striking "(which price includes a reasonable amount to cover shipping and the handling of returns)" and inserting "plus a reasonable amount to cover shipping and the handling of returns".

(b) Section 1928(d)(3)(B) (42 U.S.C. 1396s(d)(3)(B)), as added by section 13631(b)(2) of OBRA-1993, is amended by striking "and any applicable excise tax established under section 4131 of the Internal Revenue Code of 1986".

SEC. 8680. CORRECTIONS RELATING TO SECTION 13643 (DEMONSTRATION PROJECTS).

Effective as if included in the enactment of OBRA-1990, section 4745 of such Act is amended in subsection (d) by striking "shall commence not later than July 1, 1991 and".

Subtitle H—Provision Relating to AFDC Program

SEC. 8701. ENFORCEMENT OF MAINTENANCE-OF-EFFORT REQUIREMENTS THROUGH AFDC.

(a) STATE PLAN REQUIREMENT.—Section 402(a) (42 U.S.C. 602(a)) is amended—

(1) by striking "and" at the end of paragraph (44);

(2) by striking the period at the end of paragraph (45) and inserting "; and"; and

(3) by inserting after paragraph (45) the following new paragraph:

"(46) provide assurances that the State is making payments required under part 2 of subtitle B of title VIII of the Guaranteed Health Insurance Act of 1994.".

(b) WITHHOLDING AMOUNTS UNPAID.—Section 403 (42 U.S.C. 603) is amended by adding at the end the following new subsection:

"(o) Notwithstanding any other provision of this section, the Secretary shall reduce the amount of payment made to a State under this section for quarters in any fiscal year to the extent that the State fails to make the payments required for the fiscal year under part 2 of subtitle B of title VIII of the Guaranteed Health Insurance Act of 1994 in a timely manner.".

TITLE IX—QUALITY AND CONSUMER AND WORKFORCE PROTECTION

Subtitle A—Quality Management and Improvement

PART 1—NATIONAL QUALITY MANAGEMENT PROGRAM

SEC. 9001. NATIONAL QUALITY MANAGEMENT PROGRAM.

(a) ESTABLISHMENT.—The Secretary shall establish and oversee a performance-based program of quality management and improvement designed to enhance the quality, appropriateness, and effectiveness of health care services rendered in the United States. The program shall be known as the National Quality Management Program.

(b) ELEMENTS.—Subject to the specific provisions of this part, the National Quality Management Program shall consist of the following:

(1) The consumer surveys described in section 9002.

(2) The national measures of quality performance described in section 9003.

(3) The national quality standards for approved sponsors described in section 9004.

(4) The models for profiling patterns of clinical practice and improving quality of care described in section 9005.

(5) The quality-related profiling data described in section 9006.

(6) The compliance monitoring described in section 9007.

(7) The guideline development and certification and the research on health care quality described in section 9008.

(8) The contracts with approved quality improvement organizations entered into by the Secretary under section 9009.

(9) The quality management grants made to approved States by the Secretary under section 9010.

SEC. 9002. CONSUMER SURVEYS.

(a) IN GENERAL.—The Secretary shall conduct annual surveys of health care consumers to gather information, with respect to a year to which a survey pertains, concerning access to care, use of health services, health outcomes, and patient satisfaction. The surveys shall be conducted using the standard design and the sampling strategies developed under subsection (d).

(b) AUTHORITY TO CONTRACT.—The Secretary may carry out subsection (a) by entering into contracts with private individuals or entities or States pursuant to which the individuals, entities, or States undertake the duties applicable to the Secretary under the subsection.

(c) TRANSMISSION OF SURVEY RESULTS.—

(1) APPROVED SPONSORS.—The Secretary shall forward the results of any survey conducted under this section that pertains to an approved health plan provided or sponsored by an approved sponsor in a State to—

(A) the State (if the State is an approved State); and

(B) the approved quality improvement organization responsible for the geographic area that includes the State.

(2) QUALIFIED PROVIDERS.—The Secretary shall forward the results of any survey conducted under this section that pertains to health care services rendered in a State by a qualified provider to—

(A) the State (if the State is an approved State); and

(B) the approved quality improvement organization responsible for the geographic area that includes the State.

(d) DESIGN AND SAMPLING STRATEGIES.—

(1) STANDARD DESIGN.—The Secretary shall develop and approve a standard design for the surveys conducted under this section. The design shall ensure the collection of valid, reliable, and comparable survey responses.

(2) SAMPLING STRATEGIES.—The Secretary shall develop sampling strategies that ensure that survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care, including individuals with disabilities.

(3) DEADLINE.—The Secretary shall develop and approve the design under paragraph (1) and the sampling strategies under paragraph (2) not later than 12 months after the date of the enactment of this Act.

(e) TIMELINESS.—The Secretary shall carry out subsections (a) and (c) in a manner that permits a State to include the results of consumer surveys that pertain to a year in the performance report published by the State under section 9003(g) that pertains to the year.

SEC. 9003. NATIONAL MEASURES OF QUALITY PERFORMANCE.

(a) DEVELOPMENT AND UPDATING.—

(1) IN GENERAL.—The Secretary shall develop and update a uniform set of national measures of quality performance to be used to assess—

(A) the performance of approved sponsors, network providers, and health institutions;

(B) the satisfaction of individuals enrolled under an approved health plan with the access to, and quality of, items and services provided by the approved sponsor providing or sponsoring the plan and network providers with respect to the plan;

(C) the satisfaction of individuals receiving health care items and services from a health institution; and

(D) the degree to which approved sponsors, network providers, and health institutions are meeting the needs of special patient populations, including individuals with disabilities.

(2) MINIMUM INFORMATION REQUIRED TO BE PROVIDED.—The measures shall be developed and selected in a manner that ensures that approved plan sponsors and health institutions are required to provide the minimum amount of information that is necessary to perform the assessments referred to in paragraph (1).

(3) BASES FOR MEASURES.—In developing and selecting the national measures of quality performance, the Secretary shall consider the recommendations of the Health Care Quality Advisory Commission established under section 9012 (in this part referred to as the "Commission"). The measures also may be based on guidelines developed or certified under title IX of the Public Health Service Act, research sponsored under such title, or other guidelines or research, if the guidelines or research are determined to be appropriate for such purpose by the Secretary.

(4) SEQUENTIAL SETS.—The set of national measures of quality performance shall be established through the development and use of a series of interim sets of quality measures. The Secretary, in consultation with the Commission, shall establish a sequence for such sets. The initial set of national measures of quality performance shall provide information on access to care and, with respect to an approved sponsor, information on the number, types, and locations of qualified providers who are authorized to provide services or receive payments under each approved health plan provided or sponsored by the sponsor. Subsequent sets of measures shall provide additional information as such information becomes valid and available (as determined by the Secretary).

(b) SUBJECT OF MEASURES.—The national measures of quality performance shall be selected in a manner that provides accurate, comparable information on the following subjects:

(1) Access to health care services and procedures by individuals enrolled in approved health plans.

(2) Outcomes (including patient functional status), effectiveness, and appropriateness of such health care services and procedures.

(3) Risk management and reduction, through health promotion and disease prevention.

(4) Consumer experience and satisfaction.

(c) CRITERIA.—The following criteria shall be used in developing and selecting national measures of quality performance:

(1) SIGNIFICANCE.—When a measure relates to a specific disease, disorder, or other health condition, the disease, disorder, or condition shall be of significance in terms of prevalence, morbidity, mortality, or the costs associated with the prevention, diagnosis, treatment, or clinical management of the disease, disorder, or condition.

(2) RANGE OF SERVICES.—The set of measures, taken as a whole, shall be representative of the range of services provided to consumers of health care.

(3) RELIABILITY AND VALIDITY.—To the extent practicable, the measures shall be reliable and valid.

(4) UNDUE BURDEN.—The data needed to calculate the measures shall be obtained without undue burden on the entity or individual providing the data.

(5) RURAL PRACTICE.—The measures shall take into account criteria appropriate to rural clinical practice.

(6) VARIATION.—Performance with respect to a measure shall be expected to vary widely among the individuals and entities whose performance is assessed using the measure.

(7) LINKAGE TO HEALTH OUTCOME.—When a measure is established relating to a process of care, the process shall be linked to a health outcome based upon the best available scientific evidence.

(8) PROVIDER CONTROL AND RISK ADJUSTMENT.—When a measure is an outcome of the provision of care, the outcome shall be within the control of the provider and one with respect to which an adequate risk adjustment can be made.

(9) PUBLIC HEALTH.—The measures shall reflect goals identified by the Secretary for meeting public health objectives.

(d) DATA TRANSMISSION.—

(1) APPROVED SPONSORS.—An approved sponsor shall transmit the data determined by the Secretary (consistent with subtitle C) to be necessary to assess under this section the performance of the sponsor with respect to an approved health plan provided or sponsored by the sponsor in a State, and the performance of network providers with respect to the plan, to the State (if the State is an approved State).

(2) HEALTH INSTITUTIONS.—A health institution shall transmit the data determined by the Secretary (consistent with subtitle C) to be necessary to assess the performance of the institution under this section with respect to health care services rendered in a State by the institution to the State (if the State is an approved State).

(3) APPLICATION OF SUBTITLE B.—Subsections (b), (c), and (d) of section 9104 and section 9107 shall apply to the transmission of data under this subsection, to the extent that such data are health information described in paragraph (1) or (2) of section 9104(b).

(e) DATA VALIDATION.—An approved State shall conduct such audits of the data submitted to the State under subsection (d) as are necessary to ensure that the data are valid, reliable, and complete. An approved sponsor and a health institution shall maintain such records, make such reports, and cooperate with the audits to the extent necessary to permit a State to satisfy the preceding sentence.

(f) ASSESSMENT OF PERFORMANCE.—

(1) STATES.—Each approved State annually shall assess, using the national measures of quality performance, the performance of each—

(A) approved sponsor providing or sponsoring an approved health plan in the State;

(B) network provider with respect to such a plan; and

(C) health institution licensed by the State.

(2) PLAN SPONSORS.—An approved sponsor shall use the national measures of quality performance to assess—

(A) the satisfaction of individuals enrolled under an approved health plan provided or sponsored by the sponsor with the services of the sponsor and network providers with respect to the plan; and

(B) the quality of such services, as measured by access to health care and appropriateness and outcomes of health care.

(g) PERFORMANCE REPORTS.—

(1) PREPARATION.—Using a standard format prescribed by the Secretary, and not later than January 1 of each year, an approved State shall compile in the form of a performance report the results of assessments conducted by the State under subsection (f), the results of the consumer surveys conducted by the Secretary under section 9002, and any other relevant information with respect to the national quality standards under section 9004 concerning approved sponsors providing or sponsoring an approved health plan in the State. The report shall be written in language calculated to be understood by the typical individual enrolled under such a plan and in a form which will assist consumers in selecting among such plans.

(2) PUBLICATION.—An approved State—

(A) shall publish any performance report prepared under paragraph (1);

(B) shall transmit any such published report to—

(i) the Consumer Health Advocacy Office for the State or a geographic region that includes the State established through a grant made under part O of title III of the Public Health Service Act (relating to consumer resources regarding health plans);

(ii) the enrollment assistance program for the State established under section 5011(b);

(iii) any consumer purchasing cooperatives in the State; and

(iv) the Secretary; and

(C) shall otherwise make available to the public any such published report.

(3) COMPILATION FOR CONGRESS.—The Secretary annually shall compile a national performance report from the reports transmitted to the Secretary under paragraph (2). The Secretary annually shall transmit such national report to the Congress.

(h) AUTHORITY TO CONTRACT.—An approved State may carry out subsections (f) and (g) by entering into contracts with individuals or entities pursuant to which the individuals or entities undertake the duties applicable to the State under the subsection.

(i) OTHER QUALITY IMPROVEMENT ACTIVITIES.—Consistent with subtitle C, an approved State shall make any data transmitted to the State under subsection (d) available to an quality improvement organization responsible for the geographic area that includes the State, upon request by the organization. An approved quality improvement organization may use such data, consistent with subtitle C, to carry out any function of the organization under this part.

(j) DEADLINE.—The Secretary shall develop an initial set of national measures of quality performance and the standard format for the performance reports under subsection (g) not later than 12 months after the date of the enactment of this Act.

SEC. 9004. NATIONAL QUALITY STANDARDS FOR APPROVED SPONSORS.

(a) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall establish national quality standards for approved sponsors. The standards established by the Secretary shall include the standards described in subsections (b) and (c).

(b) REQUIREMENTS FOR PLAN SPONSORS.—The quality standards for approved sponsors shall require each such sponsor—

(1) to establish an internal quality improvement program to measure, assess, and improve—

(A) the satisfaction of individuals enrolled under an approved health plan provided or sponsored by the sponsor with the services provided by the sponsor and by network providers with respect to the plan;

(B) the health status of such individuals; and

(C) the quality and outcomes of such services;

(2) through such program, to cooperate with—

(A) the performance monitoring activities undertaken by approved States under section 9007; and

(B) the activities undertaken by approved quality improvement organizations under sections 9004 and 9009;

(3) to make available to individuals enrolled in an approved health plan provided or sponsored by the sponsor information about the rights and responsibilities of enrollees;

(4) to provide an appeals procedure for review of benefit determinations that satisfies the requirements of part 1 of subtitle D;

(5) to provide a grievance procedure that provides for effective and timely response to complaints for enrollees to use in pursuing complaints with respect to the sponsor that are not based on a benefit determination reviewable under part 1 of subtitle D;

(6) to establish procedures for taking appropriate remedial action whenever inappropriate or substandard services are provided by an officer or employee of the sponsor or a qualified provider who is a network provider with respect to an approved health plan provided or sponsored by the sponsor;

(7) to verify the credentials of qualified providers who are network providers with respect to an approved health plan provided or sponsored by the sponsor;

(8) to establish a policy to identify and investigate sources of dissatisfaction with a provider who is a network provider with respect to an approved health plan provided or sponsored by the sponsor, outline actions to follow up on the findings, and inform the provider of the findings;

(9) to give reasonable consideration, in selecting among qualified providers for participation in a plan network serving a geographic area, to all providers who are legally authorized to provide health care services in the area; and

(10) to establish written policies and procedures to ensure that the confidentiality of protected health information (as defined in section 9200(a)) is protected in a manner consistent with subtitle C.

(c) OTHER REQUIREMENTS.—The quality standards for approved sponsors—

(1) shall ensure that any physician incentive plan (as defined in subsection (d)) operated by an approved sponsor is required to satisfy the requirements of clauses (i) and (ii) of section 1876(i)(8)(A) of the Social Security Act in the same manner as a physician incentive plan operated by an eligible organization (as defined in section 1876(b) of such Act) is required to satisfy the requirements of such clauses;

(2) shall require each approved sponsor to provide each State in which the sponsor provides or sponsors an approved health plan with descriptive information sufficient to permit the State to determine whether the sponsor is in compliance with any requirement established with respect to such incentive plans under this section;

(3) shall require that if a physician incentive plan operated by an approved sponsor places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the sponsor shall make available, upon request by enrollees, qualified providers, or potential enrollees or providers, descriptive information regarding any financial arrangements in the plan relating to controlling utilization or costs; and

(4) shall prohibit approved sponsors from engaging in any formal or informal practice

that in any way restricts a qualified provider from communicating with a patient of the provider concerning the compensation of the provider, a term of any contract between the sponsor and the provider, or practices, protocols, or patterns of applying utilization review procedures of the sponsor, where such compensation, contract term, practice, protocol, or pattern may affect the patient's access to care.

(d) PHYSICIAN INCENTIVE PLAN DEFINED.—In this section, the term "physician incentive plan" means any compensation arrangement between an approved sponsor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled in an approved health plan provided or sponsored by the sponsor.

SEC. 9005. PROFILING PATTERNS OF PRACTICE OF QUALIFIED PROVIDERS.

(a) PROFILING OF PATTERNS OF PRACTICE; OPPORTUNITIES FOR QUALITY IMPROVEMENT.—

(1) MODEL ADOPTION.—The Secretary shall develop models for profiling the patterns of clinical practice of qualified providers and approved sponsors (to the extent that such sponsors provide health benefits in the form of items and services to enrollees).

(2) DISSEMINATION.—The Secretary shall disseminate to approved quality improvement organizations, approved sponsors, and approved States the models adopted under paragraph (1).

(3) OPPORTUNITIES FOR QUALITY IMPROVEMENT.—The Secretary shall develop and disseminate to approved quality improvement organizations models for improving quality of care where opportunities are identified through profiling and other means so as to assure the quality of health care services provided in the United States.

(4) DEADLINE.—The Secretary shall develop the models under this subsection not later than 18 months after the date of the enactment of this Act.

(b) IMPLEMENTATION BY QUALITY IMPROVEMENT ORGANIZATIONS.—

(1) IN GENERAL.—An approved quality improvement organization shall implement, on an ongoing basis, the models developed under subsection (a) with respect to—

(A) qualified providers who are licensed by a State that is in a geographic area for which the organization is responsible; and

(B) approved sponsors providing health benefits in the form of items and services to enrollees in a State—

(i) in which the sponsor provides or sponsors an approved health plan; and

(ii) that is in a geographic area for which the organization is responsible.

(2) POPULATION-BASED MONITORING.—The duties of an approved quality improvement organization under the preceding sentence shall include population-based monitoring of the patterns of clinical practice described in subsection (a)(1) for the purpose of promoting community-based quality improvement.

(3) QUALITY-RELATED PROFILING DATA.—In implementing a model for profiling patterns of clinical practice, an approved quality improvement organization shall use the quality-related profiling data transmitted to the organization under section 9006.

(c) LIMITATION ON LIABILITY.—Notwithstanding any other provision of law, a person providing information to any approved quality improvement organization may not be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless—

(1) such information is unrelated to the performance of the contract of such organization with the Secretary under section 9009;

(2) such information is transmitted in violation of section 9006; or

(3) such information is false and the person providing it knew, or had reason to believe, that such information was false.

SEC. 9006. QUALITY-RELATED PROFILING DATA.

(a) TRANSMISSION.—

(1) APPROVED SPONSORS.—An approved sponsor that provides health benefits in the form of items and services to enrollees shall transmit to each approved quality improvement organization for a geographic area that includes a State in which the sponsor provides or sponsors an approved health plan the set of quality-related profiling data established by the Secretary under subsection (b).

(2) PROVIDERS.—A qualified provider shall transmit to each approved quality improvement organization for a geographic area that includes a State in which the provider is licensed the set of quality-related profiling data established by the Secretary under subsection (b).

(3) APPLICATION OF SUBTITLE B.—Subsections (b), (c), and (d) of section 9104 and section 9107 shall apply to the transmission of data under this subsection.

(b) ESTABLISHMENT OF DATA SETS.—

(1) IN GENERAL.—The Secretary shall establish a set of quality-related profiling data to be transmitted by approved sponsors and qualified providers to approved quality improvement organizations in order to permit such organizations to carry out section 9005(b). The set of quality-related profiling data may only include data that are part of a set of health information established by the Secretary under paragraph (1) or (2) of section 9103(b). The set may only include data that an approved quality improvement organization is authorized to receive under subtitle C. The Secretary shall also specify the frequency with which approved sponsors and qualified providers are required to transmit the quality-related profiling data set.

(2) NO UNDUE BURDEN.—With respect to data developed or collected by an approved sponsor or a qualified provider under this section, the Secretary shall, in order to assure the utility, accuracy, and sufficiency of such data, establish guidelines for uniform methods of developing and collecting such data. Such guidelines shall include specifications ensuring that any set of quality-related profiling data to be transmitted under this section may be developed or collected using the least burdensome method consistent with the efficient and effective administration of this part.

(c) FREEDOM OF INFORMATION ACT.—An approved quality improvement organization, in carrying out its functions under a contract entered into under section 9009, shall not be considered a Federal agency for purposes of section 552 of title 5, United States Code.

(d) USE AND DISCLOSURE OF DATA.—The Secretary shall establish standards concerning the purposes for which, and the procedures by which, data that is transmitted to, and collected by, an approved quality improvement organization under this section or section 9009 may be used and disclosed by the organization. The standards established under this subsection shall be consistent with subtitle C and section 1160(b) of the Social Security Act. Such standards shall include standards regarding the aggregation of data in a manner that does not reveal data that identifies or can readily be associated with the identity of an individual.

(e) REQUIREMENT ON ORGANIZATIONS.—An approved quality improvement organization shall comply with the standards established by the Secretary under subsection (c).

(f) DEADLINE.—Not later than 18 months after the date of the enactment of this Act, the Secretary—

(1) shall establish the set of quality-related profiling data under subsection (b); and

(2) shall establish the standards under subsection (c).

SEC. 9007. COMPLIANCE MONITORING BY APPROVED STATES.

(a) MONITORING.—An approved State shall monitor periodically, but not less than annually, compliance with requirements applicable to approved sponsors and qualified providers under this part by—

(1) approved sponsors providing or sponsoring an approved health plan in the State; and

(2) qualified providers licensed by the State.

(b) ENFORCEMENT.—

(1) APPROVED SPONSORS.—

(A) IN GENERAL.—If an approved State finds that an approved sponsor providing or sponsoring an approved health plan in the State engages in a pattern or practice of failing to fulfill a requirement applicable to the sponsor under this part, the State shall enforce the requirement by—

(i) prohibiting the sponsor from providing coverage under the plan in the State under section 5502; or

(ii) imposing a civil money penalty not to exceed $10,000 on the sponsor in accordance with the procedures described in section 5503(a)(2).

(B) PUBLIC INFORMATION.—An approved State shall make available to the public the following information with respect to an enforcement action under subparagraph (A), if such information is applicable with respect to the action:

(i) Information disclosing that the action has resulted in a penalty being imposed on an approved sponsor under clause (i) or (ii) of subparagraph (A).

(ii) Information disclosing that a national quality standard under section 9004 was found to have been violated by an approved sponsor through the action.

(iii) Any other information relating to the action that is required to be made available to the public under State law.

(2) QUALIFIED PROVIDERS.—If an approved State finds that a qualified provider that is licensed by the State engages in a pattern or practice of failing to fulfill a requirement applicable to the provider under this part, or failing to cooperate with an approved quality improvement organization to the extent the organization is carrying out a function under section 9009(c)(2), the State shall ensure that the appropriate State board or boards responsible for licensing, accrediting, and disciplining the provider are notified.

SEC. 9008. GUIDELINE DEVELOPMENT AND RESEARCH ON HEALTH CARE QUALITY.

(a) RESEARCH SUPPORT.—Section 902(a) of the Public Health Service Act is amended—

(1) in paragraph (7), by striking "; and" and inserting a semicolon;

(2) in paragraph (8), by striking the period and inserting "; and"; and

(3) by inserting after paragraph (8) the following:

"(9) effective and efficient dissemination of information, standards, and guidelines.".

(b) DEVELOPMENT OF PEDIATRIC PRACTICE GUIDELINES.—Section 912(b) of the Public Health Service Act is amended—

(1) in paragraph (3), by striking "; and" and inserting a semicolon;

(2) in paragraph (4), by striking "; and" and inserting a semicolon;

(3) in paragraph (5), by striking the period and inserting "; and"; and

(4) by inserting after paragraph (5) the following:

"(6) include pediatric practice guidelines for the medical treatment of individuals under the age of 18.".

(c) LIMITATION OF LIABILITY.—Section 913 of the Public Health Service Act is amended by inserting after subsection (c) the following:

"(d) LIMITATION OF LIABILITY.—A member of a panel convened under this section, or an entity having a contract under this section, may not be held, by reason of the performance of any duty, function, or activity required or authorized pursuant to this part or a valid contract entered into under this section, to have violated any criminal law or to be civilly liable under any law of the United States or of any State (or political subdivision thereof), if the member or entity exercised good faith in the performance of such duty, function, or activity.".

(d) DISSEMINATION OF GUIDELINES.—Section 914(c) of the Public Health Service Act is amended by—

(1) striking "912(a)." and inserting "912(a) or certified under section 915."; and

(2) striking "bodies," and inserting "bodies, States, approved quality improvement organizations (as defined in section 9013(2) of the Guaranteed Health Insurance Act of 1994),".

(d) EVALUATION, CERTIFICATION, AND DISSEMINATION OF GUIDELINES.—Part B of title IX of the Public Health Service Act is amended by adding at the end the following:

"SEC. 915. EVALUATION, CERTIFICATION, AND DISSEMINATION OF GUIDELINES.

"(a) EVALUATION AND CERTIFICATION.—Not later than 18 months after the date of the enactment of the Guaranteed Health Insurance Act of 1994, the Administrator shall establish a procedure by which individuals and entities may submit practice guidelines of the type described in section 912(a)(1) to the Administrator for evaluation and certification by the Administrator.

"(b) GUIDELINE CLEARINGHOUSE.—The Administrator shall establish and oversee a clearinghouse and dissemination program for practice guidelines that are certified under this section.".

(e) AUTHORIZATION OF APPROPRIATIONS.—Section 1142(i) of the Social Security Act is amended—

(1) in paragraph (1)—

(A) in subparagraph (D), by striking "and";

(B) in subparagraph (E), by striking the period and inserting "; and"; and

(C) by inserting after subparagraph (E) the following:

"(F) $6,000,000 for each of the fiscal years 1995 through 2000."; and

(2) in paragraph (2), by striking "and 1994" and inserting "through 2000".

SEC. 9009. QUALITY IMPROVEMENT ORGANIZATIONS.

(a) IN GENERAL.—

(1) CONTRACTS.—Subject to subsection (e), and using competitive contracting procedures, the Secretary shall enter into contracts with quality improvement organizations to perform the functions specified in subsection (c) for the geographic areas established under subsection (d)(1).

(2) COMMENCEMENT.—The Secretary may not enter into a contract under this section before the date that is 18 months after the date of the enactment of this Act or October 1, 1997, whichever occurs later.

(b) DEFINITION.—For purposes of this part, the term "quality improvement organization" means a private nonprofit entity that—

(1) has a governing body that is broadly representative of consumers of health care, purchasers of health care, qualified providers, and representatives of academia, including experts in quality improvement;

(2) has a governing body that, to the greatest extent feasible, reflects the racial, ethnic, and gender composition of the population of the United States;

(3) has a staff that includes individuals with expertise in the fields of quality improvement, public health, patient outcome assessment, risk adjustment, clinical practice guidelines, health services data analysis, and provider and consumer education; and

(4) is able, in the judgment of the Secretary, to satisfy the requirements in paragraphs (1) and (2) of subsection (c).

(c) FUNCTIONS.—

(1) IN GENERAL.—A quality improvement organization entering into a contract with the Secretary under this section—

(A) shall fulfill each requirement that is set forth in sections 9002 through 9008 and that is applicable to quality improvement organizations;

(B) shall assist in the development of innovative programs to improve the quality of health care services, including provider education programs;

(C) shall collaborate with, and provide technical assistance to, approved sponsors and qualified providers in ongoing efforts to improve the quality of care;

(D) shall develop programs in lifetime learning;

(E) shall disseminate information about quality improvement programs;

(F) shall disseminate and encourage the appropriate application of guidelines developed, updated, or certified pursuant to title IX of the Public Health Service Act or other guidelines;

(G) shall maintain such records, make such reports (including expenditure reports), and cooperate with such audits, as the Secretary finds necessary to determine the compliance of the organization with the requirements of this part; and

(H) shall perform such duties and functions, assume such responsibilities, and comply with such other requirements as the Secretary may require under regulations promulgated to carry out this part.

(2) REFERRAL.—

(A) EVALUATION OF PRACTICES.—If a quality improvement organization entering into a contract with the Secretary under this section finds that the pattern of practice of a qualified provider or an approved sponsor that provides health benefits in the form of items and services to enrollees suggests deficiencies in the quality of care being provided by the provider or sponsor that could impair patient health or safety, the organization shall evaluate the practices that may have lead to the suggestion of deficiencies.

(B) ASSISTANCE IN ELIMINATING DEFICIENCIES.—If a quality improvement organization finds, after conducting an evaluation under subparagraph (A), that the quality of the practices of a qualified provider or an approved sponsor referred to in such subparagraph is deficient, the organization shall work with the provider to assist the provider to eliminate the deficiencies.

(C) NO SUBSTANTIAL IMPROVEMENT.—If a quality improvement organization finds, after affording reasonable opportunities for improvement, that substantial improvement in the quality of the practices of a qualified provider or an approved plan sponsor referred to in subparagraph (B) has not occurred, the organization shall determine whether the deficiencies in the quality of such practices pose a danger to patient health or safety. If the organization finds that such practices do pose such a danger, the organization shall notify the appropriate State board or boards responsible for licensing, accrediting, and disciplining the provider or sponsor.

(d) CONTRACT SPECIFICATIONS.—

(1) ESTABLISHMENT OF GEOGRAPHIC AREAS.—The Secretary shall establish throughout the United States geographic areas with respect to which contracts under this section will be made. In establishing such areas, the Secretary shall take into account the following criteria:

(A) STATE AREAS.—Each State shall generally be designated as a geographic area for purposes of this paragraph.

(B) MULTI-STATE AREAS.—The Secretary may establish geographic areas comprised of multiple contiguous States rather than State areas only where the volume of activity or other relevant factors (as determined by the Secretary) warrant such an establishment.

(2) ORGANIZATIONS ENTITLED TO CONTRACT WITH SECRETARY.—

(A) IN GENERAL.—The Secretary shall enter into a contract with a quality improvement organization for each area established under paragraph (1) if a qualified organization is available in such area and such organization and the Secretary have negotiated a proposed contract which the Secretary determines will be carried out by such organization in a manner consistent with the efficient and effective administration of this part.

(B) LIMITATION ON AFFILIATIONS WITH PAYERS.—The Secretary may not enter into a contract under this section with any entity which is, or is affiliated with (through management, ownership, or common control), an entity (other than a self-insured employer) which directly or indirectly makes payments to any qualified provider whose health care services are reviewed by such entity or would be reviewed by such entity if it entered into a contract with the Secretary under this section.

(C) LIMITATION ON AFFILIATIONS WITH PROVIDERS.—The Secretary may not enter into a contract under this section with any entity which is, or is affiliated with (through management, ownership, or common control), a qualified provider, or association of such providers, within the area served by such entity or which would be served by such entity if it entered into a contract with the Secretary under this part. For purposes of this subparagraph, an entity shall not be considered to be affiliated with a qualified provider or association of providers by reason of management, ownership, or common control if the management, ownership, or common control consists only of not more than 20 percent of the members of the governing board of the entity being affiliated (through management, ownership, or common control) with one or more of such providers or associations.

(3) TERMS OF CONTRACT.—Each contract with an organization under this section shall provide that—

(A) the organization shall perform the functions set forth in subsection (c) or may subcontract for the performance of all or some of such functions (and for purposes of subparagraphs (B) and (C) paragraph (2), a subcontract under this subparagraph shall not constitute an affiliation with a subcontractor);

(B) the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract;

(C) the contract shall be for an initial term of 3 years and shall be renewable for an additional term of 2 years thereafter without a competitive selection process based upon evidence of successful quality improvement activities;

(D) if the Secretary intends not to renew a contract, the Secretary shall notify the organization of the decision at least 90 days prior to the expiration of the contract term, and shall provide the organization an opportunity to present data, interpretations of data, and other information pertinent to its performance under the contract, which shall be reviewed in a timely manner by the Secretary;

(E) the organization may terminate the contract upon 90 days notice to the Secretary;

(F) the Secretary may terminate the contract prior to the expiration of the contract term upon 90 days notice to the organization if the Secretary determines that—

(i) the organization does not substantially meet the requirements of this section; or

(ii) the organization has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, but only after such organization has had an opportunity to submit data and have such data reviewed by the panel established under paragraph (4).

(4) EVALUATION OF PERFORMANCE.—In evaluating the performance of quality improvement organizations under contracts under this section, the Secretary shall place emphasis on the performance of such organizations in improving the quality of health care services and educating qualified providers and approved sponsors concerning the process being used by the organization and the criteria being applied by the organization.

(5) CONTRACTING AUTHORITY OF SECRETARY.—The contracting authority of the Secretary under this section may be carried out without regard to any provision of law relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the purposes of this part. The Secretary may use different contracting methods with respect to different geographical areas.

(6) TERMINATION NOT SUBJECT TO JUDICIAL REVIEW.—Any determination by the Secretary to terminate or not to renew a contract under this section shall not be subject to judicial review.

(e) ASSUMPTION OF RESPONSIBILITIES BY SECRETARY.—If the Secretary determines that there is no qualified entity available for an area with which the Secretary can enter into a contract under this section, the Secretary shall take such steps as are necessary to perform in the area the duties applicable to approved quality improvement organizations under this part. Any information required under this part to be transmitted by any person to an approved quality improvement organization for an area shall be transmitted to the Secretary in the case where there is no qualified entity available for an area with which the Secretary can enter into a contract under this section.

(f) LIMITATION OF LIABILITY.—A quality improvement organization having a contract with the Secretary under this section, a person who is employed by, or who has a fiduciary relationship with, any such organization, and a person who furnishes professional services to such organization, may not be held, by reason of the performance of any duty, function, or activity required or authorized pursuant to this part or to a valid contract entered into under this section, to have violated any criminal law or to be civilly liable under any law of the United States or of any State (or political subdivision thereof), if the organization or person exercised good faith in the performance of such duty, function, or activity.

SEC. 9010. QUALITY MANAGEMENT GRANTS.

(a) IN GENERAL.—

(1) GRANTS.—The Secretary shall make a grant to each State that satisfies the requirements of this section.

(2) COMMENCEMENT.—The Secretary may not make a grant under this section before the date that is 18 months after the date of the enactment of this Act or October 1, 1997, whichever occurs later.

(b) APPLICATIONS.—

(1) SUBMISSION.—To apply for a grant under this section for any fiscal year, a State shall submit an application to the Secretary in accordance with the procedures established by the Secretary. The Secretary shall establish a deadline for the submission of applications under this paragraph for each fiscal year.

(2) CRITERIA FOR APPROVAL.—The Secretary may not approve an application submitted under paragraph (1) unless the application includes assurances satisfactory to the Secretary that—

(A) the State has a State regulatory program approved under section 5502(b) of the Social Security Act;

(B) the State is willing and able to fulfill each requirement that is set forth in sections 9002 through 9008 that is applicable to an approved State;

(C) the State will enforce the requirements set forth in sections 9002 through 9008 that are applicable to an approved sponsor or a qualified provider with respect to each approved sponsor that provides or sponsors an approved health plan in the State and each qualified provider licensed by the State, except in the case where another individual or entity is charged with such enforcement under this part;

(D) the State will maintain such records, make such reports (including expenditure reports), and cooperate with such audits, as the Secretary finds necessary to determine the compliance of the State (and persons regulated by the State) with the requirements of this part;

(E) the State will carry out a plan, that has been submitted to the Secretary in a form and manner specified by the Secretary, to make specific improvements, in accordance with standards established by the Secretary for this purpose, in the health status of populations in the State that—

(i) experience a disproportionately high rate of morbidity and mortality; or

(ii) are historically underserved; and

(F) funds received under this section will be used for consumer protection and quality oversight activities.

(3) PETITIONS FOR RECONSIDERATION AND REAPPLICATIONS.—

(A) IN GENERAL.—With respect to an application submitted under paragraph (1) that is disapproved under this subsection, the applicant may submit to the Secretary—

(i) a petition for reconsideration of the application; and

(ii) an application that conforms to the requirements of this subsection.

(B) DEADLINES.—The Secretary shall establish a deadline for the submission of petitions for reconsideration and reapplications under this paragraph for each fiscal year. The Secretary shall approve or disapprove each such petition and reapplication before the termination of the 60-day period beginning on the date of such submission.

(c) ABILITY TO SATISFY REQUIREMENTS THROUGH ARRANGEMENTS.—A State may satisfy a requirement that is set forth in any of sections 9002 through 9008 directly or through arrangements with individuals or entities approved by the State that demonstrate to the satisfaction of the State that the individual or entity—

(1) has the ability to fulfill any duty delegated to the individual or entity by the State; and

(2) does not have a relationship with an approved sponsor or a qualified provider that would interfere with the ability of the individual or entity to fulfill any duty of a participating State under this part.

(d) PERIODIC REVIEW.—The Secretary shall periodically review the compliance by States that receive a grant under this section with the terms of the award of the grant.

(e) FEDERAL ASSUMPTION OF STATE RESPONSIBILITIES.—

(1) IN GENERAL.—In the case of a State that does not receive a grant under this section on or before January 1, 1999, or that substantially fails to satisfy a term of an award of such a grant, the Secretary shall take such steps as are necessary—

(A) to perform in the State the duties specified in sections 9002 through 9008 as duties of approved States;

(B) to enforce in the State the requirements set forth in sections 9002 through 9008 that are applicable to an approved sponsor or a qualified provider in the same manner as an approved State would be required to enforce such requirements under subsection (b)(2)(C).

(2) DATA TRANSMISSION.—Any information required under this part to be transmitted by any person to an approved State shall be transmitted to the Secretary in the case of a State described in paragraph (1).

SEC. 9011. AUTHORIZATION OF APPROPRIATIONS FOR CONTRACTS AND GRANTS.

There are authorized to be appropriated $300,000,000 for each of the fiscal years 1998 through 2002 for contracts under section 9009 and for grants under section 9010.

SEC. 9012. HEALTH CARE QUALITY ADVISORY COMMISSION.

(a) ESTABLISHMENT.—The Secretary shall provide for the appointment of a Health Care Quality Advisory Commission, to be composed of individuals from the public and private sectors with expertise in the fields of public health, financing and delivery of health care, health services research, health care quality, and privacy of health information and representatives of consumers appointed by the Secretary. To the greatest extent feasible, the membership of the Commission shall reflect the racial, ethnic, and gender composition of the population of the United States.

(b) DUTIES.—The Commission shall provide recommendations to the Secretary with respect to the—

(1) development and selection of the national measures of quality performance under section 9003, after consulting with appropriate interested parties, including the Administrator for Health Care Policy and Research, States, the National Association of Insurance Commissioners, approved sponsors, qualified providers, experts in quality

measurement, nationally recognized accrediting bodies, other Federal advisory bodies, and consumers of health care services;

(2) establishment of an appropriate sequence for the interim sets of national measures of quality performance under section 9003(a)(4);

(3) development of national goals of quality performance;

(4) design and execution of consumer surveys under section 9002;

(5) standard format for performance reports under section 9003(g);

(6) establishment and functioning approved quality improvement organizations under section 9009; and

(7) impact of the implementation of the National Quality Management Program.

(c) MEMBERSHIP.—The Commission shall be composed of 15 members. Members of the Commission shall first be appointed not later than 6 months after the date of the enactment of this Act for a term of 3 years, except that the Secretary may provide initially for such shorter terms as will ensure that (on a continuing basis) the terms of not more than 4 member expire in any one year.

(d) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Commission shall continue in existence until otherwise provided by law.

(e) REPORT.—The Commission shall submit to the Congress an annual report not later than May 1 of each year concerning the activities of the Commission under this part during the preceding year.

SEC. 9013. DEFINITIONS.

For purposes of this part:

(1) APPROVED HEALTH PLAN.—The term "approved health plan" means an insured health benefit plan or a self-insured health benefit plan, as described in title V.

(2) APPROVED QUALITY IMPROVEMENT ORGANIZATION.—The term "approved quality improvement organization" means a quality improvement organization that has a contract with the Secretary under section 9009. When used with respect to a geographic area, such term means a quality improvement organization that is responsible under such a contract for carrying out the responsibilities of approved quality improvement organizations under this part in a geographic area established under section 9009(d)(1).

(3) APPROVED SPONSOR.—The term "approved sponsor" means—

(A) a carrier providing an insured health benefit plan, as described in title V; or

(B) a sponsor of a self-insured health benefit plan, as described in such title.

(4) APPROVED STATE.—The term "approved State" means a State that receives a grant under section 9010.

(5) HEALTH INSTITUTION.—The term "health institution" means a qualified provider that is not a network provider with respect to any approved health plan and is—

(A) a hospital (as defined in section 1861(e) of the Social Security Act);

(B) a psychiatric hospital (as defined in section 1861(f) of such Act);

(C) an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care or rehabilitation services to residents for rehabilitation with respect to an illness, injury, disorder, or other health condition (regardless of whether the institution meets the requirements of section 1819 of such Act for receiving payment for items and services furnished under title 18 of such Act);

(D) an ambulatory surgical center (regardless of whether the center meets the health, safety, and other standards promulgated by the Secretary under section 1832(a)(2)(F)(i) of such Act);

(E) a provider of intensive residential services (as defined in section 1861(qq) of such Act); and

(F) a provider of intensive community-based services (as defined in section 1861(ff) of such Act).

(6) NETWORK PROVIDER.—The term "network provider", when used with respect to an approved health plan, means a qualified provider who is member of a plan network of the plan.

(7) PLAN NETWORK.—The term "plan network" means, with respect to an approved health plan, qualified providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services covered under the plan to individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

(8) QUALIFIED PROVIDER.—The term "qualified provider" means a health professional who, or a health facility that, is authorized to provide an item or service in the guaranteed national benefit package.

SEC. 9014. REFERENCES TO MEDICARE PROVISIONS.

In this part, any references to provisions of title XVIII of the Social Security Act are deemed to be references to such provisions as in effect on the day after the date of the enactment of this Act, taking into account the amendments made to such title by this Act as if the effective date of such amendments were January 1, 1997.

SEC. 9015. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), the provisions of this part shall take effect on January 1, 1998.

(b) PROVISIONS EFFECTIVE IMMEDIATELY.—

(1) SECRETARIAL RESPONSIBILITIES.—The following provisions imposing a duty on the Secretary shall take effect on the date of the enactment of this Act:

(A) Section 9001.

(B) Section 9002.

(C) Subsections (a), (b), (c), and (j) of section 9003.

(D) Section 9004.

(E) Section 9005(a).

(F) Subsections (b), (c), and (e) of section 9006.

(G) Sections 9008, 9009, 9010, 9012, 9013, and 9014.

(2) AUTHORIZATION OF APPROPRIATIONS.—Section 9011 shall take effect on the date of the enactment of this Act.

PART 2—CONSUMER RESOURCES

SEC. 9021. CONSULTATION REQUIREMENTS REGARDING ADMINISTRATION OF PROGRAM.

The Secretary of Health and Human Services shall consult with the Secretary of Labor in carrying out part O of title III of the Public Health Service Act (relating to consumer resources regarding health plans).

Subtitle B—Information Systems and Administrative Simplification

SEC. 9101. REQUIREMENTS FOR HEALTH SECURITY CARDS AND PERSONAL IDENTIFIERS.

(a) HEALTH SECURITY CARDS.—

(1) REQUIREMENT.—Each administered health plan sponsor shall issue a health security card that meets the requirements of subsection (c) for each individual who is entitled to benefits under an administered health' plan provided or sponsored by the sponsor, if the plan provides for coverage of the guaranteed national benefit package. Such card shall be issued to the individual involved or, in the case of an individual enrolled as a dependent of another individual, to that other individual.

(2) DEADLINE FOR APPLICATION OF REQUIREMENT.—The deadline specified under this paragraph for the requirement under paragraph (1) is January 1, 1997.

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—In the case of an administered health plan sponsor that fails to issue a health security card in accordance with subsection (a)(1), the sponsor is subject to a civil money penalty of not to exceed $100 for each such violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) EFFECTIVE DATE.—No penalty may be imposed under paragraph (1) for any failure occurring before the deadline specified in subsection (a)(2).

(c) STANDARDS FOR CARDS.—

(1) IN GENERAL.—The Secretary shall establish standards consistent with this subsection respecting the form and information to be contained on health security cards (for purposes of subsection (a)).

(2) PERMISSIBLE USES OF CARD.—A health security card that is issued to an individual who is entitled to benefits under an administered health plan may be used by an individual or entity, in accordance with regulations promulgated by the Secretary consistent with subtitle C, only for the purpose of providing to the individual entitled to benefits, or assisting the individual in obtaining, an item or service that is covered under such plan.

(3) ELECTRONIC.—

(A) IN GENERAL.—Subject to subparagraph (B), the card shall be in a form similar to that of a credit card and shall have, encoded in electronic or magnetic form—

(i) the identity of the individual entitled to health benefits;

(ii) the administered health plan providing for coverage of the guaranteed national benefit package in which the individual is enrolled;

(iii) the identity of each principal insured (as defined by the Secretary) for the family that includes the individual, in the case of an individual who is enrolled under a family class of enrollment;

(iv) the telephone number or numbers (or other electronic equivalent) to be used for the submission electronically of claims under the plan; and

(v) information relating to organ donation.

(B) USE OF ELECTRONIC READ-AND-WRITE CARDS.—The Secretary may provide for cards in an electronic form that permits information on the card to be readily changed. Such information may include information relating to the health coverage status of the individual and the medical history of the individual.

(C) PERSONAL IDENTIFIER.—For purposes of subparagraph (A), and for purposes of the transactions described in section 9104(a), the Social Security account number assigned to the individual by the Secretary under section 205(c)(2) of the Social Security Act or, in the case of an infant or other individual to whom such a number has not been issued, such a Social Security account number of a parent or guardian or other number as the Secretary shall specify, shall be used as the personal identifier for the individual.

(4) Additional information.—The card shall include such additional information, in electronic or other form, as the Secretary may require to carry out the purposes of this Act. In addition, the administered health plan sponsor issuing the card may include such additional information on the card as the sponsor desires, subject to such limitations as the Secretary may provide.

(5) Deadline.—The Secretary shall first establish the standards for health security cards under this subsection by not later than 18 months after the date of the enactment of this Act.

(d) Misuse of Cards.—

(1) In general.—An individual or entity may not collect, disseminate, request or require presentation of, or otherwise use (by electronic or other means) a health security card except as authorized under this section.

(2) Private right of action.—A person who is aggrieved by a violation of paragraph (1) may, in a civil action, obtain appropriate relief, including actual, compensatory, and punitive damages and equitable relief, against any appropriate party.

(3) Attorney's fees and costs.—In any action under paragraph (2) in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(4) Penalties.—

(A) Misuse of information.—The provisions of section 208(a) of the Social Security Act in relation to violations described in paragraphs (7) and (8) thereof shall apply with respect to the health security card and any information contained or encoded on such card in the same manner and to the same extent as such provisions apply with respect to the social security card and to the social security account number or other information contained or encoded on the social security card, except that, in applying such provisions, any reference therein to the Commissioner of Social Security shall be deemed a reference to the Secretary.

(B) Misuse of symbols, emblems, or names.—Section 1140 of the Social Security Act shall apply with respect to the health security card in the same manner and to the same extent as such section applies with respect to the social security card.

(5) Civil money penalty.—Any person who the Secretary determines has failed to comply with paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $1,000 for each such failure. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(7) Protection against delay or denial of services.—An individual may not have health services delayed or denied for inability or failure to produce a health security card.

SEC. 9102. NATIONAL ENROLLMENT VERIFICATION SYSTEMS.

(a) Establishment.—The Secretary shall establish national enrollment verification systems for the verification of an individual's enrollment in an administered health plan and entitlement to benefits under such plan. The systems shall assist in the identification of, and collection from, parties responsible for the payment for health care items and services furnished to individuals enrolled under an administered health plan.

(b) Information in Systems.—The enrollment verification systems shall contain such information submitted by administered health plan sponsors, the Civilian Health and Medical Program of the Uniformed Services under chapter 55 of title 10, United States Code, employers, and other individuals and entities specified by the Secretary as the Secretary shall determine in standards established under this section. The information shall be submitted in a form and manner specified by the Secretary. The information shall include the following with respect to each individual enrolled in an administered health plan (regardless of whether the individual is enrolled under an individual or a family class of enrollment):

(1) The name, address, and personal identifier of the individual and the identity of each principal insured (as defined by the Secretary under section 9101(c)(3)(A)(iii)) for the family that includes the individual, in the case of an individual who is enrolled under a family class of enrollment.

(2) The name, address, and telephone number (or other electronic equivalent) of each administered health plan in which the individual is enrolled.

(3) The type of coverage elected.

(4) Race and ethnicity data.

(5) The period for which such coverage is elected.

(6) The status of individuals with respect to deductibles, copayments, coinsurance, or out-of-pocket limits on cost sharing.

(7) Coordination of benefit information appropriate in determining liability in cases in which benefits may be payable under 2 or more administered health plans.

(c) Periodicity of Submissions.—The standards established by the Secretary under this subsection shall require the submission of information to the national enrollment verification systems on a periodic basis (as determined by the Secretary) in order to report applicable changes with respect to the information described in subsection (b).

(d) Form of Inquiry.—The verification systems shall be capable of accepting inquiries from health care providers, administered health plan sponsors, the Civilian Health and Medical Program of the Uniformed Services under chapter 55 of title 10, United States Code, (and any other individual or entity determined appropriate by the Secretary) in a variety of electronic and other forms.

(e) Form of Response.—The systems shall be capable of responding to inquiries under subsection (d) in a variety of electronic and other forms.

(f) Limits on Disclosure of Information Reported.—The disclosure of information reported to the national enrollment verification systems shall be restricted by the Secretary under standards established by the Secretary that are consistent with subtitle C.

(g) Fees.—The Secretary shall establish a schedule of fees for the acceptance of, and response to, inquiries to the verification systems. The Secretary may impose appropriate fees, according to the schedule, for such inquiries and responses.

(h) Public Domain Software to Providers.—The Secretary shall provide for the development, and shall make available without charge to health care providers, a variety of forms of computer software to enable such providers to make inquiries to, and receive responses from, the national enrollment verification systems in electronic form.

(i) Deadline.—The Secretary shall establish the system and standards under this section (and shall develop and make available the software under subsection (h)) by not later than January 1, 1996.

(j) Civil Money Penalty.—In the case of a failure of an individual or entity to report information to the enrollment verification system under a standard established by the Secretary under this section, the individual or entity shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $1000 for each day in which such failure persists. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

SEC. 9103. STANDARDS FOR HEALTH INFORMATION AND INFORMATION TRANSACTIONS.

(a) Standards to Ensure Comparability of Information.—

(1) In general.—The Secretary shall establish standards necessary to make a set of health information described in subsection (b) that is created by an administered health plan sponsor or a health provider comparable with the same set of information created by another such sponsor or provider.

(2) Data elements.—The standards shall specifically define the data elements that comprise each set of health information described in subsection (b).

(3) Format.—The standards shall include uniform presentation and format requirements for the arrangement of data elements.

(4) Electronic.—The standards under paragraph (1) shall require that health information described in such paragraph be in electronic or magnetic form.

(5) Unique identifiers.—The Secretary shall establish a system to provide for a unique identifier for each employer, administered health plan, administered health plan sponsor, group practice, and health provider. In the case of a health provider that has a unique identifier issued for purposes of the medicare program, the 2 unique identifiers shall be identical.

(6) Code sets.—The Secretary, in consultation with experts from the private sector and Federal agencies—

(A) shall select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

(B) shall establish code sets for appropriate data elements if no code set for the data elements has been developed by such entities.

(b) Sets of Health Information.—

(1) Plan and provider transactions.—The Secretary shall establish a separate set of health information that is appropriate for transmission in connection with each transaction described in section 9104(a).

(2) Encounter information.—The Secretary shall establish a set of encounter information derived from inpatient and outpatient clinical encounters that the Secretary determines—

(A) is appropriate for creation by—

(i) an administered health plan sponsor to the extent the sponsor provides health benefits in the form of items and services to enrollees; or

(ii) a network provider with respect to an administered health plan sponsored or provided by an administered health plan sponsor, but only if the sponsor does not—

(I) provide health benefits in the form of payments based on claims; or

(II) create the set of encounter information; and

(B) is necessary to provide information regarding the operation of an administered health plan sponsor described in subparagraph (A)(i), or a network provider described in subparagraph (A)(ii), that is equivalent to information derived from claims.

(3) PATIENT MEDICAL RECORD INFORMATION.—The Secretary shall establish a set of patient medical record information.

(4) ADDITIONS TO SETS.—The Secretary may make additions to a set of health information established under paragraph (1), (2), or (3) as the Secretary determines appropriate in a manner that minimizes the disruption to, and costs of compliance incurred by, an administered health plan sponsor or a health provider that is required to comply with section 9104.

(c) STANDARDS FOR INFORMATION TRANSACTIONS.—

(1) IN GENERAL.—The Secretary shall establish standards relating to technical aspects of the procedure and method by which an administered health plan sponsor or a health provider that is required to comply with section 9104 may transmit electronically health information that is included in a set of health information described in subsection (b). The standards shall include standards with respect to the format in which such information shall be transmitted under such section.

(2) CHAIN OF CUSTODY.—The standards under paragraph (1) shall ensure the suitability of health information that is included in a set of health information described in subsection (b) in a court of law.

(3) RECORD KEEPING.—The standards shall include instructions on record keeping in support of claims for benefits under an administered health plan.

(4) STANDARDS FOR CLAIMS FOR CLINICAL LABORATORY TESTS.—The standards shall provide that claims for clinical laboratory tests for which benefits are provided under an administered health plan shall be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the plan in a manner consistent with (and subject to such exceptions as are provided under) the requirement for direct submission of such claims under the medicare program.

(5) ENSURING ACCOUNTABILITY FOR CLAIMS SUBMITTED ELECTRONICALLY.—In establishing the standards, the Secretary, in consultation with appropriate agencies, shall include such methods of ensuring health provider responsibility and accountability for claims submitted electronically that are designed to control fraud and abuse in the submission of such claims.

(6) SPECIAL RULE FOR COORDINATION OF BENEFITS.—Any standards adopted by the Secretary under paragraph (1) that relate to coordination of benefits shall provide, to the maximum extent practicable, that a claim for reimbursement for health services furnished is tested by an algorithm specified by the Secretary against appropriate records of enrollment and eligibility for the individual who received such services to determine any primary and secondary obligors for payment.

(d) GENERAL REQUIREMENTS.—In establishing standards under this section, the Secretary shall, to the maximum extent practicable—

(1) establish standards that are consistent with the objective of reducing the costs of providing and paying for health care;

(2) incorporate standards that are in use and generally accepted, or developed, by standard setting or standard development organizations; and

(3) consult with experts and professional organizations in the field of information management.

(e) TIMETABLES FOR STANDARDS.—

(1) INITIAL STANDARDS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), not later than January 1, 1996, the Secretary shall establish standards under subsections (a) and (c) with respect to each set of health information described in subsection (b).

(B) EXCEPTIONS.—

(i) IN GENERAL.—Not later than January 1, 1997, the Secretary shall establish standards under subsections (a) and (c) with respect to—

(I) health information that is appropriate for transmission in connection with the submission of a claim attachment; and

(II) the set of patient medical record information established under subsection (b)(3).

(ii) ADDITIONS.—The Secretary shall establish standards under subsection (a) and (c) with respect to health information that is added to a set of health information under subsection (b)(4) in conjunction with making such addition.

(2) MODIFICATIONS TO STANDARDS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall review the standards established under this section and shall modify such standards as determined appropriate, but not more frequently than once every 6 months. Any modification under this subparagraph shall be made in a manner that minimizes the disruption to, and costs of compliance incurred by, a health information plan sponsor or a health provider that is required to comply with section 9104.

(B) SPECIAL RULES.—

(i) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—The Secretary may not modify a standard established under this section during the 12-month period beginning on the date the standard is established unless the Secretary determines that a modification is necessary in order to permit a health information plan sponsor or a health provider to comply with section 9104.

(ii) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(I) IN GENERAL.—The Secretary shall ensure that procedures exist for the enhancement of code sets to accommodate changes in public health, biomedical science, and health care delivery.

(II) ADDITIONAL RULES.—If a code set is modified under this clause, the modified code set shall include instructions on how data elements that were encoded prior to the modification are to be converted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption to, and costs of compliance incurred by, a health information plan sponsor or a health provider that is required to comply with section 9104.

(f) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards established or modified under this section. The process may include demonstration projects and analyses of the cost of implementing such standards and modifications.

(g) DISTRIBUTION OF CODE SETS.—The Secretary shall establish efficient and low-cost procedures for the distribution of code sets that are selected, established, or modified under this section.

SEC. 9104. REQUIREMENTS ON SPONSORS AND PROVIDERS.

(a) TRANSACTIONS BY SPONSORS.—

(1) TRANSACTIONS WITH PROVIDERS.—If an administered health plan sponsor conducts any of the transactions described in paragraph (3) with a health provider—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by the sponsor to the provider or by the provider to the sponsor in connection with the transaction shall be standard health information.

(2) TRANSACTIONS WITH SPONSORS.—If an administered health plan sponsor or a workers' compensation carrier conducts any of the transactions described in paragraph (3) with an administered health plan sponsor or a workers' compensation carrier—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by any such sponsor or any such carrier in connection with the transaction shall be standard health information.

(3) TRANSACTIONS.—The transactions referred to in paragraphs (1) and (2) are the following:

(A) Verification of eligibility for benefits.
(B) First report of injury.
(C) Coordination of benefits.
(D) Claim submission.
(E) Claim attachment submission.
(F) Claim status notification.
(G) Claim status verification.
(H) Claim adjudication.
(I) Payment and remittance advice.

(b) DISCLOSURE OF INFORMATION.—

(1) TRANSACTION INFORMATION.—If an administered health plan sponsor or a health provider discloses health information that was transmitted or received by the sponsor or provider in connection with a transaction described in subsection (a) to a State, a Federal or State agency, a grantee of a State or the Federal Government, or a party to a contract entered into by a State or the Federal Government, and the disclosure is made in order to fulfill a requirement under this Act—

(A) the health information disclosed shall be standard health information; and

(B) the disclosure shall be made through an electronic transmission consistent with—

(i) the standards under section 9103(c); and
(ii) subtitle C.

(2) ENCOUNTER INFORMATION.—If an administered health plan sponsor or a health provider discloses health information that is included in the set of encounter information established by the Secretary under section 9103(b)(2) to a State, a Federal or State agency, a grantee of a State or the Federal Government, or a party to a contract entered into by a State or the Federal Government, and the disclosure is made in order to fulfill a requirement under this Act—

(A) the health information disclosed shall be standard health information; and

(B) the disclosure shall be made through an electronic transmission consistent with—

(i) the standards under section 9103(c); and
(ii) subtitle C.

(3) REQUIREMENT ON GOVERNMENT AGENTS.—A State, a Federal or State agency, a grantee of a State or the Federal Government, or a party to a contract entered into by a State or the Federal Government may not impose a requirement on an administered health plan sponsor or a health provider that is inconsistent with paragraph (1) or (2).

(c) USE OF HEALTH INFORMATION NETWORK SERVICES.—A health information plan sponsor or a health provider may comply with any provision of this section by entering into an agreement or other arrangement with a health information network service certified under section 9106 pursuant to which the service undertakes the duties applicable to the sponsor or provider under the provision.

(d) TIMETABLES FOR COMPLIANCE.—

(1) INITIAL COMPLIANCE.—

(A) IN GENERAL.—A health information plan sponsor or health provider shall comply with the requirements of this section not later than January 1, 1997.

(B) ADDITIONAL HEALTH INFORMATION.—Not later than 6 months after the date on which the Secretary makes an addition to a set of health information under section 9103(b)(4), a health information plan sponsor or health provider shall comply with the requirements of this section with respect to the additional information.

(2) COMPLIANCE WITH MODIFIED STANDARDS.—

(A) IN GENERAL.—If the Secretary modifies a standard established under section 9103, a health information plan sponsor or health provider shall comply with the modified standard at such time as the Secretary determines appropriate, taking into account the nature and intent of the modification.

(B) SPECIAL RULE.—In the case of a modification to a standard under subparagraph (A) that does not occur within the 12-month period beginning on the date the standard is established, the time determined appropriate by the Secretary under subparagraph (A) may not be—

(i) earlier than the last day of the 90-day period beginning on the date the modified standard is established; or

(ii) later than the last day of the 12-month period beginning on the date the standard is established.

SEC. 9105. IMPOSITION OF ADDITIONAL REQUIREMENTS.

(a) ACCEPTANCE OF CLAIMS.—An administered health plan sponsor may not reject a claim for payment submitted by any individual or entity under an administered health plan provided or sponsored by the sponsor on the basis of the form or manner in which the claim is submitted if the claim—

(1) contains the standard health information in the set of health information with respect to claims submission established by the Secretary under section 9103(b)(1); and

(2) is submitted in accordance with the standards established under section 9103(c).

(b) ACCEPTANCE OF ATTACHMENTS.—An administered health plan sponsor may not reject a claim attachment submitted by any individual or entity in connection with a claim for payment under an administered health plan provided or sponsored by the sponsor on the basis of the form or manner in which the attachment is submitted if the attachment—

(1) contains the standard health information in the set of health information with respect to claims attachment submission established by the Secretary under section 9103(b)(1); and

(2) is submitted in accordance with the standards established under section 9103(c).

(c) LIMITATION ON OTHER TRANSACTIONS.—An administered health plan sponsor or a health provider may not require, as a condition of conducting a transaction described in section 9104(a), that any individual or entity—

(A) provide any health information that is not in the set of health information established by the Secretary under section 9103(b)(1) with respect to the transaction; or

(B) transmit any such health information in a manner inconsistent with the standards established under section 9103(c).

(d) EXCEPTIONS.—Subsections (a), (b), and (c) do not apply if—

(1) the individual or entity on whom the administered health plan sponsor or the health provider is imposing a requirement otherwise prohibited under the subsections voluntarily agrees to the imposition of the requirement; or

(2) a waiver is granted under subsection (e) to impose a requirement otherwise prohibited under such subsections.

(e) CONDITIONS FOR WAIVERS.—

(1) IN GENERAL.—An administered health plan sponsor or health provider may request a waiver from the Secretary in order to impose on an individual or entity a requirement otherwise prohibited under subsection (a), (b), or (c).

(2) CONSIDERATION OF WAIVER REQUESTS.—A waiver may not be granted under this subsection to impose an otherwise prohibited requirement unless the Secretary determines that the value of any additional information to be provided under the requirement for research or other purposes significantly outweighs the administrative cost of the imposition of the requirement, taking into account the burden of the timing of the imposition of the requirement.

(3) ANONYMOUS REPORTING.—If an administered health plan sponsor or a health provider attempts to impose on an individual or entity a requirement prohibited under subsection (a), (b), or (c), the individual or entity may contact the Secretary. The Secretary shall develop a procedure under which an individual or entity that contacts the Secretary under the preceding sentence shall remain anonymous. The Secretary shall notify the sponsor or provider imposing the requirement that the requirement may not be imposed unless the other sponsor or provider voluntarily agrees to such requirement or a waiver is obtained under this subsection.

(f) TIMETABLES FOR COMPLIANCE.—An administered health plan sponsor or a health provider shall comply with the requirements of this section not later than January 1, 1997.

SEC. 9106. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK SERVICES.

(a) STANDARDS FOR OPERATIONS.—The Secretary shall establish standards with respect to the operation of health information network services, including standards ensuring that such services—

(1) develop, operate, and cooperate with one another to form a health information network;

(2) meet all of the requirements under subtitle C that are applicable to such services;

(3) make public information concerning their performance, as measured by uniform indicators such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicator determined appropriate by the Secretary; and

(4) have the highest security procedures that are practicable with respect to the processing and handling of health information.

(b) CERTIFICATION BY SECRETARY.—

(1) ESTABLISHMENT OF PROCEDURE.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall establish a certification procedure for health information network services which ensures that services certified under this section are qualified—

(A) to meet the requirements of this part and the standards established by the Secretary under this section; and

(B) to ensure the confidentiality of protected health information (as defined in section 9200(a)) as required under subtitle C.

(2) DEEMED CERTIFICATION.—The Secretary may designate private individuals or entities to conduct the certification procedure established by the Secretary under this subsection. A health information network service certified by such an individual or entity in accordance with such designation shall be considered to be certified by the Secretary under this subsection.

(3) APPLICATION FOR CERTIFICATION.—Each entity desiring to be certified as a health information network service shall apply to the Secretary for certification in a form and manner determined appropriate by the Secretary.

(4) AUDITS AND REPORTS.—The procedure established under paragraph (1) shall provide for audits by the Secretary and reports by an entity certified under this section as the Secretary determines appropriate in order to monitor the compliance by the entity with the requirements of this part and the standards established by the Secretary under this section.

(5) RECERTIFICATION.—A health information network service shall be recertified under this subsection not less than every 3 years.

(c) LOSS OF CERTIFICATION.—

(1) MANDATORY TERMINATION.—If a health information network service violates a provision of subtitle C, the certification of the service under this section shall be terminated unless the Secretary determines that appropriate corrective action has been taken.

(2) DISCRETIONARY TERMINATION.—If a health information service violates a requirement or standard under this part and a penalty has been imposed under section 9107, the Secretary shall review the certification of the service and may terminate the certification.

(d) HEALTH INFORMATION CONTINUITY.—If a health information network service is decertified or ceases to function, in a manner that would threaten the continued availability of the standard health information held by the service, the service shall transfer the standard health information to a health information network service that is certified under this section and designated by the Secretary to receive the information.

SEC. 9107. CIVIL MONEY PENALTY.

(a) IN GENERAL.—Any person who the Secretary determines is required, but has failed, to comply with a requirement or standard imposed under this part shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $1,000 for each such failure.

(b) PROCESS.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under subsection (a) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

SEC. 9108. EFFECT ON STATE LAW.

(a) PREEMPTION OF STATE QUILL PEN LAWS.—

(1) IN GENERAL.—Any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form is deemed to be satisfied if the records are maintained in an electronic form that meets standards established by the Secretary under paragraph (2).

(2) SECRETARIAL AUTHORITY.—Not later than 1 year after the date of the enactment

of this Act, the Secretary shall issue regulations to carry out paragraph (1). The regulations shall provide for an electronic substitute that is in the form of a unique identifier (assigned to each authorized individual) that serves the functional equivalent of a signature. The regulations may provide for such exceptions to paragraph (1) as the Secretary determines to be necessary to prevent fraud and abuse, to prevent the illegal distribution of controlled substances, and in such other cases as the Secretary deems appropriate.

(b) Public Health Reporting.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

SEC. 9109. DEFINITIONS.

For purposes of this subtitle:

(1) Administered health plan.—The term "administered health plan" has the meaning given the term "health benefit plan" in section 5504(3), but includes—

(A) the medicare program, medicare supplemental health insurance, medicare part C, the medicaid program, the wrap-around benefit program under part B of title XXII of the Social Security Act; and

(B) except as the Secretary may provide, other Federal or State programs or arrangements that provide health benefits (other than coverage or insurance described in clause (i) or clauses (iii) through (ix) of section 5504(3)(B)).

(2) Administered health plan sponsor.—The term "administered health plan sponsor" has the meaning given the term "sponsor" in section 5504(13) in relation to an administered health plan (as defined in paragraph (1)).

(3) Code set.—The term "code set" means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(4) Coordination of benefits.—The term "coordination of benefits" means determining and coordinating the financial obligations of administered health plan sponsors and workers' compensation carriers when health care benefits are payable by more than one such sponsor or carrier.

(5) Health information.—The term "health information" means any information that relates to the past, present, or future physical or mental health or condition or functional status of an individual, the provision of health care to an individual, or payment for the provision of health care to an individual.

(6) Health information network service.—The term "health information network service" means a private entity or an entity operated by a State that enters into contracts—

(A) to process or facilitate the processing of nonstandard health information into standard health information;

(B) to provide the means by which individuals and entities transmit and receive standard health information to satisfy the requirements of this part; or

(C) to provide other information processing services, such as automated coordination of benefits or claim routing.

(7) Health provider.—The term "health provider" includes a provider of services (as defined in section 1861(u) of the Social Security Act), a provider of medical or other health services (as defined in section 1861(s) of such Act), and any other person (other than an administered health plan sponsor) furnishing health care items or services.

(8) Network provider.—The term "network provider", when used with respect to an administered health plan, means a health provider who is member of a plan network of the plan.

(9) Plan network.—The term "plan network" means, with respect to an administered health plan, health providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services covered under the plan to individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

(10) Standard.—The term "standard", when used with reference to health information or a transaction involving such information, means that the information or transaction meets any standard established by the Secretary under section 9103 that applies to the information or transaction.

(11) Workers' compensation carrier.—The term "workers' compensation carrier" has the meaning given such term in section 13000(4).

Subtitle C—Fair Health Information Practices

SEC. 9200. DEFINITIONS.

(a) Definitions Relating to Protected Health Information.—For purposes of this subtitle:

(1) Disclose.—The term "disclose", when used with respect to protected health information that is held by a health information trustee, means to provide access to the information, but only if such access is provided by the trustee to a person other than—

(A) the trustee or an officer or employee of the trustee;

(B) an affiliated person of the trustee; or

(C) a protected individual who is a subject of the information.

(2) Disclosure.—The term "disclosure" means the act or an instance of disclosing.

(3) Protected health information.—The term "protected health information" means any information, whether oral or recorded in any form or medium—

(A) that is created or received in a State by—

(i) a health care provider;

(ii) a health plan sponsor;

(iii) a health oversight agency;

(iv) a health information service organization; or

(v) a public health authority;

(B) that—

(i) relates in any way to—

(I) the past, present, or future physical or mental health or condition or functional status of a protected individual;

(II) the provision of health care to a protected individual;

(III) any cause or circumstance underlying the provision of such care; or

(IV) payment for the provision of such care; or

(ii) is received by a health care provider in the course of the provision of health care; and

(C) that—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(4) Protected individual.—The term "protected individual" means an individual who, with respect to a date—

(A) is living on the date; or

(B) has died within the 2-year period ending on the date.

(5) Use.—The term "use", when used with respect to protected health information that is held by a health information trustee, means—

(A) to use, or provide access to, the information in any manner that does not constitute a disclosure; or

(B) any act or instance of using, or providing access, described in subparagraph (A).

(b) Definitions Relating to Health Information Trustees.—For purposes of this subtitle:

(1) Carrier.—The term "carrier" has the meaning given such term in section 5504(2).

(2) Health plan.—The term "health plan" has the meaning given such term in section 5504(4).

(3) Health plan sponsor.—The term "health plan sponsor" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a carrier providing an insured health plan;

(B) a public or private entity sponsoring any other health plan; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(4) Health care provider.—The term "health care provider" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who is licensed, certified, registered, or otherwise authorized by law to provide an item or service that constitutes health care in the ordinary course of business or practice of a profession;

(B) a Federal or State program that directly provides items or services that constitute health care to beneficiaries; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(5) Health information service organization.—The term "health information service organization" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person, other than an affiliated person, who performs specific functions for which the Secretary has authorized (by means of a designation or certification) the person to receive access to health care information in electronic or magnetic form that is regulated by this Act; or

(B) an officer or employee of a person described in subparagraph (A).

(6) Health information trustee.—The term "health information trustee" means—

(A) a health care provider;

(B) a health information service organization;

(C) a health oversight agency;

(D) a health plan sponsor;

(E) a public health authority;

(F) a health researcher;

(G) a person who, with respect to a specific item of protected health information, is not described in subparagraphs (A) through (F) but receives the information—

(i) pursuant to—

(I) section 9227 (relating to emergency circumstances);

(II) section 9228 (relating to judicial and administrative purposes);

(III) section 9229 (relating to law enforcement); or

(IV) section 9230 (relating to subpoenas, warrants, and search warrants); or

(ii) while acting in whole or in part in the capacity of an officer or employee of a person described in clause (i).

(7) HEALTH OVERSIGHT AGENCY.—The term "health oversight agency" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers;

(B) a person who—

(i) performs or oversees the performance of an audit, assessment, evaluation, determination, or investigation relating to the effectiveness of, compliance with, or applicability of, legal, fiscal, medical, quality, or scientific standards or aspects of performance related to the delivery of, or payment for, health care; and

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a State or Federal statute regulating the assessment, evaluation, determination, or investigation; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(8) HEALTH RESEARCHER.—The term "health researcher" means a person who, with respect to a specific item of protected health information, receives the information—

(A) pursuant to section 9226 (relating to health research); or

(B) while acting in whole or in part in the capacity of an officer or employee of a person described in subparagraph (A).

(9) PUBLIC HEALTH AUTHORITY.—The term "public health authority" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) an authority of the United States, a State, or a political subdivision of a State that is responsible for public health matters;

(B) a person acting under the direction of such an authority; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(c) OTHER DEFINITIONS.—For purposes of this subtitle:

(1) AFFILIATED PERSON.—The term "affiliated person" means a person who—

(A) is not a health information trustee;

(B) is a contractor, subcontractor, associate, or subsidiary of a person who is a health information trustee; and

(C) pursuant to an agreement or other relationship with such trustee, receives, creates, uses, maintains, or discloses protected health information.

(2) APPROVED HEALTH RESEARCH PROJECT.—The term "approved health research project" means a biomedical, epidemiological, or health services research or statistics project, or a research project on behavioral and social factors affecting health, that has been approved by a certified institutional review board.

(3) CERTIFIED INSTITUTIONAL REVIEW BOARD.—The term "certified institutional review board" means a board—

(A) established by an entity to review research involving protected health information and the rights of protected individuals conducted at or supported by the entity;

(B) established in accordance with regulations of the Secretary under section 9226(e)(1); and

(C) certified by the Secretary under section 9226(e)(2).

(4) HEALTH CARE.—The term "health care"—

(A) means—

(i) any preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service, or procedure—

(I) with respect to the physical or mental condition, or functional status, of an individual; or

(II) affecting the structure or function of the human body or any part of the human body, including banking of blood, sperm, organs, or any other tissue; or

(ii) any sale or dispensing of a drug, device, equipment, or other item to an individual, or for the use of an individual, pursuant to a prescription; but

(B) does not include any item or service that is not furnished for the purpose of maintaining or improving the health of an individual.

(5) LAW ENFORCEMENT INQUIRY.—The term "law enforcement inquiry" means a lawful investigation or official proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

(6) PERSON.—The term "person" includes an authority of the United States, a State, or a political subdivision of a State.

PART 1—DUTIES OF HEALTH INFORMATION TRUSTEES

SEC. 9201. INSPECTION OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Except as provided in subsection (b), a health information trustee described in subsection (g)—

(1) shall permit a protected individual to inspect any protected health information about the individual that the trustee maintains, any accounting with respect to such information required under section 9204, and any copy of an authorization required under section 9222 that pertains to such information;

(2) shall provide the protected individual with a copy of the information upon request by the individual and subject to any conditions imposed by the trustee under subsection (d);

(3) shall permit a person who has been designated in writing by the protected individual to inspect the information on behalf of the individual or to accompany the individual during the inspection; and

(4) may offer to explain or interpret information that is inspected or copied under this subsection.

(b) EXCEPTIONS.—A health information trustee is not required by this section to permit inspection or copying of protected health information by a protected individual if any of the following conditions apply:

(1) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psychological, or mental health treatment notes about the individual, the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the notes would cause sufficient harm to the protected individual so as to outweigh the desirability of permitting access, and the trustee does not disclose the notes to any person not directly engaged in treating the individual, except with the authorization of the individual or under compulsion of law.

(2) INFORMATION ABOUT OTHERS.—The information relates to an individual, other than the protected individual or a health care provider, and the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the information would cause sufficient harm to one or both of the individuals so as to outweigh the desirability of permitting access.

(3) ENDANGERMENT TO LIFE OR SAFETY.—Inspection or copying of the information could reasonably be expected to endanger the life or physical safety of an individual.

(4) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of an individual (other than a health care provider) who provided information under a promise of confidentiality to a health care provider concerning a protected individual who is a subject of the information.

(5) ADMINISTRATIVE PURPOSES.—The information—

(A) is used by the trustee solely for administrative purposes and not in the provision of health care to a protected individual who is a subject of the information; and

(B) is not disclosed by the trustee to any person.

(6) DUPLICATIVE INFORMATION.—The information duplicates information available for inspection under subsection (a).

(7) INFORMATION COMPILED IN ANTICIPATION OF LITIGATION.—The information is compiled principally—

(A) in anticipation of a civil, criminal, or administrative action or proceeding; or

(B) for use in such an action or proceeding.

(c) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A health information trustee shall permit inspection and copying under subsection (a) of any reasonably segregable portion of a record after deletion of any portion that is exempt under subsection (b).

(d) CONDITIONS.—A health information trustee may—

(1) require a written request for the inspection and copying of protected health information under this section; and

(2) charge a reasonable cost-based fee for—

(A) permitting inspection of information under this section; and

(B) providing a copy of protected health information under this section.

(e) STATEMENT OF REASONS FOR DENIAL.—If a health information trustee denies in whole or in part a request for inspection or copying under this section, the trustee shall provide the protected individual who made the request with a written statement of the reasons for the denial.

(f) DEADLINE.—A health information trustee shall comply with or deny a request for inspection or copying of protected health information under this section within the 30-day period beginning on the date the trustee receives the request.

(g) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health plan sponsor;

(2) a health care provider;

(3) a health information service organization;

(4) a health oversight agency; or

(5) a public health authority.

SEC. 9202. AMENDMENT OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—A health information trustee described in subsection (f) shall, within the 45-day period beginning on the date the trustee receives from a protected individual about whom the trustee maintains protected health information a written request that the trustee correct or amend the information, complete the duties described in one of the following paragraphs:

(1) CORRECTION OR AMENDMENT AND NOTIFICATION.—The trustee shall—

(A) make the correction or amendment requested;

(B) inform the protected individual of the amendment or correction that has been made;

(C) make reasonable efforts to inform any person who is identified by the protected individual, who is not an employee of the trustee, and to whom the uncorrected or unamended portion of the information was previously disclosed of the correction or amendment that has been made; and

(D) at the request of the individual, make reasonable efforts to inform any known source of the uncorrected or unamended portion of the information about the correction or amendment that has been made.

(2) REASONS FOR REFUSAL AND REVIEW PROCEDURES.—The trustee shall inform the protected individual of—

(A) the reasons for the refusal of the trustee to make the correction or amendment;

(B) any procedures for further review of the refusal; and

(C) the individual's right to file with the trustee a concise statement setting forth the requested correction or amendment and the individual's reasons for disagreeing with the refusal of the trustee.

(b) STANDARDS FOR CORRECTION OR AMENDMENT.—A trustee shall correct or amend protected health information in accordance with a request made under subsection (a) if the trustee determines that the information is not accurate, relevant, timely, or complete for the purposes for which the information may be used or disclosed by the trustee.

(c) STATEMENT OF DISAGREEMENT.—After a protected individual has filed a statement of disagreement under subsection (a)(2)(C), the trustee, in any subsequent disclosure of the disputed portion of the information, shall include a copy of the individual's statement and may include a concise statement of the trustee's reasons for not making the requested correction or amendment.

(d) CONSTRUCTION.—This section may not be construed to require a health information trustee to conduct a hearing or proceeding concerning a request for a correction or amendment to protected health information the trustee maintains.

(e) CORRECTION.—For purposes of subsection (a), a correction is deemed to have been made to protected health information when—

(1) information that is not timely, accurate, relevant, or complete is clearly marked as incorrect; or

(2) supplementary correct information is made part of the information and adequately cross-referenced.

(f) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health plan sponsor;

(2) a health care provider;

(3) a health information service organization;

(4) a health oversight agency; or

(5) a public health authority.

SEC. 9203. NOTICE OF INFORMATION PRACTICES.

(a) PREPARATION OF NOTICE.—A health information trustee described in subsection (d) shall prepare a written notice of information practices describing the following:

(1) The rights under this subtitle of a protected individual who is the subject of protected health information, including the right to inspect and copy such information and the right to seek amendments to such information, and the procedures for authorizing disclosures of protected health information and for revoking such authorizations.

(2) The procedures established by the trustee for the exercise of such rights.

(3) The uses and disclosures of protected health information that are authorized under this subtitle.

(b) DISSEMINATION OF NOTICE.—A health information trustee—

(1) shall, upon request, provide any person with a copy of the trustee's notice of information practices (described in subsection (a)); and

(2) shall make reasonable efforts to inform persons in a clear and conspicuous manner of the existence and availability of such notice.

(c) MODEL NOTICES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate model notices of information practices for use by health information trustees under this section.

(d) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health plan sponsor;

(2) a health care provider;

(3) a health information service organization; or

(4) a health oversight agency.

SEC. 9204. ACCOUNTING FOR DISCLOSURES.

(a) IN GENERAL.—Except as provided in subsection (b) and section 9224, each health information trustee shall create and maintain, with respect to any protected health information the trustee discloses, a record of—

(1) the date and purpose of the disclosure;

(2) the name of the person to whom the disclosure was made;

(3) the address of the person to whom the disclosure was made or the location to which the disclosure was made; and

(4) where practicable, a description of the information disclosed.

(b) REGULATIONS.—Not later than July 1, 1996, the Secretary shall promulgate regulations that exempt a health information trustee from maintaining a record under subsection (a) with respect to protected health information disclosed by the trustee for purposes of peer review, licensing, certification, accreditation, and similar activities.

SEC. 9205. SECURITY.

(a) IN GENERAL.—Each health information trustee who receives or creates protected health information that is subject to this subtitle shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(1) to ensure the integrity and confidentiality of the information;

(2) to protect against any reasonably anticipated—

(A) threats or hazards to the security or integrity of the information; and

(B) unauthorized uses or disclosures of the information; and

(3) otherwise ensure compliance with this subtitle by the trustee and the officers and employees of the trustee.

(b) GUIDELINES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate guidelines for the implementation of this section. The guidelines shall take into account—

(1) the technical capabilities of record systems used to maintain protected health information;

(2) the costs of security measures;

(3) the need for training persons who have access to protected health information; and

(4) the value of audit trails in computerized record systems.

PART 2—USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SEC. 9221. GENERAL LIMITATIONS ON USE AND DISCLOSURE.

(a) USE.—Except as otherwise provided under this subtitle, a health information trustee may use protected health information only for a purpose—

(1) that is compatible with and directly related to the purpose for which the information—

(A) was collected; or

(B) was received by the trustee; or

(2) for which the trustee is authorized to disclose the information under this subtitle.

(b) DISCLOSURE.—A health information trustee may disclose protected health information only as authorized under this subtitle.

(c) SCOPE OF USES AND DISCLOSURES.—

(1) IN GENERAL.—A use or disclosure of protected health information by a health information trustee shall be limited, when practicable, to the minimum amount of information necessary to accomplish the purpose for which the information is used or disclosed.

(2) GUIDELINES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall issue guidelines to implement paragraph (1), which shall take into account the technical capabilities of the record systems used to maintain protected health information and the costs of limiting use and disclosure.

(d) IDENTIFICATION OF DISCLOSED INFORMATION AS PROTECTED INFORMATION.—Except with respect to protected health information that is disclosed under section 9224 (relating to next of kin and directory information), a health information trustee may disclose protected health information only if the recipient has been notified that the information is protected health information that is subject to this subtitle.

(e) AGREEMENT TO LIMIT USE OR DISCLOSURE.—A health information trustee who receives protected health information from any person pursuant to a written agreement to restrict use or disclosure of the information to a greater extent than otherwise would be required under this subtitle shall comply with the terms of the agreement, except where use or disclosure of the information in violation of the agreement is required by law. A trustee who fails to comply with the preceding sentence shall be subject to section 9261 (relating to civil actions) with respect to such failure.

(f) NO GENERAL REQUIREMENT TO DISCLOSE.—Nothing in this subtitle shall be construed to require a health information trustee to disclose protected health information not otherwise required to be disclosed by law.

SEC. 9222. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) WRITTEN AUTHORIZATIONS.—A health information trustee, other than a health information service organization, may disclose protected health information pursuant to an authorization executed by the protected individual who is the subject of the information, if each of the following requirements is satisfied:

(1) WRITING.—The authorization is in writing, signed by the individual, and dated on the date of such signature.

(2) SEPARATE FORM.—The authorization is not on a form used to authorize or facilitate the provision of, or payment for, health care.

(3) TRUSTEE DESCRIBED.—The trustee is specifically named or generically described in the authorization as authorized to disclose such information.

(4) RECIPIENT DESCRIBED.—The person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed.

(5) STATEMENT OF INTENDED USES AND DISCLOSURES RECEIVED.—The authorization contains an acknowledgment that the individual has received a statement described in subsection (b) from such person.

(6) INFORMATION DESCRIBED.—The information to be disclosed is described in the authorization.

(7) AUTHORIZATION TIMELY RECEIVED.—The authorization is received by the trustee during a period described in subsection (c)(1).

(8) DISCLOSURE TIMELY MADE.—The disclosure occurs during a period described in subsection (c)(2).

(b) STATEMENT OF INTENDED USES AND DISCLOSURES.—

(1) IN GENERAL.—A person who wishes to receive from a health information trustee protected health information about a protected individual pursuant to an authorization executed by the individual shall supply the individual, in writing and on a form that is distinct from the authorization, with a statement of the uses for which the person intends the information and the disclosures the person intends to make of the information. Such statement shall be supplied before the authorization is executed.

(2) ENFORCEMENT.—If the person uses or discloses the information in a manner that is inconsistent with such statement, the person shall be subject to section 9261 (relating to civil actions) with respect to such failure, except where such use or disclosure is required by law.

(3) MODEL STATEMENTS.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate model statements of intended uses and disclosures of the type described in paragraph (1).

(c) TIME LIMITATIONS ON AUTHORIZATIONS.—

(1) RECEIPT BY TRUSTEE.—For purposes of subsection (a)(7), an authorization is timely received if it is received by the trustee during—

(A) the 1-year period beginning on the date that the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to—

(i) a health plan sponsor;

(ii) a health care provider;

(iii) a health oversight agency;

(iv) a public health authority;

(v) a health researcher; or

(vi) a person who provides counseling or social services to individuals; or

(B) the 30-day period beginning on the date that the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person other than a person described in subparagraph (A).

(2) DISCLOSURE BY TRUSTEE.—For purposes of subsection (a)(8), a disclosure is timely made if it occurs before—

(A) the date or event (if any) specified in the authorization upon which the authorization expires; and

(B) the expiration of the 6-month period beginning on the date the trustee receives the authorization.

(d) REVOCATION OR AMENDMENT OF AUTHORIZATION.—

(1) IN GENERAL.—A protected individual in writing may revoke or amend an authorization described in subsection (a), in whole or in part, at any time, except insofar as—

(A) disclosure of protected health information has been authorized to permit validation of expenditures based on health condition by a government authority; or

(B) action has been taken in reliance on the authorization.

(2) NOTICE OF REVOCATION.—A health information trustee who discloses protected health information in reliance on an authorization that has been revoked shall not be subject to any liability or penalty under this subtitle if—

(A) the reliance was in good faith;

(B) the trustee had no notice of the revocation; and

(C) the disclosure was otherwise in accordance with the requirements of this section.

(e) ADDITIONAL REQUIREMENTS OF TRUSTEE.—A health information trustee may impose requirements for an authorization that are in addition to the requirements in this section.

(f) COPY.—A health information trustee who discloses protected health information pursuant to an authorization under this section shall maintain a copy of the authorization.

(g) CONSTRUCTION.—This section may not be construed—

(1) to require a health information trustee to disclose protected health information; or

(2) to limit the right of a health information trustee to charge a fee for the disclosure or reproduction of protected health information.

(h) SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.—If a health information trustee discloses protected health information pursuant to an authorization in order to comply with an administrative subpoena or warrant or a judicial subpoena or search warrant, the authorization—

(1) shall specifically authorize the disclosure for the purpose of permitting the trustee to comply with the subpoena, warrant, or search warrant; and

(2) shall otherwise meet the requirements in this section.

SEC. 9223. TREATMENT, PAYMENT, AND OVERSIGHT.

(a) DISCLOSURES BY PLANS, PROVIDERS, AND OVERSIGHT AGENCIES.—A health information trustee described in subsection (d) may disclose protected health information to a health plan sponsor, health care provider, or health oversight agency if the disclosure is—

(1) for the purpose of providing health care and a protected individual who is a subject of the information has not previously objected to the disclosure in writing;

(2) for the purpose of providing for the payment for health care furnished to an individual; or

(3) for use by a health oversight agency for a purpose that is described in subparagraph (A) or (B)(i) of section 9200(b)(7).

(b) SENSITIVE CLAIMS INFORMATION.—Not later than July 1, 1996, the Secretary shall establish standards consistent with this subtitle with respect to the disclosure, to any person other than a health plan sponsor, of protected health information created or received by a health care provider or a health plan sponsor in connection with a claim for benefits under a health plan, where such information—

(1) pertains to a diagnosis, item, or service; and

(2) is disclosed—

(A) concurrent with the filing of the claim; or

(B) after the claim is filed.

(c) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and related to receipt of health care or payment for health care.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any of the following:

(1) A health plan sponsor.

(2) A health care provider.

(3) A health oversight agency.

(4) A health information service organization.

SEC. 9224. NEXT OF KIN AND DIRECTORY INFORMATION.

(a) NEXT OF KIN.—A health information trustee who is a health care provider, who received protected health information pursuant to section 9227 (relating to emergency circumstances), or who is an officer or employee of such a recipient may orally disclose protected health information about a protected individual to the next of kin of the individual (as defined under State law), or to a person with whom the individual has a close personal relationship, if—

(1) the trustee has no reason to believe that the individual would consider the information especially sensitive;

(2) the individual has not previously objected to the disclosure;

(3) the disclosure is consistent with good medical or other professional practice; and

(4) the information disclosed is limited to information about health care that is being provided to the individual at or about the time of the disclosure.

(b) DIRECTORY INFORMATION.—

(1) IN GENERAL.—A health information trustee who is a health care provider, who received protected health information pursuant to section 9227 (relating to emergency circumstances), or who is an officer or employee of a such a recipient may disclose to any person the information described in paragraph (2) if—

(A) a protected individual who is a subject of the information has not objected in writing to the disclosure;

(B) the disclosure is otherwise consistent with good medical and other professional practice; and

(C) the information does not reveal specific information about the physical or mental condition or functional status of a protected individual or about the health care provided to a protected individual.

(2) INFORMATION DESCRIBED.—The information referred to in paragraph (1) is the following:

(A) The name of an individual receiving health care from a health care provider on a premises controlled by the provider.

(B) The location of the individual on such premises.

(C) The general health status of the individual, described in terms of critical, poor, fair, stable, satisfactory, or terms denoting similar conditions.

(c) NO ACCOUNTING REQUIRED.—A health information trustee who discloses protected health information under this section is not required to maintain an accounting of the disclosure under section 9204.

(d) RECIPIENTS.—A person to whom protected health information is disclosed under this section shall not, by reason of such disclosure, be subject to any requirement under this subtitle.

SEC. 9225. PUBLIC HEALTH.

(a) IN GENERAL.—A health information trustee who is a health care provider or a public health authority may disclose protected health information to—

(1) a public health authority for use in legally authorized—

(A) disease or injury reporting;

(B) public health surveillance; or

(C) public health investigation or intervention; or

(2) an individual who is authorized by law to receive the information in a public health intervention.

(b) USE IN ACTION AGAINST INDIVIDUAL.—A public health authority who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except where the use or disclosure is authorized by law for protection of the public health.

(c) INDIVIDUAL RECIPIENTS.—An individual to whom protected health information is disclosed under subsection (a)(2) shall not, by reason of such disclosure, be subject to any requirement under this subtitle.

SEC. 9226. HEALTH RESEARCH.

(a) IN GENERAL.—A health information trustee described in subsection (d) may disclose protected health information to a person if—

(1) the person is conducting an approved health research project;

(2) the information is to be used in the project; and

(3) the project has been determined by a certified institutional review board to be—

(A) of sufficient importance so as to outweigh the intrusion into the privacy of the protected individual who is the subject of the information that would result from the disclosure; and

(B) impracticable to conduct without the information.

(b) DISCLOSURES BY HEALTH INFORMATION SERVICE ORGANIZATIONS.—A health information service organization may disclose protected health information under subsection (a) only if the certified institutional review board referred to in subsection (a)(3) has been certified as being qualified to make determinations under such subsection with respect to disclosures by such organizations.

(c) LIMITATIONS ON USE AND DISCLOSURE; OBLIGATIONS OF RECIPIENT.—A health researcher who receives protected health information about a protected individual pursuant to subsection (a)—

(1) may use the information solely for purposes of an approved health research project;

(2) may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual; and

(3) shall remove or destroy, at the earliest opportunity consistent with the purposes of the approved health research project in connection with which the disclosure was made, information that would enable an individual to be identified, unless a certified institutional review board has determined that there is a health or research justification for retention of such identifiers and there is an adequate plan to protect the identifiers from use and disclosure that is inconsistent with this subtitle.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any health information trustee other than a person who, with respect to the specific protected health information to be disclosed under such subsection, received the information—

(1) pursuant to—

(A) section 9228 (relating to judicial and administrative purposes);

(B) paragraph (1), (2), or (3) of section 9229(a) (relating to law enforcement); or

(C) section 9230 (relating to subpoenas, warrants, and search warrants); or

(2) while acting in whole or in part in the capacity of an officer or employee of a person described in paragraph (1).

(e) REQUIREMENTS FOR INSTITUTIONAL REVIEW BOARDS.—

(1) REGULATIONS.—Not later than July 1, 1996, the Secretary, after opportunity for notice and comment, shall promulgate regulations establishing requirements for certified institutional review boards under this subtitle. The regulations shall be based on regulations promulgated under section 491(a) of the Public Health Service Act and shall ensure that certified institutional review boards are qualified to assess and protect the confidentiality of research subjects. The regulations shall include specific requirements for certified institutional review boards that make determinations under subsection (a)(3) with respect to disclosures by health information service organizations. To the greatest extent feasible, the membership of a certified institutional review board shall reflect the racial, ethnic, and gender composition of the population of the United States.

(2) CERTIFICATION.—The Secretary shall certify that an institutional review board satisfies the requirements of the regulations promulgated under paragraph (1).

SEC. 9227. EMERGENCY CIRCUMSTANCES.

(a) IN GENERAL.—A health information trustee may disclose protected health information if the trustee believes, on reasonable grounds, that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of an individual.

(b) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and related to receipt of health care or payment for health care.

SEC. 9228. JUDICIAL AND ADMINISTRATIVE PURPOSES.

(a) IN GENERAL.—A health information trustee described in subsection (d) may disclose protected health information—

(1) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules of other courts or administrative agencies in connection with litigation or proceedings to which a protected individual who is a subject of the information is a party and in which the individual has placed the individual's physical or mental condition or functional status in issue;

(2) if directed by a court in connection with a court-ordered examination of an individual; or

(3) to assist in the identification of a dead individual.

(b) WRITTEN STATEMENT.—A person seeking protected health information about a protected individual held by health information trustee under—

(1) subsection (a)(1)—

(A) shall notify the protected individual or the attorney of the protected individual of the request for the information;

(B) shall provide the trustee with a signed document attesting—

(i) that the protected individual is a party to the litigation or proceedings for which the information is sought;

(ii) that the individual has placed the individual's physical or mental condition or functional status in issue; and

(iii) the date on which the protected individual or the attorney of the protected individual was notified under subparagraph (A); and

(C) shall not accept any requested protected health information from the trustee until the termination of the 10-day period beginning on the date notice was given under subparagraph (A); or

(2) subsection (a)(3) shall provide the trustee with a written statement that the information is sought to assist in the identification of a dead individual.

(c) USE AND DISCLOSURE.—A person to whom protected health information is disclosed under this section may use and disclose the information only to accomplish the purpose for which the disclosure was made.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any of the following:

(1) A health plan sponsor.

(2) A health care provider.

(3) A health oversight agency.

(4) A person who, with respect to the specific protected health information to be disclosed under such subsection, received the information—

(A) pursuant to—

(i) section 9227 (relating to emergency circumstances); or

(ii) section 9230 (relating to subpoenas, warrants, and search warrants); or

(B) while acting in whole or in part in the capacity of an officer or employee of a person described in subparagraph (A).

SEC. 9229. LAW ENFORCEMENT.

(a) IN GENERAL.—A health information trustee, other than a health information service organization, may disclose protected health information to a law enforcement agency, other than a health oversight agency—

(1) if the information is disclosed for use in an investigation or prosecution of a health information trustee;

(2) in connection with criminal activity committed against the trustee or an affiliated person of the trustee or on premises controlled by the trustee; or

(3) if the information is needed to determine whether a crime has been committed and the nature of any crime that may have been committed (other than a crime that may have been committed by the protected individual who is the subject of the information).

(b) ADDITIONAL AUTHORITY OF CERTAIN TRUSTEES.—A health information trustee who is not a health information service organization, a public health authority, or a health researcher may disclose protected health information to a law enforcement agency (other than a health oversight agency)—

(1) to assist in the identification or location of a victim or witness in a law enforcement inquiry;

(2) pursuant to a law requiring the reporting of specific health care information to law enforcement authorities; or

(3) if the information is specific health information described in paragraph (2) and the trustee is operated by a Federal agency;

(c) CERTIFICATION.—Where a law enforcement agency requests a health information trustee to disclose protected health information under subsection (a) or (b)(1), the agency shall provide the trustee with a written certification that—

(1) is signed by a supervisory official of a rank designated by the head of the agency;

(2) specifies the information requested; and

(3) states that the information is needed for a lawful purpose under this section.

(d) Restrictions on Disclosure and Use.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information—

(1) in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and directly related to the action or investigation for which the information was obtained; and

(2) otherwise unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained and is not prohibited by any other provision of law.

SEC. 9230. SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.

(a) In General.—A health information trustee described in subsection (g) may disclose protected health information if the disclosure is pursuant to any of the following:

(1) A subpoena issued under the authority of a grand jury and the trustee is provided a written certification by the grand jury that the grand jury has complied with the applicable access provisions of section 9241.

(2) An administrative subpoena or warrant or a judicial subpoena or search warrant and the trustee is provided a written certification by the person seeking the information that the person has complied with the applicable access provisions of section 9241 or 9243(a).

(3) An administrative subpoena or warrant or a judicial subpoena or search warrant and the disclosure otherwise meets the conditions of one of sections 9223 through 9229.

(b) Authority of All Trustees.—Any health information trustee may disclose protected health information if the disclosure is pursuant to subsection (a)(3).

(c) Restrictions on Use and Disclosure.—Protected health information about a protected individual that is disclosed by a health information trustee pursuant to—

(1) subsection (a)(2) may not be otherwise used or disclosed by the recipient unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained; and

(2) subsection (a)(3) may not be used or disclosed by the recipient unless the recipient complies with the conditions and restrictions on use and disclosure with which the recipient would have been required to comply if the disclosure by the trustee had been made under the section referred to in subsection (a)(3) the conditions of which were met by the disclosure.

(d) Restrictions on Grand Juries.—Protected health information that is disclosed by a health information trustee under subsection (a)(1)—

(1) shall be returnable on a date when the grand jury is in session and actually presented to the grand jury;

(2) shall be used only for the purpose of considering whether to issue an indictment or report by that grand jury, or for the purpose of prosecuting a crime for which that indictment or report is issued, or for a purpose authorized by rule 6(e) of the Federal Rules of Criminal Procedure or a comparable State rule;

(3) shall be destroyed or returned to the trustee if not used for one of the purposes specified in paragraph (2); and

(4) shall not be maintained, or a description of the contents of such information shall not be maintained, by any government authority other than in the sealed records of the grand jury, unless such information has been used in the prosecution of a crime for which the grand jury issued an indictment or presentment or for a purpose authorized by rule 6(e) of the Federal Rules of Criminal Procedure or a comparable State rule.

(e) Use in Action Against Individual.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and directly related to the inquiry for which the information was obtained;

(f) Construction.—Nothing in this section shall be construed as authority for a health information trustee to refuse to comply with a valid administrative subpoena or warrant or a valid judicial subpoena or search warrant that meets the requirements of this subtitle.

(g) Applicability.—A health information trustee referred to in subsection (a) is any trustee other than the following:

(1) A health information service organization.

(2) A public health authority.

(3) A health researcher.

SEC. 9231. HEALTH INFORMATION SERVICE ORGANIZATIONS.

A health information trustee may disclose protected health information to a health information service organization for the purpose of permitting the organization to perform a function for which the Secretary has authorized (by means of a designation or certification) the organization to receive access to health care information in electronic or magnetic form that is regulated by this Act.

PART 3—ACCESS PROCEDURES AND CHALLENGE RIGHTS

SEC. 9241. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.

(a) Probable Cause Requirement.—A government authority may not obtain protected health information about a protected individual from a health information trustee under paragraph (1) or (2) of section 9230(a) for use in a law enforcement inquiry unless there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

(b) Warrants and Search Warrants.—A government authority that obtains protected health information about a protected individual from a health information trustee under circumstances described in subsection (a) and pursuant to a warrant or search warrant shall, not later than 30 days after the date the warrant was served on the trustee, serve the individual with, or mail to the last known address of the individual, a copy of the warrant.

(c) Subpoenas.—Except as provided in subsection (d), a government authority may not obtain protected health information about a protected individual from a health information trustee under circumstances described in subsection (a) and pursuant to a subpoena unless a copy of the subpoena has been served by hand delivery upon the individual, or mailed to the last known address of the individual, on or before the date on which the subpoena was served on the trustee, together with a notice (published by the Secretary under section 9245(1)) of the individual's right to challenge the subpoena in accordance with section 9242, and—

(1) 30 days have passed from the date of service, or 30 days have passed from the date of mailing, and within such time period the individual has not initiated a challenge in accordance with section 9242; or

(2) disclosure is ordered by a court under section 9242.

(d) Application for Delay.—

(1) In general.—A government authority may apply to an appropriate court to delay (for an initial period of not longer than 90 days) serving a copy of a subpoena and a notice otherwise required under subsection (c) with respect to a law enforcement inquiry. The government authority may apply to the court for extensions of the delay.

(2) Reasons for delay.—An application for a delay, or extension of a delay, under this subsection shall state, with reasonable specificity, the reasons why the delay or extension is being sought.

(3) Ex parte order.—The court shall enter an ex parte order delaying, or extending the delay of, the notice and an order prohibiting the trustee from revealing the request for, or the disclosure of, the protected health information being sought if the court finds that—

(A) the inquiry being conducted is within the lawful jurisdiction of the government authority seeking the protected health information;

(B) there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry being conducted by the government authority;

(C) the government authority's need for the information outweighs the privacy interest of the protected individual who is the subject of the information; and

(D) there are reasonable grounds to believe that receipt of a notice by the individual will result in—

(i) endangering the life or physical safety of any individual;

(ii) flight from prosecution;

(iii) destruction of or tampering with evidence or the information being sought; or

(iv) intimidation of potential witnesses.

(4) Service of application on individual.—Upon the expiration of a period of delay of notice under this subsection, the government authority shall serve upon the individual, with the service of the subpoena and the notice, a copy of any applications filed and approved under this subsection.

SEC. 9242. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS.

(a) Motion to Quash Subpoena.—Within 30 days of the date of service, or 30 days of the date of mailing, of a subpoena of a government authority seeking protected health information about a protected individual from a health information trustee under paragraph (1) or (2) of section 9230(a) (except a subpoena to which section 9243 applies), the individual may file (without filing fee) a motion to quash the subpoena—

(1) in the case of a State judicial subpoena, in the court which issued the subpoena;

(2) in the case of a subpoena issued under the authority of a State that is not a State judicial subpoena, in a court of competent jurisdiction;

(3) in the case of a subpoena issued under the authority of a Federal court, in any court of the United States of competent jurisdiction; or

(4) in the case of any other subpoena issued under the authority of the United States, in—

(A) the United States district court for the district in which the individual resides or in which the subpoena was issued; or

(B) another United States district court of competent jurisdiction.

(b) Copy.—A copy of the motion shall be served by the individual upon the government authority by delivery of registered or certified mail.

(c) AFFIDAVITS AND SWORN DOCUMENTS.—The government authority may file with the court such affidavits and other sworn documents as sustain the validity of the subpoena. The individual may file with the court, within 5 days of the date of the authority's filing, affidavits and sworn documents in response to the authority's filing. The court, upon the request of the individual, the government authority, or both, may proceed in camera.

(d) PROCEEDINGS AND DECISION ON MOTION.—The court may conduct such proceedings as it deems appropriate to rule on the motion. All such proceedings shall be completed, and the motion ruled on, within 10 calendar days of the date of the government authority's filing.

(e) EXTENSION OF TIME LIMITS FOR GOOD CAUSE.—The court, for good cause shown, may at any time in its discretion enlarge the time limits established by subsections (c) and (d).

(f) STANDARD FOR DECISION.—A court may deny a motion under subsection (a) if it finds that there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry being conducted by the government authority, unless the court finds that the individual's privacy interest outweighs the government authority's need for the information. The individual shall have the burden of demonstrating that the individual's privacy interest outweighs the need established by the government authority for the information.

(g) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (f) whether an individual's privacy interest outweighs the government authority's need for the information, the court shall consider—

(1) the particular purpose for which the information was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the inquiry being conducted by the government authority, and the importance of the information to that inquiry; and

(5) any other factor deemed relevant by the court.

(h) ATTORNEY'S FEES.—In the case of any motion brought under subsection (a) in which the individual has substantially prevailed, the court, in its discretion, may assess against a government authority a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

(i) NO INTERLOCUTORY APPEAL.—A court ruling denying a motion to quash under this section shall not be deemed a final order and no interlocutory appeal may be taken therefrom by the individual. An appeal of such a ruling may be taken by the individual within such period of time as is provided by law as part of any appeal from a final order in any legal proceeding initiated against the individual arising out of or based upon the protect health information disclosed.

SEC. 9243. ACCESS AND CHALLENGE PROCEDURES FOR OTHER SUBPOENAS.

(a) IN GENERAL.—A person (other than a government authority seeking protected health information under circumstances described in section 9241(a)) may not obtain protected health information about a protected individual from a health information trustee pursuant to a subpoena under section 9230(a)(2) unless—

(1) a copy of the subpoena has been served upon the individual or mailed to the last known address of the individual on or before the date on which the subpoena was served on the trustee, together with a notice (published by the Secretary under section 9245(2)) of the individual's right to challenge the subpoena, in accordance with subsection (b); and

(2) either—

(A) 30 days have passed from the date of service or 30 days have passed from the date of the mailing and within such time period the individual has not initiated a challenge in accordance with subsection (b); or

(B) disclosure is ordered by a court under such subsection.

(b) MOTION TO QUASH.—Within 30 days of the date of service or 30 days of the date of mailing of a subpoena seeking protected health information about a protected individual from a health information trustee under subsection (a), the individual may file (without filing fee) in any court of competent jurisdiction, a motion to quash the subpoena, with a copy served on the person seeking the information. The individual may oppose, or seek to limit, the subpoena on any grounds that would otherwise be available if the individual were in possession of the information.

(c) STANDARD FOR DECISION.—The court shall grant an individual's motion under subsection (b) if the person seeking the information has not sustained the burden of demonstrating that—

(1) there are reasonable grounds to believe that the information will be relevant to a lawsuit or other judicial or administrative proceeding; and

(2) the need of the person for the information outweighs the privacy interest of the individual.

(d) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (c) whether the need of the person for the information outweighs the privacy interest of the individual, the court shall consider—

(1) the particular purpose for which the information was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the information to the lawsuit or proceeding; and

(5) any other factor deemed relevant by the court.

(e) ATTORNEY'S FEES.—In the case of any motion brought under subsection (b) by an individual against a person in which the individual has substantially prevailed, the court, in its discretion, may assess against the person a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

SEC. 9244. CONSTRUCTION OF PART; SUSPENSION OF STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Nothing in this part shall affect the right of a health information trustee to challenge a request for protected health information. Nothing in this part shall entitle a protected individual to assert the rights of a health information trustee.

(b) EFFECT OF MOTION ON STATUTE OF LIMITATIONS.—If an individual who is the subject of protected health information files a motion under this part which has the effect of delaying the access of a government authority to such information, the period beginning on the date such motion was filed and ending on the date on which the motion is decided shall be excluded in computing any period of limitations within which the government authority may commence any civil or criminal action in connection with which the access is sought.

SEC. 9245. RESPONSIBILITIES OF SECRETARY.

Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate brief, clear, and easily understood model notices—

(1) for use under subsection (c) of section 9241, detailing the rights of a protected individual who wishes to challenge, under section 9242, the disclosure of protected health information about the individual under such subsection; and

(2) for use under subsection (a) of section 9243, detailing the rights of a protected individual who wishes to challenge, under subsection (b) of such section, the disclosure of protected health information about the individual under such section.

PART 4—MISCELLANEOUS PROVISIONS

SEC. 9251. PAYMENT CARD AND ELECTRONIC PAYMENT TRANSACTIONS.

(a) PAYMENT FOR HEALTH CARE THROUGH CARD OR ELECTRONIC MEANS.—If a protected individual pays a health information trustee for health care by presenting a debit, credit, or other payment card or account number, or by any other electronic payment means, the trustee may disclose to a person described in subsection (b) only such protected health information about the individual as is necessary for the processing of the payment transaction or the billing or collection of amounts charged to, debited from, or otherwise paid by, the individual using the card, number, or other electronic payment means.

(b) TRANSACTION PROCESSING.—A person who is a debit, credit, or other payment card issuer, is otherwise directly involved in the processing of payment transactions involving such cards or other electronic payment transactions, or is otherwise directly involved in the billing or collection of amounts paid through such means, may only use or disclose protected health information about a protected individual that has been disclosed in accordance with subsection (a) when necessary for—

(1) the authorization, settlement, billing or collection of amounts charged to, debited from, or otherwise paid by, the individual using a debit, credit, or other payment card or account number, or by other electronic payment means;

(2) the transfer of receivables, accounts, or interest therein;

(3) the audit of the credit, debit, or other payment card account information;

(4) compliance with Federal, State, or local law; or

(5) a properly authorized civil, criminal, or regulatory investigation by Federal, State, or local authorities.

SEC. 9252. ACCESS TO PROTECTED HEALTH INFORMATION OUTSIDE OF THE UNITED STATES.

(a) IN GENERAL.—Notwithstanding the provisions of part 2, and except as provided in subsection (b), a health information trustee may not permit any person who is not in a State to have access to protected health information about a protected individual unless one or more of the following conditions exist:

(1) SPECIFIC AUTHORIZATION.—The individual has specifically consented to the provision of such access outside of the United States in an authorization that meets the requirements of section 9222.

(2) EQUIVALENT PROTECTION.—The provision of such access is authorized under this subtitle and the Secretary has determined that

there are fair information practices for protected health information in the jurisdiction where the access will be provided that provide protections for individuals and protected health information that are equivalent to the protections provided for by this subtitle.

(3) ACCESS REQUIRED BY LAW.—The provision of such access is required under—

(A) a Federal statute; or

(B) a treaty or other international agreement applicable to the United States.

(b) EXCEPTIONS.—Subsection (a) does not apply where the provision of access to protected health information—

(1) is to a foreign public health authority;

(2) is authorized under section 9224 (relating to next of kin and directory information), 9226 (relating to health research), or 9227 (relating to emergency circumstances); or

(3) is necessary for the purpose of providing for payment for health care that has been provided to an individual.

SEC. 9253. STANDARDS FOR ELECTRONIC DOCUMENTS AND COMMUNICATIONS.

(a) STANDARDS.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment and in consultation with appropriate private standard-setting organizations and other interested parties, shall establish standards with respect to the creation, transmission, receipt, and maintenance, in electronic and magnetic form, of each type of written document specifically required or authorized under this subtitle. Where a signature is required under any other provision of this subtitle, such standards shall provide for an electronic or magnetic substitute that serves the functional equivalent of a signature.

(b) TREATMENT OF COMPLYING DOCUMENTS AND COMMUNICATIONS.—An electronic or magnetic document or communication that satisfies the standards established under subsection (a) with respect to such document or communication shall be treated as satisfying the requirements of this subtitle that apply to an equivalent written document.

SEC. 9254. DUTIES AND AUTHORITIES OF AFFILIATED PERSONS.

(a) REQUIREMENTS ON TRUSTEES.—

(1) PROVISION OF INFORMATION.—A health information trustee may provide protected health information to a person who, with respect to the trustee, is an affiliated person and may permit the affiliated person to use such information, only for the purpose of conducting, supporting, or facilitating an activity that the trustee is authorized to undertake.

(2) NOTICE TO AFFILIATED PERSON.—A health information trustee shall notify a person who, with respect to the trustee, is an affiliated person of any duties under this subtitle that the affiliated person is required to fulfill and of any authorities under this subtitle that the affiliated person is authorized to exercise.

(b) DUTIES OF AFFILIATED PERSONS.—

(1) IN GENERAL.—An affiliated person shall fulfill any duty under this subtitle that—

(A) the health information trustee with whom the person has an agreement or relationship described in section 9200(c)(1)(C) is required to fulfill; and

(B) the person has undertaken to fulfill pursuant to such agreement or relationship.

(2) CONSTRUCTION OF OTHER PARTS.—With respect to a duty described in paragraph (1) that an affiliated person is required to fulfill, the person shall be considered a health information trustee for purposes of this subtitle. The person shall be subject to part 5 (relating to enforcement) with respect to any such duty that the person fails to fulfill.

(3) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not relieve a health information trustee of any duty or liability under this subtitle.

(b) AUTHORITIES OF AFFILIATED PERSONS.—

(1) IN GENERAL.—An affiliated person may only exercise an authority under this subtitle that the health information trustee with whom the person is affiliated may exercise and that the person has been given by the trustee pursuant to an agreement or relationship described in section 9200(c)(1)(C). With respect to any such authority, the person shall be considered a health information trustee for purposes of this subtitle. The person shall be subject to part 5 (relating to enforcement) with respect to any act that exceeds such authority.

(2) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not affect the authority of a health information trustee under this subtitle.

SEC. 9255. AGENTS AND ATTORNEYS.

(a) IN GENERAL.—Except as provided in subsections (b) and (c), a person who is authorized by law (on grounds other than an individual's minority), or by an instrument recognized under law, to act as an agent, attorney, proxy, or other legal representative for a protected individual or the estate of a protected individual, or otherwise to exercise the rights of the individual or estate, may, to the extent authorized, exercise and discharge the rights of the individual or estate under this subtitle.

(b) HEALTH CARE POWER OF ATTORNEY.—A person who is authorized by law (on grounds other than an individual's minority), or by an instrument recognized under law, to make decisions about the provision of health care to an individual who is incapacitated may exercise and discharge the rights of the individual under this subtitle to the extent necessary to effectuate the terms or purposes of the grant of authority.

(c) NO COURT DECLARATION.—If a health care provider determines that an individual, who has not been declared to be legally incompetent, suffers from a medical condition that prevents the individual from acting knowingly or effectively on the individual's own behalf, the right of the individual to authorize disclosure under section 9222 may be exercised and discharged in the best interest of the individual by—

(1) a person described in subsection (b) with respect to the individual;

(2) a person described in subsection (a) with respect to the individual, but only if a person described in paragraph (1) cannot be contacted after a reasonable effort;

(3) the next of kin of the individual, but only if a person described in paragraph (1) or (2) cannot be contacted after a reasonable effort; or

(4) the health care provider, but only if a person described in paragraph (1), (2), or (3) cannot be contacted after a reasonable effort.

SEC. 9256. MINORS.

(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

(1) who is 18 years of age or older, all rights of the individual shall be exercised by the individual, except as provided in section 9255; or

(2) who, acting alone, has the legal capacity under State law to apply for and obtain health care and has sought such care, the individual shall exercise all rights of an individual under this subtitle with respect to protected health information relating to such care.

(b) INDIVIDUALS UNDER 18.—Except as provided in subsection (a)(2), in the case of an individual who is—

(1) under 14 years of age, all the individual's rights under this subtitle shall be exercised through the parent or legal guardian of the individual; or

(2) 14, 15, 16, or 17 years of age, the right of inspection (under section 9201), the right of amendment (under section 9202), and the right to authorize disclosure of protected health information (under section 9222) of the individual may be exercised either by the individual or by the parent or legal guardian of the individual.

SEC. 9257. MAINTENANCE OF CERTAIN PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—The Secretary shall establish a process under which the protected health information described in subsection (b) that is maintained by a person described in subsection (c) is delivered to, and maintained by, an individual or entity designated by the Secretary (which may include a State).

(b) INFORMATION DESCRIBED.—The protected health information referred to in subsection (a) is protected health information that—

(1) is recorded in any form or medium;

(2) is created by—

(A) a health care provider; or

(B) a health plan sponsor that provides health benefits in the form of items and services to enrollees and not in the form of reimbursement for items and services; and

(3) relates in any way to the past, present, or future physical or mental health or condition or functional status of a protected individual or the provision of health care to a protected individual.

(c) PERSONS DESCRIBED.—A person referred to in subsection (a) is any of the following:

(A) A health care facility that has closed.

(B) A professional practice operated by a health care provider that has closed.

(C) A health plan sponsor that—

(i) previously provided health benefits in the form of items and services to enrollees; and

(ii) has ceased to do business.

PART 5—ENFORCEMENT

SEC. 9261. CIVIL ACTIONS.

(a) IN GENERAL.—Any individual whose right under this subtitle has been knowingly or negligently violated—

(1) by a health information trustee, or any other person, who is not described in paragraph (2), (3), (4), or (5) may maintain a civil action for actual damages and for equitable relief against the health information trustee or other person;

(2) by an officer or employee of the United States while the officer or employee was acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the United States;

(3) by an officer or employee of any government authority of a State that has waived its sovereign immunity to a claim for damages resulting from a violation of this subtitle while the officer or employee was acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the State government;

(4) by an officer or employee of a government of a State that is not described in paragraph (3) may maintain a civil action for actual damages and for equitable relief against the officer or employee; or

(5) by an officer or employee of a government authority while the officer or employee

was not acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the officer or employee.

(b) KNOWING VIOLATIONS.—Any individual entitled to recover actual damages under this section because of a knowing violation of a provision of this subtitle (other than subsection (c) or (d) of section 9221) shall be entitled to recover the amount of the actual damages demonstrated or $5000, whichever is greater.

(c) ACTUAL DAMAGES.—For purposes of this section, the term "actual damages" includes damages paid to compensate an individual for nonpecuniary losses such as physical and mental injury as well as damages paid to compensate for pecuniary losses.

(d) PUNITIVE DAMAGES; ATTORNEY'S FEES.—In any action brought under this section in which the complainant has prevailed because of a knowing violation of a provision of this subtitle (other than subsection (c) or (d) of section 9221), the court may, in addition to any relief awarded under subsections (a) and (b), award such punitive damages as may be warranted. In such an action, the court, in its discretion, may allow the prevailing party a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

(e) LIMITATION.—A civil action under this section may not be commenced more than 2 years after the date on which the aggrieved individual discovered the violation or the date on which the aggrieved individual had a reasonable opportunity to discover the violation, whichever occurs first.

(f) INSPECTION AND AMENDMENT.—If a health information trustee has established a formal internal procedure that allows an individual who has been denied inspection or amendment of protected health information to appeal the denial, the individual may not maintain a civil action in connection with the denial until the earlier of—

(1) the date the appeal procedure has been exhausted; or

(2) the date that is 4 months after the date on which the appeal procedure was initiated.

(g) NO LIABILITY FOR PERMISSIBLE DISCLOSURES.—A health information trustee who makes a disclosure of protected health information about a protected individual that is permitted by this subtitle and not otherwise prohibited by State or Federal statute shall not be liable to the individual for the disclosure under common law.

(h) NO LIABILITY FOR INSTITUTIONAL REVIEW BOARD DETERMINATIONS.—If the members of a certified institutional review board have in good faith determined that an approved health research project is of sufficient importance so as to outweigh the intrusion into the privacy of an individual pursuant to section 9226(a)(1), the members, the board, and the parent institution of the board shall not be liable to the individual as a result of such determination.

(i) GOOD FAITH RELIANCE ON CERTIFICATION.—A health information trustee who relies in good faith on a certification by a government authority or other person and discloses protected health information about an individual in accordance with this subtitle shall not be liable to the individual for such disclosure.

SEC. 9262. CIVIL MONEY PENALTIES.

(a) VIOLATION.—Any health information trustee who the Secretary determines has demonstrated a pattern or practice of failure to comply with the provisions of this subtitle shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such failure. In determining the amount of any penalty to be assessed under the procedures established under subsection (b), the Secretary shall take into account the previous record of compliance of the person being assessed with the applicable requirements of this subtitle and the gravity of the violation.

(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A of such Act.

SEC. 9263. ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—Not later than July 1, 1996, the Secretary shall, by regulation, develop alternative dispute resolution methods for use by individuals, health information trustees, and other persons in resolving claims under section 9261. Such regulations may not require an individual to pursue an alternative dispute resolution method.

(b) SUSPENSION OF STATUTE OF LIMITATIONS.—The regulations established by the Secretary under subsection (a) may provide that a period in which an individual who alleges that a right of the individual under this subtitle has been violated pursues (as defined by the Secretary) an alternative dispute resolution method under this section shall be excluded in computing the period of limitations under section 9261(e).

(c) METHODS.—The methods under subsection (a) shall include at least the following:

(1) ARBITRATION.—The use of arbitration.

(2) MEDIATION.—The use of mediation.

(3) EARLY OFFERS OF SETTLEMENT.—The use of a process under which parties make early offers of settlement.

(d) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under subsection (a), the Secretary shall ensure that the methods promote the resolution of claims in a manner that—

(1) is affordable for the parties involved;

(2) provides for timely and fair resolution of claims; and

(3) provides for reasonably convenient access to dispute resolution for individuals.

SEC. 9264. AMENDMENTS TO CRIMINAL LAW.

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 89 the following:

"CHAPTER 90—PROTECTED HEALTH INFORMATION

"Sec.
"1831. Definitions.
"1832. Obtaining protected health information under false pretenses.
"1833. Monetary gain from obtaining protected health information under false pretenses.
"1834. Knowing and unlawful obtaining of protected health information.
"1835. Monetary gain from knowing and unlawful obtaining of protected health information.
"1836. Knowing and unlawful use or disclosure of protected health information.
"1837. Monetary gain from knowing and unlawful sale, transfer, or use of protected health information.

"§ 1831. Definitions

"As used in this chapter—

"(1) the term 'health information trustee' has the meaning given such term in section 9200(b)(6) of the Guaranteed Health Insurance Act of 1994;

"(2) the term 'protected health information' has the meaning given such term in section 9200(a)(3) of such Act; and

"(3) the term 'protected individual' has the meaning given such term in section 9200(a)(4) of such Act.

"§ 1832. Obtaining protected health information under false pretenses

"Whoever under false pretenses—

"(1) requests or obtains protected health information from a health information trustee; or

"(2) obtains from a protected individual an authorization for the disclosure of protected health information about the individual maintained by a health information trustee; shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1833. Monetary gain from obtaining protected health information under false pretenses

"Whoever under false pretenses—

"(1) requests or obtains protected health information from a health information trustee with the intent to sell, transfer, or use such information for profit or monetary gain; or

"(2) obtains from a protected individual an authorization for the disclosure of protected health information about the individual maintained by a health information trustee with the intent to sell, transfer, or use such authorization for profit or monetary gain;

and knowingly sells, transfers, or uses such information or authorization for profit or monetary gain shall be fined under this title or imprisoned not more than 10 years, or both.

"§ 1834. Knowing and unlawful obtaining of protected health information

"Whoever knowingly obtains protected health information from a health information trustee in violation of subtitle C of title IX of the Guaranteed Health Insurance Act of 1994, knowing that such obtaining is unlawful, shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1835. Monetary gain from knowing and unlawful obtaining of protected health information

"Whoever knowingly—

"(1) obtains protected health information from a health information trustee in violation of subtitle C of title IX of the Guaranteed Health Insurance Act of 1994, knowing that such obtaining is unlawful and with the intent to sell, transfer, or use such information for profit or monetary gain; and

"(2) knowingly sells, transfers, or uses such information for profit or monetary gain;

shall be fined under this title or imprisoned not more than 10 years, or both.

"§ 1836. Knowing and unlawful use or disclosure of protected health information

"Whoever knowingly uses or discloses protected health information in violation of subtitle C of title IX of the Guaranteed Health Insurance Act of 1994, knowing that such use or disclosure is unlawful, shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1837. Monetary gain from knowing and unlawful sale, transfer, or use of protected health information

"Whoever knowingly sells, transfers, or uses protected health information in violation of subtitle C of title IX of the Guaranteed Health Insurance Act of 1994, knowing that such sale, transfer, or use is unlawful, shall be fined under this title or imprisoned not more than 10 years, or both.".

(b) CLERICAL AMENDMENT.—The table of chapters for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 89 the following:

"90. Protected health information ...... 1831".

PART 6—AMENDMENTS TO TITLE 5, UNITED STATES CODE

SEC. 9271. AMENDMENTS TO TITLE 5, UNITED STATES CODE.

(a) NEW SUBSECTION.—Section 552a of title 5, United States Code, is amended by adding at the end the following:

"(w) MEDICAL EXEMPTIONS.—The head of an agency that is a health information trustee (as defined in section 9200(b)(6) of the Guaranteed Health Insurance Act of 1994) shall promulgate rules, in accordance with the requirements (including general notice) of subsections (b)(1), (b)(2), (b)(3), (c), and (e) of section 553 of this title, to exempt a system of records within the agency, to the extent that the system of records contains protected health information (as defined in section 9200(a)(3) of such Act), from all provisions of this section except subsections (e)(1), (e)(2), subparagraphs (A) through (C) and (E) through (I) of subsection (e)(4), and subsections (e)(5), (e)(6), (e)(9), (e)(12), (l), (n), (o), (p), (q), (r), and (u).".

(b) REPEAL.—Section 552a(f)(3) of title 5, United States Code, is amended by striking "pertaining to him," and all that follows through the semicolon and inserting "pertaining to the individual;".

PART 7—REGULATIONS, RESEARCH, AND EDUCATION; EFFECTIVE DATES; APPLICABILITY; AND RELATIONSHIP TO OTHER LAWS

SEC. 9281. REGULATIONS; RESEARCH AND EDUCATION.

(a) REGULATIONS.—Not later than July 1, 1996, the Secretary shall prescribe regulations to carry out this subtitle.

(b) RESEARCH AND TECHNICAL SUPPORT.—The Secretary may sponsor—

(1) research relating to the privacy and security of protected health information;

(2) the development of consent forms governing disclosure of such information; and

(3) the development of technology to implement standards regarding such information.

(c) EDUCATION.—The Secretary shall establish education and awareness programs—

(1) to foster adequate security practices by health information trustees;

(2) to train personnel of health information trustees respecting the duties of such personnel with respect to protected health information; and

(3) to inform individuals and employers who purchase health care respecting their rights with respect to such information.

SEC. 9282. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this subtitle, and the amendments made by this subtitle, shall take effect on January 1, 1997.

(b) PROVISIONS EFFECTIVE IMMEDIATELY.—A provision of this subtitle shall take effect on the date of the enactment of this Act if the provision—

(1) imposes a duty on the Secretary to develop, establish, or promulgate regulations, guidelines, notices, statements, or education and awareness programs;

(2) authorizes the Secretary to sponsor research or the development of forms or technology; or

(3) defines a term.

SEC. 9283. APPLICABILITY.

(a) PROTECTED HEALTH INFORMATION.—Except as provided in subsections (b) and (c), the provisions of this subtitle shall apply to any protected health information that is received, created, used, maintained, or disclosed by a health information trustee in a State on or after January 1, 1997, regardless of whether the information existed or was disclosed prior to such date.

(b) EXCEPTION.—

(1) IN GENERAL.—The provisions of this subtitle shall not apply to a trustee described in paragraph (2), except with respect to protected health information that is received by the trustee on or after January 1, 1997. With respect to protected health information that is received by such a trustee before such date, other applicable law shall continue to apply.

(2) APPLICABILITY.—A trustee referred to in paragraph (1) is—

(A) a health researcher; or

(B) a person who, with respect to specific protected health information, received the information—

(i) pursuant to—

(I) section 9227 (relating to emergency circumstances);

(II) section 9228 (relating to judicial and administrative purposes);

(III) section 9229 (relating to law enforcement); or

(IV) section 9230 (relating to subpoenas, warrants, and search warrants); or

(ii) while acting in whole or in part in the capacity of an officer or employee of a person described in clause (i).

(c) AUTHORIZATIONS FOR DISCLOSURES.—An authorization for the disclosure of protected health information about a protected individual that is executed by the individual before January 1, 1997, and is recognized and valid under State law on December 31, 1996, shall remain valid and shall not be subject to the requirements of section 9222 until January 1, 1998, or the occurrence of the date or event (if any) specified in the authorization upon which the authorization expires, whichever occurs earlier.

SEC. 9284. RELATIONSHIP TO OTHER LAWS.

(a) STATE LAW.—Except as otherwise provided in subsections (b), (c), (d), and (f), a State may not establish, continue in effect, or enforce any State law to the extent that the law is inconsistent with, or imposes additional requirements with respect to, any of the following:

(1) A duty of a health information trustee under this subtitle.

(2) A provision of part 3 (relating to access procedures and challenge rights) or part 4 (miscellaneous provisions).

(b) LAWS RELATING TO AUTHORIZED DISCLOSURES.—This part does not preempt, supersede, or modify the operation of any State law to the extent that the law prohibits or regulates a disclosure of protected health information that is authorized under this part.

(c) CRIMINAL PENALTIES.—A State may establish and enforce criminal penalties with respect to a failure to comply with a provision of this part.

(d) PRIVILEGES.—A privilege that a person has under law in a court of a State or the United States or under the rules of any agency of a State or the United States may not be diminished, waived, or otherwise affected by—

(1) the execution by a protected individual of an authorization for disclosure of protected health information under this part, if the authorization is executed for the purpose of receiving health care or providing for the payment for health care; or

(2) any provision of this part that authorizes the disclosure of protected health information for the purpose of receiving health care or providing for the payment for health care.

(e) DEPARTMENT OF VETERANS AFFAIRS.—The limitations on use and disclosure of protected health information under this part shall not be construed to prevent any exchange of such information within and among components of the Department of Veterans Affairs that determine eligibility for or entitlement to, or that provide, benefits under laws administered by the Secretary of Veterans Affairs.

(f) CERTAIN DUTIES UNDER STATE OR FEDERAL LAW.—This part shall not be construed to preempt, supersede, or modify the operation of any of the following:

(1) Any law that provides for the reporting of vital statistics such as birth or death information.

(2) Any law requiring the reporting of abuse or neglect information about any individual.

(3) Subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications of emergency response employees of possible exposure to infectious diseases).

(4) The Americans with Disabilities Act of 1990.

(5) Any Federal or State statute that establishes a privilege for records used in health professional peer review activities.

(g) SECRETARIAL AUTHORITY.—

(1) SECRETARY OF HEALTH AND HUMAN SERVICES.—A provision of this part does not preempt, supersede, or modify the operation of section 543 of the Public Health Service Act, except to the extent that the Secretary of Health and Human Services determines through regulations promulgated by such Secretary that the provision provides greater protection for protected health information, and the rights of protected individuals, than is provided under such section 543.

(2) SECRETARY OF VETERANS AFFAIRS.—A provision of this part does not preempt, supersede, or modify the operation of section 7332 of title 38, United States Code, except to the extent that the Secretary of Veterans Affairs determines through regulations promulgated by such Secretary that the provision provides greater protection for protected health information, and the rights of protected individuals, than is provided under such section 7332.

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SEC. 9300. DEFINITIONS.

For purposes of this subtitle—

(1) CERTIFIED HEALTH BENEFIT PLAN.—The term "certified health benefit plan" means—

(A) a health benefit plan (as defined in section 5504(3)) provided or sponsored by a private person (regardless of whether enrollment in such plan is facilitated by a purchasing cooperative or governmental program);

(B) a health benefit plan established or maintained by the government of a State or political subdivision thereof, or by any agency or instrumentality of such a government, for its employees; and

(C) a long-term care insurance policy (as defined in section 10111).

(2) CERTIFIED HEALTH BENEFIT PLAN SPONSOR.—The term "certified health benefit plan sponsor" has the meaning given the term "sponsor" in section 5504(13) in relation to a certified health benefit plan.

(3) DISABILITY.—The term "disability" has the meaning given such term in section 3(2) of the Americans with Disabilities Act of 1990.

(4) HEALTH PROVIDER.—The term "health provider" has the meaning given such term in section 9109(7).

(5) NETWORK PROVIDER.—The term "network provider" has the meaning given such term in section 9109(8).

(6) PLAN NETWORK.—The term "plan network" has the meaning given such term in section 9109(9).

(7) THIRD PARTY CONTRACTOR.—The term "third party contractor" means, in connection with a certified health benefit plan, any person (other than a certified health benefit plan sponsor with respect to the plan) who—

(A) administers or processes payments made under the plan pursuant to requests for payment for items and services but is not the provider of the items and services, or

(B) carries out any other duty of the certified health benefit plan sponsor under a direct or indirect contractual arrangement with the certified health benefit plan sponsor, other than providing the items and services.

PART 1—GRIEVANCE AND APPEALS PROCESS

Subpart A—Review of Refusals of Items and Services and Denials of Payment To Providers and Individuals

SEC. 9301. DETERMINATIONS BY CERTIFIED HEALTH BENEFIT PLAN SPONSORS PROVIDING ITEMS AND SERVICES.

(a) APPLICABILITY.—This section applies in the case of a certified health benefit plan to the extent it provides benefits in the form of items and services.

(b) EXPLANATION OF REASONS FOR CERTAIN REFUSALS OF ITEMS OR SERVICES.—

(1) IN GENERAL.—A certified health benefit plan sponsor shall provide any individual who is refused an item or service under the certified health benefit plan a written explanation for such refusal within three business days after a request for such explanation is made by or on behalf of the individual. Such explanation shall set forth the specific reasons for the refusal and shall meet the requirements of section 9303(a). For purposes of this section, a refusal to provide an item or service at the time requested shall be treated as a refusal of a request for the item or service. For treatment in the complaint review office of refusals involving urgent requests for items and services, see section 9306(b)(4).

(2) EXPLANATION WITH RESPECT TO CERTAIN REFUSALS.—

(A) NOT COVERED UNDER COMPREHENSIVE BENEFIT PACKAGE.—If the refusal by a certified health benefit plan sponsor of an item or service is based in whole or in part on a determination that the item or service is not covered by the comprehensive benefit package, the explanation required under paragraph (1) shall include the specific factual basis for the individual determination.

(B) EXPERIMENTAL TREATMENTS OR INVESTIGATIVE PROCEDURES.—If the refusal by a certified health benefit plan sponsor of an item or service is based in whole or in part on exclusion of coverage with respect to a service because the service is determined to comprise an experimental treatment or investigatory procedure, the explanation required under paragraph (1) shall include the medical basis for the determination and a description of the process used in making the determination.

(C) INCONSISTENCY WITH PRACTICE GUIDELINES.—If the refusal by a certified health benefit plan sponsor of an item or service is based in whole or in part on a determination that a particular treatment is not medically necessary or appropriate or is inconsistent with the plan's practice guidelines, the explanation required under paragraph (1) shall include the medical basis for the determination, the guidelines used in making the determination, the basis for such guidelines, and a description of the process used in making the determination.

(c) REQUIREMENTS RELATING TO TERMINATED OR REDUCED ITEMS OR SERVICES.—

(1) WRITTEN EXPLANATION.—A certified health benefit plan sponsor shall provide to any individual a written explanation for any intended action that would result in termination or reduction of any item or service which has been provided in a course of treatment for such individual. Such explanation shall be provided not less than one business day before the action is to be taken by the certified health benefit plan sponsor. The written explanation shall set forth the specific reasons for such action and shall meet the requirements of section 9303(a). Subsection (b)(2) shall apply with respect to such written explanation.

(2) INTERIM RELIEF IN URGENT CASES IN COMPLAINT REVIEW OFFICE.—

(A) IN GENERAL.—Upon the filing of a complaint with the appropriate complaint review office under section 9304 with respect to any proposed action described in a written explanation received pursuant to paragraph (1), together with an attestation described in subparagraph (B), the item or service proposed to be terminated or reduced shall be continued until an initial decision on the complaint is made by the complaint review office.

(B) ATTESTATION.—An attestation described in this paragraph is an attestation, with respect to the individual on whose behalf the complaint is made—

(i) that failure to immediately provide the item or service could reasonably be expected to result in—

(I) placing the health of such individual (or, with respect to such an individual who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(II) serious impairment to bodily functions, or

(III) serious dysfunction of any bodily organ or part,

or

(ii) that immediate provision of the item or service is necessary because such individual has made or is at serious risk of making an attempt to harm himself or herself or another individual.

(d) FAILURE TO MEET REQUIREMENTS ESTABLISHING RIGHT TO FILE COMPLAINT.—A refusal described in subsection (b)(1), a reduction or termination described in subsection (c), or a failure by a certified health benefit plan sponsor to comply with any requirement of this section with respect to any individual shall establish a right for the aggrieved individual to file a complaint with the complaint review office under section 9304.

SEC. 9302. DETERMINATIONS BY CERTIFIED HEALTH BENEFIT PLAN SPONSORS PROVIDING BENEFITS IN THE FORM OF PAYMENTS TO HEALTH PROVIDERS OR INDIVIDUALS FOR ITEMS AND SERVICES.

(a) APPLICABILITY.—This section applies in the case of a certified health benefit plan to the extent it provides benefits in the form of payments to health providers or individuals for items and services.

(b) TREATMENT OF REQUESTS FOR PAYMENTS FOR ITEMS AND SERVICES.—

(1) NOTICE REQUIREMENTS AND TIME LIMITS.—

(A) IN GENERAL.—In the case of a request presented to a certified health benefit plan sponsor by a health provider or individual for payment for any item or service provided to an individual, the certified health benefit plan sponsor shall provide to the health provider or individual a written notice of any denial, in whole or in part, of the payment within 20 business days after the date on which the request is presented in writing to the certified health benefit plan sponsor. Failure by any certified health benefit plan sponsor to respond to any such request within such period of 20 business days shall be treated as a final determination by the certified health benefit plan sponsor to deny the request.

(B) MATTERS TO BE INCLUDED IN NOTICE.—Such notice shall include a written explanation for such denial which sets forth the specific reasons therefor and which meets the requirements of section 9303(a).

(2) EXPLANATION WITH RESPECT TO CERTAIN DENIALS.—

(A) NOT COVERED UNDER COMPREHENSIVE BENEFIT PACKAGE.—If the denial by a certified health benefit plan sponsor of payment to a health provider or individual for an item or service is based in whole or in part on a determination that the item or service is not covered by the comprehensive benefit package, exceeds the maximum payment rate, if any, applicable to the class of service under title VI, or exceeds payment rates under any applicable fee schedule, the explanation required under paragraph (1) shall include the specific factual basis for the individual determination.

(B) Experimental Treatments or Investigative Procedures.—If the denial by a certified health benefit plan sponsor of payment to a health provider or individual for an item or service is based in whole or in part on exclusion of coverage with respect to a service because the service is determined to comprise an experimental treatment or investigatory procedure, the explanation required under paragraph (1) shall include the medical basis for the determination and a description of the process used in making the determination.

(C) Inconsistency With Practice Guidelines.—If the denial by a certified health benefit plan sponsor of payment to a health provider or individual for an item or service is based in whole or in part on a determination that a particular treatment is not medically necessary or appropriate or is inconsistent with the plan's practice guidelines, the explanation required under paragraph (1) shall include the medical basis for the determination, the guidelines used in making the determination, the basis for such guidelines, and a description of the process used in making the determination.

(c) Treatment of Requests by Health Providers or Individuals for Preauthorization of Payment for Items and Services.—

(1) In general.—Except as otherwise provided in this subsection, subsection (e)(1), and section 9306(b)(4), any request by a health provider or an individual for preauthorization of payment for any item or service under a certified health benefit plan shall be treated in the same manner as a request for payment for an item or service under subsection (b). In applying subsection (b)(1)(A) to such a request, each reference therein to "20 business days" shall be deemed a reference to "10 business days".

(2) Treatment of Urgent Requests for Preauthorization.—

(A) Applicability.—This paragraph applies to any request for preauthorization of an item or service (other than an emergency service which may not be subject to preauthorization) which is accompanied by an attestation, with respect to the individual on whose behalf the request is made—

(i) that failure to immediately provide the item or service could reasonably be expected to result in—

(I) placing the health of such individual (or, with respect to such an individual who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(II) serious impairment to bodily functions, or

(III) serious dysfunction of any bodily organ or part,

or

(ii) that immediate provision of the item or service is necessary because such individual has made or is at serious risk of making an attempt to harm himself or herself or another individual.

(B) Shortened Time Limit for Consideration of Urgent Requests for Preauthorization.—A certified health benefit plan sponsor shall approve or deny any request described in subparagraph (A) within 24 hours after the request is presented to the certified health benefit plan sponsor. Failure to comply with the requirements of this paragraph shall be treated as a final determination by the certified health benefit plan sponsor to deny the request.

(3) Denial of Previously Authorized Claims Not Permitted.—In any case in which a certified health benefit plan sponsor approves a request for preauthorization of payment for any item or service submitted by a health provider or individual pursuant to this section, the certified health benefit plan sponsor may not subsequently deny payment for such item or service, unless the certified health benefit plan sponsor makes a showing of an intentional misrepresentation of a material fact by the person making the request.

(d) Treatment of Requests to Certified Health Benefit Plan Sponsors for Continuation or Restoration of Terminated or Reduced Payment for Items or Services.—

(1) In general.—A certified health benefit plan sponsor shall provide to a health provider or individual a written explanation for any intended action that would result in termination or reduction of payment to such health provider or individual for any item or service which has been provided in the course of treatment. Such explanation shall be provided not less than one business day before the certified health benefit plan sponsor intends to take such action, shall set forth the specific reasons for such action, and shall meet the requirements of section 9303(a). Subsection (b)(2) shall apply with respect to such explanation.

(2) Interim Relief in Complaint Review Office of Urgent Requests for Continuation of Payment for Items and Services.—Upon the filing of a complaint with the appropriate complaint review office under section 9304 with respect to any proposed action described in a written explanation received pursuant to paragraph (1), accompanied by an attestation meeting the requirements of subsection (c)(2), the payment for the items and services which is proposed to be terminated or reduced shall be continued until an initial decision on the complaint is made by the complaint review office under section 9306(b)(4).

(e) Time Limit for Determination of Incompleteness of Requests for Payment.—For purposes of this section—

(1) Any urgent request referred to in subsection (c)(2) shall be treated as submitted in complete form.

(2) Any other request referred to in subsection (b), (c), or (d) and any other written request by a health provider or individual to the certified health benefit plan sponsor regarding payment for an item or service provided thereunder shall be treated as filed in complete form as of 10 business days after the date of the submission thereof, unless the certified health benefit plan sponsor provides to the health provider or individual, within such period, a written explanation of any required matter remaining to be filed in order to complete the presentation of the request. Such explanation shall meet the requirements of section 9303(a).

(f) Failure to Meet Requirements Establishing Right to File Complaint.—A denial in whole or in part by a plan of a request for payment described in subsection (b), (c), or (d) or a failure by a certified health benefit plan sponsor to comply with any requirement of this section with respect to any individual shall establish a right for such individual to file a complaint with the complaint review office under section 9304.

SEC. 9303. NOTICES; WAIVER OF RIGHTS PROHIBITED.

(a) Notice Requirements.—Each written notice or explanation required under section 9301 or 9302 shall include—

(1) the address and telephone number of the Consumer Health Advocacy Office (established pursuant to part O of title III of the Public Health Service Act, as added by title VII) serving the community-rating area in which the recipient of the notice or explanation resides or (in the case of a health provider) provides health care and the services available from such Office, and

(2) an explanation of the right of aggrieved individuals and health providers to obtain review of grievances against the certified health benefit plan sponsor in the complaint review office for the applicable community-rating area under section 9304.

Any such notice or explanation shall be written in language calculated to be understood by the average individual enrolled under the plan and shall be provided in a form which takes into account accessibility to the information by individuals whose primary language is not English and shall be provided in a manner consistent with the applicable requirements of the Americans with Disabilities Act of 1990.

(b) Waiver of Rights Prohibited.—A certified health benefit plan sponsor may not require any party to waive any right under the plan or Federal or State law, except to the extent otherwise specified in a settlement agreement under section 9319 or in a settlement agreement obtained with representation of such party by an attorney.

SEC. 9304. REVIEW OF GRIEVANCES BASED ON ACTS OR PRACTICES BY CERTIFIED HEALTH BENEFIT PLAN SPONSORS.

(a) Filings of Complaints by Aggrieved Persons.—Each State shall establish a complaint review office for each community-rating area, unless such area is adequately served by another complaint review office established by the State. Any person may, pursuant to section 9301(d) or section 9302(f), file with the complaint review office a complaint against the certified health benefit plan sponsor (or a third party contractor with respect to a certified health benefit plan) not later than three years after the alleged violation occurs.

(b) Notice of Filing.—The complaint review office shall serve by certified mail a copy of the complaint (including the date, place, and circumstances of the alleged violation) to the person or persons against whom the complaint is made within 10 days after the filing of the complaint.

SEC. 9305. INITIAL PROCEEDINGS IN COMPLAINT REVIEW OFFICES.

(a) Elections.—Whenever a complaint is brought to a complaint review office under section 9304, the complaint review office shall provide the complainant with an opportunity, in such form and manner as shall be prescribed in regulations of the Secretary, to elect one of the following:

(1) to submit the complaint as a dispute under the Early Resolution Program, if established pursuant to part 2,

(2) to proceed with the complaint to a hearing in the complaint review office under section 9306, or

(3) to forego further proceedings in the complaint review office and rely on remedies available in a court of competent jurisdiction, including remedies under section 9321.

(b) Effect of Participation in Early Resolution Program.—If the complainant makes an election to submit the complaint as a dispute under the Early Resolution Program under subsection (a)(1) and the proceedings under the Program with respect to the dispute are terminated without settlement or resolution of the dispute with respect to such matter, the complainant may proceed to an election under subsection (a)(2) or (a)(3).

SEC. 9306. HEARINGS BEFORE HEARING OFFICERS IN COMPLAINT REVIEW OFFICES.

(a) ASSIGNMENT OF COMPLAINTS TO HEARING OFFICERS AND NOTICE TO PARTIES.—

(1) IN GENERAL.—In the case of an election under section 9305(a)(2) the complaint review office shall assign the complaint to a hearing officer employed by the State in the office who shall conduct a hearing on the compliant under this section.

(2) QUALIFICATIONS FOR HEARING OFFICERS.—The hearing officer shall be qualified and shall not have any official, financial, or personal conflict of interest.

(b) HEARINGS.—

(1) DE NOVO HEARING.—Hearings under this section shall be de novo. In any such hearing, the hearing officer shall provide for—

(A) full review of the applicable law and facts,

(B) no deference to factual findings, legal findings, or plan interpretations of the decisionmaker below, and

(C) admission of any new evidence and new witnesses provided by all parties to the extent relevant to any issue being considered.

(2) RECORDED TESTIMONY.—The testimony taken by the hearing officer shall be recorded.

(3) AUTHORITY OF HEARING OFFICERS.—The hearing officer may compel, by subpoena, the attendance of witnesses and the production of evidence at any designated place or hearing. In case of contumacy or refusal to obey a subpoena lawfully issued under this paragraph and upon application of the hearing officer, the hearing officer may seek enforcement of the subpoena in an appropriate district court of the United States or in a State court of competent jurisdiction.

(4) EXPEDITED HEARINGS.—Notwithstanding section 9025 and the preceding provisions of this section, upon receipt of a complaint relating to a refusal or denial referred to in section 9301 or 9302 which is accompanied by an attestation equivalent to the attestation described in section 9301(c)(2)(B) or 9302(c)(2)(A), the complaint review office shall promptly provide the complainant with the opportunity to make an election under section 9305(a)(2) and assignment to a hearing on the complaint before a hearing officer. The complaint review office shall ensure that such a hearing commences not later than 24 hours after receipt of the complaint by the complaint hearing office and that the hearing is completed and the decision is rendered within three business days after the date on which the complaint is received.

(c) DECISION OF HEARING OFFICER.—

(1) IN GENERAL.—Within 60 days after the close of the hearing, the hearing officer shall make a decision with respect to each allegation in the complaint. The hearing officer shall decide the extent to which any party against whom the complaint is brought has acted or failed to act in violation of the terms of the certified health benefit plan or Federal or State law. Each such decision—

(A) shall be supported by substantial evidence on the record considered as a whole,

(B) shall include the hearing officer's findings of fact, and

(C) shall constitute the hearing officer's final disposition of the proceedings.

The burden of proof shall be on the party against whom the complaint is filed.

(2) DECISIONS FINDING IN FAVOR OF COMPLAINANT.—If the hearing officer rules in favor of the complainant—

(A) the hearing officer may order the party against whom the complaint is brought, as a remedy for such violation—

(i) to cease and desist from such violation,

(ii) to provide items and services under the plan, or payment requested, and to otherwise comply with the terms of the plan and the applicable requirements of Federal and State law,

(iii) to pay to the complainant actual and compensatory damages, except punitive damages, and

(iv) to pay to the complainant prejudgment interest on the actual costs incurred in obtaining the items and services, or payment therefor, at issue in the complaint, and

(B) if the complainant substantially prevails, the hearing officer shall award the complainant reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(3) FINALITY OF DECISION.—The decision of the hearing officer shall be final, unless review is sought under subsection (d).

(d) REVIEW.—

(1) IN GENERAL.—Any party to the complaint may, within 60 days after service of the decision by the complaint review office, seek review of the decision in a court of competent jurisdiction. In any such proceeding in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(2) SCOPE OF REVIEW.—The court shall set aside or modify the decision of the hearing officer if—

(A) the decision is not supported by substantial evidence on the record considered as a whole,

(B) in the case of any interpretation by the hearing officer of contractual terms (irrespective of the extent to which extrinsic evidence was considered), the determination is not supported by a preponderance of the evidence, or

(C) the decision is in excess of jurisdiction, without observance any procedure required by law, in violation of a statutory or constitutional right, or otherwise contrary to law.

(e) COURT ENFORCEMENT OF ORDERS.—If the complainant prevails and the order is not appealed, the complainant may petition any court of competent jurisdiction for enforcement of the order.

SEC. 9307. COORDINATION WITH OTHER PROVISIONS OF LAW.

Nothing under any provision of the Employee Retirement Income Security Act of 1974 or any other Federal law (other than this Act) shall be construed as limiting any right or remedy provided under this Act.

Subpart B—Early Resolution Programs

SEC. 9311. ESTABLISHMENT OF EARLY RESOLUTION PROGRAMS IN COMPLAINT REVIEW OFFICES.

(a) ESTABLISHMENT OF PROGRAMS.—Each State may establish and maintain an Early Resolution Program in each complaint review office in such State in accordance with this subpart. Any such Program shall include the establishment and maintenance of forums for mediation of disputes in accordance with this subpart.

(b) DUTIES OF COMPLAINT REVIEW OFFICES.—Each State establishing an Early Resolution Program shall—

(1) administer the Early Resolution Program in each claims review office in accordance with regulations of the Secretary,

(2) develop Program policy and procedures,

(3) maintain a roster of facilitators for each claims review office to act under the Program in mediation proceedings between parties conducted under this subpart, and coordinate the recruitment, selection, and training of such facilitators,

(4) provide meeting sites, maintain records, and provide facilitators with administrative support staff,

(5) establish and maintain attorney referral panels, and

(6) monitor and evaluate the Program on an ongoing basis.

SEC. 9312. ELIGIBILITY OF CASES FOR SUBMISSION TO EARLY RESOLUTION PROGRAM.

(a) CASE CRITERIA.—A dispute may be submitted to the Early Resolution Program only if the dispute consists of an assertion by an individual (hereinafter in this subpart referred to as the 'claimant') of—

(1) a denial or refusal by the certified health benefit plan sponsor (or a third party contractor with respect to the certified health benefit plan), contrary to the provisions of the certified health benefit plan, this Act, or State law, of one or more items or services under the plan or payment therefor, or

(2) failure or refusal by the certified health benefit plan sponsor (or a third party contractor with respect to the certified health benefit plan) to comply with the claimant's request for information or documents the disclosure of which is required under the plan, this Act, or State law (including failure or refusal to comply with any claim of entitlement to disclosure based on colorable claims to rights to benefits under the plan).

(b) REPRESENTATION.—Any claimant may be secure representation by any person.

(c) NOTICE OF PROGRAM AVAILABILITY.—Each certified health benefit plan sponsor shall ensure that, as part of review procedures established pursuant to this subpart, claimants taking part in such procedure will be informed during such procedure of the availability of the Early Resolution Program.

SEC. 9313. FACILITATORS.

(a) RECRUITMENT.—The State shall recruit individuals to serve as facilitators under the Early Resolution Program from individuals who have the requisite expertise for such service.

(b) CRITERIA.—In selecting individuals to serve as facilitators, the State shall consider the following:

(1) the individual's experience in dispute resolution;

(2) the individual's ability to act impartially;

(3) the individual's ability to perform evaluations quickly and to present them in nontechnical terms; and

(4) the individual's experience in employee benefit law and the individual's expertise pertaining to medical or disability issues;

(c) TRAINING OF FACILITATORS.—The State shall provide a training program for all new facilitators. The curriculum shall include the procedures of the Program, relevant ethical obligations, and skills in arbitration, mediation, and conciliation necessary for effective alternative dispute resolution in the applicable proceedings. A facilitator may serve only upon completion of such training program.

(d) ASSIGNMENT OF FACILITATORS TO CASES.—Upon submission of a dispute to mediation proceedings under this subpart, the State shall appoint a facilitator (as appropriate) through a random selection procedure which shall be prescribed in regulations.

(e) COMPENSATION.—Facilitators serving in the Early Resolution Program may, at their election, serve on a pro bono basis or be compensated at a fixed fee to be established by the State. Each facilitator shall receive travel expenses, including per diem in lieu of subsistence.

SEC. 9314. INITIATION OF PROCEEDINGS.

(a) FILING OF ELECTION.—A claimant with a dispute which is eligible under section 9312 for submission to the Early Resolution Program may elect to participate in proceedings under the Program by means of filing with the appropriate complaint review office an election for mediation under the Program. An election to commence mediation proceedings under the Program shall be in such form and manner as the Secretary may prescribe.

(b) AGREEMENT TO PARTICIPATE.—

(1) ELECTION BY CLAIMANTS.—A claimant may elect participation in mediation proceedings under the Program only by entering into a written agreement (including an agreement to comply with the rules of the Program and consent for the State to contact the certified health benefit plan sponsor (and any third party contractor with respect to the plan) involved regarding the agreement) and by releasing plan records to the Program for the exclusive use of the facilitator assigned to the mediation. The State may charge the claimant a filing fee of not more than $100. The State shall provide for waiver of the fee in cases of hardship, under standards which shall be prescribed by the Secretary by regulation.

(2) PARTICIPATION BY CERTIFIED HEALTH BENEFIT PLAN SPONSORS AND THIRD PARTY CONTRACTORS.—Each party whose participation in the mediation proceedings has been elected by a claimant shall participate in, and cooperate fully, in the proceedings. The complaint review office shall provide each party with a copy of the participation agreement described in paragraph (1), together with a written description of mediation under the Early Resolution Program. Each party shall submit a copy of the agreement, with the party's signature, to the complaint review office, and shall include a copy of the written record of any claims procedure completed by the plan pursuant to section 9301 or 9302 with respect to the dispute and all relevant plan documents. The State may charge each such party a filing fee of not more than $100. The relevant documents shall include all relevant medical records of the claimant and all documents under which the plan is or was administered or operated, including copies of any insurance contracts under which benefits are or were provided and any fee or reimbursement schedules for health providers requested by the facilitator.

SEC. 9315. THE MEDIATION PROCEEDINGS.

(a) IN GENERAL.—A mediation proceeding under the Early Resolution Program shall be conducted by facilitators recruited, trained, and assigned by the State under section 9313 and in accordance with fair and equitable procedures to be prescribed by the Secretary which shall be subject to the requirements of this subpart.

(b) PROCEDURAL RULES.—

(1) INAPPLICABILITY OF FORMAL RULES OF EVIDENCE.—Formal rules of evidence shall not apply to mediation proceedings under the Program. All statements made and evidence presented in the proceedings shall be admissible in such proceedings. The facilitator shall be the sole judge of the proper weight to be afforded to each submission.

(2) INAPPLICABILITY OF OATH REQUIREMENTS.—The parties to the mediation proceedings shall not be required to make statements or present evidence under oath.

(c) ANALYSIS STAGE.—In the commencement of the mediation proceedings with respect to any dispute, the facilitator assigned to the dispute shall—

(1) identify the necessary parties,

(2) confirm that the case is eligible for mediation under the Program,

(3) ensure that each party is informed of available legal representation, including such services as may be available free of charge under legal assistance programs,

(4) set a conference date,

(5) at the option of the facilitator, request position papers from the parties, if the facilitator determines that such papers are needed to clarify the parties' positions and issues in dispute, and

(6) analyze the record of any plan procedure conducted pursuant to subpart A and any position papers submitted by the parties, with appropriate legal assistance provided by the State, to determine if further case development is needed to clarify the legal and factual issues in dispute, and whether there is any need for additional information and documents, and request the parties to present any such needed information and documents.

(d) EVALUATION STAGE.—Upon completion of the procedures described in subsection (c), the mediation proceedings shall proceed as follows:

(1) COMMENCEMENT OF CONFERENCE.—The facilitator shall convene a conference between the parties. Each party shall be given the opportunity to make a statement summarizing the facts, issues, and arguments in support of such party's position, and present, or inform the facilitator of, any additional evidence such party considers to be relevant to the evaluation.

(2) NEUTRALITY OF FACILITATOR.—The facilitator shall maintain a neutral stance between the parties.

(3) PREPARATION OF SETTLEMENT AGREEMENT.—If settlement is reached, the facilitator shall assist in the preparation of a written settlement agreement (which shall remain confidential at the option of the parties) and shall ensure that the parties understand the terms of the settlement.

(4) EVALUATION UPON INITIAL FAILURE TO REACH SETTLEMENT.—If no settlement is reached, the facilitator may evaluate for the parties the likely outcome of further administrative action or litigation, based on the facilitator's assessment of the relative strength of each party's position. Any such evaluation by the facilitator shall be treated as a proceeding communication to which section 9318 applies.

(5) FURTHER PROCEEDINGS.—The facilitator shall then encourage extension of the proceedings if it is likely to lead to settlement or a substantial narrowing of the issues.

SEC. 9316. APPLICABLE TIME LIMITS.

The mediation proceedings under the Early Resolution Program with respect to any dispute shall be completed within 60 days after the date of the election to participate. The parties may agree to one extension of the proceedings of not more than 30 days.

SEC. 9317. LEGAL EFFECT OF PARTICIPATION IN PROCEEDINGS.

(a) PROCESS NONBINDING.—Findings and conclusions made in the mediation proceedings under the Early Resolution Program shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties under subpart A shall not be affected by participation in the mediation proceedings under the Program.

(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a case is settled through participation in the mediation proceedings under the Program, the facilitator shall assist the parties in drawing up an agreement which shall constitute, upon signature of the parties, a binding contract between the parties, which shall be enforceable under section 9319, and which shall be enforceable under this subpart and State law as if the terms of such agreement were terms of the plan.

(c) PRESERVATION OF RIGHTS OF NON-PARTIES.—The settlement agreement shall not have the effect of waiving or otherwise affecting any rights to review under this part, State law, or any other right under this Act, State law, or the plan with respect to any person who is not a party to the settlement agreement.

SEC. 9318. CONFIDENTIALITY.

(a) FACILITATORS.—Except as provided in subsections (d) and (e), a facilitator in a mediation proceeding under the Early Resolution Program shall not voluntarily disclose or through discovery or compulsory process be required to disclose any information concerning any proceeding communication or any communication provided in confidence to the facilitator, unless—

(1) all parties to the proceeding and the facilitator consent in writing, and, if the proceeding communication was provided by a participating nonparty, that the participating nonparty also consents in writing,

(2) the proceeding communication has already been made public,

(3) the proceeding communication is required by statute to be made public, but a facilitator may make such communication public only if no other person is reasonably available to disclose the communication, or

(4) a court determines that such testimony or disclosure is necessary to—

(A) prevent a manifest injustice,

(B) help establish a violation of law, or

(C) prevent harm to the public health or safety,

of sufficient magnitude in the particular case to outweigh the integrity of the proceedings in general by reducing the confidence of parties in future cases that their communications will remain confidential.

(b) PARTIES.—A party to a mediation proceeding under the Early Resolution Program shall not voluntarily disclose or through discovery or compulsory process be required to disclose any information concerning any proceeding communication, unless—

(1) the communication was prepared by the party seeking disclosure,

(2) all parties to the proceeding consent in writing,

(3) the proceeding communication has already been made public,

(4) the proceeding communication is required by statute to be made public,

(5) a court determines that such testimony or disclosure is necessary to—

(A) prevent a manifest injustice,

(B) help establish a violation of law, or

(C) prevent harm to the public health or safety,

of sufficient magnitude in the particular case to outweigh the integrity of the proceedings in general by reducing the confidence of parties in future cases that their communications will remain confidential,

(6) the proceeding communication is relevant to determining the existence or meaning of an agreement or award that resulted from the proceeding or to the enforcement of such an agreement or award, or

(7) the proceeding communication was provided to or was available to all parties to the proceeding.

(c) INADMISSIBILITY OF DISCLOSED INFORMATION.—Any proceeding communication that is disclosed in violation of subsection (a) or (b) shall not be admissible in any proceeding relating to the issues in controversy with respect to which the communication was made.

(d) ALTERNATIVE PROCEDURES.—The parties may agree to alternative confidential procedures for disclosures by a facilitator. Upon such agreement the parties shall inform the facilitator before the commencement of the proceeding of any modifications to the provisions of subsection (a) that will govern the confidentiality of the proceeding. If the parties do not so inform the facilitator, subsection (a) shall apply.

(e) NOTICE OF DEMANDS FOR DISCLOSURE.—If a demand for disclosure, by way of discovery request or other legal process, is made upon a facilitator regarding a proceeding communication, the facilitator shall make reasonable efforts to notify the parties and any affected participating nonparties of the demand. In any case in which such disclosure would otherwise be in violation of this section, the facilitator may perform such disclosure in accordance with such demand only if each party and affected nonparty participant who receives such notice consents to such disclosure within 15 calendar days after the date of the issuance of such notification.

(f) EXCEPTIONS.—

(1) INFORMATION OTHERWISE DISCLOSABLE.—Nothing in this section shall prevent the discovery or admissibility of any evidence that is otherwise discoverable, merely because the evidence was presented in the course of a mediation proceeding under the Early Resolution Program.

(2) DOCUMENTATION OF AGREEMENTS OR ORDERS.—Subsections (a) and (b) shall have no effect on the information and data that are necessary to document an agreement reached or order issued pursuant to a mediation proceeding under the Early Resolution Program.

(3) RESEARCH OR EDUCATIONAL PURPOSES.—Subsections (a) and (b) shall not prevent the gathering of information for research or educational purposes so long as the parties and the specific issues in controversy are not identifiable.

(4) DISPUTES BETWEEN FACILITATOR AND A PARTY.—Subsections (a) and (b) shall not prevent use of a proceeding communication to resolve a dispute between the facilitator in a mediation proceeding under the Early Resolution Program and a party to or participant in such proceeding, so long as such proceeding communication is disclosed only to the extent necessary to resolve such dispute.

(g) CIVIL REMEDIES.—

(1) CIVIL PENALTY.—The Secretary shall assess a civil penalty against any person who discloses information in violation of subsection (a) or (b) in the amount of three times the amount of the claim involved. The procedures described in section 1128A of the Social Security Act (other than subsections (a) and (b)) apply to civil money penalties under this paragraph under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A of such Act.

(2) DISQUALIFICATION FROM SERVICE.—Any facilitator who discloses information in violation of subsection (a) shall be disqualified from further service as a facilitator under this subpart.

(h) DEFINITIONS.—For purposes of this section—

(1) PROCEEDING COMMUNICATION.—The term 'proceeding communication' means any oral or written communication prepared for the purposes of a mediation proceeding under the Early Resolution Program, including any memoranda, notes, or work product of the facilitator, parties, or participating nonparties, except that such term does not include a written agreement to enter into the proceeding or a final written agreement reached as a result of the proceeding.

(2) IN CONFIDENCE.—The term 'in confidence' means, with respect to information, that the information is provided—

(A) with the expressed intent of the source that it not be disclosed, or

(B) under circumstances that would create the reasonable expectation on behalf of the source that the information will not be disclosed.

SEC. 9319. ENFORCEMENT OF SETTLEMENT AGREEMENTS.

(a) CONFIRMATION; JURISDICTION; PROCEDURE.—At any time within one year after the date of a settlement agreement entered into in mediation proceeding under the Early Resolution Program, any party to the agreement may apply to the United States district court in and for the district within which such agreement was made for an order confirming the agreement. Upon such application, the court shall grant such an order unless the agreement is vacated, modified, or corrected as prescribed in subsection (b) or (c). Notice of the application shall be served upon the adverse party. Upon such notice, the court shall have jurisdiction of such adverse party as though such adverse party had appeared generally in the proceeding. If the adverse party is a resident of the district within which the award was made, such service shall be made upon the adverse party or such party's attorney as prescribed by law for service of notice of motion in any action in the same court. If the adverse party is a nonresident, the notice of the application shall be served by the marshal of any district within which the adverse party may be found in like manner as other process of the court.

(b) VACATION; GROUNDS; REHEARING.—The court may make an order vacating the settlement agreement upon the application of any party to the agreement if—

(1) the agreement was procured under duress or by corruption, fraud, or undue means, or

(2) there was evident partiality or corruption in the facilitator who assisted in the making of the agreement.

(c) MODIFICATION OR CORRECTION; GROUNDS; ORDER.—The court may make an order modifying or correcting the settlement agreement upon the application of any party to the agreement if—

(1) there was a material miscalculation of figures or a material mistake in the description of any person, thing, or property referred to in the agreement,

(2) the agreement relates to a matter not submitted in the conference proceedings, unless it is a matter not affecting the merits of the agreement upon the matter submitted, or

(3) the agreement is imperfect in matter of form not affecting the merits of the controversy.

The order may modify and correct the agreement, so as to effect the intent thereof and promote justice between the parties.

(d) NOTICE OF MOTIONS TO VACATE OR MODIFY; SERVICE; STAY OF PROCEEDINGS.—Notice of a motion to vacate, modify, or correct a settlement agreement made in mediation proceedings under the Early Resolution Program must be served upon the adverse party or the party's attorney within 90 days after the settlement agreement is made. If the adverse party is a resident of the district within which the agreement is made, such service shall be made upon the adverse party or the party's attorney as prescribed by law for service of notice of motion in an action in the same court. If the adverse party is a nonresident, the notice of the application shall be served by the marshal of any district within which the adverse party may be found in like manner as other process of the court. For the purposes of the motion any judge who may make an order to stay the proceedings in an action brought in the same court may make an order, to be served with the notice of motion, staying the proceedings of the adverse party to enforce the agreement.

(e) PAPERS FILED WITH ORDER ON MOTIONS; JUDGMENT; DOCKETING; FORCE AND EFFECT; ENFORCEMENT.—

(1) FILING OF PAPERS.—The party moving for an order confirming, modifying, or correcting a settlement agreement made in mediation proceedings under the Early Resolution Program shall, at the time such order is filed with the clerk for the entry of judgment thereon, also file the following papers with the clerk:

(A) the agreement, and

(B) each notice, affidavit, or other paper used upon an application to confirm, modify, or correct the agreement, and a copy of each order of the court upon such an application.

(2) DOCKETING OF JUDGMENT.—The judgment shall be docketed as if it were rendered in an action.

(3) FORCE AND EFFECT; ENFORCEMENT.—The judgment so entered shall have the same force and effect, in all respects, as a judgment in an action, and shall be subject to all the provisions of law relating to such a judgment. Such judgment, including the terms of the agreement (as confirmed, modified, or corrected), may be enforced as if it had been rendered in an action in the court in which it is entered.

(f) APPEALS.—An appeal may be taken from an order confirming or denying confirmation of a settlement agreement made in mediation proceedings under the Early Resolution Program or modifying, correcting, or vacating such an agreement.

(g) ATTORNEY'S FEES AND COSTS.—In any action for court enforcement of a settlement agreement under this section in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(h) ENFORCEMENT IN STATE COURT.—Any party to a settlement agreement made in mediation proceedings under the Early Resolution Program may also apply to a State court of competent jurisdiction for an order confirming the agreement.

PART 2—GENERAL CIVIL REMEDIES

SEC. 9321. RIGHT OF ACTION AGAINST CERTIFIED HEALTH BENEFIT PLAN SPONSORS AND THIRD PARTY CONTRACTORS.

(a) IN GENERAL.—An individual or health provider who is aggrieved by an act or failure to act by a certified health benefit plan sponsor or a third party contractor in violation of the terms of a certified health benefit plan or Federal or State law may bring a civil action in a court of competent jurisdiction for the relief described in subsection (b).

(b) Relief.—In the case of any violation described in subsection (a), the certified health benefit plan sponsor, together with each third party contractor (if any) whose act or failure to act constitutes or contributes to the violation, shall be jointly and severally liable to the aggrieved individual or health provider for appropriate relief, including actual, compensatory, and punitive damages and equitable relief.

(c) Attorney's Fees and Costs.—In any action under this section in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

SEC. 9322. GENERAL PRIVATE RIGHT OF ACTION AGAINST STATES.

(a) In General.—Any person aggrieved by an act or omission of a State which constitutes a failure to comply with an applicable requirement of this Act may obtain appropriate relief from the State, including actual, compensatory, and punitive damages and equitable relief, in any court of competent jurisdiction.

(b) Exhaustion of Remedies.—In an action under subsection (a), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

(c) Attorney's Fees and Costs.—In any action under this section in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

PART 3—ANTI-DISCRIMINATION

SEC. 9331. REQUIREMENTS RELATING TO STATES.

(a) In General.—A State, or a person acting under the authority of a State, may not discriminate, or engage (directly or through contractual arrangements) in any activity that has the effect of discriminating, in carrying out any responsibility or in exercising any authority under this Act, against an individual or entity on the basis of race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services.

(b) Boundaries.—In establishing boundaries for community rating areas or consumer purchasing cooperative areas, a State may not discriminate, engage (directly or through contractual arrangements) in any activity that has the effect of discriminating, or otherwise take into account, race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services.

(c) Remedy.—A person who is aggrieved by a violation of subsection (a) or (b) may, in a civil action, obtain appropriate relief, including actual, compensatory, and punitive damages and equitable relief, against any appropriate party, including a State.

(d) Attorney's Fees and Costs.—In any action under subsection (c) in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

SEC. 9332. REQUIREMENTS RELATING TO CONSUMER PURCHASING COOPERATIVES.

(a) Activities Relating to Plans.—A consumer purchasing cooperative may not discriminate, or engage (directly or through contractual arrangements) in any activity that has the effect of discriminating, against a certified health benefit plan sponsor providing or sponsoring a certified health benefit plan on the basis of—

(1) mix of health providers associated with the plan;

(2) organizational arrangement of the plan (except as specifically provided in this Act);

(3) personal characteristics of an individual enrolled in the plan or considering enrolling in the plan that are unrelated to whether the individual is eligible to enroll in the plan, such as race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services; or

(4) personal characteristics of a health provider who is a network provider with respect to the plan, such as race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services.

(b) Other Activities.—A consumer purchasing cooperative may not discriminate, or engage (directly or through contractual arrangements) in any other activity that has the effect of discriminating, against an individual or entity on the basis of race, age, gender, sexual orientation, language, religion, national origin, income, disability, status of an eligible individual as a citizen of the United States, perceived health status, or anticipated need for health services.

(c) Remedy.—A person who is aggrieved by a violation of subsection (a) or (b) may, in a civil action, obtain appropriate relief, including actual, compensatory, and punitive damages and equitable relief, against any appropriate party.

(d) Attorney's Fees and Costs.—In any action under subsection (c) in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(e) Exhaustion of Remedies.—In an action under subsection (c), the court shall exercise jurisdiction without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law.

SEC. 9333. REQUIREMENTS RELATING TO PLAN SPONSORS.

(a) Underwriting.—A certified health benefit plan sponsor providing or sponsoring a certified health benefit plan may not engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics that are unrelated to the eligibility of an individual to enroll in the plan, such as race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services.

(b) Selection of Network Providers.—In selecting among health providers for membership in a plan network, or in establishing the terms and conditions of such membership, a certified health benefit plan sponsor described in subsection (a) may not discriminate, or engage (directly or through contractual arrangements) in any activity that has the effect of discriminating, against a health provider—

(1) based on personal characteristics of the provider, such as race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services; or

(2) based on personal characteristics of a patient of the provider, such as race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services.

(c) Other Sponsor Activities.—A certified health benefit plan sponsor described in subsection (a) may not discriminate, or engage (directly or through contractual arrangements) in any other activity that has the effect of discriminating, against an individual or entity on the basis of race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services.

(d) Business Necessity.—Except in the case of intentional discrimination, a certified health benefit plan sponsor may not be considered to be in violation of this section, or of any regulations issued under this section, if the sponsor demonstrates, in a civil action under subsection (e), that each action of the sponsor that is otherwise prohibited under this section is required by a compelling business necessity and cannot be accomplished by less discriminatory means. Nothing in this subsection shall be construed to preclude the person alleging the violation from having an opportunity to present evidence to rebut the evidence presented in support of such demonstration.

(e) Remedy.—A person who is aggrieved by a violation of this section may, in a civil action, obtain appropriate relief, including actual, compensatory, and punitive damages and equitable relief, against any appropriate party.

(f) Attorney's Fees and Costs.—In any action under subsection (e) in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(g) Exhaustion of Remedies.—In an action under subsection (e), the court shall exercise jurisdiction without regard to whether the aggrieved individual has exhausted any administrative or other remedies that may be available to the individual under part 1 or that are otherwise provided by law.

(h) Construction.—Nothing in this section may be construed to permit a right of action with respect to any practice or activity that is explicitly authorized under section 5003(b)(3) or 5008(b)(4).

SEC. 9334. NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS.

(a) In General.—No person in the United States shall, on the basis of race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity receiving Federal financial assistance.

(b) PRIVATE REMEDY.—

(1) IN GENERAL.—A person who is aggrieved by a violation of this section may, in a civil action, obtain appropriate relief, including actual, compensatory, and punitive damages and equitable relief, against any appropriate party.

(2) ATTORNEY'S FEES AND COSTS.—In any action under this subsection in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(c) ADMINISTRATIVE POWERS.—

(1) IN GENERAL.—Each Federal department and agency which is empowered to extend Federal financial assistance to any health program or activity shall effectuate the provisions of this section with respect to such program or activity in accordance with the remedies, procedures and rights set forth in title VI of the Civil Rights Act of 1964.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed to supersede, limit, or otherwise affect any provision of the Social Security Act or any duty or authority of the Secretary under such Act.

(d) DEFINITIONS.—For purposes of this section, the terms "program or activity", and "program" have the meaning given such terms in section 606 of the Civil Rights Act of 1964.

SEC. 9335. COLLECTION AND REPORTING OF DATA BY SECRETARY.

(a) IN GENERAL.—The Secretary shall promulgate regulations that provide for the routine collection, analysis, and reporting, by race, national origin, status of an eligible individual as a citizen of the United States, sex, language, income, age, and residence, of data collected from States, consumer purchasing cooperatives, certified health benefit plan sponsors, and any other person or entity determined appropriate by the Secretary that the Secretary determines are necessary or appropriate to determine whether such individuals and entities are complying with this part. The Secretary shall compile, analyze, and make public the data collected under this section.

(b) NO UNDUE BURDEN.—The regulations under subsection (a) shall include specifications ensuring that any data required to be collected under this section may be collected using the least burdensome method consistent with the efficient and effective administration of this part.

SEC. 9336. REGULATIONS.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall issue regulations to carry out this part.

Subtitle E—Fraud and Abuse

PART 1—APPLICATION OF FRAUD AND ABUSE AUTHORITIES UNDER THE SOCIAL SECURITY ACT TO OTHER PAYERS

SEC. 9401. APPLICATION OF CIVIL MONEY PENALTIES TO ALL PAYERS.

(a) ACTIONS SUBJECT TO PENALTY.—Any person who is determined by the Secretary to have committed any of the following actions with respect to a certified health plan shall be subject to a penalty in accordance with subsection (b):

(1) ACTIONS SUBJECT TO PENALTY UNDER MEDICARE, MEDICAID, AND OTHER SOCIAL SECURITY HEALTH PROGRAMS.—Any action that would subject the person to a penalty under paragraphs (1) through (9) of section 1128A(a) of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act.

(2) TERMINATION OF ENROLLMENT.—The termination of an individual's enrollment (including the refusal to re-enroll an individual) in violation of the applicable standards established under title V.

(3) DISCRIMINATING ON BASIS OF MEDICAL CONDITION.—The engagement in any practice that would reasonably be expected to have the effect of denying or discouraging the initial or continued enrollment in a certified health plan or medicare part C by individuals whose medical condition or history indicates a need for substantial future medical services.

(4) INDUCING ENROLLMENT ON FALSE PRETENSES.—The engagement in any practice to induce enrollment in a certified health plan or medicare part C through representations to individuals which the person knows or should know are false or fraudulent.

(b) PENALTIES DESCRIBED.—

(1) GENERAL RULE.—Any person who the Secretary determines has committed an action described in paragraphs (2) through (4) of subsection (a) shall be subject to a civil monetary penalty in an amount not to exceed $10,000 for each such determination.

(2) ACTIONS SUBJECT TO PENALTIES UNDER SOCIAL SECURITY ACT.—In the case of a person who the Secretary determines has committed an action described in paragraph (1) of subsection (a), the person shall be subject to the civil monetary penalty (together with any additional assessment) to which the person would be subject under section 1128A of the Social Security Act if the action on which the determination is based had been committed with respect to title V, XVIII, XIX, or XX of such Act.

(c) APPLICABILITY OF PROCEDURES UNDER SOCIAL SECURITY ACT.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil monetary penalty or assessment under this section in the same manner as such provisions apply with respect to the imposition of a penalty or assessment under section 1128A of such Act.

(d) TREATMENT OF AMOUNTS RECOVERED.—Any amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) Such portions of the amounts recovered as is determined to have been improperly paid from a certified health plan for the delivery of or payment for health care items or services shall be repaid to such plan.

(2) The remainder of the amounts recovered shall be deposited in the All-Payer Health Care Fraud and Abuse Control Account established under section 9412.

(e) NOTIFICATION OF LICENSING AUTHORITIES.—Whenever the Secretary's determination to impose a penalty or assessment under this section becomes final, the Secretary shall notify the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33) of the Social Security Act) that such a penalty or assessment has become final and the reasons therefore.

SEC. 9402. APPLICATION OF CERTAIN CRIMINAL PENALTIES TO ALL PAYERS.

Any person who is determined by the Attorney General (in consultation with the Secretary) to have committed any action with respect to a certified health plan that would subject the person to a penalty under subsection (a) or (b) of section 1128B of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act shall be subject to the penalty (together with any assessment) that would apply if the action was taken with respect to any such title.

SEC. 9403. PRIVATE RIGHT OF ACTION.

(a) AVAILABILITY OF RIGHT OF ACTION TO INSURERS.—Subject to paragraphs (2) and (3), a carrier offering an insured health benefit plan and the sponsor of a self-insured health benefit plan that suffers financial harm as a direct result of the submission of claims by an individual or entity for payment for items and services furnished under the plan which makes the individual or entity subject to a civil monetary penalty under this part may, in a civil action against the individual or entity in the United States District Court, obtain damages against the individual or entity and such equitable relief as is appropriate.

(b) RIGHT CONTINGENT UPON REFUSAL TO BRING ACTION BY SECRETARY AND ATTORNEY GENERAL.—A carrier or sponsor may bring a civil action under this section only if the carrier or sponsor provides the Secretary and the Attorney General with written notice of the intent to bring an action under this subsection, the identities of the individuals or entities the carrier or sponsor intends to name as defendants to the action, and all information the carrier or sponsor possesses regarding the activity that is the subject of the action that may materially affect the Secretary's decision to initiate a proceeding to impose a civil monetary penalty under this part against the defendants.

(c) CONDITIONS.—A carrier or sponsor may bring a civil action under this section only if any of the following conditions are met:

(1) During the 60-day period that begins on the date the Secretary receives the written notice described in paragraph (2), the Secretary does not notify the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

(2) If the Secretary notifies the carrier or sponsor during the 60-day period described in subparagraph (A) that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this part against the defendants, the Secretary subsequently notifies the carrier or sponsor that the Secretary no longer intends to initiate such a proceeding against the defendants.

(3) After the expiration of the 2-year period that begins on the date the Secretary notifies the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this part against the defendants, the Secretary has not made a good faith effort to initiate such a proceeding against the defendants.

(d) SET-ASIDE OF AMOUNTS TO ACCOUNT.—If a carrier or sponsor is awarded any amounts in an action brought under this section that are in excess of the damages suffered by the carrier or sponsor as a result of the defendant's activities, 10 percent of such amounts shall be withheld from the carrier or sponsor for payment into the Health Care Fraud and Abuse Control Account established under section 9412.

(e) STATUTE OF LIMITATIONS.—No action may be brought under this section more than 6 years after the date of the activity with respect to which the action is brought.

SEC. 9404. CONSTRUCTION OF SOCIAL SECURITY ACT REFERENCES.

(a) INCORPORATION OF OTHER AMENDMENTS.—Any reference in this part to a provision of the Social Security Act shall be considered a reference to the provision as amended under part 5 of subtitle D of title VIII.

(b) EFFECT OF SUBSEQUENT AMENDMENTS.—Except as provided in subsection (a), any reference to a provision of the Social Security

Act in this part shall be deemed to be a reference to such provision as in effect on the date of the enactment of this Act, and (except as Congress may otherwise provide) any amendments made to such provisions after such date shall not be taken into account in determining the applicability of such provisions to individuals and entities under this Act.

PART 2—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

SEC. 9411. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1996, the Secretary (acting through the Inspector General of the Department of Health and Human Services) and the Attorney General shall establish a program—

(1) to coordinate the functions of the Attorney General, the Secretary, and other organizations with respect to the prevention, detection, and control of health care fraud and abuse,

(2)(A) to conduct investigations, audits, evaluations, and inspections relating to health care fraud and abuse under the Public Health Service Act, titles V, XI, XVIII, XIX, and XX of the Social Security Act, medicare part C, and part 1 of this subtitle, and (B) to facilitate the conducting of such investigations, audits, evaluations, and inspections relating to the delivery of and payment for other health care services in the United States, and

(3) to facilitate the enforcement of this subtitle and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH OTHER INSPECTORS GENERAL.—

(1) SCOPE OF AUTHORITY OF HHS INSPECTOR GENERAL.—The Inspector General of the Department of Health and Human Services may not exercise any authority under subsection (a)(2)(A) with respect to any matter which is subject to investigation, audit, evaluation, and inspection by the Inspector General of another executive department.

(2) SCOPE OF AUTHORITY OF OTHER INSPECTORS GENERAL.—The Inspector General of each of the Department of Defense, the Office of Personnel Management, and the Department of Veterans Affairs, and the Attorney General shall conduct audits, civil and criminal investigations, inspections, and evaluations relating to the prevention, detection, and control of health care fraud and abuse in violation of any Federal law, except that such an Inspector General may not conduct any investigation, audit, evaluation, or inspection with respect to the authorities described in subsection (a)(2)(A).

(c) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Secretary and Attorney General may consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers (consistent with the requirements of subtitle C).

(d) COORDINATION WITH HEALTH PLANS.—In carrying out the program under subsection (a), the Secretary and Attorney General may consult with, and arrange for the sharing of data with representatives of certified health plans (consistent with the requirements of subtitle C).

(e) AUTHORITIES OF ATTORNEY GENERAL AND INSPECTOR GENERAL.—In carrying out duties under subsection (a), the Attorney General and the Inspector General are authorized—

(1) to conduct, supervise, and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to the program established under such subsection; and

(2) to have access (including on-line access as requested and available) to all records available to certified health plans relating to the activities described in paragraph (1) (subject to restrictions based on the confidentiality of certain information under subtitle C).

(f) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information or communications to the Secretary or Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act.

(g) AUTHORIZATIONS OF APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appropriated to the Secretary and the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such additional amounts as may be necessary to enable the Secretary and the Attorney General to conduct investigations, audits, evaluations, and inspections of allegations of health care fraud and abuse and otherwise carry out the program established under subsection (a) in a fiscal year.

(h) USE OF POWERS UNDER INSPECTOR GENERAL ACT OF 1978.—For purposes of carrying out duties and responsibilities under this section, each Inspector General referred to in subsection (b) may exercise powers that are available to that Inspector General for purposes of audits, investigations, and other activities under the Inspector General Act of 1978 (5 U.S.C. App.).

(i) CONSTRUCTION OF FEDERAL AUTHORITY.—Nothing in this section may be construed to affect the authority of States to conduct investigations, audits, evaluations, and inspections relating to violations of State law.

(j) DEFINITION.—In this subtitle, the term "Inspector General" means the Inspector General of the Department of Health and Human Services.

SEC. 9412. ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States an account to be known as the "All-Payer Health Care Fraud and Abuse Control Account" (in this section referred to as the "Anti-Fraud Account"), to be administered by the Inspector General of the Department of Health and Human Services. The Anti-Fraud Account shall consist of such gifts and bequests as may be made as provided in paragraph (2) and such amounts as may be deposited in such Anti-Fraud Account as provided in section 9401(d)(2) and title XI of the Social Security Act. It shall also include the following (but only with respect to activities of the Inspector General and the Attorney General under section 9411(a)(2)(A)):

(A) All criminal fines imposed in cases involving a Federal health care offense (as defined in subsection (d)).

(B) Penalties and damages imposed under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(C) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act and section 9401 (except as otherwise provided by law).

(D) Amounts paid under section 9403(d) (relating to a set-aside of amounts recovered under private right of action).

(D) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

Any such funds received on or after the date of the enactment of this Act shall be deposited in the Anti-Fraud Account.

(2) AUTHORIZATION TO ACCEPT GIFTS.—The Anti-Fraud Account is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Anti-Fraud Account, for the benefit of the Anti-Fraud Account or any activity financed through the Anti-Fraud Account.

(b) USE OF FUNDS.—

(1) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available without appropriation and until expended as determined jointly by the Secretary and Attorney General in carrying out the All-Payer Health Care Fraud and Abuse Control Program established under section 9411 (including the administration of the Program), and may be used to cover costs incurred in operating the Program, including—

(A) costs of prosecuting health care matters (through criminal, civil and administrative proceedings);

(B) costs of investigations (including equipment, salaries, administratively uncontrollable work, travel, and training of law enforcement personnel);

(C) costs of financial and performance audits of health care programs and operations;

(D) costs of inspections and other evaluations; and

(E) the costs of providing awards under section 3059(c)(2) of title 18, United States Code (as added by section 9428).

(2) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(c) ANNUAL REPORT.—The Inspector General shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Anti-Fraud Account in each fiscal year.

(d) USE OF SUBACCOUNTS.—

(1) SUBACCOUNTS DESCRIBED.—The Account shall consist of—

(A) the Health Care Fraud and Abuse Expenses Subaccount; and

(B) the Health Care Fraud and Abuse Reserve Subaccount.

(2) EXPENSES SUBACCOUNT.—

(A) CONTENTS.—The Expenses Subaccount consists of—

(i) amounts deposited pursuant to subsection (a)(1); and

(ii) amounts transferred from the Reserve Subaccount under paragraph (3)(B).

(B) USE.—Amounts in the Expenses Subaccount shall be available to the Inspector General for the uses described in subsection (b).

(3) RESERVE SUBACCOUNT.—

(A) DEPOSITS.—An amount otherwise required under paragraph (2)(A) to be deposited in the Expenses Subaccount in a fiscal year shall be deposited in the Reserve Subaccount, if—

(i) the amount in the Expenses Subaccount is greater than $500,000,000; and

(ii) the deposit of that amount in the Expenses Subaccount would result in the amount in the Expenses Subaccount exceeding 110 percent of the total amount deposited in the Expenses Subaccount in the preceding fiscal year.

(B) TRANSFERS TO EXPENSES SUBACCOUNT.—

(i) ESTIMATION OF SHORTFALL.—Not later than the first day of the last quarter of each fiscal year, the Inspector General shall estimate whether sufficient amounts will be available during such quarter in the Expenses Subaccount for the uses described in paragraph (2)(B).

(ii) TRANSFER TO COVER SHORTFALL.—If the Inspector General estimates under paragraph (1) that there will not be available sufficient amounts in the Expenses Subaccount during the last quarter of a fiscal year, there shall be transferred from the Reserve Subaccount to the Expenses Subaccount such amount as the Inspector General estimates is required to ensure that sufficient amounts are available in the Expenses Subaccount during such quarter.

(C) LIMITATION ON AMOUNT CARRIED OVER TO SUCCEEDING FISCAL YEAR.—There shall be transferred to the general fund of the Treasury any amount remaining in the Reserve Subaccount at the end of a fiscal year (after any transfer made under subparagraph (B)) in excess of 10 percent of the total amount authorized to be deposited in the Expenses Subaccount (consistent with subparagraph (A)) during the fiscal year.

(d) FEDERAL HEALTH CARE OFFENSE DEFINED.—The term "Federal health care offense" means a violation of, or a criminal conspiracy to violate—

(1) sections 226, 668, 1033, or 1347 of title 18, United States Code;

(2) section 1128B of the Social Security Act;

(3) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of title 18, United States Code, if the violation or conspiracy relates to health care fraud;

(4) sections 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud; or

(5) sections 301, 303(a)(2), or 303(b) or (e) of the Federal Food Drug and Cosmetic Act, if the violation or conspiracy relates to health care fraud.

(e) ACCOUNT PAYMENTS ADVISORY BOARD.—

(1) ESTABLISHMENT.—There is established the Account Payments Advisory Board, which shall make recommendations to the Inspector General regarding the equitable allocation of payments from the Anti-Fraud Account.

(2) MEMBERSHIP.—The Board shall consist of 10 members appointed by the Inspector General of the Department of Health and Human Services to represent Health Care Fraud and Abuse Control Units, of whom one shall be appointed—

(A) for each of the 10 regions established by the Director of the Office of Management and Budget under Office of Management and Budget Circular A-105, to represent Units in that region; and

(B) from among individuals recommended by the heads of those agencies in that region.

To the greatest extent feasible, the membership of the Board shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) TERMS.—The term of a member of the Board appointed under paragraph (2)(B) shall be 3 years, except that of such members first appointed 3 members shall serve an initial term of one year and 3 members shall serve an initial term of 2 years, as specified by the Inspector General at the time of appointment.

(4) VACANCIES.—A vacancy on the Board shall be filled in the same manner in which the original appointment was made, except that an individual appointed to fill a vacancy occurring before the expiration of the term for which the individual is appointed shall be appointed only for the remainder of that term.

(5) CHAIRPERSON AND BYLAWS.—The Board shall elect one of its members as chairperson and shall adopt bylaws.

(6) COMPENSATION AND EXPENSES.—Members of the Board shall serve without compensation, except that the Inspector General may pay the expenses reasonably incurred by the Board in carrying out its functions under this section.

(7) NO TERMINATION.—Section 14(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Board.

SEC. 9413. PAYMENTS TO STATES FOR HEALTH CARE FRAUD AND ABUSE CONTROL UNITS.

(a) PAYMENTS TO STATES.—

(1) IN GENERAL.—For each year for which a State has an annual plan approved under subsection (b)(3), and subject to the availability of appropriations authorized under subsection (e), the Inspector General of the Department of Health and Human Services shall pay to the State for each quarter an amount equal to 75 percent of the sums expended during the quarter by the Health Care Fraud and Abuse Control Unit described in subsection (b)(1) in conducting activities described in that subsection.

(2) TIME OF PAYMENT.—The Inspector General shall make a payment under paragraph (1) for a quarter by not later than 30 days after the end of the quarter.

(b) STATE REQUIREMENTS FOR RECEIVING PAYMENTS.—A State is eligible to receive payments under subsection (a) if the State carries out the following activities:

(1) HEALTH CARE FRAUD AND ABUSE CONTROL UNIT REQUIREMENTS.—There is a Health Care Fraud and Abuse Control Unit established by the State which is a single identifiable entity of State government which is separate and distinct from any State agency with principal responsibility for the administration of health care programs, and meets the following requirements:

(A) The entity—

(i) is a unit of the office of the State Attorney General or of another department of State government that possesses statewide authority to prosecute individuals for criminal violations;

(ii) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority, and has formal procedures, approved by the Secretary, that assure it will refer suspected criminal violations relating to health care fraud or abuse in violation of Federal law to the appropriate authority or authorities of the State for prosecution and assure it will assist such authority or authorities in such prosecutions; or

(iii) has a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and has formal procedures (including procedures under which it will refer suspected criminal violations to such office), that provide effective coordination of activities between the Health Care Fraud and Abuse Control Unit and such office with respect to the detection, investigation, and prosecution of suspected health care fraud or abuse in violation of Federal law.

(B) The entity conducts a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of health care fraud and abuse in violation of Federal law.

(C) The entity has procedures for—

(i) reviewing complaints of the abuse or neglect of patients of health care facilities in the State, and

(ii) where appropriate, investigating and prosecuting such complaints under the criminal laws of the State or for referring the complaints to other State or Federal agencies for action.

(D) The entity provides for the collection, or referral for collection to the appropriate agency, of overpayments that—

(i) are made under any federally funded or mandated health care program required by this Act, and

(ii) it discovers in carrying out its activities.

(E) The entity employs attorneys, auditors, investigators, and other necessary personnel, is organized in such a manner, and provides sufficient resources, as is necessary to promote the effective and efficient conduct of its activities.

(2) SUBMISSION OF ANNUAL PLAN.—The Health Care Fraud and Abuse Control Unit of a State has a plan preventing, detecting, and controlling health care fraud and abuse in violation of State law which is approved by the Inspector General of the Department of Health and Human Services. The Inspector General shall approve a plan submitted under paragraph (3) by the Health Care Fraud and Abuse Control Unit of a State, unless the Inspector General establishes that the plan will not enable the Unit to prevent, detect, and control health care fraud and abuse in violation of Federal law.

(3) REPORTS.—The Health Care Fraud and Abuse Control Unit submits to the Inspector General an annual report containing such information as the Inspector General determines to be necessary.

(c) SEMIANNUAL REPORTS OF INSPECTOR GENERAL OF HEALTH AND HUMAN SERVICES.—The Inspector General shall include in its semiannual reports to the Congress under section 5(a) of the Inspector General Act of 1978 (5 U.S.C. App.) an assessment of the Inspector General of how well States are preventing, detecting, and controlling health care fraud and abuse.

(d) LIMITATION ON FEDERAL LAWS AFFECTED.—In this subsection, any reference to "Federal law" shall not include any law described in section 9411(a)(2)(A).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for fiscal years beginning with fiscal year 1996 for payments under this section such sums as may be necessary for making such payments.

PART 3—AMENDMENTS TO CRIMINAL LAW

SEC. 9421. HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

"(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

"(1) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services;

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health plan or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title) such person shall be imprisoned for life or any term of years.

"(b) As used in this section, the term 'health plan' has the meaning given such term in title V of the Guaranteed Health Insurance Act of 1994.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud.".

SEC. 9422. FORFEITURES FOR VIOLATIONS OF FRAUD STATUTES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by inserting after paragraph (5) the following:

"(6) The court, in imposing sentence on a person convicted of a Federal health care offense (as defined in section 9412(d) of the Guaranteed Health Insurance Act of 1994) shall order the person to forfeit any real or personal property that—

"(A) is used in the commission of the offense, if the offense results in a financial loss or gain of $50,000 or more; or

"(B) constitutes or is derived from proceeds traceable to the commission of the offense.".

(b) PROCEEDS OF HEALTH CARE FRAUD FORFEITURES.—Section 524(c)(4)(A) of title 28, United States Code, is amended by inserting "all proceeds of forfeitures relating to Federal health care offenses (as defined in section 9412(d) of the Guaranteed Health Insurance Act of 1994), and" after "except".

SEC. 9423. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"§ 1033. False statements relating to health care matters

"(a) Whoever, in any matter involving a health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section the term 'health plan' has the meaning given such term in title V of the Guaranteed Health Insurance Act of 1994.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"1033. False statements relating to health care matters.".

SEC. 9424. BRIBERY AND GRAFT.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"§ 226. Bribery and graft in connection with health care

"(a) Whoever—

"(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises a health care official to give anything of value to any other person, with intent—

"(A) to influence any of the health care official's actions, decisions, or duties relating to a health plan;

"(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a health plan; or

"(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

"(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection;

shall be fined under this title or imprisoned not more than 15 years, or both.

"(b) Whoever, otherwise than as provided by law for the proper discharge of any duty, directly or indirectly gives, offers, or promises anything of value to a health care official, for or because of any of the health care official's actions, decisions, or duties relating to a health plan, shall be fined under this title or imprisoned not more than two years, or both.

"(c) As used in this section—

"(1) the term 'health care official' means—

"(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any health plan;

"(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any health plan;

"(C) an official or employee of a State agency having regulatory authority over any health plan;

"(D) an officer, counsel, agent, or employee of a health care sponsor; and

"(2) the term 'health care sponsor' means any individual or entity serving as the sponsor of a health plan for purposes of the Guaranteed Health Insurance Act of 1994, and includes the joint board of trustees or other similar body used by two or more employers to administer a health plan for purposes of such Act."

(b) CLERICAL AMENDMENT.—The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"226. Bribery and graft in connection with health care.".

SEC. 9425. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking "or" at the end of subparagraph (A);

(2) by inserting "or" at the end of subparagraph (B); and

(3) by adding at the end the following:

"(C) committing or about to commit a Federal health care offense (as defined in section 9412(d) of the Guaranteed Health Insurance Act of 1994);".

SEC. 9426. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

"(c) A person who is privy to grand jury information concerning a health law violation—

"(1) received in the course of duty as an attorney for the Government; or

"(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil proceeding related to a Federal health care offense (as defined in section 9412(d) of the Guaranteed Health Insurance Act of 1994).".

SEC. 9427. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"§ 668. Theft or embezzlement in connection with health care

"(a) Whoever embezzles, steals, willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, securities, premiums, credits, property, or other assets of a health plan or of any fund connected with such a plan, shall be fined under this title or imprisoned not more than 10 years, or both.

"(b) As used in this section, the term 'health plan' has the meaning given such term under title V of the Guaranteed Health Insurance Act of 1994.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"668. Theft or embezzlement in connection with health care.".

SEC. 9428. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following:

"(c)(1) The Attorney General may pay a reward not more than $50,000 to any person who furnishes information or services that lead to a conviction of a Federal health care offense as defined by section 9412 of the Guaranteed Health Insurance Act of 1994.

"(2) Rewards under this subsection are authorized to be paid out of the All-Payer Health Care Fraud and Abuse Control Account established under section 9412 of the Guaranteed Health Insurance Act of 1994.

"(3) An officer or employee of the United States (including a fiscal intermediary or carrier carrying out a program on behalf of the United States) or of a State or local government who furnishes information or renders services in the performance of official duty is ineligible for a payment under this subsection with respect to such information or services.

"(4) The granting or decision not to grant a reward under this subsection is not reviewable in any court.".

PART 4—AMENDMENTS TO CIVIL FALSE CLAIMS ACT

SEC. 9431. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.

Section 3729 of title 31, United States Code, is amended—

(1) in subsection (a)(7), by inserting "or to a health plan" after "property to the Government";

(2) in the matter following subsection (a)(7), by inserting "or health plan" before "sustains because of the act of that person," ;

(3) at the end of the first sentence of subsection (a), by inserting "or health plan" before "sustains because of the act of the person." ;

(4) in subsection (c)—

(A) by inserting "the term" after "section,"; and

(B) by adding at the end the following: "The term also includes any request or demand, whether under contract of otherwise, for money or property which is made or presented to a health plan." ; and

(5) by adding at the end the following:

"(f) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' has the meaning given such term under title V of the Guaranteed Health Insurance Act of 1994.''.

PART 5—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS APPLICABLE TO MEDICARE, MEDICAID, AND STATE HEALTH CARE PROGRAMS

SEC. 9441. REFERENCE TO AMENDMENTS.

For provisions amending the anti-fraud and abuse provisions existing under the Social Security Act, see part 5 of subtitle D of title VIII.

PART 6—PREEMPTION OF STATE CORPORATE PRACTICE LAWS

SEC. 9451. PREEMPTION OF STATE LAWS PROHIBITING CORPORATE PRACTICE OF MEDICINE.

No provision of State or local law shall apply that prohibits a corporation from practicing medicine.

Subtitle F—Physician Ownership and Referral

PART 1—EXTENSION OF LIMITATIONS ON SELF-REFERRAL UNDER MEDICARE TO REFERRALS UNDER PRIVATE PLANS

SEC. 9501. LIMITATIONS ON PHYSICIAN SELF-REFERRAL UNDER PRIVATE PLANS.

The provisions of section 1877 of the Social Security Act shall apply to items and services (and payments and claims for payment for such items and services) furnished under any certified health plan in the same manner as such provisions apply to designated health services (and payments and claims for payment for such services) under title XVIII of the Social Security Act.

SEC. 9502. CONSTRUCTION OF SOCIAL SECURITY ACT REFERENCES.

(a) INCORPORATION OF OTHER AMENDMENTS.—Any reference in this part to a provision of the Social Security Act shall be considered a reference to the provision as amended under part 6 of subtitle D of title VIII.

(b) EFFECT OF SUBSEQUENT AMENDMENTS.—Except as provided in subsection (a), any reference to a provision of the Social Security Act in this part shall be deemed to be a reference to such provision as in effect on the date of the enactment of this Act, and (except as Congress may otherwise provide) any amendments made to such provisions after such date shall not be taken into account in determining the applicability of such provisions to individuals and entities under this Act.

PART 2—AMENDMENTS TO PHYSICIAN OWNERSHIP AND REFERRAL PROVISIONS UNDER MEDICARE

SEC. 9511. REFERENCE TO AMENDMENTS.

For provisions amending section 1877 of the Social Security Act, see part 6 of subtitle D of title VIII.

Subtitle G—Workforce Protection and Training

SEC. 9600. DEFINITIONS.

For purposes of this subtitle:

(1) EMPLOY.—The term ''employ'' includes to suffer or permit to work.

(2) EMPLOYEE.—

(A) IN GENERAL.—The term ''employee'' means—

(i) any individual employed by an employer or otherwise having the status of an employee, taking into account the factors described in subparagraph (B);

(ii) any officer of a corporation;

(iii) any individual (not described in clauses (i) through (ii)) who performs for remuneration services described in section 210(j) of the Social Security Act; and

(iv) an individual described in subparagraph (C).

(B) APPLICATION OF FACTORS REFLECTING ECONOMIC DEPENDENCE.—An individual shall be deemed to be employed taking into account (and to the extent that) the following factors apply:

(i) The individual has a low degree of control over the circumstances under which the services are performed.

(ii) The individual lacks opportunities for profit or loss in performing the services.

(iii) The individual does not have an investment in facilities or equipment used in performing the services.

(iv) The individual's relation with the person (for whom the services are provided) is not temporary.

(v) The services performed for the person represent a high percentage of all services performed by the individual.

(vi) The individual's performance of the services does not require a high degree of skill.

(C) INCLUSION OF CERTAIN CONTRACT RELATIONSHIPS.—The term ''employee'' includes, with respect to any employer which during the preceding year had gross receipts in excess of an amount specified by the Secretary of Labor (which amount shall not be less than $10,000,000), an individual who performs services for the employer if—

(i) the services are not performed by the individual as an employee of another employer or as a leased employee (as defined in paragraph (8)(C));

(ii) the contract or other arrangement for services contemplates that substantially all of such services are to be performed personally by such individual; and

(iii) the individual performs the services—

(I) on the premises owned or leased by the employer,

(II) using facilities or equipment in which the employer has a substantial investment, or

(III) using facilities and equipment in which the individual does not have a substantial investment.

(D) EXCLUSION OF VOLUNTEERS.—The term ''employee'' does not include any individual who volunteers to perform services for a public agency which is a State, a political subdivision of a State or an interstate governmental agency, if—

(i) the individual receives no compensation other than reasonable expenses or a nominal fee to perform the services for which the individual volunteered, and

(ii) such services are not the same type of services which the individual is employed to perform for such public agency.

An employee of a public agency which is a State, political subdivision of a State, or an interstate governmental agency may volunteer to perform services for any other State, political subdivision, or interstate governmental agency, including a State, political subdivision, or agency with which the employing State, political subdivision, or agency has a mutual aid agreement.

(E) EXCEPTION FOR CERTAIN IMMEDIATE FAMILY.—Except as provided by the Secretary of Labor in regulations, a child under the age of 18 shall not be considered to be an employee by virtue of service performed for the child's parent or guardian.

(F) EXCLUSION OF EMPLOYEES OUTSIDE THE UNITED STATES.—The term ''employee'' does not include an individual who does not reside in the United States.

(G) EXCLUSION OF FOREIGN EMPLOYMENT.—The term ''employee'' does not include an individual—

(i) with respect to service, if the individual is not a citizen or resident of the United States and the service is performed outside the United States, or

(ii) with respect to service, if the individual is a citizen or resident of the United States and the service is performed outside the United States for an employer other than an American employer (as defined in section 210(e) of the Social Security Act).

(H) EXCLUSION OF INMATES AS EMPLOYEES.—An individual shall not be treated as an employee by virtue of services performed in a penal institution by an inmate thereof or in a hospital or other health care institution by a patient thereof.

(I) APPLICATION OF CONTROL GROUP RULES FOR EMPLOYERS.—For purposes of this subtitle:

(i) Two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group.

(ii) The term ''control group'' means a group of trades or businesses under common control.

(iii) The determination of whether a trade or business is under common control with another trade or business shall be determined under regulations of the Secretary of Labor applying principles similar to the principles applied under section 4001(a)(14)(B) of the Employee Retirement Income Security Act of 1974.

(iv) Under regulations of the Secretary of Labor, all employees of organizations which are under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer.

The regulations prescribed under clause (iv) shall be based on principles similar to the principles which apply to taxable organizations under clause (iii).

(J) ANTI-EVASION RULES.—An individual shall be treated as an employee of a person if the individual would otherwise be treated as such an employee but for an action which was undertaken by the person or another on the person's behalf to evade responsibilities imposed under this subtitle with respect to the individual as an employee.

(K) EXEMPTION OF EMPLOYEES WHO ARE MEMBERS OF CERTAIN RELIGIOUS FAITHS.—A member of certain religious faiths (as defined in section 1402(g) of the Internal Revenue Code of 1986) who elects to waive all benefits and payments provided under this Act (or the Social Security Act) with respect to the guaranteed national benefit package shall not be considered an employee for purposes of this subtitle. The election under the previous sentence shall be consistent with the waiver of benefits under section 202(v) of the Social Security Act.

(3) EMPLOYER.—

(A) IN GENERAL.—The term ''employer''—

(i) means any person engaged in any activity, business or industry in commerce or affecting commerce that employs an individual;

(ii) includes any person who acts, directly or indirectly, in the interest of an employer in relation to any of the employees of such employer; and

(iii) includes any public agency (as defined in section 3(x) of the Fair Labor Standards Act, 29 U.S.C. 203(x)).

(B) COMMERCE.—The term ''commerce'' means trade, traffic, commerce, transportation, or communication among the several States, or between the District of Columbia or any Territory of the United States and any State or other Territory, or between any foreign country and any State, Territory, or the District of Columbia, or within the district of Columbia or any Territory, or between points in the same State but through any other State or any Territory or the District of Columbia or any foreign country.

(C) AFFECTING COMMERCE.—The term "affecting commerce" means in commerce, or burdening or obstructing commerce or the free flow of commerce.

(D) SUCCESSOR EMPLOYER.—An employer is a "successor employer" if, based on the facts and circumstances, on balance after applying at least the following criteria, and consistent with any regulations promulgated by the Secretary of Labor, the employer has substantially assumed the employment-related responsibilities of another employer:

(i) Substantial continuity of the same business operations.

(ii) Use of the same plant, common facility, or work site.

(iii) Continuity of the work force.

(iv) Similarity of jobs and working conditions.

(v) Similarity of supervisory personnel.

(vi) Similarity in machinery, equipment, and productions methods.

(vii) Similarity of products or services.

(E) TREATMENT OF COMMON EMPLOYMENT.—The Secretary of Labor may promulgate regulations regarding responsibilities of employers in the case of common employment of an employee by such employers.

(4) FULL-TIME EQUIVALENT EMPLOYEES; PART-TIME EMPLOYEES.—

(A) IN GENERAL.—For purposes of this subtitle, subject to subparagraphs (D) and (E) a qualifying employee who is employed by an employer—

(i) for at least 120 hours in a month, is counted as one full-time equivalent employee for the month and shall be deemed to be employed on a full-time basis; or

(ii) for at least 40 hours, but less than 120 hours, in a month, is counted as a fraction of a full-time equivalent employee in the month equal to the full-time employment ratio (as defined in subparagraph (B)) for the employee and shall be deemed to be employed on a part-time basis.

(B) FULL-TIME EMPLOYMENT RATIO DEFINED.—For purposes of this subtitle, the term "full-time employment ratio" means, with respect to a qualifying employee of an employer in a month, subject to subparagraph (E), the lesser of 1 or the ratio of—

(i) the number of hours of employment such employee is employed by such employer for the month (as determined under paragraph (6)), to

(ii) 120 hours.

(C) FULL-TIME EMPLOYEE; PART-TIME EMPLOYEE.—For purposes of this subtitle, subject to subparagraphs (D) and (E), the terms "full-time employee" and "part-time employee" mean, with respect to an employer, an employee who is employed on a full-time basis or part-time basis (as specified in subparagraph (A)), respectively, by the employer.

(D) CONSIDERATION OF INDUSTRY PRACTICE.—As provided under rules established by the Secretary of Labor, an employee who is not described in subparagraph (C) shall be considered to be employed on a full-time or part-time basis by an employer (and to be a full-time or part-time employee of an employer) for a month (or for all months in a 12-month period) if the employee is employed by that employer on a continuing basis that, taking into account the structure or nature of the employment in the industry, represents full time or part time employment, respectively.

(E) EMPLOYMENT AT EDUCATIONAL INSTITUTIONS.—With respect to employees of an institution of higher education (as defined in section 1201(a) of the Higher Education Act of 1965) or of an elementary or secondary school (as defined in section 1471 of the Elementary and Secondary Education Act of 1965) who are exempt under section 13 of the Fair Labor Standards Act of 1938—

(i) the employees shall be considered to be employed on a full-time basis (and to be a full-time employee) if they work the customary hours that constitute full-time employment as defined at such institution;

(ii) the number of hours and, with respect to less-than-full-time employees at such an institution, the number of such customary hours shall be substituted for 120 in subparagraphs (A) and (B)(ii); and

(iii) such employees who are regular seasonal employees who are not paid during summer months or other regular periods of the year, but are assured employment at the end of such periods, shall be considered to be employed year round.

(5) HEALTH CARE EMPLOYER.—The term "health care employer" means an employer that—

(A) provides health care items or services (including such items and services not included in the guaranteed national benefit package); or

(B) provides necessary related services, including administrative, food service, janitorial or maintenance services, to an entity that provides health care items or services (as described in subparagraph (A));

except that an employer that solely manufactures or provides goods or equipment to a health care employer shall not be considered a health care employer.

(6) HOURS OF EMPLOYMENT.—

(A) IN GENERAL.—For purposes of this subtitle, the Secretary shall specify the method for computing hours of employment for employees of an employer consistent with this paragraph. The Secretary shall take into account rules used for purposes of applying the Fair Labor Standards Act of 1938.

(B) HOURLY WAGE EARNERS.—In the case of an individual who receives compensation (in the form of hourly wages or compensation) for the performance of services, the individual is considered to be "employed" by an employer for an hour if compensation is payable with respect to that hour of employment, without regard to whether or not the employee is actually performing services during such hour.

(7) QUALIFYING EMPLOYEE.—

(A) IN GENERAL.—The term "qualifying employee" means, with respect to an employer for a month, an employee (other than a young dependent, as defined in subparagraph (B)) who is employed by the employer for at least 40 hours (as determined under paragraph (6)) in the month.

(B) YOUNG DEPENDENT DEFINED.—In subparagraph (A), the term "young dependent" means an eligible individual who is a young dependent (as defined in section 1003(b)(1)(B)) and is enrolled under a health plan as a family member (as defined in section 1104(c)(2)(B)).

(8) TREATMENT OF EMPLOYEE LEASING ARRANGEMENTS.—

(A) TREATMENT AS EMPLOYEE OF LEASING ORGANIZATION.—Except as provided in subparagraph (B), with respect to any person (in this paragraph referred to as the "recipient") for whom a leased employee (as defined in subparagraph (C)) performs services the leased employee shall not be treated as an employee of the recipient.

(B) APPLICATION IN RELATION TO WORKFORCE STABILITY.—For purposes of applying sections 9621(b) and 9624(b) (relating to transitional provisions for workforce stability), leased employees shall be treated as employees of the recipient and of the leasing organization.

(C) LEASED EMPLOYEE.—For purposes of this paragraph, the term "leased employee" means any person who is not an employee of the recipient and who provides services to the recipient if—

(i) such services are provided pursuant to an agreement between the recipient and any other person (in this paragraph referred to as the "leasing organization"); and

(ii)(I) such services are of a type historically performed, in the business field of the recipient, by employees;

(II) the person provides services to the recipient for at least such number of hours per week (or such percentage of the person's time) as the Secretary of Labor specifies; or

(III) the tasks performed by the person are functionally integrated with the operations of the recipient and performed on the premises of (or using the facilities and equipment of) the recipient.

(9) TREATMENT OF EMPLOYEES IN THE ENTERTAINMENT INDUSTRY.—In the case of employees in the entertainment industry, the Secretary shall establish special rules to determine what constitutes full-time and part-time work in the industry. Such rules shall take into account the historic employment patterns in the industry.

(10) TREATMENT OF FRANCHISE NETWORKS.—

(A) IN GENERAL.—The Secretary of Labor shall prescribe regulations regarding the circumstances under which individuals performing services for a franchisee are treated as employees of a franchise network.

(B) DEFINITIONS.—For purposes of this paragraph, the terms "franchisee" and "franchise network" have the meanings given such terms in regulations of the Federal Trade Commission published in part 436 of title 16, Code of Federal Regulations.

(11) TREATMENT OF SALARIED EMPLOYEES AND EMPLOYEES PAID ON CONTINGENT OR BONUS ARRANGEMENTS.—In the case of an employee who receives compensation on a salaried basis or on the basis of a commission (or other contingent or bonus basis), rather than an hourly wage, the Secretary of Labor shall establish rules for the conversion of the compensation to hours of employment, taking into account the minimum monthly compensation levels for workers employed on a full-time basis under the Fair Labor Standards Act of 1938 and other factors the Secretary considers relevant.

(12) WAGES.—

(A) IN GENERAL.—The term "wages" has the meaning given such term in section 209(a) of the Social Security Act, except that paragraph (1) shall not apply.

(B) TIPS NOT INCLUDED.—The term "wages" does not include cash tips.

PART 1—GENERAL EMPLOYER RESPONSIBILITIES

SEC. 9601. PROHIBITION OF CERTAIN EMPLOYER DISCRIMINATION.

(a) PROHIBITION OF FAMILY DISCRIMINATION.—No employer may discriminate with respect to an employee on the basis of the family status of the employee or on the basis of the class of family enrollment selected with respect to the employee.

(b) EVASION OF OBLIGATIONS.—It shall be unlawful for any employer or other person to discharge, fine, suspend, expel, discipline, discriminate or otherwise take adverse action against any employee if a purpose of such action is to interfere with the employee's attainment of status as a qualifying employee, as a full-time employee, or as a part-time employee, or if a purpose of such action is to evade or avoid any obligation under this Act.

(c) ENFORCEMENT.—In the case of a person that violates a requirement of this section, the Secretary of Labor may impose a civil money penalty, in an amount not to exceed $10,000, for each violation with respect to each individual with respect to whom a violation occurred. The provisions of section 503 of the Migrant and Seasonal Agricultural Worker Protection Act (other than subsection (a)) shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty under such Act.

SEC. 9602. WHISTLEBLOWER PROTECTION.

(a) EMPLOYEE PROTECTIONS.—No entity under this Act may discharge, discriminate, or otherwise take adverse action against any employee with respect to compensation, terms, conditions, or privileges of employment because the employee (or any other person acting pursuant to a request of the employee) provided information to any Federal, State, or public or private supervisory agency or entity regarding a possible violation of any provision of this Act or any regulation issued pursuant to this Act.

(b) COURT ACTION.—

(1) IN GENERAL.—An employee or former employee who believes that such employee was discharged, discriminated, or otherwise subject to adverse action in violation of subsection (a), may file a civil action in the appropriate district court of the United States not later than two years after the date of such discharge, discrimination, or adverse action.

(2) DAMAGES.—If the court determines that a violation of subsection (a) has occurred, the plaintiff may obtain appropriate relief, including actual, compensatory, and punitive damages and equitable relief (including reinstatement).

(3) ATTORNEY'S FEES AND COSTS.—In any action under paragraph (1) in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

SEC. 9603. EMPLOYER NEUTRALITY.

Federal funds appropriated to carry out this Act, other than funds appropriated pursuant to title XVIII, XIX, XXI, or XXII of the Social Security Act, may not be used to assist, promote, or deter union organizing.

PART 2—TRANSITIONAL PROVISIONS FOR WORKFORCE STABILITY

SEC. 9621. APPLICATION.

(a) LIMITATION TO TRANSITION PERIOD.—The provisions of this part are intended to minimize, to the extent possible, disruptions in established employment relationships during the period of transition to a restructured health care delivery system, and shall terminate on January 1, 2004.

(b) HEALTH CARE EMPLOYERS COVERED BY PART.—The provisions of this part, including references to displacing employers, hiring employers, successors and contractors, apply only to health care employers (including successor employers) that employ more than 15 covered employees on a typical business day.

(c) COVERED EMPLOYEES DEFINED.—In this part, the term "covered employee" means an employee of a health care employer.

(d) INCLUSION OF SUCCESSOR EMPLOYERS.—In this part, the term "employer" includes a successor employer of the employer.

SEC. 9622. OBLIGATIONS OF DISPLACING EMPLOYER AND AFFILIATED ENTERPRISES IN EVENT OF DISPLACEMENT.

(a) NOTICE.—A health care employer which displaces a preference eligible employee (as defined in subsection (e)) shall provide such employee with—

(1) written notice, no later than the date of displacement, of employment rights under this part; and

(2) notice of any existing or subsequent vacancies with the displacing employer, which notice may be given by posting of such vacancies wherever notices to applicants for employment are customarily posted, by listing such vacancies with the local employment services agency, or in such other manner as the Secretary of Labor, by regulation, may specify.

Any such vacancy shall remain open for applications by preference eligible employees for not less than 14 calendar days from the date on which the initial notice is provided.

(b) HIRING PREFERENCE.—

(1) IN GENERAL.—A preference eligible employee who—

(A) meets any qualifications described in paragraph (3); and

(B) applies during the notice period described in subsection (a)(2) for a vacant position with the displacing employer which is in the employee's occupational specialty and located in the same State or Metropolitan Statistical Area in which the employee was employed prior to the displacement,

shall be given the right to accept or decline the position before the employer may offer the position to an employee who is not a preference eligible employee.

(2) MULTIPLE APPLICATIONS.—When considering applications from more than one preference eligible employee described in paragraph (1), the hiring health care employer shall have discretion as to which of such employees will be offered the position.

(3) EMPLOYMENT QUALIFICATION REQUIREMENTS.—A hiring health care employer may establish reasonable employment qualifications for a vacancy to which this part applies, except that an employee who performed essentially the same work prior to the employee's displacement shall be deemed presumptively qualified for a comparable position.

(c) TERMINATION OF PREFERENCE ELIGIBILITY.—Subject to section 9621(a), a displaced employee's preference eligibility shall terminate at such time as the displaced employee obtains substantially equivalent employment with the displacing employer.

(d) NOTICE OF JOB OPENINGS.—A health care employer, to the extent practicable, shall list all job openings for covered employees with the job bank established by the Employment Service.

(e) DEFINITIONS.—In this part:

(1) PREFERENCE ELIGIBLE EMPLOYEE.—The term "preference eligible employee" means an employee who—

(A) has been employed as a covered employee for in excess of one year by a health care employer; and

(B) has been displaced by or has received notice of an impending displacement by such employer.

(2) DISPLACEMENT.—The term "displacement" includes a lay off, termination, significant cutback in paid work hours, or other loss of employment, except that a discharge for just cause shall not constitute a displacement within the meaning of this paragraph.

SEC. 9623. EMPLOYMENT WITH OTHER HEALTH CARE EMPLOYERS.

A health care employer that replaces another health care employer in whole or in part through merger, consolidation, acquisition, contract, or other similar manner shall—

(1) provide employees who would otherwise be displaced the right to continued employment in the job positions previously held by such employees, unless the employer can establish that such positions no longer exist; and

(2) for six months from the date of their displacement by the predecessor, provide employees who are not rehired under paragraph (1) notice and the right to employment in any vacancies that become available in such job positions.

SEC. 9624. COLLECTIVE BARGAINING OBLIGATIONS DURING TRANSITION PERIOD.

(a) CONTINUATION OF PREVIOUSLY RECOGNIZED BARGAINING REPRESENTATIVES AND AGREEMENTS.—If a majority of the employees in an appropriate bargaining unit of employees of a health care employer consists of employees who were previously covered by a bargaining agreement or represented by an exclusive representative with respect to the terms and conditions of employment with the predecessor health care employer, and there has not been a substantial change in the operations performed by the employees in that unit, the employer shall recognize such representative as the exclusive representative for the unit and shall assume the bargaining agreement, except that if the application of this subsection would result in the recognition of more than one bargaining representative for a single unit, the question concerning which representative shall be recognized as the exclusive representative for the unit shall be resolved in accordance with applicable Federal or State law.

(b) JOINT EMPLOYER STATUS.—If employees of a contractor to a health care employer are assigned on a regular basis to perform work on the premises of a health care employer and the tasks performed by these employees are functionally integrated with the operations of the health care employer on whose premises such employees work, both the contractor and the health care employer shall be considered joint employers of the employees with respect to work performed on those premises for purposes of determining compliance with labor relations laws. Employees of such joint employers may not be excluded from a bargaining unit within either entity on the basis of such joint employer status.

SEC. 9625. GENERAL PROVISIONS.

(a) REGULATIONS.—Not later than 120 days after the date of enactment of this Act, the Secretary of Labor shall promulgate regulations to implement the requirements of this part.

(b) OTHER LAWS.—The standards and requirements of this part shall not preempt or excuse noncompliance with any other applicable Federal or State law, regulation, or municipal ordinance that establishes additional notice and preference standards or requirements concerning employee dislocation, employee representation, or collective bargaining.

(c) RULES OF CONSTRUCTION.—Nothing in this part shall be construed to excuse or otherwise limit the obligation of an employer to comply with the terms of any collective bargaining agreement or of any employee benefit plan that provides employees with rights in addition to those provided under this part.

(d) DISCRIMINATION.—In making decisions that would result in the displacement, retention, hiring or transfer of employees, a health care employer may not discriminate between or among employees on the basis of their protected status under this part or under any other Federal or State laws.

(e) ENFORCEMENT.—Unless otherwise specifically provided in this part, the enforcement provisions of section 107 of the Family and Medical Leave Act of 1993 shall apply (except that the limitation of paragraph (1) of subsection (a) shall not apply) with respect to the enforcement of the individual rights, including notice requirements, provided under section 9622 and 9623. The collective bargaining and contractual rights provided under section 9624 shall be enforced through administrative and judicial procedures otherwise provided under Federal or State law with respect to such rights.

PART 3—RESPONSIBILITIES OF BOARD OF INQUIRY

SEC. 9631. REQUEST FOR APPOINTMENT OF BOARD OF INQUIRY.

(a) IN GENERAL.—A health care employer or a labor organization that has been lawfully certified or recognized as the representative of the employees of a health care employer for the purpose of engaging in collective bargaining concerning wages, hours and other terms and conditions of employment, may request that the Director of the Federal Mediation and Conciliation Service (referred to in this section as the "Director") appoint an impartial Health Care Board of Inquiry to investigate the issues involved in a collective bargaining dispute between the employer and the labor organization.

(b) TIME FOR REQUEST.—Such request may be made no earlier than 60 days after notice of the existence of a collective bargaining dispute has been provided to—

(1) the Federal Mediation and Conciliation Service in accordance with clause (A) or (B) of the last sentence of section 8(d) of the Labor Management Relations Act; or

(2) if the health care employer is otherwise exempt from coverage under such Act, any comparable State or territorial agency established to mediate and conciliate disputes to which notice is required to be given under applicable State law.

SEC. 9632. APPOINTMENT OF BOARD OF INQUIRY.

(a) IN GENERAL.—Except as provided in subsection (b), the Director shall appoint a Health Care Board of Inquiry not later than 10 days after receipt of a request under section 9631. Each such Board shall be composed of such number of individuals as the Director may deem desirable. No member appointed under this section shall have any interest or involvement in a health care employer, or a labor organization, involved in the collective bargaining dispute. To the greatest extent feasible, the membership of a Board shall reflect the racial, ethnic, and gender composition of the population of the community served by the health care employer involved.

(b) LIMITATION.—With respect to the appointment of a Health Care Board of Inquiry under paragraph (1), if the Director determines that—

(1) the health care employer is—

(A) otherwise exempt from coverage under the Labor Management Relations Act, as amended; and

(B) subject to State laws containing procedures for the resolution of impasses in collective bargaining that are comparable to those that would be followed by a Board of Inquiry under this section; or

(2) the parties involved have agreed to procedures for the resolution of the impasse in collective bargaining that are comparable to those that would be followed by a Board of Inquiry;

the Director may refuse the request for the appointment of such a Board.

SEC. 9633. PUBLIC FACT FINDING.

A Health Care Board of Inquiry appointed under this section shall investigate the issues involved in the dispute and make a written report thereon to the parties and to the Director within 30 days after the establishment of such a Board. The written report shall contain the findings of fact together with the Board's recommendations for settling the dispute, with the objective of achieving a prompt, peaceful and just settlement of the dispute. The Board shall arrange for publication of such report within the community served by the health care employer involved.

SEC. 9634. COMPENSATION OF MEMBERS OF BOARD OF INQUIRY.

(a) EMPLOYEES OF FEDERAL GOVERNMENT.—Members of any Board established under this part who are otherwise employed by the Federal Government shall serve without compensation but shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in carrying out its duties under this section.

(b) OTHER MEMBERS.—Members of any Board established under this section who are not subject to paragraph (1) shall receive compensation at a rate prescribed by the Director but not to exceed the daily rate prescribed for GS-18 of the General Schedule under section 5332 of title 5, including travel for each day they are engaged in the performance of their duties under this section and shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by them in carrying out their duties under this part.

SEC. 9635. MAINTENANCE OF TERMS AND CONDITIONS OF EMPLOYMENT.

Beginning on the date on which a Board is requested under section 9631 and ending 15 days after the date any such Board has issued its report, no change in the terms and conditions of employment in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time the parties begin their bargaining in the case of an initial beginning negotiations, except by agreement, shall be made by the parties to the collective bargaining dispute.

PART 4—WORKFORCE PRIORITIES UNDER FEDERAL PAYMENTS

SEC. 9641. PROGRAMS OF THE SECRETARY OF LABOR.

(a) IN GENERAL.—

(1) FUNDING.—(A) For purposes of carrying out the programs described in this section, and for carrying out section 9642, there is authorized to be appropriated $200,000,000 for fiscal year 1995 and each subsequent fiscal year.

(B) Of the total amount authorized for each fiscal year under subparagraph (A)—

(i) not more than $10,000,000 may be used to carry out the program under subparagraph (B) of subsection (b)(1);

(ii) not more than $25,000,000 may be used to carry out the program under subparagraph (C) of subsection (b)(1);

(iii) not more than $10,000,000 may be used to carry out the program under subparagraph (D) of subsection (b)(1);

(iv) not more than $3,000,000 may be used to carry out the provisions of section 9642; and

(v) the remainder of funds shall be used to carry out the program under subparagraph (A) of subsection (b)(1).

(2) ADMINISTRATION.—The programs described in this section and carried out with amounts made available under subsection (a) shall be carried out by the Secretary of Labor.

(b) RETRAINING PROGRAMS; ADVANCED CAREER POSITIONS; WORKFORCE ADJUSTMENT PROGRAMS.—

(1) IN GENERAL.—For purposes of subsection (a), the programs described in this section are the following:

(A) A program for skills upgrading and occupational retraining (including retraining health care workers for more advanced positions as technicians, nurses, and physician assistants), and for quality and workforce improvement.

(B) A demonstration program to assist workers in health care institutions in obtaining advanced career positions.

(C) A program to ensure the expansion of the national job bank (established by the Employment Service of the Department of Labor) within local employment services agencies designed to address the needs of health care workers, subject to the following:

(i) Such job bank shall be available to all health care employers and health care workers in the community involved.

(ii)(I) With respect to each affected community, the local employment service agency or one-stop career center serving such community shall be allocated not less than one counselor whose responsibility shall include addressing the needs of health care workers.

(II) Such counselor shall ensure the solicitation of job openings from local health care employers and, not less frequently than once each month, ensure that such employers and other employers are contacted, and ensure that all job listings appropriate for health care workers adversely affected under this Act are monitored and updated regularly.

(III) Such counselor shall provide directly, or facilitate the provision of, labor exchange services by local employment service staff to eligible health care workers, including assessment, counseling, testing, job-search assistance, job referral and placement, and referral to training and educational programs.

(IV) If the impact of health care industry restructuring is such that the functions required under this clause cannot be satisfactorily provided by one counselor, additional counselors shall be allocated.

(iii) The job bank serving the community involved shall be subject to performance goals that measure the number of health care job openings and the proportion of health care employers in the community that list job openings. Such goals shall be adjusted based on specific economic, geographic, and other characteristics, including demonstrated difficulties with employer compliance.

(D) A program to provide for joint labor-management decision-making in the health care sector on workplace matters related to the restructuring of the health care delivery system provided for in this Act.

(2) USE OF FUNDS.—Amounts made available under subsection (a) for carrying out this section may be expended for program support, faculty development, trainee support, workforce analysis, and dissemination of information, as necessary to produce required performance outcomes.

(c) ADMINISTRATIVE REQUIREMENTS.—In carrying out the programs described in subsection (b), the Secretary of Labor shall, with respect to the organizations and employment positions involved, provide for the following:

(1) Joint labor-management implementation and administration.

(2) Discussion with employees as to training needs for career advancement.

(3) Commitment to a policy of internal hirings and promotion.

(4) Provision of support services.

(5) Consultations with employers and with organized labor.

SEC. 9642. NATIONAL INSTITUTE FOR HEALTH CARE WORKFORCE DEVELOPMENT.

(a) ESTABLISHMENT OF INSTITUTE.—The Secretary of Labor, in consultation with the Secretary of Health and Human Services, shall establish an office to be known as the National Institute for Health Care Workforce Development.

(b) DIRECTOR.—The Institute shall be headed by a Director, who shall be appointed by the Secretary of Labor.

(c) DUTIES.—

(1) RECOMMENDATIONS BY DIRECTOR.—The Director of the Institute shall make recommendations to the Secretary of Labor regarding—

(A) the supply of health care workers needed for proper staffing of the health care institutions serving the insured health benefit plans, and the self-insured health benefit plans, described in title V;

(B) the impact of this Act, and of related changes regarding health care, on health care workers and the needs of such workers with respect to education, training, and career development; and

(C) the development and implementation of high performance, high quality health care delivery systems, including employee participation committee systems, that will improve the health care delivery system by increasing the role, the responsibilities, and the area of independent decision-making authority of health care workers.

(2) RESPONSE TO RECOMMENDATIONS.—The Secretary of Labor, in acting upon the recommendations made under paragraph (1), may—

(A) issue timely and useful reports on health care worker supply and needs and on proper staffing of health care institutions;

(B) take actions to encourage the use of employee participation committees and other activities intended to promote the development of high performance, high quality health care delivery systems; and

(C) take such other actions as are authorized under this Act.

(d) ADVISORY BOARD.—

(1) IN GENERAL.—The Secretary of Labor shall establish an advisory board to assist in the development and implementation of recommendations under subsection (c)(1).

(2) COMPOSITION.—The advisory board established under paragraph (1) shall be composed of the following members with expertise in health care workforce issues:

(A) The Secretary of Labor.

(B) The Secretary of Health and Human Services.

(C) Five representatives of health care workers in organized labor to be appointed by Secretary of Labor.

(D) Five representatives of health institutions to be appointed by the Secretary of Health and Human Services.

(E) Two representatives from organizations that train and educate health care workers, to be appointed by the Secretary of Labor.

(F) Two representatives from consumer organizations to be appointed by the Secretary of Labor.

To the greatest extent feasible, the membership of the advisory board shall reflect the racial, ethnic, and gender composition of the population of the United States.

(e) STAFF, QUARTERS, AND OTHER ASSISTANCE.—The Secretary of Labor shall provide the Institute and the Advisory Board with such staff, quarters, and other administrative assistance as may be necessary for the Institute and the Advisory Board to carry out this section.

(f) COORDINATION.—The Secretary of Labor, in consultation with the Secretary of Health and Human Services, shall, to the extent practicable, ensure that the efforts under this section and section 792 of the Public Health Service Act are coordinated to ensure that joint planning occurs to maximize the utilization of resources, to avoid duplication of effort, and to provide for the equitable division of responsibility.

(g) DEFINITIONS.—For purposes of this section:

(1) ADVISORY BOARD.—The term "Advisory Board" means the advisory board established under subsection (d).

(2) EMPLOYEE PARTICIPATION COMMITTEE.—The term "employee participation committee" means a committee of non-managerial workers at a health care facility which—

(A) is selected without employer interference by one or more labor organizations representing such workers or, if there is no such organization, by such workers;

(B) operates without employer interference; and

(C) consults with management on issues of efficiency, productivity, and quality of care.

(3) The term "Institute" means the Institute established under subsection (a).

(h) SUNSET.—Unless otherwise extended by law, the Institute is terminated on January 1, 2004.

TITLE X—LONG-TERM CARE

Subtitle A—Long-Term Care Program

SEC. 10001. ESTABLISHMENT OF LONG-TERM CARE PROGRAM FOR HOME AND COMMUNITY-BASED SERVICES.

The Secretary shall establish a long-term care program for grants to States under this subtitle to provide home and community-based services for individuals with severe disabilities without regard to age or income through approved State plans. Nothing in this subtitle may be construed to authorize the Secretary to delegate to the States the primary responsibility for interpreting the governing provisions of this subtitle.

SEC. 10002. INDIVIDUALS WITH SEVERE DISABILITIES.

(a) IN GENERAL.—In this subtitle, the term "individual with severe disabilities" means any individual within one or more of the following 4 categories of individuals:

(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined by the Secretary) to perform three or more activities of daily living (as defined in subsection (c)), and

(B) is expected to require such assistance, supervision, or cueing over a period of at least 100 days.

(2) INDIVIDUALS WITH SEVERE COGNITIVE OR MENTAL IMPAIRMENT.—An individual of any age—

(A) whose score, on a standard mental status protocol (or protocols) specified by the Secretary as appropriate for measuring the individual's particular condition, indicates either severe cognitive impairment or severe mental impairment, or both;

(B) who—

(i) requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living,

(ii) requires hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies, or

(iii) displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; and

(C) whose is expected to meet the requirements of subparagraphs (A) and (B) over a period of at least 100 days.

(3) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

(4) SEVERELY DISABLED CHILDREN.—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition,

(B) but for receiving home and community-based services would require institutionalization in a hospital, nursing facility, or intermediate care facility for the mentally retarded, and

(C) is expected to have such disability or condition and require such services over a period of at least 100 days.

(b) DETERMINATION OF ELIGIBILITY.—

(1) IN GENERAL.—The determination of whether an individual is an individual with severe disabilities shall be made, by persons or entities (which may be local care coordination agencies) specified under the State plan (under section 10004), using a uniform protocol consisting of an initial screening and assessment specified by the Secretary. A State may collect additional information, at the time of obtaining information to be used by such persons or entities to make such determination, in order to provide for the assessment and plan described in section 10004(b) or for other purposes. The determination of such persons or entities shall be made without regard to the individual's income or (except in the case described in subsection (a)(4)) the individual's age.

(2) INITIAL SCREENING PROCESS.—The plan shall provide a process for the initial screening of individuals who appear to have some reasonable likelihood of being an individual with severe disabilities.

(3) PERIODIC REASSESSMENT.—The determination that an individual is an individual with severe disabilities shall be considered to be in effect under the State plan for a period of not more than 12 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

(4) FAIR HEARING PROCESS.—The State shall establish a fair hearing process for appeals of such determinations.

(c) ACTIVITY OF DAILY LIVING DEFINED.—In this subtitle, the term "activity of daily living" means any of the following: eating, toileting, dressing, bathing, and transferring.

SEC. 10003. HOME AND COMMUNITY-BASED SERVICES.

(a) SCOPE OF SERVICES.—

(1) IN GENERAL.—In this subtitle, the term "home and community-based services" includes, subject to paragraph (2), the following:

(A) Agency-administered and consumer-directed personal assistance services (as defined in paragraph (3)).

(B) Case management.

(C) Homemaker and chore assistance.

(D) Home modifications.

(E) Respite services.

(F) Assistive devices.

(G) Adult day services.

(H) Habilitation and rehabilitation.

(I) Supported employment.

(J) Home health services.

(L) Any other care or assistive services (approved by the Secretary) that a State determines will help individuals with severe disabilities to remain in their homes and communities.

(2) EXCLUSIONS.—Such term does not include coverage of the following:

(A) Room and board.

(B) Services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary.

(C) Items and services to the extent coverage is provided for the individual under a certified health plan or under title XVIII of the Social Security Act or medicare part C.

(3) PERSONAL ASSISTANCE SERVICES DEFINED.—

(A) IN GENERAL.—In this subsection, the term "personal assistance services" includes hands-on and standby assistance, supervision, and cueing with activities of daily living, whether agency-administered or consumer-directed (as defined in subparagraph (B)).

(B) CONSUMER-DIRECTED; AGENCY-ADMINISTERED.—In this subtitle:

(i) The term "consumer-directed" means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the individual's option, trained) by the individual receiving the services.

(ii) The term "agency-administered" means, with respect to such services, services that are not consumer-directed.

(C) LIMITATION ON LICENSURE OR CERTIFICATION.—A State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements which the Secretary finds not to be necessary for the health and safety of individuals with severe disabilities.

(b) COST SHARING.—

(1) NO OR NOMINAL COST SHARING FOR POOREST.—No cost sharing (other than nominal cost sharing) may be imposed for individuals with income (as determined under paragraph (3)) less than 150 percent of the Federal poverty level (as defined in paragraph (4)) applicable to a family of the size involved.

(2) SLIDING SCALE FOR REMAINDER.—Cost sharing in the form of coinsurance (based on the amount paid under this subtitle for a service) shall be imposed—

(A) at a rate of 10 percent for individuals with severe disabilities with income not less than 150 percent, and less than 200 percent, of the applicable Federal poverty level;

(B) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of the applicable Federal poverty level; and

(C) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such Federal poverty level.

(3) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—Each State, or an agency designated by the State, shall determine the income of an individual with severe disabilities for purposes of this subsection, in a manner specified by the Secretary.

(4) FEDERAL POVERTY LEVEL DEFINED.—In this subsection, the term "Federal poverty level" means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved for the year.

(c) SPECIFICATION OF SERVICES TO BE COVERED.—

(1) IN GENERAL.—Each State shall specify, in its plan under section 10004—

(A) the methods and standards used to select the types, and the amount, duration, and scope, of home and community-based services to be covered under the plan and to be available to each category of individuals with severe disabilities;

(B) how the types, and the amount, duration, and scope of the services specified meet the needs of individuals within each of such categories;

(C) the extent and manner in which such services would be allocated among individuals with severe disabilities and categories of such individuals;

(D) the manner in which such services are coordinated with each other and with health and long-term care services available outside the plan for individuals with severe disabilities; and

(E) the manner in which individuals with severe disabilities will be assisted in obtaining services from other programs for which they may qualify (including home health services under title XVIII or medicare part C and home and community-based services under a State plan approved under title XIX).

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—The services—

(A) shall be specified in a manner that permits sufficient flexibility for providers to meet the needs of individuals with severe disabilities in a cost effective manner;

(B) may be specified in a manner that takes into account the availability of informal care; and

(C) subject to subsection (a)(2)(B), may be delivered in an individual's home, a range of community residential arrangements, or outside the home (but not in an institutional setting).

SEC. 10004. ADMINISTRATION THROUGH STATE PLANS.

(a) IN GENERAL.—As a condition for the payment of funds to a State under section 10005, the State must have a plan for home and community-based services for individuals with severe disabilities approved by the Secretary. The Secretary may not approve such a plan unless the Secretary determines that the plan meets the requirements of subsection (b).

(b) PLAN REQUIREMENTS.—The requirements for a State plan are as follows:

(1) ELIGIBILITY PROCESS.—The plan shall provide for a process to determine if individuals are individuals with severe disabilities in accordance with section 10002(b).

(2) SPECIFICATION OF SERVICES, COST SHARING, TYPES OF PROVIDERS, AND REQUIREMENTS FOR PARTICIPATION.—The plan shall—

(A) specify, in accordance with section 10003(c), the home and community-based services to be provided under this subtitle to individuals with severe disabilities;

(B) impose cost sharing with respect to covered services in accordance with section 10003(b); and

(C) specify—

(i) the types of service providers eligible to participate in the program under the plan, and

(ii) any requirements for participation applicable to each type of service provider.

(3) PROVISION OF SERVICES.—

(A) ACCORDING TO PLAN OF CARE.—

(i) IN GENERAL.—The State plan shall provide for home and community-based services to an individual with disabilities only if such services are provided consistent with an individualized plan of care.

(ii) PLAN OF CARE.—Such plan of care shall—

(I) be based on an assessment of the individual's need for such services under section 10002(b)(1),

(II) be developed in consultation with the individual and the individual's family, and

(III) be periodically reviewed and updated, as appropriate (in accordance with section 10002(b)(3).

(iii) CONSTRUCTION.—Nothing in this subparagraph shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(B) CONSUMER CHOICE.—To the extent possible, preference is to be given to the choice of an individual with severe disabilities (and that individual's family) regarding which covered services to receive and the providers who will provide such services.

(4) PAYMENTS FOR SERVICES.—The plan provides for payment for services in accordance with the schedules and payment methodology specified in subsection (e).

(5) BUDGETING AND FISCAL MANAGEMENT.—

(A) LIMITATION ON ADMINISTRATIVE EXPENDITURES.—The plan shall contain assurances that not more than an amount or level (specified by the Secretary) of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

(B) USE OF STATE FUNDS FOR MATCHING.—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this subtitle.

(C) BUDGET PRIORITY FOR CONTINUING CURRENT SERVICES FOR CURRENT RECIPIENTS.—The State plan shall give priority to the provision of such services to individuals who are already being provided services under the plan in a fiscal year during which insufficient funds are available to provide services to each individual eligible to receive such services under 10002(a).

(6) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with subsection (f).

(7) GENERAL ADMINISTRATION.—

(A) STATE AGENCY.—The plan shall designate a State agency or agencies to manage and coordinate benefits under the plan, in accordance with specifications included in the plan.

(B) USE OF LOCAL CARE COORDINATION AGENCIES.—A State may contract with or establish local care coordination agencies throughout the State to assure the availability of home and community-based services to individuals with severe disabilities residing throughout the State.

(C) COORDINATION.—The plan shall specify how the plan—

(i) will be integrated with the State plan for medical assistance under title XIX of the Social Security Act, State plans under titles V and XX of such Act, programs under the Older Americans Act of 1965, programs under the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, and any other Federal or State programs that provide services or assistance targeted to individuals with severe disabilities, and

(ii) will be coordinated with certified health plans.

(8) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this subtitle, including the processing of claims under the plan, and

(B) such data and information as the Secretary may require in order to carry out the purpose of the program.

(9) COMPLIANCE WITH WORKER REDEPLOYMENT NEGOTIATION REQUIREMENTS.—The plan shall meet the requirements of subtitle C (relating to negotiations regarding worker redeployment).

(c) STANDARDS FOR PLAN APPROVAL.—

(1) IN GENERAL.—The Secretary shall establish standards for the approval of State plans under this section.

(2) EFFECTIVENESS.—The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before October 1, 1998, shall be effective as of such date). In order to budget funds allotted under this subtitle, the Secretary may establish a deadline for the submission of such a plan before the beginning of a fiscal year as a condition of its approval effective with that fiscal year.

(d) MONITORING STATE PERFORMANCE.—

(1) IN GENERAL.—The Secretary shall monitor the performance of States in carrying out plans under this section and shall, not less often than every two years, evaluate the performance of State agencies in carrying out their programmatic and fiscal responsibilities under this subtitle.

(2) PERFORMANCE MEASURES.—In evaluating such performance, the Secretary shall take into account at least the following:

(A) The State's ability to maintain plan expenditures within amounts for which Federal payments are available under section 10005.

(B) The plan's ability to maximize the provision of services within the State's allocation.

(C) The State's success at finding alternative sources of funding to pay for services authorized under a care plan.

(D) The plan's ability to maintain individuals with severe disabilities outside institutional settings.

(E) The State's ability to implement the requirement that the plan is a secondary payor to the State plan for medical assistance under title XIX of the Social Security Act under section 10005(f)(1).

(e) REQUIREMENTS RELATING TO PAYMENT FOR SERVICES.—

(1) IN GENERAL.—Subject to paragraph (2), payments for services under the State plan shall be made based on—

(A) the prospective payment system developed under paragraph (3)(B), or

(B) in the absence of such a system, the fee schedules developed under paragraph (3)(A), or

(C) in the absence of such a system or schedules, payment rates or methodologies developed by the providers for payment rates that are reasonable and ensure adequate provider participation and access to covered services of adequate quality.

(2) USE OF CASH PAYMENTS AND VOUCHERS.—

(A) IN GENERAL.—Under standards established by the Secretary under this section, a State plan may provide for the use of vouchers and cash payments directly to individuals with severe disabilities to pay for covered services.

(B) DETERMINATION OF PAYMENT RATES.—The plan shall specify the methods and criteria to be used to set rates for such cash payments and vouchers.

(C) USE OF INTERMEDIATE ENTITIES FOR CONSUMER-DIRECTED SERVICES.—With respect to consumer-directed services furnished to an individual with severe disabilities by a provider, the plan may provide that an entity, other than the individual or provider—

(i) would inform the individual and the provider of rights and responsibilities under all Federal and other applicable labor and tax laws, and

(ii) would act as the employer of the provider for purposes of assuming responsibility for effective billing and for payments for service tax withholding, unemployment compensation, and workers'' compensation under such laws.

In such a case individuals with severe disabilities retain the right to select, hire, terminate, and direct the work of such a provider.

(3) DEVELOPMENT OF FEE SCHEDULES AND PROSPECTIVE PAYMENT SYSTEM.—

(A) IN GENERAL.—The Secretary shall develop fee schedules for payment for home and community-based services. Such schedules shall be—

(i) based on the estimated cost of visits by discipline or service,

(ii) adjusted to take into account variations in area wage levels and such other factors as the Secretary deems appropriate, and

(iii) adequate to ensure provider participation and access to covered services of adequate quality.

(B) DEVELOPMENT OF PROSPECTIVE SCHEDULE.—To the extent practicable, the Secretary shall develop a prospective payment system for payment for home and community-based services under this subtitle. Such a system shall adjust payment rates to take into account—

(i) variations in area wage levels, and

(ii) predictable differences in the cost and utilization of such services, based on degree of dependency in relation to activities of daily living and other case-mix severity indicators of resource needs.

To the extent possible, the unit of payment shall be established on a per-episode basis rather than per-visit basis. The payment rates under such a system shall be adequate to ensure provider participation and access to covered services of adequate quality.

(4) EXTRA BILLING NOT PERMITTED.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established under this subsection) and any cost sharing permitted or provided for under the plan as payment in full for services furnished under the plan.

(f) QUALITY ASSURANCE AND SAFEGUARDS.—

(1) QUALITY ASSURANCE REQUIREMENTS.—In order to assure the health and safety of individuals with severe disabilities, the Secretary shall establish, by not later than July 1, 1999, quality assurance and certification requirements—

(A) for providers to receive payments under a State plan for furnishing home and community-based services, and

(B) for enforcement of such requirements under the plan.

(2) SAFEGUARDS.—

(A) CONFIDENTIALITY.—The State plan shall provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan.

(B) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide, through methods other than reliance on State licensure processes, that individuals receiving home and community care under this subtitle are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings.

(C) SAFEGUARDS IN CASES OF CASH PAYMENTS AND VOUCHERS.—The State plans shall provide appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with severe disabilities.

(D) INCORPORATION OF PROVISIONS.—In carrying out this subsection, the provisions of subsections (f) through (h) of section 1929 of the Social Security Act (relating to minimum requirements for care and settings) shall apply under this subtitle in the same manner as they apply under such section.

(g) REGULATIONS.—The Secretary shall issue such regulations as may be appropriate to carry out this subtitle.

SEC. 10005. PAYMENTS TO STATES; MEDICAID MAINTENANCE OF EFFORT.

(a) IN GENERAL.—The Secretary shall authorize payment to each State with a plan approved under this subtitle, for each fiscal year (beginning with fiscal year 2000), of an amount equal to six dollars for each seven dollars expended under the plan, but not to exceed the State allocation under subsection (b)(1) for the fiscal year plus the State's share of the reallotment pool under subsection (b)(3).

(b) ALLOCATION TO STATES.—

(1) ALLOCATION OF FEDERAL FUNDS.—The Secretary shall allocate all the national long-term care allocation amount (described in paragraph (2)) for each fiscal year among the States in accordance with a formula based on—

(A) the number of individuals with severe disabilities in the State within each of the categories of such individuals, and

(B) the average per capita spending amounts within each State within each of such categories for home and community-based services.

(2) NATIONAL LONG-TERM CARE ALLOCATION AMOUNT.—For any fiscal year, the national long-term care allocation amount is 125 percent of the Federal funds available under section 10006 for the fiscal year.

(3) STATE SHARE OF REALLOTMENT POOL.—

(A) IN GENERAL.—For purposes of subsection (a), the State's share of the reallotment pool for the fiscal year under this paragraph is equal to the State's share (as determined under subparagraph (B)) of the redistribution pool (as determined under subparagraph (C)) for the fiscal year.

(B) STATE SHARE.—For purposes of subparagraph (A), a State's share is equal to the ratio of—

(i) the State allocation under paragraph (1) for the fiscal year, to

(ii) the sum of such allocations for all fully participating States for the fiscal year.

(C) REDISTRIBUTION POOL.—For purposes of subparagraph (A), the redistribution pool for a fiscal year is equal to the amount by which the available Federal funds under section 10006 for the fiscal year exceeds the total payments made to States under paragraphs (1) and (2) of subsection (a) for the fiscal year.

(c) STATE ENTITLEMENT.—This subtitle constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

(d) DISALLOWANCE OF CERTAIN EXCESSIVE ADMINISTRATIVE COSTS.—For purposes of subsection (a), administrative expenditures that are in excess of the amounts permitted under section 10004(b)(5)(A) shall not be treated as expenditures under the State plan.

(e) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE RELATED TAXES.—The provisions of section 1903(w) of the Social Security Act shall apply to payments to States under this section in the same manner as they apply to payments to States under section 1903(a) of such Act .

(f) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter in a fiscal year, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of one-quarter of the total sum to be expended in such fiscal year, and such other information as the Secretary may find necessary.

(2) The Secretary shall provide for payment of the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid.

(g) REDUCTION OF PAYMENTS AUTHORIZED FOR FAILURE TO MAINTAIN MEDICAID EFFORT.—

(1) PAYER OF LAST RESORT.—The Secretary shall reduce the amount of payments otherwise made to a State under this section by the amount of any expenditures under this subtitle for services to individuals otherwise entitled to benefits under the title XVIII, medicare part C, a State plan approved under title XIX, or any certified health plan.

(2) MEDICAID MAINTENANCE OF EFFORT.—

(A) IN GENERAL.—The Secretary also may reduce the amount of payments otherwise made to a State in a fiscal year under this section by the amount by which—

(i) the State medicaid expenditures for home and community-based services in the fiscal year (as determined under subparagraph (B)), is less than

(ii) the maintenance of effort level for the State for the fiscal year (as determined under subparagraph (C)).

(B) STATE MEDICAID EXPENDITURES.—For purposes of this paragraph, a State's "medicaid expenditures for home and community-based services" in a fiscal year is—

(i) the gross amount expended on medical assistance under the State medicaid plan in the fiscal year for home and community-based services, including a reasonable allocation (determined by the Secretary) of administrative expenses attributable to the provision of such services, reduced by

(ii) the amount of the Federal financial participation attributable to such assistance and expenses under the medicaid program.

(C) MAINTENANCE-OF-EFFORT LEVEL.—For purposes of subparagraph (A)(ii), the "maintenance-of-effort level" for a State for a fiscal year (beginning with fiscal year 1998) is equal to—

(i) the State's medicaid expenditures for home and community-based services (as determined under subparagraph (B)) for fiscal year 1994,

(ii) increased by the total nominal growth in the gross domestic product between 1994 and 1997, and

(iii) increased for each year after 1998 and before the year in which the fiscal year involved ends by national medicare growth factor established under section 8201(c) for the year.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring States to determine eligibility for medical assistance under the State medicaid plan on behalf of individuals receiving benefits under this subtitle.

SEC. 10006. FEDERAL FUNDING.

(a) FISCAL YEARS 1998 THROUGH 2004.—For purposes of this subtitle, subject to subsection (c), the available Federal funds for all State plans under this subtitle—

(1) for fiscal year 1998 is $1.7 billion;

(2) for fiscal year 1999 is $1.5 billion;

(3) for fiscal year 2000 is $5.0 billion;

(4) for fiscal year 2001 is $6.6 billion;

(5) for fiscal year 2002 is $9.4 billion;

(6) for fiscal year 2003 is $19.3 billion; and

(7) for fiscal year 2004 is $22.6 billion.

(b) SUBSEQUENT FISCAL YEARS.—For purposes of this subtitle, subject to subsection (c), the available Federal funds for State plans under this subtitle for each fiscal year after fiscal year 2004 is the total available Federal funds under this section for the preceding fiscal year increased by the national medicare growth factor established under section 8201(c) for the year in which such preceding fiscal year ends.

(c) SET ASIDE FOR SERVICES UNDER THE INDIAN HEALTH CARE IMPROVEMENT ACT.—The Secretary shall set aside and pay to the Indian Health Service for each fiscal year (beginning with fiscal year 2000), for payments under section 906 of the Indian Health Care Improvement Act, 0.8 percent of the available Federal funds otherwise provided under subsection (a) or (b). Such amounts shall be treated as a reduction of amounts available under this title for purposes of computing the amount of allocations to States under section 10005(b).

Subtitle B—Federal Standards for Private Long-Term Care Insurance Policies

PART 1—GENERAL REQUIREMENT; ESTABLISHMENT OF STANDARDS

Subpart A—General Requirement

SEC. 10101. GENERAL REQUIREMENT.

(a) APPROVED REGULATORY STATES.—No long-term care insurance policy (as defined in section 10111) may be issued, sold, or offered for sale in an approved regulatory State (as defined in section 10112(3)) on or after the date specified in section 10103 unless the policy has been certified by the State commissioner of insurance under such program as meeting the standards established by the approved regulatory program in the State.

(b) OTHER STATES.—No long-term care insurance policy may be issued, sold, or offered for sale in a State that is not an approved regulatory State on or after the date specified in section 10103 unless the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 10102.

(c) TREATMENT OF ADVERTISING AND SOLICITING.—For purposes of this section, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

SEC. 10102. ESTABLISHMENT OF STANDARDS.

(a) IN GENERAL.—The Secretary shall promulgate a regulation that provides standards that incorporate the requirements of part 2 and such standards shall apply under section 10101. Such regulations shall first be published by not later than July 1, 1995.

(b) CONSULTATION.—In promulgating regulations under this section, the Secretary shall consult with the National Association of Insurance Commissioners (in this subtitle referred to as the "NAIC") and with representatives of consumer groups.

SEC. 10103. DEADLINE FOR APPLICATION OF STANDARDS IN STATES.

(a) INITIAL STANDARDS.—With respect to the initial Standards established under section 10102, subject to subsection (b), for purposes of this part, the date specified in this section for a State is—

(1) the date the State establishes an approved regulatory program, or

(2) January 1, 1997,

whichever is earlier.

(b) STATE REQUIRING LEGISLATION.—In the case of a State which the Secretary identifies as—

(1) requiring State legislation (other than legislation appropriating funds) in order for the State regulatory program under section 10161 to be implemented; but

(2) having a legislature which is not scheduled to meet in a legislative session in which such legislation may be considered in the year following the year in which the standards (or subsequent standards) are established;

the date specified in this section is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1 of the year following the year in which such standards (or subsequent standards) are established. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 10104. RELATION TO STATE LAW.

(a) PREEMPTION.—Except as provided in subsection (b), the Standards established under section 10102 preempt provisions of State law which conflict with such Standards.

(b) STRICTER STANDARDS PERMITTED.—A State may apply standards that provide greater protection to policyholders of long-term care insurance policies than the Standards.

(c) GRANDPARENTING OF CURRENT POLICIES.—Except as a State may provide, the Standards shall not apply to policies issued before the date specified in section 10103, unless and until such policies are upgraded under section 10130(c)(2).

(d) EXEMPTION FOR CERTAIN POLICIES SUBJECT TO STATE PLAN AMENDMENTS UNDER MEDICAID.—The Standards shall not apply to a policy in connection with which assets or resources are disregarded in the manner described in section 1917(b)(1)(C)(ii) of the Social Security Act, but only if the policy is certified by the State pursuant to an amendment to the State medicaid plan under section 1902(r)(2) of such Act approved on or before August 1, 1994.

SEC. 10105. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

Not later than July 1, 1995, the Secretary shall issue guidelines that shall apply to organizations and associations and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association or subsidiary. Such guidelines shall include, at a minimum, the following:

(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association or its subsidiary shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations and their subsidiaries may not function primarily as sales agents for insurance companies.

(2) Organizations and associations and their subsidiaries shall provide objective information regarding long-term care insurance policies sold or endorsed by such organizations, associations, and subsidiaries to ensure that members of such organizations, associations, and subsidiaries have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

(3) Organizations and associations and their subsidiaries selling or endorsing long-term care insurance policies shall disclose, in marketing literature concerning such policies that is provided to their members, the manner in which such policies and the insurance company issuing such policies were selected. If the organization, association, or subsidiary and the insurance company have interlocking directorates, the organization, association, or subsidiary shall disclose such fact to their members.

(4) Organizations and associations and their subsidiaries selling or endorsing long-term care insurance policies shall disclose, in marketing literature concerning such policies that is provided to their members, the precise nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the organization, association, or subsidiary receives from the endorsement or sale of the policies to its members. The Boards of Directors of organizations and associations and their subsidiaries selling or endorsing long-term care insurance policies shall review and approve the compensation arrangements relating to such policies.

(5) Organizations and associations and their subsidiaries selling or endorsing long-term care insurance policies to their members shall—

(A) disclose, in summary form, the most recent information available pertaining to the financial status (including solvency) of the carrier;

(B) make periodic actuarial or independent examinations of the policies, including their benefits, features, and rates;

(C) actively monitor the marking efforts, with respect to its members, of the carrier and its agents;

(D) review and approve all marketing materials or other insurance communications used to promote sales among, or sent to, members regarding such policies; and

(E) file with the State insurance commissioner of the State in which they are based—

(i) a copy of the policies,

(ii) a copy of the outline of coverage which accompanies such policies, and

(iii) a copy of each advertising and other marketing materials utilized in connection with the sale or endorsement of such policies.

SEC. 10106. REQUIREMENTS FOR AGENT TRAINING AND CERTIFICATION PROGRAMS.

(a) ESTABLISHMENT.—The Secretary shall establish requirements for a long-term care insurance agent training and certification program for insurance agents who desire to sell or offer for sale long-term care insurance policies. Under such program—

(1) the agent must pass either—

(A) a comprehensive examination on long-term care insurance coverage and appropriate sales techniques, or

(B) an equally comprehensive long-term care insurance portion of another examination required by a State in order for the agent to sell another insurance product in the State; and

(2) agents who have completed such program shall be certified as qualified to sell or offer for sale long-term care insurance policies.

(b) ADMINISTRATION.—The program established under subsection (a) shall be administered under an approved State regulatory program.

Subpart B—Definitions

SEC. 10111. LONG-TERM CARE INSURANCE POLICY.

(a) IN GENERAL.—In this subtitle, except as otherwise provided in this section, the term "long-term care insurance policy" means any insurance policy, certificate, or rider advertised, marketed, offered, or designed to provide coverage for each covered individual on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes a group or individual annuity or life insurance policy or rider which provides directly (or which supplements) long-term care insurance described in the previous sentence. Such term also includes an insurance policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

(b) POLICIES EXCLUDED.—Except as provided in subsections (c) and (d), in this subtitle the term "long-term care insurance policy" does not include any medicare supplemental policy (as defined in section 1882(g) of the Social Security Act) and any insurance which is offered primarily to provide—

(1) basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, or major medical expense coverage,

(2) disability income or related asset-protection coverage,

(3) accident only coverage,

(4) specified disease or specified accident coverage, or

(5) limited benefit health coverage.

(c) INCLUSION OF POLICIES MARKETED AS LONG-TERM CARE INSURANCE.—In this subtitle, the term "long-term care insurance policy" also includes any product which is advertised, marketed, or offered as long-term care insurance.

(d) DISCLOSURE REQUIREMENTS FOR CERTAIN DISABILITY INCOME POLICIES AND LIFE INSURANCE POLICIES.—

(1) IN GENERAL.—In this subtitle, the term "long-term care insurance policy" includes—

(A) a policy described in subsection (b)(2) under which the eligibility or amount of benefits are based on an assessment of functional ability (based on activities of daily living or otherwise), or

(B) a life insurance policy described in paragraph (3),

if the disclosure requirements of paragraph (2) are not met.

(2) DISCLOSURE REQUIREMENTS.—The disclosure requirements of this paragraph for a policy are that—

(A) the policy discloses (in a form and manner specified in the Standards) the fact that the policy is not a long-term care insurance policy;

(B) the policy outlines how the benefits in the policy differ from the benefits required to be provided under the Standards of a long-term care insurance policy; and

(C) in the case of a life-insurance policy described in subsection (c), at the time of policy delivery there is provided to the purchaser and the beneficiary a policy summary that includes—

(i) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

(ii) a description of the amount and length of benefits and the guaranteed lifetime benefits (if any) for each covered individual; and

(iii) any exclusions, reductions, and limitations on benefits of long-term care.

(3) CERTAIN LIFE INSURANCE POLICIES.—A life insurance policy described in this paragraph is one—

(A) which accelerates the death benefit specifically for—

(i) one or more of the qualifying events of terminal illness,

(ii) medical conditions requiring extraordinary medical intervention, or

(iii) permanent institutional confinement;

(B) which provides the option of a lump-sum payment for those benefits; or

(C) which provides benefits based on the use of nursing facility care.

SEC. 10112. OTHER TERMS.

In this subtitle:

(1) AGENT.—The term "agent" means—

(A) prior to 1 year after the date of the establishment of the agent training and certification requirements of section 10106, an individual who sells or offers for sale a long-term care insurance policy subject to the requirements of section 10101; and

(B) after the date referred to in subparagraph (A), an individual certified under a training and certification program established under section 10106.

(2) APPROVED REGULATORY PROGRAM; APPROVED REGULATORY STATE.—(A) The term "approved regulatory program" means a regulatory program in a State that the Secretary determines—

(i) provides for the application and enforcement of the standards established under section 10103, and

(ii) complies with the requirements of subpart B of part 3.

(B) APPROVED REGULATORY STATE.—The term "approved regulatory State" means a State with an approved regulatory program (as defined in subparagraph (A)).

(3) CARRIER.—The term "carrier" has the meaning given such term in section 5504.

(4) STANDARDS.—The term "Standards" means all standards established under section 10102 that apply in a State under section 10101.

(5) STATE COMMISSIONER OF INSURANCE.—The term "State commissioner of insurance" includes the State superintendent of insurance.

PART 2—STANDARDS

Subpart A—Policy Standards

SEC. 10121. USE OF STANDARD DEFINITIONS AND TERMINOLOGY AND UNIFORM FORMAT.

Each long-term care insurance policy shall, pursuant to the Standards—

(1) use uniform language and definitions for description of benefits, coverage, providers of covered services, facilities at which covered services are rendered, and eligibility for benefits, including definitions of "home and community care services", of "nursing facility services", and of "respite care", and

(2) use a uniform format and simple, easily understood English for presenting the marketing material and outline of coverage under such a policy.

SEC. 10122. MINIMUM BENEFITS; LIMITING CONDITIONS ON BENEFITS.

(a) MINIMUM BENEFITS.—

(1) IN GENERAL.—A long-term care insurance policy shall provide benefits either—

(A) for nursing facility services, but not for home and community care services, and be labeled prominently as a "nursing home care" policy;

(B) for home and community care services, but not for nursing facility services, and be labeled prominently as a "home and community care" policy; or

(C) for both nursing facility services and home and community care services, and be labeled prominently as a "comprehensive long-term care" policy.

(2) MUST OFFER ALL OPTIONS OR DISCLOSE LACK OF OPTIONS.—A carrier may not offer for sale to an individual a long-term care insurance policy described in one of the subparagraphs of paragraph (1) unless the carrier either (A) also offers for sale to the individual a policy described in each of the other 2 subparagraphs of that paragraph, or (B) discloses the fact that the carrier does not offer policies described in each of such subparagraphs.

(b) RESTRICTIONS ON CONDITIONS.—A long-term care insurance policy may not condition or limit eligibility—

(1) for benefits for a type of services to the need for or receipt of any other services, including prior hospitalization;

(2) for any benefit (where the need for such benefit has been established by an independent assessment of impairment) on any particular medical diagnosis (including any acute condition) or on one of a group of diagnoses;

(3) for benefits furnished by licensed or certified providers on compliance with conditions which are in addition to those required for licensure or certification under State law;

(4) for nursing facility services (if covered under the policy) only—

(A) to care provided in facilities which provide a specified level of care; or

(B) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State; or

(5) for benefits on the continued payment of premiums during periods when long-term care is being received and for which claims under the policy are being filed.

(c) HOME AND COMMUNITY CARE SERVICES.—

(1) SERVICES INCLUDED.—Home and community care services under a long-term care insurance policy shall include—

(A) home-based services (described in paragraph (2)) which are provided in a place of residence used as the individual's home (or, in the case of services described in subparagraphs (C), (F), and (G) of that paragraph, which may be provided outside the individual's residence), and

(B) community-based services (described in paragraph (3)).

(2) HOME-BASED SERVICES.—The home-based services described in this paragraph are as follows:

(A) Nursing care provided by or under the supervision of a registered professional nurse.

(B) Services of a homemaker/home health aide who has successfully completed a training and competency evaluation program that meets minimum standards established by the Secretary under section 1891(a)(3)(D) of the Social Security Act.

(C) Personal assistance services furnished by an individual who has successfully completed a training and competency evaluation program that meets minimum standards established by the Secretary.

(D) Medical social services.

(E) Physical, occupational, or respiratory therapy or speech-language pathology.

(F) Medical supplies (other than drugs and biologicals), assistive technologies, and equipment that assist in the performance of activities of daily living.

(G) Patient and caregiver (including family caregiver) education and training to develop skills necessary to permit the individual to remain in the home setting.

(H) Such other home-based items and services as the Secretary may approve.

(3) COMMUNITY-BASED SERVICES.—The community-based services described in this paragraph are as follows:

(A) Adult day care services provided by an adult day care program that meets minimum standards (including the provision of at least 1 meal a day and the provision of necessary transportation) established by the Secretary.

(B) In the case of individuals with chronic mental illness, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility), but only insofar as such services are equivalent to services described in subparagraph (A) and do not include individual therapy.

(C) Such other community-based items and services as the Secretary may approve.

(4) LIMITATIONS ON CONDITIONS.—If a long-term care insurance policy provides benefits for home and community care services, the policy—

(A) may not limit such benefits to services provided by registered nurses, licensed practical nurses, occupational, physical, or speech therapists, or social workers;

(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or licensed or certified home care worker acting within the scope of the worker's licensure or certification;

(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII or XIX of the Social Security Act;

(D) may not limit or exclude benefits for such services (i) by requiring that the policyholder would need nursing care in a facility if home and community care services were not provided, or (ii) by requiring that the policyholder have an acute condition before home and community care services are covered; and

(E) must provide not less than 365 days of home-based services and community-based services.

(d) NURSING FACILITY SERVICES.—

(1) TYPES OF SERVICES.—Nursing facility services under a long-term care insurance policy shall include the following:

(A) Nursing care provided by or under the supervision of a registered professional nurse.

(B) Bed and board in connection with the furnishing of such nursing care.

(C) Physical, occupational, or respiratory therapy, or speech-language pathology, furnished by the facility or by others under arrangements with them made by the facility.

(D) Medical social services.

(E) Such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the facility as are ordinarily furnished by such facility for the care and treatment of residents.

(F) Medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of section 1861(l) of the Social Security Act), under a teaching program of such hospital approved as provided in the last sentence of section 1861(b) of such Act, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect.

(G) Such other services necessary to the health of the residents as are generally provided by nursing facilities.

(2) MINIMUM DURATION.—If a long-term care insurance policy provides benefits for nursing facility services, the policy shall provide—

(A) such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act, and

(B) not less than 365 days of such benefits with respect to all such nursing facilities.

SEC. 10123. PROHIBITION OF DISCRIMINATION.

A long-term care insurance policy may not treat benefits under the policy for an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any mental disorder of a demonstrable organic origin, or with HIV disease, differently from benefits for an individual having another medical condition for which benefits may be made available. For purposes of the previous sentence, the term "HIV disease" means infection with the human immunodeficiency virus, and includes any condition arising from acquired immune deficiency syndrome.

SEC. 10124. LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.

(a) INITIAL ISSUANCE.—

(1) IN GENERAL.—Subject to paragraph (2), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the date of issuance of the policy.

(2) 6-MONTH LIMIT.—A long-term care insurance policy may exclude benefits under a policy, during its first 6 months, based on a condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before the policy became effective.

(3) REFERENCE TO MEDICAL DOCUMENTATION REQUIREMENT.—For provision requiring medical documentation for individuals 75 years or age or older at the time of policy issuance, see section 10147.

(b) REPLACEMENT POLICIES.—If a long-term care insurance policy replaces another long-term care insurance policy, the replacing policy shall waive any time periods (including waiting periods, elimination periods, and probationary periods) applicable to preexisting conditions in the new policy for similar benefits to the extent such time was spent under the original policy.

SEC. 10125. USE OF FUNCTIONAL ASSESSMENT.

(a) IN GENERAL.—If a long-term care insurance policy limits the eligibility for, or level of, benefits, the policy—

(1) shall specify that eligibility for, and the level of, benefits available under the policy based on a functional assessment (described in subsection (c)); and

(2) shall specify the level (or levels) of physical, cognitive, or mental impairment required under such an assessment to obtain benefits under the policy.

(b) CONDUCT OF ASSESSMENT.—Such assessment may not be conducted by an individual—

(1) who has a direct or indirect ownership or control interest in the carrier issuing the policy or an entity that provides services for which benefits are available under the long-term care insurance policy, or

(2) who has a direct or indirect affiliation or relationship with such a carrier or entity if there is a financial incentive that is related to the results of the assessment determination.

(c) UNIFORM ASSESSMENT INSTRUMENT AND UNIFORM FORMULAS.—Not later than July 1, 1995—

(1) the functional assessment referred to in subsection (a) must—

(A) be based on a professional assessment of the policyholder's physical, cognitive, and mental abilities, and

(B) be conducted in accordance with a standard, reproducible, uniform assessment instrument and methodology designated by the Secretary; and

(2) benefits shall be determined in accordance with an eligibility formula specified in the Standards and based on the assessment described in paragraph (1).

(d) APPEALS PROCESS.—Each long-term care insurance policy shall provide for an appeals process, meeting the Standards, for individuals who dispute the results of an assessment conducted under this section, including any determination of eligibility, level of functional impairment, or level of benefits.

SEC. 10126. REQUIREMENTS FOR PREMIUMS.

(a) INITIAL ISSUANCE.—The premiums charged for the initial issuance of a long-term care insurance policy shall be established in accordance with a system that ensures that premiums—

(1) accurately reflect the true lifetime cost of the policies (in order to minimize premium rate increases);

(2) are fully supported by an actuarial memorandum; and

(3) utilize lapse rates (in accordance with a table specified in the standards).

(b) RENEWALS.—Except as provided in subsection (c)—

(1) IN GENERAL.—The Standards shall provide limits on the increases in premiums that are allowable at the time of renewal. Such Standards shall be at least as stringent as the limitations contained in the succeeding paragraphs of this subsection.

(2) PROHIBITION ON INCREASES IN FIRST 4 YEARS.—No increase in premiums shall be granted during the first 4 years of a policy's duration.

(3) REQUIREMENTS FOR CERTAIN PREMIUM INCREASES FOR INDIVIDUALS UNDER AGE 70.—In the case of a policyholder or certificateholder of a long-term care insurance policy who is under the age of 70, a proposed premium increase for renewal of the policy that would result either—

(A) in the premium exceeding twice the original premium amount, or

(B) in a premium increase, over any 4-year period, exceeding 25 percent of the premium in effect at the beginning of such period,

shall not be granted.

(4) REQUIREMENTS FOR PREMIUM INCREASES FOR INDIVIDUALS BETWEEN 70 AND 80 YEARS OF AGE.—In the case of a policyholder or certificateholder of a long-term care insurance policy who is at least 70 years of age but under the age of 80, no proposed premium increase for renewal of the policy shall be granted if the proposed premium increase would result in a premium increase, over any 5-year period, exceeding 15 percent of the premium in effect at the beginning of the period.

(5) PROHIBITION ON PREMIUM INCREASES FOR INDIVIDUALS 80 YEARS OF AGE OR OLDER.—In the case of a policyholder or certificate holder of a long-term care insurance policy who is 80 years of age or older, the premiums for such policy may not be increased.

(c) SPECIAL RULES IN CASE OF INFLATION PROTECTION.—In the case of a policy that includes inflation protection benefits, the requirements of subsection (b) shall not apply to any proposed or expected premium increases if the increases are consistent with the increases attributable to such inflation protection as scheduled within the policy and were contained in the outline of coverage required under section 10136(b)(9).

SEC. 10127. INFLATION PROTECTION.

(a) REQUIREMENT TO OFFER.—An insurer offering for sale any long-term care insurance policy shall afford the purchaser the option to obtain coverage under such policy of annual increases in benefits (upon payment of increased premiums) at rates in accordance with subsection (b).

(b) RATE INCREASE IN BENEFITS.—For purposes of subsection (a), the benefits under a policy for each year shall be increased by a percentage of the full value of benefits under the policy for the previous year, which shall be not less than 5 percent of such value (or such other rate of increase as may be determined by the Secretary to be adequate to offset increases in the costs of long-term care services for which coverage is provided under the policy).

(c) REQUIREMENT OF WRITTEN REJECTION.—Inflation protection in accordance with subsection (b) may be excluded from the coverage under a policy only if the insured individual (or, if different, the person responsible for payment of premiums) has rejected in writing the option to obtain such coverage.

SEC. 10128. NONFORFEITURE.

(a) IN GENERAL.—Each long-term care insurance policy shall provide that if the policy lapses after the policy has been in effect for at least 3 years, the policy will provide without payment of any additional premiums benefits equal to a percentage (specified under the Standards) of the benefits otherwise available at term.

(b) STANDARDS.—The Standards may provide that the percentage under subsection (a) must increase based upon the period of time in which the policy was in effect.

SEC. 10129. DESIGNATION OF REPRESENTATIVES.

(a) IN GENERAL.—The carrier issuing a long-term care insurance policy—

(1) at the time of issuance of the policy shall require the applicant or policyholder either—

(A) to designate not more than 3 representatives whom the carrier shall notify in the event that the policyholder fails to pay premiums, or

(B) to provide a written waiver (signed and dated by the applicant or policyholder) of the right to make such designation; and

(2) shall permit the policyholder to make or alter such a designation not less frequently than annually at the time of renewal.

(b) NO LEGAL OBLIGATION TO PAY PREMIUMS.—An individual designated as a representative under subsection (a) is not under any legal obligation to pay for premiums or to otherwise act in the event of a notification under this section.

SEC. 10130. ISSUANCE, RENEWAL, AND CANCELLATION.

(a) IN GENERAL.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium (subject to subsection (d) and any nonforfeiture rights under section 10128) or fraud or material misrepresentation (subject to section 10145(c)).

(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

(1) IN GENERAL.—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facilities, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

(3) BASIS FOR CONVERSION.—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

(A) whose coverage under the group policy would otherwise be terminated for any reason; and

(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

(4) GUIDELINES FOR DETERMINATION OF SUBSTANTIAL EQUIVALENCE.—For the purpose of determining whether benefits under such policies are substantially equivalent under paragraphs (2) or (3), the Secretary shall establish guidelines for comparing long-term care insurance policies.

(5) GROUP REPLACEMENT OF POLICIES.—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased by the same policyholder, the succeeding carrier shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) PREMIUMS FOR REPLACEMENT OR CONVERSION.—In the case of a converted policy or a replacement policy issued by the same carrier that had issued a previous policy and issued to the same group or its successor, or issued to any individual covered by the previous group policy, the premium shall be calculated on the basis of the insured's age at the inception of coverage under the earliest previous policy which became the basis for the converted or replaced policy in the case of benefits which are the same as benefits that were provided under any earlier policy.

(c) GUARANTEED ISSUANCE.—

(1) IN GENERAL.—A carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual if such individual meets the minimum medical underwriting requirements of such policy as established in compliance with an age rating formula established by the Secretary.

(2) POLICY UPGRADES.—

(A) CURRENT POLICIES.—Each long-term care insurance policy in effect as of the effective date of the Standards established under section 10102 shall permit the policyholder to purchase a policy that meets all such standards and the carrier shall directly inform each such policyholder of the right to purchase an upgraded policy under this paragraph.

(B) FUTURE UPGRADES.—

(i) IN GENERAL.—If a carrier of a long-term care insurance policy provides for the issuance of policies with benefits that are greater than the benefits previously provided under such policies, the policyholder of a long-term care insurance policy previously issued by that carrier and still in force has the right to purchase a policy that provides for such upgraded benefits and the carrier shall directly inform each such policyholder of the existence of such an upgraded policy and the right to purchase an upgraded policy under this paragraph.

(ii) LIMITATION.—Clause (i) shall not apply to a policyholder who is eligible (or was eligible at any time within the previous 3 months) for benefits under the long-term care insurance policy.

(C) LIMITATION ON MEDICAL UNDERWRITING OF UPGRADED POLICIES REQUIRED UNDER FEDERAL OR STATE LAW.—With respect to a policy that offers upgraded benefits in accordance with a new Federal or State requirement, the carrier issuing the policy may not impose additional medical underwriting criteria, except that—

(i) the carrier may utilize an age rate for such policy based on the formula established by the Secretary under subsection (c)(1), and

(ii) the carrier may impose additional medical underwriting criteria in relation to benefits to the extent they were not included in the previously issued policy.

(D) LIMITATION ON MEDICAL UNDERWRITING ON OTHER UPGRADED POLICIES.—With respect to an upgraded long-term care insurance policy that offers benefits that are greater than the benefits required under Federal or State requirements, the carrier issuing the policy—

(i) except as provided in clause (ii), may not impose additional medical underwriting criteria in relation to benefits that are the same as the benefits under the previously issued policy and the premiums charged with respect to such benefits may not be greater than the premiums charged with respect to such benefits under the previously issued policy, but

(ii) may impose additional medical underwriting criteria in cases where the State insurance commissioner determines that the absence of such underwriting would result in adverse selection of insured risks.

(E) APPROVAL OF HIGHER PREMIUMS REQUIRED.—In the case of a carrier that intends to offer upgraded policies at premiums that are higher than the premiums charged for their existing policies, such carrier must have such higher premiums approved through the process specified in section 10164.

(F) CREDIT TOWARD NONFORFEITURE BENEFIT.—In the case that a policy is replaced with an upgraded policy, the upgraded policy shall provide for credit designed to assure retention of a policyholder's equity, according to a formula established by the Secretary, toward the nonforfeiture benefit for periods of coverage under the previous long-term care insurance policy issued by the same carrier.

(d) EFFECT OF INCAPACITATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), a long-term care insurance policy may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care provider, independent of the carrier issuing the policy, to be cognitively, mentally, or physically incapacitated.

(2) PERMITTED CANCELLATION.—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

(A) the period of such nonpayment is in excess of 30 days; and

(B) notice of intent to cancel (and right of reinstatement under paragraph (3)) is received by all designated representatives of the policyholder after the expiration of the period specified in subparagraph (A) and not less than 30 days prior to such cancellation.

(3) REINSTATEMENT.—If a long-term care insurance policy is canceled for nonpayment under this subsection, the policy may be reinstated without any loss in the policyholder's equity for purposes of a nonforfeiture benefit if the policyholder pays all premiums owing within a period (specified in the standards and of not less than 6 months) after the date of the cancellation.

Subpart B—Sales Practices

SEC. 10131. CERTIFICATION OF TRAINING OF SALES AGENTS.

A person may not sell or offer for sale a long-term care insurance policy unless the person has been certified under the State regulatory program or by the Secretary as having received training (in accordance with section 10106) with respect to such policies in accordance with the Standards.

SEC. 10132. DUTY OF GOOD FAITH AND FAIR DEALING.

(a) IN GENERAL.—Each person who is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

(b) PROHIBITED PRACTICES.—A person is considered to have violated subsection (a) if the person engages in any of the following practices:

(1) TWISTING.—Knowingly making any misleading representation or incomplete or fraudulent comparison of any long-term care insurance policy or carrier for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

(2) HIGH PRESSURE TACTICS.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through undue pressure.

(3) COLD LEAD ADVERTISING.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) OTHERS.—Engaging in such other practices determined inappropriate under standards established by the Secretary.

(c) PROHIBITION OF COMPLETION OF MEDICAL HISTORIES.—A person who is selling or offering for sale a long-term care insurance policy may not complete the medical history portion of an application for any other individual (other than a relative of the person).

SEC. 10133. FINANCIAL GUIDELINES.

(a) DEVELOPMENT.—The Secretary, by July 1, 1995, shall develop recommended minimum financial guidelines (including both income and asset criteria) that an individual should meet before purchasing a long-term care insurance policy.

(b) CONSTRUCTION.—Nothing in such guidelines shall permit a person who is selling or offering for sale a long-term care insurance policy to compel a potential purchaser of such a policy (directly or indirectly) to provide financial information as a condition of purchasing such a policy.

SEC. 10134. PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.

A person may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance (other than only as a qualified medicare beneficiary) under title XIX of the Social Security Act.

SEC. 10135. PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE POLICIES.

A person may not sell or issue a long-term care insurance policy—

(1) knowing that the policy provides for coverage that duplicates coverage already provided in another long-term care insurance policy (unless the policy is intended to replace such other policy), or

(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage under the new policy—

(A) does not duplicate other coverage in effect under a long-term care insurance policy,

(B) will replace another long-term care insurance policy, or

(C) is fully payable without regard to other long-term care services which may be provided to the individual.

SEC. 10136. PROVISION OF OUTLINE OF COVERAGE AND OTHER INFORMATION.

(a) OUTLINE OF COVERAGE.—A person may not sell or offer for a sale a long-term care insurance policy for the benefit of an individual without providing to the purchaser or potential purchaser (or representative), before such purchase, with—

(1) a copy of the guidelines developed under section 10133 and an explanation of such guidelines;

(2) an outline of coverage that includes the information required under subsection (b); and

(3) information (specified under the Standards) describing—

(A) the right of individuals to turn down the policy in 30 days, and

(B) the right of individuals to cancel a policy, and receive a refund on premiums paid, within 30 days after the date the policy is issued.

In applying this subsection in the case of a group long-term care insurance policy, the carrier issuing the policy is responsible for the provision of the outline and information to each certificate holder before the policy takes effect with respect to that certificate holder.

(b) CONTENTS OF OUTLINE OF COVERAGE.—The outline of coverage for each long-term care insurance policy shall be in a uniform format, utilizing simple, easily understood English, as prescribed in guidelines issued by the Secretary. Each outline shall include (in accordance with the Standards) at least the following:

(1) A description of the principal benefits and coverage under the policy, how such benefits and coverage compare to the range of potential benefits and coverage available under such policies, and the eligibility criteria (if any) for such benefits.

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy.

(3) A statement of the terms under which the policy (or certificate in the case of a group policy) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master

policy) contains the contractual provisions that govern.

(5) A description of the terms, specified in section 10140, under which a policy may be returned and the premium refunded.

(6) Information developed by the Secretary on national average nursing home lengths of stay and percentage of the population that requires nursing facility or home care services, broken down by age groups.

(7) Information on average costs (and variation in such costs) for nursing facility care (and such other care as the Secretary may specify) in the United States, information on the value of benefits relative to such costs, and a statement that this national average varies by geographic region.

(8) A comparison of benefits, over a period of at least 20 years, for policies with and without inflation protection.

(9) A declaration as to whether the amount of benefits will increase over time, and, if so, a statement of the type and amount of, any limitations on, and any premium increases for, such benefit increases.

For purposes of carrying out paragraph (7), the Secretary shall publish annually the national average costs of nursing facility care, home health care services, and other long-term care services as may be deemed appropriate by the Secretary.

(c) CERTIFICATES.—A certificate issued pursuant to a group long-term care insurance policy shall include—

(1) a description of the principal benefits and coverage provided in the policy;

(2) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

(3) a statement that the group master policy determines governing contractual provisions.

(d) LONG-TERM CARE AS PART OF LIFE INSURANCE.—In the case of a long-term care insurance policy issued as a part of or a rider on a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

(1) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

(2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person;

(3) principal exclusions, reductions, and limitations on benefits of long-term care; and

(4) a description of the tax consequences of redeeming the life insurance policy to pay for long-term care.

SEC. 10137. INFORMATION ON FINANCIAL ARRANGEMENTS WITH GROUPS.

A person may not sell or offer for sale a long-term care insurance policy with respect to a member of an organization with which the person (or the carrier issuing the policy) has a financial arrangement of any type unless the person discloses (in accordance with the Standards) the nature of the financial arrangement.

Subpart C—Carrier Standards

SEC. 10141. REFUND OF PREMIUMS (FREE LOOK).

If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance, the carrier shall refund directly to the applicant, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy.

SEC. 10142. MAILING OF POLICY.

If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall transmit to the applicant the policy of insurance not later than 30 days after the date of the approval.

SEC. 10143. PROMPT PAYMENT.

A carrier issuing a long-term care insurance policy shall make payment promptly to satisfy claims filed under such policy.

SEC. 10144. CLAIMS DENIALS.

(a) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied or results in less than full payment, the carrier shall, within 30 days of the date of the denial or partial payment—

(1) provide to the person submitting the claim, and to the persons (if any) designated under section 10129, a written explanation of the reasons for the denial or partial payment;

(2) make available to such person all information directly relating to such denial or partial payment; and

(3) inform the individual of the process established under paragraph (3) for the appeal of the claim denial.

(b) LIMITATION ON BASIS FOR DENIAL.—

(1) FAILURE TO DISCLOSE INFORMATION.—No claim under such a policy may be denied on the basis of a failure to disclose information at the time of delivery (and issuance for delivery) of the policy if the application for the policy failed to request such information.

(2) TIMELY RESOLUTION OF INSURABILITY QUESTIONS.—Before issuing a long-term care insurance policy or certificate with respect to coverage of an individual, the carrier shall resolve all reasonable questions relating to the insurability of the individual (including, if the carrier underwrites such coverage, the completion of such underwriting).

(3) TREATMENT OF INDIVIDUALS 75 YEARS OF AGE OR OLDER.—In the case of a policyholder who was 75 years of age or older at the time of delivery (and issuance for delivery) of a long-term care insurance policy, no claim under such a policy may be denied on the basis of a failure to disclose information at the time of delivery (and issuance for delivery) of the policy if the policyholder truthfully disclosed documentation obtained under section 10147.

(c) APPEALS PROCESS.—A policyholder whose policy has been rescinded, canceled, or nonrenewed, or whose claim has been fully or partly denied, or whose claim has not been acted upon with reasonable promptness shall have the right to a review of such rescission, cancellation, nonrenewal, or denial under a process specified in the Standards and shall be granted an opportunity for a fair hearing by the carrier in any case where the amount in controversy is at least $500. The Standards may provide for an appeal to the State commissioner of insurance in an appropriate State.

SEC. 10145. LIMITATION ON RESCISSION, CANCELLATION, OR NONRENEWAL OR DENIAL OF CLAIMS.

(a) IN GENERAL.—A carrier may rescind, cancel, or nonrenew a long-term care insurance policy or certificate, or deny an otherwise valid claim under such policy, only in accordance with this section.

(b) NONPAYMENT OF PREMIUMS.—A carrier may rescind, cancel, or nonrenew a long-term care insurance policy or certificate for nonpayment of premiums, except as provided in section 10130(d).

(c) FRAUD OR MISREPRESENTATION RELATING TO INSURABILITY.—A carrier may rescind, cancel, or nonrenew a long-term care insurance policy or certificate, or deny an otherwise valid claim under such policy based upon fraud or misrepresentation of facts relating to the insurability of the individual, only—

(1) based upon clear and convincing evidence—

(A) of fraud or misrepresentation of information material to the acceptance for coverage, and

(B) involve a chronic condition or dates of treatment before the date of the policy application; and

(2) if the carrier notifies the policyholder of the carrier's intention to rescind, terminate, or nonrenew the policy or deny the claim not later than—

(A) 60 days after the date the carrier discovers the fraud or misrepresentation, or

(B) 6 months (or 2 years in the case of clear and convincing evidence that the fraud or misrepresentation pertains to the condition for which benefits are sought) after the date of issuance of the policy,

whichever is earlier.

(d) FRAUD OR MISREPRESENTATION RELATING TO A GROUP POLICY.—In the case of a policyholder or certificate holder who is insured as part of a group, within 2 years after the date of issuance of the policy or certificate, a carrier may rescind, cancel, or nonrenew the policy or certificate, or deny an otherwise valid claim under such policy, based upon fraud or misrepresentation of facts relating to that individual's status as a member of the group or other relationship to that group at the time of initial coverage of that individual under the policy or certificate.

SEC. 10146. REPORTING OF INFORMATION; ACCESS TO INFORMATION.

(a) REPORTING OF INFORMATION.—Each carrier issuing a long-term care insurance policy shall periodically (not less often than annually) report to the State commissioner of insurance of each State in which the policy is sold, and shall make available to the Secretary, upon request, information respecting the following:

(1) The long-term care insurance policies of the carrier that are in force.

(2) Utilization of benefits and payment of claims under the policy.

(3) The ages of individuals purchasing the policy.

(4) Advertising and other marketing material utilized in connection with the sale of such policies, including a copy of each such item.

(5) Total premiums written and premiums earned in the previous year.

(6) The most recent premiums for such policies and the premiums imposed for such policies during the previous 5-year period.

(7) The lapse rates, replacement rates, and rescission rates for policies (by agent). For purposes of this paragraph, there shall not be included as a lapse of policy such a lapse due to the death of the policyholder.

(8) The claims denied (as a percentage of claims submitted) for such policies. For purposes of this paragraph, there shall not be included as a denied claim such a claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

(9) Complaints received with respect to such policies, and the resolution of such complaints.

(10) The rate of appeal of denied claims (as a percentage of claims denied) for such policies.

(11) The rate of reversal of denied claims on appeal (as a percentage of claim denials appealed) for such policies.

(12) Such other information as is specified in the Standards.

Information under this subsection shall be reported in a format specified in the Standards.

(b) ACCESS TO INFORMATION.—Each such carrier shall make available to the Secretary and the State commissioner of insurance of each State in which the policy is sold such additional information as the Secretary or Commissioner, may request.

(c) AVAILABILITY OF INFORMATION.—The State commissioner of insurance of each State shall make information under this section available, upon request, to the NAIC and, to the extent consistent with other laws, to other interested parties.

SEC. 10147. MEDICAL DOCUMENTATION FOR THE ELDERLY.

Each carrier issuing a long-term care insurance policy shall, with respect to an applicant who is 75 years of age or older, obtain one of the following before issuing the policy:

(1) A report of a contemporaneous physical examination.

(2) A contemporaneous assessment of functional capacity.

(3) Copies of contemporaneous medical records.

The carrier shall maintain the information obtained in its files.

SEC. 10148. LIMITS ON COMPENSATION FOR SALE OF POLICIES.

(a) IN GENERAL.—A carrier issuing a long-term care insurance policy may not provide a commission or other compensation to an agent or other representative for the sale of such a policy in an amount that exceeds a percentage of the commission or other compensation paid for selling or servicing such a policy in the second or subsequent year specified in the Standards.

(b) COMPENSATION DEFINED.—In subsection (a), the term "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certification, including deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

PART 3—ENFORCEMENT OF STANDARDS

Subpart A—General Provisions

SEC. 10151. SECRETARIAL ENFORCEMENT AUTHORITY.

(a) IN GENERAL.—The Secretary shall exercise authority under this section—

(1) in the case of a State which does not an approved regulatory program;

(2) in the case of a State which has an approved regulatory State, to the extent specified by the Secretary (under a look-behind program), to determine whether or not individual long-term health care policies in the State have failed to comply with the applicable Standards required under part 2 and whether persons or entities are otherwise in compliance with the requirements of such part;

(3) in imposing sanctions under this subpart against any pérson who sells, offers for sale, or issues a long-term care insurance policy in violation of the Standards required under subpart B of part 2; and

(4) in imposing sanctions under this subpart against a carrier that violates the Standards required under subpart C of part 2.

(b) PLAN DISAPPROVED UNDER LOOK-BEHIND AUTHORITY.—If the Secretary determines under this subpart that a long-term care insurance policy does not meet the applicable requirements of part 2 on or after the date specified in section 10103, regardless of whether or not the State has taken any action with respect to such noncompliance, no new policies may be offered under the plan on or after the date of the determination.

(c) LOSS OF STATUS AS A LONG-TERM CARE PLAN.—If an association or its subsidiary or a carrier is determined under this section not to be in compliance with applicable Standards under part 2 and is not determined to have come into compliance with such applicable Standards at the end of the 6-month period beginning on the date of the initial determination of such noncompliance, any long-term care insurance policy issued, sold, or offered for sale by such association or its subsidiary or carrier shall be considered to be issued, sold, or offered for sale in violation of section 10101(a).

SEC. 10152. COMPLAINTS AND INVESTIGATIONS.

(a) IN GENERAL.—The Secretary shall establish procedures—

(1) for individuals and entities to file written, signed complaints respecting alleged violations of the Standards required under part 2,

(2) for responding on a timely basis to such complaints, and

(3) for the investigation of—

(A) those complaints which, on their face, have a substantial probability of validity, and

(B) such other alleged violations of the requirements of part 2 as the Secretary determines to be appropriate.

(b) CONDUCT OF INVESTIGATIONS.—In conducting investigations under this section, agents of the Secretary shall have reasonable access to examine evidence of any person or entity being investigated.

(c) TREATMENT OF CARRIER VIOLATIONS.—For purposes of this subpart, a carrier whose policy was sold, offered for sale, or issued by an agent in violation of the Standards under subpart B of part 2 and who had any reason to know of such violation but did not act immediately to correct such violation in good faith, shall be deemed to have violated the Standards of such subpart.

SEC. 10153. HEARINGS.

(a) IN GENERAL.—Before imposing an order described in section 10154 against a person or entity under this section for a violation of the Standards under part 2, the Secretary shall provide the person or entity with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary) of the date of the notice, a hearing respecting the violation. If no hearing is so requested, the Secretary shall impose a final and unappealable order.

(b) CONDUCT OF HEARING.—Any hearing so requested shall be conducted before an administrative law judge under section 201 of the Social Security Act. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

(c) AUTHORITY IN HEARINGS.—

(1) IN GENERAL.—In conducting hearings under this section—

(A) agents of the Secretary and administrative law judges shall have reasonable access to examine evidence of any person or entity being investigated, and

(B) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

(2) ENFORCEMENT OF SUBPOENAS.—In case of contumacity or refusal to obey a subpoena lawfully issued under this subsection and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

(d) ISSUANCE OF ORDERS.—If the administrative law judge determines, upon the preponderance of the evidence received, that a person or entity named in the complaint has violated the Standards required under part 2, the administrative law judge shall state the findings of fact and issue and cause to be served on such person or entity an order described in section 10154. Any order issued under such section shall be provided to the agent, association or its subsidiary, or carrier and include the findings and the basis of the order.

SEC. 10154. CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.

(a) CEASE AND DESIST ORDER.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the order under this section—

(A) shall require the person or entity—

(i) to cease and desist from such violations, and

(ii) to pay a civil penalty in an amount not to exceed $25,000 (or $15,000 in the case of a violation by an agent) for each such violation; and

(B) may require the person or entity to take such other remedial action as is appropriate.

(2) AMOUNT OF CIVIL PENALTY.—The amount of a civil penalty under paragraph (1)(A)(ii) may take into account the penalties imposed by a State with respect to the same such violation.

(3) PROCEDURES FOR CIVIL PENALTY.—The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(b) CRIMINAL PENALTY FOR MULTIPLE AGENT VIOLATIONS.— In the case of an agent who has committed multiple violations of the Standards required under subpart B of part 2, such agent also may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, or both.

(c) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this section by reason of any violation if the person or entity establishes to the satisfaction of the Secretary by clear and convincing evidence that—

(1) such violation was due to reasonable cause and was not intentional and was not due to willful neglect, and

(2) such violation is corrected within the 30-day period beginning on the earliest date the person or entity knew, or exercising reasonable diligence could have known, that such a violation was occurring.

(d) WAIVER BY SECRETARY.—In the case of a violation which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed by subsection (a)(1)(A)(ii) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

(e) REVIEW BY THE SECRETARY.—The decision and order of an administrative law judge under this section shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this section.

(f) JUDICIAL REVIEW.—A person or entity adversely affected by a final order issued under this section may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

(g) Enforcement of Orders.—If a person or entity fails to comply with a final order issued under this section against the person or entity after opportunity for judicial review under subsection (f), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

Subpart B—Standards for Approval of State Regulatory Programs

SEC. 10161. GENERAL REQUIREMENT.

(a) In General.—The Secretary may not approve a State regulatory program for purposes of this subtitle, unless the Secretary determines that the program—

(1) provides for the application and enforcement of the Standards; and

(2) complies with the requirements of—

(A) section 10162 (relating to enforcement),

(B) section 10163 (relating to publication and public access to compliance information),

(C) section 10164 (relating to a process for the approval of premiums), and

(D) section 10165 (relating to annual reports).

(b) Periodic Review of State Regulatory Programs.—The Secretary periodically shall review State regulatory programs to determine if they continue to meet the requirements for approval under subsection (a). If the Secretary determines that a State regulatory program no longer meets such standards and requirements or is no longer in compliance, before making a final determination that a State regulatory program no longer meets such requirements, the Secretary shall provide the State a hearing and an opportunity of 6 months (or, in the case in which State legislation is required in order for the State to be in compliance with such standards and requirements, such longer period as is necessary to enact such legislation) to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such a hearing and opportunity, fails to meet such requirements, the Secretary shall assume responsibility under section 10101(b) with respect to certifying long-term care insurance policies in the State and shall exercise full authority under subpart A for persons and entities in the State.

SEC. 10162. ENFORCEMENT.

(a) In General.—The enforcement process under each State regulatory program—

(1) shall be designed in a manner so as to secure compliance with the Standards within 30 days after the date of a finding of noncompliance with such Standards, and

(2) shall provide for notice to the Secretary in cases where such compliance is not secured within such 30-day period.

(b) Process.—The enforcement process under each State regulatory program shall provide for—

(1) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the Standards;

(2) responding on a timely basis to such complaints;

(3) the investigation of—

(A) those complaints which, on their face, have a substantial probability of validity, and

(B) such other alleged violations of the Standards as the program finds appropriate;

(4) notice and opportunity for a hearing before executing sanctions;

(5) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty) in the case of a person or entity determined to have violated the Standards; and

(6) an annual report to the Secretary on details concerning complaints filed under the process, including the disposition of, and actions resulting from, such complaints.

SEC. 10163. PUBLICATION AND PUBLIC ACCESS TO COMPLIANCE INFORMATION.

(a) Publication of Information.—Each State regulatory program shall publish annually a summary—

(1) by carrier, of (A) the types of long-term health care policies issued and (B) the types of complaints filed concerning such policies, and

(2) of the information reported by policy under section 10146.

(b) Access to Information on Complaints.—

(1) In general.—Each State regulatory program shall provide for consumer access to complaints filed with the State commissioner of insurance with respect to long-term care insurance policies. Any such disclosure of complaint information shall be accompanied by a general disclaimer stating that no representations are being made as to the merits of such a complaint.

(2) Confidentiality.—The access provided under paragraph (1) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

SEC. 10164. PROCESS FOR APPROVAL OF PREMIUMS.

(a) In General.—Each State regulatory program shall—

(1) provide for a process for approving or disapproving proposed premium increases with respect to long-term care insurance policies, and

(2) establish a policy for receipt and consideration of public comments before approving such a premium increase.

(b) Conditions for Approval.—No such premium increase shall be approved (or deemed approved) unless the proposed increase is accompanied by an actuarial memorandum which—

(1) includes a description of the assumptions which justify the increase,

(2) fully supports the increase,

(3) contains such information as may be required under the Standards, and

(4) is made available to the public.

(c) Secretarial Authority.—In the case of a State without an approved regulatory program, the Secretary shall provide for the activities described in subsections (a) and (b).

SEC. 10165. ANNUAL REPORTS.

Each State regulatory program shall provide for annual reports to the Secretary on the implementation and enforcement of the Standards in the State.

SEC. 10166. INCREASE IN FUNDING FOR LONG-TERM CARE INSURANCE, INFORMATION, COUNSELING, AND ASSISTANCE THROUGH STATE REGULATORY PROGRAMS.

In addition to amounts otherwise authorized to be appropriated, there are authorized to be appropriated, under section 4360(f) of the Omnibus Budget Reconciliation Act of 1990, $10,000,000 for fiscal year 1997 and each subsequent fiscal year, to fund grant programs under such section for the purpose of providing information, counseling, and assistance relating to long-term care benefits under this subtitle and the procurement of adequate and appropriate long-term care insurance.

PART 4—MISCELLANEOUS PROVISIONS

SEC. 10171. REPORTS AND STUDIES.

(a) Report on Solvency Protection.—Not later than 2 years after the date of the enactment of this title, the Secretary shall prepare and submit to the appropriate committees of Congress a report on standards that may be applied under this subtitle to assure the solvency of carriers with respect to long-term care insurance policies.

(b) Study of Standard Measure of Value for Long-Term Care Insurance Policies.—The Secretary shall provide for the conduct of a study to develop a standard measure of value for long-term care insurance policies. Not later than 2 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning such study.

(c) Study of Long-Term Care Insurance Riders.—The Secretary shall review the applicability of the Standards to long-term care insurance riders. Not later than 2 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning such study.

(d) Study of Coordination With Public Programs.—The Secretary shall review the coordination of coverage under long-term care insurance policies with benefits for long-term care services under the medicare program, medicare part C, the medicaid program, the long-term care program for home and community-based services under subtitle A, and other public programs. Not later than 2 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning such study. The Secretary shall include in the report such recommendations concerning rules for such coordination as the Secretary deems appropriate.

SEC. 10172. WAIVER OF PAPERWORK REQUIREMENTS.

Chapter 35 of title 44, United States Code, and Executive Order 12291 shall not apply to information and regulations required for purposes of carrying out this subtitle.

Subtitle C—Worker Redeployment in Long-Term Care Programs

SEC. 10201. REQUIREMENT REGARDING REDEPLOYMENT OF HEALTH CARE WORKERS UNDER LONG-TERM CARE PROGRAM.

With respect to the plan required in section 10004(c) (for the long-term care program for home and community-based services under subtitle A), the plan shall, in addition to requirements under such subtitle, provide for the following:

(1) Prior to implementing the program under such plan, negotiations will be commenced with labor organizations representing the employees of the affected hospitals or other facilities providing such services.

(2) Negotiations under paragraph (1) will address the following:

(A) The impact of the implementation of the program upon the workforce.

(B) Methods to redeploy workers to positions in the proposed program or other public or private settings, in the case of workers affected by the program.

(3) The plan will provide evidence that there has been compliance with paragraphs (1) and (2).

TITLE XI—REVENUE PROVISIONS

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SEC. 11001. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Increase In Excise Taxes On Tobacco Products

SEC. 11101. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 is amended by striking paragraph (1) and all that follows and inserting the following:

"(1) SMALL CIGARETTES.—On cigarettes, weighing not more than 3 pounds per thousand, the amount per thousand determined under the following table:

"In the case of cigarettes removed—	**The tax per thousand is—**
After July 31, 1995, and before January 1, 1997	$19.50
During 1997	$24.50
During 1998	$29.50
After December 31, 1998	$34.50.

"(2) LARGE CIGARETTES.—On cigarettes, weighing more than 3 pounds per thousand, removed at any time, an amount per thousand equal to 2.1 times the tax per thousand imposed by paragraph (1) on cigarettes removed at such time; except that, if more than 6½ inches in length, they shall be taxable at the rate prescribed for cigarettes weighing not more than 3 pounds per thousand, counting each 2¾ inches, or fraction thereof, of the length of each as one cigarette."

(b) CIGARS.—Paragraphs (1) and (2) of section 5701(a) are amended to read as follows:

"(1) SMALL CIGARS.—On cigars, weighing not more than 3 pounds per thousand, the amount per thousand determined under the following table:

"In the case of cigars removed—	**The tax per thousand is—**
After July 31, 1995, and before January 1, 1997	$1.83
During 1997	$2.30
During 1998	$2.77
After December 31, 1998	$3.23.

"(2) LARGE CIGARS.—On cigars, weighing more than 3 pounds per thousand, the applicable percentage (determined under the following table) of the price for which sold but not more than the applicable limitation (determined under such table) per thousand:

In the case of cigars removed—	**The applicable percentage is—**	**The limitation is—**
After July 31, 1995 and before January 1, 1997	21 percent	$48.75
During 1997	26 percent	$61.26
During 1998	31 percent	$73.74
After December 31, 1998	37 percent	$86.25."

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 is amended—

(1) by striking "0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of cigarette papers removed—	**The tax for each 50 papers is—**
After July 31, 1995 and before January 1, 1997	1.22 cents
During 1997	1.53 cents
During 1998	1.84 cents
After December 31, 1998	2.16 cents."

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 is amended—

(1) by striking "1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of cigarette tubes removed—	**The tax for each 50 tubes is—**
After July 31, 1995 and before January 1, 1997	2.44 cents
During 1997	3.06 cents
During 1998	3.69 cents
After December 31, 1998	4.31 cents."

(e) SNUFF.—Paragraph (1) of section 5701(e) is amended—

(1) by striking "36 cents (30 cents on snuff removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of snuff removed—	**The tax per pound is—**
After July 31, 1995 and before January 1, 1997	58.5 cents
During 1997	73.5 cents
During 1998	88.5 cents
After December 31, 1998	$1.03½."

(f) CHEWING TOBACCO.—Paragraph (2) of section 5701(e) is amended—

(1) by striking "12 cents (10 cents on chewing tobacco removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of chewing tobacco removed—	**The tax per pound is—**
After July 31, 1995 and before January 1, 1997	19.5 cents
During 1997	24.5 cents
During 1998	29.5 cents

"In the case of chewing tobacco removed—	The tax per pound is—
After December 31, 1998	34.5 cents."

(g) PIPE TOBACCO.—Subsection (f) of section 5701 is amended—

(1) by striking "67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of pipe tobacco removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	$1.10
During 1997	$1.38
During 1998	$1.66
After December 31, 1998	$1.94."

(h) APPLICATION OF TAX INCREASE TO PUERTO RICO.—Section 5701 is amended by adding at the end the following new subsection:

"(h) APPLICATION OF TAXES TO PUERTO RICO.—Notwithstanding subsections (b) and (c) of section 7653 and any other provision of law—

"(1) IN GENERAL.—On tobacco products and cigarette papers and tubes, manufactured in or imported into the Commonwealth of Puerto Rico, there is hereby imposed a tax at the rate equal to the excess of—

"(A) the rate of tax applicable under this section to like articles manufactured in the United States, over

"(B) the rate referred to in subparagraph (A) as in effect on the day before the date of the enactment of the Guaranteed Health Insurance Act of 1994.

"(2) SHIPMENTS TO PUERTO RICO FROM THE UNITED STATES.—Only the rates of tax in effect on the day before the date of the enactment of the Guaranteed Health Insurance Act of 1994 shall be taken into account in determining the amount of any exemption from, or credit or drawback of, any tax imposed by this section on any article shipped to the Commonwealth of Puerto Rico from the United States.

"(3) SHIPMENTS FROM PUERTO RICO TO THE UNITED STATES.—The rates of tax taken into account under section 7652(a) with respect to tobacco products and cigarette papers and tubes coming into the United States from the Commonwealth of Puerto Rico shall be the rates of tax in effect on the day before the date of the enactment of the Guaranteed Health Insurance Act of 1994.

"(4) REGULATIONS.—To the extent provided in regulations prescribed by the Secretary, references in this chapter (other than this section) to the United States shall be treating as including references to the Commonwealth of Puerto Rico to the extent appropriate to carry out the purposes of this subsection.

"(5) DISPOSITION OF REVENUES.—The provisions of section 7652(a)(3) shall not apply to any tax imposed by reason of this subsection."

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

(j) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States or the Commonwealth of Puerto Rico which are removed before any tax-increase date and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 or 7652 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on any tax-increase date, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) on each tax-increase date an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on such date for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding any article on any tax-increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) on any tax-increase date shall be paid on or before the date which is 3 months after such tax-increase date.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on any tax-increase date shall be subject to the taxes imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) TAX-INCREASE DATE.—The term "tax-increase date" means August 1, 1995, January 1, 1997, January 1, 1998, and January 1, 1999.

(B) OTHER DEFINITIONS.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section, as amended by this Act.

(C) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or his delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 11102. MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.

(a) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR SHIPMENT FROM THE UNITED STATES.—

(1) Subsection (b) of section 5704 is amended by adding at the end the following new sentence: "Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe."

(2) Section 5761 is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

"(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

"(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which have been labeled or shipped for exportation under this chapter,

"(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

"(3) every person who aids or abets in such selling, relanding, or receiving,

shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of $1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States."

(3) Subsection (a) of section 5761 is amended by striking "subsection (b)" and inserting "subsection (b) or (c)".

(4) Subsection (d) of section 5761, as redesignated by paragraph (2), is amended by striking "The penalty imposed by subsection (b)" and inserting "The penalties imposed by subsections (b) and (c)".

(5)(A) Subchapter F of chapter 52 is amended by adding at the end the following new section:

"SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.

"(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d). For purposes of this section, section 5704(d), section 5761, and such other provisions as the Secretary may specify by regulations, references to exportation shall be treated as including a reference to shipment to the Commonwealth of Puerto Rico.

"(b) CROSS REFERENCE.—

"For penalty for the sale of tobacco products and cigarette papers and tubes in the United States which are labeled for export, see section 5761(c)."

(B) The table of sections for subchapter F of chapter 52 is amended by adding at the end thereof the following new item:

"Sec. 5754. Restriction on importation of previously exported tobacco products."

(b) IMPORTERS REQUIRED TO BE QUALIFIED.—

(1) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), and 5763(b) and (c) are each amended by inserting "or importer" after "manufacturer".

(2) The heading of subsection (b) of section 5763 is amended by inserting "QUALIFIED IMPORTERS," after "MANUFACTURERS,".

(3) The heading for subchapter B of chapter 52 is amended by inserting "**and Importers**" after "**Manufacturers**".

(4) The item relating to subchapter B in the table of subchapters for chapter 52 is amended by inserting "and importers" after "manufacturers".

(c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES OF CIGARETTE MANUFACTURERS.—

(1) Subsection (a) of section 5704 is amended—

(A) by striking "EMPLOYEE USE OR" in the heading, and

(B) by striking "for use or consumption by employees or" in the text.

(2) Subsection (e) of section 5723 is amended by striking "for use or consumption by their employees, or for experimental purposes" and inserting "for experimental purposes".

(d) REPEAL OF TAX-EXEMPT SALES TO UNITED STATES.—Subsection (b) of section 5704 is amended by striking "and manufacturers may similarly remove such articles for use of the United States;".

(e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 is amended by striking "On each book or set of cigarette papers containing more than 25 papers," and inserting "On cigarette papers,".

(f) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 is amended by inserting "under section 5704" after "internal revenue bond".

(g) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 is amended by striking "or" at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

"(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe; or".

(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—Section 7652 is amended by adding at the end thereof the following new subsection:

"(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—For purposes of this section, with respect to taxes imposed under section 5701 or this section on any tobacco product or cigarette paper or tube, the amount covered into the treasuries of Puerto Rico and the Virgin Islands shall not exceed the rate of tax under section 5701 in effect on the article on the day before the date of the enactment of the Guaranteed Health Insurance Act of 1994."

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

SEC. 11103. IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.

(a) IN GENERAL.—Section 5701 (relating to rate of tax), as amended by section 11101, is amended by redesignating subsections (g) and (h) as subsections (h) and (i), respectively, and by inserting after subsection (f) the following new subsection:

"(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United States, there shall be imposed a tax of the amount determined in accordance with the following table per pound (and a proportionate tax at the like rate on all fractional parts of a pound).

"In the case of roll-your-own tobacco removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	$1.10
During 1997	$1.38
During 1998	$1.66
After December 31, 1998	$1.94."

(b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (relating to definitions) is amended by adding at the end the following new subsection:

"(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes."

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (c) of section 5702 is amended by striking "and pipe tobacco" and inserting "pipe tobacco, and roll-your-own tobacco".

(2) Subsection (d) of section 5702 is amended—

(A) in the material preceding paragraph (1), by striking "or pipe tobacco" and inserting "pipe tobacco, or roll-your-own tobacco", and

(B) by striking paragraph (1) and inserting the following new paragraph:

"(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco solely for his own personal consumption or use, and".

(3) The chapter heading for chapter 52 is amended to read as follows:

"CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES".

(4) The table of chapters for subtitle E is amended by striking the item relating to chapter 52 and inserting the following new item:

"Chapter 52. Tobacco products and cigarette papers and tubes."

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to roll-your-own tobacco removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

(2) TRANSITIONAL RULE.—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before August 1, 1995, submits an application under subchapter B of chapter 52 of such Code to engage in such business,

may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

Subtitle B—Treatment of Employer-Provided Health Care

SEC. 11201. HEALTH BENEFITS MAY NOT BE PROVIDED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS OTHER THAN MEDICAL SAVINGS ACCOUNTS.

(a) CAFETERIA PLANS.—

(1) IN GENERAL.—Subsection (f) of section 125 (defining qualified benefits) is amended by adding at the end the following new sentence: "Such term shall not include any benefits or coverage under an accident or health plan."

(2) CONFORMING AMENDMENT.—Subsection (g) of section 125 is amended by striking paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(b) FLEXIBLE SPENDING ARRANGEMENTS.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

"(a) GENERAL RULE.—Except as provided in subsection (b), gross income of an employee does not include employer-provided coverage under an accident or health plan.

"(b) NO EXCLUSION FOR COVERAGE PROVIDED UNDER FLEXIBLE SPENDING ARRANGEMENTS.—

"(1) IN GENERAL.—Subsection (a) shall not apply to coverage provided through a flexible spending or similar arrangement.

"(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

"(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

"(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the cost of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

"(c) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

"(1) IN GENERAL.—Notwithstanding subsection (b), gross income of an eligible employee does not include amounts contributed by an employer to any medical savings account of such employee to the extent such contributions are required to be made to such account by such employer under section 1104(d)(2)(C) of the Guaranteed Health Insurance Act of 1994. For purposes of the preceding sentence, the terms 'eligible employee' and 'medical savings account' have the respective meanings given such terms by section 7705.

"(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer."

(c) MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Chapter 79 is amended by adding at the end the following new section:

"SEC. 7705. MEDICAL SAVINGS ACCOUNTS.

"(a) GENERAL RULE.—For purposes of this title, the term 'medical savings account' means a trust created or organized in the United States for the exclusive benefit of an individual or his beneficiaries, but only if the written instrument creating the trust meets the following requirements:

"(1) Except in the case of a rollover contribution described in subsection (d)(3), no contribution will be accepted unless—

"(A) it is in cash, and

"(B) such individual is an eligible employee for the period for which such contribution is made.

"(2) The trustee is a bank (as defined in section 408(n)), insurance company (as defined in section 816), or such other person who demonstrates to the satisfaction of the Secretary that the manner in which such other person will administer the trust will be consistent with the requirements of this section.

"(3) No part of the trust funds will be invested in life insurance contracts.

"(4) The interest of an individual in the balance of the account is nonforfeitable.

"(5) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(b) ELIGIBLE EMPLOYEE.—For purposes of this section—

"(1) IN GENERAL.—The term 'eligible employee' means any employee who is covered under a high deductible plan (as defined in section 5504(5) of the Guaranteed Health Insurance Act of 1994) of his employer.

"(2) EXCEPTION.—An employee shall be treated as not being an eligible employee for any calendar year if—

"(A) for any month during such year, it is reasonably expected that such employee will be eligible for subsidies under part A of title XXII of the Social Security Act, or

"(B) it is reasonably expected that, if the employee were a medicare part C covered individual for any month during such year, the amount of tax imposed by section 59B (if any) on such employee would be determined under section 59B(b).

"(c) TAX TREATMENT OF ACCOUNTS.—

"(1) ACCOUNT TAXED AS GRANTOR TRUST.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the account beneficiary of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

"(B) TREATMENT OF CAPITAL LOSSES.—With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall be allowed only to the extent of capital gains from such assets for such taxable year. Any capital loss which is disallowed under the preceding sentence shall be treated as a capital loss from the sale or exchange of such an asset in the next taxable year. For purposes of this subparagraph, all medical savings accounts of the account beneficiary shall be treated as 1 account.

"(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

"(A) IN GENERAL.—If, during any taxable year of the account beneficiary, such beneficiary engages in any transaction prohibited by section 4975 with respect to the account, the account shall cease to be a medical savings account as of the first day of such taxable year.

"(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, subsection (d) shall be applied as if—

"(i) there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day), and

"(ii) no portion of such distribution were used to pay qualified medical expenses.

"(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the account beneficiary uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed and not used to pay qualified medical expenses.

"(d) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary or of the spouse or young dependents (as defined in section 1003(b)(1) of the Guaranteed Health Insurance Act of 1994) of such beneficiary shall be included in the gross income of such beneficiary to the extent such amount does not exceed the excess of—

"(i) the aggregate contributions to such account which were not includible in gross income by reason of section 106(c), over

"(ii) the aggregate prior payments or distributions from such account which were includible in gross income under this paragraph.

"(B) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all medical savings accounts of the account beneficiary shall be treated as 1 account,

"(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by chapter 1 on the account beneficiary for any taxable year in which there is a payment or distribution from a medical savings account of such beneficiary which is includible in gross income under paragraph (1) shall be increased by 100 percent of the amount which is so includible.

"(B) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 65.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains age 65.

"(C) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

"(3) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

"(A) IN GENERAL.—Paragraph (1) shall not apply to any amount paid or distributed from a medical savings account to the account beneficiary to the extent the amount received is paid into a medical savings account for the benefit of such beneficiary not later than the 60th day after the day on which he receives the payment or distribution.

"(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in his gross income because of the application of this paragraph.

"(4) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care to the extent of the amount of such payment or distribution which is excludable from gross income solely by reason of paragraph (1)(A).

"(e) DEFINITIONS.—For purposes of this section—

"(1) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' means any expense for medical care (as defined in section 213(d)); except that such term shall not include any expense for insurance.

"(2) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual for whose benefit the medical savings account is maintained.

"(f) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

"(1) the assets of such account are held by a bank (as defined in section 408(n)), insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

"(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (a).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

"(g) REPORTS.—The trustee of a medical savings account shall keep such records and make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by such regulations."

(2) EMPLOYER PAYMENTS EXCLUDED FROM EMPLOYMENT TAX BASE.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting "; or", and by inserting after paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking "or" at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting "; or", and by inserting after paragraph (19) the following new paragraph:

"(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c) of the Internal Revenue Code of 1986."

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

"(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking "or" at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting "; or", and by inserting after paragraph (16) the following new paragraph:

"(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking "or" at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting "; or", and by inserting after paragraph (20) the following new paragraph:

"(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(3) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 (relating to prohibited transactions) is amended—

(A) by adding at the end of subsection (c) the following new paragraph:

"(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 7705) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 7705(c)(2)(A) to such account.", and

(B) by inserting "or a medical savings account described in section 7705" in subsection (e)(1) after "described in section 408(a)".

(4) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 (relating to failure to provide reports on individual retirement account or annuities) is amended—

(A) by inserting "**or on medical savings accounts**" after "**annuities**" in the heading of such section, and

(B) by adding at the end of subsection (a) the following: "The person required by section 7705(g) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause."

(5) CLERICAL AMENDMENTS.—

(A) The table of sections for chapter 79 is amended by adding at the end the following:

"Sec. 7705. Medical savings accounts."

(B) The table of sections for subchapter B of chapter 68 is amended by inserting "or on medical savings accounts" after "annuities" in the item relating to section 6693.

(d) EMPLOYMENT TAX TREATMENT OF AMOUNT NOT EXCLUDED UNDER SECTION 106.—

(1) SOCIAL SECURITY TAX.—

(A) Subsection (a) of section 3121 is amended by inserting after paragraph (22) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(B) Subsection (a) of section 209 of the Social Security Act is amended by inserting after paragraph (20) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b) of the Internal Revenue Code of 1986."

(2) RAILROAD RETIREMENT TAX.—Paragraph (1) of section 3231(e) is amended by adding at the end thereof the following new sentence:

"Nothing in clause (i) of the second sentence of this paragraph shall exclude from the term 'compensation' any amount which is required to be included in gross income under section 106(b)."

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by inserting after paragraph (17) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(4) WAGE WITHHOLDING.—Subsection (a) of section 3401 is amended by adding at the end thereof the following new sentence:

"Nothing in the preceding provisions of this subsection (other than paragraph (21)) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(e) EFFECTIVE DATE.—

(1) PROVISIONS OTHER THAN MEDICAL SAVINGS ACCOUNTS.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the amendments made by subsections (a) and (d), and so much of the amendment made by subsection (b) as relates to section 106(b) of the Internal Revenue Code of 1986, shall take effect on January 1, 1995.

(B) BENEFITS PROVIDED PURSUANT TO COLLECTIVE BARGAINING AGREEMENTS.—In the case of a cafeteria plan or flexible spending arrangement maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers which was ratified before June 30, 1994, the amendments referred to in subparagraph (A) shall not apply to benefits pursuant to any such agreement provided before the date on which the last of such agreements terminate (determined without regard to any extension thereof on or after June 30, 1994). The preceding sentence shall cease to apply with respect to any such agreement on the effective date of any modification of such agreement on or after June 30, 1994.

(C) STATE AND LOCAL EMPLOYEES COVERED BY COLLECTIVE BARGAINING AGREEMENTS.—In the case of employees of a State or political subdivision thereof—

(i) who are not entitled to the benefits of subparagraph (B),

(ii) who are covered by 1 or more collective bargaining agreements with such State or political subdivision which was ratified before June 30, 1994, and

(iii) who are eligible to participate in a cafeteria plan or flexible spending arrangement which was established by State or local law and which is in effect on such date,

the amendments referred to in subparagraph (A) shall not apply to benefits provided under such plan or arrangement (as in effect on such date) before January 1, 1999.

(2) MEDICAL SAVINGS ACCOUNTS.—The amendments made by this section (other than the amendments referred to in paragraph (1)(A)) shall take effect on January 1, 1999.

SEC. 11202. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED AND MADE PERMANENT.

(a) PROVISION MADE PERMANENT.—

(1) IN GENERAL.—Subsection (l) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to taxable years beginning after December 31, 1993.

(b) DEDUCTION INCREASED TO 80 PERCENT.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) is amended by striking "25 percent" and inserting "80 percent".

(2) OTHER COVERAGE.—Subparagraph (B) of section 162(l)(2) is amended to read as follows:

"(B) OTHER COVERAGE.—Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer or the taxpayer's spouse—

"(i) is normally employed by an employer for at least 25 hours per week, or

"(ii) is eligible to participate in a subsidized health plan maintained by any employer of such taxpayer or spouse."

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1998.

SEC. 11203. LIMITATION ON PREPAYMENT OF MEDICAL INSURANCE PREMIUMS.

(a) GENERAL RULE.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

"(10) LIMITATION ON PREPAYMENTS.—If the taxpayer pays a premium or other amount which constitutes medical care under paragraph (1), to the extent such premium or other amount is properly allocable to insurance coverage or care to be provided during periods more than 12 months after the month in which such payment is made, such premium shall be treated as paid ratably over the period during which such insurance coverage or care is to be provided. The preceding sentence shall not apply to any premium to which paragraph (7) applies."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts paid after December 31, 1994.

Subtitle C—Extending Medicare Coverage of, and Application of Hospital Insurance Tax to, All State And Local Government Employees.

SEC. 11301. EXTENDING MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, ALL STATE AND LOCAL GOVERNMENT EMPLOYEES.

(a) IN GENERAL.—

(1) APPLICATION OF HOSPITAL INSURANCE TAX.—Section 3121(u)(2) is amended by striking subparagraphs (C) and (D).

(2) COVERAGE UNDER MEDICARE.—Section 210(p) of the Social Security Act (42 U.S.C. 410(p)) is amended by striking paragraphs (3) and (4).

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services performed after December 31, 1996.

(b) PHASEIN OF AMOUNT OF TAX WITH RESPECT TO EMPLOYEES NEWLY SUBJECT TO TAX.—Subsection (u) of section 3121 is amended by adding at the end the following new paragraph:

"(4) PHASEIN OF AMOUNT OF TAX WITH RESPECT TO CERTAIN EMPLOYEES.—If the wages paid to any individual during any period before January 1, 2000, would not be subject to tax under sections 3101(b) and 3111(b) but for the repeal of subparagraphs (C) and (D) of paragraph (2), the rates of the taxes imposed by such sections with respect to such wages paid during such period shall be—

"(A) 0.3625 percent in the case of wages paid during 1997,

"(B) 0.725 percent in the case of wages paid during 1998, and

"(C) 1.0875 percent in the case of wages paid during 1999."

(c) TRANSITION IN BENEFITS FOR STATE AND LOCAL GOVERNMENT EMPLOYEES AND FORMER EMPLOYEES.—

(1) IN GENERAL.—

(A) EMPLOYEES NEWLY SUBJECT TO TAX.—For purposes of sections 226, 226A, and 1811 of the Social Security Act, in the case of any individual who performs services during the calendar quarter beginning January 1, 1997, the wages for which are subject to the tax imposed by section 3101(b) of the Internal Revenue Code of 1986 only because of the amendments made by subsection (a), the individual's medicare qualified State or local government employment (as defined in subparagraph (B)) performed before January 1, 1997, shall be considered to be "employment" (as defined for purposes of title II of such Act), but only for purposes of providing the individual (or another person) with entitlement to hospital insurance benefits under part A of title XVIII of such Act for months beginning with January 1997.

(B) MEDICARE QUALIFIED STATE OR LOCAL GOVERNMENT EMPLOYMENT DEFINED.—In this paragraph, the term "medicare qualified State or local government employment" means medicare qualified government employment described in section 210(p)(1)(B) of the Social Security Act (determined without regard to section 210(p)(3) of such Act, as in effect before its repeal under subsection (a)(2)).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to time such sums as the Secretary of Health and Human Services deems necessary for any fiscal year on account of—

(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individuals who are entitled to benefits under title XVIII of the Social Security Act solely by reason of paragraph (1),

(B) the additional administrative expenses resulting or expected to result therefrom, and

(C) any loss in interest to such Trust Fund resulting from the payment of those amounts, in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if this subsection had not been enacted.

(3) INFORMATION TO INDIVIDUALS WHO ARE PROSPECTIVE MEDICARE BENEFICIARIES BASED ON STATE AND LOCAL GOVERNMENT EMPLOYMENT.—Section 226(g) of the Social Security Act (42 U.S.C. 426(g)) is amended—

(A) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively,

(B) by inserting "(1)" after "(g)", and

(C) by adding at the end the following new paragraph:

"(2) The Secretary, in consultation with State and local governments, shall provide procedures designed to assure that individuals who perform medicare qualified government employment by virtue of service described in section 210(a)(7) are informed with respect to (A) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (B) the requirements for, and conditions of, such eligibility, and (C) the necessity of timely application as a condition of becoming entitled under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity or retirement benefit and whose eligibility for such annuity or retirement benefit is based on a disability."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (A) of section 3121(u)(2) is amended by striking "subparagraphs (B) and (C)," and inserting "subparagraph (B),".

(2) Subparagraph (B) of section 210(p)(1) of the Social Security Act (42 U.S.C. 410(p)(1)) is amended by striking "paragraphs (2) and (3)." and inserting "paragraph (2)."

(3) Section 218 of the Social Security Act (42 U.S.C. 418) is amended by striking subsection (n).

(4) The amendments made by this subsection shall apply after December 31, 1996.

Subtitle D—Treatment of Organizations Providing Health Care Services and Related Organizations

SEC. 11401. QUALIFICATION AND DISCLOSURE REQUIREMENTS FOR CERTAIN NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) TREATMENT OF HOSPITALS AND OTHER ENTITIES PROVIDING HEALTH CARE SERVICES.—Section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

"(n) QUALIFICATION OF HEALTH CARE ORGANIZATIONS AS EXEMPT ORGANIZATIONS.—

"(1) IN GENERAL.—An organization which is described in paragraph (3) or (4) of subsection (c) and the predominant activity of which is the provision of health care services shall be exempt from tax under subsection (a) only if—

"(A) such organization, with the participation of community representatives, annually—

"(i) assesses its community's needs for health care services and qualified outreach services, and

"(ii) prepares a written plan to meet those needs,

"(B) pursuant to such plan, such organization provides (directly or indirectly) significant qualified outreach services,

"(C) at least 80 percent of the members of the board of directors of such organization are independent members,

"(D) such organization does not discriminate against individuals in the provision of health care services on the basis of participation in a government-sponsored health plan,

"(E) such organization does not discriminate against individuals in the provision of emergency health care services on the basis of ability to pay, and

"(F) to the extent of such organization's financial ability, such organization does not discriminate against individuals in the provision of medically necessary health care services (other than emergency services) on the basis of ability to pay.

"(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization shall not be treated as described in subsection (c)(3) unless substantially all of its primary care health services is provided as described in subsection (m)(6)(A).

"(3) DEFINITIONS.—For purposes of this subsection—

"(A) QUALIFIED OUTREACH SERVICES.—The term 'qualified outreach services' means health care services (or preventive care, educational, or social services programs related thereto) which are provided—

"(i) in 1 or more medically underserved areas, or

"(ii) at below cost to individuals who are otherwise unable to afford such services.

Such term shall not include insurance described in subparagraph (B)(iii) unless such insurance is provided on a subsidized basis.

"(B) HEALTH CARE SERVICES.—The term 'health care services' means—

"(i) any activity of providing medical care (as defined in section 213(d)(1)(A)) to individuals,

"(ii) in the case of an organization described in subsection (c)(3), any activity which is treated as accomplishing an exempt purpose of the organization solely because it is carried on as part of an activity described in clause (i), and

"(iii) insurance (other than commercial-type insurance, as defined in subsection (m)) for the activities described in clauses (i) and (ii).

"(C) MEDICALLY UNDERSERVED AREA.—The term 'medically underserved area' means, with respect to a health care service, any area reasonably determined by the organization (in a manner not inconsistent with regulations prescribed by the Secretary) to have—

"(i) a shortage (relative to the number of individuals needing such service) of health professionals performing such service, or

"(ii) a population group experiencing such a shortage.

Such term includes a health professional shortage area (as defined in section 332 of the Public Health Service Act).

"(D) INDEPENDENT MEMBER.—The term 'independent member' means a member of the board of directors of an organization who receives no compensation (directly or indirectly)—

"(i) for medical services performed in connection with such organization, or

"(ii) for services as an officer of such organization (other than as a member of such board).

For purposes of clause (ii), the term 'officer' includes any individual having powers or responsibilities similar to those of officers.

"(4) EXCEPTION.—This subsection shall not apply to any organization which provides health care services exclusively on an uncompensated basis, regardless of ability to pay.

"(5) SAFE HARBOR FOR NURSING HOMES.—

"(A) IN GENERAL.—A nursing home shall be treated as meeting the requirement of paragraph (1)(D) if it accepts a proportion of Medicaid patients which meets a safe harbor prescribed by the Secretary for purposes of this paragraph.

"(B) DEFINITIONS.— For purposes of subparagraph (A)—

"(i) NURSING HOME.—The term 'nursing home' means any facility which is of a type which is traditionally considered a nursing home.

"(ii) MEDICAID PATIENT.—The term 'Medicaid patient' means any individual eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act.

"(6) DISALLOWANCE OF CHARITABLE DEDUCTIONS.—No gift or bequest to an organization which is not exempt from tax by reason of this subsection shall be allowed as a deduction under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522.

"(7) REQUIREMENTS SUPPLEMENT OTHER REQUIREMENTS.—The requirements of this subsection are in addition to, and not in lieu of, the requirements otherwise applicable to an organization described in paragraph (3) or (4) of subsection (c)."

(b) REPORTING AND DISCLOSURE OF NEEDS ASSESSMENT AND PLAN.—

(1) REPORTING.—

(A) ORGANIZATIONS DESCRIBED IN SECTION 501(c)(3).—Subsection (b) of section 6033 (relating to certain organizations described in section 501(c)(3)) is amended by striking "and" at the end of paragraph (9), by redesignating paragraph (10) as paragraph (14), and by inserting after paragraph (9) the following new paragraphs:

"(10) in the case of an organization which prepares a plan described in section 501(n)(1)(A) (relating to community needs)—

"(A) a copy of such plan for the year, and

"(B) information on the implementation of such plan for the year (including unrecovered costs and revenues foregone in furtherance of such plan),

"(11)(A) the amount (if any) of tax paid by the organization during the year under section 4958 (relating to tax on failure to satisfy section 501(n)), and

"(B) the amount (if any) of tax imposed by section 4958 on the organization which was not assessed, or the assessment of which was abated, pursuant to section 4958(d),

"(12) such information as the Secretary may require with respect to any excess benefit transaction (as defined in section 4959(c)),

"(13) in the case of an applicable tax-exempt health care organization (as defined in section 4960), the respective amounts (if any) of the taxes paid by the organization during the year (and such other information as the Secretary may require with respect to the activities resulting in such taxes) under—

"(A) section 4911 (relating to tax on excess expenditures to influence legislation),

"(B) section 4912 (relating to tax on disqualifying lobbying expenditures of certain organizations), and

"(C) section 4955 (relating to taxes on political expenditures of section 501(c)(3) organizations), and".

(B) ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Section 6033 is amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

"(f) CERTAIN ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Every organization described in section 501(c)(4) which is subject to the requirements of subsection (a) and which prepares a plan described in section 501(n)(1)(A) (relating to community needs) for the year—

"(1) shall include a copy of such plan with the return required under subsection (a) for the year, and

"(2) shall include on such return the information referred to in paragraphs (10)(B), (11), and (12) of subsection (b) with respect to such organization."

(2) DISCLOSURE.—

(A) IN GENERAL.—Subsection (e) of section 6104 (relating to public inspection of certain annual returns and applications for exemption) is amended by adding at the end the following new paragraph:

"(3) COMMUNITY HEALTH CARE NEEDS ASSESSMENT AND PLAN AND APPLICATION FOR EXEMPTION.—

"(A) IN GENERAL.—Every organization which is required to prepare a plan described in section 501(n)(1)(A) (relating to community needs)—

"(i) shall make a copy of such plan (and the assessment on which such plan is based) available for inspection during regular business hours by any individual at the principal office of such organization and, if such organization regularly maintains 1 or more regional or district offices having 3 or more employees, at each such regional or district office, and

"(ii) upon request of an individual made at such principal office or such a regional or district office, shall provide—

"(I) a copy of such plan (and assessment),

"(II) a copy of the annual return filed under section 6033, and

"(III) a copy of the application, papers, letters, and other documents referred to in paragraph (2)(A)(ii),

to such individual without charge other than a reasonable fee for any reproduction and mailing costs. If the request under clause (ii) is made in person, such copies shall be provided immediately and, if made other than in person, shall be provided within 30 days.

"(B) PERIOD OF AVAILABILITY.—Subparagraph (A) shall apply—

"(i) with respect to any plan (and assessment) during the 3-year period after the close of the year for which such plan is prepared,

"(ii) with respect to any return, during the 3-year period beginning on the filing date (as defined in paragraph (1)(D)), and

"(iii) with respect to the material referred to in subparagraph (A)(ii)(III), at any time.

"(C) LIMITATION.—Subparagraph (A)(ii) shall not apply to any request if the Secretary determines, upon application by an organization, that such request is part of a harassment campaign and that compliance with such request is not in the public interest."

(B) TECHNICAL AMENDMENT.—The heading for subsection (e) of section 6104 is amended by striking "AND APPLICATIONS FOR EXEMPTION" and inserting ", APPLICATIONS FOR EXEMPTION, AND COMMUNITY NEEDS ASSESSMENT AND PLAN FOR HEALTH AND OUTREACH SERVICES".

(c) FUNDRAISING SOLICITATIONS REQUIRED TO DISCLOSE AVAILABILITY OF ANNUAL RETURN.—

(1) Paragraph (1) of section 6104(e) is amended by adding at the end the following new subparagraph:

"(E) FUNDRAISING SOLICITATIONS OF CERTAIN HEALTH CARE ORGANIZATIONS REQUIRED TO DISCLOSE AVAILABILITY OF ANNUAL RETURN.—In the case of an applicable tax-exempt health care organization (as defined in section 4960), each fundraising solicitation (as defined in section 6113(c)) by (or on behalf of) such organization shall contain an express statement (in a conspicuous and easily recognizable format) that such return shall be provided to individuals upon request."

(2) PENALTY.—

(A) Section 6710 is amended by striking "section 6113" each place it appears and inserting "section 6113 or 6104(e)(1)(E)".

(B) Subsection (a) of section 6710 is amended by inserting "($100 in the case of a failure to meet the requirements of section 6104(e)(1)(E))" after "$1,000".

(C) The section heading of section 6710 is amended by inserting before the period "; failure by certain health care organizations to disclose availability of annual return".

(D) The table of sections for part I of subchapter B of chapter 68 is amended by inserting before the period at the end of the item relating to section 6710 the following: "; failure by certain health care organizations to disclose availability of annual return".

(E) Subparagraph (C) of section 6652(c)(1) is amended by striking "(e)(1)" and inserting "(e)(1) (other than subparagraph (E))".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall take effect on January 1, 1995.

(2) REQUIREMENT OF INDEPENDENT BOARD OF DIRECTORS.—Subparagraph (C) of section 501(n)(1) of the Internal Revenue Code of 1986, as added by this section, shall take effect on January 1, 1997.

(3) HMO SERVICE REQUIREMENT.—So much of the amendments made by this section as relate to section 501(n)(2) of such Code, as added by this section, shall take effect on the date of the enactment of this Act.

SEC. 11402. EXCISE TAXES FOR FAILURE BY TAX-EXEMPT HEALTH CARE ORGANIZATIONS TO MEET CERTAIN QUALIFICATION REQUIREMENTS.

(a) IN GENERAL.—Chapter 42 (relating to private foundations and certain other tax-exempt organizations) is amended by redesignating subchapter D as subchapter E and by inserting after subchapter C the following new subchapter:

"Subchapter D—Failure By Tax-Exempt Health Care Organizations To Meet Certain Qualification Requirements

"Sec. 4958. Tax on failure to satisfy section 501(n).

"Sec. 4959. Taxes on excess benefit transactions.

"Sec. 4960. Other definitions.

"SEC. 4958. TAX ON FAILURE TO SATISFY SECTION 501(n).

"(a) IMPOSITION OF TAX.—There is hereby imposed on any applicable tax-exempt health care organization which fails to meet 1 or more of the requirements of section 501(n)(1) during any taxable year a tax equal to the greater of—

"(1) $25,000, or

"(2) 5 percent of the organization's net investment income for such taxable year.

"(b) PAYMENT OF TAX.—The tax imposed by this section shall be paid by the organization.

"(c) DETERMINATION OF NET INVESTMENT INCOME.—For purposes of this section—

"(1) IN GENERAL.—The net investment income of an applicable tax-exempt health care organization shall include the net investment income of—

"(A) each organization which would be described in subparagraph (A) or (B) of section 509(a)(3) or in section 509(a)(4) with respect to such health care organization if such health care organization were described in section 509(a)(2), and

"(B) each organization which is organized and operated for the benefit of, and which directly or indirectly is controlled by, such health care organization.

"(2) NET INVESTMENT INCOME.—The term 'net investment income' has the meaning given such term by section 4940.

"(d) WAIVER.—If it is established to the satisfaction of the Secretary that—

"(1) a failure was due to reasonable cause and not to willful neglect, and

"(2) the organization has established safeguards to prevent future such failures (and has taken such additional corrective action as is prescribed by the Secretary by regulations),

then the tax imposed by subsection (a) (including interest) by reason of such failure shall not be assessed and, if assessed, the assessment shall be abated and, if collected, shall be credited or refunded as an overpayment.

"SEC. 4959. TAXES ON EXCESS BENEFIT TRANSACTIONS.

"(a) INITIAL TAXES.—

"(1) ON THE DISQUALIFIED PERSON.—There is hereby imposed on each excess benefit transaction a tax equal to 25 percent of the excess benefit. The tax imposed by this paragraph shall be paid by any disqualified person referred to in subsection (e)(1) with respect to such transaction.

"(2) ON THE MANAGEMENT.—In any case in which a tax is imposed by paragraph (1), there is hereby imposed on the participation of any organization manager in the excess benefit transaction, knowing that it is such a transaction, a tax equal to 10 percent of the excess benefit, unless such participation is not willful and is due to reasonable cause. The tax imposed by this paragraph shall be paid by any organization manager who participated in the excess benefit transaction.

"(b) Additional Tax On the Disqualified Person.—In any case in which an initial tax is imposed by subsection (a)(1) on an excess benefit transaction and the excess benefit involved in such transaction is not corrected within the taxable period, there is hereby imposed a tax equal to 200 percent of the excess benefit involved. The tax imposed by this subsection shall be paid by any disqualified person referred to in subsection (e)(1) with respect to such transaction.

"(c) Excess Benefit Transaction; Excess Benefit.—For purposes of this section—

"(1) Excess benefit transaction.—

"(A) In general.—The term 'excess benefit transaction' means any transaction in which an economic benefit is provided by an applicable tax-exempt health care organization to or for the use of any disqualified person if the value of the economic benefit provided exceeds the value of the consideration (including the performance of services) received for providing such benefit.

"(B) Loans and certain private inurement included.—The term 'excess benefit transaction' includes—

"(i) any loan of money or other extension of credit by an applicable tax-exempt health care organization to or for the use of a disqualified person described in subsection (e)(1)(A)(i), and

"(ii) any transaction in which the amount of any economic benefit provided to or for the use of a disqualified person is determined in whole or in part by the gross or net revenues of 1 or more activities of the organization but only if such transaction results in inurement not permitted under paragraph (3) or (4) of section 501(c), as the case may be.

"(2) Excess benefit.—

"(A) In general.—Except as provided in subparagraph (B), the term 'excess benefit' means the excess referred to in paragraph (1)(A).

"(B) Loans and private inurement included.—The term 'excess benefit' means—

"(i) in the case of a loan or extension of credit described in paragraph (1)(B)(i), the amount of the loan or the credit extended, and

"(ii) in the case of a transaction described in paragraph (1)(B)(ii), the amount of the inurement.

"(3) Exception for organizations subject to private foundation rules.—For purposes of this section, the term 'applicable tax-exempt health care organization' shall not include a private foundation (as defined in section 509(a)).

"(d) Special Rules.—For purposes of this section—

"(1) Joint and several liability.—If more than 1 person is liable for any tax imposed by subsection (a) or subsection (b), all such persons shall be jointly and severally liable for such tax.

"(2) Limit for management.—With respect to any 1 excess benefit transaction, the maximum amount of the tax imposed by subsection (a)(2) shall not exceed $10,000.

"(e) Other Definitions.—For purposes of this section—

"(1) Disqualified person.—The term 'disqualified person' means, with respect to any transaction—

"(A) any person who was, at any time during the 5-year period ending on the date of such transaction—

"(i) an organization manager, or

"(ii) an individual (other than an organization manager) in a position to exercise substantial influence over the affairs of the organization,

"(B) a member of the family of an individual described in subparagraph (A), and

"(C) a 35-percent controlled entity.

"(2) Organization manager.—The term 'organization manager' means, with respect to any applicable tax-exempt health care organization, any officer, director, or trustee of such organization (or any individual having powers or responsibilities similar to those of officers, directors, or trustees of the organization).

"(3) 35-percent controlled entity.—

"(A) In general.—The term '35-percent controlled entity' means—

"(i) a corporation in which persons described in subparagraph (A) or (B) of paragraph (1) own more than 35 percent of the total combined voting power,

"(ii) a partnership in which such persons own more than 35 percent of the profits interest, and

"(iii) a trust or estate in which such persons own more than 35 percent of the beneficial interest.

"(B) Constructive ownership rules.—Rules similar to the rules of paragraphs (3) and (4) of section 4946(a) shall apply for purposes of this paragraph.

"(4) Family members.—The members of an individual's family shall be determined under section 4946(d); except that such members also shall include the brothers and sisters (whether by the whole or half blood) of the individual and their spouses.

"(f) Treatment of Previously Exempt Organizations.—

"(1) In general.—For purposes of this section, the status of any organization as an applicable tax-exempt health care organization shall be terminated only if—

"(A)(i) such organization notifies the Secretary (at such time and in such manner as the Secretary may by regulations prescribe) of its intent to accomplish such termination, or

"(ii) there is a final determination by the Secretary that such status has terminated, and

"(B)(i) such organization pays the tax imposed by paragraph (2) (or any portion not abated pursuant to paragraph (3)), or

"(ii) the entire amount of such tax is abated pursuant to paragraph (3).

"(2) Imposition of tax.—There is hereby imposed on each organization referred to in paragraph (1) a tax equal to the lesser of—

"(A) the amount which the organization substantiates by adequate records or other corroborating evidence as the aggregate tax benefit resulting from its exemption from tax under section 501(a), or

"(B) the value of the net assets of such organization.

"(3) Abatement of tax.—The Secretary may abate the unpaid portion of the assessment of any tax imposed by paragraph (2), or any liability in respect thereof, if the applicable tax-exempt health care organization distributes all of its net assets to 1 or more organizations each of which has been in existence, and described in section 501(c)(3), for a continuous period of at least 60 calendar months. If the distributing organization is described in section 501(c)(4), the preceding sentence shall be applied by treating the reference to section 501(c)(3) as including a reference to section 501(c)(4).

"(4) Certain rules made applicable.—Rules similar to the rules of subsections (d), (e), and (f) of section 507 shall apply for purposes of this subsection.

"SEC. 4960. OTHER DEFINITIONS.

"(a) Applicable Tax-Exempt Health Care Organization.—For purposes of this subchapter, the term 'applicable tax-exempt health care organization' means any organization—

"(1) the predominant activity of which is the provision of health care services (as defined in section 501(n)(3)), and

"(2) which (without regard to any failure to meet any requirement of section 501(n) or any excess benefit) would be described in paragraph (3) or (4) of section 501(c) and exempt from tax under section 501(a).

"(b) Taxable Period; Correction.—For purposes of this subchapter—

"(1) Taxable period.—The term 'taxable period' means, with respect to any excess benefit transaction, the period beginning with the date on which the transaction occurs and ending on the earliest of—

"(A) the date of mailing a notice of deficiency under section 6212 with respect to the tax imposed by subsection (a)(1) of section 4959, or

"(B) the date on which the tax imposed by such subsection (a)(1) is assessed.

"(2) Correction.—The terms 'correction' and 'correct' mean, with respect to any excess benefit transaction, undoing the excess benefit to the extent possible, establishing safeguards to prevent future such excess benefit, and where fully undoing the excess benefit is not possible, such additional corrective action as is prescribed by the Secretary by regulations."

(b) Application of Private Inurement Rule to Tax-Exempt Health Care Organizations Described in Section 501(c)(4).—Paragraph (4) of section 501(c) is amended by inserting "(A)" after "(4)" and by adding at the end the following:

"(B) Subparagraph (A) shall not apply to an entity the predominant activity of which is the provision of health care services (as defined in subsection (n)(3)) unless no part of the net earnings of such entity inures to the benefit of any private shareholder or individual."

(c) Technical and Conforming Amendments.—

(1) Subsection (e) of section 4955 is amended—

(A) by striking "Section 4945" in the heading and inserting "Sections 4945 and 4959", and

(B) by inserting before the period "or an excess benefit for purposes of section 4959".

(2) Subsections (a), (b), and (c) of section 4963 are each amended by inserting "4959," after "4955,".

(3) Subsection (e) of section 6213 is amended by inserting "4959 (relating to private excess benefit)," before "4971".

(4) Paragraphs (2) and (3) of section 7422(g) are each amended by inserting "4959," after "4955,".

(5) Subsection (b) of section 7454 is amended by inserting "or whether an organization manager (as defined in section 4959(e)(2)) has 'knowingly' participated in an excess benefit transaction (as defined in section 4959(c))," after "section 4912(b),".

(6) The table of subchapters for chapter 42 is amended by striking the last item and inserting the following:

"Subchapter D. Failure by tax-exempt health care organizations to meet certain qualification requirements.

"Subchapter E. Abatement of first and second tier taxes in certain cases."

(d) Effective Dates.—

(1) SECTION 501(n) REQUIREMENTS.—The amendments made by this section, to the extent related to section 4958 of the Internal Revenue Code of 1986 (as added by this section), shall take effect on January 1, 1995.

(2) EXCESS BENEFIT TRANSACTION RULES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section, to the extent related to section 4959 of such Code (as added by this section), shall apply to excess benefit transactions occurring on or after June 30, 1994.

(B) BINDING CONTRACTS FOR PERSONAL SERVICES.—The amendments referred to in subparagraph (A) shall not apply to any transaction pursuant to any written contract for the performance of personal services which was binding on June 29, 1994, and at all times thereafter before such transaction occurred.

(3) APPLICATION OF PRIVATE INUREMENT RULE TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—

(A) IN GENERAL.—The amendment made by subsection (b) shall apply to inurement occurring on or after June 30, 1994.

(B) BINDING CONTRACTS.—The amendment made by subsection (b) shall not apply to any inurement occurring before July 1, 1996, pursuant to a written contract which was binding on June 29, 1994, and at all times thereafter before such inurement occurred.

SEC. 11403. TREATMENT OF NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) INSURANCE PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS.—Section 501(m) (relating to certain organizations providing commercial-type insurance not exempt from tax) is amended by adding at the end the following new paragraph:

"(6) CERTAIN ACTIVITIES PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS NOT TREATED AS COMMERCIAL-TYPE INSURANCE.—For purposes of this subsection, the provision of (or the arranging for the provision of) medical care on a prepaid basis by a health maintenance organization shall not be treated as commercial-type insurance if (and only if) such care is—

"(A) care provided by such organization to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization,

"(B) care provided by a health care professional to a member of such organization on a basis under which substantially all of the risks of the rates of utilization is assumed by the provider of such care, or

"(C) care (other than primary care) provided to a member of such organization pursuant to a referral by such organization, or

"(D) emergency care provided to a member of such organization at a location outside such member's area of residence."

(2) TECHNICAL AMENDMENTS.—

(A) Paragraph (3) of section 501(m) is amended by striking subparagraph (B) and by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively.

(B) Paragraph (5) of section 501(m) is amended by striking "paragraph (3)(E)" and inserting "paragraph (3)(D)".

(b) TREATMENT OF PARENT ORGANIZATIONS OF HEALTH CARE PROVIDERS.—Section 509(a) (defining private foundation) is amended by striking "and" at the end of paragraph (3), by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

"(4) an organization which is organized and operated for the benefit of, and which directly or indirectly controls, an organization described in section 170(b)(1)(A)(iii); and".

(c) CONSUMER PURCHASING COOPERATIVES EXEMPT FROM TAX.—

(1) IN GENERAL.—Subsection (c) of section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by adding at the end the following new paragraph:

"(26)(A) Any consumer purchasing cooperative described in subtitle E of title V of the Guaranteed Health Insurance Act of 1994.

"(B) Such a cooperative shall not be exempt from tax pursuant to any provision other than this paragraph.

"(C) Such a cooperative shall not be exempt from tax unless—

"(i) no part of the net earnings of such cooperative inures to the benefit of any private shareholder or individual,

"(ii) no substantial part of the activities of such cooperative is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and

"(iii) such cooperative does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office."

(2) CERTAIN PROVISIONS APPLICABLE TO ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3) MADE APPLICABLE TO CONSUMER PURCHASING COOPERATIVES.—Section 501 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

"(o) CERTAIN PROVISIONS MADE APPLICABLE TO CONSUMER PURCHASING COOPERATIVES.—A consumer purchasing cooperative described in subsection (c)(26) shall be treated—

"(1) as described in subsection (c)(3) for purposes of applying subsection (h) (relating to expenditures by public charities to influence legislation), section 4955 (relating to taxes on political expenditures of section 501(c)(3) organizations), and section 4959 (relating to private inurement), and

"(2) as described in subsection (h)(4)."

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 11404. TAX TREATMENT OF TAXABLE ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.

(a) GENERAL RULE.—Section 831 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) TREATMENT OF ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.—

"(1) GENERAL RULE.—Any organization to which this subsection applies shall be taxable under this part in the same manner as if it were an insurance company other than a life insurance company.

"(2) ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any organization—

"(A) which is not exempt from taxation under this subtitle,

"(B) which is not taxable as a life insurance company under part I of this subchapter,

"(C) which is not an organization to which section 833 applies, and

"(D) the primary and predominant business activity of which during the taxable year consists of 1 or more of the following:

"(i) Issuing accident and health insurance contracts or the reinsuring of risks undertaken by other insurance companies under such contracts.

"(ii) Operating as a health maintenance organization.

"(iii) Entering into arrangements under which—

"(I) fixed payments or premiums are received as consideration for the organization's agreement to provide or arrange for the provision of health care services, regardless of how the health care services are provided or arranged to be provided, and

"(II) substantially all of the risks of the rates of utilization of such services is assumed by the provider of such services.

In the case of an organization which has as a material business activity the issuing of accident and health insurance contracts or the reinsuring of risks undertaken by other insurance companies under such contracts, the administering of accident and health insurance contracts by such organization shall be treated as part of such business activity for purposes of subparagraph (D)(i)."

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall apply to taxable years beginning after December 31, 1994.

(2) TRANSITIONAL RULES.—

(A) ORGANIZATIONS TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any organization to which section 831(c) of the Internal Revenue Code of 1986 (as added by subsection (a)) applies for such organization's first taxable year beginning after December 31, 1994; except that this paragraph shall not apply if—

(i) such organization treated itself as an insurance company taxable under part II of subchapter L of chapter 1 of such Code on its original Federal income tax return for its taxable year beginning in 1992 and for all of its taxable years thereafter beginning before January 1, 1995, or

(ii) such organization was exempt from tax under chapter 1 of such Code for such organization's last taxable year beginning before January 1, 1995.

(B) TREATMENT OF CURRENTLY TAXABLE COMPANIES.—In the case of any organization to which this paragraph applies—

(i) the amendments made by this section shall be treated as a change in the method of accounting, and

(ii) all adjustments required to be taken into account under section 481 of the Internal Revenue Code of 1986 shall be taken into account for such company's first taxable year beginning after December 31, 1994.

SEC. 11405. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

"(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

"(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

"(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

"(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit health insurance or health-service type organizations, and

"(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization."

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1986.

SEC. 11406. TAX EXEMPTION FOR HIGH-RISK INSURANCE POOLS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

"(27) In the case of taxable years beginning before January 1, 1998, any corporation, association, or similar legal entity which is created by any State or political subdivision thereof to establish a risk pool to provide health insurance coverage to any person unable to obtain health insurance coverage in the private insurance market because of health conditions and no part of the net earnings of which inures to the benefit of any private shareholder, member, or individual."

(b) Effective Date.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1989.

Subtitle E—Treatment of Accelerated Death Benefits Under Life Insurance Contracts

SEC. 11501. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) General Rule.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

"(g) Treatment of Certain Accelerated Death Benefits.—

"(1) In general.—For purposes of this section, any amount received under a life insurance contract on the life of an insured who is a terminally ill individual shall be treated as an amount paid by reason of the death of such insured.

"(2) Necessary conditions.—

"(A) In general.—Paragraph (1) shall not apply to any amount received unless—

"(i) the total amount received is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

"(ii) the percentage reduction by reason of the distribution in the cash surrender value of the contract does not exceed the percentage reduction by reason of such distribution in the death benefit payable under the contract.

For purposes of this subparagraph, any amount referred to in paragraph (1) that is received as a loan or lien shall be treated as a reduction, at the time of receipt, in the death benefit or the cash surrender value to the extent that the death benefit or cash surrender value, respectively, are encumbered (or can become encumbered) by the amount of such loan or lien (or amounts related thereto).

"(B) Determination of present value.—The present value of a reduction in the death benefit shall be determined by—

"(i) using a discount rate not to exceed the highest rate set forth in subparagraph (C), and

"(ii) assuming that the death benefit (or the portion thereof) would have been paid on the date which is 12 months after the date of the certification referred to in paragraph (3).

"(C) Rates.—The rates set forth in this subparagraph are the following:

"(i) the 90-day Treasury bill yield,

"(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc., or any successor thereto, for the calendar month ending 2 months before the date on which the rate is determined, and

"(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum.

"(D) Liens.—To the extent a lien is imposed against the death benefit in connection with the distribution, the rate of any interest charged may not exceed the highest rate set forth in subparagraph (C), and such lien may not encumber the cash surrender value such that the percentage amount of the cash surrender value that is encumbered exceeds the percentage amount of the death benefit that is encumbered.

"(3) Terminally ill individual.—For purposes of this subsection, the term 'terminally ill individual' means an individual who the insurer has determined, after receipt of an acceptable certification by a licensed physician, has an illness or physical condition which is reasonably expected to result in death within 12 months after the date of certification.

"(4) Exception for business-related policies.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer."

(b) Effective Date.—

(1) In general.—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to amounts received after the date of the enactment of this Act.

(2) Delay in application of discounting rules.—Clause (i) of section 101(g)(2)(A) of the Internal Revenue Code of 1986 (as added by this section) shall not apply to any amount received before January 1, 1995.

(3) Issuance of rider not treated as material change.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract, the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)) shall not be treated as a modification or material change of such contract.

SEC. 11502. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) Qualified Accelerated Death Benefit Riders Treated as Life Insurance.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

"(g) Qualified Accelerated Death Benefit Riders Treated as Life Insurance.—For purposes of this part—

"(1) In general.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

"(2) Qualified accelerated death benefit riders.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g)."

(c) Effective Date.—The amendments made by this section shall take effect on January 1, 1995.

Subtitle F—Employment Status Provisions

SEC. 11601. EMPLOYMENT STATUS PROPOSAL REQUIRED FROM DEPARTMENT OF THE TREASURY.

Not later than January 1, 1996, the Secretary of the Treasury shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a legislative proposal relating to the classification of workers as employees or independent contractors.

SEC. 11602. INCREASE IN PENALTIES RELATING TO REPORTING OF PAYMENTS FOR SERVICES.

(a) Increase in Penalty.—Section 6721(a) (relating to imposition of penalty) is amended by adding at the end the following new paragraph:

"(3) Increased penalty for returns involving payments for services.—

"(A) In general.—Subject to the overall limitation of paragraph (1), the amount of the penalty under paragraph (1) for any failure with respect to any applicable return shall be equal to the greater of $50 or 5 percent of the amount required to be reported correctly but not so reported.

"(B) Exception where substantial compliance.—Subparagraph (A) shall not apply to failures with respect to applicable returns required to be filed by a person during any calendar year if the aggregate amount which is timely and correctly reported on applicable returns filed by the person for the calendar year is at least 97 percent of the aggregate amount which is required to be reported on applicable returns by the person for the calendar year.

"(C) Applicable return.—For purposes of this paragraph, the term 'applicable return' means any information return required to be filed under—

"(i) section 6041(a) but only if such return relates to payments to any person for services performed by such person (other than as an employee), or

"(ii) section 6041A(a)."

(b) Conforming Amendment.—Section 6721(a)(1) is amended by striking "In" and inserting "Except as provided in paragraph (3), in".

(c) Effective Date.—The amendments made by this section shall apply to returns the due date for which (without regard to extensions) is more than 30 days after the date of the enactment of this Act.

Subtitle G—Tax Treatment of Funding of Retiree Health Benefits

SEC. 11701. POST-RETIREMENT MEDICAL AND LIFE INSURANCE RESERVES.

(a) Minimum Period for Working Lives.—Section 419A(c)(2) (relating to additional reserve for post-retirement medical and life insurance benefits) is amended by inserting "(but not less than 10 years)" after "working lives of the covered employees".

(b) Separate Accounting.—

(1) Requirement.—Section 419A(c)(2) is amended by adding at the end the following new flush sentence:

"Such reserve shall be maintained as a separate account."

(2) Use of reserve for other purposes.—Paragraph (1) of section 4976(b) (defining disqualified benefit) is amended by striking "and" at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting ", and", and by adding after subparagraph (C) the following new subparagraph:

"(D) any payment to which subparagraph (C) does not apply which is out of an account described in section 419A(c)(2) and which is not used to provide a post-retirement medical benefit or life insurance benefit."

(c) Effective Dates.—

(1) In general.—Except as provided in paragraph (2), the amendments made by this section shall apply to contributions paid or accrued after December 31, 1994, in taxable years ending after such date.

(2) Separate accounting.—The amendments made by subsection (b) shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

Subtitle H—Excise Taxes on Insured and Self-Insured Health Plans

SEC. 11801. EXCISE TAXES ON INSURED AND SELF-INSURED HEALTH PLANS.

(a) GENERAL RULE.—Chapter 34 is amended by adding at the end the following new subchapter:

"Subchapter B—Insured and Self-Insured Health Plans

"Sec. 4375. Health insurance and health-related administrative services.

"Sec. 4376. Self-insured health plans.

"Sec. 4377. Definitions and special rules.

"SEC. 4375. HEALTH INSURANCE AND HEALTH-RELATED ADMINISTRATIVE SERVICES.

"(a) IMPOSITION OF TAX.—There is hereby imposed—

"(1) on each taxable health insurance policy, a tax equal to 2 percent of the premiums received under such policy, and

"(2) on each amount received for health-related administrative services, a tax equal to 2 percent of the amount so received.

"(b) LIABILITY FOR TAX.—

"(1) HEALTH INSURANCE.—The tax imposed by subsection (a)(1) shall be paid by the issuer of the policy.

"(2) HEALTH-RELATED ADMINISTRATIVE SERVICES.—The tax imposed by subsection (a)(2) shall be paid by the person providing the health-related administrative services.

"(c) TAXABLE HEALTH INSURANCE POLICY.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this section, the term 'taxable health insurance policy' means any accident or health insurance policy issued with respect to individuals residing in the United States.

"(2) EXEMPTION OF CERTAIN POLICIES.—The term 'taxable health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to—

"(A) liabilities incurred under workers' compensation laws,

"(B) tort liabilities,

"(C) liabilities relating to ownership or use of property,

"(D) credit insurance, or

"(E) such other similar liabilities as the Secretary may specify by regulations.

"(3) SPECIAL RULE WHERE POLICY PROVIDES OTHER COVERAGE.—In the case of any taxable health insurance policy under which amounts are payable other than for accident and health coverage, in determining the amount of the tax imposed by subsection (a)(1) on any premium received under such policy, there shall be excluded the amount of the charge for the non-accident and health coverage if—

"(A) the charge for such non-accident and health coverage is either separately stated in the policy, or furnished to the policyholder in a separate statement, and

"(B) such charge is reasonable in relation to the total charges under the policy.

In any other case, the entire amount of the premium received under such a policy shall be subject to tax under subsection (a)(1).

"(4) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

"(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

"(i) such arrangement shall be treated as a taxable health insurance policy,

"(ii) the payments or premiums referred to in subparagraph (B)(i) shall be treated as premiums received for a taxable health insurance policy, and

"(iii) the person referred to in subparagraph (B)(i) shall be treated as the issuer.

"(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement—

"(i) fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, and

"(ii) substantially all of the risks of the rates of utilization of services is assumed by such person or the provider of such services.

"(d) HEALTH-RELATED ADMINISTRATIVE SERVICES.—For purposes of this section, the term 'health-related administrative services' means—

"(1) the processing of claims or performance of other administrative services in connection with accident or health coverage under a taxable health insurance policy if the charge for such services is not included in the premiums under such policy, and

"(2) processing claims, arranging for provision of accident or health coverage, or performing other administrative services in connection with an applicable self-insured health plan (as defined in section 4376(c)) established or maintained by another person.

"SEC. 4376. SELF-INSURED HEALTH PLANS.

"(a) IMPOSITION OF TAX.—In the case of any applicable self-insured health plan, there is hereby imposed a tax for each month equal to 2 percent of the sum of—

"(1) the accident and health coverage expenditures for such month under such plan, and

"(2) the direct administrative expenditures for such month under such plan.

"(b) LIABILITY FOR TAX.—

"(1) IN GENERAL.—The tax imposed by subsection (a) shall be paid by the plan sponsor.

"(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

"(A) the employer in the case of a plan established or maintained by a single employer,

"(B) the employee organization in the case of a plan established or maintained by an employee organization,

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

"(ii) a multiple employer welfare arrangement, or

"(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

"(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

"(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

"(1) any portion of such coverage is provided other than through an insurance policy, and

"(2) such plan is established or maintained—

"(A) by one or more employers for the benefit of their employees or former employees,

"(B) by one or more employee organizations for the benefit of their members or former members,

"(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

"(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

"(E) by any organization described in section 501(c)(6), or

"(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

"(d) ACCIDENT AND HEALTH COVERAGE EXPENDITURES.—For purposes of this section—

"(1) IN GENERAL.—The accident and health coverage expenditures of any applicable self-insured health plan for any month is the aggregate expenditures for such month for accident and health coverage provided under such plan to the extent such expenditures are not subject to tax under section 4375.

"(2) TREATMENT OF REIMBURSEMENTS.—In determining accident and health coverage expenditures during any month of any applicable self-insured health plan, reimbursements (by insurance or otherwise) received during such month for accident and health coverage expenditures shall be taken into account as a reduction in accident and health coverage expenditures.

"(3) CERTAIN EXPENDITURES DISREGARDED.—Paragraph (1) shall not apply to any expenditure for the acquisition or improvement of land or for the acquisition or improvement of any property to be used in connection with the provision of accident and health coverage which is subject to the allowance under section 167, except that, for purposes of paragraph (1), allowances under section 167 shall be considered as expenditures.

"(e) DIRECT ADMINISTRATIVE EXPENDITURES.—For purposes of this section, the term 'direct administrative expenditures' means the administrative expenditures under the plan to the extent such expenditures are not subject to tax under section 4375. In determining the amount of such expenditures, rules similar to the rules of subsection (d)(3) shall apply.

"SEC. 4377. DEFINITIONS AND SPECIAL RULES.

"(a) DEFINITIONS.—For purposes of this subchapter—

"(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a taxable health insurance policy (as defined in section 4375(c).

"(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

"(3) PREMIUM.—The term 'premium' means the gross amount of premiums and other consideration (including advance premiums, deposits, fees, and assessments) arising from policies issued by a person acting as the primary insurer, adjusted for any return or additional premiums paid as a result of endorsements, cancellations, audits, or retrospective rating.

"(4) UNITED STATES.—The term 'United States' includes any possession of the United States.

"(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

"(1) IN GENERAL.—For purposes of this subchapter—

"(A) the term 'person' includes any governmental entity, and

"(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the taxes imposed by this subchapter except as provided in paragraph (2).

"(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program—

"(A) no tax shall be imposed under section 4375 on any premium received pursuant to such program or on any amount received for health-related administrative services pursuant to such program, and

"(B) no tax shall be imposed under section 4376 on any expenditures pursuant to such program.

"(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

"(A) the insurance programs established by parts A and B of title XVIII of the Social Security Act,

"(B) Medicare part C (as defined in section 59B(g)(2)),

"(C) the medical assistance program established by title XIX of the Social Security Act,

"(D) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

"(i) members of the Armed Forces of the United States, or

"(ii) veterans, and

"(E) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

"(c) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States."

(b) CLERICAL AMENDMENT.—Chapter 34 is amended by striking the chapter heading and inserting the following:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

"Subchapter A. Policies issued by foreign insurers.

"Subchapter B. Insured and self-insured health plans.

"Subchapter A—Policies Issued By Foreign Insurers".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to premiums received and expenses incurred after December 31, 1995.

Subtitle I—Other Provisions

PART 1—TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS

SEC. 11901. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by inserting after section 22 the following new section:

"SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.

"(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the product of—

"(1) the number of months during such taxable year—

"(A) during which the taxpayer is a qualified primary health services provider, and

"(B) which are within the taxpayer's mandatory service period, and

"(2) $1,000 ($500 in the case of a qualified practitioner who is not a physician).

"(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term 'qualified primary health services provider' means, with respect to any month, any qualified practitioner who—

"(1) has in effect a certification by the Bureau as a provider of primary health services and such certification is, when issued, for a health professional shortage area in which the qualified practitioner is commencing the providing of primary health services,

"(2) is providing primary health services full time in the health professional shortage area identified in such certification, and

"(3) has not received a scholarship under the National Health Service Corps Scholarship Program or any loan repayments under the National Health Service Corps Loan Repayment Program.

For purposes of paragraph (2) and subsection (e)(3), a provider shall be treated as providing services in a health professional shortage area when such area ceases to be such an area if it was such an area when the provider commenced providing services in the area.

"(c) MANDATORY SERVICE PERIOD.—For purposes of this section, the term 'mandatory service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider. A taxpayer shall not have more than 1 mandatory service period.

"(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) BUREAU.—The term 'Bureau' means the Bureau of Primary Health Care, Health Resources and Services Administration of the United States Public Health Service.

"(2) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

"(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r)(1) of the Social Security Act.

"(4) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

"(5) CERTIFIED NURSE-MIDWIFE.—The term 'certified nurse-midwife' has the meaning given to such term by section 1861(gg)(2) of the Social Security Act.

"(6) PRIMARY HEALTH SERVICES.—The term 'primary health services' has the meaning given such terms by section 330(b)(1) of the Public Health Service Act.

"(7) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' has the meaning given such term by section 332(a)(1)(A) of the Public Health Service Act.

"(e) RECAPTURE OF CREDIT.—

"(1) IN GENERAL.—If there is a recapture event during any taxable year, then—

"(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

"(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

"(i) the applicable percentage, and

"(ii) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

"(2) APPLICABLE RECAPTURE PERCENTAGE.—

"(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

"If the recapture event occurs during:	The applicable recapture percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Month 61 or thereafter	0.

"(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

"(3) RECAPTURE EVENT DEFINED.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means the failure of the taxpayer to be a qualified primary health services provider for any month during the taxpayer's mandatory service period.

"(B) SECRETARIAL WAIVER.—The Secretary, in consultation with the Secretary of Health and Human Services, may waive any recapture event caused by extraordinary circumstances.

"(4) NO CREDITS AGAINST TAX; MINIMUM TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under subpart A, B, or D of this part or for purposes of section 55."

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 22 the following new item:

"Sec. 23. Primary health services providers."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 11902. EXPENSING OF MEDICAL EQUIPMENT.

(a) IN GENERAL.—Paragraph (1) of section 179(b) (relating to dollar limitation on expensing of certain depreciable business assets) is amended to read as follows:

"(1) DOLLAR LIMITATION.—

"(A) GENERAL RULE.—The aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $17,500.

"(B) HEALTH CARE PROPERTY.—The aggregate cost which may be taken into account under subsection (a) shall be increased by the lesser of—

"(i) the cost of section 179 property which is health care property placed in service during the taxable year, or

"(ii) $10,000."

(b) DEFINITION.—Section 179(d) (relating to definitions) is amended by adding at the end the following new paragraph:

"(11) HEALTH CARE PROPERTY.—For purposes of this section, the term 'health care property' means section 179 property—

"(A) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment,

"(B) which is owned (directly or indirectly) and used by a physician (as defined in section 1861(r)(1) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act), and

"(C) substantially all the use of which is in such area."

(c) RECAPTURE.—Paragraph (10) of section 179(d) is amended by inserting before the period "and with respect to any health care property which ceases to be health care property at any time".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service in taxable years beginning after December 31, 1994.

PART 2—HEALTH CARE WORKFORCE TRUST FUND

SEC. 11911. HEALTH CARE WORKFORCE TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 (relating to trust fund code) is amended by adding at the end the following new section:

"SEC. 9512. HEALTH CARE WORKFORCE TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Workforce Trust Fund', consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

"(b) TRANSFERS TO FUND.—There are hereby appropriated to the Health Care Workforce Trust Fund amounts equivalent to 50 percent of the net revenues received in the Treasury from the taxes imposed under subchapter B of chapter 34 (relating to taxes on health insurance and health-related administrative services).

"(c) EXPENDITURES FROM FUND.—Amounts in the Health Care Workforce Trust Fund are available to the Secretary of Health and Human Services for making payments under sections 7021 and 7041 of the Guaranteed Health Insurance Act of 1994 and for making grants under sections 741 and 848 of the Public Health Service Act.

"(d) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

"(1) the taxes received in the Treasury under subchapter B of chapter 34, over

"(2) the decrease in the tax imposed by chapter 1 resulting from the taxes imposed by such subchapter.".

(b) CLERICAL AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end thereof the following new item:

"Sec. 9512. Health Care Workforce Trust Fund.".

PART 3—RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS

SEC. 11921. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS.

(a) IN GENERAL.—Subchapter A of chapter 1 is amended by adding at the end thereof the following new part:

"PART IX—CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS

"Sec. 59C. Recapture of certain health care subsidies.

"SEC. 59C. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES.

"(a) IMPOSITION OF RECAPTURE AMOUNT.—In the case of an individual, if the modified adjusted gross income of the taxpayer for the taxable year exceeds the threshold amount, such taxpayer shall pay (in addition to any other amount imposed by this subtitle) a recapture amount for such taxable year equal to the aggregate of the Medicare part B recapture amounts (if any) for months during such year that a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part.

"(b) MEDICARE PART B PREMIUM RECAPTURE AMOUNT FOR MONTH.—For purposes of this section, the Medicare part B premium recapture amount for any month is the amount equal to the excess of—

"(1) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

"(2) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

"(c) PHASEIN OF RECAPTURE AMOUNT.—

"(1) IN GENERAL.—If the modified adjusted gross income of the taxpayer for any taxable year exceeds the threshold amount by less than $15,000, the recapture amount imposed by this section for such taxable year shall be an amount which bears the same ratio to the recapture amount which would (but for this subsection) be imposed by this section for such taxable year as such excess bears to $15,000.

"(2) JOINT RETURNS.—If a recapture amount is determined separately for each spouse filing a joint return, paragraph (1) shall be applied by substituting '$30,000' for '$15,000' each place it appears.

"(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(A) except as otherwise provided in this paragraph, $90,000,

"(B) $115,000 in the case of a joint return, and

"(C) zero in the case of a taxpayer who—

"(i) is married (as determined under section 7703) but does not file a joint return for such year, and

"(ii) does not live apart from his spouse at all times during the taxable year.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 135, 911, 931, and 933, and

"(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) JOINT RETURNS.—In the case of a joint return—

"(A) the recapture amount under subsection (a) shall be the sum of the recapture amounts determined separately for each spouse, and

"(B) subsections (a) and (c) shall be applied by taking into account the combined modified adjusted gross income of the spouses.

"(4) COORDINATION WITH OTHER PROVISIONS.—

"(A) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the recapture amount imposed by this section shall be treated as if it were a tax imposed by section 1.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The recapture amount imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax under section 55.

"(C) TREATED AS PAYMENT FOR MEDICAL INSURANCE.—The recapture amount imposed by this section shall be treated as an amount paid for insurance covering medical care, within the meaning of section 213(d)."

(b) REPORTING REQUIREMENT.—

(1) Paragraph (1) of section 6050F(a) (relating to returns relating to social security benefits) is amended by striking "and" at the end of subparagraph (B) and by inserting after subparagraph (C) the following new subparagraph:

"(D) the number of months during the calendar year for which a premium was paid under part B of title XVIII of the Social Security Act for the coverage of such individual under such part, and".

(2) Paragraph (2) of section 6050F(b) is amended to read as follows:

"(2) the information required to be shown on such return with respect to such individual."

(3) Subparagraph (A) of section 6050F(c)(1) is amended by inserting before the comma "and in the case of the information specified in subsection (a)(1)(D)".

(4) The heading for section 6050F is amended by inserting "**AND MEDICARE PART B COVERAGE**" before the period.

(5) The item relating to section 6050F in the table of sections for subpart B of part III of subchapter A of chapter 61 is amended by inserting "and Medicare part B coverage" before the period.

(c) WAIVER OF CERTAIN ESTIMATED TAX PENALTIES.—No addition to tax shall be imposed under section 6654 of the Internal Revenue Code of 1986 (relating to failure to pay estimated income tax) for any period before April 16, 1998, with respect to any underpayment to the extent that such underpayment resulted from section 59C(a) of the Internal Revenue Code of 1986, as added by this section.

(d) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end thereof the following new item:

"Part IX. Certain health care subsidies received by high-income individuals."

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to periods after December 31, 1996, in taxable years ending after such date.

TITLE XII—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 12001. CONFORMING AMENDMENTS TO DEFINITIONS.

(a) MOVING DEFINITION OF GROUP HEALTH PLAN.—Subtitle B of title I of such Employee Retirement Income Security Act of 1974 is amended—

(1) in section 607 (29 U.S.C. 1167), by striking paragraph (1);

(2) by striking section 3(41) commencing with "(41) SINGLE-EMPLOYER PLAN.—"; and

(3) in section 3 (29 U.S.C. 1002) (as amended by paragraph (2)), by adding at the end the following new paragraph:

"(42) The term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries, directly or through insurance, reimbursement, or otherwise.".

(b) CLARIFICATION OF INTERRELATIONSHIP OF ERISA GUARANTEED HEALTH INSURANCE ACT OF 1994.—Section 3(42) of such Act (as amended by subsection (a)) is amended by adding at the end the following new sentence: "Such term includes a health plan (within the meaning of section 5504(4) of the Guaranteed Health Insurance Act of 1994 (as of the date of the enactment of such Act) but only to the extent such plan is an employee welfare benefit plan.".

(c) OTHER DEFINITIONS.—Section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002) is amended—

(1) by adding at the end the following new paragraphs:

"(43) The term 'insured' means, with respect to a group health plan, a group health plan insofar as the plan is funded through the purchase of one or more contracts of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract.

"(44) The term 'self-insured' means, with respect to a group health plan, a group health plan insofar as the plan is funded in a manner other than through the purchase of one or more policies or contracts described in paragraph (42).

"(45) The term 'carrier' has the meaning provided in section 5504(2) of the Guaranteed Health Insurance Act of 1994 (as of the date of the enactment of such Act).

"(46) The term 'third party contractor' means, in connection with a group health plan, any person (other than a health plan sponsor with respect to the plan) who—

"(A) administers or processes payments made under the plan pursuant to requests for payment for items and services but is not the provider of the items and services, or

"(B) carries out any other duty of the health plan sponsor under a direct or indirect contractual arrangement with the health plan sponsor, other than providing the items and services.".

SEC. 12002. REPORTING AND DISCLOSURE REQUIREMENTS FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.) is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

"SPECIAL RULES FOR GROUP HEALTH PLANS

"SEC. 111. (a) IN GENERAL.—Rules issued by the Secretary under this part with respect to group health plans shall be consistent with the purposes of this title and the Guaranteed Health Insurance Act of 1994.

"(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—The special rules provided under subsection (a) may include rules providing for—

"(1) reductions in the periods of time referred to in this part,

"(2) increases in the frequency of reports and disclosures required under this part, and

"(3) such other changes in the provisions of this part as may result in more expeditious reporting and disclosure of group health plan terms and changes in such terms to the Secretary and to plan participants and beneficiaries,

to the extent that the Secretary determines that the rules described in this subsection are necessary to ensure timely reporting and disclosure of information consistent with the purposes of this title and the Guaranteed Health Insurance Act of 1994 as they relate to group health plans.

"(c) ADDITIONAL REQUIREMENTS.—The special rules provided under subsection (a) may include rules providing for reporting and disclosure of additional information and for reporting and disclosure at more frequent intervals—

"(1) to the Secretary, and

"(2) to participants and beneficiaries,

to the extent necessary to effectively carry out this title with respect to group health plans and in a manner that is consistent with the Guaranteed Health Insurance Act of 1994.".

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

"Sec. 111. Special rules for group health plans.
"Sec. 112. Effective date."

SEC. 12003. AMENDMENTS TO ENFORCEMENT PROVISIONS OF ERISA.

(a) IMPROVEMENTS IN ENFORCEMENT.—

(1) RECOVERY OF DAMAGES FOR FAILURE TO PROVIDE BENEFITS AS REQUIRED UNDER A HEALTH PLAN.—

(A) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended by adding at the end the following new paragraph:

"(5)(A) In the case of any act or failure to act by a group health plan or the plan sponsor in violation of the terms of the plan or this title, the plan, the plan sponsor, and the carrier (in the case of an insured plan), together with each third party contractor (if any) whose act or failure to act constitutes or contributes to the violation, shall be jointly and severally liable to any plaintiff described in subsection (a)(9) aggrieved by such violation for appropriate relief, including actual, compensatory, and punitive damages and equitable relief.

"(B) Nothing in the Guaranteed Health Insurance Act of 1994 shall be construed as limiting any right or remedy provided under this title in connection with a group health plan.".

(B) STANDING OF SPONSORS AND PLANS IN ACTIONS FOR FAILURE TO MEET REQUIREMENTS.—

(i) IN GENERAL.—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(I) in paragraph (7), by striking "or" at the end;

(II) in paragraph (8), by striking the period and inserting "; or"; and

(III) by inserting after paragraph (8) the following new paragraph:

"(9) in the case of a group health plan—

"(A) by a participant or beneficiary, or by the plan sponsor (or, in the case of a self-insured plan, by any entity with a right to bring action on behalf of the plan), for the relief provided under subsection (c)(5), or

"(B) by the Secretary, on behalf of a participant or beneficiary, for the relief provided under subsection (c)(5).".

(ii) CONFORMING AMENDMENT.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(I) in the first sentence, by striking "subsection (a)(1)(B) of this section" and inserting "paragraph (1)(A) (with respect to relief under subsection (c)(5)), paragraph (1)(B), paragraph (7), or paragraph (9) of subsection (a)"; and

(II) in the second sentence, by striking "paragraphs (1)(B) and (7)" and insert "paragraphs (1)(A) (with respect to relief under subsection (c)(5)), paragraph (1)(B), paragraph (7), and paragraph (9)".

(2) ACTIONS FOR VIOLATIONS OF STATUTORY REQUIREMENTS.—Section 502(a)(1)(B) of such Act (29 U.S.C. 1132(a)(1)(B)) is amended by inserting "or the provisions of this title" after "plan" each place it appears.

(3) ACTIONS BY PLANS AGAINST FIDUCIARIES.—Section 502(a)(2) of such Act (29 U.S.C. 1132(a)(2)) is amended by striking "beneficiary or fiduciary" and inserting "a beneficiary, a fiduciary, a plan sponsor of a group health plan, or, in the case of a self-insured group health plan, any entity with a right to bring action on behalf of the plan".

(b) ATTORNEY'S FEES AND COSTS OF ACTION.—Section 502(g) of such Act (29 U.S.C. 1132(g)) is amended—

(1) in paragraph (1), by inserting "or (3)" after "paragraph (2)"; and

(2) by adding at the end the following new paragraph:

"(3) In any action or settlement proceeding under this title with respect to a group health plan by a participant or beneficiary under such plan, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs.".

(c) CIVIL MONEY PENALTIES FOR DENIAL OR DELAY IN PROVIDING GROUP HEALTH PLAN BENEFITS.—

(1) IN GENERAL.—Section 502(c) of such Act (as amended by the preceding provisions of this section) is further amended by adding at the end the following new paragraph:

"(6) CIVIL MONEY PENALTIES FOR DENIAL OR DELAY IN PROVIDING HEALTH PLAN BENEFITS.—The Secretary may assess a civil penalty against any group health plan, the plan sponsor of such plan, or the carrier (in the case of an insured plan) for unreasonable denial or delay in the provision of items or services, or payment therefor, and against any third-party contractor whose act or failure to act constitutes or contributes to the denial or delay, in an amount not to exceed—

"(A) $25,000 per violation, or $75,000 per violation in the case of a finding of bad faith on the part of the liable party, and

"(B) in the case of a finding of a pattern or practice of such violations engaged in by the liable party, $1,000,000 in addition to the total amount of penalties assessed under subparagraph (A) with respect to such violations.

For purposes of subparagraph (A), each violation with respect to any single individual shall be treated as a separate violation.".

(2) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking "subsection (c)(2) or (i) or (l)" and inserting "subsection (c)(2), (c)(6), (i), or (l)".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to violations occurring on or after the date of the enactment of this Act.

SEC. 12004. EXEMPTIONS FROM ERISA PREEMPTION.

(a) IN GENERAL.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended—

(1) by amending paragraph (5) to read as follows:

"(5) Subsection (a) shall not apply to the Hawaii Prepaid Health Care Act."; and

(2) by adding at the end the following new paragraphs:

"(9) Subsection (a) shall not apply to any provision of State law to the extent such provision implements a State single-payer system pursuant to subtitle A of title IV of the Guaranteed Health Insurance Act of 1994 (including the imposition of nondiscriminatory taxes in connection with such a system consistent with the requirements of such subtitle).

"(10) Subsection (a) shall not apply to any provision of State law to the extent such provision provides for a managed competition program under subtitle B of title IV of the Guaranteed Health Insurance Act of 1994 (including the imposition of nondiscriminatory taxes in connection with such a program consistent with the requirements of such subtitle).

"(11) Subsection (a) shall not apply to any provision of State law implementing a State provider payment system under subtitle C of title IV of the Guaranteed Health Insurance Act of 1994.".

(b) TEMPORARY TRANSITIONAL RULES.—

(1) IN GENERAL.—Section 514(b) of such Act (29 U.S.C. 1144(b)) (as amended by subsection

(a)) is further amended by adding at the end the following new paragraphs:

"(12)(A) Except as provided in subparagraphs (C) and (D), subsection (a) shall not apply to any provision of State law described in subparagraph (B) if there is in effect an exemption under this paragraph granted to the State by the Secretary under section 12004(b)(2) of the Guaranteed Health Insurance Act of 1994 with respect to such provision.

"(B) A provision of State law is described in this subparagraph if such provision is a part of a program of comprehensive health care reform adopted by the State before the date of the enactment of the Guaranteed Health Insurance Act of 1994 under which employers are obligated to make contributions on behalf of employees and their families to group health plans providing comprehensive health benefit coverage for such employees and their families.

"(C) In any case in which the program referred to in subparagraph (A) includes a tax, subparagraph (A) shall not apply with respect to the provision of State law referred to in subparagraph (A) unless such tax is nondiscriminatory.

"(D) Subparagraph (A) shall not at any time apply in the case of any plan sponsor of a group health plan if such plan and plan sponsor would at such time be in compliance with the applicable requirements of the Guaranteed Health Insurance Act of 1994 if the provisions of such Act were in effect and fully implemented at such time.

"(E) This paragraph shall cease to be effective January 1, 1999.

"(13)(A) Subsection (a) shall not apply to any provision of State law described in subparagraph (B) if there is in effect an exemption under this paragraph granted to the State by the Secretary under section 12004(b)(2) of the Guaranteed Health Insurance Act of 1994 with respect to such provision.

"(B) A provision of State law is described in this subparagraph if such provision is part of a program consisting of a comprehensive legislative effort enacted by the State to achieve full implementation of the requirements of the Guaranteed Health Insurance Act of 1994, and—

"(i) such program has the effect of imposing requirements in relation to employees, employers, and group health plans that the Secretary finds would have the effect of imposing (under the State law) requirements which would be imposed under the Guaranteed Health Insurance Act of 1994, in relation to such employees, employers, and plans, if such Act were in effect and fully implemented,

"(ii) any tax included in such program is nondiscriminatory, and

"(iii) such program does not, directly or indirectly, discriminate against an individual on the basis of race, national origin, religion, gender, sexual orientation, language, socioeconomic status, age, status of an eligible individual as a citizen of the United States, health status, or anticipated need for health services.

"(C) This paragraph shall cease to be effective January 1, 1999.

"(14)(A) Subsection (a) shall not apply to any provision of State law described in subparagraph (B) if there is in effect an exemption under this paragraph granted to the State by the Secretary under section 12004(b)(2) of the Guaranteed Health Insurance Act of 1994 with respect to such provision.

"(B) A provision of State law is described in this subparagraph to the extent such provision provides for transfer of financial responsibility for workers' compensation medical benefits to certified health plans (as defined in section 2(2) of the Guaranteed Health Insurance Act of 1994 (as of the date of the enactment of such Act)) if there is in effect an exemption granted to the State by the Secretary of Labor under this section with respect to such provision.

"(C) This paragraph shall cease to be effective 2 years after the date on which the Commission on Integration of Workers' Compensation Medical Benefits submits its report to the President and to the Congress under section 13041 of the Guaranteed Health Insurance Act of 1994.".

(2) EXEMPTION PROCEDURE.—

(A) REQUIREMENTS.—The Secretary of Labor shall grant to a State an exemption under paragraph (12), (13), or (14) of section 514(b) of the Employee Retirement Income Security Act of 1974 with respect to a provision described in such paragraph if—

(i) an application for such exemption with respect to such provision has been duly filed with the Secretary of Labor by the State in complete form in accordance with such procedures as such Secretary may prescribe, and

(ii) the Secretary of Labor finds that such exemption is—

(I) administratively feasible,

(II) not adverse to the interests of the individuals covered under certified health plans affected by the exemption, and

(III) protective of the rights and benefits of the individuals covered under such certified health plans.

An exemption granted under this subparagraph with respect to any provision of State law shall terminate at such time as any requirement of this Act which is effectively implemented by such provision takes effect.

(B) INITIAL REVIEW.—Within 40 days after receipt of each application for exemption, the Secretary of Labor shall—

(i) complete an initial review of the application,

(ii) determine whether additional information is needed from the State and notify the State in writing of such determination, and

(iii) issue a preliminary opinion concerning the likelihood that the application will be approved.

(3) DECISION.—The Secretary of Labor shall issue his or her decision on each application for an exemption under this paragraph within 60 days after the later of—

(A) the date of the his or her receipt of the application, or

(B) the date on which such Secretary receives the State's response to any notification of need for additional information made by such Secretary pursuant to paragraph (2)(B)(ii).

The decision of the Secretary of Labor shall be final, subject to reconsideration and review under paragraph (3).

(4) RECONSIDERATION AND REVIEW.—

(A) PETITIONS FOR RECONSIDERATION.—

(i) IN GENERAL.—Any State dissatisfied with the decision of the Secretary of Labor decision under paragraph (2) may, within 60 days after it has been notified of such decision, file a petition with such Secretary for reconsideration of the State's application under this paragraph (2). Within 30 days after receipt of such a petition, such Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such application. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless such Secretary and such State agree in writing to holding the hearing at another time. Such Secretary shall affirm or reverse the original decision within 60 days of the conclusion of the hearing.

(ii) NO STAYS PENDING RECONSIDERATION.—Action pursuant to a decision of the Secretary of Labor under paragraph (2) shall not be stayed pending reconsideration under clause (i).

(B) COURT REVIEW.—

(i) IN GENERAL.—Any State which is dissatisfied with the final decision of the Secretary of Labor on such State's application under this subsection, as affirmed after reconsideration under subparagraph (A), may, within 60 days after it has been notified of the action of such Secretary under subparagraph (A), file with the United States court of appeals for the circuit in which such State is located a petition for review of such decision. A copy of the petition shall be forthwith transmitted by the clerk of the court to such Secretary. Such Secretary thereupon shall file in the court the record of the proceedings on which such Secretary based the decision, as affirmed under subparagraph (A).

(ii) PROCEDURE.—The findings of fact by the Secretary of Labor, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to such Secretary to take further evidence, and such Secretary may thereupon make new or modified findings of fact and may modify such Secretary's previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(iii) JURISDICTION AND REVIEW.—The court shall have jurisdiction to affirm the action of the Secretary of Labor or to set it aside. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(c) TEMPORARY RULES GOVERNING PREEMPTION OF CERTAIN LAWS OF THE STATE OF NEW YORK.—

(1) IN GENERAL.—Section 514(b) of such Act (29 U.S.C. 1144(b)) (as amended by subsections (a) and (b)) is further amended by adding at the end the following new paragraph:

"(15)(A) Except as provided in subparagraphs (B), (D), (E), and (G), subsection (a) shall not apply to the following provisions of the law of the State of New York:

"(i) subdivisions 1(b) and 4(e) of section 2807-c of the Public Health Law (relating to 13 percent surcharge);

"(ii) subdivision 1(c) of section 2807-c of the Public Health Law (relating to uniform hospital charges);

"(iii) subdivision 2-a of section 2807-c of the Public Health Law (relating to the variable surcharge for HMOs);

"(iv) subdivision 14 of section 2807-c of the Public Health Law (relating to basic percentage allowances for bad debt and charity care);

"(v) subdivision 14-b of section 2807-c of the Public Health Law (relating to health care services allowances);

"(vi) subdivision 14-c of section 2807-c of the Public Health Law (relating to further allowances for financially distressed hospitals); and

"(vii) section 18 of chapter 266 of the laws of 1986, as amended (relating to excess malpractice insurance adjustments.

"(B) Except as provided in subparagraph (C), nothing in subparagraph (A) shall be construed to exempt from subsection (a)—

"(i) any State tax law relating to employee benefit plans, or

"(ii) any provision referred to in subparagraph (A) to the extent that any law of the State of New York appropriates amounts based on amounts collected by the State under such provision for any purpose other than carrying out the programs with respect to which the provisions described in subparagraph (A) apply.

"(C) Notwithstanding subparagraph (B), subsection (a) shall not apply to any provision of the law of the State of New York to the extent that such provision constitutes—

"(i) an HMO surcharge of the type provided for under subdivision 2-a of such section 2807-c (as in effect on February 2, 1993), or

"(ii) an allowance, of the type provided for under the provisions referred to in subparagraph (A) (as so in effect), for bad debts, charity care, health care services, or excess malpractice insurance,

but only if the law of such State appropriates or allocates amounts based on and equivalent to amounts collected by the State under such provision solely for the purpose of carrying out one or more programs with respect to which the provisions described in subparagraph (A) apply.

"(D) Subsection (a) shall apply to any provision of the law of the State of New York to the extent that such provision constitutes a surcharge of the type provided for under subdivisions 1(b) and 4(e) of section 2807-c of the Public Health Law of the State of New York (as in effect on February 2, 1993) unless such provision provides for use of amounts collected under such provision solely for the purpose of carrying out one or more programs with respect to which the provisions described in subparagraph (A) apply.

"(E) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any amendment of any provision referred to in subparagraph (A) enacted on or after February 2, 1993, to the extent it provides for more than the effective administration of such provisions as in effect on such date, unless such amendment constitutes only a change in the methodology of determining payments to hospitals and would result in—

"(i) a surcharge described in subparagraph (C)(i) of not more than 9 percent with respect to which the requirements of subparagraph (C) are met,

"(ii) an allowance described in subparagraph (C)(ii) which does not exceed in the aggregate a Statewide average of not more than 10 percent and with respect to which the requirements of subparagraph (C) are met, or

"(iii) a surcharge described in subparagraph (D) of not more than 13 percent with respect to which the requirements of subparagraph (D) are met.

"(F) Subsection (a) shall not apply to any amendment to chapter 2 of the laws of 1988 of the State of New York, as amended, to the extent that such amendment extends the period for which the provisions referred to in subparagraph (A) are in effect.

"(G) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the provisions described in subparagraph (A) (as in effect on or after February 2, 1993), but the Secretary may enter into cooperative arrangements under this subparagraph and section 506 with officials of the State of New York to assist them in effectuating the policies of such provisions which are superseded by such parts 1 and 4 and the preceding sections of this part.

"(H) Subsection (a) shall apply to any provision of the law of the State of New York to the extent that such provision requires an entity which may be deemed to be engaged in the business of insurance under paragraph (2) (including a health maintenance organization) to provide open enrollment and community rating (including premium adjustments for the purpose of risk adjustment).

"(I) References in this paragraph to provisions of the law of the State of New York shall be deemed references to such provisions as in effect August 1, 1993.

"(J) This paragraph shall not apply to any provision of the law of the State of New York to the extent such provision applies with respect to residents of the area described in the second sentence of section 4301 of the Guaranteed Health Insurance Act of 1994.".

(d) TREATMENT OF CONSUMER PURCHASING COOPERATIVES.—Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended to read as follows:

"(6) Subsection (a) shall not apply with respect to any provision of State law to the extent that such provision implements a consumer purchasing cooperative pursuant to title V of the Guaranteed Health Insurance Act of 1994.".

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) EFFECTIVE DATE AND SUNSET OF NEW YORK RULE.—Section 514(b)(13) of the Employee Retirement Income Security Act of 1974 (added by subsection (b)) shall cease to be effective 2 years after the date of the enactment of this Act. Subparagraph (H) of such section 514(b)(13) shall apply with respect to provisions of State law in effect as of April 1, 1993.

(3) EFFECTIVE DATE OF CONSUMER PURCHASING COOPERATIVE RULE.—The amendment made by subsection (c) shall take effect January 1, 1997.

SEC. 12005. TRANSITIONAL CONTINUATION COVERAGE REQUIREMENT FOR GROUP HEALTH PLANS.

Paragraph (2) of section 602 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended by adding at the end the following new sentence: "In the case of an individual whose period of coverage under this paragraph would (but for this sentence) end after the date of the enactment of the Guaranteed Health Insurance Act of 1994 and before January 1, 1999, such period shall in no event terminate by reason of this paragraph before January 1, 1999.".

SEC. 12006. COVERAGE OF PEDIATRIC VACCINES AND WELL-CHILD SERVICES UNDER GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 609(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(d)) is amended to read as follows:

"(f) COVERAGE OF COSTS OF PEDIATRIC VACCINE AND WELL-CHILD SERVICES FOR GROUP HEALTH PLANS.—

"(1) MAINTENANCE OF VACCINE COVERAGE.—A group health plan may not reduce its coverage of the costs of pediatric vaccines (as defined under section 1928(h)(6) of the Social Security Act) below the coverage it provided as of May 1, 1993.

"(2) REQUIREMENT FOR COVERAGE OF IMMUNIZATIONS AND WELL-CHILD SERVICES.—Each group health plan shall provide coverage of the following services without deductible, coinsurance, or any other form of cost-sharing:

"(A) All vaccines on the list described in section 1928(e) of the Social Security Act.

"(B) Well-child services described in section 1928(f)(2)(B) of such Act.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall take effect on the date of the enactment of this Act.

(2) PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1995.—Any amendment to a plan required to be made by the amendment made by this section shall not be required to be made before the first plan year beginning on or after January 1, 1995.

SEC. 12007. ADDITIONAL AMENDMENTS RELATING TO GROUP HEALTH PLANS.

(a) TECHNICAL CORRECTIONS.—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993—

(1) Subsection (a)(2)(B)(ii) of section 609 of the Employee Retirement Income Security Act of 1974 is amended by striking "section 13822" and inserting "section 13623".

(2) Subsection (a)(4) of such section 609 is amended by striking "section 13822" and inserting "section 13623".

(3) Subsection (d) of such section 609 is amended by striking "section 13830" and inserting "section 13631".

(4) Section 514(b)(7) of such Act (29 U.S.C. 1144(b)(7)) is amended by inserting ", qualified medical child support orders (within the meaning of section 609(a)(2)(A)), and the provisions of law referred to in section 609(a)(2)(B)(ii) to the extent enforced by qualified medical child support orders" before the period.

SEC. 12008. PLAN CLAIMS PROCEDURES.

Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting "(a) IN GENERAL.—" after "SEC. 503."; and

(2) by adding at the end the following new subsection:

"(b) GROUP HEALTH PLANS.—A group health plan shall be treated as failing to meet the requirements of subsection (a) to the extent that the requirements of sections 9301, 9302, and 9303 of the Guaranteed Health Insurance Act of 1994 are not met with respect to such plan.".

SEC. 12009. REGULATIONS DEFINING COLLECTIVE BARGAINING AGREEMENT.

Not later than 180 days after the date of the enactment of this Act, the Secretary of Labor shall prescribe regulations defining the term "collective bargaining agreement" for purposes of this Act and title I of the Employee Retirement Income Security Act of 1974.

TITLE XIII—COORDINATION OF MEDICAL PORTION OF WORKERS' COMPENSATION AND AUTOMOBILE INSURANCE

Subtitle A—Workers' Compensation Insurance

SEC. 13000. DEFINITIONS.

In this subtitle:

(1) INJURED WORKER.—The term "injured worker" means, with respect to a certified health plan, an individual enrolled under the plan who has a work-related injury or illness for which workers' compensation medical benefits are available under State law.

(2) SPECIALIZED WORKERS' COMPENSATION PROVIDER.—The term "specialized workers' compensation provider"—

(A) means a health provider that specializes in the provision of preventive services, diagnostic services, medical treatment and medical rehabilitative services relating to work-related injuries or illness, and includes a physician specializing in occupational medicine and a non-physician specialist in occupational health or a related field; and

(B) includes a center of excellence in occupational health.

(3) WORKERS' COMPENSATION MEDICAL BENEFITS.—The term "workers' compensation medical benefits" means, with respect to an enrollee who is an employee subject to the workers' compensation laws of a State, the comprehensive medical benefits for work-related injuries and illnesses provided for under such laws with respect to such an employee.

(4) WORKERS' COMPENSATION CARRIER.—The term "workers' compensation carrier" means an insurance company that underwrites workers' compensation medical benefits with respect to one or more employers and includes an employer or fund that is financially at risk for the provision of workers' compensation medical benefits.

(5) WORKERS' COMPENSATION SERVICES.—The term "workers' compensation services"—

(A) means items and services included in workers' compensation medical benefits, including rehabilitation services and long-term care services; and

(B) includes services of a case manager under section 13001(c) and the preparation of reports relating to workers' compensation medical benefits.

PART 1—HEALTH PLAN REQUIREMENTS RELATING TO WORKERS' COMPENSATION

SEC. 13001. PROVISION OF WORKERS' COMPENSATION SERVICES.

(a) PROVISION OF BENEFITS.—Subject to subsection (b)—

(1) REQUIREMENT FOR CERTIFIED HEALTH PLANS.—

(A) IN GENERAL.—Each certified health plan shall enter into such contracts and arrangements as are necessary (in accordance with subparagraph (B)) to provide or arrange for the provision of workers' compensation services to an enrollee who is an injured worker, in return for payment from the workers' compensation carrier under section 13002. The health plan shall contract with, or arrange for the provision of service from, a range of specialized workers' compensation providers (as defined in-13000(2)) sufficient to deliver the medical and rehabilitative services compensable under the State's workers' compensation laws.

(B) PROVISION OF SERVICES.—For purposes of this paragraph, a certified health plan provides (or arranges for the provision of) workers' compensation services with respect to an enrollee if the services are provided by—

(i) a participating provider in the plan,

(ii) any other specialized workers' compensation provider with whom the plan has entered into an agreement for the provision of such services, or

(iii) a center of excellence in occupational health designated by the State under section 13011(a), whether or not the center is a provider described in clause (i) or (ii).

(C) LIST OF SPECIALIZED WORKERS' COMPENSATION PROVIDERS.—Upon the request of an enrollee, a certified health plan shall provide a list of the plan's specialized workers' compensation providers and shall include, for each such provider, the provider's phone number, address, subspecialty, and a summary of the provider's training and relevant experience.

(2) INDIVIDUAL REQUIREMENT.—An individual entitled to workers' compensation medical benefits and enrolled in a certified health plan shall receive workers' compensation services through the provision (or arrangement for the provision) of such services by the health plan, regardless of whether the services are included in the guaranteed national benefit package.

(3) EXCEPTIONS FOR CERTAIN HEALTH PLANS FOR VETERANS, MILITARY PERSONNEL, AND INDIANS.—Paragraphs (1) and (2) shall not apply with respect to a health plan of the Department of Veterans' Affairs, of the Indian Health Service, or of the Department of Defense and individuals enrolled in such a plan.

(4) USE OF STATE-DESIGNATED CENTERS OF EXCELLENCE.—Either a certified health plan or the injured worker may elect to provide or receive benefits under this subsection through a center of excellence in occupational health designated under section 13011(a).

(5) ACCESS TO EMERGENCY SERVICES.—An injured worker shall have the same access to emergency workers' compensation services as the worker has with respect to other emergency services.

(b) ALTERNATIVE PERMITTED.—Subsection (a) shall not be construed as preventing an injured worker and a workers' compensation carrier from agreeing that workers' compensation services shall be provided other than by or through the certified health plan in which the worker is enrolled.

(c) COORDINATION.—

(1) DESIGNATION OF CASE MANAGER.—Each certified health plan shall employ or contract with one or more individuals, such as occupational nurses, with experience in the management of occupational illness and injury to provide case management services with respect to workers' compensation services provided through the plan under this section.

(2) FUNCTIONS OF CASE MANAGER.—The certified health plan (through the case manager described in paragraph (1)) is responsible for ensuring that—

(A) there is a plan of treatment (when appropriate) for each enrollee who is an injured worker designed to assure appropriate treatment and facilitate return to work;

(B) the plan of treatment is developed with the participation of the worker and communicated on a timely basis to the worker and to the workers' compensation carrier, the employer, or both for purposes of return to work planning;

(C) medical information to the extent needed to assure the enrollee's safe, healthful, and timely return to work is provided to the worker and to the workers' compensation carrier, the employer or both, as appropriate, that shall include the types of work activities an injured worker can safely perform and any specific work restrictions that may be appropriate to prevent the recurrence of the injury or illness and to permit the worker's complete recovery; and

(D) the health plan (and its providers) comply with legal duties and requirements under State workers' compensation law (including treatment protocols approved in accordance with such laws) and other Federal and State laws including those regarding the reporting of occupational injuries and diseases.

(d) ADMINISTRATION.—The Secretary of Labor shall administer this subtitle and, for such purposes, the Secretary is authorized to prescribe such rules and regulations as may be necessary and appropriate.

(e) WAIVER FOR CERTAIN STATES.—The Secretary shall waive the application of the provisions of this part and part 2 (other than sections 13011 and 13013) if the State demonstrates the following:

(1) The State has a comprehensive, mandatory workers' compensation system that covers an overwhelming majority of the workers in the State.

(2)(A) Injured workers in the State are assured a broad choice of health providers when seeking treatment for work-related illnesses and injuries.

(B) Injured workers are assured the right to seek workers' compensation services, when appropriate, from centers of excellence designated by the State under section 13011.

(C) If the State allows or requires injured workers to obtain workers' compensation medical benefits only from one or more organizations that restrict the workers' choice of providers from whom the benefits may be obtained—

(i) workers are provided an opportunity to select from among a reasonable choice of at least 3 such organizations;

(ii) such organizations are—

(I) certified by the State; and

(II) required by the State to meet minimum requirements related to quality, accessibility, and continuity of services; and

(iii) workers are provided the option to choose such an organization that is not owned or controlled by the workers' compensation carrier that underwrites the workers' compensation medical benefits with respect to the employer of the worker.

(3) The State has a system in place—

(A) to control increases in the costs of workers' compensation medical benefits; and

(B) to monitor and improve the quality of workers' compensation services provided to injured workers.

SEC. 13002. PAYMENT BY WORKERS' COMPENSATION CARRIER.

(a) PAYMENT.—

(1) IN GENERAL.—Each workers' compensation carrier that is liable for payment for workers' compensation services furnished by or through a certified health plan, regardless of whether the services are included in the guaranteed national benefit package, shall make payment for such services. If a certified health plan has provided or paid for services for which such a workers' compensation carrier is liable, such carrier shall reimburse the health plan for such services. If an individual has paid for services for which such a carrier is liable, the carrier shall reimburse the individual for such services (including cost sharing incurred for such services).

(2) USE OF FEE SCHEDULE.—Except as provided in subsection (b), such payment shall be made in accordance with the applicable fee schedule established by the certified health plan for services provided under the guaranteed national benefit package or section 13012.

(b) ALTERNATIVE PAYMENT METHODOLOGIES.—Subsection (a)(2) shall not apply—

(1) in the case of a State that establishes an alternative payment methodology (such as payment on a negotiated fee for each case) for payment for workers' compensation services; or

(2) in the case in which a workers' compensation carrier and the certified health plan negotiate alternative payment arrangements.

(c) LIMITATION OF LIABILITY OF INJURED WORKER.—Nothing in this part shall be construed as requiring an injured worker to make any payment (including payment of any cost sharing or any amount in excess of the applicable fee schedule) to any certified health plan or health provider for the receipt of workers' compensation services.

PART 2—REQUIREMENTS OF STATES

SEC. 13011. STATE DESIGNATION OF CENTERS OF EXCELLENCE IN OCCUPATIONAL HEALTH.

(a) IN GENERAL.—A State shall, in consultation with a panel consisting of representatives of organized labor and representatives of employers in equal numbers, designate at least one center of excellence in occupational health for each community-rating area in the State. A State may designate such a center of excellence for a community-rating area that is not located in the area or the State. Injured workers and certified health plans may elect to receive workers' compensation services through such centers under section 13001(a)(4).

(b) QUALIFICATIONS.—A State shall not designate a center of excellence under subsection (a) unless the State finds that the center meets the following requirements:

(1) The center includes, as staff members or contractors, physicians and other health providers with significant experience and training in the diagnosis, management, and treatment of occupational injuries and illnesses, including the diagnosis of chronic diseases of occupational origin.

(2) The center has the ability to serve as a technical resource to providers serving certified health plans on issues relating to occupational injury and illness.

(3) The center provides an interdisciplinary range of specialized services, including independent evaluation of occupational injuries and illnesses, assessment and control of the causes of such injuries and illnesses, methods to educate workers in the prevention of such injuries and illnesses, and rehabilitative care and other treatment to facilitate the return to work of an injured worker.

(c) PUBLICATION.—Each State shall publish a list of centers of excellence designated under subsection (a).

(d) TRAVEL PAID BY CARRIER.—Injured workers shall be reimbursed by workers' compensation carriers for reasonable expenses related to travel to centers of excellence designated under subsection (a).

SEC. 13012. DEVELOPMENT OF SUPPLEMENTAL SCHEDULES.

Each State shall develop a fee schedule applicable to payment for workers' compensation services not included in the guaranteed national benefit package, including a separate schedule for services of a case manager under section 13001(c) and the preparation of reports relating to workers' compensation medical benefits.

SEC. 13013. PROVISION OF WORKERS' COMPENSATION DATA.

Each State shall make available to the Secretary of Labor, in such form as the Secretary shall require, injury and illness data collected as part of the State's workers' compensation program. Such a State is not required to make available personally identifiable information with respect to a worker. The Secretary is authorized to reimburse the States for the cost of preparing and transmitting the data in the requested form.

SEC. 13014. EFFECT ON STATE WORKERS' COMPENSATION LAWS.

(a) IN GENERAL.—Except as provided in this subtitle, no State law shall have any effect that restricts the choice, or payment, of providers that may provide workers' compensation services for individuals enrolled in a certified health plan.

(b) DISPUTE RESOLUTION.—A State law may provide for a method for resolving disputes related to—

(1) an individual's entitlement to workers' compensation medical benefits under State law,

(2) the necessity and appropriateness of workers' compensation services provided to an injured worker, and

(3) subject to section 13002, the reasonableness of fees charged for workers' compensation services.

(c) CONSTRUCTION.—Nothing in this subtitle shall be construed as altering—

(1) the effect of a State workers' compensation law as the exclusive remedy for work-related injuries or illnesses,

(2) the determination of whether or not a person is an injured worker and entitled to workers' compensation medical benefits under State law,

(3) the scope of items and services available to injured workers entitled to workers' compensation medical benefits under State law, including protocols approved under such a law relating to provision of workers' compensation services, or

(4) the eligibility of any individual or class of individuals for workers' compensation medical benefits under State law.

(d) INTEGRATION.—Nothing in this subtitle shall prevent a State from integrating or otherwise coordinating the payment for workers' compensation medical benefits with payment for benefits under health insurance or health benefit plans.

SEC. 13015. PROTECTION AGAINST FRAUD.

A State workers' compensation law may disqualify or suspend a health provider from providing workers' compensation services if the provider is determined to have violated protocols or standards of care, to have provided unnecessary or inappropriate services, to have billed in violation of law, or to have engaged in another prohibited practice with respect to workers' compensation services.

PART 3—APPLICATION OF INFORMATION PRACTICES REQUIREMENTS; EFFECT ON PREMIUMS

SEC. 13021. APPLICATION OF INFORMATION PRACTICES REQUIREMENTS.

(a) IN GENERAL.—The provisions of subtitle C of title IX apply to the provision of workers' compensation services.

(b) RULES.—The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall promulgate rules to clarify the responsibilities of certified health plans and workers' compensation carriers in carrying out the provisions referred to in subsection (a).

SEC. 13022. REPORT ON EFFECT ON WORKERS' COMPENSATION PREMIUMS.

(a) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Labor shall provide for a study of the impact of the provisions of this subtitle on the premium rates charged to employers for workers' compensation insurance. Such study shall use information supplied by States relating to workers' compensation premiums and such other information as the Secretary of Labor finds appropriate.

(2) REPORT.—The Secretary of Labor shall submit to the Congress, by not later than two years after the date that this subtitle applies to a substantial number of employers in all States, a report on the findings of the study.

(b) WORKERS' COMPENSATION CARRIER FILINGS.—

(1) IN GENERAL.—Each workers' compensation carrier (other than an employer that is self-funded for the purpose of providing workers' compensation services) providing workers' compensation insurance in a State shall make a filing with an agency designated by the State at a time specified by the Secretary of Labor (but not earlier than one year after the date this subtitle applies to a substantial number of employers in the State). Such filing shall describe the manner in which such carrier has modified (or intends to modify) its premium rates for workers' compensation insurance provided in the State to reflect the changes brought about by the provisions in this subtitle. The filing shall include such actuarial projections and assumptions as necessary to support the modifications of such rates.

(2) REPORT TO SECRETARY.—Each State shall provide to the Secretary of Labor such information on filings made under paragraph (1) as the Secretary of Labor may specify.

SEC. 13023. PERMISSIBLE TERMS OF CERTAIN CONSTRUCTION INDUSTRY COLLECTIVE BARGAINING AGREEMENTS.

(a) IN GENERAL.—A construction industry collective bargaining agreement described in subsection (b) may include provisions relating to any of the following:

(1) A mechanism to resolve disputes relating to employee entitlement to workers' compensation benefits under applicable State workers' compensation law, including mediation or arbitration, so long as the rights and remedies of employees under such laws are not diminished.

(2) Providing benefits for injured workers or their survivors that are in addition to those provided under State workers' compensation law.

(3) Providing for a light duty, modified job, or return to work program.

(4) Providing for a vocational rehabilitation or training program.

(5) Providing for worker injury and illness prevention programs.

(b) CONSTRUCTION INDUSTRY COLLECTIVE BARGAINING AGREEMENT DESCRIBED.—A construction industry collective bargaining agreement described in this subsection is a collective bargaining agreement—

(1) between—

(A) an employer engaged primarily in the building and construction industry, and

(B) a labor organization—

(i) of which building and construction employee are members, and

(ii) which is not established, maintained, or assisted by conduct that constitutes an unfair labor practice under section 8(a) of the National Labor Relations Act;

(2) covering employees engaged (or who upon their employment will be engaged) in the building and construction industry; and

(3) that meets the prevailing standards for such an agreement in the applicable area.

(c) CONSTRUCTION.—Nothing in this section shall be construed to authorize an agreement described in subsection (b)—

(1) to reduce the benefits payable under applicable State workers' compensation laws, or

(2) to limit the rights or remedies provided to injured workers under such laws.

PART 4—DEMONSTRATION PROJECTS

SEC. 13031. AUTHORIZATION.

The Secretary of Health and Human Services and the Secretary of Labor are authorized to conduct demonstration projects under this part in one or more States with respect to—

(1) treatment of work-related injuries and illnesses;

(2) ways in which occupational health providers can promote safety and health in the workplace; and

(3) ways in which health providers can promote effective return to work of injured workers.

SEC. 13032. DEVELOPMENT OF WORK-RELATED PROTOCOLS.

(a) IN GENERAL.—Under this part, the Secretaries, in consultation with States and such experts on work-related injuries and illnesses as the Secretaries find appropriate, shall develop protocols (which may include protocols for utilization review) for the appropriate treatment of work-related conditions.

(b) TESTING OF PROTOCOLS.—The Secretaries shall enter into contracts with one or more certified health plans to test the validity of the protocols developed under subsection (a).

SEC. 13033. DEVELOPMENT OF CAPITATION PAYMENT MODELS.

The Secretaries shall develop, using protocols developed under section 13032 if possible, methods of providing for payment by workers' compensation carriers to certified health plans on a per case, capitated basis for the treatment of specified work-related injuries and illnesses.

PART 5—COMMISSION ON INTEGRATION OF WORKERS' COMPENSATION MEDICAL BENEFITS

SEC. 13041. COMMISSION.

(a) ESTABLISHMENT.—There is hereby created a Commission on Integration of Workers' Compensation Medical Benefits (in this part referred to as the "Commission").

(b) COMPOSITION.—

(1) IN GENERAL.—The Commission shall consist of the Director of the National Institute for Occupational Safety and Health (or the Director's designee) and 14 members appointed jointly by the Secretary of Health and Human Services and the Secretary of Labor. Appointed members of the Commission shall include the following:

(A) One or more individuals representing State insurance commissioners.

(B) One or more individuals representing State workers' compensation funds.

(C) One or more individuals representing organized labor.

(D) One or more members representing employers (other than workers' compensation insurance carriers).

(E) One or more members representing workers' compensation insurance carriers.

(F) One or more members of the medical profession having expertise in occupational health.

(G) One or more educators or researchers having expertise in the field of occupational health.

(H) One or more members of the legal profession who regularly represent workers' compensation claimants.

(I) One or more actuaries having expertise in the field of workers' compensation.

To the greatest extent feasible, the membership of the Commission shall reflect the racial, ethnic, and gender composition of the population of the United States.

(2) NO COMPENSATION EXCEPT TRAVEL EXPENSES.—Members of the Commission shall serve without compensation, but the Secretaries shall provide that each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(3) QUORUM.—Eight members of the Commission shall constitute a quorum.

(c) DUTIES.—

(1) IN GENERAL.—The Commission shall study the feasibility of transferring financial responsibility for workers' compensation medical benefits to certified health plans. The Commission shall consider both the potential benefits and potential disadvantages of integration, including the likely impact on—

(A) the quality of medical care delivered to workers injured or made ill on the job;

(B) the incentives for employers to maintain safe workplaces; and

(C) workers' compensation indemnity benefit costs, medical costs and the overall cost of the workers' compensation system.

(2) ISSUES TO BE ADDRESSED.—The Commission shall consider the following issues:

(A) Whether and how to maintain financial incentives for employers to prevent work-related illness and injury and to reduce workers' compensation costs.

(B) Modifications of requirements for workers' compensation carrier and certified health plan reserves, including any associated transition issues relating to the modification of such requirements.

(C) The ability of certified health plans to set capitated payment rates for workers' compensation costs, including the lack of availability of data for use by plans in setting such rates.

(D) Coverage for benefits not included in the guaranteed national benefits package, including both services and cost-sharing, that are covered under State workers' compensation laws.

(E) Variation among States in eligibility for medical and rehabilitation benefits, and the scope of such benefits, compensable under State workers' compensation laws.

(F) The ability to move the financial responsibility for workers' compensation medical benefits from an experience-rated system to a community-rated system.

(G) The need to provide appropriate incentives to encourage certified health plans, providers of health care services, and employers to return injured employees to work as soon as possible.

(H) The effect of an integrated system on the ability to preserve adequate case management of workers' compensation cases.

(I) The impact of an injured worker's choice of provider on the costs of medical care, losses in wages and benefits, and quality of care.

(J) Whether and under what circumstances a State may demonstrate that the comprehensive workers' compensation law providing for medical benefits to injured workers in effect in that State obviates the need for transferring financial responsibility for workers' compensation medical benefits to certified health plans, taking into account the impact on injured workers.

(3) DEVELOPMENT OF PLAN.—The Commission shall, based on its study of the issues under paragraphs (1) and (2), develop a detailed plan for implementing the transfer of financial responsibility for workers' compensation medical benefits to certified health plans and make a recommendation as to whether such a transfer should be effected.

(d) STAFF SUPPORT.—The Secretaries shall provide staff support for the Commission.

(e) REPORT.—The Commission shall submit a report on its work to the President and to the Congress by not later than two years after the date of the enactment of this Act. The report shall include the plan developed and its recommendation under subsection (c)(3).

(f) TERMINATION.—The Commission shall terminate 90 days after the date of submission of its report under subsection (e).

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle B—Automobile Insurance

SEC. 13100. DEFINITIONS.

In this subtitle:

(1) INJURED INDIVIDUAL.—The term "injured individual" means, with respect to a certified health plan, an individual enrolled under the plan who has an injury or illness sustained in an automobile accident for which automobile insurance medical benefits are available.

(2) AUTOMOBILE INSURANCE MEDICAL BENEFITS.—The term "automobile insurance medical benefits" means, with respect to an enrollee, the comprehensive medical benefits for injuries or illnesses sustained in automobile accidents.

(3) AUTOMOBILE INSURANCE CARRIER.—The term "automobile insurance carrier" means an insurance company that underwrites automobile insurance medical benefits and includes an employer or fund that is financially at risk for the provision of automobile insurance medical benefits.

(4) AUTOMOBILE INSURANCE MEDICAL SERVICES.—The term "automobile insurance medical services" means items and services included in automobile insurance medical benefits and includes items and services (such as rehabilitation services and long-term care services) commonly used for treatment of injuries and illnesses sustained in automobile accidents.

SEC. 13101. PROVISION OF AUTOMOBILE INSURANCE MEDICAL BENEFITS THROUGH HEALTH PLANS.

(a) IN GENERAL.—An individual entitled to automobile insurance medical benefits and enrolled in a certified health plan shall receive automobile insurance medical services through the provision (or arrangement for the provision) of such services by the health plan.

(b) REFERRAL FOR SPECIALIZED SERVICES.—Each certified health plan shall provide for such referral for automobile insurance medical services as may be necessary to assure appropriate treatment of injured individuals.

(c) EXCEPTIONS.—Subsections (a) and (b) shall not apply shall not apply with respect to a health plan of the Department of Veterans' Affairs, of the Indian Health Service, or of the Department of Defense and individuals enrolled in such a plan.

(d) ALTERNATIVE PERMITTED.—Subsection (a) shall not be construed as preventing an injured individual and an automobile insurance carrier from agreeing that automobile insurance medical services shall be provided other than by or through the certified health plan in which the individual is enrolled.

SEC. 13102. PAYMENT BY AUTOMOBILE INSURANCE CARRIER.

(a) PAYMENT.—

(1) IN GENERAL.—Except as provided in subsection (b), each automobile insurance carrier that is liable for payment for automobile insurance medical services furnished by or through a certified health plan, regardless of whether or not the services are included in the guaranteed national benefit package, shall make payment for such services directly to the health plan.

(2) PRICE DISCRIMINATION PROHIBITED.—Fees charged an automobile insurance carrier by a certified health plan or health provider for automobile insurance medical services shall not exceed fees charged by such certified health plan or health provider for similar services provided to an injured individual for an injury or illness not sustained in an automobile accident.

(3) EXCEPTION FOR MEDICARE PART C ENROLLEES.—Each health provider or certified health plan providing automobile insurance medical services to an injured individual enrolled in medicare part C shall bill the automobile insurance carrier directly for such services, and each carrier liable for payment for such services shall make payment for

such services directly to such health provider or certified health plan.

(b) ALTERNATIVE PAYMENT METHODOLOGIES.—Subsection (a) shall not apply—

(1) in the case of a State that establishes an alternative payment methodology (such as payment on a negotiated fee for each case) for payment for automobile insurance medical services; or

(2) in the case in which an automobile insurance carrier and the certified health plan negotiate alternative payment arrangements.

(c) LIMITATION OF LIABILITY OF INJURED INDIVIDUAL.—Nothing in this subtitle shall be construed as requiring an injured individual to make any payment (including payment of any cost sharing) to any certified health plan or health provider for the receipt of automobile insurance medical services for which an automobile insurance carrier is liable.

(d) PREVENTION OF DUPLICATE PAYMENT.—Except in accordance with other subsections of this section, nothing in this Act shall require any automobile insurance carrier or policyholder to make any duplicate payment to any certified health plan or health provider for automobile insurance medical services.

(e) REIMBURSEMENT FOR PAYMENTS MADE.—Nothing in this section shall impair the right of a certified health plan or automobile insurance carrier to seek reimbursement from any person legally responsible for a bodily injury or illness resulting from an automobile accident for payments made for automobile insurance medical services to treat such injury or illness.

SEC. 13103. CONSTRUCTION.

Nothing in this subtitle shall be construed as altering—

(1) the determination of whether or not a person is an injured individual and entitled to automobile insurance medical benefits under State law, or

(2) the scope of items and services available to injured individuals entitled to automobile insurance medical benefits under State law.

Subtitle C—Federal Employees' Compensation Act

SEC. 13201. APPLICATION OF POLICY.

(a) IN GENERAL.—Chapter 81 of title 5, United States Code, known as the Federal Employees' Compensation Act shall be interpreted and administered consistent with the provisions of subtitle A.

(b) CONSTRUCTION.—In applying subsection (a), subtitle A shall be applied as if the following modifications had been made in subtitle A:

(1) Any reference in section 13000, section 13001(c)(2)(D), or section 13014 to a State law is deemed to include a reference to chapter 81 of title 5, United States Code.

(2) The term "workers' compensation carrier" includes the Employees Compensation Fund (established under section 8147 of title 5, United States Code).

(c) APPLICATION TO CERTAIN OTHER LAWS.—

(1) IN GENERAL.—The provisions of section 13002(a)(2), relating to payment for workers' compensation services, shall apply to payment for medical services in the United States under the following laws, in the same manner as such provisions apply to the Federal Employees' Compensation Act under this section:

(A) The Longshore and Harbor Workers' Compensation Act (33 U.S.C. 901 et seq.).

(B) Cure for a seaman under general maritime law.

(C) The Federal Employers' Liability Act (45 U.S.C. 51 et seq.).

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as altering—

(A) the remedies available under the laws described in subparagraphs (A) through (C) of paragraph (1);

(B) the determination of whether or not a person is entitled to benefits under such laws;

(C) the scope of items and services available under such laws; or

(D) the eligibility of any individual or class of individuals for benefits under such laws.

Subtitle D—Davis-Bacon Act and Service Contract Act

SEC. 13301. COVERAGE OF BENEFITS UNDER GUARANTEED HEALTH INSURANCE ACT OF 1994.

(a) DAVIS-BACON ACT.—Subsection (b)(2) of the first section of the Davis Bacon Act (40 U.S.C. 276a(b)(2)) is amended in the matter following subparagraph (B) by inserting after "local law" the following: "(other than benefits provided pursuant to the Guaranteed Health Insurance Act of 1994)".

(b) SERVICE CONTRACT ACT OF 1965.—The second sentence of section 2(a)(2) of the Service Contract Act of 1965 (41 U.S.C. 351(a)(2)) is amended by inserting after "local law" the following: "(other than benefits provided pursuant to the Guaranteed Health Insurance Act of 1994)".

Subtitle E—Effective Dates

SEC. 13401. GENERAL EFFECTIVE DATE; APPLICATION.

The provisions of subtitles A and B of this title shall take effect on January 1, 1997, and shall apply with respect to any individual covered under a certified health plan under this Act.

SEC. 13402. FEDERAL REQUIREMENTS.

The provisions of subtitle C of this title shall take effect on January 1, 1998.

TITLE XIV—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

SEC. 14001. FINDINGS AND PURPOSES.

(a) FINDINGS.—The Congress finds the following:

(1) The Federal Employees Health Benefits Program (in this section referred to as "FEHBP") has been providing tens of millions of Federal employees, retirees, and dependents with affordable, comprehensive health insurance for over 30 years.

(2) The FEHBP, as the only model of managed competition operating on a national basis, could make a significant contribution toward making affordable, comprehensive health insurance available to the Nation's underinsured and uninsured by enrolling members of the general public.

(3) The FEHBP has a better record than most private and public health programs in constraining the average rate of increases in annual health care costs, and offers the Nation a working model for constraining health care costs.

(4) The long-term viability of the FEHBP is critical to its contributing to increasing the availability of affordable, comprehensive health insurance to the general public.

(5) The long-term viability of the FEHBP is critical to the continued fulfillment of the Federal Government's obligation as the Nation's largest employer to provide affordable, comprehensive health benefits to its employees and retirees.

(6) To maintain the long-term viability of the FEHBP, the expansion of the program to serve the general public should be accomplished in a sound, prudent, and incremental manner.

(7) The enactment of certain insurance and health policy reforms as a part of national health care reform will eliminate features of the current system that would otherwise threaten the solvency of FEHBP health benefit plans and the long-term viability of the expanded program.

(8) Opening the FEHBP to the general public should be viewed as a complement to other broad-based health care reform initiatives, such as the creation of a nationwide system of affordable, comprehensive health care benefits available to all, to ensure the long-term viability of the FEHBP, to prevent the FEHBP from being overwhelmed administratively, and to protect the interests of existing FEHBP enrollees.

(9) The general public should have available the level of benefits, quality of service, and choice of plans and providers currently received by FEHBP enrollees and their dependents.

(10) The ultimate integration of existing FEHBP enrollees into community-rated pools should await the enactment of key insurance market reforms and an employer mandate, both to ensure the creation of stable insurance markets and to protect the interests of existing FEHBP enrollees.

(b) PURPOSES.—The purposes of this title are as follows:

(1) To provide tens of millions of Americans, many of whom have no or inadequate health insurance, with access to the same affordable, comprehensive health care benefits as are available to Federal employees and retirees.

(2) To permit the future integration of Federal employees and retirees into a FEHBP expanded to serve the general public.

(3) To make necessary changes in the FEHBP.

SEC. 14002. DEFINITIONS.

For the purpose of this title—

(1) the terms "FEHBP transition period" and "universal FEHBP" have the meanings given such terms by section 8903b of title 5, United States Code (as added by section 14301); and

(2) the term "contract year" is used in the same way as under chapter 89 of title 5, United States Code.

SEC. 14003. AMENDMENT OF TITLE 5, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 5, United States Code.

Subtitle A—General Changes in Health Benefits for Federal Employees and Annuitants

SEC. 14101. TYPES OF BENEFITS.

(a) GUARANTEED NATIONAL BENEFITS.—

(1) IN GENERAL.—

(A) BENEFITS TO BE OFFERED.—Subsection (a) of section 8904 is amended to read as follows:

"(a) The benefits provided under each plan described in section 8903 shall be the same as the guaranteed national benefit package under subtitle A of title III of the Guaranteed Health Insurance Act of 1994.".

(B) CONFORMING AMENDMENTS.—Chapter 89 is amended—

(i) in section 8903(1) by striking "8904(1)" and inserting "8904(a)";

(ii) in section 8903(2) by striking "8904(2)" and inserting "8904(a)";

(iii) in section 8903(3) by striking "8904(3)" and inserting "8904(a)";

(iv) in section 8903(4)(A) by striking "8904(4)" and inserting "8904(a)"; and

(v) in section 8903a(b)(2) by striking "paragraph (1) or (2) of section 8904 of this title or both" and inserting "section 8904(a)".

(2) LEVELS OF BENEFITS.—

(A) Paragraphs (1) and (2) of section 8903 are amended by striking ", offering two levels of benefits,".

(B) Section 8905a(d)(1)(A)(i) is amended by striking "and level of benefits".

(C) Section 8906(d) is amended by striking "plan and level of benefits." and inserting "plan.".

(3) CLASSES OF ENROLLMENT.—

(A) Section 8905(a) is amended by striking "either as an individual or for self and family." and inserting "based on an appropriate class of enrollment.".

(B) Section 8905(c)(1) is amended in the first sentence by striking "as an individual or for self and family as provided in paragraph (2) of this subsection".

(C) Section 8905 is amended by adding a period at the end of subsection (b) and by striking the matter before subparagraph (A) of subsection (c)(2) and inserting the following:

"(2) Coverage under this subsection shall not be available except with respect to—".

(D) Section 8905(d) is amended to read as follows:

"(d) If an employee, annuitant, or other individual eligible to enroll in a health benefits plan under this chapter has a spouse who is also eligible to enroll, such individual may not be enrolled both as an employee, annuitant, or other individual eligible to enroll and as a family member of the spouse.".

(E) Section 8905a(d)(3)(A) is amended by striking "coverage either as an individual or, if appropriate, for self and family." and inserting "any appropriate class of enrollment.".

(F) Section 8905a(f)(3)(A) is amended by striking "for self and family" and inserting "under a class of enrollment that covered such individual".

(b) MAINTENANCE OF EFFORT.—

(1) IN GENERAL.—Chapter 89 is amended by inserting after section 8904 the following:

"§ 8904a. Maintenance of effort

"(a) For the purpose of this section, the term 'guaranteed national benefit package' means the guaranteed national benefit package referred to in section 8904(a).

"(b)(1) The Office of Personnel Management shall provide or contract for maintenance of effort policies which shall provide—

"(A) in the case of an individual covered by a comprehensive medical plan, coverage which, when considered together with the guaranteed national benefit package, is comparable to that which, during the year described in paragraph (3), was provided by the comprehensive medical plan with the largest number of enrollments in such year (as identified by the Office); and

"(B) in the case of an individual covered by any other plan under this chapter—

"(i) coverage for services and items which were available under the lower level of benefits offered by the service benefit plan during the year described in paragraph (3), but which are not included in the guaranteed national benefit package;

"(ii) coverage for services and items included in the guaranteed national benefit package, but not covered to the same extent as was the case under the lower level of benefits offered by the service benefit plan during the year described in paragraph (3), because of any limitation in amount, duration, or scope under the guaranteed national benefit package;

"(iii) coverage for deductibles, coinsurance, and copayments imposed under the guaranteed national benefit package, but not by the lower level of benefits offered by the service benefit plan during the year described in paragraph (3); or

"(iv) any combination thereof.

"(2) In developing maintenance of effort policies to be offered under this section, the Office of Personnel Management—

"(A) shall meet and confer with exclusive representatives of employees through a process to be established by the National Partnership Council; and

"(B) shall consult periodically with representatives of employees (other than those described in subparagraph (A)) and of annuitants.

"(3) The year described in this paragraph is the contract year immediately preceding the first contract year to which this section applies.

"(c) An individual shall be eligible to be covered by a maintenance of effort policy only so long as such individual is also covered by a health benefits plan under this chapter.

"(d)(1) The Government shall pay the total enrollment charge under this section in the case of any employee or annuitant for whom Government contributions are being made with respect to any health benefits plan under this chapter.

"(2)(A) Any payment under this subsection shall be made at the same time and in the same manner as if it were a Government contribution for a health benefits plan, and shall be made from the same appropriation or fund as from which any such Government contributions would, with respect to the employee or annuitant involved, be made.

"(B) The reference to 'Government contributions authorized by this section' in section 8906(g) shall be considered to include payments under this subsection.

"(e) To the extent that maintenance of effort policies are provided through carriers, section 8902 shall, with respect to the administration of this section, apply to the extent practicable.

"(f) No requirement of law relating to limiting the offering of a supplemental health benefit policy shall apply to a maintenance of effort policy offered under this section.".

(2) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by inserting after the item relating to section 8904 the following:

"8904a. Maintenance of effort.".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the date of the enactment of this Act, and shall apply with respect to contract years beginning with the contract year described in paragraph (2).

(2) CONTRACT YEAR DESCRIPTION.—The contract year described in this paragraph is the contract year beginning in the first full calendar year throughout which the requirements of section 5007 of the Guaranteed Health Insurance Act of 1994 (relating to requirement of offering of guaranteed national benefit package by health benefit plans) will be met, or will be deemed to be met, with respect to insured health benefit plans in all the States, as determined by the Office of Personnel Management.

(3) SAVINGS PROVISION.—For purposes of applying the provisions of chapter 89 of title 5, United States Code, with respect to any contract year before the contract year described in paragraph (2), this section shall be treated as if it had not been enacted.

SEC. 14102. CONTRIBUTIONS FOR GUARANTEED NATIONAL BENEFITS; OTHER PROVISIONS TAKING EFFECT IN 1997.

(a) AVERAGE SUBSCRIPTION CHARGES.—Section 8906(a) is amended to read as follows:

"(a) The Office of Personnel Management shall determine the weighted average of the subscription charges in effect on the beginning date of each contract year for all health benefits plans under this chapter (for each class of enrollment).".

(b) GOVERNMENT CONTRIBUTION.—Section 8906(b) is amended—

(1) in paragraph (1) by striking "60 percent of the average subscription charge" and inserting "80 percent of the applicable weighted average subscription charge"; and

(2) in paragraph (2) by striking "75 percent of".

(c) PART-TIME CAREER EMPLOYMENT.—Section 8913 is amended by redesignating subsection (d) as subsection (e), and by inserting after subsection (c) the following:

"(d) The regulations of the Office may provide that, for purposes of carrying out this chapter in any contract year—

"(1) the term 'part-time career employment' shall (instead of the meaning which would otherwise apply) have the same meaning as being employed on a 'part-time basis' has under section 1106(a) of the Guaranteed Health Insurance Act of 1994, but only if, in the judgment of the Office, a greater number of employees would thereby qualify to be treated as occupying a position on a part-time career employment basis in such year; and

"(2) any appropriate adjustment in the method for determining the Government contribution under section 8906(b)(3) may be made if the alternative definition under paragraph (1) is applied.".

(d) DEFINITION OF CHILD.—Section 8901(5) is amended by striking "22;" and inserting "22, or such an unmarried dependent child between 22 and 24 years of age who is a student regularly pursuing a full-time course of study or training in residence at an educational institution referred to in section 8341(a)(4)(C) (determined in a manner similar to that provided for by the last 2 sentences of section 8341(a));".

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the date of the enactment of this Act, and shall apply with respect to contract years beginning with the contract year that begins in 1997.

(2) SAVINGS PROVISION.—For purposes of applying the provisions of chapter 89 of title 5, United States Code, with respect to any contract year before the first contract year to which the amendments made by this section shall apply, subsections (a) through (d) of this section shall be treated as if they had not been enacted.

(f) TRANSITION.—For contract years beginning on or after the date of the enactment of this Act and before the 1997 contract year, notwithstanding any other provision of law, the dollar amount of the Government contribution under section 8906(b)(1) of title 5, United States Code, may not be less than the dollar amount of the Government contribution under such section 8906(b)(1) in the previous contract year, increased by the same percentage as the percentage increase in the weighted average premium of all health benefit plans offered under chapter 89 of such title between the previous contract year and the year involved.

SEC. 14103. ANNUALIZATION OF OPEN ENROLLMENT PERIODS.

Section 8905(f)(1) is amended by striking "any contract term" and all that follows through "provide" and inserting "each contract year, provide".

SEC. 14104. SUBSIDIES FOR LOW-INCOME FEDERAL EMPLOYEES AND ANNUITANTS.

Section 8906 is amended by adding at the end the following:

"(j)(1) An employee enrolled under this chapter may be eligible for a premium certificate under part A of title XXII of the Social Security Act.

"(2) In the case of an individual enrolled under this chapter who is not an employee, but who would, if such individual were an employee, be eligible for such a premium certificate, for purposes of such part—

"(A) the individual shall be deemed to be an employee; and

"(B) the administrative entity responsible for administering the provisions of this chapter relating to the enrollment of such individual shall be deemed the employer of such individual.".

SEC. 14105. PROVISIONS RELATING TO THE RETIRED FEDERAL EMPLOYEES HEALTH BENEFITS ACT.

(a) PROGRAM TERMINATION.—The Retired Federal Employees Health Benefits Act (Public Law 86-724; 74 Stat. 849) is repealed as of the date specified in subsection (c), and all contracts under such Act shall terminate not later than such date.

(b) CONTINUED AVAILABILITY OF COVERAGE FOR RETIRED EMPLOYEES.—

(1) IN GENERAL.—For purposes of health insurance coverage for any period after the date as of which coverage under the Retired Federal Employees Health Benefits Act ceases to be available as a result of the enactment of this section, retired employees who (but for this section) would be eligible for coverage under such Act shall be treated, for purposes of chapter 89 of title 5, United States Code, as if they were annuitants eligible to enroll under such chapter 89.

(2) AUTOMATIC COVERAGE.—In the case of any retired employee who is enrolled in a plan under the Retired Federal Employees Health Benefits Act during the last year in which coverage under such Act is offered, and who fails to elect to be covered under such chapter 89 or to decline such coverage with respect to the following year, such retired employee shall be automatically enrolled in a service benefit plan under such chapter 89, as determined under regulations prescribed by the Office of Personnel Management.

(3) SURVIVORS.—For the purpose of this subsection, the term "retired employee" includes a survivor of the retired employee.

(c) SPECIFICATION OF DATE.—The date specified in this subsection is the first day of the first calendar year throughout which subsidies are available under section 8906(j)(2) of title 5, United States Code (as added by section 14104) to Federal annuitants.

(d) TREATMENT OF THE FUND.—After the date specified in subsection (c), the Retired Employees Health Benefits Fund shall temporarily remain available, and amounts in that fund shall subsequently be disbursed, in a manner comparable to that provided for under section 14402.

(e) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section.

SEC. 14106. TEMPORARY EMPLOYEES.

(a) NONEXCLUDABILITY.—Paragraph (4) of section 8913(b) is amended to read as follows:

"(4) an employee who is employed on a temporary basis, if such employee either—

"(A) has completed 3 months of current continuous employment (excluding any break in service of 5 days or less);

"(B) has been (or is reasonably expected to be) employed for a period of 4 months during the previous (or succeeding) 12-month period; or

"(C) meets such other employment requirements as the Office may prescribe.".

(b) REPEAL.—

(1) IN GENERAL.—Section 8906a is repealed.

(2) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by repealing the item relating to section 8906a.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall first apply to coverage provided on and after such month (not later than the first month that begins more than 3 months after the date of the enactment of this Act) as the Office of Personnel Management specifies.

(2) TRANSITION.—The Office of Personnel Management shall provide for such special enrollment procedures and other rules as may be required to provide for enrollment of individuals described in section 8913(b)(4) of title 5, United States Code, as amended by subsection (a), for coverage on or after the first month described in paragraph (1).

SEC. 14107. STANDARDIZED CLAIMS PROCESSING.

(a) IN GENERAL.—Section 8902 is amended by adding at the end the following:

"(o) A claim for payment or reimbursement under this chapter (whether electronic or otherwise) shall be submitted on such a standard form or in such a standard manner as may be required by the Office in relation to health benefit plans. Each contract under this chapter shall include appropriate provisions to carry out the preceding sentence.".

(b) APPLICABILITY.—The amendment made by subsection (a) shall be implemented as soon as practicable, but in no event later than January 1, 1996.

SEC. 14108. ADVANCE DIRECTIVES.

(a) IN GENERAL.—Section 8907 is amended by adding at the end the following:

"(c) The Office shall—

"(1) prepare information relating to the use of advance directives regarding the type and intensity of care which an individual desires in the event that such individual becomes unable to communicate by reason of incapacity due to illness or injury; and

"(2) require, as a condition for approval of any contract under section 8902 (and in accordance with the applicable provisions (if any) of the Guaranteed Health Insurance Act of 1994), that appropriate provisions be included so that such information may be made available to enrollees of the plan involved.".

(b) APPLICABILITY.—The amendment made by subsection (a) shall apply with respect to contract terms beginning on or after January 1, 1996.

SEC. 14109. COLLECTIVE BARGAINING AUTHORITY.

(a) IN GENERAL.—Any collective bargaining rights available under title 39, United States Code, before the date of the enactment of this Act, with respect to health benefits, shall continue to be available with respect to health benefits provided for as a result of the enactment of this Act.

(b) HOLD HARMLESS PROVISION.—In no event shall the Government contribution provided by the United States Postal Service be less than that required pursuant to a collective bargaining agreement under title 39, United States Code (if such agreement was ratified before the date of the enactment of this Act) while such agreement remains in effect. The preceding sentence shall be in addition to any requirement under section 1111(c) of this Act.

(c) AMENDMENT TO TITLE 39, UNITED STATES CODE.—Section 1005(f) of title 39, United States Code, is amended by striking "87 and 89" and inserting "87, 89, and 89A".

(d) RELATED PROVISION.—Notwithstanding any other provision of (or amendment made by) this Act, any health benefits plan of an organization described in section 5305(c) of this Act may operate without regard to the number of States in which it is licensed to issue group health insurance.

Subtitle B—Provisions Relating to Universal FEHBP

SEC. 14201. UNIVERSAL FEHBP.

For provisions relating to universal FEHBP, see subtitle D of title V of this Act.

Subtitle C—Transition Rules

SEC. 14301. TREATMENT OF COMPREHENSIVE MEDICAL PLANS.

(a) IN GENERAL.—Chapter 89 is amended by adding after section 8903a the following:

"§ 8903b. Treatment of comprehensive medical plans

"(a) For the purpose of this section—

"(1) the term 'FEHBP transition period' means the 7-year period beginning on the first day of the first contract year beginning after the contract year described in subsection (b);

"(2) any reference to a particular numbered year in the FEHBP transition period refers to the corresponding contract year in such period;

"(3) the term 'old rate' means, with respect to a plan, the subscription charge for such plan under this chapter, determined—

"(A) as if the Guaranteed Health Insurance Act of 1994 had not been enacted; but

"(B) subject to subsection (c)(2);

"(4) the term 'new rate' means, with respect to a plan, the subscription charge for such plan's corresponding universal FEHBP plan;

"(5) the term 'corresponding universal FEHBP plan', as used with respect to a comprehensive medical plan, means the plan required by subsection (d) to be offered under universal FEHBP in order that such comprehensive medical plan may be offered under this chapter;

"(6) the term 'universal FEHBP' means the health insurance program under subtitle D of title V of the Guaranteed Health Insurance Act of 1994;

"(7) the term 'comprehensive medical plan' means a plan described by section 8903(4); and

"(8) the term 'guaranteed national benefit package' means the guaranteed national benefit package referred to in section 8904(a).

"(b)(1) The contract year described in this subsection is the first contract year—

"(A) for which an affirmative certification is made under paragraph (2)(A) that, with respect to each community-rating area in which individuals eligible to enroll under this chapter reside, universal FEHBP is—

"(i) operating in a stable health insurance market;

"(ii) serving a representative population; and

"(iii) offering such a range of types of health plans as is provided under this chapter (including a plan which offers an unlimited choice of providers); and

"(B) by the end of which the following provisions of law are in effect with respect to all individuals eligible to enroll in universal FEHBP:

"(i)(I) Section 59B of the Internal Revenue Code of 1986 and section 1001(b) of the Guaranteed Health Insurance Act of 1994 (relating to individual mandate); or

"(II) sections 3451 and 3455 of the Internal Revenue Code of 1986 and section 1101(a) of the Guaranteed Health Insurance Act of 1994 (relating to employer mandates).

"(ii) Section 5004 of the Guaranteed Health Insurance Act of 1994 (relating to preexisting condition exclusions).

"(iii) Subsection (a) of section 5008 of the Guaranteed Health Insurance Act of 1994 (relating to community rating of premiums), except that such subsection shall not, for purposes of this subparagraph, be considered to be in effect until the completion of the transition period established under subsection (b) of such section for all States.

"(iv) Section 5007 of the Guaranteed Health Insurance Act of 1994 (relating to requirement of offering of guaranteed national benefit package by health benefit plans).

"(v) Section 5003 of the Guaranteed Health Insurance Act of 1994 (relating to open enrollment requirements).

"(vi) Part A of title XXII of the Social Security Act (relating to premium certificates).

"(2)(A) The Office of Personnel Management shall certify for each contract year, beginning with the 1999 contract year, whether or not universal FEHBP satisfies the conditions set forth in paragraph (1)(A).

"(B) The Office shall transmit a report on each certification under subparagraph (A), including the basis for the certification, to Congress and the President not later than the tenth day after the end of the contract year to which the certification relates (unless that tenth day is a Saturday, Sunday, or legal holiday, in which case the deadline shall be the next day which is not one of the aforementioned days).

"(3) For purposes of paragraph (2)(A), the condition under paragraph (1)(A)(i) shall not be considered to be satisfied unless the community-rated market sector in which universal FEHBP is operating is large enough to yield credible experience and permit the setting of stable rates.

"(c) Notwithstanding section 8902(i) or any other provision of this chapter—

"(1) the subscription charge for each comprehensive medical plan shall—

"(A) for the first year of the FEHBP transition period, be equal to the old rate;

"(B) for the second year of the FEHBP transition period, be equal to the sum of—

"(i) 75 percent of the old rate; and

"(ii) 25 percent of the new rate;

"(C) for the third year of the FEHBP transition period, be equal to the sum of—

"(i) 50 percent of the old rate; and

"(ii) 50 percent of the new rate; and

"(D) for the fourth year of the FEHBP transition period, be equal to the sum of—

"(i) 25 percent of the old rate; and

"(ii) 75 percent of the new rate; and

"(2) the areas for which rates are established under this subsection shall, beginning with not later than the rates determined for the second year of the FEHBP transition period, be the same as under universal FEHBP.

"(d) A contract under this chapter for a comprehensive medical plan may not be made, nor may any such plan be approved, for any year in the FEHBP transition period, unless the carrier agrees to offer (in the same area) a health benefits plan under universal FEHBP in such year.

"(e) All computations under this section shall be made with respect to each class of enrollment available under the plan involved.

"(f)(1) Except in such cases as the Office may provide, effective for items and services furnished after the expiration of the fourth year of the FEHBP transition period—

"(A) health insurance coverage under a plan described by section 8903(4) shall not be available under this chapter; and

"(B) in applying this chapter, any reference to such plans shall be disregarded.

"(2) In the case of any individual who is enrolled in a plan described in section 8903(4) as of the last day of the fourth year of the FEHBP transition period, and who fails to elect to be covered under a plan under either this chapter or universal FEHBP or to decline such coverage with respect to the following year, such individual (if eligible) shall be automatically enrolled in the corresponding or most similar plan offered under universal FEHBP for the same or most similar class of enrollment, as determined under regulations prescribed by the Office.

"(g) The Office shall prescribe such regulations as may be necessary to carry out this section.".

(b) TREATMENT OF RESERVES.—For provisions relating to treatment of reserves, see section 14402.

(c) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by inserting after the item relating to section 8903a the following:

"8903b. Treatment of comprehensive medical plans.".

SEC. 14302. ELIGIBILITY FOR UNIVERSAL FEHBP.

(a) IN GENERAL.—Chapter 89 is amended by adding after section 8905a the following:

"§ 8905b. Election of coverage under universal FEHBP

"(a) For the purpose of this section, the terms 'FEHBP transition period' and 'universal FEHBP' have the meanings given such terms by section 8903b.

"(b) Effective after the fourth contract year of the FEHBP transition period, any individual who would be eligible to enroll in a health benefits plan under this chapter if the Guaranteed Health Insurance Act of 1994 had not been enacted shall be eligible to enroll in a health benefits plan under universal FEHBP.

"(c) Enrollment and all other aspects of participation in universal FEHBP pursuant to this section shall be in accordance with chapter 89A (disregarding the applicability rule under section 8932(a)(2) and any provisions relating thereto). Nothing in this subsection or chapter 89A (including any provision incorporated under chapter 89A by reference) shall, with respect to any period before the end of the FEHBP transition period, have the effect of preventing an election of coverage under this chapter.

"(d) The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this section, including provisions under which any coverage under universal FEHBP shall, for purposes of subsections (b) and (d) of section 8905, be treated as coverage under this chapter.".

(b) COORDINATION OF OPEN ENROLLMENT PERIODS.—

(1) IN GENERAL.—Subsection (f)(1) of section 8905 is amended to read as follows:

"(f)(1) The Office shall provide for a period each year (beginning and ending on the same dates as the annual open enrollment period provided for under section 5305(a) of the Guaranteed Health Insurance Act of 1994 in such year) during which any employee, annuitant, former spouse, or other individual eligible to enroll in a health benefits plan under this chapter may—

"(A) commence, terminate, or transfer such individual's enrollment in a plan under this chapter or under universal FEHBP; or

"(B) make any other election allowable under regulations prescribed by the Office.".

(2) APPLICABILITY.—The amendment made by paragraph (1) shall take effect on the first day of the fourth year of the FEHBP transition period.

(c) COORDINATION PROVISIONS RELATING TO OTHER ENROLLMENT OPPORTUNITIES.—Section 8905 is amended by adding at the end the following:

"(g) The periods during which, and the reasons for which, any change allowable under subsection (e) or (f)(2) may be made shall be at least coextensive with the provisions of section 5305(a) of the Guaranteed Health Insurance Act of 1994 which relate to special enrollment periods.".

(d) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by inserting after the item relating to section 8905a the following:

"8905b. Election of coverage under universal FEHBP.".

SEC. 14303. TREATMENT OF REMAINING PLANS.

(a) TREATMENT OF REMAINING PLANS.—Chapter 89 is amended by adding after section 8903b (as added by section 14301) the following:

"§ 8903c. Treatment of remaining plans

"(a) For the purpose of this section—

"(1) the terms 'FEHBP transition period' and 'universal FEHBP plan' have the meanings given such terms by section 8903b;

"(2) the rule of construction set forth in section 8903b(a)(2) applies;

"(3) the term 'experience-based rate' means, with respect to a plan, the subscription charge for such plan under this chapter, determined as if the Guaranteed Health Insurance Act of 1994 had not been enacted;

"(4) the term 'applicable community rate' means, with respect to a health benefits plan offered by a carrier under this chapter—

"(A) the subscription charge for the plan through which the guaranteed national benefit package is offered by such carrier under universal FEHBP within the community-rating area involved (if any); or

"(B) if subparagraph (A) cannot be applied, the weighted average of the subscription charges for the universal FEHBP plans which, in the preceding contract year, accounted for at least 80 percent of all enrollments under universal FEHBP (taken in descending order, starting with the plan which had the greatest number of enrollments) within the community-rating area involved, as determined by the Office of Personnel Management; and

"(5) the term 'community-rating area' means such an area as applied for purposes of section 5304(a)(1) of the Guaranteed Health Insurance Act of 1994.

"(b) Notwithstanding section 8902(i) or any other provision of this chapter, the subscription charge for each plan described by section 8903(1), (2), or (3) shall—

"(1)(A) for the fifth year of the FEHBP transition period, be equal to the sum of—

"(i) 75 percent of the experience-based rate; and

"(ii) 25 percent of the applicable community rate;

"(B) for the sixth year of the FEHBP transition period, be equal to the sum of—

"(i) 50 percent of the experience-based rate; and

"(ii) 50 percent of the applicable community rate; and

"(C) for the seventh year of the FEHBP transition period, be equal to the sum of—

"(i) 25 percent of the experience-based rate; and

"(ii) 75 percent of the applicable community rate; and

"(2) beginning with the rates for the fifth year of the FEHBP transition period, be determined on a community-by-community basis (except that nothing in this paragraph shall be considered to affect the way in which any experience-based rate, required for purposes of any computation under this section, is determined).

"(c) All computations under this section shall be made with respect to each class of enrollment available under the plan involved.

"(d)(1) Except in such cases as the Office may provide, effective for items and services furnished after the expiration of the FEHBP transition period—

"(A) health insurance coverage under a plan described by section 8903 (other than paragraph (4)) shall not be available under this chapter; and

"(B) in applying this chapter, any reference to such plans shall be disregarded.

"(2) In the case of any individual who is enrolled in a plan as of the last day of the FEHBP transition period, and who fails to elect to be covered under a plan under universal FEHBP or to decline such coverage with respect to the following year, such individual (if eligible) shall be automatically enrolled in the corresponding or most similar plan offered under universal FEHBP for the same or most similar class of enrollment, as determined under regulations prescribed by the Office.".

(b) Treatment of Reserves.—For provisions relating to treatment of reserves, see section 14402.

(c) Chapter Analysis.—The analysis for chapter 89 is amended by adding after the item relating to section 8903b (as added by section 14301) the following:

"8903c. Treatment of remaining plans.".

Subtitle D—Post-Transition Provisions

SEC. 14401. INTEGRATION OF FEHBP AND UNIVERSAL FEHBP.

(a) In General.—Title 5, United States Code is amended by inserting after chapter 89 the following:

"CHAPTER 89A—PROVISIONS FOR THE INTEGRATION OF FEHBP AND UNIVERSAL FEHBP

"Sec.
"8931. Definitions.
"8932. Applicability.
"8933. Coverage under universal FEHBP.
"8934. Provisions relating to plans offering the guaranteed national benefit package.
"8935. Eligibility for additional benefits.
"8936. Opportunities to enroll.
"8937. Regulations.

"§ 8931. Definitions

"For the purpose of this chapter—

"(1) any term used in this chapter which is defined for purposes of chapter 89 has the meaning given such term under such chapter; and

"(2) the term 'FEHBP transition period' has the meaning given such term by section 8903b(a)(1).

"§ 8932. Applicability

"(a) In General.—

"(1) To whom this chapter applies.—This chapter applies with respect to any employee, annuitant, or other individual who (but for the enactment of the Guaranteed Health Insurance Act of 1994) would be eligible for coverage under chapter 89 (as determined under subsection (b)).

"(2) Periods with respect to which this chapter applies.—This chapter applies with respect to any period of coverage (with respect to any such individual) beginning after the end of the FEHBP transition period.

"(b) Determining Eligibility for Coverage Under Chapter 89.—For purposes of making any determination under subsection (a)(1) as to whether or not a particular individual would be eligible for coverage under chapter 89, the provisions of such chapter (disregarding the effect of sections 8903b and 8903c) shall be applied, except that, in applying section 8905(b), any period of coverage under universal FEHBP shall be counted as a period of coverage under chapter 89.

"§ 8933. Coverage under universal FEHBP

"(a) In General.—An individual to whom this chapter applies is eligible, for purposes of any period with respect to which this chapter applies, for health insurance coverage under universal FEHBP, in accordance with section 5303 of the Guaranteed Health Insurance Act of 1994.

"(b) Family Members.—Under rules specified by the Office of Personnel Management, any individual who would be eligible to be enrolled as a family member of another individual under chapter 89 (as determined under section 8932) shall not be disqualified from being so enrolled under universal FEHBP by reason of the way in which 'family member' is defined for purposes of universal FEHBP.

"§ 8934. Provisions relating to plans offering the guaranteed national benefit package

"(a) Contributions.—The individual and Government contributions for plans offering the guaranteed national benefit package under universal FEHBP shall be governed by the provisions of section 8906, except that, in applying such provisions for purposes of this section, any reference to the weighted average under section 8906(a) shall be treated as a reference to the weighted average of the applicable premiums under universal FEHBP.

"(b) Payment of Contributions.—

"(1) In general.—Any Government contribution under this section shall be payable from the appropriation or fund from which any Government contribution on behalf of the individual would have been payable under chapter 89.

"(2) Payments for annuitants.—Any Government contributions under this section on behalf of an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

"(3) Continuation of postal service rule.—The requirement of section 8906(g)(2) shall continue to apply with respect to this section in the same manner as it applies with respect to section 8906.

"(c) Eligibility for Premium Subsidies.—An individual to whom this chapter applies who is enrolled under a health benefits plan under universal FEHBP shall be eligible for premium subsidies (referred to in section 8906(j)) to the same extent and in the same manner as would be the case under section 8906(j) with respect to an employee or other individual enrolled in a plan under chapter 89.

"§ 8935. Eligibility for additional benefits

"(a) In General.—An individual to whom this chapter applies who is enrolled under a health benefits plan under universal FEHBP—

"(1) may enroll in any supplemental health benefit policy under section 5302(b) of the Guaranteed Health Insurance Act of 1994 for which the individual is eligible;

"(2) is eligible to be covered by a maintenance of effort policy under subsection (b); and

"(3) is entitled to be provided a contribution under subsection (c).

"(b) Maintenance of Effort Policies.—

"(1) In general.—The Office shall provide or contract for one or more maintenance of effort policies of the type described in section 8904a(b)(1)(A) and of the type described in section 8904a(b)(1)(B).

"(2) Consultation.—In developing maintenance of effort policies to be offered under this subsection, the Office—

"(A) shall meet and confer with exclusive representatives of employees through a process to be established by the National Partnership Council; and

"(B) shall consult periodically with representatives of employees (other than those described in subparagraph (A)) and of annuitants.

"(3) Administration.—To the extent that maintenance of effort policies are provided through carriers, section 8902 shall, with respect to the administration of this section, apply to the extent practicable. No requirement of law relating to limiting the offering of a supplemental health benefit policy shall apply to a maintenance of effort policy offered under this section.

"(c) Contribution.—

"(1) In general.—The Government shall pay the total enrollment charge for a maintenance of effort policy under subsection (b) in the case of any employee or annuitant for whom Government contributions are being made with respect to any health benefits plan under universal FEHBP.

"(2) Payment.—Any payment under this subsection shall be made at the same time and in the same manner as if it were a Government contribution for a health benefits plan under section 8934, and shall be made from the same appropriation or fund as from which any such Government contributions would, with respect to the employee or annuitant involved, be made. In applying the previous sentence, the reference to 'Government contributions under this section' in section 8934(b)(2) shall be considered to include payments under this subsection. The requirement of section 8906(g)(2) shall continue to apply with respect to this subsection in the same manner as it applies with respect to section 8906.

"§ 8936. Opportunities to enroll

"Enrollment in plans under universal FEHBP shall be governed by section 5305(a) of the Guaranteed Health Insurance Act of 1994, except that an election opportunity may not be denied if there occurs any event or circumstance which would, if it had occurred during the last year of the FEHBP transition period, have made such an election allowable under subsection (e) or (f)(2) of section 8905.

"§ 8937. Regulations

"The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this chapter.".

(b) Clerical Amendment.—The table of chapters of subpart G of part III of title 5, United States Code, is amended by adding after the item relating to chapter 89 the following:

"89A. Provisions for the Integration of FEHBP and Universal FEHBP 8931". ....

SEC. 14402. FINAL ACCOUNTING AND DISTRIBUTION OF CERTAIN RESERVES OF CHAPTER 89 PLANS.

(a) Definitions and Rule of Construction.—For the purpose of this section—

(1) the terms "contingency reserve" and "special reserve" are used in the same way as such terms are used in section 890.503(c) of title 5, Code of Federal Regulations, as in effect on January 1, 1994;

(2) the term "qualified health plan distributee" means an individual who was enrolled—

(A) on December 31 of the fourth year of the FEHBP transition period, in a comprehensive medical plan described in section 8903(4) of title 5, United States Code; or

(B) on December 31 of the seventh year of the FEHBP transition period, in a plan described in section 8903(1), (2), or (3) of such title;

(3) the rule of construction set forth in section 8903b(a)(2) of such title applies; and

(4) the term "FEHBP transition period" has the meaning given such term by section 8903b of such title.

(b) COMPREHENSIVE MEDICAL PLANS NO LONGER IN CHAPTER 89.—

(1) FINAL ACCOUNTING.—During the fifth year of the FEHBP transition period, the Office of Personnel Management shall perform a final accounting for the preceding calendar year for each contract with a qualified health maintenance carrier (other than an experience-rated carrier) entered into under section 8902(l) of such title (as such section was in effect during such calendar year).

(2) AVAILABILITY FOR DISTRIBUTION.—After the final accounting under paragraph (1), any balance remaining in the contingency reserve of any such plan shall be available for distribution in accordance with subsection (d).

(3) DETERMINATION OF QUALIFIED HEALTH PLAN DISTRIBUTEES.—The Office shall determine who is a qualified health plan distributee with respect to each plan subject to paragraph (1).

(c) EXPERIENCE-RATED PLANS NO LONGER IN CHAPTER 89.—

(1) FINAL ACCOUNTING.—

(A) FEE FOR SERVICE PLANS.—Except as provided in subparagraph (B), during the third year beginning after the seventh year of the FEHBP transition period, the Office shall perform a final accounting for such seventh year for each plan described by section 8903(1), (2), or (3).

(B) COMPREHENSIVE MEDICAL PLANS.—In the case of a plan described by section 8903(4) that is not subject to subsection (b), the Office shall perform a final accounting during the sixth year of the FEHBP transition period for the fourth year of such period.

(2) RECONCILIATION OF RESERVE BALANCES.—Each final accounting required by paragraph (1) shall reconcile the contingency reserves and special reserves of a plan, as follows:

(A) CLAIM AND SPECIAL RESERVES.—First, if the amounts in the reserve for incurred-but-unpaid benefit claims are—

(i) insufficient to meet incurred-but-unpaid benefit claims of a plan, such claims shall be paid from the special reserve of the plan (if available);

(ii) insufficient, in combination with any available special reserve of the plan, to meet incurred-but-unpaid benefit claims of a plan, such deficit shall be a negative addition to the plan's special reserve; or

(iii) greater than the actual incurred-but-unpaid benefit claims, any excess amount in such reserve shall be transferred to the plan's special reserve.

(B) TREATMENT OF THE SPECIAL RESERVE OF A PLAN.—Second, if the balance of the special reserve of a plan after subparagraph (A) is carried out is—

(i) greater than zero, the plan shall transfer the amount in the special reserve to the Office of Personnel Management for credit to the plan's contingency reserve; or

(ii) less than zero, the moneys in the contingency reserve of the plan shall be transferred to the special reserve in an amount that is sufficient to increase the balance of the special reserve to zero or, if less, an amount that is equal to the balance in such contingency reserve.

(C) PRE-DISTRIBUTION PAYMENTS TO PLAN SPECIAL RESERVES FROM COMBINED CONTINGENCY RESERVES.—Third, after payments from plan contingency reserves are made under subparagraph (B), remaining balances of all plan contingency reserves shall be combined, and payments shall be made from such aggregate balance (if any) to plans with negative special reserves to increase such special reserves to zero.

(D) AVAILABILITY FOR DISTRIBUTION.—Fourth, any balance remaining in the aggregate contingency reserves after subparagraph (C) is carried out shall be available for distribution in accordance with subsection (d).

(3) DETERMINATION OF QUALIFIED HEALTH PLAN DISTRIBUTEES.—The Office shall determine who is a qualified health plan distributee with respect to each plan subject to paragraph (1).

(d) DISTRIBUTION OF REMAINING CONTINGENCY RESERVES.—

(1) GENERAL RULE.—

(A) DISTRIBUTION.—Amounts available for distribution pursuant to subsections (b)(2) and (c)(2)(D) shall be distributed to the qualified health plan distributees living on the date of distribution, the United States Government, and the United States Postal Service.

(B) AMOUNTS.—Such amounts shall be distributed in sums which the Office determines, in accordance with regulations which the Office shall promulgate, to be proportional to their respective contributions to health plans (determined without regard to any collective bargaining agreement under title 39, United States Code) made during the plan year for which a final accounting is made under this section.

(C) REMAINING AMOUNTS REDISTRIBUTED TO UNITED STATES GOVERNMENT AND UNITED STATES POSTAL SERVICE.—Amounts which could not be distributed to a qualified health plan distributee under subparagraph (A) after reasonable efforts shall be redistributed to the United States Government or the United States Postal Service, as appropriate.

(2) INDIVIDUAL LIMITED TO ONE DISTRIBUTION.—An individual who is determined to be a qualified health plan distributee under both subsections (b)(3) and (c)(3) may receive only one distribution under paragraph (1)(A).

(3) TREATMENT OF MONEYS RECEIVED BY THE UNITED STATES GOVERNMENT AND THE UNITED STATES POSTAL SERVICE.—

(A) UNITED STATES GOVERNMENT.—Amounts received by the United States Government pursuant to paragraph (1) shall be deposited in a special account of the Employees Health Benefits Fund. Such amounts shall be available to be used only for purposes which benefit the health of Federal employees and annuitants, including payment for the Government-provided maintenance of effort policies required by section 8935 of title 5, United States Code, as directed by Congress.

(B) UNITED STATES POSTAL SERVICE.—Amounts received by the United States Postal Service pursuant to paragraph (1) shall be deposited in a special account in the Postal Service Fund (established by section 2003 of title 39, United States Code). Such amounts shall be available to be used only for purposes which benefit the health of employees and annuitants of the United States Postal Service, including—

(i) payment for the Government-provided maintenance of effort policies required by section 8935 of title 5, United States Code, or

(ii) contributions to the financial stability of health benefits plans established on behalf of employees and annuitants of the United States Postal Service, to be made in a manner that is proportional to the number of employees and annuitants of the United States Postal Service to whom each such plan (or its predecessor) provided health benefits on the last day of the plan's participation under chapter 89 of title 5, United States Code,

as directed by Congress.

(4) DEADLINE FOR DISTRIBUTIONS.—The distributions under paragraph (1)(A) shall be completed no later than 42 months following the end of the FEHBP transition period.

(e) MID-TRANSITION PERIOD REPORT.—Not later than December 31 of the seventh year of the FEHBP transition period, the Office shall submit a report to the Congress which shall include the projected amount to be distributed under subsection (d), as well as the proposed regulations for carrying out the distribution thereunder.

SEC. 14403. TREATMENT OF INDIVIDUALS RESIDING ABROAD.

(a) IN GENERAL.—Chapter 89 is amended by adding at the end the following:

"§ 8915. Health insurance program for individuals residing abroad

"(a)(1) The Office of Personnel Management, upon making the determination described in paragraph (2), shall by regulation establish, directly or by contract, a program under which employees, annuitants, and other individuals who (but for the enactment of the Guaranteed Health Insurance Act of 1994) would be eligible for coverage under this chapter and who, because of residence abroad or other unusual circumstances, have special needs shall be eligible for health insurance.

"(2) The determination described in this paragraph is a determination that the establishment of a health insurance program is necessary to assure that health benefits made available under this chapter are available to the individuals described in paragraph (1) because health insurance coverage would otherwise cease to be available as a result of the enactment of the Guaranteed Health Insurance Act of 1994.

"(b) To the extent practicable, terms and conditions of coverage provided to individuals under such program shall be the same as the terms and conditions of coverage which would otherwise apply under this chapter to employees.

"(c) Any Government contribution payable under such program shall be made from the appropriation or fund from which any Government contribution would have been payable under this chapter on behalf of the individual involved, except that, in the case of an annuitant, any such contribution shall be payable from amounts appropriated pursuant to section 8906(g) (or similar authority under this chapter or chapter 89A).".

(b) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by adding at the end the following:

"8915. Health insurance program for individuals residing abroad.".

Subtitle E—Miscellaneous Provisions

SEC. 14501. TECHNICAL AND CONFORMING AMENDMENTS.

(a) TITLE 5, UNITED STATES CODE.—Title 5, United States Code, is amended as follows:

(1) In section 1308(c), by striking "chapter 89" and inserting "chapter 89 and relevant aspects of universal FEHBP (as defined in chapter 89A)".

(2) In section 3374(b) (in the matter following paragraph (3)), by inserting "(or, instead of chapter 89, any other applicable health benefits system)" after "89 of this title".

(3) In section 3582(a)(2)—

(A) by striking "89" each place it appears and inserting "89 (or 89A, as applicable)"; and

(B) by striking "Benefits Fund" and inserting "Benefits Fund (or the Universal FEHBP Health Benefits Fund)".

(4) In section 6386—

(A) by striking "chapter 89" and inserting "chapter 89 (or 89A)"; and

(B) by striking "(described in section 8909)," and inserting "described in section 8909 (or the Universal FEHBP Health Benefits Fund described in section 5306 of the Guaranteed Health Insurance Act of 1994, as the case may be),".

(b) OTHER REFERENCES TO CHAPTER 89.—Any reference in any provision of law in effect on the day before the date of the enactment of this Act, other than in a provision of law amended by subsection (a)—

(1) to coverage under chapter 89 of title 5, United States Code, shall be deemed to be a reference to coverage under chapter 89 or 89A of such title, as appropriate; and

(2) to the "Employees Health Benefits Fund" shall be deemed to be a reference to that fund or the Universal FEHBP Health Benefits Fund, as appropriate.

SEC. 14502. REPORT ON CONFORMING LEGISLATIVE CHANGES.

The Office of Personnel Management shall, by not later than 6 months after the date of the enactment of this Act, submit to Congress proposed legislation that conforms provisions of law to the amendments made by this title.

SEC. 14503. TREATMENT OF POSTAL SERVICE PLANS AS MULTIEMPLOYER PLANS.

For purposes of this Act (and laws amended by this Act), any health plan offered exclusively to employees of the United States Postal Service shall be treated as if it were a multiemployer plan (as defined in section 5102(c)(3) of this Act) in operation prior to September 1, 1993.

TITLE XV—DEPARTMENT OF VETERANS AFFAIRS

SEC. 15001. BENEFITS AND ELIGIBILITY THROUGH DEPARTMENT OF VETERANS AFFAIRS MEDICAL SYSTEM.

(a) DVA AS A PARTICIPANT IN HEALTH CARE REFORM.—

(1) IN GENERAL.—Title 38, United States Code, is amended by inserting after chapter 17 the following new chapter:

"CHAPTER 18—ELIGIBILITY AND BENEFITS UNDER ENROLLMENT-BASED SYSTEM

"SUBCHAPTER I—GENERAL

"1801. Definitions.

"SUBCHAPTER II—ENROLLMENT

"1811. Enrollment: veterans.
"1812. Enrollment: CHAMPVA eligibles.
"1813. Enrollment: family members.
"1814. Exclusive enrollment eligibility categories.

"SUBCHAPTER III—BENEFITS

"1821. Benefits for VA enrollees.
"1822. Chapter 17 benefits.
"1823. Supplemental benefits packages and policies.
"1824. Limitation regarding veterans enrolled with health plans outside Department.

"SUBCHAPTER IV—FINANCIAL MATTERS

"1831. Premiums, copayments, etc..
"1832. Recovery of cost of certain care and services.
"1833. Health Plan Fund.
"1834. Guaranteed funding of Government costs

"SUBCHAPTER I—GENERAL

"§ 1801. Definitions

"For purposes of this chapter:

"(1) The term 'qualified health benefit plan' means an entity that is a qualified health benefit plan for purposes of the Guaranteed Health Insurance Act of 1994.

"(2) The term 'VA health plan' means a health plan that is established and operated by the Secretary under section 7341(a) of this title.

"(3) The term 'transitional VA health plan' means a VA health plan that is operated by the Secretary during the period before January 1, 1999.

"(4) The term 'GHIA-qualified VA health plan' means a VA health plan that is certified under title V of the Guaranteed Health Insurance Act of 1994 as a qualified health benefit plan for operation under such Act after December 31, 1998.

"(5) The term 'VA enrollee' means an individual enrolled under subchapter II of this chapter in a VA health plan.

"(6) The term 'guaranteed national benefit package' means the package of benefits that as of January 1, 1999, is required to be provided by a qualified health benefit plan under title III of the Guaranteed Health Insurance Act of 1994.

"SUBCHAPTER II—ENROLLMENT

"§ 1811. Enrollment: veterans

"Each veteran who is an eligible individual within the meaning of section 1001 of the Guaranteed Health Insurance Act of 1994 may enroll with a VA health plan. After December 31, 1998, a veteran who wants to receive the benefits that are included in the guaranteed national benefit package through the Department shall enroll with a VA health plan that is GHIA-qualified VA health plan.

"§ 1812. Enrollment: CHAMPVA eligibles

"(a) ELIGIBILITY.—An individual described in subsection (b) who is an eligible individual within the meaning of section 1001 of the Guaranteed Health Insurance Act of 1994 may enroll with a VA health plan.

"(b) APPLICABILITY.—This section applies to the following individuals who are not otherwise eligible for medical care under chapter 55 of title 10 (CHAMPUS):

"(1) The surviving spouse or child of a veteran who (A) died as a result of a service-connected disability, or (B) at the time of death had a total disability permanent in nature, resulting from a service-connected disability.

"(2) The surviving spouse or child of a person who died in the active military, naval, or air service in the line of duty and not due to such person's own misconduct.

"§ 1813. Enrollment: family members

"(a) ELIGIBILITY.—The Secretary shall authorize a VA health plan to enroll members of the family of an enrollee under section 1811 or 1812 of this title. The enrollee shall have the option of enrolling in the VA health plan as an individual or with family members, in accordance with the provisions of the Guaranteed Health Insurance Act of 1994.

"(b) ENROLLMENT ELIGIBILITY TO SURVIVE DEATH OF VETERAN.—An individual who is enrolled with a VA health plan pursuant to subsection (a) as a member of the family of a veteran enrolled under section 1811 of this title shall not lose eligibility to be enrolled with VA health plans by reason of the death of that veteran.

"(c) MEMBERS OF FAMILY.—For purposes of this section, the members of the family of an enrollee are those individuals (other than the enrollee) included within the term 'family' as defined in section 3(a) of the Guaranteed Health Insurance Act of 1994.

"§ 1814. Exclusive enrollment eligibility categories

"Eligibility of individuals for enrollment in a VA health plan shall be exclusively as provided in this subchapter.

"SUBCHAPTER III—BENEFITS

"§ 1821. Benefits for VA enrollees

"The Secretary shall ensure that each VA health plan provides to each individual enrolled with it the items and services in the guaranteed national benefit package. Such benefits are entitlements for each enrolled individual.

"§ 1822. Chapter 17 benefits

"(a) CARE AND SERVICES NOT INCLUDED IN GUARANTEED NATIONAL BENEFIT PACKAGE.—In the case of care and services that may be provided under chapter 17 of this title that are not included in the guaranteed national benefit package, the Secretary shall provide to any veteran (whether or not enrolled with a VA health plan) the care and services authorized under that chapter in accordance with the terms and conditions applicable to that veteran and that care under such chapter.

"(b) VETERANS WHO ARE NOT ELIGIBLE TO ENROLL UNDER GUARANTEED HEALTH INSURANCE ACT OF 1994.—In the case of a veteran who is not an eligible individual within the meaning of section 1001 of the Guaranteed Health Insurance Act of 1994, the Secretary shall provide to the veteran the care and services that may be provided under chapter 17 of this title through any facility of the department, whether or not the facility is operating as or within a VA health plan.

"(c) PRESERVATION OF SPECIALIZED DVA TREATMENT CAPACITIES.—In carrying out subsection (a), the Secretary shall ensure that the Department maintains the capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that affords those veterans reasonable access to care and services for those specialized needs. The Secretary shall ensure that overall capacity of the Department to provide such specialized services is not reduced below the capacity of the Department, nationwide, to provide those services, as of the date of the enactment of this chapter. Nothing in this subsection precludes the Secretary from expanding the number or type of facilities or programs that provide treatment and rehabilitation services for the specialized needs of such veterans, including provision of specialized services on an outpatient basis.

"(d) ANNUAL REPORT.—Not later than March 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing the actions the Secretary has taken to carry out subsection (c) during the preceding fiscal year. Each such report shall include a statement of the number of veterans to whom the Department provided specialized services that are covered by the report and the expense of providing those services, and a description of the alternatives available in the private sector for the provision of those services to veterans.

"§ 1823. Supplemental benefits packages and policies

"The Secretary may offer supplemental health benefits packages consistent with the requirements of title V of the Guaranteed Health Insurance Act of 1994. However, the Secretary may not offer a supplemental health benefits package to a veteran that provides coverage for services that the Department is required to provide to that veteran under chapter 17 of this title. To the extent that supplemental health benefits packages and supplemental cost sharing policies are offered and accepted, benefits under such packages and policies shall be entitlements for each enrolled individual.

"§1824. Limitation regarding veterans enrolled with health plans outside Department

"(a) Reimbursement Required.—After December 31, 1998, a veteran who is enrolled in a health plan other than a GHIA-qualified VA health plan may be provided the items and services in the guaranteed national benefit package by a VA health plan operating in that area only if (except as provided in subsection (b)) the plan is reimbursed for the cost of the care provided.

(b) Exception.—The Secretary may not impose on or collect from a veteran described in subsection (a) a cost-share charge of any kind in the case of treatment for a service-connected disability that (as determined by the Secretary) requires a specialized treatment capacity for which the Department has particular expertise.

"SUBCHAPTER IV—FINANCIAL MATTERS

"§1831. Premiums, copayments, etc.

"(a) Exemption of Certain Veterans.—(1) In the case of a veteran described in subsection (b) who is a VA enrollee, there may not be imposed or collected from the veteran a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge) for items and services in the guaranteed national benefit package that are provided to the veteran by the Secretary within a VA plan provider network.

"(2) In the case of a veteran described in subsection (b) who is enrolled in a GHIA-qualified VA health plan and has a premium certificate issued under part A of title XXII of the Social Security Act, the Secretary may require the veteran to tender the certificate to the Secretary and the Secretary may accept the certificate.

"(3) The Secretary shall make such arrangements as necessary with the appropriate health insurance purchasing cooperative or with appropriate Federal, State, or other officials in order to carry out this subsection.

"(b) Veterans Exempt From Charges.—The veterans referred to in subsection (a) are the following:

"(1) Any veteran with a service-connected disability.

"(2) Any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty.

"(3) Any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section.

"(4) Any veteran who is a former prisoner of war.

"(5) Any veteran of the Mexican border period or World War I.

"(6) Any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

"(c) Establishment of Premium Rates.—(1) In the case of a transitional VA health plan, the Secretary shall establish premium rates for enrollees in the plan (other than for veterans described in subsection (b) and enrollees described in paragraph (3)) in accordance with regulations to be prescribed by the Secretary.

"(2) In the case of a GHIA-qualified VA health plan, premium rates (other than for veterans described in subsection (b) and enrollees described in paragraph (3)) shall be established in accordance with regulations prescribed by the Secretary of Health and Human Services under title V of the Guaranteed Health Insurance Act of 1994.

"(3) The Secretary may not collect a premium from an enrollee in the case of—

"(A) an individual who is enrolled in a VA health plan by reason of eligibility under section 1812 of this title; or

"(B) an individual who is enrolled in a VA health plan by reason of eligibility under section 1813 of this title and who is described in paragraph (1) of section 1713(a) of this title.

"(d) Cost-Share Charges.—(1) In the case of a transitional VA health plan, the Secretary may establish cost-sharing charges (including copayments, deductibles, and other coinsurance amounts) for enrollees in the plan (other than for veterans described in subsection (b)) in accordance with regulations to be prescribed by the Secretary.

"(2) In the case of a GHIA-qualified VA health plan, cost-sharing charges (including copayments, deductibles, and other coinsurance amounts) for enrollees in the plan (other than for veterans described in subsection (b)) shall be established in accordance with regulations prescribed by the Secretary of Health and Human Services under title V of the Guaranteed Health Insurance Act of 1994.

"(3) The Secretary may not charge or collect a copayment, deductible, or other coinsurance amount in the case of care for any disease covered under section 1710(e)(1) of this title.

"§1832. Recovery of cost of certain care and services

"(a) Recovery From Third Parties.—In the case of an individual provided care or services through a VA health plan who is covered under a supplemental health insurance policy under the Guaranteed Health Insurance Act of 1994, a Medicare supplemental health insurance plan (as defined in the Guaranteed Health Insurance Act of 1994), or any other plan or policy designed to supplement health insurance coverage, the Secretary has the right to recover or collect charges for care or services (as determined by the Secretary, but not including care or services for a service-connected disability) from the party providing that coverage to the extent that the individual (or the provider of the care or services) would be eligible to receive payment for such care or services from such party if the care or services had not been furnished by a department or agency of the United States.

"(b) Procedures.—The provisions of subsections (b) through (f) of section 1729 of this title shall apply with respect to claims by the United States under subsection (a) in the same manner as they apply to claims under subsection (a) of that section.

"§1833. Health Plan Fund

"(a) Establishment of Fund.—There is hereby established in the Treasury a revolving fund to be known as the 'Department of Veterans Affairs Health Plan Fund'.

"(b) Crediting of Amounts to Fund.—There shall be credited to the revolving fund any amount received by the Department by reason of the furnishing of health care by a VA health plan and any amount received by the Department by reason of the enrollment of an individual with a VA health plan (including amounts received as premiums, premium discount payments, copayments or coinsurance, and deductibles), any amount received as a third-party reimbursement, and any amount received as a reimbursement from another health plan for care furnished to one of its enrollees.

"(c) Crediting to Treasury.—Any amounts deposited to the revolving fund that are attributable to amounts received by the Department as a premium by reason of the enrollment with a VA health plan of a veteran described in section 1831(b) of this title shall be covered into the General Fund of the Treasury.

"(d) Availability of Funds.—Amounts in the revolving fund are hereby authorized to be appropriated for all expenses, both direct and indirect, related to the delivery by a VA health plan of the items and services in the guaranteed national benefit package and any supplemental benefits package or policy offered by the Secretary. The appropriations authorized by this subsection shall be considered mandatory appropriations for all purposes, including for purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 and the Congressional Budget Act of 1974.

"§1834. Guaranteed funding of Government costs

"(a) Required Deposits From Treasury.—The Secretary of the Treasury shall deposit into the Department of Veterans Affairs Health Plan Fund on the first day of each fiscal year quarter, from amounts not otherwise appropriated, the amount certified to the Secretary under subsection (b) with respect to the fiscal year quarter beginning on that date.

"(b) Certification of Amount.—Not later than 30 days before the beginning of each fiscal year quarter, the Secretary of Veterans Affairs shall certify to the Secretary of the Treasury the amount determined for that quarter under subsection (c).

"(c) Determination of Amount.—(1) The amount to be certified to the Secretary of the Treasury under subsection (b) for any fiscal year quarter is the product of—

"(A) the projected number of VA enrollees described in section 1831(b) of this title as of the beginning of that fiscal year quarter, and

"(B) the capitated enrollment amount for that fiscal year determined under subsection (d).

"(2) The Secretary shall adjust future certifications under this subsection to take account of—

"(A) differences between the actual number of veterans described in section 1831(b) of this title enrolled for a fiscal year quarter and the projected number used in the certification for that quarter pursuant to paragraph (1); and

"(B) any information that the Secretary finds would produce a more accurate capitated enrollment amount by enabling the Secretary to estimate more accurately the costs that the Department will incur during the period covered by any such certification in providing those services that are specified to be included in the guaranteed national benefit package.

"(d) Capitated Enrollment Amount.—(1) The Secretary shall determine the capitated enrollment amount for purposes of subsection (c). The initial capitated enrollment amount shall be determined as the amount equal to—

"(A) the annual full cost (as defined in OMB Circular A-25, issued on July 8, 1993) that has been incurred by the Department in providing those services that are specified to be included in the guaranteed national benefit package, based upon the most recent cost data available as of the time of the determination, adjusted for inflation to the date of the determination based upon the medical care consumer price index calculated by the Bureau of Labor Statistics, divided by

"(B) the total number of veterans described in section 1831(b) of this title who received those services.

"(2) The Secretary shall include in the total annual cost for purposes of paragraph (1)(A) the amount appropriated for fiscal year 1994 for medical and prosthetic research by the Veterans Health Administration.

"(3) The Secretary shall develop the methodology for determining the initial capitated enrollment amount under paragraph (1) in consultation with the Comptroller General of the United States. If the Comptroller General disagrees with the methodology proposed to be used by the Secretary, the Comptroller General shall promptly notify the Committees on Veterans' Affairs of the Senate and House of Representatives. The determination of that amount shall be made not later than June 1, 1995.

"(4) The initial capitated enrollment amount, as adjusted annually for inflation based upon the medical care consumer price index calculated by the Bureau of Labor Statistics, shall apply through the fifth fiscal year during which the Secretary operates a GHIA-qualified VA health plan.

"(5)(A) Not later than the end of the third fiscal year during which the Secretary operates a GHIA-qualified VA health plan, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on what actions, if any, would be necessary in order for the Department to change the annual capitated enrollment amount by the end of the fifth such year from the initial amount determined under paragraph (1) to an amount determined using the method described in subparagraph (B), or to amounts determined using some other methodology, without a reduction in quality of care.

"(B) The method for determining the annual capitated enrollment amount for purposes of the study under this paragraph is to determine the average premium that would be payable under the Guaranteed Health Insurance Act of 1994 for individuals enrolled in health plans other than a GHIA-qualified VA health plans which have enrollment populations with disproportionate numbers of persons with similar demographic and patient-risk characteristics to the population of VA enrollees.".

(2) CLERICAL AMENDMENT.—The tables of chapters at the beginning of title 38, United States Code, and at the beginning of part II of such title, are amended by inserting after the item relating to chapter 17 the following new item:

"18. Eligibility and Benefits Under Enrollment-Based System .... 1801".

(b) PRESERVATION OF EXISTING BENEFITS FOR FACILITIES NOT OPERATING AS HEALTH PLANS.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1704 the following new section:

"§ 1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans

"The provisions of this chapter shall apply with respect to the furnishing of care and services—

"(1) by any facility of the Department that (A) is not operating as or within a GHIA-qualified VA health plan, and (B) is not located in a State (or portion of a State) that is described in section 7342(a) of this title; and

"(2) by any facility of the Department (whether or not operating as or within a GHIA-qualified VA health plan) in the case of a veteran who is not an eligible individual with the meaning of section 1001 of the Guaranteed Health Insurance Act of 1994.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1704 the following new item:

"1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans.".

SEC. 15002. ORGANIZATION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES AS HEALTH PLANS.

(a) IN GENERAL.—Chapter 73 of title 38, United States Code, is amended—

(1) by redesignating subchapter IV as subchapter V; and

(2) by inserting after subchapter III the following new subchapter:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"§ 7341. Organization of health care facilities as health plans

"(a)(1) The Secretary shall organize health plans and operate Department facilities as or within such health plans. The Secretary shall establish standards for the organization and operation of Department health care facilities as or within health plans.

"(2) Health plans organized and operated by the Secretary shall be known as 'VA health plans'. Such plans shall be known during the period before January 1, 1999, as 'transitional VA health plans'.

"(3) With respect to the operation of such plans after December 31, 1998, standards established under paragraph (1) shall be consistent with the regulations prescribed by the Secretary of Health and Human Services pursuant to title V of the Guaranteed Health Insurance Act of 1994.

"(4) The Secretary shall seek to ensure that each health plan organized by the Secretary before January 1, 1999, is certified as a qualified health benefit plan under title V of the Guaranteed Health Insurance Act of 1994, as provided in subsection (b).

"(5) The Secretary may not operate a VA health plan after December 31, 1998, unless the plan is certified as provided in subsection (b).

"(b)(1) A health plan established under subsection (a) may be certified as a qualified health benefit plan for purposes of the Guaranteed Health Insurance Act of 1994 in accordance with regulations prescribed by the Secretary of Health and Human Services pursuant to title V of the Guaranteed Health Insurance Act of 1994.

"(2) A health plan established by the Secretary under subsection (a) that is certified as provided in paragraph (2) may be referred to as a 'GHIA-qualified VA health plan'.

"(c) Within a geographic area or region, health care facilities of the Department located within that area or region may be organized to operate as a single health plan encompassing all Department facilities within that area or region or may be organized to operate as several health plans.

"(d) The Secretary shall ensure that each health plan established by the Secretary that is certified as a qualified health benefit plan under title V of the Guaranteed Health Insurance Act of 1994 is operated (except as specifically otherwise provided in chapter 18 of this title or in this subchapter) in accordance with the provisions of the Guaranteed Health Insurance Act of 1994 (and the amendments made by the Guaranteed Health Insurance Act of 1994).

"(e)(1) In establishing and operating health plans, the Secretary (in consultation with the Comptroller General) shall take appropriate steps to ensure the financial solvency and stability of each VA health plan and of contractors and subcontractors providing services pursuant to section 7343 of this title.

"(2) In carrying out paragraph (1), the Secretary may purchase from commercial sources insurance to insure the United States against the financial risks involved in the operation of any VA health plan.

"§ 7342. Operation of health care facilities within States operating single payer programs or pure managed competition programs

"(a) In a State (or portion of a State) that under the Guaranteed Health Insurance Act of 1994 is operating as a single payer program or that uses a pure managed competition program, the Secretary shall seek to achieve the maximum participation of Department health care facilities or GHIA-qualified VA health plans, as the case may be, in that State (or portion of a State) that is permitted under applicable provisions of law.

"(b) To the extent that the Secretary determines that applicable provisions of law do not permit adequate participation by GHIA-qualified VA health plans or Department health care facilities in such a State (or portion of a State), the Secretary shall submit to Congress a report containing such legislative recommendations as the Secretary considers appropriate. Any such report shall be prepared in coordination with the Secretary of Health and Human Services.

"§ 7343. Health care resource agreements

"(a)(1) In accordance with policies established under subsection (b), an official specified in paragraph (2) may, without regard to any law or regulation specified in paragraph (3), enter into agreements with health care plans, with insurers, and with health care providers, and with any other entity or individual, to furnish or obtain any health-care resource.

"(2) An official specified in this paragraph is any of the following:

"(A) The head of a VA health plan.

"(B) The director of a Department health care facility that is operating as or within a VA health plan.

"(C) The director of a Department health care facility that is operating in a State (or portion of a State) that is described in section 7342(a) of this title.

"(3) A law or regulation specified in this paragraph is any of the following:

"(A) Section 1703 of this title.

"(B) Any other law or regulation pertaining to—

"(i) competitive procedures;

"(ii) acquisition procedures or policies (other than contract dispute settlement procedures); or

"(iii) bid protests.

"(4) For purposes of this subsection, the term 'health-care resource' has the meaning given that term in section 8152 of this title.

"(b) Policies established by the Secretary under subsection (a) shall include appropriate provisions to ensure that procurements under that subsection are carried out in a manner consistent with (1) Federal acquisition policies regarding nondiscrimination, equal opportunity, business integrity, and safeguarding against fraud and abuse, and (2) the goal of a streamlined process for the acquisition of health-care resources.

"(c) Any proceeds to the Government received from an agreement under subsection (a) shall be credited to the Department of Veterans Affairs Health Plan Fund established under section 1834 of this title and to funds that have been allotted to the facility that furnished the resource involved.

"§ 7344. Administrative and personnel flexibility

"(a) In order to carry out this subchapter, the Secretary may—

"(1) subject to section 1822(c) of this title, carry out administrative reorganizations of the Department without regard to those provisions of section 510 of this title following subsection (a) of that section; and

"(2) when the Secretary finds it is cost-effective or necessary in order to provide health care services in a timely manner—

"(A) enter into contracts for procurement of any commercially available item at a cost of under $100,000 without regard to any provision of law or regulation (i) requiring competitive procedures; (ii) mandating or giving priority to any source of supply; or (iii) pertaining to protests; and

"(B) enter into contracts without regard to section 8110(c) of this title for the performance of services previously performed by employees of the Department.

"(b)(1) Whenever the Secretary considers such action necessary for the operation of a VA health plan, the Secretary may establish alternative personnel systems or procedures for personnel at facilities operating as or within VA health plans or for personnel at facilities operating in a State (or portion of a State) that is described in section 7342(a) of this title, except that the Secretary shall provide for preference eligibles (as defined in section 2108 of title 5) in a manner comparable to the preference for such eligibles under subchapter I of chapter 33, and subchapter I of chapter 35, of such title.

"(2) In establishing alternative personnel systems or procedures under this subsection, the Secretary shall include the following:

"(A) A system that ensures that applicants for employment and employees are appointed, promoted, and assigned on the basis of merit and fitness.

"(B) An equal employment opportunity program.

"(C) Compensation systems which will be used to set rates of pay that are competitive with rates of pay paid by health-care providers other than the Department and that take into consideration the difficulty, responsibility, and qualification requirements of the work performed.

"(D) A formal performance appraisal system.

"(E) A system to address unacceptable conduct and performance by employees, including a general statement of violations, sanctions, and procedures which shall be made known to all employees, and a dispute resolution procedure.

"(F) A formal policy regarding the accrual and use of sick leave and annual leave.

"(c) The Secretary may carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department operating as or within VA health plans.

"§ 7345. Veterans Health Care Transition Fund

"(a) For each of fiscal years 1995, 1996, and 1997, the Secretary of the Treasury shall credit to a special fund (in this section referred to as the 'Fund') of the Treasury an amount equal to—

"(1) $1,250,000,000 for fiscal year 1995;

"(2) $850,000,000 for fiscal year 1996; and

"(3) $1,950,000,000 for fiscal year 1997.

"(b) Amounts in the Fund shall be available to the Secretary only for the VA health plans authorized under this chapter. Such amounts are available without fiscal year limitation for costs of commencing operation of VA health plans, including consulting services, equipment, marketing, and other costs, minor construction, and (subject to section 8104 of this title) major construction.

"(c) The Secretary shall submit to Congress, no later than March 1, 1997, a report concerning the operation of the Department of Veterans Affairs health care system during fiscal years 1995 and 1996 in preparing for commencement of operations as VA health plans. The report shall include a discussion of—

"(1) the adequacy of amounts in the Fund for the operation of VA health plans;

"(2) the quality of care provided by such plans;

"(3) the ability of such plans to attract patients; and

"(4) the need (if any) for additional funds for the Fund in fiscal years after fiscal year 1997.

"§ 7346. Funding provisions: grants and other sources of assistance

"The Secretary may apply for and accept, if awarded, any grant or other source of funding that is intended to meet the needs of special populations if funds obtained through the grant or other source of funding will be used through a facility of the Department operating as or within a health plan.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by striking out the item relating to the heading for subchapter IV and inserting in lieu thereof the following:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"7341. Organization of health care facilities as health plans.
"7342. Operation of health care facilities within States operating single payer programs or pure managed competition programs.
"7343. Health care resource agreements.
"7344. Administrative and personnel flexibility.
"7345. Veterans Health Care Transition Fund.
"7346. Funding provisions: grants and other sources of assistance.

"SUBCHAPTER V—RESEARCH CORPORATIONS".

SEC. 15003. ELIGIBILITY FOR CHAPTER 17 CARE.

(a) NURSING HOME CARE.—Section 1710(a)(1) of title 38, United States Code, is amended by inserting "(or, in the case of a veteran described in subparagraph (A) or (D) below, shall furnish nursing home care)" after "may furnish nursing home care".

(b) OUTPATIENT CARE FOR ENROLLED VETERANS.—Paragraph (1) of section 1712(a) of such title is amended—

(1) by striking out "and" at the end of subparagraph (C);

(2) by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon; and

(3) by adding at the end the following:

"(E) to any veteran described in section 1831(b) of this title who is enrolled under section 1811 of this title and the Guaranteed Health Insurance Act of 1994 with a VA health plan (as defined in section 1801 of this title), for any disability to the extent that care and treatment of that disability is not included within the guaranteed national benefit package (as defined in section 1801 of this title);".

(c) OBVIATE-THE-NEED OUTPATIENT CARE.—(1) Paragraph (2) of such section is amended by striking out "The Secretary" and all that follows through "this subsection—" and inserting in lieu thereof "Except as provided in subsection (b) of this section, the Secretary shall furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed—".

(2) Paragraph (4) of such section is amended by striking out "medical services for a purpose described in paragraph (5) of this subsection" and inserting in lieu thereof ", to the extent that facilities are available, such medical services as the Secretary determines are needed".

(3) Such section is further amended—

(A) by striking out paragraph (5); and

(B) by redesignating paragraphs (6) and (7) as paragraphs (5) and (6), respectively.

(d) CONFORMING AMENDMENTS.—(1) Section 1701(6)(A)(i) of such title is amended by striking out "(except under the conditions described in section 1712(a)(5)(A) of this title)".

(2) Section 1701(6)(B)(i)(II) of such title is amended by striking "section 1712(a)(5)(B)" and inserting in lieu thereof "section 1712".

(3) Section 1703(a)(2)(B) of such title is amended by striking out "for a purpose described in section 1712(a)(5)(B) of this title" and inserting in lieu thereof "to complete treatment incident to hospital, nursing home, or domiciliary care that has been provided by the Department".

(4) Section 1712A(b)(1) of such title is amended by striking out "section 1712(a)(5)(B)" and inserting in lieu thereof "section 1703(a)(2)(B)".

SEC. 15004. AUTHORITY TO PROVIDE HEALTH CARE FOR HERBICIDE AND RADIATION EXPOSURE.

(a) AUTHORIZED INPATIENT CARE.—Section 1710(e) of title 38, United States Code, is amended to read as follows:

"(e)(1)(A) Subject to paragraph (4), a herbicide-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for any disease specified in subparagraph (B).

"(B) The diseases referred to in subparagraph (A) are those for which the National Academy of Sciences, in a report issued in accordance with section 2 of the Agent Orange Act of 1991, has determined—

"(i) that there is sufficient evidence to conclude that there is a positive association between occurrence of the disease in humans and exposure to a herbicide agent;

"(ii) that there is evidence which is suggestive of an association between occurrence of the disease in humans and exposure to a herbicide agent, but such evidence is limited in nature; or

"(iii) that available studies are insufficient to permit a conclusion about the presence or absence of an association between occurrence of the disease in humans and exposure to a herbicide agent.

"(2) A radiation-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for—

"(A) any disease listed in section 1112(c)(2) of this title; and

"(B) any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

"(3) Subject to paragraph (4), a veteran who the Secretary finds may have been exposed while serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War to a toxic substance or environmental hazard is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability which becomes manifest before October 1, 1996, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

"(4) Hospital and nursing home care may not be provided under or by virtue of paragraph (1) after September 30, 1996, or, in the case of a veteran described in paragraph (3), after September 30, 1998.

"(5) For purposes of this subsection and section 1712 of this title—

"(A) the term 'herbicide-exposed veteran' means a veteran (i) who served on active duty in the Republic of Vietnam during the Vietnam era, and (ii) who the Secretary finds may have been exposed during such service to a herbicide agent;

"(B) the term 'herbicide agent' has the meaning given that term in section 1116(a)(4) of this title; and

"(C) the term 'radiation-exposed veteran' has the meaning given that term in section 1112(c)(4) of this title.".

(b) AUTHORIZED OUTPATIENT CARE.—Section 1712 of such title is amended—

(1) in subsection (a)(1) (as amended by section 15003(b)), by adding at the end the following:

"(F) during the period before October 1, 1996, to any herbicide-exposed veteran for any disease listed in section 1710(e)(1)(B) of this title; and

"(G) to any radiation-exposed veteran for any disease covered under section 1710(e)(1)(C) of this title."; and

(2) in subsection (i)(3)—

(A) by striking out "(A)"; and

(B) by striking out ", or (B)" and all that follows through "title".

(c) SAVINGS PROVISION.—The provisions of sections 1710(e) and 1712(a) of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, shall apply with respect to hospital care, nursing home care, and medical services in the case of any veteran furnished care or services before such date of enactment on the basis of presumed exposure to a substance or radiation under the authority of those provisions.

SEC. 15005. EXTENSION OF AUTHORITY TO PROVIDE PRIORITY OUTPATIENT HEALTH CARE FOR EXPOSURE TO ENVIRONMENTAL HAZARDS.

Section 1712(a)(1)(D) of title 38, United States Code, is amended by striking out "December 31, 1994, for any disability" and inserting in lieu thereof "October 1, 1998, for any disability which becomes manifest before October 1, 1996,".

SEC. 15006. CONFIDENTIALITY OF MEDICAL RECORDS.

Subsection (a) of section 5701 of title 38, United States Code, is amended to read as follows:

"(a)(1) Except for medical records protected by the Guaranteed Health Insurance Act of 1994, records described in paragraph (2) shall be confidential and privileged, and no disclosure of such records shall be made except as provided in this section.

"(2) Paragraph (1) applies to the following records in the possession of the Department:

"(A) All records pertaining to any claim under the laws administered by the Secretary.

"(B) All records of the names and addresses of present or former members of the Armed Forces, and their dependents, contained in records pertaining to any such claim or derived from records pertaining to any such claim.

"(3) For purposes of this paragraph, the term 'records' includes files, reports, and other papers and documents.".

SEC. 15007. REPORT ON WAIVING COST-SHARING FOR CERTAIN MEDICAL CARE FOR DEPENDENTS OF PERSIAN GULF VETERANS WHO MAY HAVE BEEN EXPOSED TO ENVIRONMENTAL HAZARDS.

(a) REPORT.—The Secretary of Veterans Affairs shall submit to Congress a report on the desirability and the feasibility of waiving any requirement for cost-sharing in the case of medical care described in subsection (b) that is provided by a VA health plan under chapter 18 of title 38, United States Code (as added by section 15001), to an individual who is a VA enrollee enrolled under family-member eligibility under section 1813 of that chapter.

(b) PERSIAN GULF WAR ILLNESS.—Medical care referred to in subsection (a) is medical care provided to a family member of a veteran described in subparagraph (C) of section 1710(e)(1) of title 38, United States Code, for any disease or disability occurring in that family member which the Secretary finds may be related to the service of the veteran in the Southwest Asia theater of operations during the Persian Gulf War.

(c) MATTERS TO BE CONSIDERED.—In preparing the report under subsection (a), the Secretary shall consider relevant studies, including those that have been (or that are being) conducted by the Department of Veterans Affairs, the Department of Defense, the National Institutes of Health, the National Academy of Sciences, and private health care providers.

(d) SUBMISSION OF REPORT.—The report under subsection (a) shall be submitted not later than 60 days after the date of the enactment of this Act.

SEC. 15008. STUDY OF THE EFFECT OF TELEMEDICINE ON THE DELIVERY OF VA HEALTH CARE SERVICES.

(a) IN GENERAL.—During each of fiscal years 1995 through 1997, the Secretary of Veterans Affairs shall carry out a study of the effect of telemedicine on the delivery, accessibility, and quality of health care services available to individuals who are eligible for enrollment in a Department of Veterans Affairs health care plan.

(b) REPORTS.—Not later than 120 days after the date of the enactment of this Act and annually thereafter through 1998, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report, including descriptions of the telemedicine applications benefiting veterans, relating to the study conducted under subsection (a).

(c) CONSULTATION.—Each study under subsection (a) shall be carried out in consultation with the Secretary of Health and Human Services, the Secretary of Defense, the Chair of the White House Information Infrastructure Task Force, and the Director of High Performance Computing and Communications in the Executive Office of the President.

SEC. 15009. CONFORMING REDUCTION IN DISCRETIONARY SPENDING LIMITS.

(a) REDUCTION IN LIMITS.—To reflect the change in certain veterans' health activities from discretionary to mandatory, the spending limits for the discretionary category set forth in section 601(a)(2) of the Congressional Budget Act of 1974 (as adjusted in conformance with section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985) are hereby reduced as follows:

(1) for fiscal year 1996, $2,170,000,000 in new budget authority and in outlays;

(2) for fiscal year 1997, $6,020,000,000 in new budget authority and in outlays; and

(3) for fiscal year 1998, $15,650,000,000 in new budget authority and in outlays.

(b) DEFICIT REDUCTION INCLUDED ON PAY-AS-YOU-GO SCORECARD.—The reduction in the discretionary outlay limits under subsection (a) shall be considered a reduction in pay-as-you-go outlays for purposes of estimates made for this Act under section 252(d) of the Balanced Budget and Emergency Deficit Control Act of 1985 (in addition to any other pay-as-you-go amount estimated for purposes of that section as a result of the enactment of this Act).

SEC. 15010. EFFECTIVE DATES.

(a) CHAPTER 18.—The provisions of chapter 18 of title 38, United States Code, as added by section 15001, shall take effect on October 1, 1996.

(b) CHAPTER 17 ELIGIBILITY REFORM.—The amendments made by section 15003 shall take effect on October 1, 1996.

(c) ADMINISTRATIVE MATTERS.—The provisions of sections 7343 and 7344 of title 38, United States Code, as added by 15002(a), shall take effect on the date of the enactment of this Act.

(d) EARLY ENROLLMENT.—The Secretary of Veterans Affairs may commence enrollment under chapter 18 of title 38, United States Code, as added by section 15001, and otherwise carry out activities related to preparation for the conduct of health care activities in the form of health plans effective as of the date of the enactment of this Act.

TITLE XVI—INDIAN HEALTH SERVICE

SEC. 16001. POLICY.

Section 3(a) of the Indian Health Care Improvement Act (25 U.S.C. 1602(a)) is amended to read as follows:

"(a) The Congress hereby declares that it is the policy of this Nation, in fulfillment of its unique trust responsibility and legal obligation to the American Indian and Alaska Native people—

"(1) to assure the highest possible health status for American Indians and Alaska Natives,

"(2) to raise the quality of health care delivery to American Indians and Alaska Natives to the highest possible level,

"(3) to provide health care services in a culturally appropriate manner which is consistent with the policies of Indian self-determination and tribal self-governance, and

"(4) to provide all resources necessary to effect paragraphs (1) through (3).".

SEC. 16002. HEALTH SECURITY FOR INDIANS.

The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended by adding at the end the following new title:

"TITLE IX—HEALTH SECURITY FOR INDIANS

"SEC. 901. DEFINITIONS.

"For the purposes of this title:

"(1) GUARANTEED NATIONAL BENEFIT PACKAGE.—The term 'guaranteed national benefit package' has the meaning given such term in section 2(5) of the Guaranteed Health Insurance Act of 1994.

"(2) HEALTH PROGRAM OF THE SERVICE.—The term 'health program of the Service' means a facility or plan which provides or arranges for the provision of health services through one or more programs operated by the Service, by a health program of an Indian tribe, or by an urban Indian program operated pursuant to title V.

"(3) HEALTH PROGRAM OF AN INDIAN TRIBE.—The term 'health program of an Indian tribe' means a program which provides or arranges for the provision of health services and is operated by an Indian tribe, tribal organization, or group of Indian tribes or tribal organizations.

"(4) FAMILY.—The term 'family' has the meaning given such term in section 3 of the Guaranteed Health Insurance Act of 1994.

"(5) CERTIFIED HEALTH PLAN.—The term 'certified health plan' has the meaning given such term in section 2(2) of the Guaranteed Health Insurance Act of 1994.

"SEC. 902. ELIGIBILITY AND HEALTH SERVICE COVERAGE OF INDIANS.

"(a) ELIGIBILITY.—

"(1) IN GENERAL.—An eligible individual (as defined in section 1001(c) of the Guaranteed Health Insurance Act of 1994) is eligible to enroll in a health program of the Service if the individual is—

"(A) eligible to receive services pursuant to sections 36.1—36.14 of title 42, Code of Federal Regulations (1986);

"(B) an urban Indian; or

"(C) an Indian described in section 809(b).

"(2) ELECTION TO ENROLL OTHER TRIBAL MEMBERS.—In addition to those individuals made eligible to enroll in a health program of the Service under paragraph (1), a tribe, which operates a health program directly or through a tribal organization, may elect to offer enrollment in a health program of the Service to members of the tribe, regardless of their residency or domicile.

"(b) ENROLLMENT.—

"(1) AUTOMATIC ENROLLMENT IN HEALTH PROGRAM OF THE SERVICE.—The Service shall enroll an individual described in subsection (a)(1) in the health program of the Service in which the individual was last an active user unless the individual elects to enroll in—

"(A) another certified health plan,

"(B) another health program of the Service, or

"(C) medicare part C program (established under title XXI of the Social Security Act).

"(2) ELECTIVE ENROLLMENT IN HEALTH PROGRAM OF THE SERVICE.—The Service shall permit an individual described in subsection (a) who is not an active user to enroll in a health program of the Service.

"(3) CONSTRUCTION.—Nothing in paragraph (1) shall prevent an individual referred to in such paragraph from disenrolling from the health plan of the Service in order to enroll in another certified health plan or to become a medicare part C eligible individual.

"(c) LIMITATION ON CHARGES.—An individual who is eligible under subsection (a) and who enrolls in a health program of the Service shall not be subject to any charge for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services provided under such program.

"SEC. 903. PROVISION OF HEALTH SERVICES TO NON-ENROLLEES AND NON-INDIANS.

"(a) PROVISION OF HEALTH SERVICES TO NON-INDIAN FAMILY MEMBERS OF INDIANS.—

"(1) IN GENERAL.—A health program of the Service may provide health services to family members of individuals described in section 902(a) if the tribe, tribes, or urban Indian organization served by the program authorizes the provision of services to such family members.

"(2) ENROLLMENT IN A HEALTH PROGRAM OF THE SERVICE.—

"(A) ELECTION.—If a health program of the Service opens enrollment pursuant to paragraph (1) to family members of individuals described in section 902(a), such program shall permit such individuals to elect family enrollment in such program.

"(B) ENROLLMENT.—

"(i) IN GENERAL.—An individual who elects family enrollment under subparagraph (A) in a health program of the Service shall enroll in such program.

"(ii) APPLICABLE INDIVIDUAL CHARGES.—The individual who enrolls in such program under clause (i) is not subject to any charge for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services provided under such program attributable to the individual, but the family members who are not eligible for a health program of the Service under section 902(a) are subject to all such charges.

(b) CONTRACTS WITH CERTIFIED HEALTH PLANS.—A health program of the Service may enter into a contract with a certified health plan that is not a health program of the Service for the provision of health care services to individuals enrolled in such certified health plan if the tribe, tribes, or urban Indian organization served by the health program of the Service—

"(1) authorizes serving non-Indians, and

"(2) determines that allowing such services to non-Indians will not result in a denial or diminution of health services to any individual described in section 902(a) who is enrolled in a health program of the Service.

"(c) PROVISION OF HEALTH SERVICES AS AN ESSENTIAL COMMUNITY PROVIDER.—A health program of the Service may elect to provide services as an essential community provider under section 5012 of the Guaranteed Health Insurance Act of 1994 if the authorization and determination specified in paragraphs (1) and (2) of subsection (b) are made.

"(d) PROVISION OF HEALTH SERVICES AS A CERTIFIED HEALTH PLAN.—A health program of the Service may elect to offer the guaranteed national benefit package to individuals not described in subsection (a) of this section or section 902(a), or as a certified health plan under title V of the Guaranteed Health Insurance Act of 1994, if the authorization and determination specified in paragraphs (1) and (2) of subsection (b) are made.

"(e) PROVISION OF HEALTH SERVICES AS A PROGRAM OTHER THAN A CERTIFIED HEALTH PLAN OR AN ESSENTIAL COMMUNITY PROVIDER.—A health program of the Service that is not a certified health plan under title V of the Guaranteed Health Insurance Act of 1994 may provide health services to individuals who are not described in subsection (a) of this section or section 902(a) if the authorization and determination specified in paragraphs (1) and (2) of subsection (b) are made.

"SEC. 904. PROVISION OF GUARANTEED NATIONAL BENEFIT PACKAGE.

"Effective January 1, 1999, the Secretary shall ensure that all health programs of the Service provide or arrange for the provision of the guaranteed national benefit package to individuals described in section 902(a).

"SEC. 905. ADMINISTRATIVE PROVISIONS.

"(a) REIMBURSEMENT FOR SERVICES PROVIDED TO INDIANS ENROLLED IN OTHER HEALTH PROGRAMS OF THE SERVICE.—A health program of the Service shall reimburse another health program of the Service for services provided to its enrollees in accordance with such reimbursement provisions as the Secretary determines to be appropriate.

"(b) RETENTION OF RECEIPTS.—

"(1) IN GENERAL.—Amounts received by a health program of the Service pursuant to this title, the Guaranteed Health Insurance Act of 1994, or an amendment made by the Guaranteed Health Insurance Act of 1994 for the delivery of health services shall remain with and may be expended by the health program of the Service.

"(2) AVAILABILITY OF FUNDS FOR EXPENDITURE BY A HEALTH PROGRAM OF THE SERVICE.—Amounts available to a health program of the Service pursuant to this subsection shall be available without further appropriation and shall remain available until expended, first for payments for the delivery of the items and services in the guaranteed national benefit package and then for other services offered by the health program of the Service, including supplemental Indian health care benefits described in section 905(g).

"(c) RISK SHARING.—

"(1) AGGREGATION OF RECEIPTS.—Health programs of the Service may aggregate fund receipts (including from contracts and subcontracts) for the purposes of retaining risk on a partial or full risk basis.

"(2) REINSURANCE POOLS.—The Secretary may establish reinsurance pools on a local, regional, or national basis—

"(A) for health programs of the Service operated by the Service,

"(B) for health programs of an Indian tribe or an urban Indian organization, at the request of the tribe, tribes, tribal organization, or urban Indian organizations concerned, or

"(C) any combination thereof, if authorized by the tribe, tribes, tribal organization, or urban Indian organizations concerned.

"(d) PAYMENT FOR SERVICES PROVIDED BY CONTRACTORS.—Nothing in this title, the Guaranteed Health Insurance Act of 1994, or an amendment made by the Guaranteed Health Insurance Act of 1994 shall be construed as—

"(1) affecting any other provision of law, regulation, or judicial or administrative interpretation of law or policy concerning the status of the Service as the payor of last resort (as defined in part 36 of title 42, Code of Federal Regulations) for Indians eligible for contract health services under a health program of the Service; or

"(2) amending or modifying section 206 of this Act (relating to reimbursement from certain third parties of costs of health services).

"(e) HEALTH PROFESSIONAL SERVICES.—With respect to any individual enrolled in a health program of the Service, in applying the guaranteed national benefit package the term 'health professional services' includes health services provided by a traditional Indian healer.

"(f) DISPOSITION OF SUBSIDIES AND EMPLOYER PREMIUMS TRANSFERRED FROM THE SECRETARY OF THE TREASURY.—With respect to amounts paid to the Secretary under section 2124(c)(2)(C) of the Social Security Act, the Secretary shall promptly provide for the appropriate distribution of such amounts to such health programs of the Service as provide services to employees and family members with respect to which such payments are made. The Secretary may not offset or limit the amount of funds obligated to any health program of the Service because of receipt of funds under this section.

"(g) FACILITATION OF APPLICATION FOR PREMIUM CERTIFICATES.—The Service shall take such actions as may be necessary to facilitate the application for premium certificates under part A of title XXII of the Social Security Act by individuals described in section 902(a).

"(h) SUPPLEMENTAL INDIAN HEALTH CARE BENEFITS.—All individuals described in section 902(a) remain eligible for all services provided under the laws administered by the Service which supplement the guaranteed national benefit package. The individual shall not be subject to any charge or any other cost for such benefits.

"(i) MEDICAL RESIDENCY TRAINING PROGRAMS.—Consistent with the provisions of subtitle A of title VII of the Guaranteed Health Insurance Act of 1994, the Secretary shall develop training sites for medical residency training programs in primary care in health programs of the Service.

"SEC. 906. LONG-TERM CARE FOR HOME AND COMMUNITY-BASED SERVICES.

"(a) DISTRIBUTION OF SET-ASIDE FOR HOME AND COMMUNITY-BASED SERVICES TO CERTAIN INDIVIDUALS.—The Service shall provide for the fair and equitable distribution of funds received under section 10006(c) of the Guaranteed Health Insurance Act of 1994 to Indian tribes and tribal organizations for the provision of home and community-based services to individuals described in section 902(a) and enrolled family members under section 903(a) of this title with severe disabilities (as defined in section 10002 of the Guaranteed Health Insurance Act of 1994).

"(b) FEDERAL QUALITY STANDARDS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), an Indian tribe or tribal organization may receive funds under subsection (a) if the tribe or tribal organization meets the quality standards prescribed by the Secretary under title X of the Guaranteed Health Insurance Act of 1994 for the provision of home and community-based services for individuals with severe disabilities.

"(2) EXCEPTION.—No Indian or family member of an Indian served through a health program of the Service shall be required to participate in cost sharing for services provided under this section.

"SEC. 907. CAPITAL INVESTMENT AND TRANSITIONAL ASSISTANCE.

"(a) CAPITAL FINANCING.—

"(1) ESTABLISHMENT OF PROGRAM.—There is established in the Service a revolving loan program. Under the program, the Secretary, acting through the Service, shall provide guaranteed loans from the amounts appropriated pursuant to paragraph (5) to health programs of an Indian tribe and urban Indian organizations.

"(2) USE OF FUNDS.—Loans made under paragraph (1) may be used for the construction and renovation of hospitals, health centers, health stations, and other facilities of the Service, tribes, tribal organizations, and urban Indian organizations for the purpose of improving and expanding such facilities to enable the delivery of the full array of items and services guaranteed in the guaranteed national benefit package.

"(3) TERMS AND CONDITIONS.—Guaranteed loans under paragraph (1) shall be subject to such terms and conditions as the Secretary may prescribe, to assure that funds are used in a manner consistent with paragraph (2).

"(4) ELIGIBILITY FOR OTHER FUNDING.—Receipt of a guaranteed loan under paragraph (1) shall not prevent such health programs from obtaining loans or loan guarantees pursuant to section 2802(a)(2)(A) of the Public Health Service Act.

"(5) AGGREGATE CAPITAL FINANCING FUNDING LEVELS.—For purposes of paragraph (1), there is authorized to be appropriated $500,000,000 for each of the fiscal years 1995 through 1997.

"(b) TRANSITIONAL ASSISTANCE.—

"(1) IN GENERAL.—There is authorized to be appropriated $200,000,000 for each of the fiscal years 1995 through 2000 to provide transitional assistance to the Service and to Indian tribes, tribal organizations, and urban Indian organizations to provide the guaranteed national benefit package.

"(2) GRANTS TO TRIBES AND TRIBAL ORGANIZATIONS.—Subject to the availability of appropriations under paragraph (1), the Service shall make grants to assist Indian tribes, tribal organizations, and urban Indian organizations, under such terms and conditions as the Secretary determines, in developing the capacity (including the establishment of computerized information and billing systems) to deliver or arrange for the delivery of services under the guaranteed national benefit package.

"SEC. 908. TREATMENT OF INDIANS ENTITLED TO VETERANS BENEFITS.

"(a) IN GENERAL.—In the case of an individual described in section 902(a) who is enrolled in a health program of the Service and is a veteran who receives items and services in the guaranteed national benefit package through the Secretary of Veterans' Affairs, the Service shall not be required to provide reimbursement to such Secretary for such items and services.

"(b) COOPERATIVE AGREEMENTS.—The Secretary shall enter into a cooperative service and payment agreement with the Secretary of Veterans' Affairs to assure that veterans who are described in section 902(a) and also eligible for enrollment in a health plan operated by the Department of Veterans' Affairs are entitled to fully participate in either health plan without payment premiums, copayments, deductibles, or coinsurance.

"(c) SURVEY OF HEALTH SERVICES AVAILABLE TO INDIAN VETERANS.—

"(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Veterans Affairs, Indian tribes and tribal organizations, shall conduct a survey to assess the availability and accessibility of health care services for Indian veterans residing on Indian reservations.

"(2) REPORT.—Not later than 180 days after the date of enactment of this title, the Secretary shall submit a report to the Congress, including recommendations, concerning the survey conducted under paragraph (1).".

SEC. 16003. TREATMENT OF PAYMENTS UNDER MEDICARE AND MEDICAID PROGRAMS.

(a) HEALTH CARE FACILITIES.—

(1) MEDICARE.—Section 401(a) of the Indian Health Care Improvement Act (25 U.S.C. 1641) is amended by striking "facility of the Service (whether operated by the Service or by an Indian tribe or tribal organization pursuant to a contract under the Indian Self-Determination Act)" and inserting "of a health program of the Service (as defined in section 901(2))".

(2) MEDICAID.—Section 402 of the Indian Health Care Improvement Act (25 U.S.C. 1642) is amended—

(A) in the first sentence of subsection (a)—

(i) by striking "facility of the Service" and inserting "health program of the Service (as defined in section 901(2))"; and

(ii) by striking "such Service" and inserting "such health programs of the Service";

(B) in the second sentence of subsection (a), by striking "the facilities of the Service" and inserting "such health programs of the Service"; and

(C) in subsection (b), by striking "such facility" and inserting "such health program of the Service".

SEC. 16004. ANNUAL CONSULTATION CONCERNING HEALTH CARE INITIATIVES.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.) is amended—

(1) redesignating section 603 as section 604; and

(2) by inserting after section 602 the following:

"ANNUAL CONSULTATION AND NATIONAL INDIAN HEALTH ADVISORY GROUP

"SEC. 603. (a) The Secretary shall consult annually with representatives of Indian tribes, tribal organizations, and urban Indian organizations concerning health care initiatives that affect Indian communities and concerning policy, funding, and administration of health programs of the Service (as defined in section 901(2)). The Secretary shall solicit and consider the views and recommendations provided by Indian tribes, tribal organizations, and urban Indian organizations in making determinations that affect Indians and Indian tribes.

"(b)(1) The Secretary shall establish a national Indian advisory group to assess and advise the Secretary on all aspects of the administration of health programs of the Service (as defined in section 901(2)), including development of the budget for such programs.

"(2) The advisory group shall be composed of not less than one representative from each Service area, to be appointed by the Secretary from nominees of tribes and tribal organizations in the respective areas and such other appointees as the Secretary determines appropriate, except that a majority of the members must have been nominated by a tribe or tribal organization.

"(3) The advisory group shall submit such reports as may be necessary to the Congress.".

SEC. 16005. PREEMPTION OF STATE REGULATORY AUTHORITY.

A State (or an entity of a State) may not impose any standard or requirement on a health program of the Service (as defined in section 901(2) of the Indian Health Care Improvement Act) that is inconsistent with this Act or any regulation prescribed under this Act or the Indian Health Care Improvement Act regarding the operation of any such health program of the Service.

SEC. 16006. RULES OF CONSTRUCTION.

Unless otherwise provided by this Act or an amendment made by this Act, no part of this Act or any such amendment shall be construed to rescind or otherwise modify any obligations, findings, or purposes contained in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) and in the Indian Self-Determination and Education Assistance Act.

SEC. 16007. PROHIBITION ON REDUCTIONS OF FULL-TIME EQUIVALENT POSITIONS IN THE INDIAN HEALTH SERVICE.

(a) PROHIBITION.—Notwithstanding any other provision of law and until January 1, 1999, no reduction may be made in the number of full-time equivalent positions in the Indian Health Service from the number of such positions on September 30, 1994.

(b) EXEMPTION.—During the period that the prohibition specified in subsection (a) is effective, no restriction imposed by law on hiring by executive agencies for the purpose of achieving workforce reductions shall apply to the Indian Health Service, including section 5 of the Federal Workforce Restructuring Act of 1994 (5 U.S.C. 3101 note).

(c) RULE OF CONSTRUCTION.—No law may be construed as suspending or modifying this section unless such law specifically refers to or amends this section.

TITLE XVII—MEDICAL MALPRACTICE AND ANTITRUST REFORMS

Subtitle A—Medical Malpractice

PART 1—LIABILITY REFORM

SEC. 17001. DEFINITIONS.

In this subtitle, the following definitions apply:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM.—The term "alternative dispute resolution system" means a system that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice liability actions.

(2) ARBITRATION.—The term "arbitration" means a nonjury, adversarial dispute resolution process that may result in a final decision as to fact, law, liability, or damages.

(3) CLAIMANT.—The term "claimant" means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(4) CONTINGENCY FEE.—The term "contingency fee" means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

(5) FUTURE DAMAGES.—The term "future damages" means damages for economic or noneconomic loss incurred after the time of judgment.

(6) HEALTH CARE PROFESSIONAL.—The term "health care professional" means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(7) HEALTH CARE PROVIDER.—The term "health care provider" means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(8) INJURY.—The term "injury" means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice claim.

(9) MANDATORY.—The term "mandatory" means required to be used by the parties to attempt to resolve a medical malpractice claim notwithstanding any other provision of an agreement, State law, or Federal law.

(10) MEDIATION.—The term "mediation" means a settlement process coordinated by a neutral third party and without the ultimate rendering of a formal opinion as to factual or legal findings.

(11) MEDICAL MALPRACTICE CLAIM.—The term "medical malpractice claim" means a claim against a health care provider, a health care professional, or a blood or tissue bank licensed or registered by the Food and Drug Administration in which a claimant alleges that injury was caused by the provision of (or the failure to provide) health care services, except that such term does not include—

(A) any claim based on an allegation of an intentional tort;

(B) any claim based on an allegation that a product is defective or unreasonably dangerous, or fails to contain an adequate warning; or

(C) any claim brought pursuant to subtitle D of title IX.

(12) MEDICAL MALPRACTICE LIABILITY ACTION.—The term "medical malpractice liability action" means a civil action brought in a State or Federal court against a health care provider, a health care professional, or a blood or tissue bank licensed or registered by the Food and Drug Administration in which the plaintiff alleges a medical malpractice claim.

SEC. 17002. FEDERAL TORT REFORM.

(a) IN GENERAL.—Except as provided in section 17003, this part shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this part shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(b) PREEMPTION.—The provisions of this part shall preempt any State law to the extent such law is inconsistent with such provisions.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this part shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this part shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 17003. ALTERNATIVE DISPUTE RESOLUTION METHODS.

(a) APPLICATION TO MALPRACTICE CLAIMS.—In any medical malpractice liability action, the alternative dispute resolution systems adopted under subsection (b) shall be available to the claimant. Participation in any of such systems shall be in lieu of any alternative dispute resolution method required by any other law or by any contractual arrangement made by or on behalf of the parties before the commencement of the action.

(b) STATE ADOPTION OF ALTERNATIVE DISPUTE RESOLUTION METHODS—Each State shall—

(1) adopt at least one of the alternative dispute resolution methods specified under subsection (c) for the resolution, subject to subsection (d), of medical malpractice claims;

(2) disclose to residents of the State the availability and procedures for resolution of consumer grievances regarding the provision of (or failure to provide) health care services, including the alternative dispute resolution methods applicable under paragraph (1); and

(3) provide that the alternative dispute resolution process may begin before or after, at the option of the claimant, the commencement of a medical malpractice liability action.

(c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE DISPUTE RESOLUTION METHODS.—

(1) IN GENERAL.—The Attorney General, in consultation with the Secretary, shall, by regulation, develop requirements with respect to the following alternative dispute resolution methods for the adoption by States:

(A) MANDATORY MEDIATION.—Mandatory mediation conducted by one or more mediators who are selected by agreement of the parties or, if the parties do not agree, who are qualified under applicable State law and selected by the court.

(B) ARBITRATION.—Arbitration entered into by agreement of the parties.

(2) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under paragraph (1), the Attorney General, in consultation with the Secretary, shall ensure that the methods promote the resolution of medical malpractice claims in a manner that—

(A) is affordable for the parties involved;

(B) encourages timely resolution of claims;

(C) encourages the consistent and fair resolution of claims;

(D) provides for reasonably convenient access to dispute resolution; and

(E) in the case of arbitration, provides rules for limiting the use of experts, for expediting discovery, and for waiving applicable rules of evidence.

(d) FURTHER REDRESS AND ADMISSIBILITY.—Any party dissatisfied with a determination reached with respect to a medical malpractice claim as a result of an alternative dispute resolution method applied under this section shall not be bound by such determination. The results of any alternative dispute resolution method applied under this section, and all statements, offers, and communications that originate during the application of such method, shall be inadmissible for purposes of adjudicating the claim.

SEC. 17004. REQUIREMENT FOR AFFIDAVIT OF MERIT.

(a) REQUIRING SUBMISSION WITH COMPLAINT.—No medical malpractice liability action may be brought by any individual unless, at the time the individual brings the action (except as provided in subsection (b)(1)), the individual (or the individual's attorney) submits an affidavit declaring that—

(1) the individual (or the individual's attorney) has consulted and reviewed the facts of the action with a qualified specialist;

(2) the individual (or the individual's attorney) has obtained a written report by a qualified specialist that clearly identifies the individual and that includes the specialist's statement of belief that, based on a review of the available medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant; and

(3) on the basis of the qualified specialist's review and consultation, that the individual (or the individual's attorney) has concluded that there is a reasonable and meritorious cause for the filing of the action.

(b) EXTENSION IN CERTAIN INSTANCES.—

(1) IN GENERAL.—Subject to paragraph (2), subsection (a) shall not apply with respect to an individual who brings a medical malpractice liability action without submitting an affidavit described in such subsection if—

(A) the individual is unable to obtain the affidavit before the expiration of the applicable statute of limitations;

(B) as of the time the individual brings the action, the individual has been unable to obtain adequate medical records or other information necessary to prepare the affidavit; or

(C) other good cause exists for failing to submit the affidavit.

(2) DEADLINE FOR SUBMISSION WHERE EXTENSION APPLIES.—In the case of an individual who brings an action for which paragraph (1) applies, the action shall be dismissed unless the individual (or the individual's attorney) submits the affidavit described in subsection (a) not later than—

(A) in the case of an action for which subparagraph (A) of paragraph (1) applies, 90 days after bringing the action;

(B) in the case of an action for which subparagraph (B) of paragraph (1) applies, 90 days after obtaining the information described in such subparagraph; or

(C) in the case of an action for which subparagraph (C) of paragraph (1) applies, 90 days after the good cause involved ceases to exist.

(c) QUALIFIED SPECIALIST DEFINED.—In subsection (a), a "qualified specialist" means, with respect to a medical malpractice liability action, a health care professional who is reasonably believed by the individual bringing the action (or the individual's attorney)—

(1) to be knowledgeable in the relevant issues involved in the action, and

(2) to practice (or to have practiced) or to teach (or to have taught) in the same, or a substantially similar, area of health care or medicine that is at issue in the action.

(d) SANCTIONS FOR SUBMITTING FALSE ALLEGATIONS.—Upon the motion of any party or its own initiative, the court in a medical malpractice liability action may impose a sanction on a party or the party's attorney (or both), including a requirement that the party reimburse the other party to the action for costs and a reasonable attorney's fee, if an affidavit described in subsection (a) is submitted without reasonable cause and is found to be untrue.

(e) CONFIDENTIALITY OF SPECIALIST.—Upon a showing of good cause by a defendant, the court may ascertain the identity of a specialist referred to in subsection (a) while preserving confidentiality.

SEC. 17005. LIMITATION ON AMOUNT OF ATTORNEYS' CONTINGENCY FEES.

(a) IN GENERAL.—

(1) AUTHORITY TO ENTER INTO CONTINGENCY FEE AGREEMENTS.—Notwithstanding any State law, an individual who intends to bring a medical malpractice liability action and an attorney may enter into an agreement for the payment of—

(A) a fee, on a contingency fee basis for services in connection with the resolution of the action, up to 33⅓ percent of the total amount recovered (exclusive of costs) by judgment or settlement; and

(B) an additional reasonable fee, subject to the approval of the court, for services in connection with any appeal of a judgment in the action.

(2) EXCLUSION OF OTHER FEES.—An attorney who represents, on a contingency fee basis, a plaintiff in a medical malpractice liability action may not charge, demand, receive, or collect for services rendered in connection with the action any fee in excess of the maximum fee payable under paragraph (1).

(b) CALCULATION IN CASE OF PERIODIC PAYMENTS.—For purposes of computing under subsection (a) the limitation on contingency fees, the value of future damages recovered in a judgment or settlement and to be paid on a periodic basis shall be based on the present value of such payments calculated according to an appropriate discount rate. The balance of the judgment or settlement shall then be paid in accordance with the schedule determined under section 17006.

SEC. 17006. PERIODIC PAYMENT OF AWARDS.

(a) AUTHORITY TO PERMIT PERIODIC PAYMENTS.—The court may instruct the trier of fact to find, or may otherwise order that, part or all of future damages that exceed $250,000 be paid on an appropriate periodic basis. The court shall ensure that the amount and present value of periodic payments constitute full recovery of the damages awarded for the claimant's injury and that the payment schedule is found to be in the best interests of all the parties to the action.

(b) BOND OR SECURITY FOR FUTURE DAMAGES.—If future damages are awarded on a periodic basis, the court shall require the defendant to post security or a bond, or otherwise ensure the full payment of such damages.

(c) MODIFICATION OF PAYMENT SCHEDULE.—Except where the parties agree otherwise, in a medical malpractice liability action, the court shall retain authority to modify, on the basis of changed circumstances, the payment schedule of any periodic payments of future damages awarded in the action.

(d) DEATH OF PLAINTIFF.—Except where the parties agree otherwise, if a plaintiff to whom future damages are awarded in a medical malpractice liability action and made payable on a periodic basis dies before completion of the payment of such damages, the court shall order the payment of any remaining portion of such damages be paid to the estate of the plaintiff.

PART 2—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 17011. PILOT PROGRAM APPLYING PRACTICE GUIDELINES TO MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) ESTABLISHMENT.—Not later than 1 year after the Secretary determines that appropriate practice guidelines are available (including clinical practice guidelines developed under title IX of the Public Health Service Act) and were developed with the input of health care providers, legal professionals, and consumer representatives, the Secretary, in consultation with the Attorney General, shall establish a pilot program under which the Secretary shall provide funds (in such amount as the Secretary considers appropriate) to one or more eligible States to determine the effect of applying practice guidelines in the resolution of medical malpractice liability actions.

(b) ELIGIBILITY OF STATE.—A State is eligible to participate in the pilot program established under subsection (a) if the State submits an application to the Secretary (at such time and in such form as the Secretary may require) containing—

(1) assurances that, under the law of the State, in the resolution of any medical malpractice liability action based on conduct addressed by an appropriate practice guideline, that—

(A) compliance with the guideline shall be admissible by any party in a medical malpractice liability action and shall be sufficient to establish a rebuttable presumption that there is no liability for medical malpractice for conduct that is within the scope of the guideline; and

(B) noncompliance with the guideline shall be admissible by any party in a medical malpractice liability action and shall be sufficient to establish a rebuttable presumption that there is liability for medical malpractice for conduct that is within the scope of the guideline; and

(2) such other information and assurances as the Secretary may require.

(c) SELECTION OF PARTICIPATING STATES.—In selecting a State to participate in the pilot project established under subsection (a), the Secretary shall determine whether the practice guideline described in the application submitted under subsection (b)—

(1) is appropriate for purposes of resolving medical malpractice liability actions based on conduct addressed by such guideline; and

(2) was developed with the input of health care providers, legal professionals, and consumer representatives.

(d) REPORTS TO CONGRESS.—Not later than 3 months after the last day of each year throughout which the pilot program established under subsection (a) is in effect, the Secretary shall submit, to the Speaker of the House of Representatives and the President pro tempore of the Senate, a report describing the operation of the program during the previous year and containing such recommendations as the Secretary considers appropriate, including recommendations relating to revisions to the laws governing medical malpractice liability.

SEC. 17012. FEDERAL STUDY ON MEDICAL MALPRACTICE.

(a) STUDY.—In order to improve the level of empirical data on the incidence and effect of medical malpractice in the United States, the Secretary, in consultation with the Attorney General, shall carry out a nationwide interdisciplinary study of medical malpractice, including an evaluation of—

(1) the incidence of injuries resulting from medical treatment and the percentage of such injuries that resulted from the medical malpractice by a health care provider or health care professional;

(2) the costs of medical expenses and lost wages to the victims of medical malpractice and their families, and their compensation for such losses under current law;

(3) the costs of legal expenses associated with medical malpractice liability actions, including attorneys' fees that are not paid on a contingency fee basis;

(4) the number of medical malpractice claims brought and their impact on the legal system;

(5) methods to reduce the incidence and costs of medical malpractice;

(6) the cost of medical malpractice insurance and methods for reducing such cost; and

(7) methods to promote the efficient and fair resolution of legal claims stemming from the incidence of medical malpractice, including methods of resolving small medical malpractice claims in a more efficient and less costly basis.

(b) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall submit, to the Speaker of the House of Representatives and the President pro tempore of the Senate, a report describing the results of the evaluation required by subsection (a).

Subtitle B—McCarran-Ferguson Reform

SEC. 17101. SHORT TITLE.

This subtitle may be cited as the "Insurance Competitive Pricing Act of 1994".

SEC. 17102. RULES OF CONSTRUCTION.

The amendments made by this subtitle preserve—

(1) the provisions relating to State taxing and regulatory authority in section 2 of the Act of March 9, 1945 (59 Stat. 34; 15 U.S.C. 1012), commonly known as the McCarran-Ferguson Act;

(2) the availability, to persons engaged in the business of insurance, of the defense of State action in the same manner and to the same extent as such defense is available to other persons;

(3) the availability, to persons engaged in the business of insurance, of any antitrust immunity or defense that may be applicable under law other than the McCarran-Ferguson Act;

(4) the legal standards applicable under the McCarran-Ferguson Act, as in effect before such Act is amended by this subtitle, to all

conduct described in the safe harbors found in subparagraphs (B), (C), (D), and (E) of section 2(b)(1) of the McCarran-Ferguson Act, as amended by this subtitle; and

(5) the provisions relating to boycott, coercion, or intimidation in section 3(b) of the McCarran-Ferguson Act.

SEC. 17103. AMENDMENTS.

Section 2 of the Act of March 9, 1945 (59 Stat. 34; 15 U.S.C. 1012), commonly known as the McCarran-Ferguson Act, is amended—

(1) in subsection (b)—

(A) by striking ": *Provided,*" and all that follows through "law." and inserting the following:

"except as follows:

"(1)(A) The antitrust laws shall be applicable to the business of insurance except as provided in subparagraphs (B), (C), (D), and (E).

"(B) The antitrust laws shall not be applicable to conduct that consists of making an agreement or engaging in joint conduct—

"(i)(I) to collect, compile, classify, or disseminate historical data;

"(II) to develop procedures to collect, compile, classify, or disseminate historical data; or

"(III) to verify that historical data is accurate and complete;

"(ii) to determine, using standard actuarial techniques, or disseminate, a loss development factor or developed losses;

"(iii) to develop or disseminate a standard insurance policy form (including a standard addendum to an insurance policy form and standard terminology in an insurance policy form) if such agreement or joint conduct does not include an agreement to adhere to such standard form, or to require adherence to such standard form, except that the fact that 2 or more persons engaged in the business of insurance use such standard form—

"(I) shall not be sufficient in itself to support a finding that an agreement to adhere, or to require adherence, to such standard form exists; and

"(II) may be used only for the purpose of supplementing or explaining direct evidence of the existence of an agreement to adhere, or to require adherence, to such standard form;

"(iv) to develop or disseminate, for use in providing insurance in a State, a manual that is filed, before dissemination, with the State entity that regulates the business of insurance under State law, if such manual includes only—

"(I) information and conduct described in clauses (i), (ii), and (iii), including relativity factors;

"(II) during the transition period, a trend factor or information to which a trend factor has been applied, to the extent permitted under subparagraph (C); and

"(III) explanations and instructions for using the manual (or any of the information contained in the manual), if such agreement or joint conduct does not include an agreement among competitors to adhere, or to require adherence, to any of such explanations or instructions;

"(v) to provide insurance pursuant to a public necessity market mechanism;

"(vi) to provide insurance as a historical underwriting capacity risk pool;

"(vii) to administer a public necessity market mechanism in a State, pursuant to the authorization of and under the supervision of such State, if all persons who provide insurance in such State pursuant to such mechanism, and all persons seeking to obtain insurance through such mechanism, have a reasonable opportunity to appeal determinations affecting them to a governmental entity;

"(viii) to develop or participate in a program to inspect commercial buildings and fire protection facilities, and evaluate government building code requirements and enforcement of such requirements, to determine the likelihood and potential extent of loss due to fire, wind, hail, earthquake, flood, or tidal wave, pursuant to a State law that provides procedures for making such a determination and provides a reasonable opportunity for an affected person to appeal such a determination to a governmental entity; or

"(ix) to develop or participate in a program, pursuant to a workers' compensation insurance plan filed with the State entity that regulates the business of insurance under State law, to measure an employer's experience with respect to occupational accidents and illnesses for which such employer is liable, against the comparable experience of other employers, and to make a modification for an individual employer based on such comparisons, if an affected employer has a reasonable opportunity to appeal a determination under such program to a governmental entity;

to the extent that such conduct is regulated by State law.

"(C) During the transition period, the antitrust laws shall not be applicable to conduct that consists of making an agreement or engaging in joint conduct to determine or disseminate a trend factor, to the extent that such conduct is regulated by State law.

"(D) The antitrust laws shall not be applicable to conduct by a director, officer, or employee of a national trade association representing insurance agents, or of a State trade association representing insurance agents that is affiliated with such national trade association, acting within the scope of the authority vested in such director, officer, or employee by the trade association involved, that consists of preparing, disseminating, or discussing a report or comment (including describing, evaluating, and suggesting possible responses for members of the association whose directors, officers, or employees prepared such report or such comment to consider) with respect to any insurer practice affecting the relationship between insurers and insurance agents, if—

"(i) such report or such comment includes a conspicuous statement that each insurance agent is expected to make his or her own decision regarding matters contained in such report or such comment and that anticompetitive agreements among insurance agents with respect to any response to such practice are illegal under the antitrust laws;

"(ii) such conduct does not involve—

"(I) monitoring or policing the extent to which any insurance agent follows, or pressuring any insurance agent to follow, any of such responses;

"(II) initiating any communication (including a mailing, association publication, or association meeting) with any member of any such association with respect to such report or such comment (including any of such responses), other than by a means designed to reach all members, or all directors and officers, of such association;

"(III) referring to any of such responses in any discussion unless the discussion emphasizes that each insurance agent is expected to make his or her own decision regarding matters contained in such report or such comment and that anticompetitive agreements among insurance agents with respect to any response to such practice are illegal under the antitrust laws; or

"(IV) the formal endorsement of such report or such comment (including any of such responses) by any part of the membership of any such association, other than a statement that dissemination of such report or such comment has been approved by the directors or officers of the association whose directors, officers, or employees prepared such report or such comment; and

"(iii) the number of directors and officers of any such association who are involved in preparing, disseminating, or discussing such report or such comment (including any of such responses) does not substantially exceed the number of directors and officers of such association serving on April 30, 1994;

and if the business of insurance is regulated by State law.

"(E) The antitrust laws shall not be applicable to conduct of an insurance agent that is a member of an association referred to in subparagraph (D) that consists of independently initiating a communication, in an issue of a regularly scheduled association publication or at a regularly scheduled association meeting, to members of a local trade association representing insurance agents of which such agent is a member, that describes or summarizes all or part of the contents of a report or comment described in such subparagraph provided to such agent by such association described in such subsection and that is made only by a means designed to reach all such members, if—

"(i) such conduct does not involve—

"(I) monitoring or policing the extent to which any insurance agent follows, or pressuring any insurance agent to follow, any of the possible responses contained in such report or such comment;

"(II) referring to any of such responses unless the references emphasizes that each insurance agent is expected to make his or her own decision regarding matters contained in such report or such comment and that anticompetitive agreements among insurance agents with respect to any response to an insurance practice discussed in such report or such comment are illegal under the antitrust laws; or

"(III) the formal endorsement of such report or such comment (including any of such responses); and

"(ii) the primary purpose of such meeting, or of such issue of such publication, is not the discussion of such report or such comment (including any of such responses);

and if the business of insurance is regulated by State law.

"(2) Subsequent to the transition period, the independent purchase of a trend factor by a person engaged in the business of insurance from a person not engaged in providing insurance (and not affiliated with a person engaged in providing insurance) shall be presumed not to violate the antitrust laws.

"(3) The Federal Trade Commission Act shall be applicable to the business of insurance to the extent that such business is not regulated by State law, except that, with respect to enforcement of the antitrust laws, section 17105 of such Act shall be applicable to the business of insurance to the same extent as the other antitrust laws.", and

(2) by adding at the end the following:

"(c) For purposes of subsection (b)—

"(1) the term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) as such section 5 applies to conduct that constitutes a violation of the Sherman Act or the Clayton Act;

"(2) the term 'developed losses' means aggregate paid losses and aggregate reserves held for received claims, as adjusted by a loss development factor;

"(3) the term 'historical underwriting capacity risk pool' means an underwriting capacity risk pool established prior to April 30, 1994—

"(A) the purpose of which is to provide insurance for a commercial risk relating to—

"(i) an airport, aviation, or aerospace activity;

"(ii) a large commercial or industrial property (including machinery, boilers, and pressure vessels);

"(iii) a grain elevator or feed mill;

"(iv) an oil, gas, or chemical peril;

"(v) the construction or operation of a nuclear energy facility;

"(vi) an inland marine peril or an ocean marine enterprise;

"(vii) a natural disaster;

"(viii) an occupational accident or illness;

"(ix) transportation of currency, mail, securities, bullion, or other valuables by a person with fiduciary responsibility for their safe transport;

"(x) foreign commercial activities undertaken in cooperation with the United States Export-Import Bank; or

"(xi) a war, rebellion, riot, or similar civil commotion;

"(B) whose conduct has not materially changed from the conduct described in accordance with subparagraph (C)(ii) in which such pool—

"(i) was authorized to engage under its charter, bylaws, or other documents of organization or governance filed in accordance with subparagraph (C)(iii); and

"(ii) did engage as so authorized;

prior to April 30, 1994; and

"(C) that, before the effective date of the Insurance Competitive Pricing Act of 1994, filed with the Attorney General of the United States, in accordance with such rules as the Attorney General may have issued, a notification—

"(i) disclosing the identities of the members of such pool on April 30, 1994;

"(ii) describing the nature and scope of the activities of such pool, and the lines of insurance in which such pool was engaged, prior to April 30, 1994; and

"(iii) containing the charter, bylaws, and other documents of organization or governance of such pool in effect on or before April 30, 1994;

"(4) the term 'historical data' means information respecting—

"(A) losses paid by, claims received by, reserves for such claims set aside by, or units of exposure to loss in insurance policies sold by any person engaged in the business of insurance; or

"(B) insurance premiums received by any person engaged in the business of insurance, if such information is not disseminated in a form from which information respecting premiums received by any separately identifiable person engaged in the business of insurance may be derived;

"(5) the term 'insurance agent' means a person that is—

"(A) engaged as an independent contractor in the business of selling insurance;

"(B) licensed under the law of a State as an insurance agent or insurance broker; and

"(C) neither an insurer in any State in which such person is so engaged, nor an employee of an insurer;

"(6) the term 'insurance policy' means a contract under which insurance is sold to an insured;

"(7) the term 'insurer' means a person that is—

"(A) engaged in the business of providing insurance; and

"(B) obligated to pay losses under the insurance policies under which it provides insurance;

"(8) the term 'loss' means an amount paid or to be paid by a person engaged in the business of insurance to (or for the benefit of) a claimant to satisfy a claim on an insurance policy, and includes any attorney, investigatory, or litigation expenses that are separately incurred, identified, and allocated by such person with respect to that particular claim;

"(9) the term 'loss development factor' means an adjustment to be made to the aggregate of losses incurred during a prior period of time that have been paid or for which claims have been received and reserves are being held, in order to estimate the aggregate of the losses incurred during such period that will ultimately be paid;

"(10) the term 'loss incurred' means a loss for which the event has occurred that ultimately gives rise to liability on a claim on an insurance policy, without regard to whether a claim based on such event has been received;

"(11) the term 'public necessity market mechanism' means a plan established by State law or by the State entity that regulates the business of insurance under State law—

"(A) for providing a type of insurance in a State;

"(B) in which the persons providing such type of insurance pursuant to such mechanism represent a substantial number of the persons engaged in the business of providing such type of insurance in such State and are either required by State law, or formally requested or ordered by such State entity to participate;

"(C) the purpose of which is to make such type of insurance available to persons who would not otherwise be able to obtain such type of insurance at affordable cost; and

"(D) in which the rate for such type of insurance is subject to the approval or disapproval of such State;

"(12) the term 'relativity factor' means a ratio comparing one classification of historical data to another such classification, or comparing developed losses in one such classification to developed losses in another such classification;

"(13) the term 'transition period' means the 2-year period beginning on the effective date of the Insurance Competitive Pricing Act of 1994;

"(14) the term 'trend factor' means an adjustment to be made to developed losses in order to account for any change that is anticipated to affect losses; and

"(15) the term 'underwriting capacity risk pool' means a business arrangement or association—

"(A) whose members consist of 2 or more persons engaged in the business of insurance; and

"(B) that operates for the purpose of providing insurance under which the liability for paying losses is spread among such members.".

SEC. 17104. PUBLICATION AND AVAILABILITY OF HISTORICAL UNDERWRITING CAPACITY RISK POOL NOTIFICATIONS.

The Attorney General shall, not later than 30 days after receiving a notification filed in accordance with section 2(c)(3)(C) of the Act of March 9, 1945 (59 Stat. 34; 15 U.S.C. 1012), commonly known as the McCarran-Ferguson Act—

(1) publish in the Federal Register—

(A) a summary of such notification; and

(B) notice that such notification is available to the public; and

(2) make such notification available to the public.

SEC. 17105. BUSINESS REVIEW.

If a person engaged in the business of insurance submits a written request to the Attorney General in accordance with section 50.6 of title 28 of the Code of Federal Regulations (July 1, 1992), as amended from time to time, for a business review letter with respect to the application of the antitrust laws to specified activities of an underwriting capacity risk pool (as defined in section 2(c)(15) of the Act of March 9, 1945, commonly known as the McCarran-Ferguson Act) of which such person is, or intends to become, a member, then the Attorney General shall issue such letter in accordance with such section.

SEC. 17106. STUDY AND REPORT.

(a) STUDY.—During the 5-year period beginning on the effective date of this Act, the Attorney General shall conduct a study to determine the effect of this subtitle, and the amendments made by this subtitle, on the business of insurance.

(b) REPORT.—Not later than 1 year after the expiration of the 5-year period referred to in subsection (a), the Attorney General shall submit, to the Speaker of the House of Representatives and the President pro tempore of the Senate, a report summarizing the results of the study required by subsection (a).

SEC. 17107. EFFECTIVE DATES.

(a) GENERAL EFFECTIVE DATE.—Except as provided in subsection (b), this subtitle shall take effect 1 year after the date of the enactment of this Act.

(b) EFFECTIVE DATE OF SECTIONS 17104 AND 17105.—Sections 17104 and 17105 shall take effect on the date of the enactment of this Act.

AMENDMENT IN THE NATURE OF A SUBSTITUTE TO BE OFFERED BY REPRESENTATIVE SAM JOHNSON OF TEXAS

Strike out all after the enacting clause and insert in lieu thereof the text of H.R. 4840 (as introduced).

AMENDMENT IN THE NATURE OF A SUBSTITUTE TO BE OFFERED BY REPRESENTATIVE MCDERMOTT OF WASHINGTON

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "American Health Security Act of 1994".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—ESTABLISHMENT OF A STATE-BASED AMERICAN HEALTH SECURITY PROGRAM; UNIVERSAL ENTITLEMENT; ENROLLMENT

Sec. 101. Establishment of a State-based American Health Security Program.
Sec. 102. Universal entitlement.
Sec. 103. Enrollment.
Sec. 104. Portability of benefits.
Sec. 105. Effective date of benefits.
Sec. 106. Relationship to existing Federal health programs.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG TERM CARE

Sec. 201. Comprehensive benefits.
Sec. 202. Definitions relating to services.
Sec. 203. Special rules for home and community-based long-term care services.

Sec. 204. Exclusions and limitations.
Sec. 205. Certification; quality review; plans of care.

TITLE III—PROVIDER PARTICIPATION

Sec. 301. Provider participation and standards.
Sec. 302. Qualifications for providers.
Sec. 303. Qualifications for comprehensive health service organizations.
Sec. 304. Limitation on certain physician referrals.

TITLE IV—ADMINISTRATION

Subtitle A—General Administrative Provisions

Sec. 401. American Health Security Standards Board.
Sec. 402. American Health Security Advisory Council.
Sec. 403. Professional, technical, and temporary advisory committees.
Sec. 404. American Health Security Quality Council.
Sec. 405. State health security programs.
Sec. 406. Complementary conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

Sec. 411. Application of Federal sanctions to all fraud and abuse under American Health Security Program.
Sec. 412. National health care fraud data base.
Sec. 413. Requirements for operation of State health care fraud and abuse control units.
Sec. 414. Assignment of unique provider and patient identifiers.

TITLE V—QUALITY ASSESSMENT

Sec. 501. Functions of Quality Council; development of practice guidelines and application to outliers.
Sec. 502. State quality review programs.
Sec. 503. Elimination of existing utilization review programs; transition.
Sec. 504. Development of national electronic data base.

TITLE VI—NATIONAL HEALTH SECURITY BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting and Payments to States

Sec. 601. National health security budget.
Sec. 602. Computation of individual and State capitation amounts.
Sec. 603. State health security budgets.
Sec. 604. Federal payments to States.
Sec. 605. Account for health professional education expenditures.

Subtitle B—Payments by States to Providers

Sec. 611. Payments to hospitals and other facility-based services for operating expenses on the basis of approved global budgets.
Sec. 612. Payments to health care practitioners based on prospective fee schedule.
Sec. 613. Payments to comprehensive health service organizations.
Sec. 614. Payments for community-based primary health services.
Sec. 615. Payments for prescription drugs.
Sec. 616. Approved devices and equipment.
Sec. 617. Payments for other items and services.
Sec. 618. Payment incentives for medically underserved areas.
Sec. 619. Authority for alternative payment methodologies.

Subtitle C—Mandatory Assignment and Administrative Provisions

Sec. 621. Mandatory assignment.
Sec. 622. Procedures for reimbursement; appeals.

TITLE VII—PROMOTION OF PRIMARY HEALTH CARE; DEVELOPMENT OF HEALTH SERVICE CAPACITY; PROGRAMS TO ASSIST THE MEDICALLY UNDERSERVED

Subtitle A—Promotion and Expansion of Primary Care Professional Training

Sec. 701. Role of Board; establishment of primary care professional output goals.
Sec. 702. Establishment of Advisory Committee on Health Professional Education.
Sec. 703. Grants for health professions education, nurse education, and the National Health Service Corps.

Subtitle B—Direct Health Care Delivery

Sec. 711. Setaside for public health block grants.
Sec. 712. Setaside for primary health care delivery.
Sec. 713. Primary care service expansion grants.

Subtitle C—Primary Care and Outcomes Research

Sec. 721. Set-aside for outcomes research.
Sec. 722. Office of Primary Care and Prevention Research.

Subtitle D—School-Related Health Services

Sec. 731. Authorizations of appropriations.
Sec. 732. Eligibility for development and operation grants.
Sec. 733. Preferences.
Sec. 734. Grants for development of projects.
Sec. 735. Grants for operation of projects.
Sec. 736. Federal administrative costs.
Sec. 737. Definitions.

TITLE VIII—FINANCING PROVISIONS; AMERICAN HEALTH SECURITY TRUST FUND

Sec. 800. Amendment of 1986 code; section 15 not to apply.

Subtitle A—American Health Security Trust Fund

Sec. 801. American health security trust fund.

Subtitle B—Taxes Based on Income and Wages

Sec. 811. Payroll tax on employers.
Sec. 812. Health care income tax.

Subtitle C—Increase in Excise Taxes on Tobacco Products

Sec. 821. Increase in excise taxes on tobacco products.

Subtitle D—Increase in Taxes on Firearms and Ammunition

Sec. 831. Increase in taxes on firearms and ammunition.

TITLE IX—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Sec. 901. ERISA inapplicable to health coverage arrangements under State health security programs.
Sec. 902. Exemption of State health security programs from ERISA preemption.
Sec. 903. Prohibition of employee benefits duplicative of benefits under State health security programs.
Sec. 904. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.
Sec. 905. Effective date of title.

TITLE I—ESTABLISHMENT OF A STATE-BASED AMERICAN HEALTH SECURITY PROGRAM; UNIVERSAL ENTITLEMENT; ENROLLMENT

SEC. 101. ESTABLISHMENT OF A STATE-BASED AMERICAN HEALTH SECURITY PROGRAM.

(a) IN GENERAL.—There is hereby established in the United States a State-Based American Health Security Program to be administered by the individual States in accordance with Federal standards specified in, or established under, this Act.

(b) STATE HEALTH SECURITY PROGRAMS.—In order for a State to be eligible to receive payment under section 604, a State must establish a State health security program in accordance with this Act.

(c) STATE DEFINED.—

(1) IN GENERAL.—In this Act, subject to paragraph (2), the term "State" means each of the fifty States and the District of Columbia.

(2) ELECTION.—If the Governor of Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands certifies to the President that the legislature of the Commonwealth or territory has enacted legislation desiring that the Commonwealth or territory be included as a State under the provisions of this Act, such Commonwealth or territory shall be included as a "State" under this Act beginning January 1 of the first year beginning ninety days after the President receives the notification.

SEC. 102. UNIVERSAL ENTITLEMENT.

(a) IN GENERAL.—Every individual who is a resident of the United States and is a citizen or national of the United States or lawful resident alien (as defined in subsection (d) is entitled to benefits for health care services under this Act under the appropriate State health security program. In this section, the term "appropriate State health security program" means, with respect to an individual, the State health security program for the State in which the individual maintains a primary residence.

(b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

(1) IN GENERAL.—The American Health Security Standards Board (in this Act referred to as the "Board") may make eligible for benefits for health care services under the appropriate State health security program under this Act such classes of aliens admitted to the United States as nonimmigrants as the Board may provide.

(2) CONSIDERATION.—In providing for eligibility under paragraph (1), the Board shall consider reciprocity in health care services offered to United States citizens who are nonimmigrants in other foreign states, and such other factors as the Board determines to be appropriate.

(c) TREATMENT OF OTHER INDIVIDUALS.—

(1) BY BOARD.—The Board also may make eligible for benefits for health care services under the appropriate State health security program under this Act other individuals not described in subsection (a) or (b), and regulate the nature of the eligibility of such individuals, in order—

(A) to preserve the public health of communities,

(B) to compensate States for the additional health care financing burdens created by such individuals, and

(C) to prevent adverse financial and medical consequences of uncompensated care, while inhibiting travel and immigration to the United States for the sole purpose of obtaining health care services.

(2) BY STATES.—Any State health security program may make individuals described in

paragraph (1) eligible for benefits at the expense of the State.

(d) LAWFUL RESIDENT ALIEN DEFINED.—For purposes of this section, the term "lawful resident alien" means an alien lawfully admitted for permanent residence and any other alien lawfully residing permanently in the United States under color of law, including an alien with lawful temporary resident status under section 210, 210A, or 234A of the Immigration and Nationality Act (8 U.S.C. 1160, 1161, or 1255a).

SEC. 103. ENROLLMENT.

(a) IN GENERAL.—Each State health security program shall provide a mechanism for the enrollment of individuals entitled or eligible for benefits under this Act. The mechanism shall—

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States and at the time of immigration into the United States or other acquisition of lawful resident status in the United States,

(2) provide for the enrollment, as of January 1, 1996, of all individuals who are eligible to be enrolled as of such date, and

(3) include a process for the enrollment of individuals made eligible for health care services under subsections (b) and (c) of section 102.

(b) AVAILABILITY OF APPLICATIONS.—Each State health security program shall make applications for enrollment under the program available—

(1) at employment and payroll offices of employers located in the State,

(2) at local offices of the Social Security Administration,

(3) at social services locations,

(4) at out-reach sites (such as provider and practitioner locations), and

(5) at other locations (including post offices and schools) accessible to a broad cross-section of individuals eligible to enroll.

(c) ISSUANCE OF HEALTH SECURITY CARDS.—In conjunction with an individual's enrollment for benefits under this Act, the State health security program shall provide for the issuance of a health security card which shall be used for purposes of identification and processing of claims for benefits under the program. The State health security program may provide for issuance of such cards by employers for purposes of carrying out enrollment pursuant to subsection (a)(2).

SEC. 104. PORTABILITY OF BENEFITS.

(a) IN GENERAL.—To ensure continuous access to benefits for health care services covered under this Act, each State health security program—

(1) shall not impose any minimum period of residence in the State, or waiting period, in excess of three months before residents of the State are entitled to, or eligible for, such benefits under the program;

(2) shall provide continuation of payment for covered health care services to individuals who have terminated their residence in the State and established their residence in another State, for the duration of any waiting period imposed in the State of new residency for establishing entitlement to, or eligibility for, such services; and

(3) shall provide for the payment for health care services covered under this Act provided to individuals while temporarily absent from the State based on the following principles:

(A) Payment for such health care services is at the rate that is approved by the State health security program in the State in which the services are provided, unless the States concerned agree to apportion the cost between them in a different manner.

(B) Payment for such health care services provided outside the United States is made on the basis of the amount that would have been paid by the State health security program for similar services rendered in the State, with due regard, in the case of hospital services, to the size of the hospital, standards of service, and other relevant factors.

(b) CROSS-BORDER ARRANGEMENTS.—A State health security program for a State may negotiate with such a program in an adjacent State a reciprocal arrangement for the coverage under such other program of health care services to enrollees residing in the border region.

SEC. 105. EFFECTIVE DATE OF BENEFITS.

Benefits shall first be available under this Act for items and services furnished on or after January 1, 1996.

SEC. 106. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

(a) MEDICARE AND MEDICAID.—

(1) IN GENERAL.—Notwithstanding any other provision of law, subject to paragraph (2)—

(A) no benefits shall be available under title XVIII of the Social Security Act for any item or service furnished after December 31, 1995,

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished after such date, and

(C) no payment shall be made to a State under section 1903(a) of such Act with respect to medical assistance for any item or service furnished after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before January 1, 1996, and which had not ended as of such date, for which benefits are provided under title XVIII, or under a State plan under title XIX, of the Social Security Act, the Secretary of Health and Human Services and each State plan, respectively, shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(b) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—No benefits shall be made available under chapter 89 of title 5, United States Code, for any part of a coverage period occurring after December 31, 1995.

(c) CHAMPUS.—No benefits shall be made available under sections 1079 and 1086 of title 10, United States Code, for items or services furnished after December 31, 1995.

(d) TREATMENT OF BENEFITS FOR VETERANS AND NATIVE AMERICANS.—Nothing in this Act shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG TERM CARE

SEC. 201. COMPREHENSIVE BENEFITS.

(a) IN GENERAL.—Subject to the succeeding provisions of this title, individuals enrolled for benefits under this Act are entitled to have payment made under a State health security program for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(1) HOSPITAL SERVICES.—Inpatient and outpatient hospital care, including 24-hour a day emergency services.

(2) PROFESSIONAL SERVICES.—Professional services of health care practitioners authorized to provide health care services under State law, including patient education and training in self-management techniques.

(3) COMMUNITY-BASED PRIMARY HEALTH SERVICES.—Community-based primary health services (as defined in section 202(a)).

(4) PREVENTIVE SERVICES.—Preventive services (as defined in section 202(b)).

(5) LONG-TERM, ACUTE, AND CHRONIC CARE SERVICES.—

(A) Nursing facility services.

(B) Home health services.

(C) Home and community-based long term care services (as defined in section 202(c)) for individuals described in section 203(a).

(D) Hospice care.

(E) Services in intermediate care facilities for individuals with mental retardation.

(6) PRESCRIPTION DRUGS, BIOLOGICALS, INSULIN, MEDICAL FOODS.—

(A) Outpatient prescription drugs and biologicals, as specified by the Board consistent with section 515.

(B) Insulin.

(C) Medical foods (as defined in section 202(e)).

(7) DENTAL SERVICES.—Dental services (as defined in section 202(i)).

(8) MENTAL HEALTH SERVICES.—Mental health services (as defined in section 202(f)).

(9) SUBSTANCE ABUSE TREATMENT SERVICES.—Substance abuse treatment services (as defined in section 202(g)).

(10) DIAGNOSTIC TESTS.—Diagnostic tests.

(11) OTHER ITEMS AND SERVICES.—

(A) OUTPATIENT THERAPY.—Outpatient physical therapy services, outpatient speech pathology services, and outpatient occupational therapy services in all settings.

(B) DURABLE MEDICAL EQUIPMENT.—Durable medical equipment.

(C) HOME DIALYSIS.—Home dialysis supplies and equipment.

(D) AMBULANCE.—Emergency ambulance service.

(E) PROSTHETIC DEVICES.—Prosthetic devices, including replacements of such devices.

(F) ADDITIONAL ITEMS AND SERVICES.—Such other medical or health care items or services as the Board may specify.

(b) COST-SHARING.—

(1) IN GENERAL.—Except as provided in this subsection, there are no deductibles, coinsurance, or copayments applicable to acute care and preventive benefits provided under this title.

(2) COST-SHARING FOR LONG-TERM CARE SERVICES.—

(A) IN GENERAL.—

(i) payments for home and community-based long-term care services are subject to coinsurance of 20 percent, and

(ii) payments for nursing facility services are subject to coinsurance of 35 percent.

(B) EXCEPTION.—With respect to the coinsurance established under subparagraph (A)—

(i) such coinsurance shall not apply to an individual with income (as defined by the Secretary) of not more than 100 percent of the income official poverty line applicable to a family of the size involved; and

(ii) in the case of an individual with such income that exceeds 100 percent, but is less than 200 percent, of such applicable poverty line, the coinsurance shall be reduced in the same proportion as the proportion of such income is less than 200 percent of such applicable poverty line.

(c) PROHIBITION OF BALANCE BILLING.—As provided in section 531, no person may impose a charge for covered services for which benefits are provided under this Act.

(d) No Duplicate Health Insurance.—Each State health security program shall prohibit the sale of health insurance in the State if payment under the insurance duplicates payment for any items or services for which payment may be made under such a program.

(e) State Program May Provide Additional Benefits.—Nothing in this Act shall be construed as limiting the benefits that may be made available under a State health security program to residents of the State at the expense of the State.

(f) Employers May Provide Additional Benefits.—Nothing in this Act shall be construed as limiting the additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.

SEC. 202. DEFINITIONS RELATING TO SERVICES.

(a) Community-Based Primary Health Services.—In this title, the term "community-based primary health services" means ambulatory health services furnished—

(1) by a rural health clinic;

(2) by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act), and which, for purposes of this Act, include services furnished by State and local health agencies;

(3) in a school-based setting;

(4) by public educational agencies and other providers of services to children entitled to assistance under the Individuals with Disabilities Education Act for services furnished pursuant to a written Individualized Family Services Plan or Individual Education Plan under such Act; and

(5) public and private non-profit entities receiving Federal assistance under the Public Health Service Act.

(b) Preventive Services.—

(1) In general.—In this title, the term "preventive services" means items and services—

(A) which—

(i) are specified in paragraph (2), or

(ii) the Board determines to be effective in the maintenance and promotion of health or minimizing the effect of illness, disease, or medical condition; and

(B) which are provided consistent with the periodicity schedule established under paragraph (3).

(2) Specified preventive services.—The services specified in this paragraph are as follows:

(A) Basic immunizations.

(B) Prenatal and well-baby care (for infants under one year of age).

(C) Well-child care (including periodic physical examinations, hearing and vision screening, and developmental screening and examinations) for individuals under 18 years of age.

(D) Periodic screening mammography, Pap smears, and colorectal examinations and examinations for prostate cancer.

(E) Physical examinations.

(F) Family planning services.

(G) Routine eye examinations, eyeglasses, and contact lenses.

(H) Hearing aids, but only upon a determination of a certified audiologist or physician that a hearing problem exists and is caused by a condition that can be corrected by use of a hearing aid.

(3) Schedule.—The Board shall establish, in consultation with experts in preventive medicine and public health and taking into consideration those preventive services recommended by the Preventive Services Task Force and published as the Guide to Clinical Preventive Services, a periodicity schedule for the coverage of preventive services under paragraph (1). Such schedule shall take into consideration the cost-effectiveness of appropriate preventive care and shall be revised not less frequently than once every 5 years, in consultation with experts in preventive medicine and public health.

(c) Home and Community-Based Long-Term Care Services.—In this title, the term "home and community-based long term care services" means the following services provided to an individual to enable the individual to remain in such individual's place of residence within the community:

(1) Homemaker services, including meals.

(2) Home health aide services.

(3) Adult day health care, social day care or psychiatric day care.

(4) Medical social work services.

(5) Care coordination services, as defined in subsection (h)(1).

(6) Respite care, including training for informal caregivers.

(7) Personal assistance services.

(d) Home Health Services.—

(1) In general.—The term "home health services" means items and services described in section 1861(m) of the Social Security Act and includes home infusion services.

(2) Home infusion services.—The term "home infusion services" includes the nursing, pharmacy, and related services that are necessary to conduct the home infusion of a drug regimen safely and effectively under a plan established and periodically reviewed by a physician and that are provided in compliance with quality assurance requirements established by the Secretary.

(e) Medical Foods.—In this title, the term "medical foods" means foods which are formulated to be consumed or administered enterally under the supervision of a physician and which are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

(f) Mental Health Services.—In this title, the term "mental health services" means services related to the prevention, diagnosis, treatment, and rehabilitation of mental illness and promotion of mental health, including the following services:

(1) Crisis intervention.

(2) Outpatient mental health services.

(3) Partial hospitalization and day and evening treatment programs.

(4) Psychosocial rehabilitation services.

(5) Pharmacotherapeutic interventions.

(6) Other rehabilitation services, including halfway and three-quarter-way house care.

(7) Inpatient mental health services.

(8) Care coordination services (as defined in subsection (h)(1)).

(g) Substance Abuse Treatment Services.—In this title, the term "substance abuse treatment services" means services for the treatment of dependency on alcohol or controlled substances provided through a treatment program meeting State qualification standards and includes the following services:

(1) Crisis intervention, including assessment, diagnosis, and referral.

(2) Detoxification services, in ambulatory and inpatient settings.

(3) Outpatient services, including intensive day and evening programs, continuing care, and family services.

(4) Short-term residential services in a hospital or free-standing program.

(5) Long-term residential services, including therapeutic communities and halfway houses.

(6) Pharmacotherapeutic interventions.

(7) Care coordination services (as defined in subsection (h)(1)).

(h) Care Coordination Services.—

(1) In general.—In this title, the term "care coordination services" means services provided by care coordinators (as defined in paragraph (2)) to individuals described in paragraph (3) for the coordination and monitoring of mental health services, substance abuse treatment services, and home and community-based long term care services to ensure appropriate, cost-effective utilization of such services in a comprehensive and continuous manner, and includes—

(A) transition management between inpatient facilities and community-based services, including assisting patients in identifying and gaining access to appropriate ancillary services; and

(B) evaluating and recommending appropriate treatment services, in cooperation with patients and other providers and in conjunction with any quality review program or plan of care under section 205.

(2) Care coordinator.—

(A) In general.—In this title, the term "care coordinator" means an individual or nonprofit or public agency or organization which the State health security program determines—

(i) is capable of performing directly, efficiently, and effectively the duties of a care coordinator described in paragraph (1), and

(ii) demonstrates capability in establishing and periodically reviewing and revising plans of care, and in arranging for and monitoring the provision and quality of services under any plan.

(B) Independence.—State health security programs shall establish safeguards to assure that care coordinators have no financial interest in treatment decisions or placements. Care coordination may not be provided through any structure or mechanism through which quality review is performed.

(3) Eligible individuals.—An individual described in this paragraph is an individual—

(A) described in section 203 (relating to individuals qualifying for long term and chronic care services); or

(B) determined (in a manner specified by the Board)—

(i) to have a serious mental illness (as defined by the Board), or

(ii) to have a history of substance abuse displaying severe associated illness or previous treatment failure (as defined by the Board).

(i) Dental Services.—

(1) In general.—In this title, subject to subsection (b), the term "dental services" means the following:

(A) Emergency dental treatment, including extractions, for bleeding, pain, acute infections, and injuries to the maxillofacial region.

(B) Prevention and diagnosis of dental disease, including examinations of the hard and soft tissues of the oral cavity and related structures, radiographs, dental sealants, fluorides, and dental prophylaxis.

(C) Treatment of dental disease, including non-cast fillings, periodontal maintenance services, and endodontic services.

(D) Space maintenance procedures to prevent orthodontic complications.

(E) Orthodontic treatment to prevent severe malocclusions.

(F) Full dentures.

(G) Medically necessary oral health care.

(H) Any items and services for special needs patients that are not described in subparagraphs (A) through (G) and that—

(i) are required to provide such patients the items and services described in subparagraphs (A) through (G);

(ii) are required to establish oral function (including general anesthesia for individuals with physical or emotional limitations that prevent the provision of dental care without such anesthesia);

(iii) consist of orthodontic care for severe dentofacial abnormalities; or

(iv) consist of prosthetic dental devices for genetic or birth defects or fitting for such devices.

(I) Any dental care for individuals with a seizure disorder that is not described in subparagraphs (A) through (H) and that is required because of an illness, injury, disorder, or other health condition that results from such seizure disorder.

(2) LIMITATIONS.—Dental services are subject to the following limitations:

(A) PREVENTION AND DIAGNOSIS.—

(i) EXAMINATIONS AND PROPHYLAXIS.—The examinations and prophylaxis described in paragraph (1)(B) are covered only consistent with a periodicity schedule established by the Board, which schedule may provide for special treatment of individuals less than 18 years of age and of special needs patients.

(ii) DENTAL SEALANTS.—The dental sealants described in such paragraph are not covered for individuals 18 years of age or older. Such sealants are covered for individuals less than 10 years of age for protection of the 1st permanent molars. Such sealants are covered for individuals 10 years of age or older for protection of the 2d permanent molars.

(B) TREATMENT OF DENTAL DISEASE.—Prior to January 1, 2001, the items and services described in paragraph (1)(C) are covered only for individuals less than 18 years of age and special needs patients. On or after such date, such items and services are covered for all individuals enrolled for benefits under this Act, except that endodontic services are not covered for individuals 18 years of age or older.

(C) SPACE MAINTENANCE.—The items and services described in paragraph (1)(D) are covered only for individuals at least 3 years of age, but less than 13 years of age and—

(i) are limited to posterior teeth;

(ii) involve maintenance of a space or spaces for permanent posterior teeth that would otherwise be prevented from normal eruption if the space were not maintained; and

(iii) do not include a space maintainer that is placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

(D) ORTHODONTIC TREATMENT.—Prior to January 1, 2001, the items and services described in paragraph (1)(E) are covered only for individuals at least 6 years of age, but less than 12 years of age, who have severe dentofacial abnormalities. On or after such date, such items and services are covered only for individuals at least 6 years of age, but less than 12 years of age.

(E) DENTURES.—Prior to January 1, 2001, the dentures described in paragraph (1)(F) are not covered, except for special needs patients. On or after such date, dentures are covered for an individual consistent with a periodicity schedule established by the Board, except that the limitation of periodicity provided in such schedule shall not apply to a special needs patient.

(3) DEFINITIONS.—For purposes of this title:

(A) MEDICALLY NECESSARY ORAL HEALTH CARE.—The term "medically necessary oral health care" means oral health care that is required as a direct result of, or would have a direct impact on, an underlying medical condition. Such term includes oral health care directed towards control or elimination of pain, infection, or reestablishment of oral function.

(B) SPECIAL NEEDS PATIENT.—The term "special needs patient" includes an individual with a genetic or birth defect, a developmental disability, or an acquired medical disability.

(j) NURSING FACILITY; NURSING FACILITY SERVICES.—Except as may be provided by the Board, the terms "nursing facility" and "nursing facility services" have the meanings given such terms in sections 1919(a) and 1905(f), respectively, of the Social Security Act.

(k) SERVICES IN INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH MENTAL RETARDATION.—Except as may be provided by the Board—

(1) the term "intermediate care facility for individuals with mental retardation" has the meaning specified in section 1905(d) of the Social Security Act (as in effect before the enactment of this Act); and

(2) the term "services in intermediate care facilities for individuals with mental retardation" means services described in section 1905(a)(15) of such Act (as so in effect) in an intermediate care facility for individuals with mental retardation to an individual determined to require such services in accordance with standards specified by the Board and comparable to the standards described in section 1902(a)(31)(A) of such Act (as so in effect).

(l) OTHER TERMS.—Except as may be provided by the Board, the definitions contained in section 1861 of the Social Security Act shall apply.

SEC. 203. SPECIAL RULES FOR HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.

(a) QUALIFYING INDIVIDUALS.—For purposes of section 201(a)(5)(C), individuals described in this subsection are the following individuals:

(1) ADULTS.—Individuals 18 years of age or older determined (in a manner specified by the Board)—

(A) to be unable to perform, without the assistance of an individual, at least 2 of the following 5 activities of daily living (or who has a similar level of disability due to cognitive impairment)—

(i) bathing;

(ii) eating;

(iii) dressing;

(iv) toileting; and

(v) transferring in and out of a bed or in and out of a chair; or

(B) due to cognitive or mental impairments, requires supervision (or queuing to perform activities of daily living) because the individual behaves in a manner that poses health or safety hazards to himself or herself or others.

(2) CHILDREN.—Individuals under 18 years of age determined (in a manner specified by the Board) to meet such alternative standard of disability for children as the Board develops. Such alternative standard shall be comparable to the standard for adults and appropriate for children.

(b) LIMIT ON SERVICES.—

(1) IN GENERAL.—The aggregate expenditures by a State health security program with respect to home and community-based long-term care services in a period (specified by the Board) may not exceed 65 percent (or such alternative ratio as the Board establishes under paragraph (2)) of the average of the amount of payment that would have been made under the program during the period if all the home-based long-term care beneficiaries had been residents of nursing facilities in the same area in which the services were provided.

(2) ALTERNATIVE RATIO.—The Board may establish for purposes of paragraph (1) an alternative ratio (of payments for home and community-based long term care services to payments for nursing facility services) as the Board determines to be more consistent with the goal of providing cost-effective long-term care in the most appropriate and least restrictive setting.

SEC. 204. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Subject to section 201(e), benefits for service are not available under this Act unless the services meet the standards specified in section 201(a).

(b) MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE TREATMENT SERVICES.—

(1) IN GENERAL.—Mental health services and substance abuse treatment services furnished for an individual in excess of a threshold specified in paragraph (2) are not covered services unless the services are determined under a utilization review program to meet the standards specified in section 201(a) and, with respect to inpatient or residential treatment services, to be provided in the least restrictive and most appropriate setting.

(2) UTILIZATION REVIEW THRESHOLD.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the thresholds specified in this paragraph are—

(i) 20 outpatient visits in a year, and

(ii) 15 days of inpatient services in a year.

(B) ALTERNATIVE NATIONAL THRESHOLDS.—The Board may specify alternative thresholds to those specified in subparagraph (A).

(C) ADDITIONAL STATE THRESHOLDS.—A State health security program may specify thresholds in addition to those established under the previous subparagraphs, which thresholds may be higher or lower than the number of outpatient visits or days of inpatient services otherwise specified.

(3) SPECIAL DELIVERY REQUIREMENTS FOR SERVICES PROVIDED TO CHILDREN.—

(A) REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.—A State health security program shall ensure that mental health services and substance abuse treatment services are furnished through an organized system of care, as described in subparagraph (B), if—

(i) the services are provided to an individual less than 22 years of age;

(ii) the individual has a serious emotional disturbance or a substance abuse disorder; and

(iii) the individual is, or is at imminent risk of being, subject to the authority of, or in need of the services of, at least 1 public agency that serves the needs of children, including an agency involved with child welfare, special education, juvenile justice, or criminal justice.

(B) REQUIREMENTS FOR SYSTEM OF CARE.—In this paragraph, an "organized system of care" is a community-based service delivery network, which may consist of public and private providers, that meets the following requirements:

(i) The system has established linkages with existing mental health services and substance abuse treatment service delivery programs in the plan service area (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

(ii) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile justice, criminal justice, health care, mental health, and substance abuse prevention and treatment.

(iii) The system provides for the involvement of the families of children to whom mental health services and substance abuse treatment services are provided in the planning of treatment and the delivery of services.

(iv) The system provides for the development and implementation of individualized treatment plans by multidisciplinary and multiagency teams, which are recognized and followed by the applicable agencies and providers in the area.

(v) The system ensures the delivery and coordination of the range of mental health services and substance abuse treatment services required by individuals under 22 years of age who have a serious emotion disturbance or a substance abuse disorder.

(vi) The system provides for the management of the individualized treatment plans described in clause (iv) and for a flexible response to changes in treatment needs over time.

(c) TREATMENT OF EXPERIMENTAL SERVICES.—In applying subsection (a), the Board shall make, after consultation with a technical advisory committee, national coverage determinations with respect to those services that are experimental in nature. Such determinations shall be made consistent with a process that provides for professional input and public comment.

(d) APPLICATION OF NATIONAL PRACTICE GUIDELINES.—In the case of services for which the Board has recognized national practice guidelines, the services are considered to meet the standards specified in section 201(a) only if they have been provided in accordance with such guidelines or in accordance with such guidelines as are provided by the State health security program consistent with title V.

(e) SPECIFIC LIMITATIONS.—

(1) LIMITATIONS ON EYEGLASSES, CONTACT LENSES, HEARING AIDS, AND DURABLE MEDICAL EQUIPMENT.—Subject to section 201(e), the Board may impose such limits relating to the costs and frequency of replacement of eyeglasses, contact lenses, hearing aids, and durable medical equipment to which individuals enrolled for benefits under this Act are entitled to have payment made under a State health security program as the Board deems appropriate.

(2) OVERLAP WITH PREVENTIVE SERVICES.—The coverage of services described in section 201(a) (other than paragraph (3)) which also are preventive services are required to be covered only to the extent that they are required to be covered as preventive services.

(3) MISCELLANEOUS EXCLUSIONS FROM COVERED SERVICES.—Covered services under this Act do not include the following:

(A) Surgery and other procedures (such as orthodontia) performed solely for cosmetic purposes (as defined in regulations) and hospital or other services incident thereto, unless—

(i) required to correct a congenital anomaly;

(ii) required to restore or correct a part of the body which has been altered as a result of accidental injury, disease, or surgery; or

(iii) otherwise determined to be medically necessary and appropriate under section 201(a).

(B) Personal comfort items or private rooms in inpatient facilities, unless determined to be medically necessary and appropriate under section 201(a).

(C) The services of a professional practitioner if they are furnished in a hospital or other facility which is not a participating provider.

(f) NURSING FACILITY SERVICES AND HOME HEALTH SERVICES.—Nursing facility services and home health services (other than post-hospital services, as defined by the Board) furnished to an individual who is not described in section 203(a) are not covered services unless the services are determined to meet the standards specified in section 201(a) and, with respect to nursing facility services, to be provided in the least restrictive and most appropriate setting.

SEC. 205. CERTIFICATION; QUALITY REVIEW; PLANS OF CARE.

(a) CERTIFICATIONS.—State health security programs may require, as a condition of payment for institutional health care services and other services of the type described in such sections 1814(a) and 1835(a) of the Social Security Act, periodic professional certifications of the kind described in such sections.

(b) QUALITY REVIEW.—For requirement that each State health security program establish a quality review program that meets the requirements for such a program under title V, see section 405(b)(1)(H).

(c) PLAN OF CARE REQUIREMENTS.—A State health security program may require, consistent with standards established by the Board, that payment for services exceeding specified levels or duration be provided only as consistent with a plan of care or treatment formulated by one or more providers of the services or other qualified professionals. Such a plan may include, consistent with subsection (b), case management at specified intervals as a further condition of payment for services.

TITLE III—PROVIDER PARTICIPATION

SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.

(a) IN GENERAL.—An individual or other entity furnishing any covered service under a State health security program under this Act is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the services under section 302;

(2) has filed with the State health security program a participation agreement described in subsection (b); and

(3) meets such other qualifications and conditions as are established by the Board or the State health security program under this Act.

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection between a State health security program and a provider shall provide at least for the following:

(A) Services to eligible persons will be furnished by the provider without discrimination on the ground of race, national origin, income, religion, age, sex or sexual orientation, disability, handicapping condition, or (subject to the professional qualifications of the provider) illness. Nothing in this subparagraph shall be construed as requiring the provision of a type or class of services which services are outside the scope of the provider's normal practice.

(B) No charge will be made for any covered services other than for payment authorized by this Act.

(C) The provider agrees to furnish such information as may be reasonably required by the Board or a State health security program, in accordance with uniform reporting standards established under section 401(g)(1), for—

(i) quality review by designated entities;

(ii) the making of payments under this Act (including the examination of records as may be necessary for the verification of information on which payments are based);

(iii) statistical or other studies required for the implementation of this Act; and

(iv) such other purposes as the Board or State may specify.

(D) The provider agrees not to bill the program for any services for which benefits are not available because of section 204(d).

(E) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider who or which has had a participation agreement under this subsection terminated for cause.

(F) In the case of a provider paid under a fee-for-service basis under section 612, the provider agrees to submit bills and any required supporting documentation relating to the provision of covered services within 30 days (or such shorter period as a State health security program may require) after the date of providing such services.

(2) TERMINATION OF PARTICIPATION AGREEMENTS.—

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

(i) by the Board or a State health security program for failure to meet the requirements of this title, or

(ii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Board or a State health security program terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to provide covered services if the provider is licensed or certified and meets—

(1) all the requirements of State law to provide such services,

(2) applicable requirements of Federal law to provide such services, and

(3) any applicable standards established under subsection (b).

(b) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Board shall establish, evaluate, and update national minimum standards to assure the quality of services provided under this Act and to monitor efforts by State health security programs to assure the quality of such services. A State health security program may also establish additional minimum standards which providers must meet.

(2) NATIONAL MINIMUM STANDARDS.—The national minimum standards under paragraph (1) shall be established for institutional providers of services, individual health care practitioners, and comprehensive health service organizations. Except as the Board may specify in order to carry out this title, a hospital, nursing facility, or other institutional provider of services shall meet standards for such a facility under the medicare program under title XVIII of the Social Security Act. Such standards also may include, where appropriate, elements relating to—

(A) adequacy and quality of facilities;

(B) training and competence of personnel (including continuing education requirements);

(C) comprehensiveness of service;

(D) continuity of service;

(E) patient satisfaction (including waiting time and access to services); and

(F) performance standards (including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation).

(3) TRANSITION IN APPLICATION.—If the Board provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(4) EXCHANGE OF INFORMATION.—The Board shall provide for an exchange, at least annually, among State health security programs of information with respect to quality assurance and cost containment.

SEC. 303. QUALIFICATIONS FOR COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—For purposes of this Act, a comprehensive health service organization (in this section referred to as a "CHSO") is a public or private organization which, in return for a capitated payment amount, undertakes to furnish, arrange for the provision of, or provide payment with respect to—

(1) a full range of health services (as identified by the Board), including at least hospital services and physicians services, and

(2) out-of-area coverage in the case of urgently needed services, to an identified population which is living in or near a specified service area and which enrolls voluntarily in the organization.

(b) ENROLLMENT.—

(1) IN GENERAL.—All eligible persons living in or near the specified service area of a CHSO are eligible to enroll in the organization; except that the number of enrollees may be limited to avoid overtaxing the resources of the organization.

(2) MINIMUM ENROLLMENT PERIOD.—Subject to paragraph (3), the minimum period of enrollment with a CHSO shall be twelve months, unless the enrolled individual becomes ineligible to enroll with the organization.

(3) WITHDRAWAL FOR CAUSE.—Each CHSO shall permit an enrolled individual to disenroll from the organization for cause at any time.

(c) REQUIREMENTS FOR CHSOS.—

(1) ACCESSIBLE SERVICES.—Each CHSO, to the maximum extent feasible, shall make all services readily and promptly accessible to enrollees who live in the specified service area.

(2) CONTINUITY OF CARE.—Each CHSO shall furnish services in such manner as to provide continuity of care and (when services are furnished by different providers) shall provide ready referral of patients to such services and at such times as may be medically appropriate.

(3) BOARD OF DIRECTORS.—In the case of a CHSO that is a private organization—

(A) CONSUMER REPRESENTATION.—At least one-third of the members of the CHSO's board of directors must be consumer members with no direct or indirect, personal or family financial relationship to the organization.

(B) PROVIDER REPRESENTATION.—The CHSO's board of directors must include at least one member who represents health care providers.

(4) PATIENT GRIEVANCE PROGRAM.—Each CHSO must have in effect a patient grievance program and must conduct regularly surveys of the satisfaction of members with services provided by or through the organization.

(5) MEDICAL STANDARDS.—Each CHSO must provide that a committee or committees of health care practitioners associated with the organization will promulgate medical standards, oversee the professional aspects of the delivery of care, perform the functions of a pharmacy and drug therapeutics committee, and monitor and review the quality of all health services (including drugs, education, and preventive services).

(6) PREMIUMS.—Premiums or other charges by a CHSO for any services not paid for under this Act must be reasonable.

(7) UTILIZATION AND BONUS INFORMATION.—Each CHSO must—

(A) comply with the requirements of section 1876(i)(8) of the Social Security Act (relating to prohibiting physician incentive plans that provide specific inducements to reduce or limit medically necessary services), and

(B) make available to its membership utilization information and data regarding financial performance, including bonus or incentive payment arrangements to practitioners.

(8) PROVISION OF SERVICES TO ENROLLEES AT INSTITUTIONS OPERATING UNDER GLOBAL BUDGETS.—The organization shall arrange to reimburse for hospital services and other facility-based services (as identified by the Board) for services provided to members of the organization in accordance with the global operating budget of the hospital or facility approved under section 611.

(9) BROAD MARKETING.—Each CHSO must provide for the marketing of its services (including dissemination of marketing materials) to potential enrollees in a manner that is designed to enroll individuals representative of the different population groups and geographic areas included within its service area and meets such requirements as the Board or a State health security program may specify.

(10) ADDITIONAL REQUIREMENTS.—Each CHSO must meet—

(A) such requirements relating to minimum enrollment,

(B) such requirements relating to financial solvency,

(C) such requirements relating to quality and availability of care, and

(D) such other requirements,

as the Board or a State health security program may specify.

(d) PROVISION OF EMERGENCY SERVICES TO NONENROLLEES.—A CHSO may furnish emergency services to persons who are not enrolled in the organization. Payment for such services, if they are covered services to eligible persons, shall be made to the organization unless the organization requests that it be made to the individual provider who furnished the services.

SEC. 304. LIMITATION ON CERTAIN PHYSICIAN REFERRALS.

(a) APPLICATION TO AMERICAN HEALTH SECURITY PROGRAM.—Section 1877 of the Social Security Act, as amended by subsections (b) and (c), shall apply under this Act in the same manner as it applies under title XVIII of the Social Security Act; except that in applying such section under this Act any references in such section to the Secretary or title XVIII of the Social Security Act are deemed references to the Board and the American Health Security Program under this Act, respectively.

(b) EXPANSION OF PROHIBITION TO CERTAIN ADDITIONAL DESIGNATED SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by adding at the end the following:

"(L) Ambulance services.

"(M) Home infusion therapy services.".

(c) CONFORMING AMENDMENTS.—Section 1877 of such Act is further amended—

(1) in subsection (a)(1)(A), by striking "for which payment otherwise may be made under this title" and by inserting "for which a charge is imposed";

(2) in subsection (a)(1)(B), by striking "under this title";

(3) by amending paragraph (1) of subsection (g) to read as follows:

"(1) DENIAL OF PAYMENT.—No payment may be made under a State health security program for a designated health service for which a claim is presented in violation of subsection (a)(1)(B). No individual, third party payor, or other entity is liable for payment for designated health services for which a claim is presented in violation of such subsection."; and

(4) in subsection (g)(3), by striking "for which payment may not be made under paragraph (1)" and by inserting "for which such a claim may not be presented under subsection (a)(1)".

TITLE IV—ADMINISTRATION

Subtitle A—General Administrative Provisions

SEC. 401. AMERICAN HEALTH SECURITY STANDARDS BOARD.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Standards Board.

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Board shall be composed of—

(A) the Secretary of Health and Human Services, and

(B) 6 other individuals (described in paragraph (2)) appointed by the President with the advice and consent of the Senate.

The President shall first nominate individuals under subparagraph (B) on a timely basis so as to provide for the operation of the Board by not later than January 1, 1995.

(2) SELECTION OF APPOINTED MEMBERS.—With respect to the individuals appointed under paragraph (1)(B):

(A) They shall be chosen on the basis of backgrounds in health policy, health economics, the healing professions, and the administration of health care institutions.

(B) They shall provide a balanced point of view with respect to the various health care interests and at least two of them shall represent the interests of individual consumers.

(C) Not more than three of them shall be from the same political party.

(D) To the greatest extent feasible, they shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) TERMS OF APPOINTED MEMBERS.—Individuals appointed under paragraph (1)(B) shall serve for a term of 6 years, except that the terms of 5 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, 4, and 5 years. During a term of membership on the Board, no member shall engage in any other business, vocation or employment.

(c) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the Board in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Board.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint an appointed member of the Board for a second term in the same manner as the original appointment. A member who has served for two consecutive 6-year terms shall not be eligible for reappointment until two years after the member has ceased to serve.

(4) REMOVAL FOR CAUSE.—Upon confirmation, members of the Board may not be removed except by the President for cause.

(d) CHAIR.—The President shall designate one of the members of the Board, other than the Secretary, to serve at the will of the President as Chair of the Board.

(e) COMPENSATION.—Members of the Board (other than the Secretary) shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

(f) GENERAL DUTIES OF THE BOARD.—

(1) IN GENERAL.—The Board shall develop policies, procedures, guidelines, and requirements to carry out this Act, including those related to—

(A) eligibility;

(B) enrollment;

(C) benefits;

(D) provider participation standards and qualifications, as defined in title III;

(E) national and State funding levels;

(F) methods for determining amounts of payments to providers of covered services, consistent with subtitle B of title VI;

(G) the determination of medical necessity and appropriateness with respect to coverage of certain services;

(H) assisting State health security programs with planning for capital expenditures and service delivery;

(I) planning for health professional education funding (as specified in title VI);

(J) allocating funds provided under title VII; and

(K) encouraging States to develop regional planning mechanisms (described in section 405(a)(3)).

(2) REGULATIONS.—Regulations authorized by this Act shall be issued by the Board in accordance with the provisions of section 553 of title 5, United States Code.

(g) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Board shall establish uniform reporting requirements and standards to ensure an adequate national data base regarding health services practitioners, services and finances of State health security programs, approved plans, providers, and the costs of facilities and practitioners providing services. Such standards shall include, to the maximum extent feasible, health outcome measures.

(B) REPORTS.—The Board shall analyze regularly information reported to it, and to State health security programs pursuant to such requirements and standards.

(2) ANNUAL REPORT.—Beginning January 1, of the second year beginning after the date of the enactment of this Act, the Board shall annually report to Congress on the following:

(A) The status of implementation of the Act.

(B) Enrollment under this Act.

(C) Benefits under this Act.

(D) Expenditures and financing under this Act.

(E) Cost-containment measures and achievements under this Act.

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the program.

(H) Long-range plans and goals for the delivery of health services.

(I) Differences in the health status of the populations of the different States, including income and racial characteristics.

(J) Necessary changes in the education of health personnel.

(K) Plans for improving service to medically underserved populations.

(L) Transition problems as a result of implementation of this Act.

(M) Opportunities for improvements under this Act.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Board may, either directly or by contract—

(A) make statistical and other studies, on a nationwide, regional, state, or local basis, of any aspect of the operation of this Act, including studies of the effect of the Act upon the health of the people of the United States and the effect of comprehensive health services upon the health of persons receiving such services;

(B) develop and test methods of providing through payment for services or otherwise, additional incentives for adherence by providers to standards of adequacy, access, and quality; methods of consumer and peer review and peer control of the utilization of drugs, of laboratory services, and of other services; and methods of consumer and peer review of the quality of services;

(C) develop and test, for use by the Board, records and information retrieval systems and budget systems for health services administration, and develop and test model systems for use by providers of services;

(D) develop and test, for use by providers of services, records and information retrieval systems useful in the furnishing of preventive or diagnostic services;

(E) develop, in collaboration with the pharmaceutical profession, and test, improved administrative practices or improved methods for the reimbursement of independent pharmacies for the cost of furnishing drugs as a covered service; and

(F) make such other studies as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this Act.

(4) REPORT ON USE OF EXISTING FEDERAL HEALTH CARE FACILITIES.—Not later than one year after the date of the enactment of this Act, the Board shall recommend to the Congress one or more proposals for the treatment of health care facilities of the Federal Government.

(h) EXECUTIVE DIRECTOR.—

(1) APPOINTMENT.—There is hereby established the position of Executive Director of the Board. The Director shall be appointed by the Board and shall serve as secretary to the Board and perform such duties in the administration of this title as the Board may assign.

(2) DELEGATION.—The Board is authorized to delegate to the Director or to any other officer or employee of the Board or, with the approval of the Secretary of Health and Human Services (and subject to reimbursement of identifiable costs), to any other officer or employee of the Department of Health and Human Services, any of its functions or duties under this Act other than—

(A) the issuance of regulations; or

(B) the determination of the availability of funds and their allocation to implement this Act.

(3) COMPENSATION.—The Executive Director of the Board shall be entitled to compensation at a level equivalent to level III of the Executive Schedule, in accordance with section 5314 of title 5, United States Code.

(i) INSPECTOR GENERAL.—The Inspector General Act of 1978 (5 U.S.C. App.) is amended—

(1) in section 11(1) by inserting after "Corporation;" the following: "the Chair of the American Health Security Standards Board;";

(2) in section 11(2) by inserting after "Information Agency," the following: "the American Health Security Standards Board,"; and

(3) by inserting after the second section 8G the following:

"§ 8I. Special provisions concerning American Health Security Standards Board

"The Inspector General of the American Health Security Standards Board, in addition to the other authorities vested by this Act, shall have the same authority, with respect to the Board and the American Health Security Program under this Act, as the Inspector General for the Department of Health and Human Services has with respect to the Secretary of Health and Human Services and the medicare and medicaid programs, respectively.".

(j) STAFF.—The Board shall employ such staff as the Board may deem necessary.

(k) ACCESS TO INFORMATION.—The Secretary of Health and Human Services shall make available to the Board all information available from sources within the Department or from other sources, pertaining to the duties of the Board.

SEC. 402. AMERICAN HEALTH SECURITY ADVISORY COUNCIL.

(a) IN GENERAL.—The Board shall provide for an American Health Security Advisory Council (in this section referred to as the "Council") to advise the Board on its activities.

(b) MEMBERSHIP.—The Council shall be composed of—

(1) the Chair of the Board, who shall serve as Chair of the Council, and

(2) twenty members, not otherwise in the employ of the United States, appointed by the Board without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

The appointed members shall include, in accordance with subsection (e), individuals who are representative of State health security programs, public health professionals, providers of health services, and of individuals (who shall constitute a majority of the Council) who are representative of consumers of such services, including a balanced representation of employers, unions, consumer organizations, and population groups with special health care needs. To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(c) TERMS OF MEMBERS.—Each appointed member shall hold office for a term of four years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which the member's predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of the members first taking office shall expire, as designated by the Board at the time of appointment, five at the end of the first year, five at the end of the second year, five at the end of the third year,

and five at the end of the fourth year after the date of enactment of this Act.

(d) VACANCIES.—

(1) IN GENERAL.—The Board shall fill any vacancy in the membership of the Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The Board may reappoint an appointed member of the Council for a second term in the same manner as the original appointment.

(e) QUALIFICATIONS.—

(1) PUBLIC HEALTH REPRESENTATIVES.—Members of the Council who are representative of State health security programs and public health professionals shall be individuals who have extensive experience in the financing and delivery of care under public health programs.

(2) PROVIDERS.—Members of the Council who are representative of providers of health care shall be individuals who are outstanding in fields related to medical, hospital, or other health activities, or who are representative of organizations or associations of professional health practitioners.

(3) CONSUMERS.—Members who are representative of consumers of such care shall be individuals, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the consumption of such services.

(f) DUTIES.—

(1) IN GENERAL.—It shall be the duty of the Council—

(A) to advise the Board on matters of general policy in the administration of this Act, in the formulation of regulations, and in the performance of the Board's duties under section 401; and

(B) to study the operation of this Act and the utilization of health services under it, with a view to recommending any changes in the administration of the Act or in its provisions which may appear desirable.

(2) REPORT.—The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and the Board shall promptly transmit the report to the Congress, together with a report by the Board on any recommendations of the Council that have not been followed.

(g) STAFF.—The Council, its members, and any committees of the Council shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions.

(h) MEETINGS.—The Council shall meet as frequently as the Board deems necessary, but not less than four times each year. Upon request by seven or more members it shall be the duty of the Chair to call a meeting of the Council.

(i) COMPENSATION.—Members of the Council shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Board in accordance with subchapter I of chapter 57 of title 5, United States Code.

(j) FACA NOT APPLICABLE.—The provisions of the Federal Advisory Committee Act shall not apply to the Council.

SEC. 403. PROFESSIONAL, TECHNICAL, AND TEMPORARY ADVISORY COMMITTEES.

(a) IN GENERAL.—The Board shall appoint the standing advisory committees specified in subsections (b) through (f), and such other standing professional and technical committees in order to advise it in carrying out its duties under this Act.

(b) ADVISORY COMMITTEE ON BENEFITS.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Benefits to advise it with respect to the several classes of covered services under this Act.

(2) MEMBERSHIP.—The membership of the committee shall include individuals (in such number as the Board may determine) drawn from the health professions, from consumers of health services, from providers of health services (including non-medical licensed and non-licensed providers), or from other sources, whom the Board deems best qualified to advise it with respect to the professional and technical aspects of the furnishing and utilization of, and the evaluation of, a class of covered services designated by the Board, and with respect to the relationship of that class of services to other covered services. In appointing such individuals, the Board shall assure significant representation of consumers of health services and providers of health services. To the greatest extent feasible, the membership of the committee shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(c) ADVISORY COMMITTEE ON COST CONTAINMENT.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Cost Containment to advise it with respect to the payments and cost containment measures contained in title VI of this Act.

(2) MEMBERSHIP.—The membership of the committee shall include individuals (in such number as the Board may determine) with national recognition for their expertise in health economics, health care financing, provider reimbursement, and related fields. In appointing individuals the Board shall assure significant representation of consumers of health services and providers of health services. To the greatest extent feasible, the membership of the committee shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(d) ADVISORY COMMITTEE ON PRIMARY CARE AND THE MEDICALLY UNDERSERVED.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Primary Care and the Medically Underserved to advise it with respect to title VII of this Act, including with respect to the delivery of services and the education and training of health professionals, and to consider means of increasing the supply and expanding the scope of practice of mid-level professionals and the use of community health outreach workers and other non-professional health care workers.

(2) MEMBERSHIP.—The membership of the committee shall include individuals (in such number as the Board may determine) from the health professions and health services with expertise in—

(A) primary care services;

(B) the education and training of primary care practitioners;

(C) the special health needs of medically underserved populations;

(D) the training, educational, and financial incentives that would encourage health practitioners to serve in medically underserved areas;

(E) the delivery of health services through community-based and public facilities; and

(F) developing alternative models of delivering primary health services to medically underserved populations.

In appointing such individuals, the Board shall assure significant representation of consumers of health services and providers of health services. To the greatest extent feasible, the membership of the committee shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(e) ADVISORY COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Mental Health and Substance Abuse Treatment Services to advise it with respect to the manner in which the benefits under this Act for mental health services and substance abuse treatment services should be modified to best meet the objectives of this Act.

(2) MEMBERSHIP.—The membership of the committee shall include individuals (in such number as the Board may determine) with expertise in health care economics, who are representative of the multi-disciplinary range of providers of such services, who are consumers of such services, and who represent advocacy groups representing consumers of such services. To the greatest extent feasible, the membership of the committee shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) RESPONSIBILITIES.—The committee shall—

(A) study changes in the utilization patterns and costs which accompany the provision of mental health services and substance abuse treatment services;

(B) study and make recommendations on any changes that may be advisable in the utilization review thresholds specified in section 204(b)(2)(A);

(C) make recommendations on ways to create a continuum of care and encourage the provision of care in the least restrictive appropriate setting;

(D) develop a standard set of practices for care coordination services, including—

(i) the range of care coordination services that should be offered for a specific target population,

(ii) the organizational structure in which care coordination services should be based,

(iii) the minimum training requirements for care coordinators, and

(iv) the standards for the clinical necessity of care coordination services,

and study (and make recommendations concerning) peer care coordination services; and

(E) report any initial recommendations to the Board by January 1, 1996.

(4) ROLE OF SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—The Board shall consult with the Administrator of the Substance Abuse and Mental Health Services Administration in the appointment of members to, and operation of, the committee.

(f) ADVISORY COMMITTEE ON PRESCRIPTION DRUGS.—

(1) IN GENERAL.—The Board shall appoint a standing Advisory Committee on Prescription Drugs to advise it with respect to the list of approved prescription drugs and biologicals under section 616(a)(1) and other

matters relating to the coverage of prescription drugs under this Act.

(2) MEMBERSHIP.—

(A) IN GENERAL.—The membership of the committee shall include individuals (in such number as the Board may determine) with expertise in appropriate utilization of prescription and nonprescription drug and biological therapies and of the relative safety and efficacy of prescription drugs and biologicals.

(B) AREAS OF EXPERTISE.—A majority of the members of the committee shall be physicians. Members of the committee shall include at least a dentist, a nurse, and a pharmacist, and individuals with special knowledge or expertise in at least the following areas: geriatric, obstetric, pediatric, psychiatric, and neurological problems associated with drug therapies; clinical pharmacology; pharmacoepidemiology; and comparative clinical trials of drugs (including statisticians and biopharmaceutic specialists).

(C) CONFLICT OF INTEREST PROHIBITION.—No individual who is an employee of a manufacturer of a drug or biological or who otherwise has a material financial interest directly or indirectly with respect to such a manufacturer, or who has an immediate family member (as defined by the Board) who is such an employee or has such an interest, shall serve as a member of the committee.

(D) DIVERSITY OF MEMBERSHIP.—To the greatest extent feasible, the membership of the committee shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) RESPONSIBILITIES.—The committee shall—

(A) continuously review scientific and medical information pertaining to the relative safety and efficacy, and the comparability, of prescription drugs and biologicals approved for marketing in the United States; and

(B) recommend drug use classifications and identify, within such a classification, drugs that are therapeutic alternates for a given indication and indications for which particular drugs are superior based on safety and efficacy.

The committee is not authorized to engage in drug price negotiations nor define acceptable costs for any product.

(4) CONSUMER INPUT.—In conducting its activities, the committee shall solicit advice and comments from a panel of consumer advocates.

(g) TEMPORARY COMMITTEES.—The Board is authorized to appoint such temporary professional and technical committees as it deems necessary to advise it on special problems not encompassed in the assignments of standing committees appointed under this section or to supplement the advice of standing committees.

(h) REPORTING.—Committees appointed under this section shall report from time to time (but not less often than biannually) to the Board, and copies of their reports shall be transmitted by the Board to the American Health Security Advisory Council and be made readily available to the public.

(i) COMPENSATION.—All members of the committees established under this section shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Board in accordance with subchapter I of chapter 57 of title 5, United States Code.

(j) ADVICE FROM PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, PRACTITIONER PAYMENT REVIEW COMMISSION, ETC.—For provisions relating to role of certain commissions in reviewing payment rates, see section 620.

SEC. 404. AMERICAN HEALTH SECURITY QUALITY COUNCIL.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Quality Council.

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Council shall be composed of 10 members appointed by the President. The President shall first appoint individuals on a timely basis so as to provide for the operation of the Council by not later than January 1, 1995.

(2) SELECTION OF MEMBERS.—Each member of the Council shall be a member of a health profession. Six members of the Council shall be physicians. Individuals shall be appointed to the Council on the basis of national reputations for clinical and academic excellence. To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) TERMS OF MEMBERS.—Individuals appointed to the Council shall serve for a term of 5 years, except that the terms of 4 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, and 4 years.

(c) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint a member of the Council for a second term in the same manner as the original appointment. A member who has served for two consecutive 5-year terms shall not be eligible for reappointment until two years after the member has ceased to serve.

(d) CHAIR.—The President shall designate one of the members of the Council to serve at the will of the President as Chair of the Council.

(e) COMPENSATION.—Members of the Council who are not employees of the Federal Government shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

(f) GENERAL DUTIES OF THE COUNCIL.—The Council shall develop and update a set of national quality and performance measures which will apply to State health security programs, institutions, and health care professionals. In developing and selecting national measures of quality of performance, the Council shall consult with the Secretary of Health and Human Services and with appropriate interested parties, including States, health care providers, nationally recognized accrediting bodies, experts in quality measurement, and consumers. National measures of quality performance shall be selected and defined in a manner that will provide accurate and comparable information. The Council shall develop minimum criteria for competence for entities that can qualify to conduct ongoing and continuous external quality review for State quality review programs. Such entities must be independent of the State agency responsible for payments under the State health security program. The Council shall ensure coordination and reporting by State review entities to assure national consistency in quality standards. The Council is responsible for quality review activities under title V. The Council shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually specifically on findings from outcomes research and development of practice guidelines that may affect the Board's determination of coverage of services under section 401(f)(1)(G).

SEC. 405. STATE HEALTH SECURITY PROGRAMS.

(a) SUBMISSION OF PLANS.—

(1) IN GENERAL.—Each State shall submit to the Board a plan for a State health security program for providing for health care services to the residents of the State in accordance with this Act.

(2) REGIONAL PROGRAMS.—A State may join with one or more neighboring States to submit to the Board a plan for a regional health security program instead of separate State health security programs.

(3) REGIONAL PLANNING MECHANISMS.—The Board shall provide incentives for States to develop regional planning mechanisms to promote the rational distribution of, adequate access to, and efficient use of, tertiary care facilities, equipment, and services.

(b) REVIEW AND APPROVAL OF PLANS.—

(1) IN GENERAL.—The Board shall review plans submitted under subsection (a) and determine whether such plans meet the requirements for approval. The Board shall not approve such a plan unless it finds that the plan (or State law) provides, consistent with the provisions of this Act, for the following:

(A) Payment for required health services for eligible individuals in the State in accordance with this Act.

(B) Adequate administration, including the designation of a single State agency responsible for the administration (or supervision of the administration) of the program.

(C) The establishment of a State health security budget.

(D) Establishment of payment methodologies (consistent with subtitle B of title VII).

(E) Assurances that individuals have the freedom to choose practitioners and other health care providers for services covered under this Act.

(F) A procedure for carrying out long-term regional management and planning functions with respect to the delivery and distribution of health care services that—

(i) ensures participation of consumers of health services and providers of health services, and

(ii) gives priority to the most acute shortages and maldistributions of health personnel and facilities and the most serious deficiencies in the delivery of covered services and to the means for the speedy alleviation of these shortcomings.

(G) The licensure and regulation of all health providers and facilities to ensure compliance with Federal and State laws and to promote quality of care.

(H) Establishment of a quality review system in accordance with section 502.

(I) Establishment of an independent ombudsman for consumers to register complaints about the organization and administration of the State health security program and to help resolve complaints and disputes between consumers and providers.

(J) Publication of an annual report on the operation of the State health security program, which report shall include information on cost, progress towards achieving full enrollment, public access to health services, quality review, health outcomes, health professional training, and the needs of medically underserved populations.

(K) Provision of a fraud and abuse prevention and control unit that the Inspector General determines meets the requirements of section 413(a).

(L) Provision that—

(i) all claims or requests for payment for services shall be accompanied by the unique provider identifier assigned under section 414(a) to the provider and the unique patient identifier assigned to the individual under section 414(b);

(ii) no payment shall be made under the program for the provision of health care services by any provider unless the provider has furnished the program with the unique provider identifier assigned under section 414(a);

(iii) the plan shall use the unique patient identifier assigned under section 414(b) to an individual as the identifier of the individual in the processing of claims and other purposes (as specified by the Board); and

(iv) queries made under section 412(c)(2) shall be made using the unique provider identifier specified under section 414(a).

(M) Prohibit payment in cases of prohibited physician referrals under section 304.

(N) Effective January 1, 2001, provide for use of a uniform electronic data base in accordance with section 504(a).

(2) CONSEQUENCES OF FAILURE TO COMPLY.—If the Board finds that a State plan submitted under paragraph (1) does not meet the requirements for approval under this section or that a State health security program or specific portion of such program, the plan for which was previously approved, no longer meets such requirements, the Board shall provide notice to the State of such failure and that unless corrective action is taken within a period specified by the Board, the Board shall place the State health security program (or specific portions of such program) in receivership under the jurisdiction of the Board.

(c) STATE HEALTH SECURITY ADVISORY COUNCILS.—

(1) IN GENERAL.—For each State, the Governor shall provide for appointment of a State Health Security Advisory Council to advise and make recommendations to the Governor and State with respect to the implementation of the State health security program in the State.

(2) MEMBERSHIP.—Each State Health Security Advisory Council shall be composed of at least 11 individuals. The appointed members shall include individuals who are representative of the State health security program, public health professionals, providers of health services, and of individuals (who shall constitute a majority) who are representative of consumers of such services, including a balanced representation of employers, unions and consumer organizations. To the greatest extent feasible, the membership of each State Health Security Advisory Council shall represent the various geographic regions of the State and shall reflect the racial, ethnic, and gender composition of the population of the State.

(3) DUTIES.—

(A) IN GENERAL.—Each State Health Security Advisory Council shall review, and submit comments to the Governor concerning the implementation of the State health security program in the State.

(B) ASSISTANCE.—Each State Health Security Advisory Council shall provide assistance and technical support to community organizations and public and private non-profit agencies submitting applications for funding under appropriate State and Federal public health programs, with particular emphasis placed on assisting those applicants with broad consumer representation.

(d) STATE USE OF FISCAL AGENTS.—

(1) IN GENERAL.—Each State health security program, using competitive bidding procedures, may enter into such contracts with qualified entities, such as voluntary associations, as the State determines to be appropriate to process claims and to perform other related functions of fiscal agents under the State health security program.

(2) RESTRICTION.—Except as the Board may provide for good cause shown, in no case may more than one contract described in paragraph (1) be entered into under a State health security program.

SEC. 406. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, the Secretary of Health and Human Services shall direct all activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this Act.

Subtitle B—Control Over Fraud and Abuse

SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL FRAUD AND ABUSE UNDER AMERICAN HEALTH SECURITY PROGRAM.

The following sections of the Social Security Act shall apply to State health security programs in the same manner as they apply to State medical assistance plans under title XIX of such Act (except that in applying such provisions any reference to the Secretary is deemed a reference to the Board):

(1) Section 1128 (relating to exclusion of individuals and entities).

(2) Section 1128A (civil monetary penalties).

(3) Section 1128B (criminal penalties).

(4) Section 1124 (relating to disclosure of ownership and related information).

(5) Section 1126 (relating to disclosure of certain owners).

SEC. 412. NATIONAL HEALTH CARE FRAUD DATA BASE.

(a) ESTABLISHMENT.—The American Health Security Standards Board, through the Inspector General, shall establish a national data base (in this section referred to as the "data base") containing information relating to health care fraud and abuse.

(b) DATA INCLUDED.—

(1) IN GENERAL.—The data base shall include such information as the Inspector General, in consultation with the Board, shall specify, and shall include at least the information described in paragraph (2).

(2) SPECIFIED INFORMATION.—The information specified in this paragraph is, with respect to providers of health care services, the identity of any provider—

(A) that has been convicted of a crime for which the provider may be excluded from participation under a health program (as defined in paragraph (3));

(B) whose license to provide health care has been revoked or suspended (as described in section 1128(b)(5) of the Social Security Act);

(C) that has been excluded or suspended from a health program under section 1128 of the Social Security Act or from any other Federal or State health care program;

(D) with respect to whom a civil money penalty has been imposed under this Act or the Social Security Act; or

(E) that otherwise is subject to exclusion from participation under a health program.

(3) HEALTH PROGRAM DEFINED.—In this section, the term "health program" means a State health security program and includes the medicare program (under title XVIII of the Social Security Act) and a State health care program (as defined in section 1128(h) of such Act).

(c) REPORTING REQUIREMENT.—

(1) REPORTING.—Each State health security program shall provide such information to the Inspector General as the Inspector General may require in order to carry out fraud and abuse control activities and for purposes of maintaining the data base.

(2) QUERYING.—In accordance with rules established by the Board (in consultation with the Inspector General), each State health security program shall query periodically (as specified by the Inspector General)—

(A) the data base to determine if providers of health services for which the program makes payment are not disqualified from providing such services, and

(B) the Secretary of Health and Human Services, concerning information obtained by the Secretary under part B of the Health Care Quality Improvement Act of 1986 relating to practitioners.

(3) COORDINATION WITH MALPRACTICE DATA BASE.—The Secretary of Health and Human Services shall provide for the coordination of the reporting and disclosure of information under this section with information under part B of the Health Care Quality Improvement Act of 1986.

(4) UNIFORM MANNER.—Information shall be reported under this subsection in a uniform manner (in accordance with standards of the Inspector General) that permits aggregation of reported information.

(5) ACCESS FOR AUDIT.—Each State health security program shall provide the Inspector General such access to information as may be required to verify the information reported under this subsection.

(6) PENALTY FOR FALSE INFORMATION.—Any person that submits false information required to be provided under this subsection or that denies access to information under paragraph (5) may be imprisoned for not more than 5 years, or fined, or both, in accordance with title 18, United States Code.

(7) CONFIDENTIALITY.—The Board shall establish rules that protect the confidentiality of the information in the data base.

SEC. 413. REQUIREMENTS FOR OPERATION OF STATE HEALTH CARE FRAUD AND ABUSE CONTROL UNITS.

(a) REQUIREMENT.—In order to meet the requirement of section 405(b)(1)(K), each State health security program must establish and maintain a health care fraud and abuse control unit (in this section referred to as a "fraud unit") that meets requirements of this section and other requirements of the Board. Such a unit may be a State medicaid fraud control unit (described in section 1903(q) of the Social Security Act).

(b) STRUCTURE OF UNIT.—The fraud unit must—

(1) be a single identifiable entity of the State government;

(2) be separate and distinct from the State agency with principal responsibility for the administration of the State health security program; and

(3) meet 1 of the following requirements:

(A) It must be a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations.

(B) If it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Board, that (i) assure its referral of suspected criminal violations relating to the State health insurance plan to the appropriate authority or authorities in the States for prosecution, and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions.

(C) It must have a formal working relationship with the office of the State Attorney General and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Board and which provide effective coordination of activities between the fraud unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the State health insurance plan.

(c) FUNCTIONS.—The fraud unit must—

(1) have the function of conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of health care services and activities of providers of such services under the State health security program;

(2) have procedures for reviewing complaints of the abuse and neglect of patients of providers and facilities that receive payments under the State health security program, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action; and

(3) provide for the collection, or referral for collection to a single State agency, of overpayments that are made under the State health security program to providers and that are discovered by the fraud unit in carrying out its activities.

(d) RESOURCES.—The fraud unit must—

(1) employ such auditors, attorneys, investigators, and other necessary personnel,

(2) be organized in such a manner, and

(3) provide sufficient resources (as specified by the Board),

as is necessary to promote the effective and efficient conduct of the unit's activities.

(e) COOPERATIVE AGREEMENTS.—The fraud unit must have cooperative agreements (as specified by the Board) with—

(1) similar fraud units in other States,

(2) the Inspector General, and

(3) the Attorney General of the United States.

(f) REPORTS.—The fraud unit must submit to the Inspector General an application and annual reports containing such information as the Inspector General determines to be necessary to determine whether the unit meets the previous requirements of this section.

SEC. 414. ASSIGNMENT OF UNIQUE PROVIDER AND PATIENT IDENTIFIERS.

(a) PROVIDER IDENTIFIERS.—

(1) IN GENERAL.—The Board shall provide for the assignment, to each individual or entity providing health care services under a State health security program, of a unique provider identifier.

(2) RESPONSE TO QUERIES.—Upon the request of a State health security program with respect to a provider, the Board shall provide the program with the unique provider identifier (if any) assigned to the provider under paragraph (1).

(b) PATIENT IDENTIFIERS.—The Board shall provide for the assignment, to each eligible individual, of a unique patient identifier. The identifier so assigned may be the Social Security account number of the individual.

(c) REQUIREMENT TO USE IDENTIFIERS.—Each State health security program is required under section 405(b)(1)(L) to use the unique identifiers assigned under this section.

TITLE V—QUALITY ASSESSMENT

SEC. 501. FUNCTIONS OF QUALITY COUNCIL; DEVELOPMENT OF PRACTICE GUIDELINES AND APPLICATION TO OUTLIERS.

(a) DEVELOPMENT OF PRACTICE GUIDELINES.—The American Health Security Quality Council (in this title referred to as the "Council")—

(1) shall collect data from outcomes research, including data on patient satisfaction and post-hospital discharge experience, on an ongoing basis (whether conducted by the Federal Government or other entities), and

(2) on the basis of such data and existing clinical knowledge, shall develop practice guidelines.

Such guidelines may vary based upon the area in which the services are provided and the degree of training, specialization, or similar characteristics of providers. Such guidelines must be updated on an annual basis and based on monitoring of outcomes research and other clinical data. Such guidelines shall be based on the degree to which a process of care increases the probability of desired patient outcomes.

(b) PROFILING OF PATTERNS OF PRACTICE; IDENTIFICATION OF OUTLIERS.—The Council shall adopt methodologies for profiling the patterns of practice of health care professionals and for identifying outliers (as defined in subsection (f)).

(c) CENTERS OF EXCELLENCE.—The Council shall develop guidelines for certain medical procedures designated by the Board to be performed only at tertiary care centers which can meet standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome. Reimbursement under this Act for such a designated procedure may only be provided if the procedure was performed at a center that meets such standards.

(d) REMEDIAL ACTIONS.—The Council shall develop standards for education and sanctions with respect to outliers so as to assure the quality of health care services provided under this Act. The Council shall develop criteria for referral of providers to the State licensing board if education proves ineffective in correcting provider practice behavior.

(e) DISSEMINATION.—The Council shall disseminate to the State—

(1) the guidelines developed under subsections (a) and (c),

(2) the methodologies adopted under subsection (b), and

(3) the standards developed under subsection (d),

for use by the States under section 502.

(f) OUTLIER DEFINED.—In this title, the term "outlier" means a health care provider whose pattern of practice, relative to applicable practice guidelines, suggests deficiencies in the quality of health care services being provided.

SEC. 502. STATE QUALITY REVIEW PROGRAMS.

(a) REQUIREMENT.—In order to meet the requirement of section 405(b)(1)(H), each State health security program shall establish one or more qualified entities to conduct quality reviews of persons providing covered services under the program, in accordance with standards established under subsection (b)(1) (except as provided in subsection (b)(2)) and subsection (d).

(b) FEDERAL STANDARDS.—

(1) IN GENERAL.—The Council shall establish standards with respect to—

(A) the adoption of practice guidelines (developed under section 501(a)),

(B) the identification of outliers (consistent with methodologies adopted under section 501(b)),

(C) the development of remedial programs and monitoring for outliers, and

(D) the application of sanctions (consistent with the standards developed under section 501(c)).

(2) STATE DISCRETION.—A State may apply under subsection (a) standards other than those established under paragraph (1) so long as the State demonstrates to the satisfaction of the Council on an annual basis that the standards applied have been as efficacious in promoting and achieving improved quality of care as the application of the standards established under paragraph (1). Positive improvements in quality shall be documented by reductions in the variations of clinical care process and improvement in patient outcomes.

(c) QUALIFICATIONS.—

(1) IN GENERAL.—An entity is not qualified to conduct quality reviews under subsection (a) unless the entity—

(A) is administratively independent of the individual or board that administers the State health security program, and

(B) does not provide any financial incentive to reviewers to favor one pattern of practice over another.

(2) PROVIDER-SPECIFIC ENTITIES.—Subject to paragraph (1), a State may provide that an individual hospital (or other institutional provider) may serve as a qualified entity to conduct quality reviews under subsection (a).

SEC. 503. ELIMINATION OF UTILIZATION REVIEW PROGRAMS; TRANSITION.

(a) INTENT.—It is the intention of this title to replace by January 1, 1998, random utilization controls with a systematic review of patterns of practice that compromise the quality of care.

(b) SUPERSEDING CASE REVIEWS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the program of quality review provided under the previous sections of this title supersede all existing Federal requirements for utilization review programs, including requirements for random case-by-case reviews and programs requiring pre-certification of medical procedures on a case-by-case basis.

(2) TRANSITION.—Before January 1, 1998, the Board and the States may employ existing utilization review standards and mechanisms as may be necessary to effect the transition to pattern of practice-based reviews.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) as precluding the case-by-case review of the provision of care—

(i) in individual incidents where the quality of care has significantly deviated from acceptable standards of practice, and

(ii) with respect to a provider who has been determined to be an outlier; or

(B) as precluding the case management of catastrophic, mental health, or substance abuse cases where such management is necessary to achieve appropriate, cost-effective, and beneficial comprehensive medical care, as provided for in section 204.

SEC. 504. DEVELOPMENT OF NATIONAL ELECTRONIC DATA BASE.

(a) USE BY STATES.—In order to meet the requirement of this section, for purposes of section 405(b)(1)(N)), each State health security program shall develop and use a uniform electronic data base which uses the software designated under subsection (b) and which assures confidentiality under subsection (c), for all patient records in order to enable systematic quality review and outcomes analysis. Subject to subsection (c), data in such data base shall be made available, under rules established by the Board, in order to facilitate the portability of patient records and comparative outcomes research analysis.

(b) UNIFORM SOFTWARE.—The Board shall designate the uniform software that shall be used by States in the operation of their electronic data bases, in order to facilitate the portability of patient records and comparative outcomes research analysis. The Board shall not grant any waiver of the requirement of the previous sentence.

(c) CONFIDENTIALITY.—The Board shall establish standards that are designed to protect the privacy and otherwise shield the identity of the patients whose records are included in the data base. Under such standards, government agencies shall not have access to information in the data base that will identify individual patients except in cases of quality review procedures which require that individual patients be informed of necessary changes in their treatment.

TITLE VI—HEALTH SECURITY BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting and Payments to States

SEC. 601. NATIONAL HEALTH SECURITY BUDGET.

(a) NATIONAL HEALTH SECURITY BUDGET.—

(1) IN GENERAL.—By not later than September 1 before the beginning of each year (beginning with 1995), the Board shall establish a national health security budget, which—

(A) specifies the total expenditures (including expenditures for administrative costs) to be made by the Federal Government and the States for covered health care services under this Act, and

(B) allocates those expenditures among the States consistent with section 604.

Pursuant to subsection (b), such budget for a year shall not exceed the budget for the preceding year increased by the percentage increase in gross domestic product.

(2) DIVISION OF BUDGET INTO COMPONENTS.—The national health security budget shall consist of at least 4 components:

(A) A component for quality assessment activities (described in title V).

(B) A component for health professional education expenditures.

(C) A component for administrative costs.

(D) A component (in this title referred to as the "operating component") for operating and other expenditures not described in subparagraphs (A) through (C), consisting of amounts not included in the other components. A State may provide for the allocation of this component between capital expenditures and other expenditures.

(3) ALLOCATION AMONG COMPONENTS.—Taking into account the State health security budgets established and submitted under section 603, the Board shall allocate the national health security budget among the components in a manner that—

(A) assures a fair allocation for quality assessment activities (consistent with the national health security spending growth limit); and

(B) assures that the health professional education expenditure component is sufficient to provide for the amount of health professional education expenditures sufficient to meet the need for covered health care services (consistent with the national health security spending growth limit under subsection (b)(2)).

(b) BASIS FOR TOTAL EXPENDITURES.—

(1) IN GENERAL.—The total expenditures specified in such budget shall be the sum of the capitation amounts computed under section 602(a) and the amount of Federal administrative expenditures needed to carry out this Act.

(2) NATIONAL HEALTH SECURITY SPENDING GROWTH LIMIT.—For purposes of this subtitle, the national health security spending growth limit described in this paragraph for a year is zero, or, if greater, the percentage increase in the gross domestic product (in current dollars) from the first quarter of the second previous year to the first quarter of the previous year.

(c) DEFINITIONS.—In this title:

(1) CAPITAL EXPENDITURES.—The term "capital expenditures" means expenses for the purchase, lease, construction, or renovation of capital facilities and for equipment and includes return on equity capital.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term "health professional education expenditures" means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

SEC. 602. COMPUTATION OF INDIVIDUAL AND STATE CAPITATION AMOUNTS.

(a) CAPITATION AMOUNTS.—

(1) INDIVIDUAL CAPITATION AMOUNTS.—In establishing the national health security budget under section 601(a) and in computing the national average per capita cost under subsection (b) for each year, the Board shall establish a method for computing the capitation amount for each eligible individual residing in each State. The capitation amount for an eligible individual in a State classified within a risk group (established under subsection (d)(2)) is the product of—

(A) a national average per capita cost for all covered health care services (computed under subsection (b)),

(B) the State adjustment factor (established under subsection (c)) for the State, and

(C) the risk adjustment factor (established under subsection (d)) for the risk group.

(2) STATE CAPITATION AMOUNT.—

(A) IN GENERAL.—For purposes of this title, the term "State capitation amount" means, for a State for a year, the sum of the capitation amounts computed under paragraph (1) for all the residents of the State in the year, as estimated by the Board before the beginning of the year involved.

(B) USE OF STATISTICAL MODEL.—The Board may provide for the computation of State capitation amounts based on statistical models that fairly reflect the elements that comprise the State capitation amount described in subparagraph (A).

(C) POPULATION INFORMATION.—The Bureau of the Census shall assist the Board in determining the number, place of residence, and risk group classification of eligible individuals.

(b) COMPUTATION OF NATIONAL AVERAGE PER CAPITA COST.—

(1) FOR 1995.—For 1995, the national average per capita cost under this paragraph is equal to—

(A) the average per capita health care expenditures in the United States in 1993 (as estimated by the Board),

(B) increased to 1994 by the Board's estimate of the actual amount of such per capita expenditures during 1994, and

(C) updated to 1995 by the national health security spending growth limit specified in section 601(b)(2) for 1995.

(2) FOR SUCCEEDING YEARS.—For each succeeding year, the national average per capita cost under this subsection is equal to the national average per capita cost computed under this subsection for the previous year increased by the national health security spending growth limit (specified in section 601(b)(2)) for the year involved.

(c) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the Board shall develop for each State a factor to adjust the national average per capita costs to reflect differences between the State and the United States in—

(A) average labor and nonlabor costs that are necessary to provide covered health services;

(B) any social, environmental, or geographic condition affecting health status or the need for health care services, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d);

(C) the geographic distribution of the State's population, particularly the proportion of the population residing in medically underserved areas, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d); and

(D) any other factor relating to operating costs required to assure equitable distribution of funds among the States.

(2) MODIFICATION OF HEALTH PROFESSIONAL EDUCATION COMPONENT.—With respect to the portion of the national health security budget allocated to expenditures for health professional education, the Board shall modify the State adjustment factors so as to take into account—

(A) differences among States in health professional education programs in operation as of the date of the enactment of this Act, and

(B) differences among States in their relative need for expenditures for health professional education, taking into account the health professional education expenditures proposed in State health security budgets under section 603(a).

(3) BUDGET NEUTRALITY.—The State adjustment factors, as modified under paragraph (2), shall be applied under this subsection in a manner that results in neither an increase nor a decrease in the total amount of the Federal contributions to all State health security programs under subsection (b) as a result of the application of such factors.

(4) PHASE-IN.—In applying State adjustment factors under this subsection during the five-year period beginning with 1995, the Board shall phase-in, over such period, the use of factors described in paragraph (1) in a manner so that the adjustment factor for a State is based on a blend of such factors and a factor that reflects the relative actual average per capita costs of health services of the different States as of the time of enactment of this Act.

(5) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the State adjustment factors under this subsection.

(d) ADJUSTMENTS FOR RISK GROUP CLASSIFICATION.—

(1) IN GENERAL.—The Board shall develop an adjustment factor to the national average

per capita costs computed under subsection (b) for individuals classified in each risk group (as designated under paragraph (2)) to reflect the difference between the average national average per capita costs and the national average per capita cost for individuals classified in the risk group.

(2) RISK GROUPS.—The Board shall designate a series of risk groups, determined by age, health indicators, and other factors that represent distinct patterns of health care services utilization and costs.

(3) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the risk adjustment factors under this subsection.

SEC. 603. STATE HEALTH SECURITY BUDGETS.

(a) ESTABLISHMENT AND SUBMISSION OF BUDGETS.—

(1) IN GENERAL.—Each State health security program shall establish and submit to the Board for each year a proposed and a final State health security budget, which specifies the following:

(A) The total expenditures (including expenditures for administrative costs) to be made under the program in the State for covered health care services under this Act, consistent with subsection (b), broken down as follows:

(i) By the 4 components (described in section 601(a)(2)), consistent with subsection (b).

(ii) Within the operating component—

(I) expenditures for operating costs of hospitals and other facility-based services in the State,

(II) expenditures for payment to comprehensive health service organizations,

(III) expenditures for payment of services provided by health care practitioners, and

(IV) expenditures for other covered items and services.

Amounts included in the operating component include amounts that may be used by providers for capital expenditures.

(B) The total revenues required to meet the State health security expenditures.

(2) PROPOSED BUDGET DEADLINE.—The proposed budget for a year shall be submitted under paragraph (1) not later than June 1 before the year.

(3) FINAL BUDGET.—The final budget for a year shall—

(A) be established and submitted under paragraph (1) not later than October 1 before the year, and

(B) take into account the amounts established under the national health security budget under section 601 for the year.

(4) ADJUSTMENT IN ALLOCATIONS PERMITTED.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), in the case of a final budget, a State may change the allocation of amounts among components.

(B) NOTICE.—No such change may be made unless the State has provided prior notice of the change to the Board.

(C) DENIAL.—Such a change may not be made if the Board, within such time period as the Board specifies, disapproves such change.

(b) EXPENDITURE LIMITS.—

(1) IN GENERAL.—The total expenditures specified in each State health security budget under subsection (a)(1) shall take into account Federal contributions made under section 604.

(2) LIMIT ON CLAIMS PROCESSING AND BILLING EXPENDITURES.—Each State health security budget shall provide that State administrative expenditures, including expenditures for claims processing and billing, shall not exceed 3 percent of the total expenditures under the State health security program, unless the Board determines, on a case-by-case basis, that additional administrative expenditures would improve health care quality and cost effectiveness.

(3) WORKER ASSISTANCE.—A State health security program may provide that, for budgets for years before 2000, up to 1 percent of the budget may be used for purposes of programs providing assistance to workers who are currently performing functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of the program.

(c) APPROVAL PROCESS FOR CAPITAL EXPENDITURES PERMITTED.—Nothing in this title shall be construed as preventing a State health security program from providing for a process for the approval of capital expenditures based on information derived from regional planning agencies.

SEC. 604. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Each State with an approved State health security program is entitled to receive, from amounts in the American Health Security Trust Fund, on a monthly basis each year, of an amount equal to one-twelfth of the product of—

(1) the State capitation amount (computed under section 602(a)(2)) for the State for the year, and

(2) the Federal contribution percentage (established under subsection (b)).

(b) FEDERAL CONTRIBUTION PERCENTAGE.—The Board shall establish a formula for the establishment of a Federal contribution percentage for each State. Such formula shall take into consideration a State's per capita income and revenue capacity and such other relevant economic indicators as the Board determines to be appropriate. In addition, during the 5-year period beginning with 1995, the Board may provide for a transition adjustment to the formula in order to take into account current expenditures by the State (and local governments thereof) for health services covered under the State health security program. The weighted-average Federal contribution percentage for all States shall equal 86 percent and in no event shall such percentage be less than 81 percent nor more than 91 percent.

(c) USE OF PAYMENTS.—All payments made under this section may only be used to carry out the State health security program.

(d) EFFECT OF SPENDING EXCESS OR SURPLUS.—

(1) SPENDING EXCESS.—If a State exceeds its budget in a given year, the State shall continue to fund covered health services from its own revenues.

(2) SURPLUS.—If a State provides all covered health services for less than the budgeted amount for a year, it may retain its Federal payment for that year for uses consistent with this Act.

SEC. 605. ACCOUNT FOR HEALTH PROFESSIONAL EDUCATION EXPENDITURES.

(a) SEPARATE ACCOUNT.—Each State health security program shall—

(1) include a separate account for health professional education expenditures, and

(2) specify the general manner, consistent with subsection (b), in which such expenditures are to be distributed among different types of institutions and the different areas of the State.

(b) DISTRIBUTION RULES.—The distribution of funds to hospitals and other health care facilities from the account must conform to the following principles:

(1) The disbursement of funds must be consistent with achievement of the national and program goals (specified in section 701(b)) within the State health security program and the distribution of funds from the account must be conditioned upon the receipt of such reports as the Board may require in order to monitor compliance with such goals.

(2) The distribution of funds from the account must take into account the potentially higher costs of placing health professional students in clinical education programs in health professional shortage areas.

Subtitle B—Payments by States to Providers

SEC. 611. PAYMENTS TO HOSPITALS AND OTHER FACILITY-BASED SERVICES FOR OPERATING EXPENSES ON THE BASIS OF APPROVED GLOBAL BUDGETS.

(a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—Payment for operating expenses for institutional and facility-based care, including hospital services and nursing facility services, under State health security programs shall be made directly to each institution or facility by each State health security program under an annual prospective global budget approved under the program. Such a budget shall include payment for outpatient care and non-facility-based care that is furnished by or through the facility. In the case of a hospital that is wholly owned (or controlled) by a comprehensive health service organization that is paid under section 614 on the basis of a global budget, the global budget of the organization shall include the budget for the hospital.

(b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

(1) IN GENERAL.—The prospective global budget for an institution or facility shall be developed through annual negotiations between the State health security program and the institution or facility and be based on a nationally uniform system of cost accounting established under standards of the Board.

(2) CONSIDERATIONS.—In developing a budget through negotiations, there shall be taken into account at least the following:

(A) With respect to inpatient hospital services, the number, and classification by diagnosis-related group, of discharges.

(B) An institution's or facility's past expenditures.

(C) The extent to which debt service for capital expenditures has been included in the proposed operating budget.

(D) Change in the consumer price index and other price indices.

(E) The cost of reasonable compensation to health care practitioners.

(F) The compensation level of the institution's or facility's workforce.

(G) The extent to which the institution or facility is providing health care services to meet the needs of residents in the area served by the institution or facility, including the institution's or facility's occupancy level.

(H) The institution's or facility's previous financial and clinical performance, based on utilization and outcomes data provided under this Act.

(I) The type of institution or facility, including whether the institution or facility is part of a clinical education program or serves a health professional education, research or other training purpose.

(J) Technological advances or changes.

(K) Costs of the institution or facility associated with meeting Federal and State regulations.

(L) The costs associated with necessary public outreach activities.

(M) In the case of a for-profit facility, a reasonable rate of return on equity capital, independent of those operating expenses necessary to fulfill the objectives of this Act.

(N) Incentives to facilities that maintain costs below previous reasonable budgeted levels without reducing the care provided.

(O) With respect to facilities that provide mental health services and substance abuse treatment services, any additional costs involved in the treatment of dually diagnosed individuals.

The portion of such a budget that relates to expenditures for health professional education shall be consistent with the State health security budget for such expenditures.

(3) PROVISION OF REQUIRED INFORMATION; DIAGNOSIS-RELATED GROUP.—No budget for an institution or facility for a year may be approved unless the institution or facility has submitted on a timely basis to the State health security program such information as the program or the Board shall specify, including in the case of hospitals, information on discharges classified by diagnosis-related group.

(c) ADJUSTMENTS IN APPROVED BUDGETS.—

(1) ADJUSTMENTS TO GLOBAL BUDGETS THAT CONTRACT WITH COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.—Each State health security program shall develop an administrative mechanism for reducing operating funds to institutions or facilities in proportion to payments made to such institutions or facilities for services contracted for by a comprehensive health service organization.

(2) AMENDMENTS.—In accordance with standards established by the Board, an operating and capital budget approved under this section for a year may be amended before, during, or after the year if there is a substantial change in any of the factors relevant to budget approval.

(d) DONATIONS PERMISSIBLE.—The States health security programs may permit institutions and facilities to raise funds from private sources to pay for newly constructed facilities, major renovations, and equipment. The expenditure of such funds, whether for operating or capital expenditures, does not obligate the State health security program to provide for continued support for such expenditures unless included in an approved global budget.

SEC. 612. PAYMENTS TO HEALTH CARE PRACTITIONERS BASED ON PROSPECTIVE FEE SCHEDULE.

(a) FEE FOR SERVICE.—

(1) IN GENERAL.—Every independent health care practitioner is entitled to be paid, for the provision of covered health services under the State health security program, a fee for each billable covered service.

(2) GLOBAL FEE PAYMENT METHODOLOGIES.—The Board shall establish models and encourage State health security programs to implement alternative payment methodologies that incorporate global fees for related services (such as all outpatient procedures for treatment of a condition) or for a basic group of services (such as primary care services) furnished to an individual over a period of time, in order to encourage continuity and efficiency in the provision of services. Such methodologies shall be designed to ensure a high quality of care.

(3) BILLING DEADLINES; ELECTRONIC BILLING.—A State health security program may deny payment for any service of an independent health care practitioner for which it did not receive a bill and appropriate supporting documentation (which had been previously specified) within 30 days after the date the service was provided. Such a program may require that bills for services for which payment may be made under this section, or for any class of such services, be submitted electronically.

(b) PAYMENT RATES BASED ON NEGOTIATED PROSPECTIVE FEE SCHEDULES.—With respect to any payment method for a class of services of practitioners, the State health security program shall establish, on a prospective basis, a payment schedule. The State health security program may establish such a schedule after negotiations with organizations representing the practitioners involved. Such fee schedules shall be designed to provide incentives for practitioners to choose primary care medicine, including general internal medicine and pediatrics, over medical specialization. Nothing in this section shall be construed as preventing a State from adjusting the payment schedule amounts on a quarterly or other periodic basis depending on whether expenditures under the schedule will exceed the budgeted amount with respect to such expenditures.

(c) BILLABLE COVERED SERVICE DEFINED.—In this section, the term "billable covered service" means a service covered under section 201 for which a practitioner is entitled to compensation by payment of a fee determined under this section.

SEC. 613. PAYMENTS TO COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—Payment under a State health security program to a comprehensive health service organization to its enrollees shall be determined by the State—

(1) based on a global budget described in section 611, or

(2) based on the basic capitation amount described in subsection (b) for each of its enrollees.

(b) BASIC CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic capitation amount described in this subsection for an enrollee shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for covered health care services for an enrollee, based on actuarial characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the organization.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the cost of covered health care services that are not provided by the comprehensive health service organization under section 303(a).

SEC. 614. PAYMENTS FOR COMMUNITY-BASED PRIMARY HEALTH SERVICES.

(a) IN GENERAL.—In the case of community-based primary health services, subject to subsection (b), payments under a State health security program shall—

(1) be based on a global budget described in section 611,

(2) be based on the basic primary care capitation amount described in subsection (c) for each individual enrolled with the provider of such services, or

(3) be made on a fee-for-service basis under section 612.

(b) PAYMENT ADJUSTMENT.—Payments under subsection (a) may include, consistent with the budgets developed under this title—

(1) an additional amount, as set by the State health security program, to cover the costs incurred by a provider which serves persons not covered by this Act whose health care is essential to overall community health and the control of communicable disease, and for whom the cost of such care is otherwise uncompensated,

(2) an additional amount, as set by the State health security program, to cover the reasonable costs incurred by a provider that furnishes case management services (as defined in section 1915(g)(2) of the Social Security Act), transportation services, and translation services, and

(3) an additional amount, as set by the State health security program, to cover the costs incurred by a provider in conducting health professional education programs in connection with the provision of such services.

(c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic primary care capitation amount described in this subsection for an enrollee with a provider of community-based primary health services shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for such an enrollee, based on actuarial characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the provider.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the cost of community-based primary health services that are not provided by the provider.

(d) COMMUNITY-BASED PRIMARY HEALTH SERVICES DEFINED.—In this section, the term "community-based primary health services" has the meaning given such term in section 202(a).

SEC. 615. PAYMENTS FOR PRESCRIPTION DRUGS.

(a) ESTABLISHMENT OF LIST.—

(1) IN GENERAL.—Based upon the recommendations of the Advisory Committee on Prescription Drugs under section 403, the Board shall establish a list of approved prescription drugs and biologicals that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this Act.

(2) EXCLUSIONS.—The Board may exclude reimbursement under this Act for ineffective, unsafe, or over-priced products where better alternatives are determined to be available.

(b) PRICES.—For each such listed prescription drug or biological covered under this Act, for insulin, and for medical foods, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this Act as the cost of a drug to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with product manufacturers and distributors in determining the applicable product price or prices.

(c) CHARGES BY INDEPENDENT PHARMACIES.—Each State health security program shall provide for payment for a prescription drug or biological or insulin furnished by an independent pharmacy based on the drug's cost to the pharmacy (not in excess of the applicable product price established under subsection (b)) plus a dispensing fee. In accordance with standards established by the Board, each State health security program, after consultation with representatives of the pharmaceutical profession, shall establish schedules of dispensing fees, designed to afford reasonable compensation to independent pharmacies after taking into account variations in their cost of operation resulting from regional differences, differences in the volume of prescription drugs dispensed, differences in services provided, the need to maintain expenditures within the budgets established under this title, and other relevant factors.

SEC. 616. PAYMENTS FOR APPROVED DEVICES AND EQUIPMENT.

(a) ESTABLISHMENT OF LIST.—The Board shall establish a list of approved durable medical equipment and therapeutic devices and equipment (including eyeglasses, hearing aids, and prosthetic appliances), that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this Act.

(b) CONSIDERATIONS AND CONDITIONS.—In establishing the list under subsection (a), the Board shall take into consideration the efficacy, safety, and cost of each item contained on such list, and shall attach to any item such conditions as the Board determines appropriate with respect to the circumstances under which, or the frequency with which, the item may be prescribed.

(c) PRICES.—For each such listed item covered under this Act, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this Act as the cost of the item to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with equipment and device manufacturers and distributors in determining the applicable product price or prices.

(d) EXCLUSIONS.—The Board may exclude from coverage under this Act ineffective, unsafe, or overpriced products where better alternatives are determined to be available.

SEC. 617. PAYMENTS FOR OTHER ITEMS AND SERVICES.

In the case of payment for other covered health services, the amount of payment under a State health security program shall be established by the program—

(1) in accordance with payment methodologies which are specified by the Board, after consultation with the American Health Security Advisory Council, or methodologies established by the State under section 620, and

(2) consistent with the State health security budget.

SEC. 618. PAYMENT INCENTIVES FOR MEDICALLY UNDERSERVED AREAS.

(a) MODEL PAYMENT METHODOLOGIES.—In addition to the payment amounts otherwise provided in this title, the Board shall establish model payment methodologies and other incentives that promote the provision of covered health care services in medically underserved areas, particularly in rural and inner-city underserved areas.

(b) CONSTRUCTION.—Nothing in this title shall be construed as limiting the authority of State health security programs to increase payment amounts or otherwise provide additional incentives, consistent with the State health security budget, to encourage the provision of medically necessary and appropriate services in underserved areas.

SEC. 619. AUTHORITY FOR ALTERNATIVE PAYMENT METHODOLOGIES.

A State health security program, as part of its plan under section 405(a), may use a payment methodology other than a methodology required under this subtitle so long as—

(1) such payment methodology does not affect the entitlement of individuals to coverage, the weighting of fee schedules to encourage an increase in the number of primary care providers, the ability of individuals to choose among qualified providers, the benefits covered under the program, or the compliance of the program with the State health security budget under subtitle A, and

(2) the program submits periodic reports to the Board showing the operation and effectiveness of the alternative methodology, in order for the Board to evaluate the appropriateness of applying the alternative methodology to other States.

Subtitle C—Mandatory Assignment and Administrative Provisions

SEC. 631. MANDATORY ASSIGNMENT.

(a) NO BALANCE BILLING.—Payments for benefits under this Act shall constitute payment in full for such benefits and the entity furnishing an item or service for which payment is made under this Act shall accept such payment as payment in full for the item or service and may not accept any payment or impose any charge for any such item or service other than accepting payment from the State health security program in accordance with this Act.

(b) ENFORCEMENT.—If an entity knowingly and willfully bills for an item or service or accepts payment in violation of subsection (a), the Board may apply sanctions against the entity in the same manner as sanctions could have been imposed under section 1842(j)(2) of the Social Security Act for a violation of section 1842(j)(1) of such Act. Such sanctions are in addition to any sanctions that a State may impose under its State health security program.

SEC. 632. PROCEDURES FOR REIMBURSEMENT; APPEALS.

(a) PROCEDURES FOR REIMBURSEMENT.—In accordance with standards issued by the Board, a State health security program shall establish a timely and administratively simple procedure to assure payment within 60 days of the date of submission of clean claims by providers under this Act.

(b) APPEALS PROCESS.—Each State health security program shall establish an appeals process to handle all grievances pertaining to payment to providers under this title.

TITLE VII—PROMOTION OF PRIMARY HEALTH CARE; DEVELOPMENT OF HEALTH SERVICE CAPACITY; PROGRAMS TO ASSIST THE MEDICALLY UNDERSERVED

Subtitle A—Promotion and Expansion of Primary Care Professional Training

SEC. 701. ROLE OF BOARD; ESTABLISHMENT OF PRIMARY CARE PROFESSIONAL OUTPUT GOALS.

(a) IN GENERAL.—The Board is responsible for—

(1) coordinating health professional education policies and goals, in consultation with the Secretary of Health and Human Services (in this title referred to as the "Secretary"), to achieve the national goals specified in subsection (b);

(2) overseeing the health professional education expenditures of the State health security programs from the account established under section 602(c);

(3) developing and maintaining, in cooperation with the Secretary, a system to monitor the number and specialties of individuals through their health professional education, any postgraduate training, and professional practice; and

(4) developing, coordinating, and promoting other policies that expand the number of primary care practitioners.

(b) NATIONAL GOALS.—The national goals specified in this subsection are as follows:

(1) GRADUATE MEDICAL EDUCATION.—By not later than 5 years after the date of the enactment of this Act, at least 50 percent of the residents in medical residency education programs (as defined in subsection (e)(1)) are primary care residents (as defined in subsection (e)(3)).

(2) MIDLEVEL PRIMARY CARE PRACTITIONERS.—To assure an adequate supply of primary care practitioners, there shall be a number, specified by the Board, of midlevel primary care practitioners (as defined in subsection (e)(2)) employed in the health care system as of January 1, 2000.

(c) METHOD FOR ATTAINMENT OF NATIONAL GOAL FOR GRADUATE MEDICAL EDUCATION; PROGRAM GOALS.—

(1) IN GENERAL.—The Board shall establish a method of applying the national goal in subsection (b)(1) to program goals for each medical residency education program or to medical residency education consortia.

(2) CONSIDERATION.—The program goals under paragraph (1) shall be based on the distribution of medical schools and other teaching facilities within each State health security program, and the number of positions for graduate medical education.

(3) MEDICAL RESIDENCY EDUCATION CONSORTIUM.—In this subsection, the term "medical residency education consortium" means a consortium of medical residency education programs in a contiguous geographic area (which may be an interstate area) if the consortium—

(A) includes at least one medical school with a teaching hospital and related teaching settings, and

(B) has an affiliation with qualified community-based primary health service providers described in section 202(a) and with at least one comprehensive health service organization established under section 303.

(4) ENFORCEMENT THROUGH STATE HEALTH SECURITY BUDGETS.—The Board shall develop a formula for reducing payments to State health security programs (that provide for payments to a medical residency education program) that failed to meet the goal for the program established under this subsection.

(d) METHOD FOR ATTAINMENT OF NATIONAL GOAL FOR MIDLEVEL PRIMARY CARE PRACTITIONERS.—To assist in attaining the national goal identified in subsection (b)(2), the Board shall—

(1) advise the Public Health Service on allocations of funding under titles VII and VIII of the Public Health Service Act, the National Health Service Corps, and other programs in order to increase the supply of midlevel primary care practitioners, and

(2) commission a study of the potential benefits and disadvantages of expanding the scope of practice authorized under State laws for any class of midlevel primary care practitioners.

(e) DEFINITIONS.—In this title:

(1) MEDICAL RESIDENCY EDUCATION PROGRAM.—The term "medical residency education program" means a program that provides education and training to graduates of medical schools in order to meet requirements for licensing and certification as a physician, and includes the medical school supervising the program and includes the

hospital or other facility in which the program is operated.

(2) Midlevel Primary Care Practitioner.—The term "midlevel primary care practitioner" means a clinical nurse practitioner, certified nurse midwife, physician assistance, or other non-physician practitioner, specified by the Board, as authorized to practice under State law.

(3) Primary Care Resident.—The term "primary care resident" means (in accordance with criteria established by the Board) a resident being trained in a distinct program of family practice medicine, general practice, general internal medicine, or general pediatrics.

SEC. 702. ESTABLISHMENT OF ADVISORY COMMITTEE ON HEALTH PROFESSIONAL EDUCATION.

(a) In General.—The Board shall provide for an Advisory Committee on Health Professional Education (in this section referred to as the "Committee") to advise the Board on its activities under section 701.

(b) Membership.—The Committee shall be composed of—

(1) the Chair of the Board, who shall serve as Chair of the Committee, and

(2) 12 members, not otherwise in the employ of the United States, appointed by the Board without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

The appointed members shall provide a balanced point of view with respect to health professional education, primary care disciplines, and health care policy and shall include individuals who are representative of medical schools, other health professional schools, residency programs, primary care practitioners, teaching hospitals, professional associations, public health organizations, State health security programs, and consumers.

(c) Terms of Members.—Each appointed member shall hold office for a term of five years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which the member's predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of the members first taking office shall expire, as designated by the Board at the time of appointment, two at the end of the second year, two at the end of the third year, two at the end of the fourth year, and three at the end of the fifth year after the date of enactment of this Act.

(d) Vacancies.—

(1) In general.—The Board shall fill any vacancy in the membership of the Committee in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Committee.

(2) Vacancy appointments.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) Reappointment.—The Board may reappoint an appointed member of the Committee for a second term in the same manner as the original appointment.

(e) Duties.—It shall be the duty of the Committee to advise the Board concerning graduate medical education policies under this title.

(f) Staff.—The Committee, its members, and any committees of the Committee shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions.

(g) Meetings.—The Committee shall meet as frequently as the Board deems necessary, but not less than 4 times each year. Upon request by four or more members it shall be the duty of the Chair to call a meeting of the Committee.

(h) Compensation.—Members of the Committee shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Board in accordance with subchapter I of chapter 57 of title 5, United States Code.

(i) FACA Not Applicable.—The provisions of the Federal Advisory Committee Act shall not apply to the Committee.

SEC. 703. GRANTS FOR HEALTH PROFESSIONS EDUCATION, NURSE EDUCATION, AND THE NATIONAL HEALTH SERVICE CORPS.

(a) Transfers to Public Health Service.—From the amounts provided under subsection (c), the Board shall make transfers from the American Health Security Trust Fund to the Public Health Service under subpart II of part D of title III, title VII, and title VIII of the Public Health Service Act for the support of the National Health Service Corps, health professions education, and nursing education, including education of clinical nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and physician assistants. Of the amounts so transferred in each year, not less than 50 percent shall be expended for the support of the National Health Service Corps.

(b) Range of Funds.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 4/100 percent and not to exceed 6/100 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(c) Funds Supplemental to Other Funds.—The funds provided under this section with respect to provision of services are in addition to, and not in replacement of, funds made available under the provisions referred to in subsection (a) and shall be administered in accordance with the terms of such provisions. The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations for the programs authorized by such provisions are less than the total amount appropriated for such programs in fiscal year 1993.

Subtitle B—Direct Health Care Delivery

SEC. 711. SETASIDE FOR PUBLIC HEALTH.

(a) Transfers to Public Health Service.—From the amounts provided under subsection (c), the Board shall make transfers from the American Health Security Trust Fund to the Public Health Service for the following purposes (other than payment for services covered under title II):

(1) For payments to States under the maternal and child health block grants under title V of the Social Security Act.

(2) For prevention and treatment of tuberculosis under section 317 of the Public Health Service Act.

(3) For the prevention and treatment of sexually transmitted diseases under section 318 of the Public Health Service Act.

(4) Preventive health block grants under part A of title XIX of the Public Health Service Act.

(5) Grants to States for community mental health services under subpart I of part B of title XIX of the Public Health Service Act.

(6) Grants to States for prevention and treatment of substance abuse under subpart II of part B of title XIX of the Public Health Service Act.

(7) Grants for HIV health care services under parts A, B, and C of title XXVI of the Public Health Service Act.

(8) Public health formula grants described in subsection (d).

(b) Range of Funds.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 1/10 percent and not to exceed 14/100 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(c) Funds Supplemental to Other Funds.—The funds provided under this section with respect to provision of services are in addition to, and not in replacement of, funds made available under the programs referred to in subsection (a) and shall be administered in accordance with the terms of such programs.

(d) Required Reports on Health Status.—The Secretary shall require each State receiving funds under this section to submit annual reports to the Secretary on the health status of the population and measurable objectives for improving the health of the public in the State. Such reports shall include the following:

(1) A comparison of the measures of the State and local public health system compared to relevant objectives set forth in "Health People 2000" or subsequent national objectives set by the Secretary.

(2) A description of health status measures to be improved within the State (at the State and local levels) through expanded public health functions and health promotion and disease prevention programs.

(3) Measurable outcomes and process objectives for improving health status, and a report on outcomes from the previous year.

(4) Information regarding how Federal funding has improved population-based prevention activities and programs.

(5) A description of the core public health functions to be carried out at the local level.

(6) A description of the relationship between the State's public health system, community-based health promotion and disease prevention providers, and the State health security program.

(e) Limitation on Fund Transfers.—The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations for such programs are less than the total amount appropriated for such programs in fiscal year 1993.

(f) Public Health Formula Grants.—The Secretary shall provide stable funds to States through formula grants for the purpose of carrying out core public health functions to monitor and protect the health of communities from communicable diseases and exposure to toxic environmental pollutants, occupational hazards, harmful products, and poor health outcomes. Such functions include the following:

(1) Data collection, analysis, and assessment of public health data, vital statistics, and personal health data to assess community health status and outcomes reporting. This function includes the acquisition and installation of hardware and software, and personnel training and technical assistance to operate and support automated and integrated information systems.

(2) Activities to protect the environment and to assure the safety of housing, workplaces, food, and water.

(3) Investigation and control of adverse health conditions, and threats to the health status of individuals and the community. This function includes the identification and

control of outbreaks of infectious disease, patterns of chronic disease and injury, and cooperative activities to reduce the levels of violence.

(4) Health promotion and disease prevention activities for which there is a significant need and a high priority of the Public Health Service.

(5) The provision of public health laboratory services to complement private clinical laboratory services, including—

(A) screening tests for metabolic diseases in newborns,

(B) toxicology assessments of blood lead levels and other environmental toxins,

(C) tuberculosis and other disease requiring partner notification, and

(D) testing for infectious and food-borne diseases.

(6) Training and education for the public health professions.

(7) Research on effective and cost-effective public health practices. This function includes the development, testing, evaluation, and publication of results of new prevention and public health control interventions.

(8) Integration and coordination of the prevention programs and services of community-based providers, local and State health departments, and other sectors of State and local government that affect health.

SEC. 712. SETASIDE FOR PRIMARY HEALTH CARE DELIVERY.

(a) TRANSFERS TO PUBLIC HEALTH SERVICE.—From the amounts provided under subsection (c), the Board shall make transfers from the American Health Security Trust Fund to the Public Health Service for the program of primary care service expansion grants under subpart V of part D of title III of the Public Health Service Act (as added by section 713 of this Act).

(b) RANGE OF FUNDS.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 6/100 percent and not to exceed 1/10 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The funds provided under this section with respect to provision of services are in addition to, and not in replacement of, funds made available under the sections 329, 330, 340, 340A, 1001, and 2655 of the Public Health Service Act. The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations for such sections are less than the total amount appropriated under such sections in fiscal year 1993.

SEC. 713. PRIMARY CARE SERVICE EXPANSION GRANTS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end thereof the following new subpart:

"Subpart IX—Primary Care Expansion

"SEC. 340E. EXPANDING PRIMARY CARE DELIVERY CAPACITY IN URBAN AND RURAL AREAS.

"(a) GRANTS FOR PRIMARY CARE CENTERS.—From the amounts described in subsection (c), the American Health Security Standards Board shall make grants to public and nonprofit private entities for projects to plan and develop primary care centers which will serve medically underserved populations (as defined in section 330(b)(3)) in urban and rural areas and to deliver primary care services to such populations in such areas. The funds provided under such a grant may be used for the same purposes for which a grant may be made under subsection (c) or (d) of section 330.

"(b) PROCESS OF AWARDING GRANTS.—The provisions of subsection (e)(1) of section 330 shall apply to a grant under this section in the same manner as they apply to a grant under subsection (c) of such section. The provisions of subsection (g)(3) of such section shall apply to grants for projects to plan and develop primary care centers under this section in the same manner as they apply to grants under such section.

"(c) FUNDING AS SET-ASIDE FROM TRUST FUND.—Funding to carry out this section is provided from the American Health Security Trust Fund in accordance with section 912 of the American Health Security Act.

"(d) PRIMARY CARE CENTER DEFINED.—In this section, the term 'primary care center' means—

"(1) a migrant health center (as defined in section 329(a)(1)),

"(2) a community health center (as defined in section 330(a)),

"(3) an entity qualified to receive a grant under section 340, 340A, 1001, or 2655, or

"(4) a Federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act).".

Subtitle C—Primary Care and Outcomes Research

SEC. 721. SET-ASIDE FOR OUTCOMES RESEARCH.

(a) GRANTS FOR OUTCOMES RESEARCH.—The Board shall make transfers from the American Health Security Trust Fund to the Agency for Health Care Policy and Research under title IX of the Public Health Service Act for the purpose of carrying out activities under such title. The Secretary shall assure that there is a special emphasis placed on pediatric outcomes research.

(b) RANGE OF FUNDS.—The amount of transfers under subsection (a) for any fiscal year shall be an amount (specified by the Board each year) not less than 1/100 percent and not to exceed 2/100 percent of the amounts the Board estimates will be expended from the Trust Fund in the fiscal year.

(c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The funds provided under this section with respect to provision of services are in addition to, and not in replacement of, funds made available to the Agency for Health Care Policy and Research under section 926 of the Public Health Service Act. The Board shall make no transfer of funds under this section for any fiscal year for which the total appropriations under such section are less than the total amount appropriated under such section and title in fiscal year 1993.

(d) CONFORMING AMENDMENT.—Section 926(a) of the Public Health Service Act (42 U.S.C. 299c–5(a)) is amended by striking "$115,000,000" and all that follows and inserting "for each fiscal year (beginning with fiscal year 1994) such sums as may be necessary.".

SEC. 722. OFFICE OF PRIMARY CARE AND PREVENTION RESEARCH.

(a) IN GENERAL.—Title IV of the Public Health Service Act, as amended by section 141 of Public Law 103–43 (107 Stat. 136), is amended—

(1) by redesignating parts G through I as parts H through J, respectively; and

(2) by inserting after part F the following new part:

"PART G—RESEARCH ON PRIMARY CARE AND PREVENTION

"SEC. 486E. OFFICE OF PRIMARY CARE AND PREVENTION RESEARCH.

"(a) ESTABLISHMENT.—There is established within the Office of the Director of NIH an office to be known as the Office of Primary Care and Prevention Research (in this part referred to as the 'Office'). The Office shall be headed by a director, who shall be appointed by the Director of NIH.

"(b) PURPOSE.—The Director of the Office shall—

"(1) identify projects of research on primary care and prevention, for children as well as adults, that should be conducted or supported by the national research institutes, with particular emphasis on—

"(A) clinical patient care, with special emphasis on pediatric clinical care and diagnosis,

"(B) diagnostic effectiveness,

"(C) primary care education,

"(D) health and family planning services,

"(E) medical effectiveness outcomes of primary care procedures and interventions,

"(F) the use of multidisciplinary teams of health care practitioners,

"(2) identify multidisciplinary research related to primary care and prevention that should be so conducted;

"(3) promote coordination and collaboration among entities conducting research identified under any of paragraphs (1) and (2);

"(4) encourage the conduct of such research by entities receiving funds from the national research institutes;

"(5) recommend an agenda for conducting and supporting such research;

"(6) promote the sufficient allocation of the resources of the national research institutes for conducting and supporting such research; and

"(7) prepare the report required in section 486G.

"(c) PRIMARY CARE AND PREVENTION RESEARCH DEFINED.—For purposes of this part, the term 'primary care and prevention research' means research on improvement of the practice of family medicine, general internal medicine, and general pediatrics, and includes research relating to—

"(1) obstetrics and gynecology, dentistry, or mental health or substance abuse treatment when provided by a primary care physician or other primary care practitioner, and

"(2) primary care provided by multidisciplinary teams.

"SEC. 486F. NATIONAL DATA SYSTEM AND CLEARINGHOUSE ON PRIMARY CARE AND PREVENTION RESEARCH.

"(a) DATA SYSTEM.—The Director of NIH, in consultation with the Director of the Office, shall establish a data system for the collection, storage, analysis, retrieval, and dissemination of information regarding primary care and prevention research that is conducted or supported by the national research institutes. Information from the data system shall be available through information systems available to health care professionals and providers, researchers, and members of the public.

"(b) CLEARINGHOUSE.—The Director of NIH, in consultation with the Director of the Office and with the National Library of Medicine, shall establish, maintain, and operate a program to provide, and encourage the use of, information on research and prevention activities of the national research institutes that relate to primary care and prevention research.

"SEC. 486G. BIENNIAL REPORT.

"(a) IN GENERAL.—With respect to primary care and prevention research, the Director of the Office shall, not later than one year after the date of the enactment of this part, and biennially thereafter, prepare a report—

"(1) describing and evaluating the progress made during the preceding two fiscal years in research and treatment conducted or supported by the National Institutes of Health;

"(2) summarizing and analyzing expenditures made by the agencies of such Institutes (and by such Office) during the preceding two fiscal years; and

"(3) making such recommendations for legislative and administrative initiatives as the Director of the Office determines to be appropriate.

"(b) INCLUSION IN BIENNIAL REPORT OF DIRECTOR OF NIH.—The Director of the Office shall submit each report prepared under subsection (a) to the Director of NIH for inclusion in the report submitted to the President and the Congress under section 403.

"SEC. 486H. AUTHORIZATION OF APPROPRIATIONS.

"For the Office of Primary Care and Prevention Research, there are authorized to be appropriated $150,000,000 for fiscal year 1994, $180,000,000 for fiscal year 1995, and $216,000,000 for fiscal year 1996.".

(b) REQUIREMENT OF SUFFICIENT ALLOCATION OF RESOURCES OF INSTITUTES.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) in paragraph (11), by striking "and" after the semicolon at the end;

(2) in paragraph (12), by striking the period at the end and inserting "; and"; and

(3) by inserting after paragraph (12) the following new paragraph:

"(13) after consultation with the Director of the Office of Primary Care and Prevention Research, shall ensure that resources of the National Institutes of Health are sufficiently allocated for projects on primary care and prevention research that are identified under section 486E(b).".

Subtitle D—School-Related Health Services

SEC. 731. AUTHORIZATIONS OF APPROPRIATIONS.

(a) FUNDING FOR SCHOOL-RELATED HEALTH SERVICES.—For the purpose of carrying out this subtitle, there are authorized to be appropriated $100,000,000 for fiscal year 1997, $275,000,000 for fiscal year 1998, $350,000,000 for fiscal year 1999, and $400,000,000 for each of the fiscal years 2000 and 2001.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

SEC. 732. ELIGIBILITY FOR DEVELOPMENT AND OPERATION GRANTS.

(a) IN GENERAL.—Entities eligible to apply for and receive grants under section 734 or 735 are the following:

(1) State health agencies that apply on behalf of local community partnerships and other communities in need of health services for school-aged children within the State.

(2) Local community partnerships in States in which health agencies have not applied.

(b) LOCAL COMMUNITY PARTNERSHIPS.—

(1) IN GENERAL.—A local community partnership under subsection (a)(2) is an entity that, at a minimum, includes—

(A) a local health care provider with experience in delivering services to school-aged children;

(B) one or more local public schools; and

(C) at least one community based organization located in the community to be served that has a history of providing services to school-aged children in the community who are at-risk.

(2) PARTICIPATION.—A partnership described in paragraph (1) shall, to the maximum extent feasible, involve broad based community participation from parents and adolescent children to be served, health and social service providers, teachers and other public school and school board personnel, development and service organizations for adolescent children, and interested business leaders. Such participation may be evidenced through an expanded partnership, or an advisory board to such partnership.

(c) DEFINITIONS REGARDING CHILDREN.—For purposes of this subtitle:

(1) The term "adolescent children" means school-aged children who are adolescents.

(2) The term "school-aged children" means individuals who are between the ages of 4 and 19 (inclusive).

SEC. 733. PREFERENCES.

(a) IN GENERAL.—In making grants under sections 734 and 735, the Secretary shall give preference to applicants whose communities to be served show the most substantial level of need for such services among school-aged children, as measured by indicators of community health including the following:

(1) High levels of poverty.

(2) The presence of a medically underserved population.

(3) The presence of a health professional shortage area.

(4) High rates of indicators of health risk among school-aged children, including a high proportion of such children receiving services through the Individuals with Disabilities Education Act, adolescent pregnancy, sexually transmitted disease (including infection with the human immunodeficiency virus), preventable disease, communicable disease, intentional and unintentional injuries, community and gang violence, unemployment among adolescent children, juvenile justice involvement, and high rates of drug and alcohol exposure.

(b) LINKAGE TO COMMUNITY HEALTH CENTERS.—In making grants under sections 734 and 735, the Secretary shall give preference to applicants that demonstrate a linkage to community health centers.

SEC. 734. GRANTS FOR DEVELOPMENT OF PROJECTS.

(a) IN GENERAL.—The Secretary may make grants to State health agencies or to local community partnerships to develop school health service sites.

(b) USE OF FUNDS.—A project for which a grant may be made under subsection (a) may include but not be limited to the cost of the following:

(1) Planning for the provision of school health services.

(2) Recruitment, compensation, and training of health and administrative staff.

(3) The development of agreements, and the acquisition and development of equipment and information services, necessary to support information exchange between school health service sites and health plans, health providers, and other entities authorized to collect information under this Act.

(4) Other activities necessary to assume operational status.

(c) APPLICATION FOR GRANT.—

(1) IN GENERAL.—Applicants shall submit applications in a form and manner prescribed by the Secretary.

(2) APPLICATIONS BY STATE HEALTH AGENCIES.—

(A) In the case of applicants that are State health agencies, the application shall contain assurances that the State health agency is applying for funds—

(i) on behalf of at least one local community partnership; and

(ii) on behalf of at least one other community identified by the State as in need of the services funded under this subtitle but without a local community partnership.

(B) In the case of the communities identified in applications submitted by State health agencies that do not yet have local community partnerships (including the community identified under subparagraph (A)(ii)), the State shall describe the steps that will be taken to aid the communities in developing a local community partnership.

(C) A State applying on behalf of local community partnerships and other communities may retain not more than 10 percent of grants awarded under this subtitle for administrative costs.

(d) CONTENTS OF APPLICATION.—In order to receive a grant under this section, an applicant must include in the application the following information:

(1) An assessment of the need for school health services in the communities to be served, using the latest available health data and health goals and objectives established by the Secretary.

(2) A description of how the applicant will design the proposed school health services to reach the maximum number of school-aged children who are at risk.

(3) An explanation of how the applicant will integrate its services with those of other health and social service programs within the community.

(4) A description of a quality assurance program which complies with standards that the Secretary may prescribe.

(e) NUMBER OF GRANTS.—Not more than one planning grant may be made to a single applicant. A planning grant may not exceed two years in duration.

SEC. 735. GRANTS FOR OPERATION OF PROJECTS.

(a) IN GENERAL.—The Secretary may make grants to State health agencies or to local community partnerships for the cost of operating school health service sites.

(b) USE OF GRANT.—The costs for which a grant may be made under this section include but are not limited to the following:

(1) The cost of furnishing health services that are not otherwise covered under this Act or by any other public or private insurer.

(2) The cost of furnishing services whose purpose is to increase the capacity of individuals to utilize available health services, including transportation, community and patient outreach, patient education, translation services, and such other services as the Secretary determines to be appropriate in carrying out such purpose.

(3) Training, recruitment and compensation of health professionals and other staff.

(4) Outreach services to school-aged children who are at-risk and to the parents of such children.

(5) Linkage of individuals to health plans, community health services and social services.

(6) Other activities deemed necessary by the Secretary.

(c) APPLICATION FOR GRANT.—Applicants shall submit applications in a form and manner prescribed by the Secretary. In order to receive a grant under this section, an applicant must include in the application the following information:

(1) A description of the services to be furnished by the applicant.

(2) The amounts and sources of funding that the applicant will expend, including estimates of the amount of payments the applicant will receive from sources other than the grant.

(3) Such other information as the Secretary determines to be appropriate.

(d) ADDITIONAL CONTENTS OF APPLICATION.—In order to receive a grant under this section, an applicant must meet the following conditions:

(1) The applicant furnishes the following services:

(A) Diagnosis and treatment of simple illnesses and minor injuries.

(B) Preventive health services, including health screenings.

(C) Services provided for the purpose described in subsection (b)(2).

(D) Referrals and followups in situations involving illness or injury.

(E) Health and social services, counseling services, and necessary referrals, including referrals regarding mental health and substance abuse.

(F) Such other services as the Secretary determines to be appropriate.

(2) The applicant is a participating provider in the State's program for medical assistance under title XIX of the Social Security Act.

(3) The applicant does not impose charges on students or their families for services (including collection of any cost-sharing for services under the comprehensive benefit package that otherwise would be required).

(4) The applicant has reviewed and will periodically review the needs of the population served by the applicant in order to ensure that its services are accessible to the maximum number of school-aged children in the area, and that, to the maximum extent possible, barriers to access to services of the applicant are removed (including barriers resulting from the area's physical characteristics, its economic, social and cultural grouping, the health care utilization patterns of such children, and available transportation).

(5) In the case of an applicant which serves a population that includes a substantial proportion of individuals of limited English speaking ability, the applicant has developed a plan to meet the needs of such population to the extent practicable in the language and cultural context most appropriate to such individuals.

(6) The applicant will provide non-Federal contributions toward the cost of the project in an amount determined by the Secretary.

(7) The applicant will operate a quality assurance program consistent with section 734(d).

(e) DURATION OF GRANT.—A grant under this section shall be for a period determined by the Secretary.

(f) REPORTS.—A recipient of funding under this section shall provide such reports and information as are required in regulations of the Secretary.

SEC. 736. FEDERAL ADMINISTRATIVE COSTS.

Of the amounts made available under section 731, the Secretary may reserve not more than 5 percent for administrative expenses regarding this subtitle.

SEC. 737. DEFINITIONS.

For purposes of this subtitle:

(1) The term "adolescent children" has the meaning given such term in section 732(c).

(2) The term "at risk" means at-risk with respect to health.

(3) The term "community health center" has the meaning given such term in section 330 of the Public Health Service Act.

(4) The term "health professional shortage area" means a health professional shortage area designated under section 332 of the Public Health Service Act.

(5) The term "medically underserved population" has the meaning given such term in section 330 of the Public Health Service Act.

(6) The term "school-aged children" has the meaning given such term in section 732(c).

TITLE VIII—FINANCING PROVISIONS; AMERICAN HEALTH SECURITY TRUST FUND

SEC. 800. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO APPLY.

(a) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(b) SECTION 15 NOT TO APPLY.—The amendments made by subtitle B shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

Subtitle A—American Health Security Trust Fund

SEC. 801. AMERICAN HEALTH SECURITY TRUST FUND.

(a) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the American Health Security Trust Fund (in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 1995), out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the aggregate increase in tax liabilities under the Internal Revenue Code of 1986 which is attributable to the application of the amendments made by this title. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—Notwithstanding any other provision of law, there are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 1995) the amounts that would otherwise have been appropriated to carry out the following programs:

(A) The medicare program, under parts A and B of title XVIII of the Social Security Act (other than amounts attributable to any premiums under such parts).

(B) The medicaid program, under State plans approved under title XIX of such Act.

(C) The Federal employees health benefit program, under chapter 89 of title 5, United States Code.

(D) The CHAMPUS program, under chapter 55 of title 10, United States Code.

(E) The maternal and child health program (under title V of the Social Security Act), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by the Board, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health services the payment of which may be made under this Act.

(c) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act shall apply to the Trust Fund under this Act in the same manner as they applied to the Federal Hospital Insurance Trust Fund under part A of title XVIII of such Act, except that the American Health Security Standards Board shall constitute the Board of Trustees of the Trust Fund.

(d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund after the settlement of claims for payments under title XVIII have been completed, shall be transferred into the American Health Security Trust Fund.

Subtitle B—Taxes Based on Income and Wages

SEC. 811. PAYROLL TAX ON EMPLOYERS.

(a) IN GENERAL.—Section 3111 (relating to tax on employers) is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) HEALTH CARE.—

"(1) IN GENERAL.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the applicable percentage of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means—

"(A) 4 percent in the case of a small employer, and

"(B) 8.4 percent in the case of any other employer.

"(3) SMALL EMPLOYER.—

"(A) IN GENERAL.—For purposes of paragraph (2), the term 'small employer' means any employer if—

"(i) the average number of full-time employees (or the equivalent) of such employer during the preceding calendar year is less than 75, and

"(ii) the average annual wages (as defined in section 3121(a)) paid by such employer to such employees during such year is less than $24,000.

"(B) CONTROLLED GROUPS.—All persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as 1 employer for purposes of subparagraph (A)."

(b) SELF-EMPLOYMENT INCOME.—Section 1401 (relating to rate of tax on self-employment income) is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) HEALTH CARE.—

"(1) IN GENERAL.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to the applicable percentage (as defined in section 3111(c)) of the amount of the self-employment income for such taxable year.

"(2) SPECIAL RULE FOR DETERMINING APPLICABLE PERCENTAGE.—In determining the applicable percentage for purposes of paragraph (1), section 3111(c) shall be applied by treating such individual as an employee receiving wages equal to such individual's self-employment income for the taxable year."

(c) COMPARABLE TAXES FOR RAILROAD SERVICES.—

(1) TAX ON EMPLOYERS.—Section 3221 is amended by redesignating subsections (c), (d), and (e) as subsections (d), (e), and (f), respectively, and by inserting after subsection (b) the following new subsection:

"(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the applicable percentage (as defined in section 3111(c)) of the compensation paid by such employer for services rendered to such employer."

(2) TAX ON EMPLOYEE REPRESENTATIVES.—Subsection (a) of section 3211 (relating to tax on employee representatives) is amended by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

"(3) HEALTH CARE.—

"(A) IN GENERAL.—In addition to other taxes, there is hereby imposed on the income of each employee representative a tax equal to the applicable percentage of the compensation received during the calendar year by such employee representative for services rendered by such employee representative.

"(B) SPECIAL RULE FOR DETERMINING APPLICABLE PERCENTAGE.—In determining the applicable percentage for purposes of subparagraph (A), section 3111(c) shall be applied by treated such individual as an employee receiving wages equal to such individual's compensation for the taxable year."

(3) NO APPLICABLE BASE.—Subparagraph (A) of section 3231(e)(2) is amended by adding at the end thereof the following new clause:

"(iv) HEALTH CARE TAXES.—Clause (i) shall not apply to the taxes imposed by sections 3221(c) and 3211(a)(3)."

(4) TECHNICAL AMENDMENTS.—

(A) Paragraph (4) of section 3211, as redesignated by paragraph (2), is amended by striking "and (2)" and inserting ", (2), and (3)".

(B) Subsection (f) of section 3221, as redesignated by paragraph (1), is amended by striking "and (b)" and inserting ", (b), and (c)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to remuneration paid after December 31, 1996.

SEC. 812. HEALTH CARE INCOME TAX.

(a) GENERAL RULE.—Subchapter A of chapter 1 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

"PART VIII—HEALTH CARE INCOME TAX ON INDIVIDUALS

"Sec. 59B. Health care income tax.

"SEC. 59B. HEALTH CARE INCOME TAX.

"(a) IMPOSITION OF TAX.—In the case of an individual, there is hereby imposed a tax (in addition to any other tax imposed by this subtitle) equal to 2.1 percent of the taxable income of the taxpayer for the taxable year.

"(b) NO CREDITS AGAINST TAX; NO EFFECT ON MINIMUM TAX.—The tax imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(1) the amount of any credit allowable under this chapter, or

"(2) the amount of the minimum tax imposed by section 55.

"(c) SPECIAL RULES.—

"(1) TAX TO BE WITHHELD, ETC.—For purposes of this title, the tax imposed by this section shall be treated as imposed by section 1.

"(2) REIMBURSEMENT OF TAX BY EMPLOYER NOT INCLUDIBLE IN GROSS INCOME.—The gross income of an employee shall not include any payment by his employer to reimburse the employee for the tax paid by the employee under this section.

"(3) OTHER RULES.—The rules of section 59A(d) shall apply to the tax imposed by this section."

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end the following new item:

"Part VIII. Health care income tax on individuals."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle C—Increase in Excise Taxes on Tobacco Products

SEC. 821. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 is amended—

(1) by striking "$12 per thousand ($10 per thousand on cigarettes removed during 1991 or 1992)" in paragraph (1) and inserting "$100 per thousand", and

(2) by striking "$25.20 per thousand ($21 per thousand on cigarettes removed during 1991 or 1992)" in paragraph (2) and inserting "$210 per thousand".

(b) CIGARS.—Subsection (a) of section 5701 is amended—

(1) by striking "$1.125 cents per thousand (93.75 cents per thousand on cigars removed during 1991 or 1992)" in paragraph (1) and inserting "$9.38 per thousand", and

(2) by striking "equal to" and all that follows in paragraph (2) and inserting "equal to 106.25 percent of the price for which sold but not more than $250 per thousand."

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 is amended by striking "0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)" and inserting "6.25 cents".

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 is amended by striking "1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)" and inserting "12.5 cents".

(e) SMOKELESS TOBACCO.—Subsection (e) of section 5701 is amended—

(1) by striking "36 cents (30 cents on snuff removed during 1991 or 1992)" in paragraph (1) and inserting "$3.00", and

(2) by striking "12 cents (10 cents on chewing tobacco removed during 1991 or 1992)" in paragraph (2) and inserting "$1.00".

(f) PIPE TOBACCO.—Subsection (f) of section 5701 is amended by striking "67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)" and inserting "$5.63".

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986) after December 31, 1996.

(h) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States which are removed before January 1, 1997, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 or 7652 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on January 1, 1997, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding any article on January 1, 1997, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before July 31, 1997.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on January 1, 1997, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section.

(B) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or his delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

Subtitle D—Increase in Taxes on Firearms and Ammunition

SEC. 831. INCREASE IN TAXES ON FIREARMS AND AMMUNITION.

(a) PISTOLS AND REVOLVERS.—The text of section 4181 (relating to imposition of tax on firearms) is amended to read as follows:

"There is hereby imposed upon the sale by the manufacturer, producer, or importer of any pistol, revolver, firearm, shell, or cartridge a tax equal to 50 percent of the price for which so sold."

(b) ADDITIONAL TAXES NOT ADDED TO WILDLIFE FUND.—Section 3(a) of the Act of September 2, 1937 (16 U.S.C. 669b(a)), commonly referred to as the "Pittman-Robertson Wildlife Restoration Act", is amended by adding at the end the following new sentence: "There shall not be covered into the fund the portion of the tax imposed by such section 4181 that is attributable to any increase in amounts received in the Treasury under such section by reason of the amendment made by section 831 of the American Health Security Act, as estimated by the Secretary.".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

(d) FLOOR STOCKS TAX.—

(1) IMPOSITION OF TAX.—In the case of any taxable article on which tax was imposed under section 4181 of the Internal Revenue Code of 1986 before January 1, 1997, and which is held by a dealer on such date, there is hereby imposed a floor stocks tax equal to the excess of—

(A) the tax which would be imposed by such section if such article had been sold by the manufacturer, producer, or importer on such date, over

(B) the tax imposed by such section on such article.

(2) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—The dealer holding the taxable article on January 1, 1997, to which the tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary of the Treasury or his delegate shall prescribe.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before July 31, 1997.

(3) DEFINITIONS.—For purposes of this subsection—

(A) TAXABLE ARTICLE.—The term "taxable article" means any article subject to tax under section 4181 of such Code, other than an article exempt from such tax under section 4182 of such Code.

(B) HELD BY A DEALER.—The term "held by a dealer" has the meaning given such term by section 6412 of such Code.

(4) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on January 1, 1997, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(5) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 4181 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply with respect to the floor stock taxes imposed by paragraph (1) to the same extent as if such taxes were imposed by such section 4181.

TITLE IX—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 901. ERISA INAPPLICABLE TO HEALTH COVERAGE ARRANGEMENTS UNDER STATE HEALTH SECURITY PROGRAMS.

Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended—

(1) in subsection (a), by striking "subsection (b)" and inserting "subsections (b) and (c)"; and

(2) by adding at the end the following new subsection:

"(c) The provisions of this title shall not apply to any arrangement forming a part of a State health security program established pursuant to section 101(b) of the American Health Security Act of 1994.".

SEC. 902. EXEMPTION OF STATE HEALTH SECURITY PROGRAMS FROM ERISA PREEMPTION.

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by adding at the end the following new paragraph:

"(9) Subsection (a) of this section shall not apply to State health security programs established pursuant to section 101(b) of the American Health Security Act of 1994.".

SEC. 903. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF BENEFITS UNDER STATE HEALTH SECURITY PROGRAMS.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

"PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF STATE HEALTH SECURITY PROGRAM BENEFITS

"SEC. 516. No employee benefit plan may provide benefits which duplicate payment for any items or services for which payment may be made under a State health security program established pursuant to section 101(b) of the American Health Security Act of 1994.".

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 514 the following new items:

"Sec. 515. Delinquent contributions.
"Sec. 516. Prohibition of employee benefits duplicative of State health security program benefits.".

SEC. 904. REPEAL OF CONTINUATION COVERAGE REQUIREMENTS UNDER ERISA AND CERTAIN OTHER REQUIREMENTS RELATING TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(A) by adding "or" at the end of paragraph (6);

(B) by striking paragraph (7); and

(C) by redesignating paragraph (8) as paragraph (7).

(2) Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by striking "paragraph (1) or (4) of section 606 or".

(3) Section 4301(c)(4) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66; 107 Stat. 377) and the amendments made thereby are repealed.

(4) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the items relating to part 6 of subtitle B of title I of such Act.

SEC. 905. EFFECTIVE DATE OF TITLE.

The amendments made by this title shall take effect January 1, 1996.

AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 3600, AS REPORTED OFFERED BY MR. MANZULLO OF ILLINOIS

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the "Small Business Health Insurance Choice Act".

(b) FINDINGS RELATING TO INTERSTATE COMMERCE.—Congress finds that health insurance is a critical part of the economy of the United States and interstate commerce, consumes a significant percentage of public and private spending, and affects all industries and individuals in the United States.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

Sec. 1. Short title; findings.
Sec. 2. Table of contents.

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Increased Availability and Continuity of Health Coverage for Employees and Their Families

PART 1—PREEXISTING CONDITIONS AND CONTINUITY OF COVERAGE; RENEWABILITY

Sec. 101. Limitation on pre-existing condition clauses.
Sec. 102. Assurance of continuity of coverage through previous satisfaction of pre-existing condition requirement.
Sec. 103. Requirements relating to renewability generally.

PART 2—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

Sec. 111. Enforcement.
Sec. 112. Effective dates.
Sec. 113. Definitions.

Subtitle B—Preemption of Scope of State Regulation

Sec. 121. Prohibition of State benefit mandates for group health plans.
Sec. 122. Prohibition of provisions prohibiting employer groups from purchasing health insurance.
Sec. 123. Restrictions on managed care.
Sec. 124. Definitions.

Subtitle C—Health Deduction Fairness

Sec. 131. Permanent extension and increase in health insurance tax deduction for self-employed individuals.
Sec. 132. Deduction of health insurance premiums for certain previously uninsured individuals.

TITLE II—REMOVING ANTI-TRUST IMPEDIMENTS

Sec. 201. Establishment of limited exemption program for health care joint ventures.
Sec. 202. Issuance of health care certificates of public advantage.
Sec. 203. Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care.
Sec. 204. Definitions.

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Increased Availability and Continuity of Health Coverage for Employees and Their Families

PART 1—PREEXISTING CONDITIONS AND CONTINUITY OF COVERAGE; RENEWABILITY

SEC. 101. LIMITATION ON PRE-EXISTING CONDITION CLAUSES.

A group health plan may not impose (and an insurer may not require an employer under a group health plan to impose through a waiting period for coverage under a plan or similar requirement) a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition pre-existed the effective date of the plan with respect to an individual if—

(1) the condition relates to a condition that was not diagnosed or treated within 3 months before the date of coverage under the plan;

(2) the limitation or exclusion extends over more than 6 months after the date of coverage under the plan;

(3) the limitation or exclusion applies to an individual who, as of the date of birth, was covered under the plan; or

(4) the limitation or exclusion relates to pregnancy.

In the case of an individual who is eligible for coverage under a plan but for a waiting period imposed by the employer, in applying paragraphs (1) and (2), the individual shall be treated as having been covered under the plan as of the earliest date of the beginning of the waiting period.

SEC. 102. ASSURANCE OF CONTINUITY OF COVERAGE THROUGH PREVIOUS SATISFACTION OF PRE-EXISTING CONDITION REQUIREMENT.

(a) IN GENERAL.—Each group health plan shall waive any period applicable to a preexisting condition for similar benefits with respect to an individual to the extent that the individual, prior to the date of such individual's enrollment in such plan, was covered for the condition under any other health plan that was in effect before such date.

(b) CONTINUOUS COVERAGE REQUIRED.—

(1) IN GENERAL.—Subsection (a) shall no longer apply if there is a continuous period of more than 60 days (or, in the case of an individual described in paragraph (3), 6 months) on which the individual was not covered under a group health plan.

(2) TREATMENT OF WAITING PERIODS.—In applying paragraph (1), any waiting period imposed by an employer before an employee is eligible to be covered under a plan shall be treated as a period in which the employee was covered under a group health plan.

(3) JOB TERMINATION.—An individual is described in this paragraph if the individual loses coverage under a group health plan due to termination of employment.

(4) EXCLUSION OF CASH-ONLY AND DREAD DISEASE PLANS.—In this subsection, the term "group health plan" does not include any group health plan which is offered primarily to provide—

(A) coverage for a specified disease or illness, or

(B) a hospital or fixed indemnity policy, unless the Secretary determines that such a plan provides sufficiently comprehensive coverage of a benefit so that it should be treated as a group health plan under this subsection.

SEC. 103. REQUIREMENTS RELATING TO RENEWABILITY GENERALLY.

(a) MULTIEMPLOYER PLANS AND EXEMPTED MULTIPLE EMPLOYER HEALTH PLANS.—A multiemployer plan and an exempted multiple employer health plan may not cancel coverage or deny renewal of coverage under such a plan with respect to an employer other than—

(1) for nonpayment of contributions,

(2) for fraud or other misrepresentation by the employer,

(3) for noncompliance with plan provisions,

(4) for misuse of a provider network provision, or

(5) because the plan is ceasing to provide any coverage in a geographic area.

(b) INSURERS.—

(1) IN GENERAL.—An insurer may not cancel a health insurance plan or deny renewal of coverage under such a plan other than—

(A) for nonpayment of premiums,

(B) for fraud or other misrepresentation by the insured,

(C) for noncompliance with plan provisions,

(D) for misuse of a provider network provision, or

(E) because the insurer is ceasing to provide any health insurance plan in a State, or, in the case of a health maintenance organization, in a geographic area.

(2) LIMITATION ON MARKET REENTRY.—If an insurer terminates the offering of health insurance plans in an area, the insurer may not offer such a health insurance plan to any employer in the area until 5 years after the date of the termination.

PART 2—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

SEC. 111. ENFORCEMENT.

(a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR EMPLOYERS AND GROUP HEALTH PLANS.—

(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of part 1 of this subtitle shall be deemed to be provisions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor under this subtitle pursuant to subsection (a), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

(b) ENFORCEMENT BY EXCISE TAX FOR INSURERS.—

(1) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding at the end thereof the following new section:

"SEC. 4980C. FAILURE OF INSURER TO COMPLY WITH HEALTH INSURANCE STANDARDS.

"(a) IMPOSITION OF TAX.—

"(1) IN GENERAL.—There is hereby imposed a tax on the failure of an insurer to comply with the requirements applicable to the insurer under part 1 of subtitle A of title I of the Small Business Health Insurance Choice Act.

"(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by an insurer in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an insurer.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each individual to which such failure relates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

"(2) LIMITATION.—The amount of the tax imposed by subsection (a) for an insurer with respect to a health insurance plan shall not exceed 25 percent of the amounts received under the plan for coverage during the period such failure persists.

"(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the insurer.

"(d) EXCEPTIONS.—

"(1) CORRECTIONS WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) by reason of any failure if—

"(A) such failure was due to reasonable cause and not to willful neglect, and

"(B) such failure is corrected within the 30-day period beginning on earliest date the insurer knew, or exercising reasonable diligence would have known, that such failure existed.

"(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of such tax would be excessive relative to the failure involved.

"(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance plan' and 'insurer' have the respective meanings given such terms in section 113 of the Small Business Health Insurance Choice Act."

(2) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end thereof the following new items:

"Sec. 4980C. Failure of insurer to comply with health insurance standards."

SEC. 112. EFFECTIVE DATES.

(a) PART 1.—The requirements of part 1 with respect to—

(1) group health plans and employers shall apply to plans years beginning after December 31, 1994, and

(2) insurers shall take effect on January 1, 1995.

SEC. 113. DEFINITIONS.

(a) IN GENERAL.—For purposes of this subtitle:

(1) EMPLOYER.—The term "employer" shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(2) EXEMPTED MULTIPLE EMPLOYER HEALTH PLAN.—The term "exempted multiple employer health plan" means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of an exemption under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by part 2 of subtitle C of this title).

(3) GROUP HEALTH PLAN; PLAN.—(A) The term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance plan under section 1107(4)(B).

(B) The term "plan" means, unless used with a modifying term or the context specifically indicates otherwise, a group health plan (including any such plan which is a multiemployer plan), an exempted multiple employer health plan, or an insured multiple employer health plan.

(4) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "health insurance plan" means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following—

(i) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance, or

(v) automobile medical-payment insurance,

or any combination thereof.

(5) INSURED MULTIPLE EMPLOYER HEALTH PLAN.—The term "insured multiple employer health plan" means a fully insured multiple employer welfare arrangement under which benefits consist solely of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (disregarding such incidental benefits as the Secretary of Health and Human Services shall specify by regulations).

(6) INSURER.—The term "insurer" means a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization offering such a plan to an employer, and includes a similar organization regulated under State law for solvency.

(7) STATE.—The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Subtitle B—Preemption of Scope of State Regulation

SEC. 121. PROHIBITION OF STATE BENEFIT MANDATES FOR GROUP HEALTH PLANS.

In the case of a group health plan, no provision of State or local law shall apply that requires the coverage of one or more specific benefits, services, or categories of health care, or services of any class or type of provider of health care.

SEC. 122. PROHIBITION OF PROVISIONS PROHIBITING EMPLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.

No provision of State or local law shall apply that prohibits 2 or more employers from obtaining coverage under an insured multiple employer health plan.

SEC. 123. RESTRICTIONS ON MANAGED CARE.

(a) PREEMPTION OF STATE LAW PROVISIONS.—Subject to subsection (c), the following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a group health plan to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a group health plan may require a beneficiary to pay when a nonplan provider is used on a non-emergency basis.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effectiveness of the use of managed care in the delivery of health services.

(2) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations (including whether the provisions of subsection (a) should be extended) as may be appropriate.

(c) SUNSET.—Unless otherwise provided, subsection (a) shall not apply 5 years after the date of the enactment of this Act.

SEC. 124. DEFINITIONS.

For purposes of this subtitle, the terms "employee", "employer", "group health plan", "health insurance plan", "insured multiple employer health plan", and "State" have the meanings given such terms in section 113.

Subtitle C—Health Deduction Fairness

SEC. 131. PERMANENT EXTENSION AND INCREASE IN HEALTH INSURANCE TAX DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.

(a) PERMANENT EXTENSION OF DEDUCTION.—

(1) IN GENERAL.—Subsection (l) of section 162 of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 1994.

(b) INCREASE IN AMOUNT OF DEDUCTION.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) of such Code is amended by striking "25 percent of" and inserting "100 percent (50 percent in the case of taxable years beginning in 1996 or 1997) of".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1994.

SEC. 132. DEDUCTION OF HEALTH INSURANCE PREMIUMS FOR CERTAIN PREVIOUSLY UNINSURED INDIVIDUALS.

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended by adding at the end thereof the following new subsection:

"(f) DEDUCTION FOR HEALTH INSURANCE COSTS DETERMINED WITHOUT REGARD TO ADJUSTED GROSS INCOME THRESHOLD.—

"(1) IN GENERAL.—Subsection (a) shall be applied without regard to the limitation based on adjusted gross income in the case of the applicable percentage of the amounts paid for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means—

"(A) 25 percent for taxable years beginning in 1995 or 1996,

"(B) 50 percent for taxable years beginning in 1997 or 1998, and

"(C) 100 percent for taxable years beginning after 1999.

"(3) DEDUCTION NOT ALLOWED TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

"(A) IN GENERAL.—Paragraph (1) shall not apply to any individual—

"(i) who is eligible to participate in any subsidized health plan maintained by an employer of such individual or the spouse of such individual, or

"(ii) who is (or whose spouse is) a member of a subsidized class of employees of an employer.

"(B) SUBSIDIZED CLASS.—For purposes of subparagraph (A), an individual is a member of a subsidized class of employees of an employer if, at any time during the 3 calendar years ending with or within the taxable year, any member of such class was eligible to participate in any subsidized health plan maintained by such employer.

"(C) SPECIAL RULES.—

"(i) CONTROLLED GROUPS.—All persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as a single employer for purposes of subparagraph (B).

"(ii) CLASSES.—Classes of employees shall be determined under regulations prescribed by the Secretary based on such factors as the Secretary determines appropriate to carry out the purposes of this subsection.

"(4) COORDINATION WITH DEDUCTION FOR OTHER AMOUNTS.—Amounts allowable as a deduction under subsection (a) by reason of this subsection shall not be taken into account in determining the deduction under subsection (a) for other amounts.

"(5) SUBSECTION NOT TO APPLY TO INDIVIDUALS ELIGIBLE FOR MEDICARE.—This subsection shall not apply to amount paid for insurance covering an individual who is eligible for benefits under title XVIII of the Social Security Act."

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (15) the following new paragraph:

"(16) COSTS OF CERTAIN HEALTH INSURANCE.—The deduction allowed by section 213 to the extent allowable by reason of section 213(f)."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

TITLE II—REMOVING ANTITRUST IMPEDIMENTS

SEC. 201. ESTABLISHMENT OF LIMITED EXEMPTION PROGRAM FOR HEALTH CARE JOINT VENTURES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Attorney General, after consultation with the Secretary of Health and Human Services and the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care, shall promulgate specific guidelines under which a health care joint venture may submit an application requesting that the Attorney General provide the entities participating in the joint venture with an exemption under which (notwithstanding any other provision of law)—

(A) monetary recovery on a claim under the antitrust laws shall be limited to actual damages if the claim results from conduct within the scope of the joint venture that occurs while the exemption is in effect; and

(B) the conduct of the entity in making or performing a contract to carry out the joint venture shall not be deemed illegal per se under the antitrust laws but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including (but not limited to) effects on competition in properly defined, relevant research, development, product, process, and service markets (taking into consideration worldwide capacity to the extent that it may be appropriate in the circumstances).

(2) DEADLINE FOR RESPONSE.—The Attorney General, after consultation with the Secretary and the Advisory Committee, shall approve or disapprove the application of a health care joint venture for an exemption under this subsection not later than 30 days after the Attorney General receives the joint venture's application.

(3) PROVIDING REASONS FOR DISAPPROVAL.—If the Attorney General disapproves the application of a health care joint venture for an exemption under this subsection, the Attorney General shall provide the joint venture with a statement explaining the reasons for the Attorney General's disapproval.

(b) REQUIREMENTS FOR APPROVAL.—For purposes of subsection (a), the Attorney General shall approve the application of a health care joint venture for an exemption under subsection (a) if an entity participating in the joint venture submits to the Attorney General an application not later than 30 days after the entity has entered into a written agreement to participate in the joint venture (or not later than 30 days after the date of the enactment of this Act in the case of a joint venture in effect as of such date) that contains the following information and assurances:

(1) The identities of the parties to the joint venture.

(2) The nature, objectives, and planned activities of the joint venture.

(3) Assurances that the entities participating in the joint venture shall notify the Attorney General of any changes in the information described in paragraphs (1) and (2) during the period for which the exemption is in effect.

(c) REVOCATION OF EXEMPTION.—

(1) IN GENERAL.—The Attorney General, after consultation with the Secretary, may revoke an exemption provided to a health care joint venture under this section if, at any time during which the exemption is in effect, the Attorney General finds that the joint venture no longer meets the applicable requirements for approval under subsection (b), except that the Attorney General may not revoke such an exemption if the failure of the health care joint venture to meet such requirements is merely technical in nature.

(2) TIMING.—The revocation of an exemption under paragraph (1) shall apply only to conduct of the health care joint venture occurring after the exemption is no longer in effect.

(d) WITHDRAWAL OF APPLICATION.—Any party that submits an application under this section may withdraw such application at any time before the Attorney General's response to the application.

(e) REQUIREMENTS RELATING TO NOTICE AND PUBLICATION OF EXEMPTIONS AND RELATED INFORMATION.—

(1) PUBLICATION OF APPROVED APPLICATIONS FOR EXEMPTIONS IN FEDERAL REGISTER.—

(A) IN GENERAL.—With respect to each exemption for a health care joint venture provided under subsection (a), the Attorney General (acting jointly with the Secretary) shall—

(i) prepare a notice with respect to the joint venture that identifies the parties to the venture and that describes the planned activities of the venture;

(ii) submit the notice to the entities participating in the joint venture; and

(iii) after submitting the notice to such entities (but not later than 30 days after approving the application for the exemption for the joint venture), publish the notice in the Federal Register.

(B) EFFECT OF PUBLICATION.—An exemption provided by the Attorney General under subsection (a) shall take effect as of the date of the publication in the Federal Register of the notice with respect to the exemption pursuant to subparagraph (A).

(2) WAIVER OF DISCLOSURE REQUIREMENTS FOR INFORMATION RELATING TO APPLICATIONS FOR EXEMPTIONS.—

(A) IN GENERAL.—All information and documentary material submitted as part of an application of a health care joint venture for an exemption under subsection (a), together with any other information obtained by the Attorney General, the Secretary, or the Advisory Committee in the course of any investigation, administrative proceeding, or case with respect to a potential violation of the antitrust laws by the joint venture with respect to which the exemption applies, shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies, except as relevant to a law enforcement investigation or in a judicial or administrative proceeding in which such information and material is subject to any protective order.

(B) EXCEPTION FOR INFORMATION INCLUDED IN FEDERAL REGISTER NOTICE.—Subparagraph (A) shall not apply with respect to information contained in a notice published in the Federal Register pursuant to paragraph (1).

(3) USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the fact of disclosure of conduct under an application for an exemption under subsection (a) and the fact of publication of a notice in the Federal Register under paragraph (1) shall be admissible into evidence in any judicial or administrative proceeding for the sole purpose of establishing that a person is entitled to the protections provided by an exemption granted under subsection (a).

(B) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an application for an exemption under subsection (a), or revokes an exemption under such section, neither the negative determination nor the statement of reasons therefore shall be admissible into evidence in any administrative or judicial proceeding for the purpose of supporting or answering any claim under the antitrust laws.

SEC. 202. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary and the Advisory Committee, shall issue in accordance with this section a certificate of public advantage to each eligible health care joint venture that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such venture, and the parties to such venture, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such venture if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

(1) STANDARDS TO BE MET.—The Attorney General shall issue a certificate to an eligible health care joint venture if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the venture outweigh the reduction in competition (if any) that is likely to result from the venture, and

(B) such reduction in competition is reasonably necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the venture is likely—

(i) to maintain or to increase the quality of health care,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care joint venture and the entities responsible for making payments to such providers to negotiate societally optimal payment and service arrangements,

(ii) the effects of the health care joint venture on premiums and other charges imposed by the entities described in clause (i), and

(iii) the availability of equally efficient, less restrictive alternatives to achieve the benefits that are intended to be achieved by carrying out the venture.

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care joint venture (in the case of a venture in existence as of the time of the application) and implementation plan for the joint venture.

(d) ELIGIBLE HEALTH CARE JOINT VENTURE.—To be an eligible health care joint venture for purposes of this section, a health care joint venture shall submit to the Attorney General an application that complies with the rules in effect under subsection (c) and that includes—

(1) an agreement by the parties to the venture that the venture will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the venture,

(2) an agreement that the venture will submit to the Attorney General annually a report that describes the operations of the venture and information regarding the impact of the venture on health care and on competition in health care, and

(3) an agreement that the parties to the venture will notify the Attorney General and the Secretary of the termination of the venture not later than 30 days after such termination occurs.

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 30 days after an eligible health care joint venture submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 30-day period, the Attorney General fails to issue or deny the issuance of such certificate, the Attorney General shall be deemed to have issued such certificate.

(f) REVOCATION OF CERTIFICATE.—Whenever the Attorney General finds that a health care joint venture with respect to which a certificate is in effect does not meet the standards specified in subsection (b), the Attorney General shall revoke such certificate.

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an application for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care joint venture involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care joint venture involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

(2) to attempt to enter into any health care joint venture with respect to which such a certificate is in effect.

SEC. 203. INTERAGENCY ADVISORY COMMITTEE ON COMPETITION, ANTITRUST POLICY, AND HEALTH CARE.

(a) ESTABLISHMENT.—There is hereby established the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care. The Advisory Committee shall be composed of—

(1) the Secretary of Health and Human Services (or the designee of the Secretary);

(2) the Attorney General (or the designee of the Attorney General);

(3) the Director of the Office of Management and Budget (or the designee of the Director); and

(4) a representative of the Federal Trade Commission.

(b) DUTIES.—The duties of the Advisory Committee are—

(1) to discuss and evaluate competition and antitrust policy, and their implications with respect to the performance of health care markets;

(2) to analyze the effectiveness of health care joint ventures receiving exemptions under the program established under section 201(a) or certificates under section 202 in reducing the costs of and expanding access to the health care services that are the subject of such ventures; and

(3) to make such recommendations to Congress not later than 2 years after the date of the enactment of this Act (and at such subsequent periods as the Advisory Committee considers appropriate) regarding modifications to the program established under section 201(a) or to section 202 as the Advisory Committee considers appropriate, including modifications relating to the costs to health care providers of obtaining an exemption for a joint venture under such program.

SEC. 204. DEFINITIONS.

For purposes of this title:

(1) The term "Advisory Committee" means the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care established under section 203.

(2) The term "antitrust laws"—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(3) The term "certificate" means a certificate of public advantage authorized to be issued under section 202(a).

(4) The term "health care joint venture" means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of sharing in the provision of health care services and that involves substantial integration or financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

(5) The term "health care services" includes services related to the delivery or administration of health care services.

(6) The term "liable" means liable for any civil or criminal violation of the antitrust laws.

(7) The term "provider of health care services" means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(8) The term "Secretary" means the Secretary of Health and Human Services.

Amendment To H.R. 3600

Offered By Mr. Michel of Illinois

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Affordable Health Care Now Act of 1994".

(b) TABLE OF CONTENTS OF TITLES AND SUBTITLES IN ACT.—The following are the titles and subtitles contained in this Act:

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Increased Availability and Continuity of Health Coverage for Individuals and Their Families
Subtitle B—Reform of Health Insurance
Subtitle C—Preemption
Subtitle D—Health Deduction Fairness
Subtitle E—Improved Access to Community Health Services
Subtitle F—Improved Access to Rural Health Services
Subtitle G—Assistance in Enrolling Uninsured Children in Health Insurance
Subtitle H—Medicaid Reform
Subtitle I—Remedies and Enforcement with Respect to Group Health Plans
Subtitle J—Delivery of Health Care Services to Illegal Immigrants

TITLE II—HEALTH CARE COST CONTAINMENT AND QUALITY ENHANCEMENT

Subtitle A—Medical Malpractice Liability Reform
Subtitle B—Administrative Cost Savings and Fair Health Information Practices
Subtitle C—Deduction for Cost of Catastrophic Health Plan; Medical Savings Accounts
Subtitle D—Anti-Fraud
Subtitle E—Increased Medicare Beneficiary Choice; Additional Medicare Reforms
Subtitle F—Health Care Antitrust Improvements
Subtitle G—Encouraging Enforcement Activities of Medical Self-Regulatory Entities
Subtitle H—Reform of Clinical Laboratory Requirements for Simple Tests
Subtitle I—Miscellaneous Provisions

TITLE III—LONG-TERM CARE

Subtitle A—Tax Treatment of Long-term Care Insurance
Subtitle B—Establishment of Federal Standards for Long-term Care Insurance
Subtitle C—Protection of Assets Under Medicaid Through Use of Qualified Long-term Care Insurance
Subtitle D—Studies
Subtitle E—Volunteer Service Credit Demonstration Projects

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

TABLE OF CONTENTS OF TITLE

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Increased Availability and Continuity of Health Coverage for Individuals and Their Families

PART 1—REQUIRED COVERAGE OPTIONS FOR ELIGIBLE EMPLOYEES, SPOUSES, AND DEPENDENTS

Sec. 1001. Requiring employers to offer option of coverage for eligible individuals.

PART 2—PORTABILITY AND NONDISCRIMINATION

Sec. 1011. Nondiscrimination based on health status.
Sec. 1012. Portability.
Sec. 1013. Requirements relating to renewability generally.

PART 3—STANDARDS FOR MANAGED CARE ARRANGEMENTS AND ESSENTIAL COMMUNITY PROVIDERS

Sec. 1021. Standards for managed care arrangements.
Sec. 1022. Utilization review.

PART 4—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

Sec. 1031. Enforcement.
Sec. 1032. Effective dates.
Sec. 1033. Definitions and special rules.

Subtitle B—Reform of Health Insurance

PART 1—MARKETPLACE FOR SMALL BUSINESS

Sec. 1101. Requirement for insurers to offer MedAccess coverage.
Sec. 1102. MedAccess coverage defined.
Sec. 1103. Establishment of other MedAccess standards.
Sec. 1104. Use of modified community rating, uniform marketing materials, and miscellaneous consumer protections.
Sec. 1105. Monitoring and response to adverse selection; risk adjustment programs.
Sec. 1106. Establishment of reinsurance or allocation of risk mechanisms for high risk individuals in marketplace for small business and marketplace for individuals.

PART 2—MARKETPLACE FOR INDIVIDUALS

Sec. 1111. Application of similar requirements.

PART 3—VOLUNTARY HEALTH PURCHASING ARRANGEMENTS
Sec. 1121. Establishment and organization.
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Sec. 1123. Provision of information.
Sec. 1124. Enrolling eligible employees and eligible individuals through a purchasing arrangement.
Sec. 1125. Restriction on charges.
PART 4—DEFINITIONS AND MISCELLANEOUS PROVISIONS
Sec. 1131. Definitions.
Sec. 1132. Prohibition of improper incentives.
Sec. 1133. Enforcement.
Sec. 1134. Annual reports.
Sec. 1135. Research and demonstration projects; development of a health risk pooling model.
Subtitle C—Preemption
PART 1—SCOPE OF STATE REGULATION
Sec. 1201. Prohibition of State benefit mandates for group health plans.
Sec. 1202. Prohibition of provisions prohibiting employer groups from purchasing health insurance.
Sec. 1203. Preemption of State anti-managed care laws.
Sec. 1204. Definitions.
PART 2—MULTIPLE EMPLOYER HEALTH BENEFITS PROTECTIONS
Sec. 1211. Limited exemption from certain restrictions on ERISA preemption of State law for health plans maintained by multiple employers subject to certain Federal standards.
"PART 7—MULTIPLE EMPLOYER HEALTH PLANS
"Sec. 701. Definitions.
"Sec. 702. Exempted multiple employer health plans relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.
"Sec. 703. Exemption procedure.
"Sec. 704. Eligibility requirements.
"Sec. 705. Additional requirements applicable to exempted multiple employer health plans.
"Sec. 706. Disclosure to participating employers by arrangements providing medical care.
"Sec. 707. Maintenance of reserves.
"Sec. 708. Corrective actions.
"Sec. 709. Expiration, suspension, or revocation of exemption.
"Sec. 710. Review of actions of the Secretary.
Sec. 1212. Clarification of scope of preemption rules.
Sec. 1213. Clarification of treatment of single employer arrangements.
Sec. 1214. Clarification of treatment of certain collectively bargained arrangements.
Sec. 1215. Employee leasing healthcare arrangements.
Sec. 1216. Enforcement provisions relating to multiple employer welfare arrangements and employee leasing healthcare arrangements.
Sec. 1217. Solvency requirements for certain self-insured group health plans.
Sec. 1218. Filing requirements for multiple employer welfare arrangements providing health benefits.
Sec. 1219. Cooperation between Federal and State authorities.
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Sec. 1221. Eliminating commonality of interest or geographic location requirement for tax exempt trust status.
Sec. 1222. Single annual filing for all participating employers.
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Subtitle D—Health Deduction Fairness
Sec. 1301. Permanent extension and increase in health insurance tax deduction for self-employed individuals.
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Subtitle E—Improved Access to Community Health Services
PART 1—INCREASED AUTHORIZATION FOR COMMUNITY AND MIGRANT HEALTH CENTERS
Sec. 1401. Grant program to promote primary health care services for underserved populations.
PART 2—GRANTS FOR PROJECTS FOR COORDINATING DELIVERY OF SERVICES
Sec. 1411. Projects for coordinating delivery of outpatient primary health services.
PART 3—COMMUNITY HEALTH NETWORKS
Sec. 1421. Qualifications for community health networks.
Subtitle F—Improved Access to Rural Health Services
PART 1—ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS UNDER MEDICARE
Sec. 1501. Rural emergency access care hospitals described.
Sec. 1502. Coverage of and payment for services.
Sec. 1503. Effective date.
PART 2—RURAL MEDICAL EMERGENCIES AIR TRANSPORT
Sec. 1511. Grants to States regarding aircraft for transporting rural victims of medical emergencies.
PART 3—EMERGENCY MEDICAL SERVICES AMENDMENTS
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PART 4—ADDITIONAL RURAL HEALTH CARE PROVISIONS
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Subtitle A—Increased Availability and Continuity of Health Coverage for Individuals and Their Families

PART 1—REQUIRED COVERAGE OPTIONS FOR ELIGIBLE EMPLOYEES, SPOUSES, AND DEPENDENTS

SEC. 1001. REQUIRING EMPLOYERS TO OFFER OPTION OF COVERAGE FOR ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Each employer shall make available with respect to each eligible employee a group health plan under which—

(1) coverage of each eligible individual with respect to such an eligible employee may be elected on an annual basis for each plan year,

(2) subject to subsection (d), coverage is provided for at least the required coverage specified in subsection (c), and

(3) each eligible employee electing such coverage may elect to have any premiums owed by the employee collected through payroll deduction.

An employer is not required under this subsection to make any contribution to the cost of coverage under such a plan.

(b) SPECIAL RULES.—

(1) EXCLUSION OF NEW EMPLOYERS AND CERTAIN SMALL EMPLOYERS.—Subsection (a) shall not apply to any employer for any plan year if, as of the beginning of such plan year—

(A) such employer (including any predecessor thereof) has been an employer for less than 2 years,

(B) such employer has no more than 2 eligible full-time employees, or

(C) there are no more than 2 full-time eligible employees who both are not covered under any group health plan and do not have health insurance coverage.

(2) EXCLUSION OF FAMILY MEMBERS.—Under such procedures as the Secretary may prescribe, any relative of an employer may be, at the election of the employer, excluded from consideration as an eligible employee for purposes of applying the requirements of subsection (a). In the case of an employer that is not an individual, an employee who is a relative of a key employee (as defined in section 416(i)(1) of the Internal Revenue Code of 1986) of the employer may, at the election of the key employee, be considered a relative excludable under this paragraph.

(3) OPTIONAL APPLICATION OF WAITING PERIOD.—A group health plan shall not be treated as failing to meet the requirements of subsection (a) solely because a period of service by an eligible employee of not more than 60 days is required under the plan for coverage under the plan of eligible individuals with respect to such employee.

(c) REQUIRED COVERAGE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the required coverage specified in this subsection is standard coverage (consistent with section 1102(c)), including at least one option (either a fee-for-service option or a point-of-service option) that permits covered individuals an unlimited choice of the lawful providers for which covered benefits are made available.

(2) SPECIAL TREATMENT OF SMALL EMPLOYERS NOT CONTRIBUTING TO EMPLOYEE COVERAGE.—In the case of a small employer (as defined in section 1131(9)) that has not contributed during the previous plan year to the cost of coverage for any eligible employee under any group health plan, the required coverage specified in this subsection for the plan year (with respect to each eligible employee) is—

(A) MedAccess standard coverage, with a fee-for-service option and, if available, a point-of-service option and a managed care option (as defined in section 1033);,

(B) MedAccess catastrophic coverage; and

(C) if available, MedAccess medisave coverage,

as such terms are defined in section 1102(a)(2).

(3) CONSTRUCTION.—Nothing in this section shall be construed as limiting the group health plans, or types of coverage under such a plan, that an employer may offer to an employee.

(d) 5-YEAR TRANSITION FOR EXISTING GROUP HEALTH PLANS.—

(1) IN GENERAL.—The requirement of subsection (a)(2) shall not apply to a group health plan for a plan year if—

(A) the group health plan is in effect in the plan year in which July 1, 1994, occurs, and

(B) the employer makes (or offers to make), in such plan year and each subsequent plan year through the plan year involved, a contribution to the plan on behalf of each employee who is eligible to participate in the plan.

(2) SUNSET.—Paragraph (1) shall only apply to a group health plan for each of the 5 plan years beginning with the first plan year to which the requirement of subsection (a) applies.

PART 2—PORTABILITY AND NONDISCRIMINATION

SEC. 1011. NONDISCRIMINATION BASED ON HEALTH STATUS.

(a) IN GENERAL.—A group health plan and an insurer providing health insurance coverage may not deny or impose (and an insurer may not require an employer under a group health plan to impose or otherwise to impose through a waiting period for coverage under a plan or similar requirement) a limitation or exclusion of benefits relating to treatment of a condition based on health status or based on the fact that the condition preexisted the effective date of coverage of the individual under the plan if—

(1) in the case of any individual eligible for such coverage, such individual has such coverage at the time at which such individual first becomes eligible;

(2) the limitation or exclusion applies to an individual who, as of the date of birth, was covered under the plan;

(3) the limitation or exclusion relates to pregnancy;

(4) the condition relates to a condition that was not diagnosed or treated within 3 months (or 6 months in the case of coverage not under a group health plan) before the date of such coverage; or

(5) the limitation or exclusion extends over more than 6 months (or 12 months in the case of coverage not under a group health plan) after the date of such coverage.

In the case of an individual who is eligible for coverage but for a waiting period imposed by the employer, in applying paragraphs (4) and (5), the individual shall be treated as having had such coverage as of the earliest date of the beginning of the waiting period.

(b) ONE-TIME AMNESTY PERIOD.—

(1) IN GENERAL.—In the case of an individual who, as of the first date of the amnesty period is—

(A) covered under a group health plan or has health insurance coverage, such coverage shall not be subject to pre-existing condition exclusions on and after such date; or

(B) not so covered, if the individual obtains coverage under a group health plan or health insurance coverage during the next available open enrollment period with respect to the individual, coverage so obtained shall not be subject to pre-existing condition exclusions on and after the effective date of such coverage.

(2) AMNESTY PERIOD.—The amnesty period described in this paragraph, with respect to an individual who is a resident of a State, is the 45-calendar-day period beginning on the effective date of this part (under section 1032(b)).

(3) ESTABLISHMENT OF SPECIAL ALLOCATION OF RISK POOL FOR AMNESTY.—Each State shall establish rules and requirements relating to the allocation of risk among insurers with respect to additional risks assumed as a result of the amnesty period under this subsection (including individuals previously covered for whom a preexisting condition exclusion will be no longer applicable).

(c) APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization that provides health insurance coverage shall not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwithstanding that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provisions of this part so long as such exclusion is applied consistent with the provisions of this part.

SEC. 1012. PORTABILITY.

(a) IN GENERAL.—Each group health plan and an insurer providing health insurance coverage shall waive any period applicable to a preexisting condition for similar benefits with respect to an individual to the extent that the individual, immediately prior to the date of such individual's enrollment in such plan, had health insurance coverage for the condition, or was covered for the condition under a group health plan, that was in effect before such date.

(b) CONTINUOUS COVERAGE REQUIRED.—

(1) IN GENERAL.—Subsection (a) shall no longer apply if there is a continuous period of more than 60 days (or, in the case of an individual described in paragraph (2), 6 months) for which the individual did not have health insurance coverage for the condition or was not covered under a group health plan for the condition.

(2) JOB TERMINATION.—An individual is described in this paragraph if the individual loses coverage under a group health plan due to termination of employment.

(3) EXCLUSION OF CASH-ONLY AND DREAD DISEASE PLANS.—In this subsection, the term "group health plan" does not include any group health plan which is offered primarily to provide—

(A) coverage for a specified disease or illness, or

(B) a hospital or fixed indemnity policy, unless the Secretary determines that such a plan provides sufficiently comprehensive coverage of a benefit so that it should be treated as a group health plan under this subsection.

(c) TRANSITION FOR NON-CONFORMING POLICIES.—Notwithstanding State law or the provision of any agreement to the contrary, effective January 1, 1997, an insurer may cancel or refuse to renew health insurance coverage in a State prior to the application of this subtitle to health insurance coverage issued in the State if the coverage does not provide for either standard or catastrophic coverage, but only if the insurer offers the covered individual affected the opportunity to obtain health insurance coverage that meets the applicable requirements of this title.

(d) APPLICABILITY OF COVERAGE UNDER PUBLIC INSURANCE.—In this section, an individual shall be considered to have health insurance coverage for a condition without regard to whether such coverage is under a private or public plan.

SEC. 1013. REQUIREMENTS RELATING TO RENEWABILITY GENERALLY.

(a) MULTIEMPLOYER PLANS AND EXEMPTED MULTIPLE EMPLOYER HEALTH PLANS.—A multiemployer plan and an exempted multiple employer health plan may not cancel coverage or deny renewal of coverage under such a plan with respect to an employer other than—

(1) for nonpayment of contributions,

(2) for fraud or other misrepresentation by the employer,

(3) for noncompliance with plan provisions, or

(4) because the plan is ceasing to provide any coverage in a geographic area.

(b) INSURERS.—

(1) IN GENERAL.—An insurer may not cancel health insurance coverage or deny renewal of such coverage other than—

(A) for nonpayment of premiums,

(B) for fraud or other misrepresentation by the insured,

(C) for noncompliance with plan provisions, or

(D) subject to paragraph (2), because the insurer is ceasing to provide any health insurance coverage (or the same type of health insurance coverage in the same individual or small employer insurance market) in a State, or, in the case of a health maintenance organization or other network plan, in a geographic area.

(2) NOTICE REQUIREMENT FOR MARKET EXIT.—Paragraph (1)(D) shall not apply to an insurer ceasing to provide coverage unless the insurer provides notice of such termination to employers and individuals covered at least 180 days before the date of termination of coverage.

(3) LIMITATION ON REENTRY IN EMPLOYER AND INDIVIDUAL MARKETS.—If an insurer ceases to offer or provide health insurance coverage (or a type of insurance coverage) in an area with respect to the individual or small group market, the insurer may not offer such health insurance coverage (or type of coverage) in the area in such market until 5 years after the date of the termination.

(4) TYPE OF COVERAGE AND INSURANCE MARKET DEFINED.—In this subsection—

(A) MedAccess standard coverage, MedAccess catastrophic coverage, and MedAccess medisave coverage shall each be considered to be separate types of health insurance coverage;

(B) the term "small group market" means the insurance market offered to individuals seeking health care coverage on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to an employer or an association.

PART 3—STANDARDS FOR MANAGED CARE ARRANGEMENTS AND ESSENTIAL COMMUNITY PROVIDERS

SEC. 1021. STANDARDS FOR MANAGED CARE ARRANGEMENTS.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each group health plan, and each insurer providing health insurance coverage, for health care through a managed care arrangement shall comply with the applicable requirements of this section.

(2) DEFINITIONS.—In this section:

(A) MANAGED CARE ARRANGEMENT DEFINED.—The term "managed care arrangement" means, with respect to an arrangement under a group health plan or under health insurance coverage, providers who have entered into an agreement under the arrangement under which such providers are obligated to provide items and services covered under the arrangement to individuals covered under the plan or who have such coverage.

(B) PROVIDER NETWORK.—The term "provider network" means, with respect to a group health plan or health insurance coverage, providers who have entered into an agreement described in subparagraph (A) under a managed care arrangement.

(b) SCOPE OF ARRANGEMENTS WITH PROVIDERS.—

(1) IN GENERAL.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage shall enter into such agreements with health care providers (including primary and specialty providers for children) or have such other arrangements as may be necessary to assure that covered individuals have reasonably prompt access through the entity's provider network to all items and services contained in the package of benefits for which coverage is provided (including access to emergency services on a 24-hour basis where medically necessary), in a manner that assures the continuity of the provision of such items and services.

(2) ACCESS TO CENTERS OF EXCELLENCE.—

(A) IN GENERAL.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage shall demonstrate that covered individuals (including individuals with chronic diseases) have access through the entity's provider network to specialized treatment expertise of designated centers of excellence. Such entity shall demonstrate such access according to standards developed by the Secretary, including requirements relating to arrangements with such centers and referral of patients to such centers.

(B) DESIGNATION OF CENTERS OF EXCELLENCE.—The Secretary shall establish a process for the designation of facilities, including children's hospitals and other pediatric facilities, as centers of excellence for purposes of this paragraph. A facility may not be designated unless the facility is determined—

(i) to provide specialty care,

(ii) to deliver care for complex cases requiring specialized treatment and for individuals with chronic diseases, and

(iii) to meet other requirements that may be established by the Secretary relating to specialized education and training of health professionals, participation in peer-reviewed research, or treatment of patients from outside the geographic area of the facility.

(3) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—An entity providing for a managed care arrangement may not require an individual to obtain a referral from a physician in order to obtain covered items and services within the network of the arrangement from a physician who specializes in obstetrics and gynecology.

(c) PROVISION OF EMERGENCY AND URGENT CARE SERVICES.—

(1) IN GENERAL.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage must cover medically necessary emergency and urgent care services provided to covered individuals (including trauma services provided by designated trauma centers), without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the entity to provide items or services to covered individuals and, in the case of services furnished for the treatment of an emergency medical condition (as defined in section 1867(e)(1) of the Social Security Act), without regard to prior authorization.

(2) DESIGNATED TRAUMA CENTERS DEFINED.—In paragraph (1), the term "designated trauma center"—

(A) has the meaning given such term in section 1231 of the Public Health Service Act, and

(B) includes (for years prior to 2001) a trauma center that—

(i) is located in a State that has not designated trauma centers under section 1213 of such Act, and

(ii) the Secretary finds meets the standards under such section to be a designated trauma center.

(d) DUE PROCESS STANDARDS RELATING TO PROVIDER NETWORKS.—

(1) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—

(A) ESTABLISHMENT.—The entity providing for a managed care arrangement on behalf of a group health plan or under health insurance coverage shall establish standards to be used by the entity for contracting with health care providers with respect the entity's provider network. Such standards shall be established in consultation with providers who are members of the network.

(B) DISTRIBUTION OF INFORMATION.—Descriptive information regarding these standards shall be made available upon request to enrollees, providers who are members of the network, and prospective enrollees and prospective participating providers.

(2) NOTICE REQUIREMENT.—

(A) IN GENERAL.—The entity may not terminate or refuse to renew an agreement with a provider to participate in the entity's provider network unless the entity provides written notification to the provider of the entity's decision to terminate or to refuse to renew the agreement. The notification shall include a statement of the reasons for the entity's decision, consistent with the standards established under paragraph (1).

(B) TIMING OF NOTIFICATION.—The entity shall provide the notification required under subparagraph (A) at least 45 days prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of a covered individual.

(3) REVIEW PROCESS.—

(A) IN GENERAL.—The entity shall provide a process under which the provider may request a review of the entity's decision to terminate or refuse to renew the provider's participation agreement. Such review shall be conducted by a group of individuals the majority of whom are health care providers who are members of the entity's provider network or employees of the entity, and who are members of the same profession as the provider who requests the review.

(B) COUNSEL.—If the provider requests in advance, the entity shall permit an attorney representing the provider to be present at the provider's review.

(C) REVIEW ADVISORY.—The findings and conclusions of a review under this paragraph shall be advisory and non-binding.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed to affect any other provision of law that provides an appeals process or other form of relief to a provider of health care services.

SEC. 1022. UTILIZATION REVIEW.

(a) REQUIRING REVIEW TO MEET STANDARDS.—A group health plan or insurer providing health insurance coverage may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets the standards established by the Secretary under this section.

(b) ESTABLISHMENT OF STANDARDS BY SECRETARY.—The Secretary shall establish standards for utilization review programs, consistent with subsection (c), and shall periodically review and update such standards to reflect changes in the delivery of health care services. The Secretary shall establish such standards in consultation with appropriate parties, including representatives of health care providers, specialists, insurers, plan administrators, and other experts.

(c) REQUIREMENTS FOR STANDARDS.—Under the standards established under subsection (a)—

(1) individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage;

(2) negative determinations of the medical necessity or appropriateness of services or the site at which services are furnished may be made only by clinically qualified personnel;

(3) the utilization review program shall provide for a process under which an enrollee or provider may obtain timely review of a denial of coverage;

(4) utilization review shall be conducted in accordance with uniformly applied standards that are based on the most currently available medical evidence; and

(5) providers shall participate in the development of the utilization review program.

(d) PREEMPTION.—For provision preempting State laws relating to utilization review, see section 1203(a)(3).

PART 4—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

SEC. 1031. ENFORCEMENT.

(a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR EMPLOYERS AND GROUP HEALTH PLANS.—

(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts 1 and 2 of this subtitle and part 1 of subtitle B shall be deemed to be provisions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor under this subtitle pursuant to subsection (a), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

(b) ENFORCEMENT BY PENALTY FOR INSURERS.—

(1) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding at the end thereof the following new section:

"SEC. 4980C. FAILURE OF INSURER TO COMPLY WITH HEALTH INSURANCE STANDARDS.

"(a) IMPOSITION OF PENALTY.—

"(1) IN GENERAL.—There is hereby imposed a tax on the failure of an insurer to comply with the requirements applicable to the insurer under parts 2 and 3 of subtitle A of title I and subtitle B of the Affordable Health Care Now Act of 1994.

"(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by an insurer in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an insurer.

"(b) AMOUNT OF PENALTY.—

"(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each individual to which such failure relates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

"(2) LIMITATION.—The amount of the tax imposed by subsection (a) for an insurer with respect to health insurance coverage shall not exceed 25 percent of the amounts received for such coverage during the period such failure persists.

"(c) LIABILITY FOR PENALTY.—The penalty imposed by this section shall be paid by the insurer.

"(d) EXCEPTIONS.—

"(1) CORRECTIONS WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) by reason of any failure if—

"(A) such failure was due to reasonable cause and not to willful neglect, and

"(B) such failure is corrected within the 30-day period beginning on the earliest date the insurer knew, or exercising reasonable diligence would have known, that such failure existed.

"(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of such tax would be excessive relative to the failure involved.

"(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance coverage' and 'insurer' have the respective meanings given such terms in section 1033 of the Affordable Health Care Now Act of 1994."

(2) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end thereof the following new items:

"Sec. 4980C. Failure of insurer to comply with health insurance standards."

SEC. 1032. EFFECTIVE DATES.

(a) PART 1.—The requirements of part 1 shall apply to plans years beginning after December 31, 1996.

(b) PARTS 2 AND 3.—The requirements of parts 2 and 3 shall apply with respect to—

(1) group health plans and employers shall apply to plans years beginning after December 31, 1996, and

(2) insurers shall take effect on January 1, 1997.

SEC. 1033. DEFINITIONS AND SPECIAL RULES.

(a) IN GENERAL.—For purposes of this subtitle:

(1) DEPENDENT.—The term "dependent" means, with respect to any individual, any person who is—

(A) the spouse or surviving spouse of the individual, or

(B) under regulations of the Secretary, a child (including an adopted child) of such individual and—

(i) under 19 years of age, or

(ii) under 25 years of age and a full-time student.

(2) ELIGIBLE EMPLOYEE.—The term "eligible employee" means, with respect to an employer, an employee who normally performs on a monthly basis at least 10 hours of service per week for that employer. Such term shall not include any employee who is not reasonably expected as of the 1st day of a month to be employed by the employer for a period of 120 consecutive days during any 365-day period that includes such 1st day.

(3) ELIGIBLE INDIVIDUAL.—The term "eligible individual" means, with respect to an eligible employee, such employee, and any dependent of such employee.

(4) EMPLOYER.—The term "employer" shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(5) EXEMPTED MULTIPLE EMPLOYER HEALTH PLAN.—The term "exempted multiple employer health plan" means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of an exemption under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by part 2 of subtitle C of this title).

(6) GROUP HEALTH PLAN; PLAN.—(A) The term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance coverage under section 1131(4)(B).

(B) The term "plan" means a group health plan (including any such plan which is a multiemployer plan) and an exempted multiple employer health plan.

(7) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" shall have the meaning applicable under section 1131(4).

(8) FULLY INSURED.—The term "fully insured" shall have the meaning applicable under section 701(9) of Employee Retirement Income Security Act of 1974 (as added by section 1211 of this title).

(9) INSURER.—The term "insurer" has the meaning given such term in section 1131(6).

(10) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—The term "multiple employer welfare arrangement" shall have the meaning applicable under section 3(40) of the Employee Retirement Income Security Act of 1974.

(11) OPTIONS.—

(A) FEE-FOR-SERVICE OPTION.—Standard coverage is considered to provide a "fee-for-service option" if benefits with respect to the covered items and services in the coverage are made available for such items and services provided through any lawful provider of such covered items and services.

(B) MANAGED CARE OPTION.—Standard coverage is considered to provide a "managed care option" if benefits with respect to the covered items and services in the coverage are made available exclusively through a managed care arrangement (as defined in section 1021(a)(2)), except in the case of emergency and urgent services and as otherwise required under law.

(C) POINT-OF-SERVICE OPTION.—Standard coverage is considered to provide a "point-of-service option" if the benefits with respect to covered items and services in the coverage are made available principally through a managed care arrangement, with the choice of the enrollee to obtain such benefits for items and services provided through any lawful provider of such covered items and services. The coverage may provide for different cost sharing schedules based on whether the items and services are provided through such an arrangement or outside such an arrangement.

(b) APPLICATION OF ERISA DEFINITIONS.—Except as otherwise provided in this subtitle, terms used in this subtitle shall have the meanings applicable to such terms under section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002).

(c) SECRETARY.—Except with respect to references specifically to the Secretary of Labor, the term "Secretary" means the Secretary of Health and Human Services.

Subtitle B—Reform of Health Insurance

PART 1—MARKETPLACE FOR SMALL BUSINESS

SEC. 1101. REQUIREMENT FOR INSURERS TO OFFER MEDACCESS COVERAGE.

(a) REQUIREMENT.—

(1) IN GENERAL.—Each insurer (as defined in section 1131(6)) that makes available any health insurance coverage (as defined in section 1131(4)) to a small employer (as defined in section 1131(9)) in a State—

(A) shall make available to each small employer in the State MedAccess standard coverage (as defined in section 1102(a)(2)), with a fee-for-service option and, if available, a point-of-service option and a managed care option (as defined in section 1033),

(B) shall make available to each small employer in the State MedAccess catastrophic coverage (as defined in section 1102(a)(2)), and

(C) may make available to each small employer in the State MedAccess medisave coverage (as defined in section 1102(a)(2)).

(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—The requirements of paragraph (1)(A) (with regard to requiring a fee-

for-service option), and paragraphs (1)(B) and (1)(C) shall not apply with respect to a health insurance coverage that—

(A) is provided by a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), or

(B) is not provided by such an organization but is provided by an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

(3) EXCEPTION IF STATE PROVIDES FOR GUARANTEED AVAILABILITY (RATHER THAN GUARANTEED ISSUE).—Paragraph (1) shall not apply to an insurer in a State if the State is providing—

(A) access to each small employer in the State to MedAccess standard coverage, to MedAccess catastrophic coverage, and to a MedAccess medisave coverage, and

(B) a risk allocation mechanism described in subsection (c).

(b) GUARANTEED ISSUE OF MEDACCESS COVERAGE.—Subject to subsection (c)—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), each insurer that offers MedAccess coverage to a small employer in a State—

(A) must accept every small employer in the State that applies for such coverage; and

(B) must accept for enrollment under such coverage every eligible individual (as defined in paragraph (5)) who applies for enrollment on a timely basis (consistent with paragraph (4)) and may not place any restriction on the eligibility of an individual to enroll so long as such individual is an eligible individual.

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of coverage offered by a health maintenance organization or other network plan, the organization may—

(A) limit the employers that may apply for such coverage to those with eligible individuals residing in the service area of the plan;

(B) limit the individuals who may be enrolled under such coverage to those who reside in the service area for such organization; and

(C) within the service area of such organization, deny such coverage to such employers if the organization demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this subparagraph uniformly to all employers without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

In this paragraph, the term "health maintenance organization" includes an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

(3) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—In the case of coverage offered by an insurer other than a health maintenance organization or network plan, the insurer may deny such coverage to small employers if the organization demonstrates that—

(A) it does not have the financial reserves necessary to underwrite additional coverage, and

(B) it is applying this paragraph uniformly to all employers without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

(4) CLARIFICATION OF TIMELY ENROLLMENT.—

(A) GENERAL INITIAL ENROLLMENT REQUIREMENT.—Except as provided in this paragraph, enrollment of an eligible individual for MedAccess coverage may be considered not to be timely if the eligible employee or dependent fails to enroll under such coverage during an initial enrollment period, if such period is at least 30 days long.

(B) ENROLLMENT DUE TO LOSS OF PREVIOUS COVERAGE.—Enrollment under MedAccess coverage is considered to be timely in the case of an eligible individual who—

(i) was covered under a group health plan or had other health insurance coverage at the time of the individual's initial enrollment period,

(ii) stated at the time of the initial enrollment period that coverage under a group health plan or other health insurance coverage was the reason for declining enrollment,

(iii) lost coverage under a group health plan or other health insurance coverage (as a result of the termination of the coverage, termination or reduction of employment, or other reason), and

(iv) requests enrollment within 30 days after termination of the coverage.

(C) REQUIREMENT APPLIES DURING OPEN ENROLLMENT PERIODS.—Each insurer and each group health plan providing MedAccess coverage shall provide for at least one period (of not less than 30 days) each year during which enrollment under such coverage shall be considered to be timely.

(D) EXCEPTION FOR COURT ORDERS.—Enrollment of a spouse or minor child of an employee shall be considered to be timely if—

(i) a court has ordered that coverage be provided for the spouse or child under a covered employee's group health plan, and

(ii) a request for enrollment is made within 30 days after the date the court issues the order.

(E) ENROLLMENT OF SPOUSES AND DEPENDENTS.—

(i) IN GENERAL.—Enrollment of the spouse (including a child of the spouse) and any dependent child of an eligible employee shall be considered to be timely if a request for enrollment is made either—

(I) within 30 days of the date of the marriage or of the date of the birth or adoption of a child, if family coverage is available as of such date, or

(II) within 30 days of the date family coverage is first made available.

(ii) COVERAGE.—If available coverage includes family coverage and enrollment is made under such coverage on a timely basis under clause (i)(I), the coverage shall become effective not later than the first day of the first month beginning after the date of the marriage or the date of birth or adoption of the child (as the case may be).

(5) DEFINITIONS.—In this subsection, the terms "eligible individual" and "group health plan" have the meanings given such terms in section 1023(a).

(c) STATE OPTION OF GUARANTEED AVAILABILITY THROUGH ALLOCATION OF RISK (RATHER THAN THROUGH GUARANTEED ISSUE).—The requirements of subsection (b) shall not apply in a State if the State has provided (in accordance with standards established under this part) a mechanism under which—

(1) each insurer offering health insurance coverage to a small employer in the State must participate in a program for assigning high-risk small employer groups (or individuals within such a group) among some or all such insurers, and

(2) the insurers to which such high-risk small employer groups or individuals are so assigned comply with the requirements of subsection (b).

SEC. 1102. MEDACCESS COVERAGE DEFINED.

(a) MEDACCESS COVERAGE DEFINED.—In this subtitle:

(1) IN GENERAL.—The term "MedAccess coverage" means a health insurance coverage (whether under a managed-care plan, indemnity plan, or other plan) that meets the following requirements:

(A) The coverage—

(i) is designed to provide standard coverage (consistent with subsection (c)) with substantial cost-sharing,

(ii) is designed to provide only catastrophic coverage (consistent with subsection (d)), or

(iii) is designed to provide medisave coverage (consistent with subsection (e)).

(B) The coverage includes only services, including (but not limited to) medical, surgical, hospital, and preventive services, which are essential and medically necessary; except that no specific procedure or treatment, or classes thereof, is required to be included in such coverage, by this Act or through regulations.

(C) The coverage meets the applicable requirements of section 1101(b) (relating to guaranteed issue).

(D) The coverage meets the consumer protection standards established under section 1103(a)(1)(B).

(2) MEDACCESS STANDARD, CATASTROPHIC, AND MEDISAVE COVERAGE.—The terms "MedAccess standard coverage", "MedAccess catastrophic coverage", "MedAccess medisave coverage" mean MedAccess coverage that provides for at least standard coverage (referred to in paragraph (1)(A)(i)), for only catastrophic coverage (referred to in paragraph (1)(A)(ii)), or medisave coverage (referred to in paragraph (1)(A)(iii)), respectively.

(b) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

(1) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a set of rules, including an appropriate set of safe-harbors, which the NAIC determines is sufficient for determining, in the case of any health insurance coverage and for purposes of this section, the actuarial value of the coverage offered.

(2) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a set of rules that comply with the requirements of paragraph (1), the Secretary shall certify such set of rules for use under this part. If the Secretary determines that such a set of rules has not been submitted or does not comply with such requirements, the Secretary shall promptly establish a set of rules that meets such requirements.

(c) STANDARD COVERAGE.—

(1) IN GENERAL.—For purposes of this Act, health insurance coverage is considered to provide standard coverage consistent with this subsection if the benefits are specified in a written instrument providing for such coverage as essential and medically necessary services described in subsection (a)(1)(B) and determined, in accordance with the set of actuarial equivalence rules certified under subsection (b), to have a value that is within 5 percentage points of the applicable target actuarial value for standard coverage established under paragraph (2).

(2) INITIAL DETERMINATION OF APPLICABLE TARGET ACTUARIAL VALUE FOR STANDARD COVERAGE.—

(A) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within

6 months after the date of the enactment of this Act, a procedure for determining the applicable target actuarial value for standard coverage (which may vary by geographic area). Such value shall be equal to the average actuarial value of a representative range of the different types of health benefits provisions (which include cost-sharing) typically offered as standard coverage in the small employer health coverage market. In determining the actuarial value, the benefits considered should be sufficient to cover only services, including (but not limited to) medical, surgical, hospital, and preventive services, which are essential and medically necessary; except that no specific procedure or treatment, or classes thereof, is required to be considered in such determination by this Act or through regulations. The determination of such value shall be based on a representative distribution of the population of eligible employees offered such coverage and a single set of standardized utilization and cost factors (which may vary by geographic area).

(B) Certification.—If the Secretary determines that the NAIC has submitted a procedure for determining the applicable target actuarial value for standard coverage that complies with the requirements of subparagraph (A), the Secretary shall certify such procedure for use under this part. If the Secretary determines that such a procedure has not been submitted or does not comply with such requirements, the Secretary shall promptly prescribe such a procedure that meets such requirements.

(d) Catastrophic Coverage.—

(1) In general.—For purposes of subsection (a)(1)(B), health insurance coverage is considered to provide catastrophic coverage consistent with this subsection if—

(A) benefits are available under such coverage for a year only to the extent that expenses for covered services in a year exceed a deductible amount that is consistent with the dollar amounts specified in section 220(c)(2)(A) of the Internal Revenue Code of 1986, as added by section 2202, and

(B) the benefits are determined, in accordance with the set of actuarial equivalence rules certified under subsection (b), to have a value that is within 5 percentage points of the target actuarial value for catastrophic coverage established under paragraph (2).

(2) Initial determination of target actuarial value for catastrophic coverage.—

(A) Initial determination.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this Act, a target actuarial value for catastrophic coverage equal to the actuarial value that would have been computed under subsection (c)(2)(A) if a deductible that represents the midpoint of the range of deductibles permitted consistent with subsections (b)(2) and (c)(2)(A) of section 220 of the Internal Revenue Code of 1986 were used in place of any deductible that otherwise would be applicable.

(B) Certification.—If the Secretary determines that the NAIC has submitted a target actuarial value for catastrophic coverage that comply with the requirements of subparagraph (A), the Secretary shall certify such value for use under this part. If the Secretary determines that such a value has not been submitted or does not comply with such requirements, the Secretary shall promptly determine such a target actuarial value that meets such requirements.

(e) Medisave Coverage.—

(1) In general.—For purposes of subsection (a)(1)(C), health insurance coverage is considered to provide medisave coverage consistent with this subsection if such coverage consists of—

(A) coverage under a catastrophic health plan (within the meaning of section 220(c)(2) of the Internal Revenue Code of 1986, as inserted by section 2202 of this Act), and

(B) a medical savings account described in section 220(d)(1)(B) of such Code.

(f) Subsequent Revisions.—

(1) NAIC.—The NAIC may submit from time to time to the Secretary revisions of the set of rules of actuarial equivalence previously established or determined under this section if the NAIC determines such revision necessary to take into account changes in the relevant types of health benefits provisions, in deductible levels for catastrophic coverage, or in demographic conditions which form the basis for such set of rules. The provisions of subsection (b)(2) shall apply to such a revision in the same manner as they apply to the initial determination of the set of rules.

(2) Secretary.—The Secretary may by regulation revise such set of rules and values from time to time if the Secretary determines such revision necessary to take into account changes described in paragraph (1).

SEC. 1103. ESTABLISHMENT OF OTHER MEDACCESS STANDARDS.

(a) Establishment of General Standards.—

(1) Role of NAIC.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, model regulations that specify standards with respect to each of the following:

(A)(i) The requirement, under section 1101(a), that insurers make available MedAccess coverage.

(ii) The requirements of guaranteed availability of MedAccess coverage to small employers under section 1101(b).

(B) The requirements of section 1104 (relating to use of modified community rating, uniform marketing materials, and miscellaneous consumer protections).

If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirements, such standards shall serve as the standards under this section, with such amendments as the Secretary deems necessary.

(2) Contingency.—If the NAIC does not develop such model regulations within such period or the Secretary determines that such regulations do not specify standards that meet the requirements described in paragraph (1), the Secretary shall specify, within 15 months after the date of the enactment of this Act, standards to carry out those requirements.

(3) Effective date.—The MedAccess standards and consumer protection standards (as defined in paragraph (5)) shall apply to MedAccess coverage and health insurance coverage provided in a State on or after the respective date the standards are implemented in the State under subsections (b) and (c).

(4) Preemption of state law.—

(A) In general.—Except as provided in subparagraph (B), a State may not establish or enforce standards for health insurance coverage made available to small employers and individuals that are different from the standards established under this part.

(B) Grandfather.—In the case of a State that, as of August 1, 1994, required that premiums in the individual and small group market sectors be community-rated and not vary based on age, the State continue such standards (and reasonable modifications thereof) in force.

(5) Definitions.—In this section:

(A) Consumer protection standards.—The term "consumer protection standards" means the standards established under paragraph (1)(B).

(B) MedAccess standards.—The term "MedAccess standards" means the standards established under paragraph (1)(A) (relating to the requirements of section 1101), and includes the consumer protection standards insofar as they relate to MedAccess coverage.

(b) Application of Standards Through States.—

(1) Application of medaccess standards.—

(A) In general.—Each State shall submit to the Secretary, by the deadline specified in subparagraph (B), a report on steps the State is taking to implement and enforce the consumer protection standards with respect to insurers, and MedAccess coverage offered, not later than such deadline.

(B) Deadline for report.—

(i) 1 year after standards established.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date the MedAccess standards are established under subsection (a).

(ii) Exception for legislation.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for insurers and plans providing MedAccess coverage offered to meet the MedAccess standards established under subsection (a), but

(II) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered, the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) Federal role.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or finds that the State has not implemented and provided adequate enforcement of the MedAccess standards under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards in the State as the Secretary determines to be appropriate. Such implementation and enforcement shall take effect with respect to insurers, and plans providing MedAccess coverage offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected. In exercising authority under this subparagraph, the Secretary shall determine whether the use of a risk-allocation mechanism, described in section 1101(c), would be more consistent with

the small employer group health coverage market in the State than the guaranteed availability provisions of section 1101(b).

(2) APPLICATION OF CONSUMER PROTECTION STANDARDS.—

(A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in subparagraph (B), a report on steps the State is taking to implement and enforce the MedAccess standards with respect to insurers, and health insurance coverage (other than MedAccess coverage) offered, not later than such deadline.

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date the consumer protection standards are established under subsection (a).

(ii) EXCEPTION FOR LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for insurers and plans providing health insurance coverage offered to meet the consumer protection standards established under subsection (a), but

(II) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered, the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) FEDERAL ROLE.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or finds that the State has not implemented and provided adequate enforcement of the consumer protection standards under such paragraph, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such paragraph. If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards in the State as the Secretary determines to be appropriate. Such implementation and enforcement shall take effect with respect to insurers, and health insurance coverage (other than MedAccess coverage) offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected.

SEC. 1104. USE OF MODIFIED COMMUNITY RATING, UNIFORM MARKETING MATERIALS, AND MISCELLANEOUS CONSUMER PROTECTIONS.

(a) USE OF MODIFIED COMMUNITY RATING.—

(1) IN GENERAL.—As a standard under section 1103(a)(1)(B), subject to paragraph (2), the premium rate established by an insurer for coverage may not vary within a plan design except by the following:

(A) AGE.—By age, based on classes of age established by a State.

(B) GEOGRAPHIC AREA.—By geographic area, based on 3-digit zip code or counties, as identified by a State.

(C) FAMILY SIZE.—Family size, based on a classification of individual, individual with one or more children, married couple without children, and married couple with children.

(2) DISCOUNT FOR EMPLOYER WELLNESS PROGRAM.—An insurer may provide for a group discount with respect to an employer that provides for a wellness program for employees.

(b) FULL DISCLOSURE OF RATING PRACTICES.—At the time an insurer offers health insurance coverage to a small employer, the insurer shall fully disclose to the employer rating practices for health insurance coverage, including rating practices for different plan designs.

(c) ACTUARIAL CERTIFICATION.—Each insurer that offers health insurance coverage to a small employer in a State shall file annually with the State commissioner of insurance a written statement by a member of the American Academy of Actuaries (or other individual acceptable to the commissioner) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for applicable health insurance coverage—

(1) the insurer is in compliance with the applicable provisions of this section, and

(2) the rating methods are actuarially sound.

Each such insurer shall retain a copy of such statement for examination at its principal place of business.

(d) REGISTRATION AND REPORTING.—Each insurer that issues any health insurance coverage to a small employer in a State shall be registered or licensed with the State commissioner of insurance and shall comply with any reporting requirements of the commissioner relating to such coverage.

(e) MARKETING MATERIAL.—Each insurer that issues any health insurance coverage to a small employer in a State shall file with the State those marketing materials relating to the offer and sale of health insurance coverage to be used for distribution before the materials are used. Such materials shall be in a uniform format specified under the standards established under section 1101. Such materials (including information on plan designs offered by different insurers) shall be distributed to employers that do not contribute to health insurance coverage for their employees, in order to distribute such information to their employees as part of the offer of coverage under section 1001(a).

SEC. 1105. MONITORING AND RESPONSE TO ADVERSE SELECTION; RISK ADJUSTMENT PROGRAMS.

(a) MONITORING.—The Secretary of Labor shall monitor the prevalence and impact of adverse risk selection in the fully insured plans made available to small employers resulting from the decision of small employers to self insure. State insurance commissioners may submit to the Secretary such information on such adverse risk selection as they determine to be appropriate.

(b) RESPONSE.—If the Secretary of Labor determines, on the basis of such information or otherwise, that, due to decisions of small employers to self-insure, there has been substantial or significant favorable selection with respect to self-insured plans or unfavorable selection with respect to fully insured plans in a State, the Secretary shall develop a risk adjustment program under subsection (c) that responds to such a pattern in the State. The Secretary shall request the NAIC to submit to the Secretary recommendations regarding the structure and operation of such a program.

(c) ESTABLISHMENT OF RISK ADJUSTMENT PROGRAM.—The risk adjustment program applied in a State under this subsection—

(1) shall be designed to be operated on a non-governmental basis,

(2) shall require participation of each small employer in the State that is self-insured,

(3) shall require the imposition of such assessments on self-insured plans offered by such employers as may be appropriate to prevent further adverse or favorable selection, and

(4) shall provide for the distribution of such assessments to the State involved for purposes of making payments to insurers to stabilize the small group insurance market.

The amounts of the assessments under paragraph (3) for individual employers may take into account the number of lives covered under the plans of such employers and the area of residence of the lives covered.

SEC. 1106. ESTABLISHMENT OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS FOR HIGH RISK INDIVIDUALS IN MARKETPLACE FOR SMALL BUSINESS AND MARKETPLACE FOR INDIVIDUALS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) ROLE OF NAIC.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, models for reinsurance or allocation of risk mechanisms (each in this section referred to as a "reinsurance or allocation of risk mechanism") for health insurance coverage made available to small employers and for whom an insurer is at risk of incurring high costs in providing such coverage. If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for an effective reinsurance or allocation of risk mechanism. Such review shall be completed within 30 days after the date the models are developed. Unless the Secretary determines within such period that such a model is not an effective reinsurance or allocation of risk mechanism, such remaining models shall serve as the models under this section, with such amendments as the Secretary deems necessary.

(2) CONTINGENCY.—If the NAIC does not develop such models within such period or the Secretary determines that all such models do not provide for an effective reinsurance or allocation of risk mechanism, the Secretary shall specify, within 15 months after the date of the enactment of this Act, models to carry out this section.

(b) IMPLEMENTATION OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS.—

(1) BY STATES.—Each State shall establish and maintain one or more reinsurance or allocation of risk mechanisms that are consistent with a model established under subsection (a) by not later than the deadline specified in section 1103(b)(1)(B). A State may establish and maintain such a mechanism jointly with one or more other States.

(2) FEDERAL ROLE.—

(A) IN GENERAL.—If the Secretary determines that a State has failed to establish or maintain a reinsurance or allocation of risk mechanism in accordance with paragraph (1), the Secretary shall establish and maintain such a reinsurance or allocation of risk mechanism meeting the requirements of this paragraph.

(B) REINSURANCE MECHANISM.—Unless the Secretary determines under subparagraph (C) that an allocation of risk mechanism is the appropriate mechanism to use in a State under this paragraph, the Secretary shall establish and maintain for use under this section for each State an appropriate reinsurance mechanism.

(C) ALLOCATION OF RISK MECHANISM.—If the Secretary determines that, due to the nature of the health coverage market in the State (including a relatively small number of plans offered providing health insurance coverage or a relatively small number of uninsurable small employers), an allocation of risk mechanism would be a better mechanism than a reinsurance mechanism, the Secretary shall establish and maintain for use under this section for a State an allocation of risk mechanism under which small employers with employees who are at higher risk of significantly higher claims would be equitably assigned among insurers offering health insurance coverage to small employers.

(c) CONSTRUCTION.—Nothing in this section shall be construed to prohibit reinsurance or allocation of risk arrangements relating to health insurance coverage, whether on a State or multi-State basis, not required under this section.

PART 2—MARKETPLACE FOR INDIVIDUALS

SEC. 1111. APPLICATION OF SIMILAR REQUIREMENTS.

(a) IN GENERAL.—Except as provided in subsection (c)—

(1) the provisions of part 1 of this subtitle shall apply to insurers offering health insurance coverage to individuals in the individual market (as defined in subsection (b)) in the same manner as such provisions apply to insurers offering health insurance coverage to employers, and

(2) the standards established under section 1103 shall apply under this part in the same manner as they apply under part 1.

For purposes of this subsection, any reference to an employee or eligible employee is deemed a reference to such an individual.

(b) INDIVIDUAL MARKET DEFINED.—In subsection (a), the term "individual market" means the insurance market offered to individuals seeking health care coverage on behalf of themselves (and their dependents) and not seeking coverage on the basis of employment, membership in a organization, or through another group purchasing arrangement.

(c) EXCEPTION AND SPECIAL RULE.—

(1) WELLNESS DISCOUNTS.—Section 1104(a)(2) (relating to discounts for employer wellness programs) shall not apply under this part.

(2) SEPARATE APPLICATION OF RISK ADJUSTMENT TO INDIVIDUAL MARKET SECTOR.—Section 1105 (relating to monitoring and response to adverse selection; risk adjustment programs) shall be applied under this part in a manner that is separate from its application under part A.

(3) SEPARATE AGE RATING FACTOR FOR THE INDIVIDUAL MARKET.—The provisions regarding age under section 1104(a)(1)(A) shall be determined separately for each year of age and not by the classes of age referred to in such section.

(4) CONVERSION OF PERMANENT HEALTH INSURANCE POLICIES.—The provisions of section 1104 shall not apply in connection with a permanent policy of health insurance existing on the effective date, if each individual covered under the policy is given the option to convert the policy to a policy of health insurance subject to this part.

(d) APPLICATION OF REQUIREMENTS.—Coverage offered by an insurer shall not be treated as MedAccess coverage under this part unless the insurer complies with the requirements of part 3 of subtitle A (relating to standards for managed care arrangements and essential community providers) in the same manner as such requirements apply to a group health plan.

PART 3—VOLUNTARY HEALTH PURCHASING ARRANGEMENTS

SEC. 1121. ESTABLISHMENT AND ORGANIZATION.

(a) IN GENERAL.—Voluntary health purchasing arrangements (in this part referred to as "purchasing arrangements") may be established in accordance with this part. Each purchasing arrangement shall be chartered under State law and operated as a not-for-profit corporation. An insurer may not form, underwrite, or possess a majority vote of a purchasing arrangement, but may administer such an arrangement.

(b) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each purchasing arrangement shall be governed by a Board of Directors. Such Board shall initially be appointed under procedures established by the State in which it operates. Subsequently, the Board shall be elected by the members of the arrangement in accordance with paragraph (3). Such Board shall be composed of individuals who are small employers (or representatives of small employers), eligible employees of small employers (or representatives of such employees), and eligible individuals in the area in which the arrangement operates.

(2) MEMBERSHIP.—A purchasing arrangement shall accept all small employers, eligible employees, and eligible individuals residing within the area served by the arrangement as members if such employers, employees or individuals request such membership.

(3) VOTING.—Members of a purchasing arrangement shall have voting rights consistent with the rules established under the bylaws governing the arrangement.

(c) DUTIES OF PURCHASING ARRANGEMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), each purchasing arrangement shall—

(A) market MedAccess coverage to members throughout the entire area served by the arrangement;

(B) enter into agreements with insurers offering MedAccess coverage under section 1122;

(C) enter into agreements with small employers under section 1123;

(D) enroll individuals in MedAccess coverage, only in accordance with section 1124; and

(E) carry out other functions provided for under this part.

(2) LIMITATION ON ACTIVITIES.—A purchasing arrangement shall not—

(A) perform any activity (including review, approval, or enforcement) relating to payment rates for providers;

(B) perform any activity (including certification or enforcement) relating to compliance of insurers or coverage with the requirements of parts 1 or 2;

(C) assume financial risk in relation to any such coverage; or

(D) perform other activities identified by the State as being inconsistent with the performance of its duties under paragraph (1).

(3) CHARACTERISTICS OF SERVICE AREA.—A purchasing arrangement need not serve areas that are contiguous, but the geographic boundaries of such areas shall be consistent with the boundaries established for geographic areas used in establishing premium rates in the individual and small group marketplace. If a purchasing arrangement serves a part of a metropolitan statistical area the arrangement shall serve the entire area.

(d) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

(1) that a purchasing arrangement be established in each area of a State in which it operates; and

(2) that there be only one purchasing arrangement established with respect to any area.

SEC. 1122. AGREEMENTS WITH INSURERS.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (3), each purchasing arrangement for an area shall enter into an agreement under this section with each insurer that desires to make MedAccess coverage available through the purchasing arrangement (consistent with any procedures established by the State).

(2) TERMINATION OF AGREEMENT.—An agreement under paragraph (1) shall remain in effect for a 12-month period, except that the purchasing arrangement may terminate an agreement under paragraph (1) if the insurer's license or certification under State law is terminated or for other good cause shown.

(3) LIMITATION ON RENEWAL OF AGREEMENTS.—Subsequent to the 12-month period described in paragraph (2), a purchasing arrangement may—

(A) refuse to enter into a subsequent agreement with an insurer if the arrangement determines that the enrollment or premium is too low, and

(B) if a previous agreement with an insurer was terminated for good cause and the arrangement determines appropriate actions have not been taken to correct the problems, refuse to enter into a subsequent agreement with the insurer.

(4) NO PROHIBITION ON OFFERING OF COVERAGE.—Nothing in this subsection shall be construed as prohibiting an insurer that does not enter into an agreement under paragraph (1) from offering health insurance coverage to small employers and eligible individuals within any area, so long as the premium rates charged outside such arrangement are the same as those charged within the arrangement (subject to reasonable differences in premiums that only reflect savings in administrative costs under such an arrangement).

(b) RECEIPT OF PREMIUMS ON BEHALF OF PLANS.—

(1) IN GENERAL.—Under an agreement under this section between a purchasing arrangement and an insurer—

(A) premiums shall be payable , and

(B) payment of premiums may be made by individuals (or employers on their behalf) directly to the purchasing arrangement for the benefit of the insurer.

(2) TIMING OF PAYMENT OF PREMIUMS.—Premiums may be payable on a monthly basis (or, at the option of an eligible employee or individual, on a quarterly basis). The purchasing arrangement may provide for reasonable penalties and grace periods for late payment.

(3) QUALIFIED HEALTH PLANS RETAIN RISK OF NONPAYMENT.—Nothing in this subsection shall be construed as placing upon a purchasing arrangement any risk associated with the failure of individuals and employers to make prompt payment of premiums to the purchasing arrangement (other than the portion of the premium representing the purchasing arrangement administrative fee under section 1125). Each small employer and eligible individual who enrolls with an insurer through the purchasing arrangement is liable to the insurer for premiums.

(c) FORWARDING OF PREMIUMS.—

(1) IN GENERAL.—If, under an agreement under subsection (a), premium payments for an insurer are made to the purchasing arrangement, the purchasing arrangement shall forward to the insurer the amount of the premiums and the purchasing arrangement (and not the employer or individual)

shall be liable for the premium payment collected under such arrangement.

(2) Payments.—Payments shall be made by the purchasing arrangement under this subsection within a period of days (specified by the Secretary and not to exceed 7 days) after receipt of the premium from the small employer of the eligible employee or the eligible individual, as the case may be.

SEC. 1123. PROVISION OF INFORMATION.

(a) In General.—Each purchasing arrangement for an area shall provide, upon request, to each small employer that employs individuals in the area and to each eligible individual who resides in the area—

(1) information provided to the purchasing arrangement by the State or insurers in accordance with rules by the State in which such arrangement is located, and

(2) the opportunity to enter into an agreement with the arrangement for the purchase of coverage through the insurer.

(b) Forwarding Information and Payroll Deductions.—As part of an agreement entered into under this section, a small employer shall forward the information and make the payroll deductions required under section 1001.

SEC. 1124. ENROLLING ELIGIBLE EMPLOYEES AND ELIGIBLE INDIVIDUALS THROUGH A PURCHASING ARRANGEMENT.

A purchasing arrangement shall offer, on behalf of each insurer with which an agreement was entered into under section 1122 and in accordance with the enrollment procedures of such insurers, enrollment in health insurance coverage only to—

(1) all eligible employees employed by small employers in the area served by the purchasing arrangement; and

(2) all eligible individuals residing in such area.

SEC. 1125. RESTRICTION ON CHARGES.

(a) In General.—A purchasing arrangement may impose an administrative fee with respect to an eligible employee or eligible individual obtaining coverage through the purchasing arrangement.

(b) Fee.—A purchasing arrangement that elects to impose a fee under subsection (a) shall ensure that such fee is set as a percentage of the premium for such coverage and is imposed uniformly with respect to all coverage provided through the arrangement.

PART 4—DEFINITIONS AND MISCELLANEOUS PROVISIONS

SEC. 1131. DEFINITIONS.

Except as otherwise specifically provided, for purposes of this subtitle:

(1) Dependent child.—The term "dependent child" means a child (including an adopted child) who is under 19 years of age or who is a full-time student and under 25 years of age.

(2) Eligible employee.—The term "eligible employee" means, with respect to an employer, an employee who—

(A) normally performs on a monthly basis at least 10 hours of service per week for that employer; or

(B) is reasonably expected as of the 1st day of such month to be employed by the employer for a period of 120 consecutive days during any 365-day period that includes such 1st day.

(3) Employer.—The term "employer" shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(4) Health insurance coverage.—

(A) In general.—Except as provided in subparagraph (B), the term "health insurance coverage" means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

(B) Exception.—Such term does not include any of the following:

(i) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

(ii) Medicare supplemental health insurance.

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Worker's compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital or fixed indemnity policy.

(5) Network plan.—The term "network plan" includes, as defined in standards established under section 1103, an organization that provides health insurance coverage which meets specified standards and under which health services are offered to be provided on a prepaid, at-risk basis primarily through a defined set of providers.

(6) Insurer.—The term "insurer" means a licensed insurance company, an entity offering prepaid hospital or medical services, and a health maintenance organization offering such services to an employer, and includes a similar organization regulated under State law for solvency.

(7) NAIC.—The term "NAIC" means the National Association of Insurance Commissioners.

(8) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.

(9) Small employer.—The term "small employer" means, with respect to a calendar year, an employer that normally employs more than 1 but less than 51 eligible employees on a typical business day. For the purposes of this paragraph, the term "employee" includes a self-employed individual. For purposes of determining if an employer is a small employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

(10) State.—The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(11) State commissioner of insurance.—The term "State commissioner of insurance" includes a State superintendent of insurance.

SEC. 1132. ENFORCEMENT.

For enforcement of requirements of this subtitle, see section 1031.

SEC. 1133. PROHIBITION OF IMPROPER INCENTIVES.

(a) Limitation on Financial Incentives.—No insurer that offers health insurance coverage may vary the commission or financial or other remuneration to a person based on the claims experience or health status of individuals enrolled by or through the person.

(b) Prohibition of Tie-in Arrangements.—No insurer that offers health insurance coverage may require the purchase of any other insurance or product as a condition for the purchase of such coverage.

SEC. 1134. ANNUAL REPORTS.

(a) In General.—The Secretary shall submit to Congress an annual report on the implementation of this subtitle and the need for additional reforms to assure and expand coverage.

(b) Information Regarding Impact of Reforms.—Each annual report shall include information concerning at least the following:

(1) Implementation and enforcement of the applicable MedAccess standards and consumer protection standards under this subtitle by the States and by the Secretary.

(2) An evaluation of the impact of the reforms under this subtitle on the availability of affordable health coverage for individuals and for small employers that purchase group health coverage and for their employees, and, in particular, the impact of—

(A) guaranteed availability of health coverage,

(B) limitations of restrictions from coverage of preexisting conditions,

(C) requirement for continuity of coverage,

(D) risk-management mechanisms for health coverage,

(E) limits on premium variations, and

(F) preemption of State benefit mandates.

In performing such evaluation, the Secretary shall seek to discount the effect of the insurance cycle on health insurance premiums.

(3) An assessment of the implications of the reforms on adverse selection among health insurance plans and the distribution of risk among health insurance plans.

(c) Information Regarding Coverage of the Uninsured.—The report submitted under this section 5 years after the date of the enactment of this Act also shall include findings and recommendations regarding each of the following:

(1) Characteristics of the insured and uninsured, including demographic characteristics, working status, health status, and geographic distribution.

(2) Steps which should be taken to improve access to health care and increase health insurance coverage of the chronically uninsured.

(3) Effectiveness of efforts to measure and improve health care outcomes in the public and private sectors.

(4) Effectiveness of initiatives targeted to improving access of underserved urban and rural populations to health care services.

(5) Effectiveness of new Federal subsidy programs, including recommendations to restrain future growth of such programs.

SEC. 1135. RESEARCH AND DEMONSTRATION PROJECTS; DEVELOPMENT OF A HEALTH RISK POOLING MODEL.

(a) Research and Demonstrations.—The Secretary is authorized, directly, by contract, and through grants and cooperative agreements within the Department of Health and Human Services and outside the Department—

(1) to conduct research on the impact of this subtitle on the availability of affordable health coverage for employees and dependents in the small employers group and individual health care coverage market and other topics described in section 1134(b), and

(2) to conduct demonstration projects relating to such topics.

(b) Development of Methods of Measuring Relative Health Risk.—

(1) In general.—The Secretary shall develop methods for measuring, in terms of the expected costs of providing benefits under health insurance plans and, in particular, MedAccess plans, the relative health risks of eligible individuals.

(2) Methodology.—The methods—

(A) shall rely on diagnosis or other health-related information that is predictive of individual health care needs,

(B) may rely upon information routinely collected in the process of making payments under group health plans, and

(C) may provide for such random, sample audits of records as may be necessary to verify the accuracy of measurements.

(c) DEVELOPMENT OF A HEALTH RISK POOLING MODEL.—

(1) IN GENERAL.—The Secretary shall develop a model, based on the methods of measuring risks under subsection (b), for equitably distributing health risks among insurers and group health plans in the small employer and individual health care coverage market.

(2) REDISTRIBUTION OF RISK.—Under such model, insurers and group health plans with below average health risks would be required to contribute to a common fund for payment to insurers and group health plans with above average health risks, each in relation to the degree of their favorable or adverse risk selection.

(3) INCENTIVES.—Such model shall include incentives to encourage continuous coverage of individuals and eligible individuals and small employers.

(d) CONSULTATION.—The methods and model under this section shall be developed in consultation with the NAIC.

(e) REPORT.—By not later than January 1, 1996, the Secretary shall submit to Congress a report on the methods and model developed under this section (as well as on research and demonstration projects conducted under subsection (a)). The Secretary shall include in the report such recommendations respecting the application of the model to insurers and group health plans (and, in particular, to MedAccess plans) under this subtitle as the Secretary deems appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 in each of fiscal years 1995 through 1999.

Subtitle C—Preemption

PART 1—SCOPE OF STATE REGULATION

SEC. 1201. PROHIBITION OF STATE BENEFIT MANDATES FOR GROUP HEALTH PLANS.

In the case of a group health plan, no provision of State or local law shall apply that requires the coverage of one or more specific benefits, services, or categories of health care, or services of any class or type of provider of health care.

SEC. 1202. PROHIBITION OF PROVISIONS PROHIBITING EMPLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.

No provision of State or local law shall apply that prohibits 2 or more employers from obtaining coverage under a multiple employer welfare arrangement under which all coverage consists of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 and is fully insured.

SEC. 1203. PREEMPTION OF STATE ANTI-MANAGED CARE LAWS.

(a) PREEMPTION OF STATE LAW PROVISIONS.—Subject to subsection (c), the following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a group health plan or insurer to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a group health plan or insurer may require a beneficiary to pay when a non-plan provider is used on a nonemergency basis.

(3) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—Any law that—

(A) prohibits utilization review of any or all treatments and conditions,

(B) requires that such review be made (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being reviewed,

(C) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews,

(D) requires payments to providers for the expenses of responding to utilization review requests,

(E) imposes liability for delays in performing such review, or

(F) requires standards in addition to or inconsistent with standards established under section 1022(b).

Nothing in subparagraph (B) shall be construed as prohibiting a State from (i) requiring a licensed physician or other health care professional be available at some time in the review or appeal process, or (ii) requiring that any decision in an appeal from such a review be made by a licensed physician.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effectiveness of the use of managed care in the delivery of health services.

(2) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations (including whether the provisions of subsection (a) should be extended) as may be appropriate.

(c) SUNSET.—Unless otherwise provided, subsection (a) shall not apply 5 years after the date of the enactment of this Act.

SEC. 1204. DEFINITIONS.

For purposes of this part, the terms "dependent", "employee", "employer", "fully insured", "group health plan", "health insurance plan", "multiple employer welfare arrangement", and "State" have the meanings given such terms in section 1023(a).

PART 2—MULTIPLE EMPLOYER HEALTH BENEFITS PROTECTIONS

SEC. 1211. LIMITED EXEMPTION FROM CERTAIN RESTRICTIONS ON ERISA PREEMPTION OF STATE LAW FOR HEALTH PLANS MAINTAINED BY MULTIPLE EMPLOYERS SUBJECT TO CERTAIN FEDERAL STANDARDS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

"Part 7—Multiple Employer Health Plans

"SEC. 701. DEFINITIONS.

"For purposes of this part—

"(1) INSURER.—The term 'insurer' means an insurance company, insurance service, or insurance organization, licensed to engage in the business of insurance by a State.

"(2) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the dependents of its employees, are or were covered under such arrangement in connection with the employment of the employees.

"(3) EXCESS/STOP LOSS COVERAGE.—The term 'excess/stop loss coverage' means, in connection with a multiple employer welfare arrangement, a contract under which an insurer provides for payment with respect to claims under the arrangement, relating to participants or beneficiaries individually or otherwise, in excess of an amount or amounts specified in such contract.

"(4) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

"(5) SPONSOR.—The term 'sponsor' means, in connection with a multiple employer welfare arrangement, the association or other entity which establishes or maintains the arrangement.

"(6) STATE INSURANCE COMMISSIONER.—The term 'State insurance commissioner' means the insurance commissioner (or similar official) of a State.

"(7) DOMICILE STATE.—The term 'domicile State' means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for an exemption under this part, most individuals to be covered under the arrangement are located, except that, in any case in which information contained in the latest annual report of the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different State.

"(8) FULLY INSURED.—Coverage under a multiple employer welfare arrangement is 'fully insured' if one or more insurers, health maintenance organizations, similar organizations regulated under State law for solvency, or any combination thereof are liable under one or more insurance policies or contracts for all benefits under the arrangement (irrespective of any recourse they may have against other parties).

"(9) EXEMPTED MULTIPLE EMPLOYER HEALTH PLAN.—The term 'exempted multiple employer health plan' means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of an exemption under this part.

"(10) COMMUNITY HEALTH NETWORK.—The term 'community health network' has the meaning given such term in section 1421 of the Affordable Health Care Now Act of 1994.

"SEC. 702. EXEMPTED MULTIPLE EMPLOYER HEALTH PLANS RELIEVED OF CERTAIN RESTRICTIONS ON PREEMPTION OF STATE LAW AND TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.

"(a) IN GENERAL.—Subject to subsection (b), a multiple employer welfare arrangement under which coverage is not fully insured and with respect to which there is in effect an exemption granted by the Secretary under this part (or with respect to which there is pending a complete application for such an exemption and the Secretary determines that provisional protection under this part is appropriate)—

"(1) shall be treated for purposes of subtitle A and the preceding parts of this subtitle as an employee welfare benefit plan, irrespective of whether such arrangement is an employee welfare benefit plan, and

"(2) shall be exempt from section 514(b)(6)(A)(ii).

"(b) BENEFITS MUST CONSIST OF MEDICAL CARE.—Subsection (a) shall apply to a multiple employer welfare arrangement only if the benefits provided thereunder consist solely of medical care described in section 607(1) (disregarding such incidental benefits as the Secretary shall specify by regulation).

"(c) RESTRICTION ON COMMENCEMENT OF NEW ARRANGEMENTS.—A multiple employer welfare arrangement providing benefits which consist of medical care described in section 607(1) which has not commenced operations as of January 1, 1995, may commence operations only if an exemption granted to the arrangement under this part is in effect (or there is pending with respect to the arrangement a complete application for such an exemption and the Secretary determines that provisional protection under this part is appropriate).

"SEC. 703. EXEMPTION PROCEDURE.

"(a) IN GENERAL.—The Secretary shall grant an exemption described in section 702(a) to a multiple employer welfare arrangement if—

"(1) an application for such exemption with respect to such arrangement, identified individually or by class, has been duly filed in complete form with the Secretary in accordance with this part,

"(2) such application demonstrates compliance with the requirements of section 704 with respect to such arrangement, and

"(3) the Secretary finds that such exemption is—

"(A) administratively feasible,

"(B) not adverse to the interests of the individuals covered under the arrangement, and

"(C) protective of the rights and benefits of the individuals covered under the arrangement.

"(b) NOTICE AND HEARING.—Before granting an exemption under this section, the Secretary shall publish notice in the Federal Register of the pendency of the exemption, shall require that adequate notice be given to interested persons, including the State insurance commissioner of each State in which covered individuals under the arrangement are, or are expected to be, located, and shall afford interested persons opportunity to present views. The Secretary may not grant an exemption under this section unless the Secretary affords an opportunity for a hearing and makes a determination on the record with respect to the findings required under subsection (a)(3). The Secretary shall, to the maximum extent practicable, make a final determination with respect to any application filed under this section in the case of a newly established arrangement within 90 days after the date which the Secretary determines is the date on which such application is filed in complete form.

"SEC. 704. ELIGIBILITY REQUIREMENTS.

"(a) APPLICATION FOR EXEMPTION.—

"(1) IN GENERAL.—An exemption may be granted by the Secretary under this part only on the basis of an application filed with the Secretary in such form and manner as shall be prescribed in regulations of the Secretary. Any such application shall be signed by the operating committee and the sponsor of the arrangement.

"(2) FILING FEE.—The arrangement shall pay to the Secretary at the time of filing an application under this section a filing fee in the amount of $5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the exemption procedures under this part.

"(3) INFORMATION INCLUDED.—An application filed under this section shall include, in a manner and form prescribed in regulations of the Secretary, at least the following information:

"(A) IDENTIFYING INFORMATION.—The names and addresses of—

"(i) the sponsor, and

"(ii) the members of the operating committee of the arrangement.

"(B) STATES IN WHICH ARRANGEMENT INTENDS TO DO BUSINESS.—The States in which individuals covered under the arrangement are to be located and the number of such individuals expected to be located in each such State.

"(C) BONDING REQUIREMENTS.—Evidence provided by the operating committee that the bonding requirements of section 412 will be met as of the date of the application.

"(D) PLAN DOCUMENTS.—A copy of the documents governing the arrangement (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits and coverage that will be provided to individuals covered under the arrangement.

"(E) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the arrangement and contract administrators and other service providers.

"(F) FUNDING REPORT.—A report setting forth information determined as of a date within the 120-day period ending with the date of the application, including the following:

"(i) RESERVES.—A statement, certified by the operating committee of the arrangement, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 707 are or will be met in accordance with regulations which the Secretary shall prescribe.

"(ii) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the arrangement for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the arrangement. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

"(iii) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the arrangement and a projection of the assets, liabilities, income, and expenses of the arrangement for the 12-month period referred to in clause (ii). The income statement shall identify separately the arrangement's administrative expenses and claims.

"(iv) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the arrangement.

"(v) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

"(b) OTHER REQUIREMENTS.—A complete application for an exemption under this part shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

"(1) SPONSOR.—

"(A) IN GENERAL.—Except in a case to which subparagraph (B) or (C) applies, the sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care described in section 607(1), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members.

"(B) SPECIAL RULE FOR COMMUNITY HEALTH NETWORKS.—In the case of an arrangement that is a community health network (as defined in section 701(11)), the sponsor is the operating committee of the network.

"(C) SPECIAL RULE FOR EMPLOYERS IN THE SAME TRADE OR BUSINESS.—In the case of an arrangement under which all participating employers are engaged in a common type of trade or business, the sponsor is the operating committee of the arrangement.

"(2) OPERATING COMMITTEE.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the arrangement is operated, pursuant to a trust agreement, by an operating committee which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the operating committee has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the committee are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the committee if they constitute not more than 25 percent of the membership of the committee and they do not provide services to the arrangement other than on behalf of the sponsor. The committee has sole authority to approve applications for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

"(B) SPECIAL RULE FOR COMMUNITY HEALTH NETWORKS.—In the case of an arrangement that is a community health network (as defined in section 701(11)), the operating committee is the board of the entity that is the network.

"(3) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the arrangement include a written instrument, meeting the requirements of an instrument required under section 1212(a)(1), which—

"(A) provides that the committee serves as the named fiduciary required for plans under section 1212(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

"(B) provides that the sponsor is to serve as plan sponsor (referred to in section 3(16)(B)),

"(C) incorporates the requirements of section 707, and

"(D) provides that, effective upon the granting of an exemption under this part—

"(i) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

"(ii) all individuals thereafter commencing coverage under the arrangement must be—

"(I) active or retired owners, officers, directors, or employees of, or partners in, participating employers, or

"(II) the beneficiaries of individuals described in subclause (I).

"(4) CONTRIBUTION RATES.—The contribution rates referred to in subsection (a)(3)(F)(ii) are adequate.

"(5) REGULATORY REQUIREMENTS.—Such other requirements as the Secretary may prescribe by regulation as necessary to carry out the purposes of this part.

"(c) TREATMENT OF PARTY SEEKING EXEMPTION WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

"(1) IN GENERAL.—In the case of any application for an exemption under this part with respect to a multiple employer welfare arrangement, if the Secretary determines that the sponsor of the arrangement or any other person associated with the arrangement is subject to disqualification under paragraph (2), the Secretary may deny the exemption with respect to such arrangement.

"(2) DISQUALIFICATION.—A person is subject to disqualification under this paragraph if such person—

"(A) has intentionally made a material misstatement in the application for exemption;

"(B) has obtained or attempted to obtain an exemption under this part through misrepresentation or fraud;

"(C) has misappropriated or converted to such person's own use, or improperly withheld, money held under a plan or any multiple employer welfare arrangement;

"(D) is prohibited (or would be prohibited if the arrangement were a plan) from serving in any capacity in connection with the arrangement under section 411,

"(E) has failed to appear without reasonable cause or excuse in response to a subpoena, examination, warrant, or any other order lawfully issued by the Secretary compelling such response,

"(F) has previously been subject to a determination under this part resulting in the denial, suspension, or revocation of an exemption under this part on similar grounds, or

"(G) has otherwise violated any provision of this title with respect to a matter which the Secretary determines of sufficient consequence to merit disqualification for purposes of this part.

"(d) FRANCHISE NETWORKS.—In the case of a multiple employer welfare arrangement established and maintained by a franchisor for a franchise network consisting of its franchisees, such franchisor shall be treated as the sponsor referred to in the preceding provisions of this section, such network shall be treated as an association referred to in such provisions, and each franchisee shall be treated as a member (of the association and the sponsor) referred to in such provisions, if all participating employers are such franchisees and the requirements of subsection (b)(1) with respect to a sponsor are met with respect to the network.

"(e) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In applying the preceding provisions of this section in the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but for the failure to meet any requirement of section 3(40)(C)—

"(1) paragraphs (1) and (2) of subsection (b) and subparagraphs (A), (B), and (D) of paragraph (3) of subsection (b) shall be disregarded, and

"(2) the joint board of trustees shall be considered the operating committee of the arrangement.

"(f) CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

"(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple employer welfare arrangement are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer, subsection (b)(3)(D) shall be disregarded.

"(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are 'related' if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

"SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO EXEMPTED MULTIPLE EMPLOYER HEALTH PLANS.

"(a) NOTICE OF MATERIAL CHANGES.—In the case of any exempted multiple employer health plan, descriptions of material changes in any information which was required to be submitted with the application for the exemption granted under this part shall be filed in such form and manner as shall be prescribed in regulations of the Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the exemption.

"(b) REPORTING REQUIREMENTS.—Under regulations of the Secretary, the requirements of sections 102, 103, and 104 shall apply with respect to any multiple employer welfare arrangement which is or has been an exempted multiple employer health plan in the same manner and to the same extent as such requirements apply to employee welfare benefit plans, irrespective of whether such exemption continues in effect. The annual report required under section 103 for any plan year in the case of any such multiple employer welfare arrangement shall also include information described in section 704(a)(3)(F) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year.

"(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The operating committee of each multiple employer welfare arrangement which is or has been an exempted multiple employer health plan shall engage, on behalf of all covered individuals, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

"(1) are in the aggregate reasonably related to the experience of the arrangement and to reasonable expectations, and

"(2) represent such actuary's best estimate of anticipated experience under the arrangement.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

"(d) FILING NOTICE OF EXEMPTION WITH STATES.—An exemption granted to a multiple employer welfare arrangement under this part shall not be effective unless written notice of such exemption is filed with the State insurance commissioner of each State in which at least 5 percent of the individuals covered under the arrangement are located. For purposes of this paragraph, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed. The Secretary may by regulation provide in specified cases for the application of the preceding sentence with lesser percentages in lieu of such 5 percent amount.

"SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY ARRANGEMENTS PROVIDING MEDICAL CARE.

"(a) IN GENERAL.—A multiple employer welfare arrangement providing benefits consisting of medical care described in section 607(1) shall issue to each participating employer—

"(1) a document equivalent to the summary plan description required of plans under part 1,

"(2) information describing the contribution rates applicable to participating employers, and

"(3) a statement indicating—

"(A) that the arrangement is not a licensed insurer under the laws of any State,

"(B) whether coverage under the arrangement is fully insured,

"(C) if coverage under the arrangement if not fully insured, (i) whether the arrangement is (or has ceased to be) an exempted multiple employer health plan, and (ii) if such an arrangement is an exempted multiple employer health plan, that such arrangement is treated as an employee welfare benefit plan under this title.

"(b) TIME FOR DISCLOSURE.—Such information shall be issued to employers within such reasonable period of time before becoming participating employers as may be prescribed in regulations of the Secretary.

"SEC. 707. MAINTENANCE OF RESERVES.

"(a) IN GENERAL.—Each multiple employer welfare arrangement which is or has been an exempted multiple employer health plan and under which coverage is not fully insured shall establish and maintain reserves, consisting of—

"(1) a reserve for unearned contributions,

"(2) a reserve for payment of claims reported and not yet paid and claims incurred but not yet reported, and for expected administrative costs with respect to such claims, and

"(3) a reserve, in an amount recommended by the qualified actuary, for any other obligations of the arrangement.

"(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—The total of the reserves described in subsection (a)(2) shall not be less than an amount equal to 25 percent of expected incurred claims and expenses for the plan year.

"(c) REQUIRED MARGIN.—In determining the amounts of reserves required under this section in connection with any multiple employer welfare arrangement, the qualified actuary shall include a margin for error and other fluctuations taking into account the specific circumstances of such arrangement.

"(d) ADDITIONAL REQUIREMENTS.—The Secretary may provide such additional requirements relating to reserves and excess/stop loss coverage as the Secretary considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any arrangement or any class of arrangements.

"(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COVERAGE.—The Secretary may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such arrangement or arrangements.

"(f) ALTERNATIVE MEANS OF COMPLIANCE.—The Secretary may permit an arrangement (including a community health network) to substitute, for all or part of the reserves required under subsection (a), such security, guarantee, or other financial arrangement as the Secretary determines to be adequate to enable the arrangement to fully meet all its financial obligations on a timely basis.

"SEC. 708. CORRECTIVE ACTIONS.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—A multiple employer welfare arrangement with respect to which there is or has been in effect an exemption granted under this part shall continue to meet the requirements of section 707, irrespective of whether such exemption continues in effect. The operating committee of such arrangement shall determine semiannually whether the requirements of section 707 are met. In any case in which the committee determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination and so notifies the committee, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the end of the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with section 707. Not later than 10 days after receiving from the actuary recommendations for corrective actions, the committee shall notify the Secretary (in such form and manner as the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the committee has taken or plans to take in response to such recommendations. The committee shall thereafter report to the Secretary, in such form and frequency as the Secretary may specify to the committee, regarding corrective action taken by the committee until the requirements of section 707 are met.

"(b) TERMINATION.—

"(1) NOTICE OF TERMINATION.—In any case in which the operating committee of a multiple employer welfare arrangement which is or has been an exempted multiple employer health plan determines that there is reason to believe that the arrangement will terminate, the committee shall so inform the Secretary, shall develop a plan for winding up the affairs of the arrangement in connection with such termination in a manner which will result in timely payment of all benefits for which the arrangement is obligated, and shall submit such plan in writing to the Secretary. Actions required under this paragraph shall be taken in such form and manner as may be prescribed in regulations of the Secretary.

"(2) ACTIONS REQUIRED IN CONNECTION WITH TERMINATION.—In any case in which—

"(A) the Secretary has been notified under subsection (a) of a failure of a multiple employer welfare arrangement which is or has been an exempted multiple employer health plan to meet the requirements of section 707 and has not been notified by the operating committee of the arrangement that corrective action has restored compliance with such requirements, and

"(B) the Secretary determines that the continuing failure to meet the requirements of section 707 can be reasonably expected to result in a continuing failure to pay benefits for which the arrangement is obligated,

the operating committee of the arrangement shall, at the direction of the Secretary, terminate the arrangement and, in the course of the termination, take such actions as the Secretary may require as necessary to ensure that the affairs of the arrangement will be, to the maximum extent possible, wound up in a manner which will result in timely payment of all benefits for which the arrangement is obligated.

"SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF EXEMPTION.

"(a) EXPIRATION AND RENEWAL OF EXEMPTION.—An exemption granted to a multiple employer welfare arrangement under this part shall expire 3 years after the date on which the exemption is granted. An exemption which has expired may be renewed by means of application for an exemption in accordance with section 704.

"(b) SUSPENSION OR REVOCATION OF EXEMPTION BY SECRETARY.—The Secretary may suspend or revoke an exemption granted to a multiple employer welfare arrangement under this part—

"(1) for any cause that may serve as the basis for the denial of an initial application for such an exemption under section 704, or

"(2) if the Secretary finds that—

"(A) the arrangement, or the sponsor thereof, in the transaction of business while under the exemption, has used fraudulent, coercive, or dishonest practices, or has demonstrated incompetence, untrustworthiness, or financial irresponsibility,

"(B) the arrangement, or the sponsor thereof, is using such methods or practices in the conduct of its operations, so as to render its further transaction of operations hazardous or injurious to participating employers, or covered individuals,

"(C) the arrangement, or the sponsor thereof, has refused to be examined in accordance with this part or to produce its accounts, records, and files for examination in accordance with this part, or

"(D) any of the officers of the arrangement, or the sponsor thereof, has refused to give information with respect to the affairs of the arrangement or the sponsor or to perform any other legal obligation relating to such an examination when required by the Secretary in accordance with this part.

Any such suspension or revocation under this subsection shall be effective only upon a final decision of the Secretary made after notice and opportunity for a hearing is provided in accordance with section 710.

"(c) SUSPENSION OR REVOCATION OF EXEMPTION UNDER COURT PROCEEDINGS.—An exemption granted to a multiple employer welfare arrangement under this part may be suspended or revoked by a court of competent jurisdiction in an action by the Secretary brought under paragraph (2), (5), or (6) of section 502(a), except that the suspension or revocation under this subsection shall be effective only upon notification of the Secretary of such suspension or revocation.

"(d) NOTIFICATION OF PARTICIPATING EMPLOYERS.—All participating employers in a multiple employer welfare arrangement shall be notified of the expiration, suspension, or revocation of an exemption granted to such arrangement under this part, by such persons and in such form and manner as shall be prescribed in regulations of the Secretary, not later than 20 days after such expiration or after receipt of notice of a final decision requiring such suspension or revocation.

"(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS, AND REVOCATIONS.—The Secretary shall publish all expirations of, and all final decisions to suspend or revoke, exemptions granted under this part.

"SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.

"(a) IN GENERAL.—Any decision by the Secretary which involves the denial of an application by a multiple employer welfare arrangement for an exemption under this part or the suspension or revocation of such an exemption shall contain a statement of the specific reason or reasons supporting the Secretary's action, including reference to the specific terms of the exemption and the statutory provision or provisions relevant to the determination.

"(b) DENIALS OF APPLICATIONS.—In the case of the denial of an application for an exemption under this part, the Secretary shall send a copy of the decision to the applicant by certified or registered mail at the address specified in the records of the Secretary. Such decision shall constitute the final decision of the Secretary unless the arrangement, or any party that would be prejudiced by the decision, files a written appeal of the denial within 30 days after the mailing of such decision. The Secretary may affirm, modify, or reverse the initial decision. The decision on appeal shall become final upon the mailing of a copy by certified or registered mail to the arrangement or party that filed the appeal.

"(c) SUSPENSIONS OR REVOCATIONS OF EXEMPTION.—In the case of the suspension or revocation of an exemption granted under this part, the Secretary shall send a copy of the decision to the arrangement by certified or registered mail at its address, as specified in the records of the Secretary. Upon the request of the arrangement, or any party that would be prejudiced by the suspension or revocation, filed within 15 days of the mailing of the Secretary's decision, the Secretary shall schedule a hearing on such decision by written notice, sent by certified or registered mail to the arrangement or party requesting such hearing. Such notice shall set forth—

"(1) a specific date and time for the hearing, which shall be within the 10-day period commencing 20 days after the date of the mailing of the notice, and

"(2) a specific place for the hearing, which shall be in the District of Columbia or in the State and county thereof (or parish or other similar political subdivision thereof) in which is located the arrangement's principal place of business.

The decision as affirmed or modified in such hearing shall constitute the final decision of the Secretary, unless such decision is reversed in such hearing.".

(b) CONFORMING AMENDMENT TO DEFINITION OF PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 1002(16)(B)) is amended by adding at the end the following new sentence: "Such term also includes the sponsor (as defined in section 701(5)) of a multiple employer welfare arrangement which is or has been an exempted multiple employer health plan (as defined in section 701(10)).".

(c) ALTERNATIVE MEANS OF DISTRIBUTION OF SUMMARY PLAN DESCRIPTIONS.—Section 110 of such Act (29 U.S.C. 1030) is amended by adding at the end the following new subsection:

"(c) The Secretary shall prescribe, as an alternative method for distributing summary plan descriptions in order to meet the requirements of section 104(b)(1) in the case of multiple employer welfare arrangements providing benefits consisting of medical care described in section 607(1), a means of distribution of such descriptions by participating employers.".

(d) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 608 the following new items:

"PART 7—MULTIPLE EMPLOYER HEALTH PLANS

"Sec. 701. Definitions.
"Sec. 702. Exempted multiple employer health plans relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.
"Sec. 703. Exemption procedure.
"Sec. 704. Eligibility requirements.
"Sec. 705. Additional requirements applicable to exempted multiple employer health plans.
"Sec. 706. Disclosure to participating employers by arrangements providing medical care.
"Sec. 707. Maintenance of reserves.
"Sec. 708. Corrective actions.
"Sec. 709. Expiration, suspension, or revocation of exemption.
"Sec. 710. Review of actions of the secretary."

SEC. 1212. CLARIFICATION OF SCOPE OF PREEMPTION RULES.

(a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting ", but only, in the case of an arrangement which provides medical care described in section 607(1) and with respect to which an exemption under part 7 is not in effect," before "to the extent not inconsistent with the preceding sections of this title".

(b) CROSS-REFERENCE.—Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

"(E) For additional rules relating to exemption from subparagraph (A)(ii) of multiple employer welfare arrangements providing medical care, see part 7.".

SEC. 1213. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting "for any plan year of any such plan, or any fiscal year of any such other arrangement," after "single employer", and by inserting "during such year or at any time during the preceding 1-year period" after "common control";

(2) in clause (iii), by striking "common control shall not be based on an interest of less than 25 percent" and inserting "an interest of greater than 25 percent may not be required as the minimum interest necessary for common control", and by striking "and" at the end,

(3) by redesignating clause (iv) as clause (v), and

(4) by inserting after clause (iii) the following new clause:

"(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, at the time the determination under clause (i) is made, the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 95 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement.".

SEC. 1214. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

"(i) under or pursuant to one or more collective bargaining agreements,".

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

"(C) Clause (i) of subparagraph (A) shall apply only if—

"(i) the plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

"(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement, or

"(II) pay a commission or any other type of compensation to a person that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement,

"(ii) not less than 85 percent of the covered individuals under the plan or other arrangement are individuals who—

"(I) are employed within a bargaining unit covered by at least one of the collective bargaining agreements with a participating employer (or are covered on the basis of an individual's employment in such a bargaining unit), or

"(II) are present or former employees of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (or are covered on the basis of such present or former employment),

"(iii) the plan or other arrangement does not provide benefits to individuals (other than individuals described in clause (ii)(II)) who work outside the standard metropolitan statistical area in which the sponsoring employee organization represents employees (or to individuals (other than individuals described in clause (ii)(II)) on the basis of such work by others), except that in the case of a sponsoring employee organization that represents employees who work outside of any standard metropolitan statistical area, this clause shall be applied by reference to the State in which the sponsoring organization represents employees,

"(iv) the employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary—

"(I) that the plan or other arrangement meets the requirements of clauses (i), (ii), and (iii), and

"(II) if, for any year, 10 percent or more of the covered individuals under the plan are individuals not described in subclause (I) or (II) of clause (ii), the total number of covered individuals and the total number of covered individuals not so described.

"(D)(i) Clause (i) of subparagraph (A) shall not apply to a plan or other arrangement that is established or maintained pursuant to one or more collective bargaining agreements which the National Labor Relations Boards determines to have been negotiated or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)).

"(ii)(I) Whenever a State insurance commissioner has reason to believe that this subparagraph is applicable to part or all of a plan or other arrangement, the State insurance commissioner may file a petition with the National Labor Relations Board for a determination under clause (i), along with sworn written testimony supporting the petition.

"(II) The Board shall give any such petition priority over all other petitions and cases, other than other petitions under subclause (I) or cases given priority under section 10 of the National Labor Relations Act (29 U.S.C. 160).

"(III) The Board shall determine, upon the petition and any response, whether, on the facts before it, the plan or other arrangement was negotiated, created, or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)). Such determination shall constitute a final determination for purposes of this subparagraph and shall be binding in all Federal or State actions with respect to the status of the plan or other arrangement under this subparagraph.

"(IV) A person aggrieved by the determination of the Board under subclause (III) may obtain review of the determination in any United States court of appeals in the circuit in which the collective bargaining at issue occurred. Commencement of proceedings under this subclause shall not, unless specifically ordered by the court, operate as a stay of any State administrative or judicial action or proceeding related to the status of the plan or other arrangement, except that in no case may the court stay, before the completion of the review, an order which prohibits the enrollment of new individuals into coverage under a plan or arrangement.".

SEC. 1215. EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

(a) EMPLOYEE LEASING HEALTHCARE ARRANGEMENT DEFINED.—Section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

"(43) EMPLOYEE LEASING HEALTHCARE ARRANGEMENT.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'employee leasing healthcare arrangement' means any labor leasing arrangement, staff leasing arrangement, extended employee staffing or supply arrangement, or other arrangement under which—

"(i) one business or other entity (hereinafter in this paragraph referred to as the 'lessee'), under a lease or other arrangement entered into with any other business or other entity (hereinafter in this paragraph referred to as the 'lessor'), receives from the lessor the services of individuals to be performed under such lease or other arrangement, and

"(ii) benefits consisting of medical care described in section 607(1) are provided to such individuals or such individuals and their dependents as participants and beneficiaries.

"(B) EXCEPTION.—Such term does not include an arrangement described in subparagraph (A) if, under such arrangement, the lessor retains, both legally and in fact, a complete right of direction and control within the scope of employment over the individuals whose services are supplied under such lease or other arrangement, and such individuals perform a specified function for the lessee which is separate and divisible from the primary business or operations of the lessee.".

(b) TREATMENT OF EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS AS MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) (as amended by the preceding provisions of this title) is further amended by adding at the end the following new subparagraph:

"(E) The term 'multiple employer welfare arrangement' includes any employee leasing healthcare arrangement.".

(c) SPECIAL RULES FOR EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of such Act (as added by the preceding provisions of this Act) is amended by adding at the end the following new section:

"SEC. 711. SPECIAL RULES FOR EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

"(a) IN GENERAL.—The requirements of paragraphs (1), (2), and (3) of section 704(b) shall be treated as satisfied in the case of a multiple employer welfare arrangement that is an employee leasing healthcare arrangement if the application for exemption includes information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

"(1) 3-YEAR TENURE.—The lessor has been in operation for not less than 3 years.

"(2) SOLICITATION RESTRICTIONS.—Employee leasing services provided under the arrangement are not solicited, advertised, or marketed through licensed insurance agents or brokers acting in such capacity.

"(3) CREATION OF EMPLOYMENT RELATIONSHIP.—

"(A) DISCLOSURE STATEMENT.—Written notice is provided to each applicant for employment subject to coverage under the arrangement, at the time of application for employment and before commencing coverage under the arrangement, stating that the employer is the lessor under the arrangement.

"(B) INFORMED CONSENT.—Each such applicant signs a written statement consenting to the employment relationship with the lessor.

"(C) INFORMED RECRUITMENT OF LESSEE'S EMPLOYEES.—In any case in which the lessor offers employment to an employee of a lessee under the arrangement, the lessor informs each employee in writing that his or her acceptance of employment with the lessor is voluntary and that refusal of such offer will not be deemed to be resignation from or abandonment of current employment.

"(4) REQUISITE EMPLOYER-EMPLOYEE RELATIONSHIP UNDER ARRANGEMENT.—Under the employer-employee relationship with the employees of the lessor—

"(A) the lessor retains the ultimate authority to hire, terminate, and reassign such employees,

"(B) the lessor is responsible for the payment of wages, payroll-related taxes, and employee benefits, without regard to payment by the lessee to the lessor for its services,

"(C) the lessor maintains the right of direction and control over its employees, except to the extent that the lessee is responsible for supervision of the work performed consistent with the lessee's responsibility for its product or service, and

"(D) in accordance with section 301(a) of the Labor Management Relations Act, 1947 (29 U.S.C. 185(a)), the lessor retains in the absence of an applicable collective bargaining agreement, the right to enter into arbitration and to decide employee grievances, and

"(E) no owner, officer, or director of, or partner in, a lessee is an employee of the lessor, and not more than 10 percent of the individuals covered under the arrangement consist of owners, officers, or directors of, or partners in, such a lessee (or any combination thereof).

"(b) DEFINITIONS.—For purposes of this section—

"(1) LESSOR.—The term 'lessor' means the business or other entity from which services of individuals are obtained under an employee leasing healthcare arrangement.

"(2) LESSEE.—The term 'lessee' means a business or other entity which receives the services of individuals provided under an employee leasing healthcare arrangement.".

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act (as amended by the preceding provisions of this title) is further amended by inserting after the item relating to section 710 the following new item:

"Sec. 711. Employee leasing healthcare arrangements.".

SEC. 1216. ENFORCEMENT PROVISIONS RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND EMPLOYEE LEASING HEALTHCARE ARRANGEMENTS.

(a) ENFORCEMENT OF FILING REQUIREMENTS.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking "subsection (c)(2) or (i) or (l)" and inserting "paragraph (2) or (4) of subsection (c) or subsection (i) or (l)"; and

(2) by adding at the end of subsection (c) the following new paragraph:

"(4) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of such person's failure or refusal to file the information required to be filed with the Secretary under section 101(e).".

(b) ACTIONS BY STATES IN FEDERAL COURT.—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(1) in paragraph (5), by striking "or" at the end;

(2) in paragraph (6), by striking the period and inserting ", or"; and

(3) by adding at the end the following:

"(7) by a State official having authority under the law of such State to enforce the laws of such State regulating insurance, to enjoin any act or practice which violates any provision of part 7 which such State has the power to enforce under part 7.".

(c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of such Act (29 U.S.C. 1131) is amended—

(1) by inserting "(a)" after "SEC. 501."; and

(2) by adding at the end the following new subsection:

"(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

"(1) being an exempted multiple employer welfare arrangement (as defined in section 701(10)),

"(2) being an employee leasing healthcare arrangement under an exemption granted under part 7, or

"(3) having been established or maintained under or pursuant to a collective bargaining agreement,

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.".

(d) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

"(m)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of a multiple employer welfare arrangement providing benefits consisting of medical care described in section 607(1) that—

"(A) is not licensed, registered, or otherwise approved under the insurance laws of the States in which the arrangement offers or provides benefits, or

"(B) is not operating in accordance with the terms of an exemption granted by the Secretary under part 7,

a district court of the United States shall enter an order requiring that the arrangement cease activities.

"(2) Paragraph (1) shall not apply in the case of a multiple employer welfare arrangement if the arrangement shows that—

"(A) coverage under it is fully insured, within the meaning of section 701(9),

"(B) it is licensed, registered, or otherwise approved in each State in which it offers or provides benefits, except to the extent that such State does not require licensing, registration, or approval of multiple employer welfare arrangements under which all coverage is fully insured, and

"(C) with respect to each such State, it is operating in accordance with applicable State insurance laws that are not superseded under section 514.

"(3) The court may grant such additional equitable or remedial relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the arrangement.".

(e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by adding at the end (after and below paragraph (2)) the following new sentence: "The terms of each multiple employer welfare arrangement to which this section applies and which provides benefits consisting of medical care described in section 607(1) shall require the operating committee or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the arrangement.".

SEC. 1217. SOLVENCY REQUIREMENTS FOR CERTAIN SELF-INSURED GROUP HEALTH PLANS.

(a) IN GENERAL.—The Secretary of Labor shall prescribe by regulation provisions described in subsection (b) applicable to group health plans which are not multiple employer health plans, which offer coverage with respect to employees of small employers (as defined in section 1131), and under which some or all coverage is not fully insured (within the meaning of section 701(9) of the Employee Retirement Income Security Act of 1974)), for the purpose of promoting adequate funding of such plans.

(b) REQUIREMENTS.—

(1) GENERAL RULE.—Except as provided in paragraph (2), the provisions described in subsection (a) shall require the group health plan to establish and maintain reserves, consisting of—

(A) a reserve for unearned contributions, and

(B) a reserve for payment of claims reported and not yet paid and claims incurred but not yet reported, and for expected administrative costs with respect to such claims.

(2) EXCEPTION.—The Secretary may in such regulations permit a group health plan to substitute, for all or part of the reserves required under paragraph (1), such security, guarantee, or other financial arrangement as the Secretary determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis.

(c) CRITERIA FOR COMPLIANCE.—The criteria that the Secretary shall take into account in determining compliance with the requirements described in subsection (b) shall include:

(1) the size of the employer involved;

(2) the benefit package provided under the plan;

(3) whether the coverage provided under the plan is in the form of a fee-for-service arrangement, a health maintenance organization, or any other type of coverage;

(4) the extent to which excess/stop loss coverage is maintained for the plan; and

(5) the nature of any security, guarantee, or other financial arrangement described in subsection (b)(2) obtained for the plan.

SEC. 1218. FILING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS PROVIDING HEALTH BENEFITS.

Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection:

"(e)(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1995) and no later than February 15 of each year (in the case of an arrangement in operation since the beginning of such year), unless, as of the date by which such filing otherwise must be made, such arrangement provides no benefits consisting of medical care described in section 607(1).

"(2) Each registration statement—

"(A) shall be filed in such form, and contain such information concerning the multiple employer welfare arrangement and any persons involved in its operation (including whether coverage under the arrangement is fully insured), as shall be provided in regulations which shall be prescribed by the Secretary, and

"(B) if coverage under the arrangement is not fully insured, shall contain a certification that copies of such registration statement have been transmitted by certified mail to—

"(i) in the case of an arrangement which is an exempted multiple employer health plan (as defined in section 701(10)), the State insurance commissioner of the domicile State of such arrangement, or

"(ii) in the case of an arrangement which is not an exempted multiple employer health plan, the State insurance commissioner of each State in which the arrangement is located.

"(3) The person or persons responsible for filing the annual registration statement are—

"(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or

"(B) in the case of a multiple employer welfare arrangement for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually responsible for the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.

"(4) Any agreement entered into under section 506(c) with a State as the primary domicile State with respect to any multiple employer welfare arrangement shall provide for simultaneous filings of reports required under this subsection with the Secretary and with the State insurance commissioner of such State.".

SEC. 1219. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

"(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

"(1) STATE ENFORCEMENT.—

"(A) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the provisions of this title applicable to multiple employer welfare arrangements which are or have been exempted multiple employer health plans (as defined in section 701(10)). The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

"(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

"(C) CONCURRENT AUTHORITY OF THE SECRETARY.—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

"(D) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular multiple employer welfare arrangement, as the primary domicile State to which authority has been delegated pursuant to such agreements.

"(2) ASSISTANCE TO STATES.—The Secretary shall—

"(A) provide enforcement assistance to the States with respect to multiple employer welfare arrangements, including, but not limited to, coordinating Federal and State efforts through the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

"(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act,

"(C) assist the States in obtaining from the Office of Regulations and Interpretations timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

"(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.".

SEC. 1220. EFFECTIVE DATE; TRANSITIONAL RULES.

(a) EFFECTIVE DATE.—The amendments made by this part shall take effect January 1, 1995, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) TRANSITIONAL RULES.—If the sponsor of a multiple employer welfare arrangement which, as of January 1, 1995, provides benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)) files with the Secretary of Labor an application for an exemption under part 7 of subtitle B of title I of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement during the 18-month period following such date. If the Secretary determines, at any time after the date of enactment of this Act, that any such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such Act of a multiple employer welfare arrangement would be detrimental to the interests of individuals covered under such arrangement, such exclusion shall cease as of the date of the determination. Any determination made by the Secretary under this subsection shall be in the Secretary's sole discretion.

PART 3—ENCOURAGEMENT OF MULTIPLE EMPLOYER ARRANGEMENTS PROVIDING BASIC HEALTH BENEFITS

SEC. 1221. ELIMINATING COMMONALITY OF INTEREST OR GEOGRAPHIC LOCATION REQUIREMENT FOR TAX EXEMPT TRUST STATUS.

(a) IN GENERAL.—Paragraph (9) of section 501(c) of the Internal Revenue Code of 1986 (relating to exempt organizations) is amended—

(1) by inserting "(A)" after "(9)"; and

(2) by adding at the end the following:

"(B) Any determination of whether a multiple employer health plan (as defined in section 701(10) of the Employee Retirement Income Security Act of 1974) or an insured multiple employer health plan (as defined in section 701(11) of such Act) is a voluntary employees' beneficiary association meeting the requirements of this paragraph shall be made without regard to any determination of commonality of interest or geographic location if—

"(i) such plan provides at least standard coverage (consistent with section 102(c) of the Affordable Health Care Now Act of 1994), and

"(ii) in the case of an insured multiple employer health plan, it meets the requirements enforceable under section 514(b)(6)(B)(i) of the Employee Retirement Income Security Act of 1974 to the extent not preempted by section 1202 of the Affordable Health Care Now Act of 1994.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to determinations made on or after January 1, 1995.

SEC. 1222. SINGLE ANNUAL FILING FOR ALL PARTICIPATING EMPLOYERS.

(a) IN GENERAL.—Section 110 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1030), as amended by section 1211(c) of this subtitle, is amended by adding at the end the following new subsection:

"(d) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are participating employers under a multiple employer welfare arrangement under which all coverage consists of medical care (described in section 607(1)) and is fully insured (as defined in section 701(9))."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. The Secretary of Labor shall prescribe the alternative method referred to in section 110(d) of the Employee Retirement Income Security Act of 1974, as added by such amendment, within 90 days after the date of the enactment of this Act.

SEC. 1223. COMPLIANCE WITH COVERAGE REQUIREMENTS THROUGH MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.

(a) COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH MULTIEMPLOYER PLANS.—In any case in which an eligible employee is, for any plan year, a participant in a group health plan which is a multiemployer plan, the requirements of section 1001(a) shall be deemed to be met with respect to such employee for such plan year if the employer requirements of subsection (c) are met with respect to the eligible employee, irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

(b) COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH OTHER MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.—

(1) IN GENERAL.—In any case in which an employer is, for any plan year, a participating employer (as defined in paragraph (3)) in an exempted multiple employer health plan or in a multiple employer welfare arrangement under which all coverage consists of medical care (described in section 607(1) of the Employee Retirement Income Security Act of 1974) and is fully insured (as defined in section 701(9) of such Act), the requirements of section 1001(a) shall be deemed to be met (and the ERISA requirements of paragraph (2) shall be deemed to be met by the employer) with respect to an eligible employee of the employer if—

(A) the employer requirements of subsection (c) are met with respect to the eligible employee, and

(B) the applicable ERISA requirements of paragraph (2) are met by the plan or arrangement with respect to the plan or arrangement,

irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

(2) APPLICABLE ERISA REQUIREMENTS.—The applicable ERISA requirements of this paragraph are the requirements of—

(A) part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (relating to reporting and disclosure),

(B) section 503 of such Act (relating to claims procedure), and

(C) part 6 of subtitle B of such title I (relating to group health plans),

to the extent that such requirements relate to employers as plan sponsors or plan administrators.

(3) PARTICIPATING EMPLOYER.—In this subsection, the term "participating employer" means, in connection with an exempted multiple employer health plan or a multiple employer welfare arrangement under which all coverage consists of medical care (described in section 607(1) of the Employee Retirement Income Security Act of 1974) and is fully insured (as defined in section 701(9) of such Act), any employer if any of its employees, or any of the dependents of its employees, are or were covered under such plan or arrangement in connection with the employment of the employees.

(c) EMPLOYER REQUIREMENTS.—The employer requirements of this subsection are met under a plan or arrangement with respect to an eligible employee if—

(1) the employee is eligible under the plan or arrangement to elect coverage on an annual basis and is provided a reasonable opportunity to make the election in such form and manner and at such times as are provided by the plan or arrangement,

(2) subject to section 1001(c), such coverage includes at least the standard coverage (consistent with section 1102(c)),

(3) the employer facilitates collection of any employee contributions under the plan or arrangement and permits the employee to elect to have employee contributions under the plan or arrangement collected through payroll deduction, and

(4) in the case of a plan or arrangement to which part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 does not otherwise apply, the employer provides to the employee a summary plan description described in section 102(a)(1) of such Act in the form and manner and at such times as are required under such part 1 with respect to employee welfare benefit plans.

Subtitle D—Health Deduction Fairness

SEC. 1301. PERMANENT EXTENSION AND INCREASE IN HEALTH INSURANCE TAX DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.

(a) PERMANENT EXTENSION OF DEDUCTION.—

(1) IN GENERAL.—Subsection (l) of section 162 of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 1993.

(b) INCREASE IN AMOUNT OF DEDUCTION; INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—

(1) INCREASE IN AMOUNT OF DEDUCTION.—Paragraph (1) of section 162(l) of such Code is amended by striking "25 percent of" and inserting "100 percent (25 percent in the case of taxable years beginning in 1994 or 1995 and 50 percent in the case of taxable years beginning in 1996 or 1997) of".

(2) INSURANCE PURCHASED MUST MEET CERTAIN STANDARDS.—Paragraph (2) of section 162(l) of such Code is amended by adding at the end thereof the following new subparagraph:

"(C) TREATMENT OF GROUP HEALTH PLANS.—For purposes of this subsection, an amount paid into a multiple employer health plan (as defined in section 701(10) of the Employee Retirement Income Security Act of 1974) shall be deemed to be an amount paid for insurance which constitutes medical care."

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1994.

SEC. 1302. DEDUCTION OF HEALTH INSURANCE PREMIUMS FOR CERTAIN PREVIOUSLY UNINSURED INDIVIDUALS.

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended by adding at the end thereof the following new subsection:

"(f) DEDUCTION FOR CERTAIN HEALTH INSURANCE COSTS DETERMINED WITHOUT REGARD TO ADJUSTED GROSS INCOME THRESHOLD.—

"(1) IN GENERAL.—Subsection (a) shall be applied without regard to the limitation based on adjusted gross income in the case of the applicable percentage of the amounts paid for insurance referred to in section 162(l)(2)(C) (and including payments referred to in section 162(l)(2)(D)).

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means—

"(A) 25 percent for taxable years beginning in 1994 or 1995,

"(B) 50 percent for taxable years beginning in 1996 or 1997, and

"(C) 100 percent for taxable years beginning after 1997.

"(3) DEDUCTION NOT ALLOWED TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

"(A) IN GENERAL.—Paragraph (1) shall not apply to any individual—

"(i) who is eligible to participate in any subsidized health plan maintained by an employer of such individual or the spouse of such individual, or

"(ii) who is (or whose spouse is) a member of a subsidized class of employees of an employer of such individual or spouse.

"(B) SUBSIDIZED CLASS.—For purposes of subparagraph (A), an individual is a member of a subsidized class of employees of an employer if, at any time during the 3 calendar years ending with or within the taxable year, any member of such class was eligible to participate in any subsidized health plan maintained by such employer.

"(C) SPECIAL RULES.—

"(i) CONTROLLED GROUPS.—All persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as a single employer for purposes of subparagraph (B).

"(ii) CLASSES.—Classes of employees shall be determined under regulations prescribed by the Secretary based on such factors as the Secretary determines appropriate to carry out the purposes of this subsection.

"(4) COORDINATION WITH DEDUCTION FOR OTHER AMOUNTS.—Amounts allowable as a deduction under subsection (a) by reason of this subsection shall not be taken into account in determining the deduction under subsection (a) for other amounts.

"(5) SUBSECTION NOT TO APPLY TO INDIVIDUALS ELIGIBLE FOR MEDICARE.—This subsection shall not apply to amount paid for insurance covering an individual who is eligible for benefits under title XVIII of the Social Security Act."

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (15) the following new paragraph:

"(16) COSTS OF CERTAIN HEALTH INSURANCE.—The deduction allowed by section 213 to the extent allowable by reason of section 213(f)."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

Subtitle E—Improved Access to Community Health Services

PART 1—INCREASED AUTHORIZATION FOR COMMUNITY AND MIGRANT HEALTH CENTERS

SEC. 1401. GRANT PROGRAM TO PROMOTE PRIMARY HEALTH CARE SERVICES FOR UNDERSERVED POPULATIONS.

(a) AUTHORIZATION.—The Secretary of Health and Human Services shall provide for a program of grants to migrant and community health centers (receiving grants or contracts under section 329, 330, or 340 of the Public Health Service Act) in order to promote the provision of primary health care services for underserved individuals. Such grants may be used—

(1) to promote the provision of off-site services (through means such as mobile medical clinics);

(2) to improve birth outcomes in areas with high infant mortality and morbidity;

(3) to establish primary care clinics in areas identified as in need of such clinics; and

(4) for recruitment and training costs of necessary providers and operating costs for unreimbursed services.

(b) CONDITIONS.—(1) Grants under this subsection shall only be made upon application, approved by the Secretary.

(2) The amount of grants made under this section shall be determined by the Secretary.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

(1) in fiscal year 1995, $100,000,000,

(2) in fiscal year 1996, $200,000,000,

(3) in fiscal year 1997, $300,000,000,

(4) in fiscal year 1998, $400,000,000, and

(5) in fiscal year 1999, $500,000,000,

to carry out this section. Of the amounts appropriated each fiscal year under this section, at least 10 percent shall be used for grants described in subsection (a)(1) and at least 10 percent shall be used for grants described in subsection (a)(2). The Secretary may use not to exceed 50 percent of the amounts appropriated to carry out this section for the purpose of making new grants or contracts under sections 329, 330, and 340 of the Public Health Service Act.

(d) STUDY AND REPORT.—The Secretary shall conduct a study of the impact of the grants made under this section to migrant and community health centers on access to health care, birth outcomes, and the use of emergency room services. Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on such study and on recommendations for changes in the programs under this section in order to promote the appropriate use of cost-effective outpatient services.

PART 2—GRANTS FOR PROJECTS FOR COORDINATING DELIVERY OF SERVICES

SEC. 1411. PROJECTS FOR COORDINATING DELIVERY OF OUTPATIENT PRIMARY HEALTH SERVICES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

"Subpart VII—Delivery of Services

"PROJECTS FOR COORDINATING DELIVERY OF SERVICES

"SEC. 340E. (a) AUTHORITY FOR GRANTS.—

"(1) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities to carry out demonstration projects for the purpose of increasing access to outpatient primary health services in geographic areas described in subsection (b) through coordinating the delivery of such services under Federal, State, local, and private programs.

"(2) REQUIREMENT REGARDING PLAN.—The Secretary may make a grant under paragraph (1) only if—

"(A) the applicant involved has received a grant under subsection (l) and the Secretary has approved the plan developed with such grant; and

"(B) the applicant agrees to carry out the project under paragraph (1) in accordance with the plan.

"(b) QUALIFIED HEALTH SERVICE AREAS.—

"(1) IN GENERAL.—A geographic area described in this subsection is a geographic area that—

"(A) is a rational area for the delivery of health services;

"(B) has a population of not more than 500,000 individuals; and

"(C)(i) has been designated by the Secretary as an area with a shortage of personal health services; or

"(ii) has a significant number of individuals who have low incomes or who have insufficient insurance regarding health care.

"(2) AUTHORITY REGARDING MULTIPLE POLITICAL SUBDIVISIONS.—The Secretary shall make a determination of whether a geographic area is a geographic area described in paragraph (1) without regard to whether the area is a political subdivision, without regard to whether the area is located in 2 or more political subdivisions or States, and without regard to whether the area encompasses 2 or more political subdivisions.

"(c) PREFERENCES IN MAKING GRANTS.—In making grants under subsection (a), the Secretary shall give preference to applicants demonstrating that, with respect to the outpatient primary health services that will be the subject of the project conducted by the applicant under such subsection—

"(1)(A) the project will result in the reduction of administrative expenses associated with such services by increasing the efficiency of the administrative processes of the providers participating in the project, and (B) the resulting savings will be expended for the direct provision of such services for the designated population; or

"(2) the services that will be the subject of the project will be provided in facilities that are underutilized.

"(d) ACTIVITIES OF PROJECT MUST SERVE DESIGNATED POPULATION.—The Secretary may make a grant under subsection (a) to an applicant only if the applicant demonstrates that carrying out the project under such subsection will increase access to outpatient primary health services for a significant segment of the designated population.

"(e) MATCHING FUNDS.—

"(1) IN GENERAL.—With respect to the costs of the project to be carried out under subsection (a) by an applicant, the Secretary may make a grant under such subsection only if the applicant agrees to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 50 percent of such costs.

"(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(f) CERTAIN LIMITATIONS REGARDING GRANTS.—

"(1) PROVISION OF HEALTH SERVICES; CONSTRUCTION OF FACILITIES.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that the grant will not be expended for the direct provision of any health service or for the construction or renovation of facilities.

"(2) DURATION AND AMOUNT OF GRANT.—The period during which payments are made for a project under subsection (a) may not exceed 4 years, and the aggregate amount of such payments for the period may not exceed $200,000. The provision of such payments shall be subject to annual approval by the Secretary of the payments and subject to the availability of appropriations for the fiscal year involved to make the payments.

"(3) FINANCIAL CAPACITY FOR CONTINUATION OF PROJECT AFTER TERMINATION OF GRANT.—The Secretary may make a grant under subsection (a) only if the Secretary determines that there is a reasonable basis for believing that, after termination of payments under such subsection pursuant to paragraph (2), the project under such subsection will have the financial capacity to continue operating.

"(g) AGREEMENTS AMONG PARTICIPANTS IN PROJECTS.—

"(1) REQUIRED PARTICIPANTS.—The Secretary may make a grant under subsection (a) only if the applicant for the grant has, for purposes of carrying out a project under such subsection, entered into agreements with—

"(A) the chief public health officers, and the chief health officers for the elementary and secondary schools, of each of the political subdivisions of the qualified health service area in which the project under such subsection is to be carried out (or, in the case of a political subdivision that does not have such an official, with another appropriate official of such subdivision);

"(B) each hospital in the qualified health service area;

"(C) representatives of entities in such area that provide outpatient primary health services under Federal, State, local, or private programs;

"(D) representatives of businesses in such area, including small businesses; and

"(E) representatives of nonprofit private entities in such area.

"(2) OPTIONAL PARTICIPANTS.—With respect to compliance with this section, a grantee under subsection (a) may, for purposes of carrying out a project under such subsection, enter into such agreements with public and private entities in the qualified health service area involved (in addition to the entities specified in paragraph (1)) as the grantee may elect.

"(h) EXPENDITURES OF GRANT.—With respect to a project under subsection (a), the purposes for which a grant under such subsection may be expended include (but are not limited to) expenditures to increase the efficiency of the administrative processes of providers participating in the project, paying the costs of hiring and compensating staff, obtaining computers and other equipment (including vehicles to transport individuals to programs providing outpatient primary health services), and developing and operating provider networks.

"(i) MAINTENANCE OF EFFORT.—In the case of services and populations that are the subject of a project under subsection (a), the Secretary may make such a grant for a fiscal year only if the applicant involved agrees that the applicant, and each entity making an agreement under subsection (g), will maintain expenditures of non-Federal amounts for such services and populations at a level that is not less than the level of such expenditures maintained by the applicant and the entity, respectively, for the fiscal year preceding the first fiscal year for which the applicant receives such a grant.

"(j) REPORTS TO SECRETARY.—The Secretary may make a grant under subsection (a) only if the applicant involved agrees to submit to the Secretary such reports on the project carried out under such subsection as the Secretary may require.

"(k) EVALUATIONS AND DISSEMINATION OF INFORMATION.—The Secretary shall provide for evaluations of projects carried out under subsection (a), and for the collection and dissemination of information developed as a result of such projects and as a result of similar projects.

"(l) PLANNING GRANTS.—

"(1) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for the purpose of developing plans to carry out projects under subsection (a). Such a grant may be made only if the applicant involved submits to the Secretary information—

"(A) providing a detailed statement of the proposal of the applicant for carrying out the project;

"(B) identifying the geographic area in which the project is to be carried out; and

"(C) demonstrating that the area is a qualified health service area and that the proposal otherwise is in accordance with the requirements established in this section for the receipt of a grant under subsection (a).

"(2) DURATION AND AMOUNT OF GRANT.—The period during which payments are made under paragraph (1) for the development of a plan under such paragraph may not exceed 1 year, and the amount of such payments may not exceed $100,000.

"(m) APPLICATION FOR GRANT.—The Secretary may make a grant under subsection (a) or (l) only if the applicant for the grant submits an application to the Secretary that—

"(1) contains any agreements, assurances, and information required in this section with respect to the grant; and

"(2) is in such form, is made in such manner, and contains such other agreements, assurances, and information as the Secretary determines to be necessary to carry out the purpose for which the grant is to be provided.

"(n) DEFINITIONS.—For purposes of this section:

"(1) The term 'designated population' means individuals described in subsection (b)(1)(C)(ii).

"(2) The term 'primary health services' includes preventive health services.

"(3) The term 'qualified health service area' means a geographic area described in subsection (b).

"(o) AUTHORIZATION OF APPROPRIATIONS.—

"(1) PLANNING FOR PROJECTS.—For the purpose of grants under subsection (l), there is authorized to be appropriated $5,000,000 for fiscal year 1995, to remain available until expended.

"(2) OPERATION OF PROJECTS.—For the purpose of grants under subsection (a), there is authorized to be appropriated an aggregate $10,000,000 for the fiscal years 1996 through 1999.".

PART 3—COMMUNITY HEALTH NETWORKS

SEC. 1421. QUALIFICATIONS FOR COMMUNITY HEALTH NETWORKS.

(a) COMMUNITY HEALTH NETWORK DEFINED.—For purposes of part 7 of subtitle B of title I of Employee Retirement Income Security Act of 1974 and this Act, added by section 1211(a) of this title, the term "community health network" means an arrangement that—

(1) is organized by health care providers (including medical practitioners), community groups, or both, and such other organizations as may be designated by the arrangement, to provide health care services to an enrolled population in a service area,

(2) provides to its enrollees at least the benefits included in standard coverage (consistent with section 1102(c)),

(3) receives payment for such services on a prospective capitated basis, which may vary only by family composition, geographic area, and age,

(4) meets the requirements of subsection (b) (relating to public accountability),

(5) meets the requirements of subsection (c) (relating to coordination and integration of care),

(6) meets the requirements of subsection (d) to the extent the arrangement is organized as a nonprofit entity, and

(7) meets the requirements of section 707 of the Employee Retirement Income Security Act of 1974 (relating to maintenance of reserves), added by section 1211.

(b) PUBLIC ACCOUNTABILITY REQUIREMENTS.—The public accountability requirements of this subsection, with respect to a network, are as follows:

(1) PERFORMANCE MEASURES.—The network must establish and implement procedures for developing, compiling, evaluating, and reporting performance measures, statistics, and other information on—

(A) the cost and financial performance of network operations,

(B) the service utilization patterns of enrollees,

(C) the availability, accessibility, and acceptability of health care services to enrollees,

(D) ownership and governance of the network, and

(E) demographic characteristics of enrollees, and

Such information shall be published annually and disseminated to enrollees and the public.

(2) QUALITY ASSURANCE PROGRAM.—The network must have an organizational arrangement for an ongoing quality assurance program for all health services it provides which—

(A) stresses health outcomes,

(B) to the maximum extent possible, relies primarily on evaluating and comparing practice patterns (rather than routine case-by-case review) to identify problems,

(C) provides review by physicians and other health professionals of the outcomes and process followed in the provision of health services, and

(D) makes the coverage and utilization review requirements of the plan, and the standards applied for such review, available to providers and the public.

(3) ENROLLMENT.—The network does not expel or refuse to enroll any applicant or limit coverage of services included in standard coverage for any applicant because of the health status or requirements for health services.

(4) CREDENTIALING.—The network must develop and implement a process for the credentialing (and renewal of credentials) of network providers (including practitioners).

(5) GRIEVANCE PROCESS.—The network must have an enrollee complaint and grievance resolution process which shall meet any requirements of applicable law.

(c) COORDINATION AND INTEGRATION OF CARE REQUIREMENTS.—The coordination and integration of care requirements of this subsection, with respect to a network, are as follows:

(1) COORDINATION AND INTEGRATION OF CARE.—The network must establish and implement mechanisms for coordinating the delivery of care across provider settings and over time, including at least mechanisms for—

(A) linking patient registration and medical record information so that it is accessible to all parts of the network and, consistent with State law, assures the confidentiality of patient information,

(B) assisting enrollees to obtain necessary care, including preventive services, and

(C) coordinating the services furnished to an enrollee when more than one practitioner or provider is involved.

(2) OUT-OF-AREA COVERAGE.—The network must provide care within a defined service area established by the arrangement and must provide for reimbursement for standard coverage (consistent with section 1102(c)) for enrollees who are temporarily outside such area.

(3) COMMON MALPRACTICE POLICY.—Providers (including practitioners) that provide standard coverage to network enrollees must be covered for malpractice in accordance with documented criteria established by the arrangement.

(4) RECORD KEEPING.—The network must use a unified patient registration system and medical records system that is accessible to all parts of the network and assures confidentiality of patient information, consistent with State law.

(d) REQUIREMENTS FOR NETWORKS ORGANIZED AS NONPROFIT ENTITIES.—The requirements of this subsection, with respect to a network, are as follows:

(1) COMMUNITY HEALTH STATUS IMPROVEMENT PROCESS.—The network develops and implements a community health status improvement process, in cooperation with other existing networks and community organizations from the same service area, that—

(A) provides for an assessment of community health status that identifies important health status problems in such area,

(B) implements measures to address such problems, and

(C) evaluates the efficiency and effectiveness of such measures in addressing such problems.

The results of evaluations made pursuant to subparagraph (C) shall be made publicly available on at least an annual basis.

(2) ENROLLMENT.—The network enrolls individuals who are broadly representative of the various age, social, and income groups within the area it serves.

Subtitle F—Improved Access to Rural Health Services

PART 1—ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS UNDER MEDICARE

SEC. 1501. RURAL EMERGENCY ACCESS CARE HOSPITALS DESCRIBED.

Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

"(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

"(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

"(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

"(C) The facility is in danger of closing due to low inpatient utilization rates and negative operating losses, and the closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

"(D) The facility has entered into (or plans to enter into), with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receives data from and transmits data to the facility.

"(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

"(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

"(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

"(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

"(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

"(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'), except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

"(2) The term 'rural emergency access care hospital services' means medical and other health services furnished by a rural emergency access care hospital.".

SEC. 1502. COVERAGE OF AND PAYMENT FOR SERVICES.

(a) COVERAGE UNDER PART B.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking "and" at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).".

(b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1833(a)(6) of the Social Security Act (42 U.S.C. 1395l(a)(6)) is amended by striking "services," and inserting "services and rural emergency access care hospital services,".

(2) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in the heading, by striking "SERVICES" and inserting "SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES"; and

(B) in paragraph (1), by striking "during a year before 1993" and inserting "during a year before the prospective payment system described in paragraph (2) is in effect";

(C) in paragraph (1), by adding at the end the following:

"The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.";

(D) in paragraph (2), by striking "January 1, 1993," and inserting "January 1, 1996,"; and

(E) by adding at the end the following new paragraph:

"(3) APPLICATION OF METHODS TO PAYMENT FOR RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES.—The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.".

SEC. 1503. EFFECTIVE DATE.

The amendments made by sections 1501 and 1502 shall apply to fiscal years beginning on or after October 1, 1994.

PART 2—RURAL MEDICAL EMERGENCIES AIR TRANSPORT

SEC. 1511. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d-51 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL VICTIMS OF MEDICAL EMERGENCIES.

"(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

"(b) APPLICATION AND PLAN.—

"(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

"(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

"(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

"(B) demonstrates that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

"(C) demonstrate that there is a lack of facilities available and equipped to deliver advanced levels of medical care in the geographic areas to be served;

"(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

"(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are effectively meeting the emergency medical needs of the populations they serve;

"(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

"(G) demonstrate that the State, in utilizing the grant proceeds, will—

"(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received; and

"(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

"(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan;

"(I) contain such other information as the Secretary may determine appropriate.

"(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

"(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

"(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

"(d) STATE ADMINISTRATION AND USE OF GRANT.—

"(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

"(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

"(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

"(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

"(f) REPORTS.—

"(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

"(A) a description of the manner in which the grant proceeds were utilized;

"(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

"(C) such other information as the Secretary may require.

"(2) Termination of Funding.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

"(g) Definition.—As used in this section, the term 'rural areas' means geographic areas that are located outside of standard metropolitan statistical areas, as identified by the Secretary.

"(h) Authorization of Appropriations.—There are authorized to be appropriated to make grants under this section, $15,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1996 and 1997.".

PART 3—EMERGENCY MEDICAL SERVICES AMENDMENTS

SEC. 1521. ESTABLISHMENT OF OFFICE OF EMERGENCY MEDICAL SERVICES.

Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in the heading for the title, by striking "TRAUMA CARE" and inserting "EMERGENCY MEDICAL SERVICES";

(2) in the heading for part A, by striking "GENERAL" and all that follows and inserting "General Authorities and Duties"; and

(3) by amending section 1201 to read as follows:

"SEC. 1201. ESTABLISHMENT OF OFFICE OF EMERGENCY MEDICAL SERVICES.

"(a) In General.—The Secretary shall establish an office to be known as the Office of Emergency Medical Services, which shall be headed by a director appointed by the Secretary. The Secretary shall carry out this title acting through the Director of such Office.

"(b) General Authorities and Duties.—With respect to emergency medical services (including trauma care), the Secretary shall—

"(1) conduct and support research, training, evaluations, and demonstration projects;

"(2) foster the development of appropriate, modern systems of such services through the sharing of information among agencies and individuals involved in the study and provision of such services;

"(3) sponsor workshops and conferences;

"(4) as appropriate, disseminate to public and private entities information obtained in carrying out paragraphs (1) through (4);

"(5) provide technical assistance to State and local agencies;

"(6) coordinate activities of the Department of Health and Human Services; and

"(7) as appropriate, coordinate activities of such Department with activities of other Federal agencies.

"(c) Certain Requirements.—With respect to emergency medical services (including trauma care), the Secretary shall ensure that activities under subsection (b) are carried out regarding—

"(1) maintaining an adequate number of health professionals with expertise in the provision of the services, including hospital-based professionals and prehospital-based professionals;

"(2) developing, periodically reviewing, and revising as appropriate, in collaboration with appropriate public and private entities, guidelines for the provision of such services (including, for various typical circumstances, guidelines on the number and variety of professionals, on equipment, and on training);

"(3) the appropriate use of available technologies, including communications technologies; and

"(4) the unique needs of underserved inner-city areas and underserved rural areas.

"(d) Grants, Cooperative Agreements, and Contracts.—In carrying out subsections (b) and (c), the Secretary may make grants and enter into cooperative agreements and contracts.

"(e) Definitions.—For purposes of this part:

"(1) The term 'hospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at a medical facility.

"(2) The term 'prehospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at the site of the medical emergency or during transport to a medical facility.".

SEC. 1522. STATE OFFICES OF EMERGENCY MEDICAL SERVICES.

(a) Technical Amendments to Facilitate Establishment of Program.—

(1) In general.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(A) by redesignating section 1239 as section 1235;

(B) by redesignating sections 1231 and 1233 as sections 1236 and 1237, respectively; and

(C) by redesignating sections 1211 through 1222 as sections 1221 through 1232, respectively.

(2) Modifications in format of title XII.—Title XII of the Public Health Service Act, as amended by paragraph (1) of this subsection, is amended—

(A) by striking "Part B" and all that follow through "State Plans" and inserting the following:

"Subpart II—Formula Grants With Respect to Modifications of State Plans";

(B) by striking "Part C—General Provisions" and inserting the following:

"Subpart III—General Provisions";

(C) by redesignating sections 1202 and 1203 as sections 1211 and 1212, respectively; and

(D) by inserting before section 1211 (as so redesignated) the following:

"Part B—Trauma Care

"Subpart I—Advisory Council; Clearinghouse".

(b) State Offices.—Title XII of the Public Health Service Act, as amended by subsection (a) of this section, is amended by inserting after section 1201 the following new section:

"SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL SERVICES.

"(a) Program of Grants.—The Secretary may make grants to States for the purpose of improving the availability and quality of emergency medical services through the operation of State offices of emergency medical services.

"(b) Requirement of Matching Funds.—

"(1) In general.—The Secretary may not make a grant under subsection (a) unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such subsection, to provide non-Federal contributions toward such costs in an amount that—

"(A) for the first fiscal year of payments under the grant, is not less than $1 for each $3 of Federal funds provided in the grant;

"(B) for any second fiscal year of such payments, is not less than $1 for each $1 of Federal funds provided in the grant; and

"(C) for any third fiscal year of such payments, is not less than $3 for each $1 of Federal funds provided in the grant.

"(2) Determination of amount of non-Federal contribution.—

"(A) Subject to subparagraph (B), non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(B) The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

"(i) for the first fiscal year of payments under the grant, 100 percent or less of the non-Federal contributions required in paragraph (1) will be provided in the form of in-kind contributions;

"(ii) for any second fiscal year of such payments, not more than 50 percent of such non-Federal contributions will be provided in the form of in-kind contributions; and

"(iii) for any third fiscal year of such payments, such non-Federal contributions will be provided solely in the form of cash.

"(c) Certain Required Activities.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that activities carried out by an office operated pursuant to such subsection will include—

"(1) coordinating the activities carried out in the State that relate to emergency medical services;

"(2) activities regarding the matters described in paragraphs (1) through (4) section 1201(b);

"(3) identifying Federal and State programs regarding emergency medical services and providing technical assistance to public and nonprofit private entities regarding participation in such programs.

"(d) Requirement Regarding Annual Budget for Office.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, for any fiscal year for which the State receives such a grant, the office operated pursuant to subsection (a) will be provided with an annual budget of not less than $50,000.

"(e) Certain Uses of Funds.—

"(1) Restrictions.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

"(A) if research with respect to emergency medical services is conducted pursuant to the grant, not more than 10 percent of the grant will be expended for such research; and

"(B) the grant will not be expended to provide emergency medical services (including providing cash payments regarding such services).

"(2) Establishment of office.—Activities for which a State may expend a grant under subsection (a) include paying the costs of establishing an office of emergency medical services for purposes of such subsection.

"(f) Reports.—The Secretary may not make a grant under subsection (a) unless the State involved agrees to submit to the Secretary reports containing such information as the Secretary may require regarding activities carried out under this section by the State.

"(g) Requirement of Application.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.".

SEC. 1523. PROGRAMS FOR RURAL AREAS.

(a) In General.—Title XII of the Public Health Service Act, as amended by section 1522, is amended—

(1) by transferring section 1204 to part A;

(2) by redesignating such section as section 1203;

(3) by inserting such section after section 1202; and

(4) in section 1203 (as so redesignated)—

(A) by redesignating subsection (c) as subsection (d); and

(B) by inserting after subsection (b) the following new subsection:

"(c) Demonstration Program Regarding Telecommunications.—

"(1) Linkages for rural facilities.—Projects under subsection (a)(1) shall include demonstration projects to establish telecommunications between rural medical facilities and medical facilities that have expertise or equipment that can be utilized by the rural facilities through the telecommunications.

"(2) Modes of communication.—The Secretary shall ensure that the telecommunications technologies demonstrated under paragraph (1) include interactive video telecommunications, static video imaging transmitted through the telephone system, and facsimiles transmitted through such system.".

(b) Conforming Amendment.—Section 1203 of the Public Health Service Act, as redesignated by subsection (a)(2) of this section, is amended in the heading for the section by striking "**establishment**" and all that follows and inserting "**programs for rural areas**".

SEC. 1524. FUNDING.

Title XII of the Public Health Service Act, as amended by the preceding provisions of this title, is amended—

(1) by redesignating parts C through F as parts D through G, respectively;

(2) by inserting after subpart III of part B the following:

"Part C—Funding";

(3) by transferring section 1239 to part C (as so added); and

(4) in such section, by striking subsections (a) and (b) and inserting the following:

"(a) Emergency Medical Services Generally.—

"(1) In general.—For the purpose of carrying out section 1201 other than with respect to trauma care, there are authorized to be appropriated $2,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997.

"(2) State offices.—For the purpose of carrying out section 1202, there are authorized to be appropriated $3,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997.

"(3) Certain telecommunications demonstrations.—For the purpose of carrying out section 1203(c), there are authorized to be appropriated $10,000,000 for fiscal year 1995 and such sums as may be necessary for each of the fiscal years 1996 and 1997.

"(b) Trauma Care and Certain Other Activities.—

"(1) In general.—For the purpose of carrying out part B, section 1201 with respect to trauma care, and section 1203 (other than subsection (c) of such section), there are authorized to be appropriated $60,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997.

"(2) Allocation of funds by Secretary.—

"(A) For the purpose of carrying out subpart I of part B, section 1201 with respect to trauma care, and section 1203 (other than subsection (c) of such section), the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under paragraph (1).

"(B) For the purpose of carrying out section 1203 (other than subsection (c) of such section), the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under paragraph (1).

"(C)(i) For the purpose of making allotments under section 1221(a), the Secretary shall, subject to subsection (c), make available 80 percent of the amounts appropriated for a fiscal year under paragraph (1).

"(ii) Amounts paid to a State under section 1221(a) for a fiscal year shall, for the purposes for which the amounts were paid, remain available for obligation until the end of the fiscal year immediately following the fiscal year for which the amounts were paid.".

SEC. 1525. CONFORMING AMENDMENTS.

Title XII of the Public Health Service Act, as amended by the preceding provisions of this title, is amended—

(1) in section 1203(b), by striking "1214(c)(1)" and inserting "1224(c)(1)";

(2) in section 1211(b)(3), by striking "1213(c)" and inserting "1223(c)";

(3) in section 1221—

(A) in subsection (a)—

(i) by striking "1218" and inserting "1228"; and

(ii) by striking "1217" and inserting "1227"; and

(B) in subsection (b)—

(i) by striking "1233" and inserting "1237"; and

(ii) by striking "1213" and inserting "1223";

(4) in section 1222—

(A) in subsection (a)—

(i) in paragraph (1), by striking "1211(a)" and inserting "1221(a)"; and

(ii) in paragraph (2)(A), by striking "1211(c)" and inserting "1221(c)"; and

(B) in subsection (b), by striking "1211(a)" and inserting "1221(a)";

(5) in section 1223—

(A) in subsection (a), by striking "1211(b)" and inserting "1221(b)";

(B) in subsection (b)—

(i) in paragraph (1), by striking "1211(a)" and inserting "1221(a)"; and

(ii) in paragraph (3), by striking "1211(a)" and inserting "1221(a)"; and

(C) in subsection (d), by striking "1211(a)" and inserting "1221(a)";

(6) in section 1224—

(A) in each of subsections (a) through (c), by striking "1211(a)" and inserting "1221(a)"; and

(B) in subsection (b), by striking "1213(a)(7)" and inserting "1223(a)(7)";

(7) in section 1225—

(A) in subsection (a)—

(i) by striking "1211(a)" and inserting "1221(a)"; and

(ii) by striking "1233" and inserting "1237"; and

(B) in subsection (b), by striking "1211(b)" and inserting "1221(b)";

(8) in section 1226, in each of subsections (a) through (c), by striking "1211(a)" and inserting "1221(a)";

(9) in section 1227—

(A) by striking "1211(a)" and inserting "1221(a)"; and

(B) by striking "1214" and inserting "1224";

(10) in section 1228—

(A) in each of subsections (a) through (c), by striking "1211(a)" each place such term appears and inserting "1221(a)";

(B) in subsection (b), in each of paragraphs (2)(A) and (3)(A), by striking "1232(a)" and inserting "1239(a)"; and

(C) in subsection (c)(2)—

(i) by striking "1232(b)(3)" and inserting "1239(b)(3)"; and

(ii) by striking "1217" and inserting "1227";

(11) in section 1229(a), by striking "1211(a)" each place such term appears and inserting "1221(a)";

(12) in section 1230(a), by striking "1211(a)" each place such term appears and inserting "1221(a)";

(13) in section 1231—

(A) in each of subsections (a) and (b), by striking "1211(a)" each place such term appears and inserting "1221(a)"; and

(B) in each of subsections (a) and (b), by striking "1211(b)" and inserting "1221(b)";

(14) in section 1232, by striking "1211" and inserting "1221";

(15) in section 1236—

(A) in the matter preceding paragraph (1), by striking "this title" and inserting "this part"; and

(B) in paragraph (1), by striking "1213" and inserting "1223";

(16) in section 1237—

(A) in each of subsections (a) and (b), by striking "1211" each place such term appears and inserting "1221";

(B) in subsection (b)—

(i) by striking "part B" and inserting "subpart II"; and

(ii) by striking "1214(c)(1)" and inserting "1224(c)(1)"; and

(C) in subsection (c), by striking "1213" and inserting "1223"; and

(17) in section 1239(c)(1)—

(A) by striking "1211(a)" and inserting "1221(a)";

(B) by striking "1218(a)(2)" and inserting "1228(a)(2)"; and

(C) by striking "part B" and inserting "subpart II".

SEC. 1526. EFFECTIVE DATE.

The amendments made by this part shall take effect October 1, 1994, or upon the date of the enactment of this Act, whichever occurs later.

PART 4—ADDITIONAL RURAL HEALTH CARE PROVISIONS

SEC. 1531. DEVELOPMENT OF COMMUNITY-OPERATED HEALTH PLANS IN RURAL AND FRONTIER AREAS.

(a) Community-Operated Health Plans.—The Secretary of Health and Human Services (in this part referred to as the "Secretary") may make grants to public and nonprofit private entities for the purpose of carrying out projects to develop health plans to provide services exclusively in rural and frontier areas.

(b) Community Involvement.—The Secretary may make a grant under subsection (a) only if the applicant involved meets the following conditions:

(1) In developing the proposal of the applicant for a project under such subsection, the applicant has consulted with the local governments of the geographic area to be served by the health plan developed through the project, with individuals who reside in the area, and with a reasonable number and variety of health professionals who provide services in the area.

(2) The applicant agrees that the principal legal authority over the operation of the health plan will be vested in individuals who reside in such geographic area.

(3) In the proposal the applicant specifies how a full continuum of services will be provided.

(4) In the proposal the applicant specifies how the proposed health plan will utilize existing health care facilities in a manner that avoids unnecessary duplication.

(c) USE OF FUNDS.—

(1) IN GENERAL.—Funds made available under this section may be used for the following:

(A) To develop integrated health networks, utilizing existing local providers and facilities where appropriate, with community involvement.

(B) For information systems, including telecommunications.

(C) For transportation services.

(D) To develop rural emergency access care hospitals (as defined in section 1861(oo)(1) of the Social Security Act, as added by section 1501).

(2) LIMITATIONS.—Funds made available under this section shall not be used for the following:

(A) For a telecommunications system, unless the system is coordinated with, and does not duplicate, such a system existing in the area.

(B) For paying off existing debt.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $25,000,000 in each of fiscal years 1996, 1997, and 1998 to carry out this section.

SEC. 1532. PRIMARY HEALTH CARE FOR MEDICALLY UNDERSERVED RURAL COMMUNITIES; INCREASED CAPACITY OF HOSPITALS AND OUTPATIENT FACILITIES.

(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private hospitals in medically underserved rural communities, and to public and nonprofit outpatient facilities in such communities, for the purpose of carrying out projects to develop or increase the capacity of the hospitals and facilities to provide primary health services.

(b) MEDICALLY UNDERSERVED RURAL COMMUNITY.—For purposes of this section, the term "medically underserved rural community" means—

(1) a rural area that has a substantial number of individuals who are members of a medically underserved population, as defined in section 330 of the Public Health Service Act; or

(2) a rural area a significant portion of which is a health professional shortage area designated under section 332 of such Act.

(c) CERTAIN EXPENDITURES.—The purposes for which the Secretary may authorize a grant under subsection (a) to be expended include the renovation of facilities, the purchase of equipment, and the training of personnel.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) HOSPITALS.—There are authorized to be appropriated $50,000,000 in each of fiscal years 1996, 1997, and 1998 for the purpose of making grants to hospitals under subsection (a).

(2) OUTPATIENT FACILITIES.—There are authorized to be appropriated $25,000,000 in each of fiscal years 1996, 1997, and 1998 for the purpose of making grants to outpatient facilities under subsection (a).

SEC. 1533. INNOVATIVE APPROACHES TO DELIVERY OF HEALTH SERVICES IN RURAL AREAS.

(a) IN GENERAL.—The Secretary, acting through the Administrator for Health Care Policy and Research, may make grants to public and nonprofit private entities for the purposes of conducting research and carrying out demonstration projects to develop innovative approaches to the delivery of health care in rural areas, such as the use of telemedicine and the use of mobile delivery units.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $15,000,000 in each of fiscal years 1996 through 2000 to carry out this section.

SEC. 1534. TRAINING OF RURAL HEALTH PROFESSIONALS OTHER THAN PHYSICIANS.

(a) FUNDING FOR PROGRAMS UNDER PUBLIC HEALTH SERVICE ACT.—With respect to programs of title VII or VIII of the Public Health Service Act that provide for the training of individuals as health professionals other than physicians, there are authorized to be appropriated, in addition to amounts otherwise authorized to be appropriated, $50,000,000 in each of fiscal years 1996 through 2000 for the purpose of the Secretary carrying out such programs through entities described in subsection (b).

(b) ELIGIBILITY.—With respect to a program referred to in subsection (a), an entity described in this subsection is an entity—

(1) that is eligible to receive grants or contracts under the program (as provided in the applicable provisions of title VII or VIII of the Public Health Service Act); and

(2) a substantial number of whose designated graduates are providing health services in a rural area.

(c) DEFINITION OF DESIGNATED GRADUATE.—For purposes of this section, the term "designated graduate", with respect to an entity, means an individual completing the training involved during the 5-year period preceding the fiscal year for which the entity is applying to receive a grant or contract under the applicable program referred to in subsection (a).

(d) RELATIONSHIP TO OTHER FUNDS.—The amounts made available in subsection (a) for carrying out programs referred to in such subsection are in addition to any other amounts that are available for carrying out the programs.

SEC. 1535. GENERAL PROVISIONS.

(a) APPLICATION FOR GRANT.—The Secretary may make a grant under any section of this part only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out the program involved.

(b) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to recipients of grants or contracts under this part with respect to the planning, development, and operation of activities under the grants or contracts.

Subtitle G—Assistance in Enrolling Uninsured Children in Health Insurance

SEC. 1601. ESTABLISHMENT OF STATE PROGRAMS.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) by striking "and" at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(63) provide for a State program furnishing premium subsidies for needy children in accordance with section 1932.".

(b) STATE PROGRAMS FOR PREMIUM SUBSIDIES FOR NEEDY CHILDREN.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

"STATE PREMIUM SUBSIDY PROGRAMS FOR NEEDY CHILDREN

"SEC. 1932. (a) REQUIREMENT TO OPERATE STATE PROGRAM.—

"(1) IN GENERAL.—A State with a State plan approved under this title shall have in effect a premium subsidy program for furnishing premium subsidy under subsection (b) to premium subsidy eligible children in the State in fiscal years beginning with fiscal year 1998.

"(2) DESIGNATION OF STATE AGENCY.—A State may designate any appropriate State agency to administer the program under this section.

"(b) ASSISTANCE WITH PREMIUMS FOR STANDARD HEALTH COVERAGE.—

"(1) ELIGIBILITY.—

"(A) IN GENERAL.—An eligible individual who has been determined by a State to be a premium subsidy eligible child (as defined in paragraph (2)) shall be entitled to premium subsidies in the amount determined under subsection (b).

"(B) PREMIUM SUBSIDY ELIGIBLE CHILD.—For purposes of this section, the term 'premium subsidy eligible child' means an individual—

"(i) under 19 years of age,

"(ii) whose family has a family income determined under this section which does not exceed 185 percent (or such lesser percent as the Secretary may specify for a fiscal year, based on available funds during such fiscal year) of the poverty line, and

"(iii) except as provided in subparagraph (C), who is not otherwise eligible for medical assistance under the State plan (or would be eligible for such assistance on the basis of the plan in effect as of the date of the enactment of the Affordable Health Care Now Act of 1994).

"(C) ELIGIBILITY OF CHILDREN BECOMING ELIGIBLE FOR MEDICAID.—At the option of the State, a premium subsidy eligible child may include an individual who meets the requirements of clauses (i) and (ii) of subparagraph (B) and is eligible for medical assistance under the State plan if the individual was formerly a premium subsidy eligible child under subparagraph (B).

"(D) ADDITIONAL CHILDREN USING STATE-ONLY FUNDS.—Nothing in this section shall be construed as preventing a State, using its own funds and without any Federal financial participation, from covering additional children as premium subsidy eligible children.

"(c) AMOUNT OF PREMIUM SUBSIDY.—

"(1) IN GENERAL.—

"(A) IN GENERAL.—The premium subsidy amount determined under this paragraph is a monthly amount equal to the subsidy percentage of 1/12th of the lesser of—

"(i) the annual premium for certified standard health coverage provided the child, or

"(ii) the actuarial value of the standard option, nationwide service benefit plan (taking into account cost sharing) made available under chapter 89 of title, United States Code for the year, adjusted to reflect a premium for a single child of the age involved and adjusted to reflect the relative cost of premiums for health coverage of premium subsidy eligible children in the geographic area in which the child resides compared to the national average.

"(B) SUBSIDY PERCENTAGE.—For purposes of paragraph (1), an individual's 'subsidy percentage' means 100 percent reduced (but not below zero percent) by 0.85 percentage points for each percentage point (or portion thereof) such individual's income equals or exceeds 100 percent of the poverty line.

"(d) PAYMENTS.—

"(1) IN GENERAL.—The amount of the premium subsidy available to a premium subsidy eligible child under subsection (b) shall be paid by the State in which the individual resides directly to the insurer that provides the coverage for the premium subsidy eligible child. Payments under the preceding sentence shall commence in the first month during which the individual is provided coverage and determined under this section to be a premium subsidy eligible child.

"(2) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium subsidy paid based on an eligibility determination error to the extent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

"(e) ELIGIBILITY DETERMINATIONS.—

"(1) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State programs under this section with respect to determining eligibility for premium subsidy, including requirements with respect to—

"(A) application procedures;

"(B) information verification procedures;

"(C) timeliness of eligibility determinations;

"(D) procedures for applicants to appeal adverse decisions; and

"(E) any other matters determined appropriate by the Secretary.

"(2) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under paragraph (1) shall include the following requirements:

"(A) FREQUENCY OF APPLICATIONS.—A State program shall provide that an individual may file an application for assistance with an agency designated by the State at any time, in person or by mail.

"(B) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under this section.

"(C) DISTRIBUTION OF APPLICATIONS.—A State program shall distribute applications for assistance through employers and appropriate public agencies.

"(D) REQUIREMENT TO SUBMIT REVISED APPLICATION.—A State program shall, in accordance with regulations promulgated by the Secretary, require individuals to submit revised applications during a year to reflect changes in estimated family incomes, including changes in employment status of family members, during the year. The State shall revise the amount of any premium subsidy based on such a revised application.

"(E) VERIFICATION.—A State program shall provide for verification of the information supplied in applications under this section. Such verification may include examining return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

"(f) ADMINISTRATION OF STATE PROGRAMS.—

"(1) IN GENERAL.—The Secretary shall establish standards for States operating programs under this section which ensure that such programs are operated in a uniform manner with respect to application procedures, data processing systems, and such other administrative activities as the Secretary determines to be necessary.

"(2) APPLICATION FORMS.—The Secretary shall develop an application form for assistance which shall—

"(A) be simple in form and understandable to the average individual;

"(B) require the provision of information necessary to make a determination as to whether an individual is a premium subsidy eligible child including a declaration of estimated income by the individual based, at the election of the individual—

"(i) on multiplying by a factor of 4 the individual's family income for the 3-month period immediately preceding the month in which the application is made, or

"(ii) on estimated income for the entire year for which the application is submitted; and

"(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

"(3) OUTREACH ACTIVITIES.—A State operating a program under this section shall conduct such outreach activities as the Secretary determines appropriate.

"(4) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM SUBSIDIES.—A determination by a State that an individual is a premium subsidy eligible child shall be effective for the calendar year for which such determination is made unless a revised application submitted under paragraph (2) indicates that an individual is no longer eligible for premium subsidies.

"(5) PENALTIES FOR MATERIAL MISREPRESENTATIONS.—

"(A) IN GENERAL.—Any individual who knowingly makes a material misrepresentation of information in an application for assistance under this section shall be liable to the Federal Government for the amount of any premium subsidy received by individual on the basis of a misrepresentation and interest on such amount at a rate specified by the Secretary, and shall, in addition, be liable to the Federal Government for $2,000 or, if greater, 3 times the amount any premium subsidy received by individual on the basis of a misrepresentation.

"(B) COLLECTION OF PENALTY AMOUNTS.—A State which receives an application for assistance with respect to which a material misrepresentation has been made shall collect the penalty amount required under subparagraph (A) and submit 50 percent of such amount to the Secretary in a timely manner.

"(g) END-OF-YEAR RECONCILIATION FOR PREMIUM SUBSIDY.—

"(1) IN GENERAL.—

"(A) REQUIREMENT TO FILE STATEMENT.—An individual who received premium subsidies under this section from a State for any month in a calendar year shall file with the State an income reconciliation statement to verify the individual's family income for the year. Such a statement shall be filed at such time, and contain such information, as the State may specify in accordance with regulations promulgated by the Secretary.

"(B) NOTICE OF REQUIREMENT.—A State shall provide a written notice of the requirement under subparagraph (A) at the end of the year to an individual who received premium subsidies under this part from such State in any month during the year.

"(2) RECONCILIATION OF PREMIUM SUBSIDY BASED ON ACTUAL INCOME.—

"(A) IN GENERAL.—Based on and using the income reported in the reconciliation statement filed under paragraph (1) with respect to an individual, the State shall compute the amount of premium subsidy that should have been provided under this section with respect to the individual for the year involved.

"(B) OVERPAYMENT OF ASSISTANCE.—If the total amount of the premium subsidy provided was greater than the amount computed under subparagraph (A), the individual is liable to the State to pay an amount equal to the amount of the excess payment. Any amount collected by a State under this subparagraph shall be submitted to the Secretary in a timely manner.

"(C) UNDERPAYMENT OF ASSISTANCE.—If the total amount of the premium subsidy provided was less than the amount computed under subparagraph (A), the State shall pay to the individual an amount equal to the amount of the deficit.

"(D) STATE OPTION.—A State may, in accordance with regulations promulgated by the Secretary, establish a procedure under which any overpayments or underpayments of premium subsidy determined under subparagraphs (A) and (B) with respect to an individual for a year may be collected or paid, as appropriate, through adjustments to the premium subsidy furnished to such individual in the succeeding year.

"(3) VERIFICATION.—Each State may use such information as it has available to verify income of individuals with applications filed under this section, including return information disclosed to the state for such purpose under section 6103(l)(15) of the internal revenue code of 1986.

"(4) PENALTIES FOR FAILURE TO FILE.—In the case of an individual who is required to file a statement under this subsection in a year who fails to file such a statement by such date as the Secretary shall specify in regulations, the entire amount of the premium subsidy provided in such year shall be considered an excess amount under paragraph (2)(A) and such individual shall not be eligible for premium subsidy assistance under this section until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this paragraph if the individual establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis

"(5) PENALTIES FOR FALSE INFORMATION.—Any individual who provides false information in a statement filed under paragraph (1) is subject to the same penalties as are provided under subsection (f)(5) for a misrepresentation of material fact described in such section.

"(h) SPECIAL RULES ON FEDERAL FINANCIAL PARTICIPATION.—

"(1) PREMIUM SUBSIDY.—In applying section 1903(a)(1) with respect to expenditures for premium subsidy (other than administrative expenses) under this section—

"(A) such expenditures shall be considered to be expenditures on medical assistance;

"(B) in the case of assistance for a premium subsidy eligible child not described in subsection (b)(1)(C), the Federal medical assistance percentage is deemed to be 100 percent, and

"(C) the total amount of Federal financial participation with respect to any State for quarters in any fiscal year shall not exceed the State allotment under subsection (i)(2) for that year.

"(2) ADMINISTRATION EXPENSES.—The amount of expenditures that may be taken into account in computing amounts that are payable to a State under section 1903(a) (other than paragraph (1)) with respect to the administration of the program under this section may not exceed 3 percent of the total expenditures

"(i) TOTAL FEDERAL BUDGET FOR PROGRAM; ALLOTMENTS TO STATES.—

"(1) TOTAL FEDERAL BUDGET.—

"(A) FISCAL YEARS 1998 THROUGH 2004.—Subject to subparagraph (E) (iii), for purposes of this section, the total Federal payments to States under this section may not exceed the following:

"(i) For fiscal year 1998, $5.2 billion.

"(ii) For fiscal year 1999, $7.0 billion.

"(iii) For fiscal year 2000, $10.0 billion.

"(iv) For fiscal year 2001, $11.3 billion.

"(v) For fiscal year 2002, $15.3 billion.

"(vi) For fiscal year 2003, $18.0 billion.

"(vii) For fiscal year 2004, $22.4 billion.

"(B) SUBSEQUENT FISCAL YEARS.—For purposes of this section, the total Federal budget for State plans under this part for each fiscal year after fiscal year 2004 is the total Federal budget under this subsection for the preceding fiscal year multiplied by the Secretary's estimate of the percentage increase in private sector health expenditures for the year.

"(2) ALLOTMENTS TO STATES.—

"(A) IN GENERAL.—The amount of a State's allotment under this section for a fiscal year shall be equal to the product of—

"(i) the limit on the total amount of Federal payments for the year under paragraph (1)(A); and

"(ii) the State's allotment percentage under subparagraph (B).

"(B) STATE ALLOTMENT PERCENTAGE.—In subparagraph (A), a State's allotment percentage for a fiscal year is equal to the percentage of all premium subsidy eligible children in the United States who are residents of the State (as estimated by the Secretary prior to the beginning of the fiscal year).

"(j) CERTIFIED STANDARD HEALTH COVERAGE DEFINED.—

"(1) IN GENERAL.—In this section, health insurance coverage is considered to provide certified standard health coverage if—

"(A) benefits under such coverage are provided within at least each of the required categories of benefits described in subparagraph (A) of paragraph (2) and consistent with such paragraph;

"(B) the actuarial value of the benefits meets the requirements of paragraph (3),

"(C) the benefits comply with the minimum requirements specified in paragraph (4), and

"(D) the benefits do not violate the antidiscrimination rules described in paragraph (5).

"(2) REQUIRED CATEGORIES OF COVERED BENEFITS.—

"(A) IN GENERAL.—The categories of covered benefits described in this subparagraph are the types of benefits specified in subparagraphs (A), (B), (C), (D), and (F) of paragraph (1), and subparagraphs (E) and (F) of paragraph (2), of section 8904(a) of title 5, United States Code (relating to types of benefits required to be in health insurance offered to Federal employees).

"(B) COVERAGE OF OFF-LABEL USE.—An off-label use for a drug that has been found to be safe and effective under section 505 of the Federal Food, Drug, and Cosmetic Act shall be covered if the medical indication for which it is used is listed in one of the following 3 compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

"(C) NO COVERAGE OF SPECIFIC TREATMENT, PROCEDURES, OR CLASSES REQUIRED.—Nothing in this subsection may be construed to require the coverage of any specific procedure or treatment or class of service in certified standard health coverage under this Act or through regulation.

"(3) STANDARD ACTUARIAL VALUE.—

"(A) IN GENERAL.—The actuarial value of the benefits under standard coverage in a rating area meets the requirements of this paragraph if such value is equivalent to the standard actuarial value described in subparagraph (B) for the area, as adjusted for inflation under subparagraph (D). The actuarial value of benefits under standard coverage shall be determined using the standardized population and set of standardized utilization and cost factors described in subparagraph (C).

"(B) STANDARD ACTUARIAL VALUE DESCRIBED.—The standard actuarial value described in this subparagraph for coverage in a geographic area is the actuarial value of benchmark coverage during 1994 in such area. Such actuarial value shall be determined using the standardized population and set of standardized utilization and cost factors described in subparagraph (C).

"(C) ADJUSTMENTS FOR STANDARDIZED POPULATION, STANDARDIZED UTILIZATION AND COST FACTORS, AND GEOGRAPHIC AREA.—The adjustment under this subparagraph—

"(i) for a standardized population shall be made by not taking into account individuals 65 years of age or older, employees of the United States Postal Service, and retirees; and

"(ii) for a geographic area shall be made in a manner that reflects the ratio of the actuarial value of benchmark coverage in such geographic area (as adjusted under clause (i)) to such actuarial value for such benchmark coverage for the United States as a whole, taking into account standardized actuarial utilization and cost factors.

"(D) ADJUSTMENT FOR INFLATION.—

"(i) IN GENERAL.—The adjustment under this paragraph for a year (beginning with 1995) is the FEHBP national rolling increase percentage for the year involved, compounded by such increase for each preceding year after 1994.

"(ii) FEHBP NATIONAL ROLLING INCREASE PERCENTAGE.—For purposes of this paragraph, the term "FEHBP national rolling increase percentage" means, for a year, the 5-year average of the annual national percentage increase in the premiums for health plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code) for the period ending with the previous year. Such increase shall be determined by the Secretary in consultation with the Director of Office of Personnel Management based on the best information available.

"(4) MINIMUM REQUIREMENTS.—Benefits offered under standard coverage within any category shall be not less than the narrowest scope and shortest duration of benefits within that category, in an approved health benefits plan under chapter 89 of title 5, United States Code, except that under such coverage—

"(A) no cost-sharing may be imposed for preventive services (as specified by the Secretary); and

"(B) any cost-sharing imposed for other items and services may only be nominal.

"(k) DEFINITIONS; DETERMINATIONS OF INCOME.—For purposes of this part:

"(1) DETERMINATIONS OF INCOME.—

"(A) FAMILY INCOME.—The term 'family income' means, with respect to an individual who—

"(i) is not a dependent (as defined in subparagraph (B)) of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (D)) for the individual, the individual's spouse, and dependents of the individual; or

"(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes for the other individual, the other individual's spouse, and dependents of the other individual.

"(B) DEPENDENT.—The term 'dependent' shall have the meaning given such term under paragraphs (1) or (2) of section 152(a) of the Internal Revenue Code of 1986.

"(C) SPECIAL RULE FOR FOSTER CHILDREN.—For purposes of subparagraph (A), a child who is placed in foster care by a State agency shall not be considered a dependent of another individual.

"(D) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

"(i) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code, and

"(ii) increased by—

"(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax, and

"(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during the taxable year to the extent not included in gross income under section 86 of such Code.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

"(2) ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—The term 'eligible individual' means an individual who is residing in the United States and who is—

"(i) a citizen or national of the United States; or

"(ii) an alien permanently residing in the United States under color of law (as defined in subparagraph (C)).

"(B) EXCLUSION.—The term 'eligible individual' shall not include an individual who is an inmate of a public institution (except as a patient of a medical institution).

"(C) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term 'alien permanently residing in the United States under color of law' means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

"(i) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

"(ii) An alien who is granted asylum under section 208 of such Act.

"(iii) An alien whose deportation is withheld under section 243(h) of such Act.

"(iv) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

"(v) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

"(vi) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

"(3) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) that—

"(A) in the case of a family of less than five individuals, is applicable to a family of the size involved; and

"(B) in the case of a family of more than four individuals, is applicable to a family of four persons.

"(4) PREMIUM.—Any reference to the term 'premium' includes a reference to premium equivalence for self-insured plans.".

Subtitle H—Medicaid Reform

PART 1—STATE FLEXIBILITY IN THE MEDICAID PROGRAM: THE MEDICAL HEALTH ALLOWANCE PROGRAM

SEC. 1701. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 1601, is further amended—

(1) by redesignating section 1932 as section 1933; and

(2) by inserting after section 1931 the following new section:

"STATE HEALTH ALLOWANCE PROGRAMS

"SEC. 1932. (a) TREATMENT OF EXPENDITURES UNDER HEALTH ALLOWANCE PROGRAMS AS MEDICAL ASSISTANCE UNDER STATE PLAN.—

"(1) IN GENERAL.—Notwithstanding any other provision of this title, for purposes of determining the amount to be paid to a State under section 1903(a)(1) for quarters in any fiscal year, amounts expended by an eligible State (as described in subsection (b)) during the fiscal year under a State health allowance program (as described in subsection (c)) shall be included in the total amount expended during the fiscal year as medical assistance under the State plan (except as provided under paragraphs (2) and (3) and under subsection (d)(1)(C)).

"(2) FEDERAL PAYMENT RESTRICTED TO ACUTE CARE SERVICES.—No amounts expended under a State health allowance program that are attributable to medical assistance described in paragraphs (4), (14), (15), (23), or (24) of section 1905(a) shall be included in the total amount expended as medical assistance under the State plan.

"(3) AMOUNT OF FEDERAL PAYMENT BASED UPON UNUSED PREMIUM SUBSIDY PROGRAM ALLOTMENT.—In no case shall this subsection result in the total Federal payments to the State under this title (including payments attributable to this section and section 1923) for quarters in a fiscal year exceeding an amount equal to the difference between—

"(A) the State's allotment for the premium subsidy program for children under section 1931(i)(2) for such fiscal year; and

"(B) the amount paid to the State for such program for such fiscal year.

"(b) ELIGIBILITY OF STATE.—A State is eligible for purposes of subsection (a) if the State submits (at such time and in such form as the Secretary may require) an application to the Secretary containing such information and assurances as the Secretary may require, including assurances that the State has adopted and is enforcing standards regarding quality assurance for group health plans participating in the State health allowance program, including standards regarding—

"(1) uniform reporting requirements for such plans relating to a minimum set of clinical data, patient satisfaction data, and other information that may be used by individuals to compare the quality of various plans; and

"(2) the establishment or designation of an entity of the State government to collect the data described in subparagraph (A) and to regularly report such data to the Secretary.

"(c) STATE HEALTH ALLOWANCE PROGRAM DESCRIBED.—

"(1) ENROLLMENT OF PARTICIPATING INDIVIDUALS IN APPROVED GROUP HEALTH PLANS.—In this section, a State health allowance program is a program in effect in all the political subdivisions of the State (except as provided in (c)) under which the State makes payments to a group health plan (approved under paragraph (2)) which provides coverage to the individual as an allowance towards the costs of providing the individual with benefits under the plan.

"(2) APPROVED PLANS DESCRIBED.—For purposes of paragraph (1), a State shall approve group health plans in accordance with such standards as the State may establish, except that—

"(A) the State may not approve a plan for a year unless the plan provides certified standard health coverage described in section 1931(j);

"(B) at least one of the plans approved by the State shall be a health maintenance organization or other plan under which payments are otherwise made on a capitated basis for providing medical assistance to individuals enrolled in the State plan under this title; and

"(C) in the case of an individual who is entitled to benefits under the State plan under this title as of the first month during which the State health allowance program is in effect, an approved plan may not require the individual to contribute a greater amount of cost-sharing than the individual would have been required to contribute under the State plan (except as may be imposed on an individual described in subparagraph (B) or subparagraph (C) of subsection (d)(1)).

"(3) WAIVER OF STATEWIDENESS REQUIREMENT.—At the request of a State, the Secretary may waive for a period not to exceed 3 years (subject to one 3-year extension) the requirement under paragraph (1) that the State health allowance program be in effect in all political subdivisions of the State.

"(d) ELIGIBILITY OF INDIVIDUALS TO PARTICIPATE IN ALLOWANCE PROGRAM.—

"(1) AUTOMATIC ELIGIBILITY OF MEDICAID CATEGORICALLY ELIGIBLE INDIVIDUALS.—Subject to subsection (e), any individual to whom the State makes medical assistance available under the State plan under this title pursuant to clause (i) of section 1902(a)(10)(A) shall be eligible to participate in the State health allowance program.

"(2) MANDATORY ELIGIBILITY OF PREGNANT WOMEN WITH INCOME UNDER 150 PERCENT OF THE POVERTY LEVEL.—

"(A) IN GENERAL.—Subject to subsection (e) and subparagraph (B), an individual lawfully residing in the State shall be eligible to participate in the program if the individual is a pregnant woman and the income of the individual's family is equal to or less than 150 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1991) applicable to a family of the size involved.

"(B) EXCEPTION.—If the application of subparagraph (A) would result in—

"(i) the total State expenditures for a quarter under this title (including expenditures attributable to this section and section 1923), exceeding

"(ii) the total State expenditures that the Secretary estimates would have been made under this title for the quarter if the State did not have a program under this section,

then there shall be substituted for 150 percent in subparagraph (A) such percent as would result in the amount described in clause (i) equaling the amount described in clause (ii).

"(3) OPTIONAL ELIGIBILITY OF OTHER INDIVIDUALS WITH INCOME UP TO 150 PERCENT OF POVERTY LEVEL.—

"(A) IN GENERAL.—Subject to subsection (e), a State operating a State health allowance program under this section may make an individual lawfully residing in the State who is not described in paragraph (2) eligible to participate in the program if the income of the individual's family is not greater than 150 percent of such official poverty line.

"(B) CONTRIBUTION MAY BE REQUIRED.—In the case of an individual who is participating in the program under this paragraph and whose family income is greater than 100 percent of the official poverty line, the program may require such an individual to contribute all (or a portion) of the premiums for such a group health plan if the amount of such contribution is determined in accordance with a sliding scale based on the individual's family income.

"(e) EXCLUSION AND USE OF RESOURCE STANDARD.—

"(1) EXCLUSION OF ELDERLY MEDICARE-ELIGIBLE INDIVIDUALS.—No individual shall be eligible to participate in the program if the individual is entitled to benefits under title XVIII pursuant to section 226.

"(2) USE OF RESOURCE STANDARD.—A State may require an individual to meet a resource standard as a condition of eligibility to participate in the program only if the Secretary approves the State's use of such a standard.

"(f) CONSTRUCTION.—No provision of any Federal law shall prevent a State from enrolling any employee or other individual in accordance with this section. The previous sentence shall not be construed as permitting a State to require the employer of an individual participating in the program to contribute toward the individual's premium required for such participation.

"(g) EVALUATIONS AND REPORTS.—

"(1) EVALUATIONS.—Not later than 3 years after the date of the enactment of this section (and at such subsequent intervals as the Secretary considers appropriate), the Secretary shall evaluate the effectiveness of the State health allowance programs for which Federal financial participation is provided under this section, and the impact of such programs on increasing the number of individuals with health insurance coverage in participating States and in controlling the costs of health care in such States.

"(2) REPORTS.—Not later than 3 years after the date of the enactment of this section (and at such subsequent intervals as the Secretary considers appropriate), the Secretary shall submit a report on the program to Congress.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar quarters beginning on or after January 1, 1996.

SEC. 1702. OPTIONAL USE OF PROGRAM TO OFFER COVERAGE TO SOME OR ALL STATE RESIDENTS.

Section 1932 of the Social Security Act, as inserted by section 1701(a)(2), is amended—

(1) in subsection (c)(2)(A), in the matter before clause (i), by inserting ", except as provided in subsection (d)(4)(B)(iii)," after "unless", and

(2) by adding at the end of subsection (d) the following new paragraphs:

"(4) OPTIONAL ENROLLMENT OF OTHER INDIVIDUALS.—

"(A) IN GENERAL.—Subject to subsection (e), a State operating a State health allowance program under this section may make any individual (or class of individuals) who is not described in paragraph (1), (2), or (3) and who is not offered coverage under an employer group health plan eligible to participate in the program.

"(B) SPECIAL RULES.—

"(i) CONTRIBUTION MAY BE REQUIRED.—In the case of an individual who is participating in the program under this paragraph, the program may require such an individual to contribute all (or a portion) of the premiums and cost-sharing of such a group health plan.

"(ii) NO FEDERAL MATCHING PAYMENTS.—For purposes of payment to States under section 1903(a), no amounts expended by the State under the program during a fiscal year on behalf of an individual enrolled under subparagraph (A) may be included in the total amount expended during the fiscal year as medical assistance under the State plan.

"(5) OFFERING OF COVERAGE THROUGH OTHER PROGRAMS.—Nothing in this section shall be construed as preventing a State which—

"(A) does not operate a State health allowance program under this section from assuring that individuals in the State who are not offered coverage under an employer group health plan are offered coverage under a health plan, or

"(B) does operate such a program from assuring that individuals in the State who are not described in paragraph (1), (2), or (3) and who are not offered coverage under an employer group health plan are offered coverage under a health plan other than through such program.".

PART 2—MEDICAID PROGRAM FLEXIBILITY

SEC. 1711. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CONTRACTING FOR COORDINATED CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended—

(1) by striking all that precedes paragraph (4) and inserting the following:

"(m) COORDINATED CARE.—

"(1) PAYMENT CONDITIONED ON COMPLIANCE.—

"(A) GENERAL RULE.—No payment shall be made under this title to a State with respect to expenditures incurred by it for payment to a risk contracting entity or primary care case management entity (as defined in subparagraph (B)), or with respect to an undertaking described in paragraph (6), unless the State and the entity or undertaking meet the applicable requirements of this subsection. For purposes of determining whether payment may be made under this section, the Secretary may reject a State's determination of compliance with any provision of this subsection.

"(B) GENERAL DEFINITIONS.—For purposes of this title—

"(i) RISK CONTRACTING ENTITY.—The term 'risk contracting entity' means an entity that has a contract with the State agency under which the entity—

"(I) provides or arranges for the provision of health care items or services to individuals eligible for medical assistance under the State plan under this title, and

"(II) is at risk (as defined in clause (iv)) for part or all of the cost of such items or services furnished to such individuals.

"(ii) PRIMARY CARE CASE MANAGEMENT PROGRAM.—The term 'primary care case management program' means a State program under which individuals eligible for medical assistance under the State plan under this title are enrolled with primary care case management entities, and are entitled to receive specified health care items and services covered under such plan only as arranged for and approved by such entities.

"(iii) AT RISK.—An entity is 'at risk', for purposes of this subparagraph, if it has a contract with the State agency under which it is paid a fixed amount for providing or arranging for the provision of specified health care items or services to an individual eligible for medical assistance and enrolled with the entity, regardless of whether such items or services are furnished to such individual, and is liable for all or part of the cost of furnishing such items or services, regardless of whether or the extent to which such cost exceeds such fixed payment.

"(iv) PRIMARY CARE CASE MANAGEMENT ENTITY.—The term 'primary care case management entity' means a health care provider (whether an individual or an entity) that, under a State primary care case management program meeting the requirements of paragraph (7), has a contract with the State agency under which the entity arranges for or authorizes the provision of health care items and services to individuals eligible for medical assistance under the State plan under this title, but is not at risk (as defined in clause (iv)) for the cost of such items or services provided to such individuals.

"(2) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

"(A) FEDERAL OR STATE QUALIFICATION.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if it either—

"(i) is a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as determined by the Secretary pursuant to section 1312 of that Act, or

"(ii) is an entity which the State agency has determined—

"(I) affords, to individuals eligible for medical assistance under the State plan and enrolled with the entity, access to health care items and services furnished by the entity, within the area served by the entity, at least equivalent to the access such individuals would have to such health care items and services in such area if not enrolled with the entity, and

"(II) has made adequate provision against the risk of insolvency, and assures that individuals eligible for medical assistance under this title are not held liable for the entity's debts in case of the entity's insolvency.

"(B) INTERNAL QUALITY ASSURANCE.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if it has in effect an internal quality assurance program that meets the requirements of paragraph (9).

"(C) CONTRACT WITH STATE AGENCY.—Subject to paragraph (3), a risk contracting entity meets the requirements of this subsection only if the entity has a written contract with the State agency that provides—

"(i) that the entity will comply with all applicable provisions of this subsection;

"(ii) for a payment methodology based on experience rating or another actuarially sound methodology approved by the Secretary, which guarantees (as demonstrated by such models or formulas as the Secretary may approve) that payments to the entity under the contract shall not exceed 100 percent of expenditures that would have been made by the State agency in the absence of the contract;

"(iii) that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain—

"(I) to the ability of the entity to bear the risk of potential financial losses, or

"(II) to services performed or determinations of amounts payable under the contract;

"(iv) that in the entity's enrollment, reenrollment, or disenrollment of individuals eligible for medical assistance under this title and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

"(v)(I) that individuals eligible for medical assistance under the State plan who have enrolled with the entity are permitted to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination (or at such times as required pursuant to paragraph (8)), and

"(II) for notification of each such individual, at the time of the individual's enrollment, of the right to terminate enrollment;

"(vi) for reimbursement, either by the entity or by the State agency, for medically necessary services provided—

"(I) to an individual eligible for medical assistance under the State plan and enrolled with the entity, and

"(II) other than through the entity because the services were immediately required due to an unforeseen illness, injury, or condition;

"(vii) for disclosure of information in accordance with paragraph (4);

"(viii) in the case of an entity that has entered into a contract with a Federally-qualified health center for the provision of services of such center—

"(I) that rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1902(a)(13)(E), and

"(II) that, at the election of such center, payments made by the entity to such center for services described in section 1905(a)(2)(C) are made at the rates of payment specified in section 1902(a)(13)(E);

"(ix) that any physician incentive plan that the entity operates meets the requirements of section 1876(i)(8);

"(x) for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients; and

"(xi) that the entity complies with the requirement of section 1902(w) with respect to each enrollee.

"(3) EXCEPTIONS TO REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—The requirements of paragraph (2) (other than subparagraph (C)(viii)) do not apply to an entity that—

"(A)(i) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title, has been the recipient of a grant under either such section; and

"(ii) provides to its enrollees, on a prepaid capitation or other risk basis, all of the services described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(10)(D) to be provided under the State plan, the services described in section 1905(a)(7);

"(B) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

"(i) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965), and "(ii) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation or other risk basis; or

"(C) which has contracted with the State agency for the provision of services (but not including inpatient hospital services) to persons eligible for medical assistance under this title on a prepaid risk basis prior to 1970."; and

(2) by adding after paragraph (6) the following new paragraphs:

"(7) GENERAL REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT.—A State that elects in its State plan under this title to implement a primary care case management program under this subsection shall include in the plan methods for the selection and monitoring of participating primary care case management entities to ensure that—

"(A) the numbers, geographic locations, hours of operation, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance reasonable access to and choice among such entities;

"(B) such entities and their professional personnel are qualified to provide health care case management services, through methods including ongoing monitoring of compliance with applicable requirements for licensing of health care providers, providing training and certification of primary care case managers, and providing information and technical assistance; and

"(C) such entities are making timely and appropriate decisions with respect to enrollees' need for health care items and services, and are giving timely approval and referral to providers of adequate quality where such items and services are determined to be medically necessary.

"(8) STATE OPTIONS WITH RESPECT TO ENROLLMENT AND DISENROLLMENT.—

"(A) MANDATORY ENROLLMENT OPTION.—A State plan may require an individual eligible for medical assistance under the State plan (other than a medicare qualified beneficiary) to enroll with a risk contracting entity or primary care case management entity, without regard to the requirement of section 1902(a)(1) (concerning statewideness), the requirements of section 1902(a)(10)(B) (concerning comparability of benefits), or the requirements of section 1902(a)(23) (concerning freedom of choice of provider), if the individual is permitted a choice—

"(i) between or among two or more risk contracting entities,

"(ii) between a risk contracting entity and a primary care case management entity, or

"(iii) between or among two or more primary care case management entities.

"(B)(i) RESTRICTIONS ON DISENROLLMENT WITHOUT CAUSE.—A State plan may restrict the period in which individuals enrolled with a qualifying risk contracting entity (as defined in clause (ii)) may terminate such enrollment without cause to the first month of each period of enrollment (as defined in clause (iii)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

"(ii) For purposes of this subparagraph, the term 'qualifying risk contracting entity' means a risk contracting entity that is—

"(I) a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act;

"(II) an eligible organization with a contract under section 1876;

"(III) an entity that is receiving (and has received during the previous 2 years) a grant of at least $100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act;

"(IV) an entity that is receiving (and has received during the previous 2 years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965;

"(V) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under part B of title XVIII or eligible for medical assistance under this title, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity; or

"(VI) an entity that, on the date of enactment of this provision, had a contract with the State agency under a waiver under section 1115 or 1915(b) and was not subject to a requirement under this subsection to permit disenrollment without cause.

"(iii) For purposes of this subparagraph, the term 'period of enrollment' means—

"(I) a period not to exceed 6 months in duration, or

"(II) a period not to exceed one year in duration, in the case of a State that, on the effective date of this subparagraph, had in effect a waiver under section 1115 of requirements under this title under which the State could establish a 1-year minimum period of enrollment with risk contracting entities.

"(C) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

"(i) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this subsection,

"(ii) in the next month (or next 2 months) is not eligible for such medical assistance, but

"(iii) in the succeeding month is again eligible for such benefits,

the State plan may enroll the individual for that succeeding month with such entity, if the entity continues to have a contract with the State agency under this subsection.

"(9) REQUIREMENTS FOR INTERNAL QUALITY ASSURANCE PROGRAMS.—The requirements for an internal quality assurance program of a risk contracting entity are that program is written and the program—

"(A) specifies a systematic process including ongoing monitoring, corrective action, and other appropriate activities to achieve specified and measurable goals and objectives for quality of care, and including annual evaluation of the program;

"(B) identifies the organizational units responsible for performing specific quality assurance functions, and ensure that they are accountable to the governing body of the entity and that they have adequate supervision, staff, and other necessary resources to perform these functions effectively;

"(C) if any quality assistance functions are delegated to other entities, ensures that the risk contracting entity remains accountable for all quality assurance functions, and has mechanisms to ensure that all quality assurance activities are carried out;

"(D) includes methods to ensure that physicians and other health care professionals under contract with the entity are qualified to perform the services they provide, and that these qualifications are ensured through appropriate credentialing and recredentialing procedures;

"(E) includes policies addressing enrollee rights and responsibilities, including grievance mechanisms and mechanisms to inform enrollees about access to and use of services provided by the entity;

"(F) provides for continuous monitoring of the delivery of health care, including—

"(i) identification of clinical areas to be monitored,

"(ii) use of quality indicators and standards for assessing care delivered, including availability and accessibility of care,

"(iii) monitoring, through use of epidemiological data or chart review, the care of individuals, as appropriate, and patterns of care overall, and

"(iv) implementation of corrective actions; and

"(G) meets any other requirements prescribed by the Secretary after consultation with States.

"(10) INDEPENDENT REVIEW AND QUALITY ASSURANCE.—

"(A) STATE GRIEVANCE PROCEDURE.—A State contracting with a risk contracting entity or primary care case management entity under this subsection shall provide for a grievance procedure for enrollees of such entity with at least the following elements:

"(i) A toll-free telephone number for enrollee questions and grievances.

"(ii) A State-operated enrollee grievance procedure.

"(iii) Periodic notification of enrollees of their rights with respect to such entity or program.

"(iv) Periodic sample reviews of grievances registered with such entity or program or with the State.

"(v) Periodic survey and analysis of enrollee satisfaction with such entity or program.

"(B) STATE MONITORING OF RISK CONTRACTING ENTITIES' QUALITY ASSURANCE PROGRAMS.—A State contracting with a risk contracting entity under this subsection shall periodically review such entity's quality assurance program to ensure that it meets the requirements of paragraph (9).

"(C) EXTERNAL INDEPENDENT REVIEW OF INTERNAL QUALITY ASSURANCE.—A State contracting with a risk contracting entity under this subsection shall provide for annual external independent review (by a utilization control and peer review organization with a contract under section 1153, or another organization unaffiliated with the State government approved by the Secretary) of such entity's internal quality assurance activities. Such independent review shall include—

"(i) review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of inappropriate utilization and treatment,

"(ii) review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine quality trends,

"(iii) review of the entity's internal quality assurance activities, and

"(iv) notification of the entity and the State, and appropriate followup activities, when the review under this subparagraph indicates inappropriate care or treatment.".

(b) State Option To Guarantee Medicaid Eligibility.—Section 1902(e)(2) of such Act (42 U.S.C. 1396a(e)(2)) is amended—

(A) in subparagraph (A), by striking all that precedes "(but for this paragraph)" and inserting "In the case of an individual who is enrolled—

"(i) with a risk contracting entity (as defined in section 1903(m)(1)(B)(i)) responsible for the provision of inpatient hospital services and any other service described in paragraphs (2), (3), (4), (5), and (7) of section 1905(a),

"(ii) with any risk contracting entity (as so defined) in a State that, on the effective date of this provision, had in effect a waiver under section 1115 of requirements under this title under which the State could extend eligibility for medical assistance for enrollees of such entity, or

"(iii) with an eligible organization with a contract under section 1876 and who would", and

(B) in subparagraph (B), by striking "organization or" each place it appears.

(c) Conforming Amendments.—

(1) Section 1128(b)(6)(C)(i) of such Act (42 U.S.C. 1320a-7(b)(6)(C)(i)) is amended by striking "health maintenance organization" and inserting "risk contracting entity".

(2) Section 1902(a)(25)(A) of such Act (42 U.S.C. 1396a(a)(25)(A)), as amended by section 13622(a)(1) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking "health maintenance organizations" and inserting "risk contracting entities".

(3) Section 1902(a)(25)(H) of such Act (42 U.S.C. 1396a(a)(25)(H)), as added by section 13622(b)(3) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking "health maintenance organization" and inserting "risk contracting entity".

(4) Section 1902(a)(30)(C) of such Act (42 U.S.C. 1396a(a)(30)(C)) is amended by striking all that precedes "with the results" and inserting "provide for independent review and quality assurance of entities with contracts under section 1903(m), in accordance with paragraph (10) of such section,".

(5) Section 1902(a)(57) of such Act (42 U.S.C. 1396a(a)(57)) is amended by striking "or health maintenance organization" and inserting "or risk contracting entity".

(6) Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by sections 13623(a), 13625(a), and 13631(a) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(A) by striking "and" at the end of paragraph (61);

(B) by striking the period at the end of paragraph (62) and inserting "; and"; and

(C) by adding at the end the following new paragraph:

"(63) at State option, provide for a primary care case management program in accordance with section 1903(m)(7).".

(7) Section 1902(p)(2) of such Act (42 U.S.C. 1396a(p)(2)) is amended by striking "health maintenance organization" and inserting "risk contracting entity".

(8) Section 1902(w) of such Act (42 U.S.C. 1396a(w)) is amended—

(A) in paragraph (1), by striking "section 1903(m)(1)(A)" and inserting "section 1903(m)(2)(C)(xi)", and

(B) in paragraph (2)(E), by striking "health maintenance organization" and "the organization" and inserting "risk contracting entity" and "the entity", respectively.

(9) Section 1903(k) of such Act (42 U.S.C. 1396b(k)) is amended by striking "health maintenance organization" and inserting "risk contracting entity".

(10) Section 1903(m)(4)(A) of such Act (42 U.S.C. 1396b(m)(4)(A)) is amended—

(A) in the first sentence, by striking "Each health maintenance organization" and inserting "Each risk contracting entity",

(B) in the first sentence, by striking "the organization" each place it appears and inserting "the entity", and

(C) in the second sentence, by striking "an organization" and "the organization" and inserting "a risk contracting entity" and "the risk contracting entity", respectively.

(11) Section 1903(m)(4)(B) of such Act (42 U.S.C. 1396b(m)(4)(B)) is amended by striking "organization" and inserting "risk contracting entity".

(12) Section 1903(m)(5) of such Act (42 U.S.C. 1396b(m)(5)) is amended in paragraphs (A)(iii) and (B)(ii) by striking "organization" and inserting "entity".

(13) Section 1903(o) (42 U.S.C. 1396b(o)), as amended by section 13622(a)(2) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking "health maintenance organization" and inserting "risk contracting entity".

(14) Section 1903(w)(7)(A)(viii) of such Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking "health maintenance organizations (and other organizations with contracts under section 1903(m))" and inserting "risk contracting entities with contracts under section 1903(m)".

(15) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding clause (i), by inserting "(which may be on a prepaid capitation or other risk basis)" after "payment" the first place it appears.

(16) Section 1908(b) of such Act, as added by section 13623(b) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking "health maintenance organization" and inserting "risk contracting entity".

(17) Section 1916(b)(2)(D) of such Act (42 U.S.C. 1396o(b)(2)(D)) is amended by striking "health maintenance organization" and inserting "risk contracting entity".

(18) Section 1925(b)(4)(D)(iv) of such Act (42 U.S.C. 1396r-6(b)(4)(D)(iv)) is amended—

(A) in the heading, by striking "HMO" and inserting "RISK CONTRACTING ENTITY",

(B) by striking "health maintenance organization" and inserting "risk contracting entity" each place it appears, and

(C) by striking "section 1903(m)(1)(A)" and inserting "section 1903(m)(1)(B)(i)".

(19) Paragraphs (1) and (2) of section 1926(a) of such Act (42 U.S.C. 1396r-7(a)) are each amended by striking "health maintenance organizations" and inserting "risk contracting entities".

(20) Section 1927 of such Act (42 U.S.C. 1396s) is amended—

(A) in subsection (c)(1)(C)(i), as amended by section 13602(a)(1) of the Omnibus Budget Reconciliation Act of 1993, by striking "health maintenance organization" and inserting "risk contracting entity" , and

(B) in subsection (j)(1), by striking "*** Health Maintenance Organizations, including those organizations" and inserting "risk contracting entities".

(d) Effective Date.—The amendments made by this section shall become effective with respect to calendar quarters beginning on or after January 1, 1995.

SEC. 1712. PERIOD OF CERTAIN WAIVERS.

(a) In General.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended by striking "No waiver" and all that follows through "unless the Secretary" and inserting "A waiver under this section (other than under subsection (c), (d), or (e)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5 year periods unless the Secretary".

(b) Effective Date.—The amendment made by subsection (a) shall apply to waivers pursuant to applications which are approved, and with respect to continuations of waivers for which requests are made, later than 30 days after the date of the enactment of this Act.

SEC. 1713. ELIMINATION OF DUPLICATIVE PEDIATRIC IMMUNIZATION PROGRAM.

Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993, title XIX of the Social Security Act is amended as follows:

(1) Section 1902(a) is amended—

(A) by adding "and" at the end of paragraph (60),

(B) by striking "; and" at the end of paragraph (61) and inserting a period, and

(C) by striking paragraph (62).

(2) Section 1928 is repealed.

(3) Section 1903(i) is amended—

(A) by inserting "or" at the end of paragraph (12),

(B) by striking the semicolon at the end of paragraph (13) and inserting a period, and

(C) by striking paragraphs (14) and (15).

(4) Section 1902(a)(32) is amended—

(A) by adding "and" at the end of subparagraph (B),

(B) by striking "; and" at the end of subparagraph (C) and inserting a period, and

(C) by striking subparagraph (D).

(5) Section 1902(a) is amended—

(A) in paragraph (11)(B)—

(ii) by inserting "and" before "(ii)", and

(iii) by striking "to the individual under section 1903, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services" and inserting "to him under section 1903";

(B) in paragraph (11)(C), by striking ", including the provision of information and education on pediatric vaccinations and the delivery of immunization services," and

(C) in paragraph (43)(A), by striking "and the need for age-appropriate immunizations against vaccine-preventable diseases".

(6) Section 1905(r)(1) is amended—

(A) in subparagraph (A)(i), by striking "and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines"; and

(B) in subparagraph (B)(iii), by striking "(according to the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines)".

PART 3—MEDICAID DISPROPORTIONATE SHARE ADJUSTMENT

SEC. 1721. 25 PERCENT REDUCTION IN AMOUNT OF PAYMENT ADJUSTMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) In General.—Section 1923 of the Social Security Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

"(h) Reduction in Federal Financial Participation for Disproportionate Share Adjustments.—Notwithstanding any other provision of this section, the amount of payments under section 1903(a) with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year shall not exceed 75 percent of the amount otherwise determined under subsection (f).".

(b) Conforming Amendment.—Section 1923(c) of such Act (42 U.S.C. 1396r-4(c)) is amended in the matter preceding paragraph (1) by striking "(f) and (g)" and inserting "(f), (g), and (h)".

(c) Effective Date.—The amendments made by subsections (a) and (b) shall apply to quarters in fiscal years beginning on or after October 1, 1996.

Subtitle I—Remedies and Enforcement With Respect to Group Health Plans

SEC. 1801. CLAIMS PROCEDURE FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting "(a) IN GENERAL.—" after "SEC. 503."; and

(2) by adding at the end the following new subsection:

"(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

"(1) IN GENERAL.—In addition to meeting the requirements of subsection (a), every group health plan shall afford a reasonable opportunity to any participant or beneficiary, whose request for a preauthorization, an emergency preauthorization, a utilization review determination, or an emergency utilization review determination has been denied, for a full and fair review by the appropriate fiduciary of the decision denying the request.

"(2) TIME LIMITS FOR DECIDING CLAIMS.—

"(A) INITIAL DECISIONS.—A group health plan shall issue an initial approval or denial of any claim for medical, surgical, or hospital benefits not later than 30 days after its filing completion date. Failure to approve or deny such a claim within such 30-day period shall be treated as a denial of the claim.

"(B) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under subparagraph (A) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial shall be treated as a final decision denying the claim.

"(3) TIME LIMIT FOR DECIDING REQUESTS FOR PREAUTHORIZATION.—

"(A) GENERAL RULE.—Except as provided in subparagraph (B)—

"(i) INITIAL DECISIONS.—If a request for preauthorization is required under the terms of a group health plan, the plan shall approve or deny any such request not later than 30 days after its filing completion date. Failure to approve or deny such a request within such 30-day period shall be treated as a denial of the request.

"(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial within such 30-day period shall be treated as a final decision denying the request.

"(B) REQUESTS FOR EMERGENCY PREAUTHORIZATION.—

"(i) INITIAL DECISIONS.—In any case in which a request for preauthorization required under the terms of a group health plan is a request for emergency preauthorization, the plan shall approve or deny any such request not later than 10 days after its filing completion date (24 hours after such date in cases involving emergency medical care). Failure to approve or deny such a request within such 10-day period (or 24-hour period) shall be treated as a denial of the request.

"(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 10 days after the review filing date (24 hours after such date in cases involving emergency medical care). Failure to issue a decision affirming, reversing, or modifying the initial denial within such 10-day period (or 24-hour period) shall be treated as a final decision denying the request.

"(4) TIME LIMIT FOR DECIDING REQUESTS FOR UTILIZATION REVIEW DETERMINATIONS.—

"(A) GENERAL RULE.—Except as provided in subparagraph (B)—

"(i) INITIAL DECISIONS.—If a request for a utilization review determination is required under the terms of a group health plan, the plan shall approve or deny any such request not later than 30 days after its filing completion date. Failure to approve or deny such a request within such 30-day period shall be treated as a denial of the request.

"(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial within such 30-day period shall be treated as a final decision denying the request.

"(B) REQUESTS FOR EMERGENCY UTILIZATION REVIEW DETERMINATIONS.—

"(i) INITIAL DECISIONS.—In any case in which a request for a utilization review determination required under the terms of a group health plan is a request for an emergency utilization review determination, the plan shall approve or deny any such request not later than 10 days after its filing completion date (24 hours after such date in cases involving emergency medical care). Failure to approve or deny such a request within such 10-day period (or 24-hour period) shall be treated as a denial of the request.

"(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 10 days after the review filing date (24 hours after such date in cases involving emergency medical care). Failure to issue a decision affirming, reversing, or modifying the initial denial within such 10-day period (or 24-hour period) shall be treated as a final decision denying the request.

"(5) DEFINITIONS.—For purposes of this subsection—

"(A) CLAIM FOR MEDICAL, SURGICAL, OR HOSPITAL BENEFITS.—The term 'claim for medical, surgical, or hospital benefits' means a request for payment by a group health plan of such benefits made by or on behalf of a participant or beneficiary after the expense for medical, surgical, or hospital care has been incurred.

"(B) UTILIZATION REVIEW DETERMINATION.—The term 'utilization review determination' means a determination under a group health plan solely that proposed medical, surgical, or hospital care is medically necessary (as defined in section 1131(7) of the Health Security Act). Unless otherwise expressly provided under the terms of the plan, any such determination shall not by itself constitute a guarantee that benefits under the plan will be provided.

"(C) PREAUTHORIZATION.—The term 'preauthorization' means a determination under a group health plan that proposed medical, surgical, or hospital care meets the plan's terms and conditions of coverage. Such a determination shall constitute a guarantee that benefits under the plan will be provided.

"(D) REQUEST FOR PREAUTHORIZATION.—The term 'request for preauthorization' means a request for preauthorization by a group health plan of medical, surgical, or hospital benefits made by or on behalf of a participant or beneficiary before the expense for such care has been incurred.

"(E) REQUEST FOR EMERGENCY PREAUTHORIZATION.—The term 'request for emergency preauthorization' means a request for preauthorization by a group health plan in any case in which the medical, surgical, or hospital benefits for which the expense is to be incurred constitutes urgent medical care or emergency medical care.

"(F) REQUEST FOR UTILIZATION REVIEW DETERMINATION.—The term 'request for a utilization review determination' means a request by or on behalf of a participant or beneficiary, made before an expense for medical, hospital, or surgical care has been incurred, for a utilization review determination by a plan.

"(G) REQUEST FOR EMERGENCY UTILIZATION REVIEW DETERMINATION.—The term 'request for an emergency utilization review determination' means a request for a utilization review determination in any case in which the medical, hospital, or surgical care to be incurred constitutes urgent medical care or emergency medical care.

"(H) URGENT MEDICAL CARE.—The term 'urgent medical care' means medical, surgical, or hospital care in any case in which a physician with appropriate expertise has certified in writing that failure to provide the participant or beneficiary with such care within 45 days will result in either—

"(i) the death of the participant or beneficiary within 120 days, or

"(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary within 120 days which will significantly increase the reasonable likelihood of death of the participant or beneficiary.

"(I) EMERGENCY MEDICAL CARE.—The term 'emergency medical care' means medical, surgical, or hospital care in any case in which a physician with appropriate expertise has certified in writing—

"(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

"(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

"(II) serious impairment to bodily functions, or

"(III) serious dysfunction of any bodily organ or part,

or

"(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

"(J) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required to make an initial decision to approve or deny a claim for medical, surgical, or hospital benefits, a request for preauthorization, a request for emergency preauthorization, a request for a utilization review determination or a request for an emergency utilization review determination.

"(K) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the appropriate fiduciary is in receipt of all information reasonably required to make a decision upon a full and fair review of the denial, in whole or in part, of a claim for medical, surgical, or hospital benefits, a request for preauthorization, a request for emergency preauthorization, a request for a utilization review determination or a request for an emergency utilization review determination.

"(L) APPROPRIATE FIDUCIARY.—The term 'appropriate fiduciary' means with respect to any determination under a group health plan a person designated by the plan to make such determination. One or more appropriate fiduciaries shall be designated under each group health plan for making determinations under the plan.".

(b) DEFINITION OF GROUP HEALTH PLAN.—

(1) IN GENERAL.—Section 3 of such Act (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

"(42) The term 'group health plan' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.".

(2) CONFORMING AMENDMENT.—Section 607 of such Act (29 U.S.C. 1167) is amended by striking paragraph (1).

SEC. 1802. MEDIATION OF GROUP HEALTH PLAN CLAIMS.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by inserting below the heading for part 5 the following:

"Subpart A—In General";

and

(2) by adding at the end the following new subpart:

"Subpart B—Mediation of Group Health Plan Claims

"SEC. 521. ELIGIBILITY FOR SUBMISSION TO MEDIATION.

"(a) IN GENERAL.—The Secretary shall establish a mediation program under this subpart (hereinafter in this subpart referred to as the 'mediation program') for the purpose of facilitating mediation of disputes meeting the requirements specified in subsection (b). At the time notice is provided to any participant or beneficiary of a group health plan's denial of any claim for benefits pursuant to section 503, the plan shall provide reasonable notice in writing to the participant or beneficiary whose claim for benefits under the plan has been denied of the availability of mediation under this subpart at the election of either the claimant or the plan.

"(b) DISPUTE CRITERIA.—A dispute may be submitted for mediation under the mediation program only if the following requirements are met with respect to such dispute:

"(1) PARTIES.—The dispute consists of an assertion by a participant, a beneficiary, or the duly authorized representative of a participant or beneficiary (or, in the case of an assignment, the assignee) of one or more claims under a group health plan, and a denial of such claims, or a denial of appropriate reimbursement based on such claims, by such plan or an appropriate fiduciary.

"(2) NATURE OF CLAIM.—The claim consists of a claim for benefits for medical, surgical, or hospital expenses under a group health plan which consist of benefits described in section 3(1).

"(3) SUBMISSION AFTER EXHAUSTION OF PLAN REMEDIES.—The claimant has received a final determination regarding the claim under the plans' claims procedure under section 503, or has otherwise exhausted all remedies under the plan provided pursuant to section 503.

"(4) APPROPRIATE FIDUCIARY.—For purposes of this subpart, the term 'appropriate fiduciary' has the meaning provided in section 503(b)(5)(K).

"SEC. 522. FACILITATORS.

"(a) ROSTER.—The Secretary shall maintain a list of individuals with appropriate expertise to serve as facilitators in proceedings under the mediation program.

"(b) CRITERIA.—In identifying individuals to serve as facilitators, the Secretary shall consider the following:

"(1) the individual's experience in dispute resolution;

"(2) the individual's ability to act impartially;

"(3) the individual's ability to perform evaluations quickly and to present them in nontechnical terms; and

"(4) the individual's experience in employee medical, hospital, and surgical benefits.

"(c) APPOINTMENT OF FACILITATOR.—Within 15 days after either party files with the Secretary an election of mediation with respect to a dispute, the Secretary shall propose a facilitator, selected under a random selection procedure prescribed in regulations, and notify the parties of such selection. Within 10 days after receipt of the notification of the selection of a facilitator, either party may reject the proposed facilitator. If neither party objects to the Secretary's proposed facilitator within such 10-day period, the appointment shall become final. If either party objects to the Secretary's proposed facilitator, the procedure set forth in the preceding provisions of this subsection shall be repeated. Each party is limited to 1 objection to the Secretary's proposed facilitator for each mediation.

"SEC. 523. ROLE OF ATTORNEYS.

"Parties may represent themselves or be represented by attorneys throughout the mediation process.

"SEC. 524. INITIATION OF MEDIATION.

"(a) CLAIMANT INITIATION.—A claimant may initiate mediation of a dispute under this subpart only if no action has been commenced by the claimant under section 502 with respect to any claim involved. To initiate mediation, a claimant shall file an election for mediation with the Secretary (and shall file a copy of the election with the plan or the appropriate fiduciary) within 30 days after a final determination regarding the claim pursuant to section 503.

"(b) PLAN INITIATION.—A participant or beneficiary may not commence an action under section 502 with respect to any claim until the participant or beneficiary has provided to the plan or the appropriate fiduciary 10 days advance notice of the filing of such action. Within the earlier of (1) 25 days after receipt of such a notice with respect to any claim or (2) the date preceding the date on which such claim is filed in court, the plan or the appropriate fiduciary may elect mediation of a dispute under this subpart involving such claim by filing an election for mediation with the Secretary (and a copy of the election with the claimant). Upon a timely election of mediation by the plan or the appropriate fiduciary, the claimant's right to pursue the claim under section 502 shall be suspended until the earlier of 75 days after the date of the filing of the election of mediation or the termination of the mediation proceedings.

"(c) ELECTION FOR MEDIATION.—An election by any party for mediation under this subpart shall be in such form and manner as the Secretary shall prescribe by regulation.

"(d) PARTICIPATION.—The claimant and the plan shall participate in the mediation. Each party shall provide the facilitator a written summary of its position with respect to the dispute accompanied by supporting documentation.

"(e) FILING FEE.—The party initiating mediation under this section shall include with any election for mediation under this subpart a reasonable nonrefundable filing fee payable to the Secretary. The filing fee shall be determined pursuant to regulations prescribed by the Secretary.

"(f) TOLLING OF STATUTES OF LIMITATIONS.—The applicable statute of limitations with respect to any claim involved in a dispute subject to mediation proceedings under this subpart shall be tolled for the period commencing with the 10-day notice period required under subsection (b) and ending with the termination of the mediation proceedings with respect to such dispute. In no event shall the applicable statute of limitations be tolled beyond the 60-day-time limit for completion of mediation provided under section 526.

"SEC. 525. MEDIATION PROCEDURE.

"(a) IN GENERAL.—Mediation proceedings under this subpart shall be conducted, at locations convenient to complainants, by facilitators recruited and assigned by the Secretary under section 522.

"(b) DUTIES OF FACILITATOR.—The Secretary shall prescribe by regulation the duties and role of the facilitator during the mediation process. Such regulations may require the facilitator to identify parties, establish a schedule, request position papers from the parties, and evaluate positions of the parties. Such regulations shall provide that the mediation will be informal, convenient, inexpensive, and expeditious for all parties.

"(c) NEUTRALITY OF FACILITATOR.—The facilitator shall maintain a neutral stance between the parties.

"SEC. 526. MEDIATION TIME LIMIT.

"Any mediation proceedings commenced under this subpart shall be completed within 60 days from the final appointment of a facilitator pursuant to section 522(c).

"SEC. 527. COST OF MEDIATION.

"All reasonable costs of the mediation process under this subpart with respect to any dispute, including the cost of the facilitator, shall be divided equally among the parties. Facilitators shall be compensated at a rate established by the Secretary by regulation. The Secretary shall prescribe regulations specifying reasonable mediation costs and alternative means of allocating the costs in cases of hardship on the part of the claimant.

"SEC. 528. LEGAL EFFECT OF PARTICIPATION IN MEDIATION PROGRAM.

"(a) NONBINDING MEDIATION.—The results of any mediation under this subpart shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties shall not be affected by participation in the mediation program.

"(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a dispute is settled through participation in the mediation program, the facilitator shall, upon the request of either party, assist the parties in drawing up a settlement agreement between the parties.

"SEC. 529. CONFIDENTIALITY AND ADMISSIBILITY.

"(a) IN GENERAL.—All documents and communications made during or generated in connection with the mediation program, as well as any settlement offers or agreements made or entered into under such program—

"(1) shall be privileged and confidential, and

"(2) shall not be admissible as evidence in any Federal or State judicial proceeding unless all parties to the mediation consent in writing.

"(b) EXECUTION OF PRIVILEGE.—Any individual or entity involved in the mediation (including any party or facilitator or other individual who acts on behalf of a party or who provides information or an opinion in connection with the mediation) receiving a subpoena or other lawful process seeking disclosure of any information or documents rendered privileged and confidential under subsection (a) shall assert the privilege provided under subsection (a) and promptly notify all parties to the mediation proceedings of the request for disclosure. The privilege provided for in this section shall be in addition to any attorney-client privilege or other privilege which may be asserted by a party and nothing in this section shall constitute a waiver of such attorney-client privilege or other privilege.".

(b) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended—

(1) by inserting after the item relating to the heading for part 5 of subtitle B of title I the following new item:

"Subpart A—General Provisions";

and

(2) by inserting after the item relating to section 514 the following new items:

"Subpart B—Mediation of Group Health Plan Claims

"Sec. 521. Eligibility for submission to mediation.
"Sec. 522. Facilitators.
"Sec. 523. Role of attorneys.
"Sec. 524. Initiation of mediation.
"Sec. 525. Mediation procedure.
"Sec. 526. Mediation time limit.
"Sec. 527. Cost of mediation.
"Sec. 528. Legal effect of participation in mediation program.
"Sec. 529. Confidentiality and admissibility.".

SEC. 1803. AVAILABLE COURT REMEDIES.

(a) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new paragraphs:

"(5) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in a failure to provide an item or service, or payment therefor, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for provision of such item or service, or payment therefor, upon finding in favor of the plaintiff, the court shall cause to be served on the defendant an order requiring the defendant—

"(i) to cease and desist from the alleged action or failure to act,

"(ii) to provide the item or service, or payment therefor, and to otherwise comply with the terms of the plan and the applicable requirements of this title,

"(iii) to pay to the plaintiff prejudgment interest on the actual costs incurred in obtaining any item or service, or payment therefor, at issue in the complaint, and

"(iv) to pay to the plaintiff a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to the action on the charges on which the plaintiff prevails.

The remedies provided under this paragraph shall be in addition to remedies otherwise provided under this section.

"(6)(A) The Secretary may assess a civil penalty against the plan administrator of, or the appropriate fiduciary (as defined in section 503(b)(5)(K)) of, one or more group health plans for any pattern or practice thereof of repeated failures to provide benefits under the terms of the plan or plans without any reasonable basis or repeated violations thereby of the requirements of section 503 with respect to such plan or plans. Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

"(B) Such penalty shall be in an amount not to exceed the lesser of—

"(i) 20 percent of the aggregate value of claims shown by the Secretary to have been denied, or unlawfully delayed in violation of section 503, under such pattern or practice, or

"(ii) $1,000,000.

"(C) The plan administrator or the appropriate fiduciary of any group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involvement, with respect to such plan or plans, for a period of not less than 7 years.

"(D) For purposes of this paragraph, the phrase 'without any reasonable basis' means, in connection with any denial of claims for benefits under a group health plan, that such denial does not have any reasonable basis, support, or justification under—

"(i) the facts regarding such claim which were reasonably available to the plan administrator or the appropriate fiduciary at the time the claim was denied, and

"(ii) the terms of the plan.

(b) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by inserting "or (c)(6)" after "(c)(2)".

SEC. 1804. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect January 1, 1995, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this subtitle before the effective date thereof.

Subtitle I—Remedies and Enforcement With Respect to Group Health Plans

SEC. 1801. CLAIMS PROCEDURE FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting "(a) IN GENERAL.—" after "SEC. 503."; and

(2) by adding at the end the following new subsection:

"(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

"(1) IN GENERAL.—In addition to meeting the requirements of subsection (a), every group health plan shall afford a reasonable opportunity to any participant or beneficiary, whose request for a preauthorization, an emergency preauthorization, a utilization review determination, or an emergency utilization review determination has been denied, for a full and fair review by the appropriate fiduciary of the decision denying the request

"(2) TIME LIMITS FOR DECIDING CLAIMS.—

"(A) INITIAL DECISIONS.—A group health plan shall issue an initial approval or denial of any claim for medical, surgical, or hospital benefits not later than 30 days after its filing completion date. Failure to approve or deny such a claim within such 30-day period shall be treated as a denial of the claim.

"(B) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under subparagraph (A) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial shall be treated as a final decision denying the claim.

"(3) TIME LIMIT FOR DECIDING REQUESTS FOR PREAUTHORIZATION.—

"(A) GENERAL RULE.—Except as provided in subparagraph (B)—

"(i) INITIAL DECISIONS.—If a request for preauthorization is required under the terms of a group health plan, the plan shall approve or deny any such request not later than 30 days after its filing completion date. Failure to approve or deny such a request within such 30-day period shall be treated as a denial of the request.

"(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial within such 30-day period shall be treated as a final decision denying the request.

"(B) REQUESTS FOR EMERGENCY PREAUTHORIZATION.—

"(i) INITIAL DECISIONS.—In any case in which a request for preauthorization required under the terms of a group health plan is a request for emergency preauthorization, the plan shall approve or deny any such request not later than 10 days after its filing completion date (24 hours after such date in cases involving emergency medical care). Failure to approve or deny such a request within such 10-day period (or 24-hour period) shall be treated as a denial of the request.

"(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 10 days after the review filing date (24 hours after such date in cases involving emergency medical care). Failure to issue a decision affirming, reversing, or modifying the initial denial within such 10-day period (or 24-hour period) shall be treated as a final decision denying the request.

"(4) TIME LIMIT FOR DECIDING REQUESTS FOR UTILIZATION REVIEW DETERMINATIONS.—

"(A) GENERAL RULE.—Except as provided in subparagraph (B)—

"(i) INITIAL DECISIONS.—If a request for a utilization review determination is required under the terms of a group health plan, the plan shall approve or deny any such request not later than 30 days after its filing completion date. Failure to approve or deny such a request within such 30-day period shall be treated as a denial of the request.

"(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 30 days after the review filing date. Failure to issue a decision affirming, reversing, or modifying the initial denial within such 30-day period shall be treated as a final decision denying the request.

"(B) REQUESTS FOR EMERGENCY UTILIZATION REVIEW DETERMINATIONS.—

"(i) INITIAL DECISIONS.—In any case in which a request for a utilization review determination required under the terms of a group health plan is a request for an emergency utilization review determination, the plan shall approve or deny any such request not later than 10 days after its filing completion date (24 hours after such date in cases involving emergency medical care). Failure to approve or deny such a request within such 10-day period (or 24-hour period) shall be treated as a denial of the request.

"(ii) REVIEWS OF INITIAL DECISIONS.—Every review by a fiduciary required under paragraph (1) of an initial denial under clause (i) shall be completed not later than 10 days after the review filing date (24 hours after such date in cases involving emergency medical care). Failure to issue a decision affirming, reversing, or modifying the initial denial within such 10-day period (or 24-hour period) shall be treated as a final decision denying the request.

"(5) DEFINITIONS.—For purposes of this subsection—

"(A) CLAIM FOR MEDICAL, SURGICAL, OR HOSPITAL BENEFITS.—The term 'claim for medical, surgical, or hospital benefits' means a request for payment by a group health plan of such benefits made by or on behalf of a participant or beneficiary after the expense for medical, surgical, or hospital care has been incurred.

"(B) UTILIZATION REVIEW DETERMINATION.—The term 'utilization review determination' means a determination under a group health plan solely that proposed medical, surgical, or hospital care is medically necessary (as defined in section 1131(7) of the Health Security Act). Unless otherwise expressly provided under the terms of the plan, any such determination shall not by itself constitute a guarantee that benefits under the plan will be provided.

"(C) PREAUTHORIZATION.—The term 'preauthorization' means a determination under a group health plan that proposed medical, surgical, or hospital care meets the plan's terms and conditions of coverage. Such a determination shall constitute a guarantee that benefits under the plan will be provided.

"(D) REQUEST FOR PREAUTHORIZATION.—The term 'request for preauthorization' means a request for preauthorization by a group health plan of medical, surgical, or hospital benefits made by or on behalf of a participant or beneficiary before the expense for such care has been incurred.

"(E) REQUEST FOR EMERGENCY PREAUTHORIZATION.—The term 'request for emergency preauthorization' means a request for preauthorization by a group health plan in any case in which the medical, surgical, or hospital benefits for which the expense is to be incurred constitutes urgent medical care or emergency medical care.

"(F) REQUEST FOR UTILIZATION REVIEW DETERMINATION.—The term 'request for a utilization review determination' means a request by or on behalf of a participant or beneficiary, made before an expense for medical, hospital, or surgical care has been incurred, for a utilization review determination by a plan.

"(G) REQUEST FOR EMERGENCY UTILIZATION REVIEW DETERMINATION.—The term 'request for an emergency utilization review determination' means a request for a utilization review determination in any case in which the medical, hospital, or surgical care to be incurred constitutes urgent medical care or emergency medical care.

"(H) URGENT MEDICAL CARE.—The term 'urgent medical care' means medical, surgical, or hospital care in any case in which a physician with appropriate expertise has certified in writing that failure to provide the participant or beneficiary with such care within 45 days will result in either—

"(i) the death of the participant or beneficiary within 120 days, or

"(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary within 120 days which will significantly increase the reasonable likelihood of death of the participant or beneficiary.

"(I) EMERGENCY MEDICAL CARE.—The term 'emergency medical care' means medical, surgical, or hospital care in any case in which a physician with appropriate expertise has certified in writing—

"(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

"(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

"(II) serious impairment to bodily functions, or

"(III) serious dysfunction of any bodily organ or part,

or

"(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

"(J) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required to make an initial decision to approve or deny a claim for medical, surgical, or hospital benefits, a request for preauthorization, a request for emergency preauthorization, a request for a utilization review determination or a request for an emergency utilization review determination.

"(K) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the appropriate fiduciary is in receipt of all information reasonably required to make a decision upon a full and fair review of the denial, in whole or in part, of a claim for medical, surgical, or hospital benefits, a request for preauthorization, a request for emergency preauthorization, a request for a utilization review determination or a request for an emergency utilization review determination.

"(L) APPROPRIATE FIDUCIARY.—The term 'appropriate fiduciary' means with respect to any determination under a group health plan a person designated by the plan to make such determination. One or more appropriate fiduciaries shall be designated under each group health plan for making determinations under the plan.".

(b) DEFINITION OF GROUP HEALTH PLAN.—

(1) IN GENERAL.—Section 3 of such Act (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

"(42) The term 'group health plan' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.".

(2) CONFORMING AMENDMENT.—Section 607 of such Act (29 U.S.C. 1167) is amended by striking paragraph (1).

SEC. 1802. MEDIATION OF GROUP HEALTH PLAN CLAIMS.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by inserting below the heading for part 5 the following:

"Subpart A—In General";

and

(2) by adding at the end the following new subpart:

"Subpart B—Mediation of Group Health Plan Claims

"SEC. 521. ELIGIBILITY FOR SUBMISSION TO MEDIATION.

"(a) IN GENERAL.—The Secretary shall establish a mediation program under this subpart (hereinafter in this subpart referred to as the 'mediation program') for the purpose of facilitating mediation of disputes meeting the requirements specified in subsection (b). At the time notice is provided to any participant or beneficiary of a group health plan's denial of any claim for benefits pursuant to section 503, the plan shall provide reasonable notice in writing to the participant or beneficiary whose claim for benefits under the plan has been denied of the availability of mediation under this subpart at the election of either the claimant or the plan.

"(b) DISPUTE CRITERIA.—A dispute may be submitted for mediation under the mediation program only if the following requirements are met with respect to such dispute:

"(1) PARTIES.—The dispute consists of an assertion by a participant, a beneficiary, or the duly authorized representative of a participant or beneficiary (or, in the case of an assignment, the assignee) of one or more claims under a group health plan, and a denial of such claims, or a denial of appropriate reimbursement based on such claims, by such plan or an appropriate fiduciary.

"(2) NATURE OF CLAIM.—The claim consists of a claim for benefits for medical, surgical, or hospital expenses under a group health plan which consist of benefits described in section 3(1).

"(3) SUBMISSION AFTER EXHAUSTION OF PLAN REMEDIES.—The claimant has received a final determination regarding the claim under the plans' claims procedure under section 503, or has otherwise exhausted all remedies under the plan provided pursuant to section 503.

"(4) APPROPRIATE FIDUCIARY.—For purposes of this subpart, the term 'appropriate fiduciary' has the meaning provided in section 503(b)(5)(K).

"SEC. 522. FACILITATORS.

"(a) ROSTER.—The Secretary shall maintain a list of individuals with appropriate expertise to serve as facilitators in proceedings under the mediation program.

"(b) CRITERIA.—In identifying individuals to serve as facilitators, the Secretary shall consider the following:

"(1) the individual's experience in dispute resolution;

"(2) the individual's ability to act impartially;

"(3) the individual's ability to perform evaluations quickly and to present them in nontechnical terms; and

"(4) the individual's experience in employee medical, hospital, and surgical benefits.

"(c) APPOINTMENT OF FACILITATOR.—Within 15 days after either party files with the Secretary an election of mediation with respect to a dispute, the Secretary shall propose a facilitator, selected under a random selection procedure prescribed in regulations, and notify the parties of such selection. Within 10 days after receipt of the notification of the selection of a facilitator, either party may reject the proposed facilitator. If neither party objects to the Secretary's proposed facilitator within such 10-day period, the appointment shall become final. If either party objects to the Secretary's proposed facilitator, the procedure set forth in the preceding provisions of this subsection shall be repeated. Each party is limited to 1 objection to the Secretary's proposed facilitator for each mediation.

"SEC. 523. ROLE OF ATTORNEYS.

"Parties may represent themselves or be represented by attorneys throughout the mediation process.

"SEC. 524. INITIATION OF MEDIATION.

"(a) CLAIMANT INITIATION.—A claimant may initiate mediation of a dispute under this subpart only if no action has been commenced by the claimant under section 502 with respect to any claim involved. To initiate mediation, a claimant shall file an election for mediation with the Secretary (and shall file a copy of the election with the plan or the appropriate fiduciary) within 30 days after a final determination regarding the claim pursuant to section 503.

"(b) PLAN INITIATION.—A participant or beneficiary may not commence an action under section 502 with respect to any claim until the participant or beneficiary has provided to the plan or the appropriate fiduciary 10 days advance notice of the filing of such action. Within the earlier of (1) 25 days after receipt of such a notice with respect to any claim or (2) the date preceding the date on which such claim is filed in court, the plan or the appropriate fiduciary may elect mediation of a dispute under this subpart involving such claim by filing an election for mediation with the Secretary (and a copy of the election with the claimant). Upon a timely election of mediation by the plan or the appropriate fiduciary, the claimant's right to pursue the claim under section 502 shall be suspended until the earlier of 75 days after the date of the filing of the election of mediation or the termination of the mediation proceedings.

"(c) ELECTION FOR MEDIATION.—An election by any party for mediation under this subpart shall be in such form and manner as the Secretary shall prescribe by regulation.

"(d) PARTICIPATION.—The claimant and the plan shall participate in the mediation. Each party shall provide the facilitator a written summary of its position with respect to the dispute accompanied by supporting documentation.

"(e) FILING FEE.—The party initiating mediation under this section shall include with any election for mediation under this subpart a reasonable nonrefundable filing fee payable to the Secretary. The filing fee shall be determined pursuant to regulations prescribed by the Secretary.

"(f) TOLLING OF STATUTES OF LIMITATIONS.—The applicable statute of limitations with respect to any claim involved in a dispute subject to mediation proceedings under this subpart shall be tolled for the period commencing with the 10-day notice period required under subsection (b) and ending with the termination of the mediation proceedings with respect to such dispute. In no event shall the applicable statute of limitations be tolled beyond the 60-day-time limit for completion of mediation provided under section 526.

"SEC. 525. MEDIATION PROCEDURE.

"(a) IN GENERAL.—Mediation proceedings under this subpart shall be conducted, at locations convenient to complainants, by facilitators recruited and assigned by the Secretary under section 522.

"(b) DUTIES OF FACILITATOR.—The Secretary shall prescribe by regulation the duties and role of the facilitator during the mediation process. Such regulations may require the facilitator to identify parties, establish a schedule, request position papers from the parties, and evaluate positions of the parties. Such regulations shall provide that the mediation will be informal, convenient, inexpensive, and expeditious for all parties.

"(c) NEUTRALITY OF FACILITATOR.—The facilitator shall maintain a neutral stance between the parties.

"SEC. 526. MEDIATION TIME LIMIT.

"Any mediation proceedings commenced under this subpart shall be completed within 60 days from the final appointment of a facilitator pursuant to section 522(c).

"SEC. 527. COST OF MEDIATION.

"All reasonable costs of the mediation process under this subpart with respect to any dispute, including the cost of the facilitator, shall be divided equally among the parties. Facilitators shall be compensated at a rate established by the Secretary by regulation. The Secretary shall prescribe regulations specifying reasonable mediation costs and alternative means of allocating the costs in cases of hardship on the part of the claimant.

"SEC. 528. LEGAL EFFECT OF PARTICIPATION IN MEDIATION PROGRAM.

"(a) NONBINDING MEDIATION.—The results of any mediation under this subpart shall be treated as advisory in nature and nonbinding. Except as provided in subsection (b), the rights of the parties shall not be affected by participation in the mediation program.

"(b) RESOLUTION THROUGH SETTLEMENT AGREEMENT.—If a dispute is settled through participation in the mediation program, the facilitator shall, upon the request of either party, assist the parties in drawing up a settlement agreement between the parties.

"SEC. 529. CONFIDENTIALITY AND ADMISSIBILITY.

"(a) IN GENERAL.—All documents and communications made during or generated in connection with the mediation program, as well as any settlement offers or agreements made or entered into under such program—

"(1) shall be privileged and confidential, and

"(2) shall not be admissible as evidence in any Federal or State judicial proceeding unless all parties to the mediation consent in writing.

"(b) EXECUTION OF PRIVILEGE.—Any individual or entity involved in the mediation (including any party or facilitator or other individual who acts on behalf of a party or who provides information or an opinion in connection with the mediation) receiving a subpoena or other lawful process seeking disclosure of any information or documents rendered privileged and confidential under subsection (a) shall assert the privilege provided under subsection (a) and promptly notify all parties to the mediation proceedings of the request for disclosure. The privilege provided for in this section shall be in addition to any attorney-client privilege or other privilege which may be asserted by a party and nothing in this section shall constitute a waiver of such attorney-client privilege or other privilege.".

(b) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended—

(1) by inserting after the item relating to the heading for part 5 of subtitle B of title I the following new item:

"Subpart A—General Provisions";

and

(2) by inserting after the item relating to section 514 the following new items:

"Subpart B—Mediation of Group Health Plan Claims

"Sec. 521. Eligibility for submission to mediation.
"Sec. 522. Facilitators.
"Sec. 523. Role of attorneys.
"Sec. 524. Initiation of mediation.
"Sec. 525. Mediation procedure.
"Sec. 526. Mediation time limit.
"Sec. 527. Cost of mediation.
"Sec. 528. Legal effect of participation in mediation program.
"Sec. 529. Confidentiality and admissibility.".

SEC. 1803. AVAILABLE COURT REMEDIES.

(a) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new paragraphs:

"(5) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in a failure to provide an item or service, or payment therefor, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for provision of such item or service, or payment therefor, upon finding in favor of the plaintiff, the court shall cause to be served on the defendant an order requiring the defendant—

"(i) to cease and desist from the alleged action or failure to act,

"(ii) to provide the item or service, or payment therefor, and to otherwise comply with the terms of the plan and the applicable requirements of this title,

"(iii) to pay to the plaintiff prejudgment interest on the actual costs incurred in obtaining any item or service, or payment therefor, at issue in the complaint, and

"(iv) to pay to the plaintiff a reasonable attorney's fee, reasonable expert witness fees, and other reasonable costs relating to the action on the charges on which the plaintiff prevails.

The remedies provided under this paragraph shall be in addition to remedies otherwise provided under this section.

"(6)(A) The Secretary may assess a civil penalty against the plan administrator of, or the appropriate fiduciary (as defined in section 503(b)(5)(K)) of, one or more group health plans for any pattern or practice thereof of repeated failures to provide benefits under the terms of the plan or plans without any reasonable basis or repeated violations thereby of the requirements of section 503 with respect to such plan or plans. Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

"(B) Such penalty shall be in an amount not to exceed the lesser of—

"(i) 20 percent of the aggregate value of claims shown by the Secretary to have been denied, or unlawfully delayed in violation of section 503, under such pattern or practice, or

"(ii) $1,000,000.

"(C) The plan administrator or the appropriate fiduciary of any group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involvement, with respect to such plan or plans, for a period of not less than 7 years.

"(D) For purposes of this paragraph, the phrase 'without any reasonable basis' means, in connection with any denial of claims for benefits under a group health plan, that such denial does not have any reasonable basis, support, or justification under—

"(i) the facts regarding such claim which were reasonably available to the plan administrator or the appropriate fiduciary at the time the claim was denied, and

"(ii) the terms of the plan.

(b) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by inserting "or (c)(6)" after "(c)(2)".

SEC. 1804. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect January 1, 1995, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this subtitle before the effective date thereof.

Subtitle J—Delivery of Health Care Services to Illegal Immigrants

SEC. 1901. STUDY ON THE DELIVERY OF HEALTH CARE SERVICES TO ILLEGAL IMMIGRANTS.

(a) IN GENERAL.—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct a detailed study of health care in the United States to populations of individuals immigrating to the United States illegally, including the effect of illegal immigration on levels of health costs and the shifting of health costs.

(b) MATTERS TO BE ANALYZED.—In conducting the study under this section, the Secretary shall analyze—

(1) the extent to which individuals illegally immigrating into the United States obtain health care services in the United States,

(2) the costs of such services,

(3) the means currently used to finance such costs,

(4) the means currently used for identifying, evaluating, preventing, and resolving health problems of populations comprised of such individuals,

(5) the extent of efforts currently being undertaken to prevent or resolve such health problems,

(6) the extent of efforts currently being undertaken to educate populations comprised of such individuals concerning such health problems and to coordinate such efforts,

(7) the programs currently in place for carrying out the activities described in paragraphs (3) through (6), and

(8) the extent of intergovernmental cooperation currently in place between the United States and other countries in dealing with health problems described in the preceding provisions of this subsection.

SEC. 1902. REPORT.

Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to each House of the Congress a final report on the matters analyzed in the study conducted under section 1801. The Secretary shall include in such report any recommendations derived by the Secretary regarding appropriate means of—

(1) alleviating the health problems peculiar to populations of individuals who have immigrated to the United States illegally,

(2) financing health care provided to such populations, and

(3) increasing intergovernmental cooperation and coordination of efforts between the United States and other countries to alleviate such health problems and to finance such efforts.

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Subtitle A—Medical Malpractice Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 2001. FEDERAL REFORM OF MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any medical malpractice liability claim and to any medical malpractice liability action brought in any State or Federal court, except that this subtitle shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(b) PREEMPTION.—The provisions of this subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 2002. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term "alternative dispute resolution system" or "ADR" means a system established under this subtitle that provides for the resolution of medical malpractice liability claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term "claimant" means any person who alleges a medical malpractice liability claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) CLEAR AND CONVINCING EVIDENCE.—The term "clear and convincing evidence" is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

(4) ECONOMIC DAMAGES.—The term "economic damages" means damages paid to compensate an individual for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(5) HEALTH CARE PROFESSIONAL.—The term "health care professional" means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(6) HEALTH CARE PROVIDER.—The term "health care provider" means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(7) INJURY.—The term "injury" means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice liability claim.

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term "medical malpractice liability action" means a civil action brought in a State or Federal court against a health care provider or health care professional in which the plaintiff alleges a medical malpractice

liability claim, but does not include any action in which the plaintiff's sole allegation is an allegation of an intentional tort.

(9) MEDICAL MALPRACTICE LIABILITY CLAIM.—The term "medical malpractice liability claim" means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services or the use of a medical product.

(10) MEDICAL PRODUCT.—

(A) IN GENERAL.—The term "medical product" means, with respect to the allegation of a claimant, a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) if—

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect to the safety of the formulation or performance of the aspect of such drug or device which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term "medical product" shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(11) NONECONOMIC DAMAGES.—The term "noneconomic damages" means damages paid to compensate an individual for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary losses, but does not include punitive damages.

(12) PUNITIVE DAMAGES; EXEMPLARY DAMAGES.—The terms "punitive damages" and "exemplary damages" mean compensation, in addition to compensation for actual harm suffered, that is awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

(13) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(14) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

SEC. 2003. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b) and section 2017(c), this subtitle shall apply with respect to claims accruing or actions brought on or after the expiration of the 3-year period that begins on the date of the enactment of this Act.

(b) EXCEPTION FOR STATES REQUESTING EARLIER IMPLEMENTATION OF REFORMS.—

(1) APPLICATION.—A State may submit an application to the Secretary requesting the early implementation of this subtitle with respect to claims or actions brought in the State.

(2) DECISION BY SECRETARY.—The Secretary shall issue a response to a State's application under paragraph (1) not later than 90 days after receiving the application. If the Secretary determines that the State meets the requirements of this subtitle at the time of submitting its application, the Secretary shall approve the State's application, and this subtitle shall apply with respect to actions brought in the State on or after the expiration of the 90-day period that begins on the date the Secretary issues the response. If the Secretary denies the State's application, the Secretary shall provide the State with a written explanation of the grounds for the decision.

PART 2—MEDICAL MALPRACTICE AND PRODUCT LIABILITY REFORM

SEC. 2011. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 2032(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section 2032(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in any Federal court under section 1332 of title 28, United States Code, during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system referred to in paragraph (1) that applied in the State whose law applies in such action.

(3) CLAIMS AGAINST UNITED STATES.—

(A) ESTABLISHMENT OF PROCESS FOR CLAIMS.—The Attorney General shall establish an alternative dispute resolution process for the resolution of tort claims consisting of medical malpractice liability claims brought against the United States under chapter 171 of title 28, United States Code. Under such process, the resolution of a claim shall occur after the completion of the administrative claim process applicable to the claim under section 2675 of such title.

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A) may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process established by the Attorney General under such subparagraph.

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is "initially resolved" under an alternative dispute resolution system if—

(A) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

(B) if the ADR determines that the defendant is liable, the ADR reaches a decision on the amount of damages assessed against the defendant.

(c) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice liability claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

(2) DEADLINE FOR FILING ACTION.—A medical malpractice liability action may not be brought by a party unless—

(A) the party has filed the notice of intent required by paragraph (1); and

(B) the party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term "court of competent jurisdiction" means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court. The previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (c)(1).

SEC. 2012. CALCULATION AND PAYMENT OF DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant and the members of the claimant's family for losses resulting from the injury which is the subject of a medical malpractice liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) BASIS FOR RECOVERY.—Punitive or exemplary damages shall not be awarded in a medical malpractice liability action unless the claimant establishes by clear and convincing evidence that the injury suffered was the direct result of conduct manifesting a malicious, wanton, willful, or excessively reckless disregard of the safety of others.

(2) NO AWARD AGAINST MANUFACTURER OF MEDICAL PRODUCT.—In the case of a medical malpractice liability action in which the plaintiff alleges a claim against the manufacturer of a medical product, no punitive or exemplary damages may be awarded against such manufacturer.

(3) PAYMENTS TO STATE FOR MEDICAL QUALITY ASSURANCE ACTIVITIES.—

(A) IN GENERAL.—Any punitive or exemplary damages awarded in a medical malpractice liability action shall be paid to the State in which the action is brought or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided.

(B) ACTIVITIES DESCRIBED.—A State shall use amounts paid pursuant to subparagraph (A) to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

(i) licensing or certifying health care professionals and health care providers in the State;

(ii) operating alternative dispute resolution systems;

(iii) carrying out public education programs relating to medical malpractice and the availability of alternative dispute resolution systems in the State; and

(iv) carrying out programs to reduce malpractice-related costs for retired providers or other providers volunteering to provide services in medically underserved areas.

(C) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to subparagraph (A) to supplement and not to replace amounts spent by the State for the activities described in subparagraph (B).

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) WAIVER.—A court may waive the application of paragraph (1) with respect to a defendant if the court determines that it is not in the best interests of the plaintiff to receive payments for damages on such a periodic basis.

(d) MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.—

(1) IN GENERAL.—With respect to a medical malpractice liability claim or action, the total amount of damages received by an individual under such claim or action shall be reduced, in accordance with paragraph (2), by any other payment that has been, or will be, made to an individual to compensate such individual for the injury that was the subject of such claim or action.

(2) AMOUNT OF REDUCTION.—The amount by which an award of damages to an individual for an injury shall be reduced under paragraph (1) shall be—

(A) the total amount of any payments (other than such award) that have been made or that will be made to such individual to pay costs of or compensate such individual for the injury that was the subject of the claim or action; minus

(B) the amount paid by such individual (or by the spouse, parent, or legal guardian of such individual) to secure the payments described in subparagraph (A).

SEC. 2013. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) LIMITATION ON AMOUNT OF CONTINGENCY FEES.—

(1) IN GENERAL.—An attorney who represents, on a contingency fee basis, a claimant in a medical malpractice liability claim may not charge, demand, receive, or collect for services rendered in connection with such claim in excess of the following amount recovered by judgment or settlement under such claim:

(A) 25 percent of the first $150,000 (or portion thereof) recovered, plus

(B) 10 percent of any amount in excess of $150,000 recovered.

(2) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under paragraph (1) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

(b) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(1) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to section 2011(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim under the alternative dispute resolution system), but only if—

(A) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action does not exceed the amount of damages awarded to the party under the ADR system by at least 10 percent; and

(B) in the case of an action in which the party that contested the ruling is the defendant, the amount of damages assessed against the party under the action is not at least 10 percent less than the amount of damages assessed under the ADR system.

(2) EXCEPTIONS.—Paragraph (1) shall not apply if—

(A) the party contesting the ruling made under the previous alternative dispute resolution system shows that—

(i) the ruling was procured by corruption, fraud, or undue means,

(ii) there was partiality or corruption under the system,

(iii) there was other misconduct under the system that materially prejudiced the party's rights, or

(iv) the ruling was based on an error of law;

(B) the party contesting the ruling made under the alternative dispute resolution system presents new evidence before the trier of fact that was not available for presentation under the ADR system;

(C) the medical malpractice liability action raised a novel issue of law; or

(D) the court finds that the application of such paragraph to a party would constitute an undue hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(3) REQUIREMENT FOR PERFORMANCE BOND.—The court in a medical malpractice liability action shall require the party that (pursuant to section 2011(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to post a performance bond (in such amount and consisting of such funds and assets as the court determines to be appropriate), except that the court may waive the application of such requirement to a party if the court determines that the posting of such a bond is not necessary to ensure that the party shall meet the requirements of this subsection to pay the opposing party the costs incurred by the opposing party under the action.

(4) LIMIT ON ATTORNEY'S FEES PAID.—Attorneys' fees that are required to be paid under paragraph (1) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency fee agreement, the amount of attorneys' fees for purposes of the preceding sentence shall not exceed the reasonable value of those services.

(5) RECORDS.—In order to receive attorneys' fees under paragraph (1), counsel of record in the medical malpractice liability action involved shall maintain accurate, complete records of hours worked on the action, regardless of the fee arrangement with the client involved.

(c) CONTINGENCY FEE DEFINED.—As used in this section, the term "contingency fee" means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 2014. JOINT AND SEVERAL LIABILITY.

A defendant may be held severally but not jointly liable in a medical malpractice action. A person found liable for damages in any such action may be found liable, if at all, only for those damages directly attributable to the person's proportionate share of fault or responsibility for the injury, and may not be found liable for damages attributable to the proportionate share of fault or responsibility of any other person (without regard to whether that person is a party to the action) for the injury, including any person bringing the action.

SEC. 2015. STATUTE OF LIMITATIONS.

A medical malpractice liability claim may not be brought after the expiration of the 7-year period that begins on the date the alleged injury that is the subject of the claim occurred. If the commencement of such an action is stayed or enjoined, the running of the statute of limitations under this section shall be suspended for the period of the stay or injunction.

SEC. 2016. UNIFORM STANDARD FOR DETERMINING NEGLIGENCE.

A defendant in a medical malpractice liability action may not be found to have acted negligently unless the defendant's conduct at the time of providing the health care services that are the subject of the action was not reasonable.

SEC. 2017. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IMPOSITION OF HIGHER STANDARD OF PROOF.—In the case of a medical malpractice liability claim relating to services provided during labor or the delivery of a baby, if the health care professional against whom the claim is brought did not previously treat the individual alleged to have been injured for the pregnancy, the trier of fact may not find that the defendant committed malpractice and may not assess damages against the health care professional unless the malpractice is proven by clear and convincing evidence.

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another health care professional.

(c) EFFECTIVE DATE.—This section shall apply with respect to claims accruing or actions brought on or after the expiration of the 2-year period that begins on the date of the enactment of this Act.

PART 3—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS (ADR)

SEC. 2031. BASIC REQUIREMENTS.

(a) IN GENERAL.—A State's alternative dispute resolution system meets the requirements of this section if the system—

(1) applies to all medical malpractice liability claims under the jurisdiction of the courts of that State;

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

(5) with respect to a State system that consists of multiple dispute resolution procedures—

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator for Health Care Policy and Research of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of part 2 shall apply with respect to claims brought under a State alternative dispute resolution system or the alternative Federal system in the same manner as such provisions apply with respect to medical malpractice liability actions brought in the State.

SEC. 2032. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) IN GENERAL.—Not later than October 1 of each year (beginning with 1995), the Secretary, in consultation with the Attorney General, shall determine whether a State's alternative dispute resolution system meets the requirements of this part for the following calendar year.

(2) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection for a calendar year if the Secretary determines under paragraph (1) that the system meets the requirements of section 2031.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1995, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 2031(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims brought under the system shall be heard and resolved by arbitrators appointed by the Secretary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year—

(A) the State shall reimburse the United States (at such time and in such manner as the Secretary may require) for the costs incurred by the United States during the year as a result of the application of the system with respect to the State; and

(B) notwithstanding any other provision of law, no funds may be paid to the State (or to any unit of local government in the State) or to any entity in the State pursuant to the Public Health Service Act.

SEC. 2033. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this part and the alternative Federal system established under section 2032(b).

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

(A) the effect of the alternative dispute resolution systems on the cost of health care within each State,

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within the State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which medical malpractice liability claims shall be resolved on a no-fault basis.

PART 4—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 2041. PERMITTING STATE PROFESSIONAL SOCIETIES TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.

(a) ROLE OF PROFESSIONAL SOCIETIES.—Notwithstanding any other provision of State or Federal law, a State agency responsible for the conduct of disciplinary actions for a type of health care practitioner may enter into agreements with State or county professional societies of such type of health care practitioner to permit such societies to participate in the licensing of such health care practitioner, and to review any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of any such health care practitioner. Any such agreement shall comply with subsection (b).

(b) REQUIREMENTS OF AGREEMENTS.—Any agreement entered into under subsection (a) for licensing activities or the review of any health care malpractice action, health care malpractice claim or allegation, or other information concerning the practice patterns of a health care practitioner shall provide that—

(1) the health care professional society conducts such activities or review as expeditiously as possible;

(2) after the completion of such review, such society shall report its findings to the State agency with which it entered into such agreement;

(3) the conduct of such activities or review and the reporting of such findings be conducted in a manner which assures the preservation of confidentiality of health care information and of the review process; and

(4) no individual affiliated with such society is liable for any damages or injury directly caused by the individual's actions in conducting such activities or review.

(c) AGREEMENTS NOT MANDATORY.—Nothing in this section may be construed to require a State to enter into agreements with societies described in subsection (a) to conduct the activities described in such subsection.

(d) EFFECTIVE DATE.—This section shall take effect 2 years after the date of the enactment of this Act.

SEC. 2042. STUDY OF INCENTIVES TO ENCOURAGE VOLUNTARY SERVICE BY PHYSICIANS.

(a) STUDY.—The Secretary shall conduct a study analyzing the existence and effectiveness of incentives adopted by State and local governments, insurers, medical societies, and other entities to encourage physicians (whether practicing or retired) to volunteer to provide health care services in medically underserved areas.

(b) REPORTS.—(1) Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit an interim report to Congress on the study conducted under subsection (a), together with the Secretary's recommendations for actions to increase the number of physicians volunteering to provide health care services in medically underserved areas.

(2) Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit a final report to the Congress on the study conducted under subsection (a) (taking into account the effects of this subtitle on the incidence and costs of medical malpractice), together with the Secretary's recommendations for actions to increase the number of physicians volunteering to provide health care services in medically underserved areas.

SEC. 2043. REQUIREMENTS FOR RISK MANAGEMENT PROGRAMS.

(a) REQUIREMENTS FOR PROVIDERS.—Each State shall require each health care professional and health care provider providing services in the State to participate in a risk management program to prevent and provide early warning of practices which may result in injuries to patients or which otherwise may endanger patient safety.

(b) REQUIREMENTS FOR INSURERS.—Each State shall require each entity which provides health care professional or provider liability insurance to health care professionals and health care providers in the State to—

(1) establish risk management programs based on data available to such entity or sanction programs of risk management for health care professionals and health care providers provided by other entities; and

(2) require each such professional or provider, as a condition of maintaining insurance, to participate in one program described in paragraph (1) at least once in each 3-year period.

(c) EFFECTIVE DATE.—This section shall take effect 2 years after the date of the enactment of this Act.

SEC. 2044. GRANTS FOR MEDICAL SAFETY PROMOTION.

(a) RESEARCH ON MEDICAL INJURY PREVENTION AND COMPENSATION.—

(1) IN GENERAL.—The Secretary shall make grants for the conduct of basic research in the prevention of and compensation for injuries resulting from health care professional or health care provider malpractice, and research of the outcomes of health care procedures.

(2) PREFERENCE FOR RESEARCH ON CERTAIN ACTIVITIES.—In making grants under paragraph (1), the Secretary shall give preference to applications for grants to conduct research on the behavior of health care providers and health care professionals in carrying out their professional duties and of other participants in systems for compensating individuals injured by medical malpractice, the effects of financial and other incentives on such behavior, the determinants of compensation system outcomes, and the costs and benefits of alternative compensation policy options.

(3) APPLICATION.—The Secretary may not make a grant under paragraph (1) unless an applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary may require.

(b) GRANTS FOR LICENSING AND DISCIPLINARY ACTIVITIES.—

(1) IN GENERAL.—The Secretary shall make grants to States to assist States in improving the State's ability to license and discipline health care professionals.

(2) USES FOR GRANTS.—A State may use a grant awarded under subsection (a) to develop and implement improved mechanisms for monitoring the practices of health care professionals or for conducting disciplinary activities.

(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States receiving grants under paragraph (1) to assist them in evaluating their medical practice acts and procedures and to encourage the use of efficient and effective early warning systems and other mechanisms for detecting practices which endanger patient safety and for disciplining health care professionals.

(4) APPLICATIONS.—The Secretary may not make a grant under paragraph (1) unless the applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary shall require.

(c) GRANTS FOR PUBLIC EDUCATION PROGRAMS.—

(1) IN GENERAL.—The Secretary shall make grants to States and to local governments, private nonprofit organizations, and health professional schools (as defined in paragraph (3)) for—

(A) educating the general public about the appropriate use of health care and realistic expectations of medical intervention;

(B) educating the public about the resources and role of health care professional licensing and disciplinary boards in investigating claims of incompetence or health care malpractice; and

(C) developing programs of faculty training and curricula for educating health care professionals in quality assurance, risk management, and medical injury prevention.

(2) APPLICATIONS.—The Secretary may not make a grant under paragraph (1) unless the applicant submits an application to the Secretary at such time, in such form, in such manner, and containing such information as the Secretary shall require.

(3) HEALTH PROFESSIONAL SCHOOL DEFINED.—In paragraph (1), the term "health professional school" means a school of nursing (as defined in section 853(2) of the Public Health Service Act) or a school or program under section 799(1) of such Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated not more than $15,000,000 for each of the first 5 fiscal years beginning on or after the date of the enactment of this Act for grants under this section.

Subtitle B—Administrative Cost Savings and Fair Health Information Practices

PART 1—ADMINISTRATIVE COST SAVINGS

SEC. 2100. PURPOSE.

It is the purpose of this part to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act, by encouraging the development of a health information network through the adoption of standards and the establishment of requirements for the electronic transmission of certain health information.

SEC. 2101. DEFINITIONS.

For purposes of this part:

(1) CODE SET.—The term "code set" means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(2) COORDINATION OF BENEFITS.—The term "coordination of benefits" means determining and coordinating the financial obligations of plan sponsors when health care benefits are payable by more than one such sponsor.

(3) EMPLOYER.—The term "employer" has the meaning given such term in section 3(5) of the Employee Retirement Income Security Act of 1974.

(4) HEALTH INFORMATION.—The term "health information" means any information that relates to the past, present, or future physical or mental health or condition or functional status of an individual, the provision of health care to an individual, or payment for the provision of health care to an individual.

(5) HEALTH INFORMATION NETWORK.—The term "health information network" means the health information system that is formed through the application of the requirements and standards established under this part.

(6) HEALTH INFORMATION NETWORK SERVICE.—The term "health information network service"—

(A) means a private entity or an entity operated by a State that enters into contracts—

(i) to process or facilitate the processing of nonstandard data elements of health information into standard data elements;

(ii) to provide the means by which persons are connected to the health information network for purposes of meeting the requirements of this part, including the holding of standard data elements of health information;

(iii) to provide authorized access to health information through the health information network; or

(iv) to provide specific information processing services, such as automated coordination of benefits and claims transaction routing; and

(B) includes a health information protection service.

(7) HEALTH INFORMATION PROTECTION SERVICE.—The term "health information protection service" means a private entity or an entity operated by a State that accesses standard data elements of health information through the health information network, processes such information into non-identifiable health information, and may store such information.

(8) HEALTH PROVIDER.—The term "health provider" includes a provider of services (as defined in section 1861(u) of the Social Security Act), a provider of medical or other health services (as defined in section 1861(s) of such Act), and any other person (other than a plan sponsor) furnishing health care items or services.

(9) NON-IDENTIFIABLE HEALTH INFORMATION.—The term "non-identifiable health information" means health information that is not protected health information (as defined in part 2).

(10) PLAN SPONSOR.—The term "plan sponsor" means—

(A) a plan (as defined in section 1033(6)(B));

(B) an insurer (as defined in section 1131(6)) providing health insurance coverage (as defined in section 1131(4)); and

(C) a State, or the Federal Government, acting in a capacity as a provider of health benefits to eligible individuals that is equivalent to that of an insurer.

(11) PURCHASING ARRANGEMENT.—The term "purchasing arrangement" means a voluntary health purchasing arrangement described in part 3 of subtitle B of title I.

(12) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(13) STANDARD.—The term "standard", when used with reference to a transaction or to data elements of health information, means that the transaction or data elements meet any standard adopted by the Secretary under subpart A that applies to the transaction or data elements.

Subpart A—Standards for Data Elements and Transactions

SEC. 2103. GENERAL REQUIREMENTS ON SECRETARY.

(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this part that are—

(1) consistent with the objective of reducing the costs of providing and paying for health care; and

(2) in use and generally accepted, developed, or modified by the standard-setting organizations accredited by the American National Standard Institute.

(b) INITIAL STANDARDS.—The Secretary may develop an expedited process for the adoption of initial standards under this subpart.

(c) PROTECTION OF COMMERCIAL INFORMATION.—In adopting standards under this part, the Secretary may not require disclosure of trade secrets and confidential commercial information by any person.

SEC. 2104. STANDARDS FOR DATA ELEMENTS OF HEALTH INFORMATION.

(a) IN GENERAL.—The Secretary shall adopt standards necessary to make uniform and compatible for electronic transmission through the health information network the data elements of any health information that the Secretary determines is appropriate for transmission in connection with a transaction described in section 2111.

(b) ADDITIONS.—The Secretary may make additions to any set of data elements adopted under subsection (a) as the Secretary determines appropriate in a manner that minimizes the disruption and cost of compliance with such additions.

(c) CERTAIN DATA ELEMENTS.—

(1) UNIQUE HEALTH IDENTIFIERS.—The Secretary shall establish a system to provide for a standard unique health identifier for each individual, employer, plan sponsor, and health provider for use in the health care system.

(2) CODE SETS.—

(A) IN GENERAL.—The Secretary, in consultation with experts from the private sector and Federal agencies, shall—

(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution of code sets and modifications to code sets.

SEC. 2105. INFORMATION TRANSACTION STANDARDS.

(a) IN GENERAL.—The Secretary shall adopt technical standards that are consistent with part 2 relating to the method by which standard data elements of health information may be transmitted electronically, including standards with respect to the format in which such data elements may be transmitted.

(b) SPECIAL RULE FOR COORDINATION OF BENEFITS.—Any standard adopted by the Secretary under paragraph (1) that relates to coordination of benefits shall provide that a claim for reimbursement for health services furnished shall be tested, by an algorithm specified by the Secretary, against all records of enrollment and eligibility for the individual who received such services that are available to the recipient of the claim through the health information network to determine any primary and secondary obligors for payment.

(c) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which shall be deemed to satisfy State and Federal statutory requirements for written signatures with respect to transactions described in section 2111 and written signatures on health records and prescriptions.

(d) STANDARDS FOR CLAIMS FOR CLINICAL LABORATORY TESTS.—The standards under this section shall provide that claims for clinical laboratory tests for which benefits are payable by a plan sponsor shall be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the sponsor in a manner consistent with (and subject to such exceptions as are provided under) the requirement for direct submission of such claims under the medicare program.

SEC. 2106. TIMETABLES FOR ADOPTION OF STANDARDS.

(a) INITIAL STANDARDS FOR DATA ELEMENTS.—The Secretary shall adopt standards relating to—

(1) the data elements for the information described in section 2104(a) not later than 9 months after the date of the enactment of this Act (except in the case of standards with respect to data elements for claims attachments, which shall be adopted not later than 24 months after the date of the enactment of this Act); and

(2) any addition to a set of data elements, in conjunction with making such an addition.

(b) INITIAL STANDARDS FOR INFORMATION TRANSACTIONS.—The Secretary shall adopt standards relating to information transactions under section 2105 not later than 9 months after the date of the enactment of this Act (except in the case of standards for claims attachments, which shall be adopted not later than 24 months after the date of the enactment of this Act).

(c) MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this subpart and shall adopt modified standards as determined appropriate, but not more frequently than once every 6 months. Any modification to standards shall be completed in a manner which minimizes the disruption to, and costs of compliance incurred by, a plan sponsor, health provider, or purchasing arrangement that is required to comply with subpart B.

(2) SPECIAL RULES.—

(A) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this subpart during the 12-month period beginning on the date the standard is adopted, unless the Secretary determines that the modification is necessary in order to permit a plan sponsor, a health provider, or a purchasing arrangement to comply with subpart B.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements that were encoded prior to the modification are to be converted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption to, and costs of compliance incurred by, a plan sponsor, health provider, or purchasing arrangement that is required to comply with subpart B.

(d) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this subpart. Such process may include demonstration projects and analyses of the cost of implementing such standards and modifications.

Subpart B—Requirements With Respect to Certain Transactions and Information

SEC. 2111. STANDARD TRANSACTIONS AND INFORMATION.

(a) TRANSACTIONS BY SPONSORS.—

(1) TRANSACTIONS WITH PROVIDERS.—If a plan sponsor conducts any of the transactions described in paragraph (3) with a health provider—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by the sponsor to the provider or by the provider to the sponsor in connection with the transaction shall be in the form of standard data elements.

(2) TRANSACTIONS WITH SPONSORS.—If a plan sponsor conducts any of the transactions described in paragraph (3) with another plan sponsor—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by either sponsor in connection with the transaction shall be in the form of standard data elements.

(3) TRANSACTIONS.—The transactions referred to in paragraphs (1) and (2) are the following:

(A) Verification of eligibility for benefits.

(B) Coordination of benefits.

(C) Claim submission.

(D) Claim attachment submission.

(E) Claim status notification.

(F) Claim status verification.

(G) Claim adjudication.

(H) Payment and remittance advice.

(I) Certification or authorization of a referral to a health provider who is not part of the defined set of providers providing items and services under a network plan (as defined in section 1131(5)).

(b) TRANSACTIONS BY PURCHASING ARRANGEMENTS.—

(1) IN GENERAL.—If a purchasing arrangement conducts any of the transactions described in paragraph (2) with a plan sponsor—

(A) the transaction shall be a standard transaction; and

(B) the health information transmitted by the arrangement to the sponsor or by the sponsor to the arrangement in connection with the transaction shall be in the form of standard data elements.

(2) TRANSACTIONS.—The transactions referred to in paragraph (1) are the following:

(A) Enrollment and disenrollment.

(B) Premium payment.

(c) USE OF HEALTH INFORMATION NETWORK SERVICES.—A plan sponsor, a health provider, or a purchasing arrangement may comply with any provision of this section by entering into an agreement or other arrangement with a health information network service certified under section 2121 pursuant to which the service undertakes the duties applicable to the sponsor, provider, or arrangement under the provision.

SEC. 2112. ACCESSING HEALTH INFORMATION FOR AUTHORIZED PURPOSES.

(a) PROCUREMENT RULE FOR GOVERNMENT AGENCIES.—

(1) IN GENERAL.—A health information protection service that is certified under section 2121 shall make available to a Federal or State agency, pursuant to a cost-type contract (as defined under the Federal Acquisition Regulation), any non-identifiable health information, including non-identifiable health information that is derived from protected health information, that—

(A) is held by the service or may be obtained by the service under paragraph (2) or subsection (b);

(B) consists of data elements that are subject to a standard under subpart A; and

(C) is requested by the agency to fulfill a requirement under this Act.

(2) CERTAIN INFORMATION AVAILABLE AT LOW COST.—If a health information protection service requires health information consisting of data elements that are subject to a standard under subpart A from a plan sponsor or a health provider in order to comply with a request made by a Federal or State agency under paragraph (1), the sponsor or

provider shall make such information available to such organization for a charge that does not exceed the reasonable cost of transmitting the information.

(b) Procurement Rule for Information Protection Services.—A health information protection service that makes non-identifiable health information available to a Federal or State agency under subsection (a) shall make such non-identifiable information available, for a charge that does not exceed the reasonable cost of transmitting the information, to any other health information protection service that—

(A) is certified under section 2121; and

(B) requests the information.

SEC. 2113. ENSURING AVAILABILITY OF INFORMATION.

The Secretary shall establish a procedure under which a plan sponsor or health provider that does not have the ability to transmit standard data elements directly, and does not have access to a health information network service certified under section 2121, may comply with the provisions of this subpart.

SEC. 2114. TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.

(a) Initial Compliance.—

(1) In general.—Not later than 12 months after the date on which standards are adopted under subpart A with respect to a type of transaction, or data elements for a type of health information, a plan sponsor, health provider, or purchasing arrangement shall comply with the requirements of this subpart with respect to such transaction or information.

(2) Additional data elements.—Not later than 12 months after the date on which the Secretary adopts an addition to a set of data elements for health information under section 2104, a plan sponsor, health provider, or purchasing arrangement shall comply with the requirements of this subpart using such data elements.

(b) Compliance With Modified Standards.—

(1) In general.—If the Secretary adopts a modified standard under section 2106(c), a plan sponsor, health provider, or purchasing arrangement shall comply with the modified standard at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification.

(2) Special rule.—In the case of a modification to a standard that does not occur within the 12-month period beginning on the date the standard is adopted, the time determined appropriate by the Secretary under paragraph (1) may not be—

(A) earlier than the last day of the 90-day period beginning on the date the modified standard is adopted; or

(B) later than the last day of the 12-month period beginning on the date the modified standard is adopted.

Subpart C—Miscellaneous Provisions

SEC. 2121. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK SERVICES.

(a) Standards for Operation.—The Secretary shall establish standards with respect to the operation of health information network services, including standards ensuring that such services—

(1) develop, operate, and cooperate with one another to form the health information network;

(2) meet all of the requirements under part 2 that are applicable to the services;

(3) make public information concerning their performance, as measured by uniform indicators such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicator determined appropriate by the Secretary;

(4) have security procedures that are consistent with the requirements under part 2, including secure methods of accessing and transmitting data; and

(5) if they are part of a larger organization, have policies and procedures in place which isolate their activities with respect to processing information in a manner that prevents access to such information by such larger organization.

(b) Certification by the Secretary.—

(1) Establishment.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall establish a certification procedure for health information network services which ensures that certified services are qualified to meet the requirements of this part and the standards established by the Secretary under this section. Such certification procedure shall be implemented in a manner that minimizes the costs and delays of operations for such services.

(2) Application.—Each entity desiring to be certified as a health information network service shall apply to the Secretary for certification in a form and manner determined appropriate by the Secretary.

(3) Audits and reports.—The procedure established under paragraph (1) shall provide for audits by the Secretary and reports by an entity certified under this section as the Secretary determines appropriate in order to monitor such entity's compliance with the requirements of this part, part 2, and the standards established by the Secretary under this section.

(4) Recertification.—A health information network service shall be recertified under this subsection at least every 3 years.

(c) Loss of Certification.—

(1) Mandatory termination.—Except as provided in paragraph (2), if a health information network service violates a requirement imposed on such service under part 2, its certification under this section shall be terminated unless the Secretary determines that appropriate corrective action has been taken.

(2) Conditional certification—The Secretary may establish a procedure under which a health information network service may remain certified on a conditional basis if the service is operating consistently with a plan intended to correct any violations described in paragraph (1). Such procedure may provide for the appointment of a trustee to continue operation of the service until the requirements for full certification are met.

(d) Certification by Private Entities.—The Secretary may designate private entities to conduct the certification procedures established by the Secretary under this section. A health information network service certified by such an entity in accordance with such designation shall be considered to be certified by the Secretary.

(e) Information Held by Health Information Network Services.—If a health information network service certified under this section loses its certified status or takes any action that would threaten the continued availability of the standard data elements of health information held by such service, such data elements shall be transferred to another health information network service certified under this section that has been designated by the Secretary.

SEC. 2122. IMPOSITION OF ADDITIONAL REQUIREMENTS.

(a) In General.—Except as provided in subsection (c), after the Secretary has established standards under section 2104 that are necessary to make uniform and compatible for electronic transmission the data elements that the Secretary determines are appropriate for transmission in connection with a transaction described in subpart B, an individual or entity may not require an individual or entity, to provide in any manner any additional data element in connection with—

(1) the transaction; or

(2) an inquiry with respect to the transaction.

(b) Transmission Method.—Except as provided in subsection (c), after the Secretary has established standards under section 2105 relating to the method by which data elements that the Secretary determines are appropriate for transmission in connection with a transaction described in subpart B may be transmitted electronically, an individual or entity may not require an individual or entity to transmit any data element in a manner inconsistent with the standards in connection with—

(1) the transaction; or

(2) an inquiry with respect to the transaction.

(c) Exception.—Subsections (a) and (b) do not apply if—

(1) an individual or entity voluntarily agrees to provide the additional data element; or

(2) a waiver is granted under subsection (d) to permit the requirement.

(d) Conditions for Waivers.—

(1) In general.—An individual or entity may request a waiver from the Secretary in order to impose on an individual or entity a requirement otherwise prohibited under subsection (a) or (b).

(2) Consideration of waiver requests.—A waiver may not be granted under this subsection to impose an otherwise prohibited requirement unless the Secretary determines that the value of any additional information to be provided under the requirement for research or other purposes significantly outweighs the administrative cost of the imposition of the requirement, taking into account the burden of the timing of the imposition of the requirement.

(3) Anonymous reporting.—If an individual or entity attempts to impose on an individual or entity a requirement prohibited under subsection (a) or (b), the individual or entity on whom the requirement is being imposed may contact the Secretary. The Secretary shall develop a procedure under which an individual or entity that contacts the Secretary under the preceding sentence shall remain anonymous. The Secretary shall notify the individual or entity imposing the requirement that the requirement may not be imposed unless the other individual or entity voluntarily agrees to such requirement or a waiver is obtained under this subsection.

SEC. 2123. EFFECT ON STATE LAW.

(a) In General.—Except as otherwise provided in this section, a provision, requirement, or standard under this part shall supersede any contrary provision of State law.

(b) State "Quill and Pen" Laws.—A State may not establish, continue in effect, or enforce any provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form, except where the Secretary determines that the provision is necessary to prevent fraud and abuse, with respect to controlled substances, or for other purposes.

(c) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

(d) PUBLIC USE FUNCTIONS.—Nothing in this part shall be construed to limit the authority of a Federal or State agency to make non-identifiable health information available for public use.

(e) PAYMENT FOR HEALTH CARE SERVICES OR PREMIUMS.—Nothing in this part shall be construed to prohibit a consumer from paying for health care items or services, or plan or health insurance coverage premiums, by debit, credit, or other payment cards or numbers or other electronic payment means.

SEC. 2124. GRANTS FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary may make grants for demonstration projects to promote the development and use of electronically integrated community-based clinical information systems and computerized patient medical records.

(b) APPLICATIONS.—

(1) SUBMISSION.—To apply for a grant under this section for any fiscal year, an applicant shall submit an application to the Secretary in accordance with the procedures established by the Secretary.

(2) CRITERIA FOR APPROVAL.—The Secretary may not approve an application submitted under paragraph (1) unless the application includes assurances satisfactory to the Secretary regarding the following:

(A) USE OF EXISTING TECHNOLOGY.—Funds received under this section will be used to apply telecommunications and information systems technology that is in existence on the date the application is submitted in a manner that improves the quality of health care, reduces the costs of such care, and protects the privacy and confidentiality of information relating to the physical or mental condition of an individual.

(B) USE OF EXISTING INFORMATION SYSTEMS.—Funds received under this section will be used—

(i) to enhance telecommunications or information systems that are operating on the date the application is submitted;

(ii) to integrate telecommunications or information systems that are operating on the date the application is submitted; or

(iii) to connect additional users to telecommunications or information networks or systems that are operating on the date the application is submitted.

(C) MATCHING FUNDS.—The applicant shall make available funds for the demonstration project in an amount that equals at least 20 percent of the cost of the project.

(c) GEOGRAPHIC DIVERSITY.—In making any grants under this section, the Secretary shall, to the extent practicable, make grants to persons representing different geographic areas of the United States, including urban and rural areas.

(d) REVIEW AND SANCTIONS.—The Secretary shall review at least annually the compliance of a person receiving a grant under this section with the provisions of this section. The Secretary shall establish a procedure for determining whether such a person has failed to comply substantially within the provisions of this section and the sanctions to be imposed for any such noncompliance.

(e) ANNUAL REPORT.—The Secretary shall submit an annual report to the President for transmittal to Congress containing a description of the activities carried out under this section.

Subpart D—Assistance to the Secretary

SEC. 2131. GENERAL REQUIREMENT ON SECRETARY.

In complying with any requirements imposed on the Secretary under this part, the Secretary shall rely on recommendations of the Health Information Advisory Committee established under section 2132 and shall consult with appropriate Federal agencies.

SEC. 2132. HEALTH INFORMATION ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—There is established a committee to be known as the Health Care Information Advisory Committee.

(b) DUTY.—

(1) IN GENERAL.—The committee shall—

(A) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this part and part 2;

(B) be generally responsible for advising the Secretary and the Congress on the status of the health information network; and

(C) make recommendations to correct any problems that may occur in the network's implementation and ongoing operations and to refine and improve the network.

(2) TECHNICAL ASSISTANCE.—In performing its duties under this subsection, the committee shall receive technical assistance from appropriate Federal agencies.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The committee shall consist of 15 members to be appointed by the President not later than 60 days after the date of the enactment of this part. The President shall designate 1 member as the Chair.

(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the committee.

(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of no more than 3 members expire at one time.

(4) VACANCIES.—

(A) IN GENERAL.—A vacancy on the committee shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

(5) CONFLICTS OF INTEREST.—Members of the committee shall disclose upon appointment to the committee or at any subsequent time that it may occur, conflicts of interest.

(d) MEETINGS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the committee shall meet at the call of the Chair.

(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the committee have been appointed, the committee shall hold its first meeting.

(3) QUORUM.—A majority of the members of the committee shall constitute a quorum, but a lesser number of members may hold hearings.

(e) POWER TO HOLD HEARINGS.—The committee may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the committee considers advisable to carry out the purposes of this section.

(f) OTHER ADMINISTRATIVE PROVISIONS.—Subparagraphs (C), (D), and (H) of section 1886(e)(6) of the Social Security Act shall apply to the committee in the same manner as they apply to the Prospective Payment Assessment Commission.

(g) REPORTS.—

(1) IN GENERAL.—The committee shall annually prepare and submit to Congress and the Secretary a report including at least an analysis of—

(A) the status of the health information network established under this part, including whether the network is fulfilling the purpose described in section 2100;

(B) the savings and costs of the network;

(C) the activities of health information network services certified under section 2121, health providers, and plan sponsors under this part;

(D) the extent to which entities described in subparagraph (C) are meeting the standards adopted under this part and working together to form an integrated network that meets the needs of its users;

(E) the extent to which entities described in subparagraph (C) are meeting the privacy and security protections of part 2;

(F) whether the Federal Government and State Governments are receiving information of sufficient quality to meet their responsibilities under this Act;

(G) any problems with respect to implementation of the network;

(H) the extent to which timetables under this part for the adoption and implementation of standards are being met; and

(I) any legislative recommendations related to the health information network.

(2) AVAILABILITY TO THE PUBLIC.—Any information in the report submitted to Congress under paragraph (1) shall be made available to the public, unless such information may not be disclosed by law.

(h) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the committee shall continue in existence until otherwise provided by law.

PART 2—FAIR HEALTH INFORMATION PRACTICES

SEC. 2140. DEFINITIONS.

(a) DEFINITIONS RELATING TO PROTECTED HEALTH INFORMATION.—For purposes of this part:

(1) DISCLOSE.—The term "disclose", when used with respect to protected health information that is held by a health information trustee, means to provide access to the information, but only if such access is provided by the trustee to a person other than—

(A) the trustee or an officer or employee of the trustee;

(B) an affiliated person of the trustee; or

(C) a protected individual who is a subject of the information.

(2) DISCLOSURE.—The term "disclosure" means the act or an instance of disclosing.

(3) PROTECTED HEALTH INFORMATION.—The term "protected health information" means any information, whether oral or recorded in any form or medium—

(A) that is created or received in a State by—

(i) a health care provider;

(ii) a health benefit plan sponsor;

(iii) a health oversight agency;

(iv) a health information service organization; or

(v) a public health authority;

(B) that relates in any way to the past, present, or future physical or mental health or condition or functional status of a protected individual, the provision of health care to a protected individual, or payment for the provision of health care to a protected individual; and

(C) that—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(4) PROTECTED INDIVIDUAL.—The term "protected individual" means an individual who, with respect to a date—

(A) is living on the date; or

(B) has died within the 2-year period ending on the date.

(5) USE.—The term "use", when used with respect to protected health information that is held by a health information trustee, means—

(A) to use, or provide access to, the information in any manner that does not constitute a disclosure; or

(B) any act or instance of using, or providing access, described in subparagraph (A).

(b) DEFINITIONS RELATING TO HEALTH INFORMATION TRUSTEES.—For purposes of this part:

(1) CARRIER.—The term "carrier" means a licensed insurance company, a hospital or medical service corporation (including an existing Blue Cross or Blue Shield organization, within the meaning of section 833(c)(2) of the Internal Revenue Code of 1986), a health maintenance organization, or other entity licensed or certified by a State to provide health insurance or health benefits.

(2) HEALTH BENEFIT PLAN.—The term "health benefit plan" means—

(A) any contract of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract, that is provided by a carrier; and

(B) an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits and is funded in a manner other than through the purchase of one or more policies or contracts described in subparagraph (A).

(3) HEALTH BENEFIT PLAN SPONSOR.—The term "health benefit plan sponsor" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a carrier providing a health benefit plan;

(B) any other provider of a health benefit plan, including any public entity that provides payments for health care items and services under a health benefit plan that are equivalent to payments provided by a private person under such a plan; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(4) HEALTH CARE PROVIDER.—The term "health care provider" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who is licensed, certified, registered, or otherwise authorized by law to provide an item or service that constitutes health care in the ordinary course of business or practice of a profession;

(B) a Federal or State program that directly provides items or services that constitute health care to beneficiaries; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(5) HEALTH INFORMATION SERVICE ORGANIZATION.—The term "health information service organization" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person, other than an affiliated person, who performs specific functions for which the Secretary has authorized (by means of a designation or certification) the person to receive access to health care data in electronic or magnetic form that are regulated by this Act; or

(B) an officer or employee of a person described in subparagraph (A).

(6) HEALTH INFORMATION TRUSTEE.—The term "health information trustee" means—

(A) a health care provider;

(B) a health information service organization;

(C) a health oversight agency;

(D) a health benefit plan sponsor;

(E) a public health authority;

(F) a health researcher;

(G) a person who, with respect to a specific item of protected health information, is not described in subparagraphs (A) through (F) but receives the information—

(i) pursuant to—

(I) section 2157 (relating to emergency circumstances);

(II) section 2158 (relating to judicial and administrative purposes);

(III) section 2159 (relating to law enforcement); or

(IV) section 2160 (relating to subpoenas, warrants, and search warrants); or

(ii) while acting in whole or in part in the capacity of an officer or employee of a person described in clause (i).

(7) HEALTH OVERSIGHT AGENCY.—The term "health oversight agency" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers;

(B) a person who—

(i) performs or oversees the performance of an audit, assessment, evaluation, determination, or investigation relating to the effectiveness of, compliance with, or applicability of, legal, fiscal, medical, or scientific standards or aspects of performance related to the delivery of, or payment for, health care; and

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a State or Federal statute regulating the assessment, evaluation, determination, or investigation; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(8) HEALTH RESEARCHER.—The term "health researcher" means a person who, with respect to a specific item of protected health information, receives the information—

(A) pursuant to section 2156 (relating to health research); or

(B) while acting in whole or in part in the capacity of an officer or employee of a person described in subparagraph (A).

(9) PUBLIC HEALTH AUTHORITY.—The term "public health authority" means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) an authority of the United States, a State, or a political subdivision of a State that is responsible for public health matters;

(B) a person acting under the direction of such an authority; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(c) OTHER DEFINITIONS.—For purposes of this part:

(1) AFFILIATED PERSON.—The term "affiliated person" means a person who—

(A) is not a health information trustee;

(B) is a contractor, subcontractor, associate, or subsidiary of a person who is a health information trustee; and

(C) pursuant to an agreement or other relationship with such trustee, receives, creates, uses, maintains, or discloses protected health information.

(2) APPROVED HEALTH RESEARCH PROJECT.—The term "approved health research project" means a biomedical, epidemiological, or health services research or statistics project, or a research project on behavioral and social factors affecting health, that has been approved by a certified institutional review board.

(3) CERTIFIED INSTITUTIONAL REVIEW BOARD.—The term "certified institutional review board" means a board—

(A) established by an entity to review research involving protected health information and the rights of protected individuals conducted at or supported by the entity;

(B) established in accordance with regulations of the Secretary under section 2156(e)(1); and

(C) certified by the Secretary under section 2156(e)(2).

(4) HEALTH CARE.—The term "health care"—

(A) means—

(i) any preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service, or procedure—

(I) with respect to the physical or mental condition, or functional status, of an individual; or

(II) affecting the structure or function of the human body or any part of the human body, including banking of blood, sperm, organs, or any other tissue; or

(ii) any sale or dispensing of a drug, device, equipment, or other item to an individual, or for the use of an individual, pursuant to a prescription; but

(B) does not include any item or service that is not furnished for the purpose of maintaining or improving the health of an individual.

(5) LAW ENFORCEMENT INQUIRY.—The term "law enforcement inquiry" means a lawful investigation or official proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

(6) PERSON.—The term "person" includes an authority of the United States, a State, or a political subdivision of a State.

Subpart A—Duties of Health Information Trustees

SEC. 2141. INSPECTION OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Except as provided in subsection (b), a health information trustee described in subsection (g)—

(1) shall permit a protected individual to inspect any protected health information about the individual that the trustee maintains, any accounting with respect to such information required under section 2144, and any copy of an authorization required under

section 2152 that pertains to such information;

(2) shall provide the protected individual with a copy of the information upon request by the individual and subject to any conditions imposed by the trustee under subsection (d);

(3) shall permit a person who has been designated in writing by the protected individual to inspect the information on behalf of the individual or to accompany the individual during the inspection; and

(4) may offer to explain or interpret information that is inspected or copied under this subsection.

(b) EXCEPTIONS.—A health information trustee is not required by this section to permit inspection or copying of protected health information by a protected individual if any of the following conditions apply:

(1) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psychological, or mental health treatment notes about the individual, the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the notes would cause sufficient harm to the protected individual so as to outweigh the desirability of permitting access, and the trustee does not disclose the notes to any person not directly engaged in treating the individual, except with the authorization of the individual or under compulsion of law.

(2) INFORMATION ABOUT OTHERS.—The information relates to an individual, other than the protected individual or a health care provider, and the trustee determines in the exercise of reasonable professional judgment that inspection or copying of the information would cause sufficient harm to one or both of the individuals so as to outweigh the desirability of permitting access.

(3) ENDANGERMENT TO LIFE OR SAFETY.—Inspection or copying of the information could reasonably be expected to endanger the life or physical safety of an individual.

(4) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of an individual (other than a health care provider) who provided information under a promise of confidentiality to a health care provider concerning a protected individual who is a subject of the information.

(5) ADMINISTRATIVE PURPOSES.—The information—

(A) is used by the trustee solely for administrative purposes and not in the provision of health care to a protected individual who is a subject of the information; and

(B) is not disclosed by the trustee to any person.

(6) DUPLICATIVE INFORMATION.—The information duplicates information available for inspection under subsection (a).

(7) INFORMATION COMPILED IN ANTICIPATION OF LITIGATION.—The information is compiled principally—

(A) in anticipation of a civil, criminal, or administrative action or proceeding; or

(B) for use in such an action or proceeding.

(c) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A health information trustee shall permit inspection and copying under subsection (a) of any reasonably segregable portion of a record after deletion of any portion that is exempt under subsection (b).

(d) CONDITIONS.—A health information trustee may—

(1) require a written request for the inspection and copying of protected health information under this section; and

(2) charge a reasonable cost-based fee for—

(A) permitting inspection of information under this section; and

(B) providing a copy of protected health information under this section.

(e) STATEMENT OF REASONS FOR DENIAL.—If a health information trustee denies in whole or in part a request for inspection or copying under this section, the trustee shall provide the protected individual who made the request with a written statement of the reasons for the denial.

(f) DEADLINE.—A health information trustee shall comply with or deny a request for inspection or copying of protected health information under this section within the 30-day period beginning on the date the trustee receives the request.

(g) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health benefit plan sponsor;

(2) a health care provider;

(3) a health information service organization;

(4) a health oversight agency; or

(5) a public health authority.

SEC. 2142. AMENDMENT OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—A health information trustee described in subsection (f) shall, within the 45-day period beginning on the date the trustee receives from a protected individual about whom the trustee maintains protected health information a written request that the trustee correct or amend the information, complete the duties described in one of the following paragraphs:

(1) CORRECTION OR AMENDMENT AND NOTIFICATION.—The trustee shall—

(A) make the correction or amendment requested;

(B) inform the protected individual of the amendment or correction that has been made;

(C) make reasonable efforts to inform any person who is identified by the protected individual, who is not an employee of the trustee, and to whom the uncorrected or unamended portion of the information was previously disclosed of the correction or amendment that has been made; and

(D) at the request of the individual, make reasonable efforts to inform any known source of the uncorrected or unamended portion of the information about the correction or amendment that has been made.

(2) REASONS FOR REFUSAL AND REVIEW PROCEDURES.—The trustee shall inform the protected individual of—

(A) the reasons for the refusal of the trustee to make the correction or amendment;

(B) any procedures for further review of the refusal; and

(C) the individual's right to file with the trustee a concise statement setting forth the requested correction or amendment and the individual's reasons for disagreeing with the refusal of the trustee.

(b) STANDARDS FOR CORRECTION OR AMENDMENT.—A trustee shall correct or amend protected health information in accordance with a request made under subsection (a) if the trustee determines that the information is not accurate, relevant, timely, or complete for the purposes for which the information may be used or disclosed by the trustee.

(c) STATEMENT OF DISAGREEMENT.—After a protected individual has filed a statement of disagreement under subsection (a)(2)(C), the trustee, in any subsequent disclosure of the disputed portion of the information, shall include a copy of the individual's statement and may include a concise statement of the trustee's reasons for not making the requested correction or amendment.

(d) CONSTRUCTION.—This section may not be construed to require a health information trustee to conduct a hearing or proceeding concerning a request for a correction or amendment to protected health information the trustee maintains.

(e) CORRECTION.—For purposes of subsection (a), a correction is deemed to have been made to protected health information when—

(1) information that is not timely, accurate, relevant, or complete is clearly marked as incorrect; or

(2) supplementary correct information is made part of the information and adequately cross-referenced.

(f) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health benefit plan sponsor;

(2) a health care provider;

(3) a health information service organization;

(4) a health oversight agency; or

(5) a public health authority.

SEC. 2143. NOTICE OF INFORMATION PRACTICES.

(a) PREPARATION OF NOTICE.—A health information trustee described in subsection (d) shall prepare a written notice of information practices describing the following:

(1) The rights under this part of a protected individual who is the subject of protected health information, including the right to inspect and copy such information and the right to seek amendments to such information, and the procedures for authorizing disclosures of protected health information and for revoking such authorizations.

(2) The procedures established by the trustee for the exercise of such rights.

(3) The uses and disclosures of protected health information that are authorized under this part.

(b) DISSEMINATION OF NOTICE.—A health information trustee—

(1) shall, upon request, provide any person with a copy of the trustee's notice of information practices (described in subsection (a)); and

(2) shall make reasonable efforts to inform persons in a clear and conspicuous manner of the existence and availability of such notice.

(c) MODEL NOTICES.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate model notices of information practices for use by health information trustees under this section.

(d) APPLICABILITY.—This section applies to a health information trustee who is—

(1) a health benefit plan sponsor;

(2) a health care provider;

(3) a health information service organization; or

(4) a health oversight agency.

SEC. 2144. ACCOUNTING FOR DISCLOSURES.

(a) IN GENERAL.—Except as provided in subsection (b) and section 2154, each health information trustee shall create and maintain, with respect to any protected health information the trustee discloses, a record of—

(1) the date and purpose of the disclosure;

(2) the name of the person to whom the disclosure was made;

(3) the address of the person to whom the disclosure was made or the location to which the disclosure was made; and

(4) where practicable, a description of the information disclosed.

(b) REGULATIONS.—Not later than July 1, 1996, the Secretary shall promulgate regulations that exempt a health information trustee from maintaining a record under subsection (a) with respect to protected health information disclosed by the trustee for purposes of peer review, licensing, certification, accreditation, and similar activities.

SEC. 2145. SECURITY.

(a) In General.—Each health information trustee who receives or creates protected health information that is subject to this part shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(1) to ensure the integrity and confidentiality of the information;

(2) to protect against any reasonably anticipated—

(A) threats or hazards to the security or integrity of the information; and

(B) unauthorized uses or disclosures of the information; and

(3) otherwise ensure compliance with this part by the trustee and the officers and employees of the trustee.

(b) Guidelines.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate guidelines for the implementation of this section. The guidelines shall take into account—

(1) the technical capabilities of record systems used to maintain protected health information;

(2) the costs of security measures;

(3) the need for training persons who have access to protected health information; and

(4) the value of audit trails in computerized record systems.

Subpart B—Use and Disclosure of Protected Health Information

SEC. 2151. GENERAL LIMITATIONS ON USE AND DISCLOSURE.

(a) Use.—Except as otherwise provided under this part, a health information trustee may use protected health information only for a purpose—

(1) that is compatible with and directly related to the purpose for which the information—

(A) was collected; or

(B) was received by the trustee; or

(2) for which the trustee is authorized to disclose the information under this part.

(b) Disclosure.—A health information trustee may disclose protected health information only as authorized under this part.

(c) Scope of Uses and Disclosures.—

(1) In general.—A use or disclosure of protected health information by a health information trustee shall be limited, when practicable, to the minimum amount of information necessary to accomplish the purpose for which the information is used or disclosed.

(2) Guidelines.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall issue guidelines to implement paragraph (1), which shall take into account the technical capabilities of the record systems used to maintain protected health information and the costs of limiting use and disclosure.

(d) Identification of Disclosed Information as Protected Information.—Except with respect to protected health information that is disclosed under section 2154 (relating to next of kin and directory information), a health information trustee may disclose protected health information only if the recipient has been notified that the information is protected health information that is subject to this part.

(e) Agreement to Limit Use or Disclosure.—A health information trustee who receives protected health information from any person pursuant to a written agreement to restrict use or disclosure of the information to a greater extent than otherwise would be required under this part shall comply with the terms of the agreement, except where use or disclosure of the information in violation of the agreement is required by law. A trustee who fails to comply with the preceding sentence shall be subject to section 2191 (relating to civil actions) with respect to such failure.

(f) No General Requirement to Disclose.—Nothing in this part shall be construed to require a health information trustee to disclose protected health information not otherwise required to be disclosed by law.

SEC. 2152. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(a) Written Authorizations.—A health information trustee, other than a health information service organization, may disclose protected health information pursuant to an authorization executed by the protected individual who is the subject of the information, if each of the following requirements is satisfied:

(1) Writing.—The authorization is in writing, signed by the individual, and dated on the date of such signature.

(2) Separate form.—The authorization is not on a form used to authorize or facilitate the provision of, or payment for, health care.

(3) Trustee described.—The trustee is specifically named or generically described in the authorization as authorized to disclose such information.

(4) Recipient described.—The person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed.

(5) Statement of intended uses and disclosures received.—The authorization contains an acknowledgment that the individual has received a statement described in subsection (b) from such person.

(6) Information described.—The information to be disclosed is described in the authorization.

(7) Authorization timely received.—The authorization is received by the trustee during a period described in subsection (c)(1).

(8) Disclosure timely made.—The disclosure occurs during a period described in subsection (c)(2).

(b) Statement of Intended Uses and Disclosures.—

(1) In general.—A person who wishes to receive from a health information trustee protected health information about a protected individual pursuant to an authorization executed by the individual shall supply the individual, in writing and on a form that is distinct from the authorization, with a statement of the uses for which the person intends the information and the disclosures the person intends to make of the information. Such statement shall be supplied before the authorization is executed.

(2) Enforcement.—If the person uses or discloses the information in a manner that is inconsistent with such statement, the person shall be subject to section 2191 (relating to civil actions) with respect to such failure, except where such use or disclosure is required by law.

(3) Model statements.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate model statements of intended uses and disclosures of the type described in paragraph (1).

(c) Time Limitations on Authorizations.—

(1) Receipt by trustee.—For purposes of subsection (a)(7), an authorization is timely received if it is received by the trustee during—

(A) the 1-year period beginning on the date that the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to—

(i) a health benefit plan sponsor;

(ii) a health care provider;

(iii) a health oversight agency;

(iv) a public health authority;

(v) a health researcher; or

(vi) a person who provides counseling or social services to individuals; or

(B) the 30-day period beginning on the date that the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person other than a person described in subparagraph (A).

(2) Disclosure by trustee.—For purposes of subsection (a)(8), a disclosure is timely made if it occurs before—

(A) the date or event (if any) specified in the authorization upon which the authorization expires; and

(B) the expiration of the 6-month period beginning on the date the trustee receives the authorization.

(d) Revocation or Amendment of Authorization.—

(1) In general.—A protected individual in writing may revoke or amend an authorization described in subsection (a), in whole or in part, at any time, except insofar as—

(A) disclosure of protected health information has been authorized to permit validation of expenditures based on health condition by a government authority; or

(B) action has been taken in reliance on the authorization.

(2) Notice of revocation.—A health information trustee who discloses protected health information in reliance on an authorization that has been revoked shall not be subject to any liability or penalty under this part if—

(A) the reliance was in good faith;

(B) the trustee had no notice of the revocation; and

(C) the disclosure was otherwise in accordance with the requirements of this section.

(e) Additional Requirements of Trustee.—A health information trustee may impose requirements for an authorization that are in addition to the requirements in this section.

(f) Copy.—A health information trustee who discloses protected health information pursuant to an authorization under this section shall maintain a copy of the authorization.

(g) Construction.—This section may not be construed—

(1) to require a health information trustee to disclose protected health information; or

(2) to limit the right of a health information trustee to charge a fee for the disclosure or reproduction of protected health information.

(h) Subpoenas, Warrants, and Search Warrants.—If a health information trustee discloses protected health information pursuant to an authorization in order to comply with an administrative subpoena or warrant or a judicial subpoena or search warrant, the authorization—

(1) shall specifically authorize the disclosure for the purpose of permitting the trustee to comply with the subpoena, warrant, or search warrant; and

(2) shall otherwise meet the requirements in this section.

SEC. 2153. TREATMENT, PAYMENT, AND OVERSIGHT.

(a) Disclosures by Plans, Providers, and Oversight Agencies.—A health information trustee described in subsection (d) may disclose protected health information to a health benefit plan sponsor, health care provider, or health oversight agency if the disclosure is—

(1) for the purpose of providing health care and a protected individual who is a subject of the information has not previously objected to the disclosure in writing;

(2) for the purpose of providing for the payment for health care furnished to an individual; or

(3) for use by a health oversight agency for a purpose that is described in subparagraph (A) or (B)(i) of section 2140(b)(7).

(b) DISCLOSURES BY CERTAIN OTHER TRUSTEES.—A health information trustee may disclose protected health information to a health care provider if—

(1) the disclosure is for the purpose described in subsection (a)(1); and

(2) the trustee—

(A) is a public health authority;

(B) received protected health information pursuant to section 2157 (relating to emergency circumstances); or

(C) is an officer or employee of a trustee described in subsection (B).

(c) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and related to receipt of health care or payment for health care.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any of the following:

(1) A health benefit plan sponsor.

(2) A health care provider.

(3) A health oversight agency.

(4) A health information service organization.

SEC. 2154. NEXT OF KIN AND DIRECTORY INFORMATION.

(a) NEXT OF KIN.—A health information trustee who is a health care provider, who received protected health information pursuant to section 2157 (relating to emergency circumstances), or who is an officer or employee of such a recipient may orally disclose protected health information about a protected individual to the next of kin of the individual (as defined under State law), or to a person with whom the individual has a close personal relationship, if—

(1) the trustee has no reason to believe that the individual would consider the information especially sensitive;

(2) the individual has not previously objected to the disclosure;

(3) the disclosure is consistent with good medical or other professional practice; and

(4) the information disclosed is limited to information about health care that is being provided to the individual at or about the time of the disclosure.

(b) DIRECTORY INFORMATION.—

(1) IN GENERAL.—A health information trustee who is a health care provider, who received protected health information pursuant to section 2157 (relating to emergency circumstances), or who is an officer or employee of a such a recipient may disclose to any person the information described in paragraph (2) if—

(A) a protected individual who is a subject of the information has not objected in writing to the disclosure;

(B) the disclosure is otherwise consistent with good medical and other professional practice; and

(C) the information does not reveal specific information about the physical or mental condition or functional status of a protected individual or about the health care provided to a protected individual.

(2) INFORMATION DESCRIBED.—The information referred to in paragraph (1) is the following:

(A) The name of an individual receiving health care from a health care provider on a premises controlled by the provider.

(B) The location of the individual on such premises.

(C) The general health status of the individual, described in terms of critical, poor, fair, stable, satisfactory, or terms denoting similar conditions.

(c) NO ACCOUNTING REQUIRED.—A health information trustee who discloses protected health information under this section is not required to maintain an accounting of the disclosure under section 2144.

(d) RECIPIENTS.—A person to whom protected health information is disclosed under this section shall not, by reason of such disclosure, be subject to any requirement under this part.

SEC. 2155. PUBLIC HEALTH.

(a) IN GENERAL.—A health information trustee who is a health care provider or a public health authority may disclose protected health information to—

(1) a public health authority for use in legally authorized—

(A) disease or injury reporting;

(B) public health surveillance; or

(C) public health investigation or intervention; or

(2) an individual who is authorized by law to receive the information in a public health intervention.

(b) USE IN ACTION AGAINST INDIVIDUAL.—A public health authority who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except where the use or disclosure is authorized by law for protection of the public health.

(c) INDIVIDUAL RECIPIENTS.—An individual to whom protected health information is disclosed under subsection (a)(2) shall not, by reason of such disclosure, be subject to any requirement under this part.

SEC. 2156. HEALTH RESEARCH.

(a) IN GENERAL.—A health information trustee described in subsection (d) may disclose protected health information to a person if—

(1) the person is conducting an approved health research project;

(2) the information is to be used in the project; and

(3) the project has been determined by a certified institutional review board to be—

(A) of sufficient importance so as to outweigh the intrusion into the privacy of the protected individual who is the subject of the information that would result from the disclosure; and

(B) impracticable to conduct without the information.

(b) DISCLOSURES BY HEALTH INFORMATION SERVICE ORGANIZATIONS.—A health information service organization may disclose protected health information under subsection (a) only if the certified institutional review board referred to in subsection (a)(3) has been certified as being qualified to make determinations under such subsection with respect to disclosures by such organizations.

(c) LIMITATIONS ON USE AND DISCLOSURE; OBLIGATIONS OF RECIPIENT.—A health researcher who receives protected health information about a protected individual pursuant to subsection (a)—

(1) may use the information solely for purposes of an approved health research project;

(2) may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual; and

(3) shall remove or destroy, at the earliest opportunity consistent with the purposes of the approved health research project in connection with which the disclosure was made, information that would enable an individual to be identified, unless a certified institutional review board has determined that there is a health or research justification for retention of such identifiers and there is an adequate plan to protect the identifiers from use and disclosure that is inconsistent with this part.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any health information trustee other than a person who, with respect to the specific protected health information to be disclosed under such subsection, received the information—

(1) pursuant to—

(A) section 2158 (relating to judicial and administrative purposes);

(B) paragraph (1), (2), or (3) of section 2159(a) (relating to law enforcement); or

(C) section 2160 (relating to subpoenas, warrants, and search warrants); or

(2) while acting in whole or in part in the capacity of an officer or employee of a person described in paragraph (1).

(e) REQUIREMENTS FOR INSTITUTIONAL REVIEW BOARDS.—

(1) REGULATIONS.—Not later than July 1, 1996, the Secretary, after opportunity for notice and comment, shall promulgate regulations establishing requirements for certified institutional review boards under this part. The regulations shall be based on regulations promulgated under section 491(a) of the Public Health Service Act and shall ensure that certified institutional review boards are qualified to assess and protect the confidentiality of research subjects. The regulations shall include specific requirements for certified institutional review boards that make determinations under subsection (a)(3) with respect to disclosures by health information service organizations.

(2) CERTIFICATION.—The Secretary shall certify that an institutional review board satisfies the requirements of the regulations promulgated under paragraph (1).

SEC. 2157. EMERGENCY CIRCUMSTANCES.

(a) IN GENERAL.—A health information trustee may disclose protected health information if the trustee believes, on reasonable grounds, that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of an individual.

(b) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and related to receipt of health care or payment for health care.

SEC. 2158. JUDICIAL AND ADMINISTRATIVE PURPOSES.

(a) IN GENERAL.—A health information trustee described in subsection (d) may disclose protected health information—

(1) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal

Procedure, or comparable rules of other courts or administrative agencies in connection with litigation or proceedings to which a protected individual who is a subject of the information is a party and in which the individual has placed the individual's physical or mental condition or functional status in issue;

(2) if directed by a court in connection with a court-ordered examination of an individual; or

(3) to assist in the identification of a dead individual.

(b) WRITTEN STATEMENT.—A person seeking protected health information about a protected individual held by health information trustee under—

(1) subsection (a)(1)—

(A) shall notify the protected individual or the attorney of the protected individual of the request for the information;

(B) shall provide the trustee with a signed document attesting—

(i) that the protected individual is a party to the litigation or proceedings for which the information is sought;

(ii) that the individual has placed the individual's physical or mental condition or functional status in issue; and

(iii) the date on which the protected individual or the attorney of the protected individual was notified under subparagraph (A); and

(C) shall not accept any requested protected health information from the trustee until the termination of the 10-day period beginning on the date notice was given under subparagraph (A); or

(2) subsection (a)(3) shall provide the trustee with a written statement that the information is sought to assist in the identification of a dead individual.

(c) USE AND DISCLOSURE.—A person to whom protected health information is disclosed under this section may use and disclose the information only to accomplish the purpose for which the disclosure was made.

(d) APPLICABILITY.—A health information trustee referred to in subsection (a) is any of the following:

(1) A health benefit plan sponsor.

(2) A health care provider.

(3) A health oversight agency.

(4) A person who, with respect to the specific protected health information to be disclosed under such subsection, received the information—

(A) pursuant to—

(i) section 2157 (relating to emergency circumstances); or

(ii) section 2160 (relating to subpoenas, warrants, and search warrants); or

(B) while acting in whole or in part in the capacity of an officer or employee of a person described in subparagraph (A).

SEC. 2159. LAW ENFORCEMENT.

(a) IN GENERAL.—A health information trustee, other than a health information service organization, may disclose protected health information to a law enforcement agency, other than a health oversight agency—

(1) if the information is disclosed for use in an investigation or prosecution of a health information trustee;

(2) in connection with criminal activity committed against the trustee or an affiliated person of the trustee or on premises controlled by the trustee; or

(3) if the information is needed to determine whether a crime has been committed and the nature of any crime that may have been committed (other than a crime that may have been committed by the protected individual who is the subject of the information).

(b) ADDITIONAL AUTHORITY OF CERTAIN TRUSTEES.—A health information trustee who is not a health information service organization, a public health authority, or a health researcher may disclose protected health information to a law enforcement agency (other than a health oversight agency)—

(1) to assist in the identification or location of a victim, fugitive, or witness in a law enforcement inquiry;

(2) pursuant to a law requiring the reporting of specific health care information to law enforcement authorities; or

(3) if the information is specific health information described in paragraph (2) and the trustee is operated by a Federal agency;

(c) CERTIFICATION.—Where a law enforcement agency requests a health information trustee to disclose protected health information under subsection (a) or (b)(1), the agency shall provide the trustee with a written certification that—

(1) is signed by a supervisory official of a rank designated by the head of the agency;

(2) specifies the information requested; and

(3) states that the information is needed for a lawful purpose under this section.

(d) RESTRICTIONS ON DISCLOSURE AND USE.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information—

(1) in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and directly related to the action or investigation for which the information was obtained; and

(2) otherwise unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained and is not prohibited by any other provision of law.

SEC. 2160. SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.

(a) IN GENERAL.—A health information trustee described in subsection (g) may disclose protected health information if the disclosure is pursuant to any of the following:

(1) A subpoena issued under the authority of a grand jury and the trustee is provided a written certification by the grand jury that the grand jury has complied with the applicable access provisions of section 2171.

(2) An administrative subpoena or warrant or a judicial subpoena or search warrant and the trustee is provided a written certification by the person seeking the information that the person has complied with the applicable access provisions of section 2171 or 2173(a).

(3) An administrative subpoena or warrant or a judicial subpoena or search warrant and the disclosure otherwise meets the conditions of one of sections 2153 through 2159.

(b) AUTHORITY OF ALL TRUSTEES.—Any health information trustee may disclose protected health information if the disclosure is pursuant to subsection (a)(3).

(c) RESTRICTIONS ON USE AND DISCLOSURE.—Protected health information about a protected individual that is disclosed by a health information trustee pursuant to—

(1) subsection (a)(2) may not be otherwise used or disclosed by the recipient unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained; and

(2) subsection (a)(3) may not be used or disclosed by the recipient unless the recipient complies with the conditions and restrictions on use and disclosure with which the recipient would have been required to comply if the disclosure by the trustee had been made under the section referred to in subsection (a)(3) the conditions of which were met by the disclosure.

(d) RESTRICTIONS ON GRAND JURIES.—Protected health information that is disclosed by a health information trustee under subsection (a)(1)—

(1) shall be returnable on a date when the grand jury is in session and actually presented to the grand jury;

(2) shall be used only for the purpose of considering whether to issue an indictment or report by that grand jury, or for the purpose of prosecuting a crime for which that indictment or report is issued, or for a purpose authorized by rule 6(e) of the Federal Rules of Criminal Procedure or a comparable State rule;

(3) shall be destroyed or returned to the trustee if not used for one of the purposes specified in paragraph (2); and

(4) shall not be maintained, or a description of the contents of such information shall not be maintained, by any government authority other than in the sealed records of the grand jury, unless such information has been used in the prosecution of a crime for which the grand jury issued an indictment or presentment or for a purpose authorized by rule 6(e) of the Federal Rules of Criminal Procedure or a comparable State rule.

(e) USE IN ACTION AGAINST INDIVIDUAL.—A person who receives protected health information about a protected individual through a disclosure under this section may not use or disclose the information in any administrative, civil, or criminal action or investigation directed against the individual, except an action or investigation arising out of and directly related to the inquiry for which the information was obtained;

(f) CONSTRUCTION.—Nothing in this section shall be construed as authority for a health information trustee to refuse to comply with a valid administrative subpoena or warrant or a valid judicial subpoena or search warrant that meets the requirements of this part.

(g) APPLICABILITY.—A health information trustee referred to in subsection (a) is any trustee other than the following:

(1) A health information service organization.

(2) A public health authority.

(3) A health researcher.

SEC. 2161. HEALTH INFORMATION SERVICE ORGANIZATIONS.

A health information trustee may disclose protected health information to a health information service organization for the purpose of permitting the organization to perform a function for which the Secretary has authorized (by means of a designation or certification) the organization to receive access to health care data in electronic or magnetic form that are regulated by this Act .

Subpart C—Access Procedures and Challenge Rights

SEC. 2171. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS, WARRANTS, AND SEARCH WARRANTS.

(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about a protected individual from a health information trustee under paragraph (1) or (2) of section 2160(a) for use in a law enforcement inquiry unless there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

(b) WARRANTS AND SEARCH WARRANTS.—A government authority that obtains protected health information about a protected individual from a health information trustee under circumstances described in subsection (a) and pursuant to a warrant or search warrant shall, not later than 30 days after the date the warrant was served on the trustee, serve the individual with, or mail to the last known address of the individual, a copy of the warrant.

(c) SUBPOENAS.—Except as provided in subsection (d), a government authority may not obtain protected health information about a protected individual from a health information trustee under circumstances described in subsection (a) and pursuant to a subpoena unless a copy of the subpoena has been served by hand delivery upon the individual, or mailed to the last known address of the individual, on or before the date on which the subpoena was served on the trustee, together with a notice (published by the Secretary under section 2175(1)) of the individual's right to challenge the subpoena in accordance with section 2172, and—

(1) 30 days have passed from the date of service, or 30 days have passed from the date of mailing, and within such time period the individual has not initiated a challenge in accordance with section 2172; or

(2) disclosure is ordered by a court under section 2172.

(d) APPLICATION FOR DELAY.—

(1) IN GENERAL.—A government authority may apply to an appropriate court to delay (for an initial period of not longer than 90 days) serving a copy of a subpoena and a notice otherwise required under subsection (c) with respect to a law enforcement inquiry. The government authority may apply to the court for extensions of the delay.

(2) REASONS FOR DELAY.—An application for a delay, or extension of a delay, under this subsection shall state, with reasonable specificity, the reasons why the delay or extension is being sought.

(3) EX PARTE ORDER.—The court shall enter an ex parte order delaying, or extending the delay of, the notice and an order prohibiting the trustee from revealing the request for, or the disclosure of, the protected health information being sought if the court finds that—

(A) the inquiry being conducted is within the lawful jurisdiction of the government authority seeking the protected health information;

(B) there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry being conducted by the government authority;

(C) the government authority's need for the information outweighs the privacy interest of the protected individual who is the subject of the information; and

(D) there are reasonable grounds to believe that receipt of a notice by the individual will result in—

(i) endangering the life or physical safety of any individual;

(ii) flight from prosecution;

(iii) destruction of or tampering with evidence or the information being sought; or

(iv) intimidation of potential witnesses.

(4) SERVICE OF APPLICATION ON INDIVIDUAL.—Upon the expiration of a period of delay of notice under this subsection, the government authority shall serve upon the individual, with the service of the subpoena and the notice, a copy of any applications filed and approved under this subsection.

SEC. 2172. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS.

(a) MOTION TO QUASH SUBPOENA.—Within 30 days of the date of service, or 30 days of the date of mailing, of a subpoena of a government authority seeking protected health information about a protected individual from a health information trustee under paragraph (1) or (2) of section 2160(a) (except a subpoena to which section 2173 applies), the individual may file (without filing fee) a motion to quash the subpoena—

(1) in the case of a State judicial subpoena, in the court which issued the subpoena;

(2) in the case of a subpoena issued under the authority of a State that is not a State judicial subpoena, in a court of competent jurisdiction;

(3) in the case of a subpoena issued under the authority of a Federal court, in any court of the United States of competent jurisdiction; or

(4) in the case of any other subpoena issued under the authority of the United States, in—

(A) the United States district court for the district in which the individual resides or in which the subpoena was issued; or

(B) another United States district court of competent jurisdiction.

(b) COPY.—A copy of the motion shall be served by the individual upon the government authority by delivery of registered or certified mail.

(c) AFFIDAVITS AND SWORN DOCUMENTS.—The government authority may file with the court such affidavits and other sworn documents as sustain the validity of the subpoena. The individual may file with the court, within 5 days of the date of the authority's filing, affidavits and sworn documents in response to the authority's filing. The court, upon the request of the individual, the government authority, or both, may proceed in camera.

(d) PROCEEDINGS AND DECISION ON MOTION.—The court may conduct such proceedings as it deems appropriate to rule on the motion. All such proceedings shall be completed, and the motion ruled on, within 10 calendar days of the date of the government authority's filing.

(e) EXTENSION OF TIME LIMITS FOR GOOD CAUSE.—The court, for good cause shown, may at any time in its discretion enlarge the time limits established by subsections (c) and (d).

(f) STANDARD FOR DECISION.—A court may deny a motion under subsection (a) if it finds that there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry being conducted by the government authority, unless the court finds that the individual's privacy interest outweighs the government authority's need for the information. The individual shall have the burden of demonstrating that the individual's privacy interest outweighs the need established by the government authority for the information.

(g) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (f) whether an individual's privacy interest outweighs the government authority's need for the information, the court shall consider—

(1) the particular purpose for which the information was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the inquiry being conducted by the government authority, and the importance of the information to that inquiry; and

(5) any other factor deemed relevant by the court.

(h) ATTORNEY'S FEES.—In the case of any motion brought under subsection (a) in which the individual has substantially prevailed, the court, in its discretion, may assess against a government authority a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

(i) NO INTERLOCUTORY APPEAL.—A court ruling denying a motion to quash under this section shall not be deemed a final order and no interlocutory appeal may be taken therefrom by the individual. An appeal of such a ruling may be taken by the individual within such period of time as is provided by law as part of any appeal from a final order in any legal proceeding initiated against the individual arising out of or based upon the protect health information disclosed.

SEC. 2173. ACCESS AND CHALLENGE PROCEDURES FOR OTHER SUBPOENAS.

(a) IN GENERAL.—A person (other than a government authority seeking protected health information under circumstances described in section 2171(a)) may not obtain protected health information about a protected individual from a health information trustee pursuant to a subpoena under section 2160(a)(2) unless—

(1) a copy of the subpoena has been served upon the individual or mailed to the last known address of the individual on or before the date on which the subpoena was served on the trustee, together with a notice (published by the Secretary under section 2175(2)) of the individual's right to challenge the subpoena, in accordance with subsection (b); and

(2) either—

(A) 30 days have passed from the date of service or 30 days have passed from the date of the mailing and within such time period the individual has not initiated a challenge in accordance with subsection (b); or

(B) disclosure is ordered by a court under such subsection.

(b) MOTION TO QUASH.—Within 30 days of the date of service or 30 days of the date of mailing of a subpoena seeking protected health information about a protected individual from a health information trustee under subsection (a), the individual may file (without filing fee) in any court of competent jurisdiction, a motion to quash the subpoena, with a copy served on the person seeking the information. The individual may oppose, or seek to limit, the subpoena on any grounds that would otherwise be available if the individual were in possession of the information.

(c) STANDARD FOR DECISION.—The court shall grant an individual's motion under subsection (b) if the person seeking the information has not sustained the burden of demonstrating that—

(1) there are reasonable grounds to believe that the information will be relevant to a lawsuit or other judicial or administrative proceeding; and

(2) the need of the person for the information outweighs the privacy interest of the individual.

(d) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (c) whether the need of the person for the information outweighs the privacy interest of the individual, the court shall consider—

(1) the particular purpose for which the information was collected by the trustee;

(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

(3) the effect of the disclosure on the individual's future health care;

(4) the importance of the information to the lawsuit or proceeding; and

(5) any other factor deemed relevant by the court.

(e) ATTORNEY'S FEES.—In the case of any motion brought under subsection (b) by an individual against a person in which the individual has substantially prevailed, the court, in its discretion, may assess against the person a reasonable attorney's fee and other litigation costs (including expert fees) reasonably incurred.

SEC. 2174. CONSTRUCTION OF SUBPART; SUSPENSION OF STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Nothing in this subpart shall affect the right of a health information trustee to challenge a request for protected health information. Nothing in this subpart shall entitle a protected individual to assert the rights of a health information trustee.

(b) EFFECT OF MOTION ON STATUTE OF LIMITATIONS.—If an individual who is the subject of protected health information files a motion under this subpart which has the effect of delaying the access of a government authority to such information, the period beginning on the date such motion was filed and ending on the date on which the motion is decided shall be excluded in computing any period of limitations within which the government authority may commence any civil or criminal action in connection with which the access is sought.

SEC. 2175. RESPONSIBILITIES OF SECRETARY.

Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment, shall develop and disseminate brief, clear, and easily understood model notices—

(1) for use under subsection (c) of section 2171, detailing the rights of a protected individual who wishes to challenge, under section 2172, the disclosure of protected health information about the individual under such subsection; and

(2) for use under subsection (a) of section 2173, detailing the rights of a protected individual who wishes to challenge, under subsection (b) of such section, the disclosure of protected health information about the individual under such section.

Subpart D—Miscellaneous Provisions

SEC. 2181. PAYMENT CARD AND ELECTRONIC PAYMENT TRANSACTIONS.

(a) PAYMENT FOR HEALTH CARE THROUGH CARD OR ELECTRONIC MEANS.—If a protected individual pays a health information trustee for health care by presenting a debit, credit, or other payment card or account number, or by any other electronic payment means, the trustee may disclose to a person described in subsection (b) only such protected health information about the individual as is necessary for the processing of the payment transaction or the billing or collection of amounts charged to, debited from, or otherwise paid by, the individual using the card, number, or other electronic payment means.

(b) TRANSACTION PROCESSING.—A person who is a debit, credit, or other payment card issuer, is otherwise directly involved in the processing of payment transactions involving such cards or other electronic payment transactions, or is otherwise directly involved in the billing or collection of amounts paid through such means, may only use or disclose protected health information about a protected individual that has been disclosed in accordance with subsection (a) when necessary for—

(1) the authorization, settlement, billing or collection of amounts charged to, debited from, or otherwise paid by, the individual using a debit, credit, or other payment card or account number, or by other electronic payment means;

(2) the transfer of receivables, accounts, or interest therein;

(3) the audit of the credit, debit, or other payment card account information;

(4) compliance with Federal, State, or local law; or

(5) a properly authorized civil, criminal, or regulatory investigation by Federal, State, or local authorities.

SEC. 2182. ACCESS TO PROTECTED HEALTH INFORMATION OUTSIDE OF THE UNITED STATES.

(a) IN GENERAL.—Notwithstanding the provisions of subpart B, and except as provided in subsection (b), a health information trustee may not permit any person who is not in a State to have access to protected health information about a protected individual unless one or more of the following conditions exist:

(1) SPECIFIC AUTHORIZATION.—The individual has specifically consented to the provision of such access outside of the United States in an authorization that meets the requirements of section 2152.

(2) EQUIVALENT PROTECTION.—The provision of such access is authorized under this part and the Secretary has determined that there are fair information practices for protected health information in the jurisdiction where the access will be provided that provide protections for individuals and protected health information that are equivalent to the protections provided for by this part.

(3) ACCESS REQUIRED BY LAW.—The provision of such access is required under—

(A) a Federal statute; or

(B) a treaty or other international agreement applicable to the United States.

(b) EXCEPTIONS.—Subsection (a) does not apply where the provision of access to protected health information—

(1) is to a foreign public health authority;

(2) is authorized under section 2154 (relating to next of kin and directory information), 2156 (relating to health research), or 2157 (relating to emergency circumstances); or

(3) is necessary for the purpose of providing for payment for health care that has been provided to an individual.

SEC. 2183. STANDARDS FOR ELECTRONIC DOCUMENTS AND COMMUNICATIONS.

(a) STANDARDS.—Not later than July 1, 1996, the Secretary, after notice and opportunity for public comment and in consultation with appropriate private standard-setting organizations and other interested parties, shall establish standards with respect to the creation, transmission, receipt, and maintenance, in electronic and magnetic form, of each type of written document specifically required or authorized under this part. Where a signature is required under any other provision of this part, such standards shall provide for an electronic or magnetic substitute that serves the functional equivalent of a signature.

(b) TREATMENT OF COMPLYING DOCUMENTS AND COMMUNICATIONS.—An electronic or magnetic document or communication that satisfies the standards established under subsection (a) with respect to such document or communication shall be treated as satisfying the requirements of this part that apply to an equivalent written document.

SEC. 2184. DUTIES AND AUTHORITIES OF AFFILIATED PERSONS.

(a) REQUIREMENTS ON TRUSTEES.—

(1) PROVISION OF INFORMATION.—A health information trustee may provide protected health information to a person who, with respect to the trustee, is an affiliated person and may permit the affiliated person to use such information, only for the purpose of conducting, supporting, or facilitating an activity that the trustee is authorized to undertake.

(2) NOTICE TO AFFILIATED PERSON.—A health information trustee shall notify a person who, with respect to the trustee, is an affiliated person of any duties under this part that the affiliated person is required to fulfill and of any authorities under this part that the affiliated person is authorized to exercise.

(b) DUTIES OF AFFILIATED PERSONS.—

(1) IN GENERAL.—An affiliated person shall fulfill any duty under this part that—

(A) the health information trustee with whom the person has an agreement or relationship described in section 2140(c)(1)(C) is required to fulfill; and

(B) the person has undertaken to fulfill pursuant to such agreement or relationship.

(2) CONSTRUCTION OF OTHER SUBPARTS.—With respect to a duty described in paragraph (1) that an affiliated person is required to fulfill, the person shall be considered a health information trustee for purposes of this part. The person shall be subject to subpart E (relating to enforcement) with respect to any such duty that the person fails to fulfill.

(3) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not relieve a health information trustee of any duty or liability under this part.

(b) AUTHORITIES OF AFFILIATED PERSONS.—

(1) IN GENERAL.—An affiliated person may only exercise an authority under this part that the health information trustee with whom the person is affiliated may exercise and that the person has been given by the trustee pursuant to an agreement or relationship described in section 2140(c)(1)(C). With respect to any such authority, the person shall be considered a health information trustee for purposes of this part. The person shall be subject to subpart E (relating to enforcement) with respect to any act that exceeds such authority.

(2) EFFECT ON TRUSTEE.—An agreement or relationship with an affiliated person does not affect the authority of a health information trustee under this part.

SEC. 2185. AGENTS AND ATTORNEYS.

(a) IN GENERAL.—Except as provided in subsections (b) and (c), a person who is authorized by law (on grounds other than an individual's minority), or by an instrument recognized under law, to act as an agent, attorney, proxy, or other legal representative for a protected individual or the estate of a protected individual, or otherwise to exercise the rights of the individual or estate, may, to the extent authorized, exercise and discharge the rights of the individual or estate under this part.

(b) HEALTH CARE POWER OF ATTORNEY.—A person who is authorized by law (on grounds other than an individual's minority), or by an instrument recognized under law, to make decisions about the provision of health care to an individual who is incapacitated may exercise and discharge the rights of the individual under this part to the extent necessary to effectuate the terms or purposes of the grant of authority.

(c) NO COURT DECLARATION.—If a health care provider determines that an individual, who has not been declared to be legally incompetent, suffers from a medical condition that prevents the individual from acting knowingly or effectively on the individual's own behalf, the right of the individual to authorize disclosure under section 2152 may be exercised and discharged in the best interest of the individual by—

(1) a person described in subsection (b) with respect to the individual;

(2) a person described in subsection (a) with respect to the individual, but only if a person described in paragraph (1) cannot be contacted after a reasonable effort;

(3) the next of kin of the individual, but only if a person described in paragraph (1) or (2) cannot be contacted after a reasonable effort; or

(4) the health care provider, but only if a person described in paragraph (1), (2), or (3) cannot be contacted after a reasonable effort.

SEC. 2186. MINORS.

(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

(1) who is 18 years of age or older, all rights of the individual shall be exercised by the individual, except as provided in section 2185; or

(2) who, acting alone, has the legal capacity to apply for and obtain health care and has sought such care, the individual shall exercise all rights of an individual under this part with respect to protected health information relating to such care.

(b) INDIVIDUALS UNDER 18.—Except as provided in subsection (a)(2), in the case of an individual who is—

(1) under 14 years of age, all the individual's rights under this part shall be exercised through the parent or legal guardian of the individual; or

(2) 14, 15, 16, or 17 years of age, the right of inspection (under section 2141), the right of amendment (under section 2142), and the right to authorize disclosure of protected health information (under section 2152) of the individual may be exercised either by the individual or by the parent or legal guardian of the individual.

SEC. 2187. MAINTENANCE OF CERTAIN PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—A State shall establish a process under which the protected health information described in subsection (b) that is maintained by a person described in subsection (c) is delivered to, and maintained by, the State or an individual or entity designated by the State.

(b) INFORMATION DESCRIBED.—The protected health information referred to in subsection (a) is protected health information that—

(1) is recorded in any form or medium;

(2) is created by—

(A) a health care provider; or

(B) a health benefit plan sponsor that provides benefits in the form of items and services to enrollees and not in the form of reimbursement for items and services; and

(3) relates in any way to the past, present, or future physical or mental health or condition or functional status of a protected individual or the provision of health care to a protected individual.

(c) PERSONS DESCRIBED.—A person referred to in subsection (a) is any of the following:

(A) A health care facility previously located in the State that has closed.

(B) A professional practice previously operated by a health care provider in the State that has closed.

(C) A health benefit plan sponsor that—

(i) previously provided benefits in the form of items and services to enrollees in the State; and

(ii) has ceased to do business.

Subpart E—Enforcement

SEC. 2191. CIVIL ACTIONS.

(a) IN GENERAL.—Any individual whose right under this part has been knowingly or negligently violated—

(1) by a health information trustee, or any other person, who is not described in paragraph (2), (3), (4), or (5) may maintain a civil action for actual damages and for equitable relief against the health information trustee or other person;

(2) by an officer or employee of the United States while the officer or employee was acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the United States;

(3) by an officer or employee of any government authority of a State that has waived its sovereign immunity to a claim for damages resulting from a violation of this part while the officer or employee was acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the State government;

(4) by an officer or employee of a government of a State that is not described in paragraph (3) may maintain a civil action for actual damages and for equitable relief against the officer or employee; or

(5) by an officer or employee of a government authority while the officer or employee was not acting within the scope of the office or employment may maintain a civil action for actual damages and for equitable relief against the officer or employee.

(b) KNOWING VIOLATIONS.—Any individual entitled to recover actual damages under this section because of a knowing violation of a provision of this part (other than subsection (c) or (d) of section 2151) shall be entitled to recover the amount of the actual damages demonstrated or $5000, whichever is greater.

(c) ACTUAL DAMAGES.—For purposes of this section, the term "actual damages" includes damages paid to compensate an individual for nonpecuniary losses such as physical and mental injury as well as damages paid to compensate for pecuniary losses.

(d) PUNITIVE DAMAGES; ATTORNEY'S FEES.—In any action brought under this section in which the complainant has prevailed because of a knowing violation of a provision of this part (other than subsection (c) or (d) of section 2151), the court may, in addition to any relief awarded under subsections (a) and (b), award such punitive damages as may be warranted. In such an action, the court, in its discretion, may allow the prevailing party a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

(e) LIMITATION.—A civil action under this section may not be commenced more than 2 years after the date on which the aggrieved individual discovered the violation or the date on which the aggrieved individual had a reasonable opportunity to discover the violation, whichever occurs first.

(f) INSPECTION AND AMENDMENT.—If a health information trustee has established a formal internal procedure that allows an individual who has been denied inspection or amendment of protected health information to appeal the denial, the individual may not maintain a civil action in connection with the denial until the earlier of—

(1) the date the appeal procedure has been exhausted; or

(2) the date that is 4 months after the date on which the appeal procedure was initiated.

(g) NO LIABILITY FOR PERMISSIBLE DISCLOSURES.—A health information trustee who makes a disclosure of protected health information about a protected individual that is permitted by this part and not otherwise prohibited by State or Federal statute shall not be liable to the individual for the disclosure under common law.

(h) NO LIABILITY FOR INSTITUTIONAL REVIEW BOARD DETERMINATIONS.—If the members of a certified institutional review board have in good faith determined that an approved health research project is of sufficient importance so as to outweigh the intrusion into the privacy of an individual pursuant to section 2156(a)(1), the members, the board, and the parent institution of the board shall not be liable to the individual as a result of such determination.

(i) GOOD FAITH RELIANCE ON CERTIFICATION.—A health information trustee who relies in good faith on a certification by a government authority or other person and discloses protected health information about an individual in accordance with this part shall not be liable to the individual for such disclosure.

SEC. 2192. CIVIL MONEY PENALTIES.

(a) VIOLATION.—Any health information trustee who the Secretary determines has demonstrated a pattern or practice of failure to comply with the provisions of this part shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such failure. In determining the amount of any penalty to be assessed under the procedures established under subsection (b), the Secretary shall take into account the previous record of compliance of the person being assessed with the applicable requirements of this part and the gravity of the violation.

(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A of such Act.

SEC. 2193. ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—Not later than July 1, 1996, the Secretary shall, by regulation, develop alternative dispute resolution methods for use by individuals, health information trustees, and other persons in resolving claims under section 2191.

(b) EFFECT ON INITIATION OF CIVIL ACTIONS.—

(1) IN GENERAL.—Subject to paragraph (2), the regulations established under subsection (a) may provide that an individual alleging that a right of the individual under this part has been violated shall pursue at least one alternative dispute resolution method developed under such subsection as a condition precedent to commencing a civil action under section 2191.

(2) LIMITATION.—Such regulations may not require an individual to refrain from commencing a civil action to pursue one or more alternative dispute resolution method for a period that is greater than 6 months.

(3) SUSPENSION OF STATUTE OF LIMITATIONS.—The regulations established by the Secretary under subsection (a) may provide that a period in which an individual described in paragraph (1) pursues (as defined by the Secretary) an alternative dispute resolution method under this section shall be excluded in computing the period of limitations under section 2191(e).

(c) METHODS.—The methods under subsection (a) shall include at least the following:

(1) ARBITRATION.—The use of arbitration.

(2) MEDIATION.—The use of mediation.

(3) EARLY OFFERS OF SETTLEMENT.—The use of a process under which parties make early offers of settlement.

(d) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under subsection (a), the Secretary shall ensure that the methods promote the resolution of claims in a manner that—

(1) is affordable for the parties involved;

(2) provides for timely and fair resolution of claims; and

(3) provides for reasonably convenient access to dispute resolution for individuals.

SEC. 2194. AMENDMENTS TO CRIMINAL LAW.

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 89 the following:

"CHAPTER 90—PROTECTED HEALTH INFORMATION

"Sec.
"1831. Definitions.
"1832. Obtaining protected health information under false pretenses.
"1833. Monetary gain from obtaining protected health information under false pretenses.
"1834. Knowing and unlawful obtaining of protected health information.
"1835. Monetary gain from knowing and unlawful obtaining of protected health information.
"1836. Knowing and unlawful use or disclosure of protected health information.
"1837. Monetary gain from knowing and unlawful sale, transfer, or use of protected health information.

"§ 1831. Definitions

"As used in this chapter—

"(1) the term 'health information trustee' has the meaning given such term in section 2140(b)(6) of the Affordable Health Care Now Act of 1994;

"(2) the term 'protected health information' has the meaning given such term in section 2140(a)(3) of such Act; and

"(3) the term 'protected individual' has the meaning given such term in section 2140(a)(4) of such Act.

"§ 1832. Obtaining protected health information under false pretenses

"Whoever under false pretenses—

"(1) requests or obtains protected health information from a health information trustee; or

"(2) obtains from a protected individual an authorization for the disclosure of protected health information about the individual maintained by a health information trustee;

shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1833. Monetary gain from obtaining protected health information under false pretenses

"Whoever under false pretenses—

"(1) requests or obtains protected health information from a health information trustee with the intent to sell, transfer, or use such information for profit or monetary gain; or

"(2) obtains from a protected individual an authorization for the disclosure of protected health information about the individual maintained by a health information trustee with the intent to sell, transfer, or use such authorization for profit or monetary gain;

and knowingly sells, transfers, or uses such information or authorization for profit or monetary gain shall be fined under this title or imprisoned not more than 10 years, or both.

"§ 1834. Knowing and unlawful obtaining of protected health information

"Whoever knowingly obtains protected health information from a health information trustee in violation of part 2 of subtitle B of title II of the Affordable Health Care Now Act of 1994, knowing that such obtaining is unlawful, shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1835. Monetary gain from knowing and unlawful obtaining of protected health information

"Whoever knowingly—

"(1) obtains protected health information from a health information trustee in violation of part 2 of subtitle B of title II of the Affordable Health Care Now Act of 1994, knowing that such obtaining is unlawful and with the intent to sell, transfer, or use such information for profit or monetary gain; and

"(2) knowingly sells, transfers, or uses such information for profit or monetary gain;

shall be fined under this title or imprisoned not more than 10 years, or both.

"§ 1836. Knowing and unlawful use or disclosure of protected health information

"Whoever knowingly uses or discloses protected health information in violation of part 2 of subtitle B of title II of the Affordable Health Care Now Act of 1994, knowing that such use or disclosure is unlawful, shall be fined under this title or imprisoned not more than 5 years, or both.

"§ 1837. Monetary gain from knowing and unlawful sale, transfer, or use of protected health information

"Whoever knowingly sells, transfers, or uses protected health information in violation of part 2 of subtitle B of title II of the Affordable Health Care Now Act of 1994, knowing that such sale, transfer, or use is unlawful, shall be fined under this title or imprisoned not more than 10 years, or both.".

(b) CLERICAL AMENDMENT.—The table of chapters for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 89 the following:

"90. Protected health information ...... 1831".

Subpart F—Amendments to Title 5, United States Code

SEC. 2195. AMENDMENTS TO TITLE 5, UNITED STATES CODE.

(a) NEW SUBSECTION.—Section 552a of title 5, United States Code, is amended by adding at the end the following:

"(w) MEDICAL EXEMPTIONS.—The head of an agency that is a health information trustee (as defined in section 2140(b)(6) of the Affordable Health Care Now Act of 1994) shall promulgate rules, in accordance with the requirements (including general notice) of subsections (b)(1), (b)(2), (b)(3), (c), and (e) of section 553 of this title, to exempt a system of records within the agency, to the extent that the system of records contains protected health information (as defined in section 2140(a)(3) of such Act), from all provisions of this section except subsections (e)(1), (e)(2), subparagraphs (A) through (C) and (E) through (I) of subsection (e)(4), and subsections (e)(5), (e)(6), (e)(9), (e)(12), (l), (n), (o), (p), (q), (r), and (u).".

(b) REPEAL.—Section 552a(f)(3) of title 5, United States Code, is amended by striking "pertaining to him," and all that follows through the semicolon and inserting "pertaining to the individual;".

Subpart G—Regulations, Research, and Education; Effective Dates; Applicability; and Relationship to Other Laws

SEC. 2196. REGULATIONS; RESEARCH AND EDUCATION.

(a) REGULATIONS.—Not later than July 1, 1996, the Secretary shall prescribe regulations to carry out this part.

(b) RESEARCH AND TECHNICAL SUPPORT.—The Secretary may sponsor—

(1) research relating to the privacy and security of protected health information;

(2) the development of consent forms governing disclosure of such information; and

(3) the development of technology to implement standards regarding such information.

(c) EDUCATION.—The Secretary shall establish education and awareness programs—

(1) to foster adequate security practices by health information trustees;

(2) to train personnel of health information trustees respecting the duties of such personnel with respect to protected health information; and

(3) to inform individuals and employers who purchase health care respecting their rights with respect to such information.

SEC. 2197. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsection (b), this part, and the amendments made by this part, shall take effect on January 1, 1997.

(b) PROVISIONS EFFECTIVE IMMEDIATELY.—A provision of this part shall take effect on the date of the enactment of this Act if the provision—

(1) imposes a duty on the Secretary to develop, establish, or promulgate regulations, guidelines, notices, statements, or education and awareness programs; or

(2) authorizes the Secretary to sponsor research or the development of forms or technology.

SEC. 2198. APPLICABILITY.

(a) PROTECTED HEALTH INFORMATION.—Except as provided in subsections (b) and (c), the provisions of this part shall apply to any protected health information that is received, created, used, maintained, or disclosed by a health information trustee in a State on or after January 1, 1997, regardless of whether the information existed or was disclosed prior to such date.

(b) EXCEPTION.—

(1) IN GENERAL.—The provisions of this part shall not apply to a trustee described in paragraph (2), except with respect to protected health information that is received by the trustee on or after January 1, 1997.

(2) APPLICABILITY.—A trustee referred to in paragraph (1) is—

(A) a health researcher; or

(B) a person who, with respect to specific protected health information, received the information—

(i) pursuant to—

(I) section 2157 (relating to emergency circumstances);

(II) section 2158 (relating to judicial and administrative purposes);

(III) section 2159 (relating to law enforcement); or

(IV) section 2160 (relating to subpoenas, warrants, and search warrants); or

(ii) while acting in whole or in part in the capacity of an officer or employee of a person described in clause (i).

(c) AUTHORIZATIONS FOR DISCLOSURES.—An authorization for the disclosure of protected health information about a protected individual that is executed by the individual before January 1, 1997, and is recognized and valid under State law on December 31, 1996, shall remain valid and shall not be subject to the requirements of section 2152 until January 1, 1998, or the occurrence of the date or event (if any) specified in the authorization upon which the authorization expires, whichever occurs earlier.

SEC. 2199. RELATIONSHIP TO OTHER LAWS.

(a) STATE LAW.—Except as otherwise provided in subsections (b), (c), (d), and (f), a State may not establish, continue in effect, or enforce any State law to the extent that the law is inconsistent with, or imposes additional requirements with respect to, any of the following:

(1) A duty of a health information trustee under this part.

(2) An authority of a health information trustee under this part to disclose protected health information.

(3) A provision of subpart C (relating to access procedures and challenge rights), subpart D (miscellaneous provisions), or subpart (E) (relating to enforcement).

(b) LAWS RELATING TO PUBLIC HEALTH AND MENTAL HEALTH.—This part does not preempt, supersede, or modify the operation of any State law regarding public health or mental health to the extent that the law prohibits or regulates a disclosure of protected health information that is permitted under this part.

(c) CRIMINAL PENALTIES.—A State may establish and enforce criminal penalties with respect to a failure to comply with a provision of this part.

(d) PRIVILEGES.—A privilege that a person has under law in a court of a State or the United States or under the rules of any agency of a State or the United States may not be diminished, waived, or otherwise affected by—

(1) the execution by a protected individual of an authorization for disclosure of protected health information under this part, if the authorization is executed for the purpose of receiving health care or providing for the payment for health care; or

(2) any provision of this part that authorizes the disclosure of protected health information for the purpose of receiving health care or providing for the payment for health care.

(e) DEPARTMENT OF VETERANS AFFAIRS.—The limitations on use and disclosure of protected health information under this part shall not be construed to prevent any exchange of such information within and among components of the Department of Veterans Affairs that determine eligibility for or entitlement to, or that provide, benefits under laws administered by the Secretary of Veterans Affairs.

(f) CERTAIN DUTIES UNDER STATE OR FEDERAL LAW.—This part shall not be construed to preempt, supersede, or modify the operation of any of the following:

(1) Any law that provides for the reporting of vital statistics such as birth or death information.

(2) Any law requiring the reporting of abuse or neglect information about any individual.

(3) Subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications of emergency response employees of possible exposure to infectious diseases).

(4) The Americans with Disabilities Act of 1990.

(5) Any Federal or State statute that establishes a privilege for records used in health professional peer review activities.

(g) SECRETARIAL AUTHORITY.—

(1) SECRETARY OF HEALTH AND HUMAN SERVICES.—A provision of this part does not preempt, supersede, or modify the operation of section 543 of the Public Health Service Act, except to the extent that the Secretary of Health and Human Services determines through regulations promulgated by such Secretary that the provision provides greater protection for protected health information, and the rights of protected individuals, than is provided under such section 543.

(2) SECRETARY OF VETERANS AFFAIRS.—A provision of this part does not preempt, supersede, or modify the operation of section 7332 of title 38, United States Code, except to the extent that the Secretary of Veterans Affairs determines through regulations promulgated by such Secretary that the provision provides greater protection for protected health information, and the rights of protected individuals, than is provided under such section 7332.

Subtitle C—Deduction for Cost of Catastrophic Health Plan; Medical Savings Accounts

SEC. 2201. INDIVIDUALS ALLOWED DEDUCTION FROM GROSS INCOME FOR COST OF CATASTROPHIC HEALTH PLAN.

(a) IN GENERAL.—Subsection (a) of section 62 of the Internal Revenue Code of 1986, as amended by title I, is amended by inserting after paragraph (16) the following new paragraph:

"(17) MEDICAL EXPENSES ATTRIBUTABLE TO CATASTROPHIC HEALTH PLAN COVERAGE.—

"(A) IN GENERAL.—The deduction allowed by section 213 to the extent attributable to coverage under a catastrophic health plan (as defined in section 220(c)(2)).

"(B) EXCEPTION.—Subparagraph (A) shall not apply to coverage of an individual who has coverage described in section 220(c)(1)(B)(i).".

(b) COORDINATION WITH DEDUCTION FOR OTHER MEDICAL EXPENSES.—Subsection (a) of section 213 of such Code is amended to read as follows:

"(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the expenses paid during the taxable year, not compensated by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent (as defined in section 152) in an amount equal to the sum of—

"(1) the portion of such expenses attributable to coverage under a catastrophic health plan (as defined in section 220(c)(2)), and

"(2) the excess of such expenses (other than expenses described in paragraph (1)) over 7.5 percent of the adjusted gross income of the taxpayer."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

SEC. 2202. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. MEDICAL SAVINGS ACCOUNTS.

"(a) DEDUCTION ALLOWED.—

"(1) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a deduction the applicable percentage of the amounts paid in cash during the taxable year by or on behalf of such individual to a medical savings account for the benefit of such individual and (if any) such individual's spouse and dependents if such spouse and dependents are eligible individuals.

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means—

"(A) 25 percent for taxable years beginning in 1994 or 1995,

"(B) 50 percent for taxable years beginning in 1996 or 1997, and

"(C) 100 percent for taxable years beginning after 1997.

"(b) LIMITATIONS.—

"(1) ONLY 1 ACCOUNT PER FAMILY.—Except as provided in regulations prescribed by this Secretary, no deduction shall be allowed under subsection (a) for amounts paid to any medical savings account for the benefit of an individual, such individual's spouse, or any dependent of such individual or spouse if such individual, spouse, or dependent is a beneficiary of any other medical savings account.

"(2) DOLLAR LIMITATION.—The amount allowable as a deduction under subsection (a) for the taxable year shall not exceed whichever of the following is the least:

"(A) The lowest deductible under any catastrophic health plan providing coverage to any beneficiary of the medical savings account.

"(B) $2,500 ($5,000 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual).

"(C) The excess of—

"(i) the applicable target actuarial value for standard coverage established under section 1102(c)(2) of the Affordable Health Care Now Act of 1994, over

"(ii) the deduction allowed by section 213 for the taxable year to the extent attributable to coverage under a catastrophic health plan.

Under rules of the Secretary, the target actuarial value under subparagraph (C)(i) shall be made applicable to individual and family coverage. A beneficiary of such account who has attained age 65 before the close of the taxable year shall not be taken into account in determining the limitation under the preceding sentence.

"(c) DEFINITIONS.—For purposes of this section—

"(1) ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—The term 'eligible individual' means any individual who is covered under a catastrophic health plan throughout the calendar year in which or with which the taxable year ends.

"(B) LIMITATIONS.—Such term does not include—

"(i) an individual who is 65 years of age or older, unless the individual is covered under a catastrophic health plan that is a primary plan (within the meaning of section 1862(b)(2)(A) of the Social Security Act); and

"(ii) an individual who has coverage under a group health plan or health insurance plan (other than a plan described in 1131(4)(B) of the Affordable Health Care Now Act of 1994) that has either a deductible that is less than the minimum deductible required under a catastrophic health plan (as defined in paragraph (2)) or has an actuarial value that is greater than the value for MedAccess catastrophic coverage (as provided in section 1102(d) of such Act).

"(C) DEDUCTION NOT ALLOWED BEFORE 1999 TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—In the case of any taxable year beginning before January 1, 1999, such term does not include an individual—

"(i) who is eligible to participate in any subsidized health plan maintained by an employer of such individual or the spouse of such individual, or

"(ii) who is (or whose spouse is) a member of a subsidized class of employees of an employer.

The rules of subparagraphs (B) and (C) of section 213(f)(3) shall apply for purposes of this preceding sentence.

"(2) CATASTROPHIC HEALTH PLAN.—For purposes of paragraph (1)—

"(A) IN GENERAL.—The term 'catastrophic health plan' means a health plan covering specified expenses incurred by an individual for medical care for such individual and the spouse and dependents (as defined in section 152) of such individual only to the extent such expenses covered by the plan for any calendar year exceed $1,800 ($3,600 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual) or such higher amounts as may be specified by the plan.

"(B) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year after 1994, each dollar amount in subparagraph (A) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(d) MEDICAL SAVINGS ACCOUNTS.—For purposes of this section—

"(1) MEDICAL SAVINGS ACCOUNT.—

"(A) IN GENERAL.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the medical expenses of the beneficiaries of such trust, but only if the written governing instrument creating the trust meets the following requirements:

"(i) Except in the case of a rollover contribution described in subsection (e)(4), no contribution will be accepted unless it is in cash, and contributions will not be accepted in excess of the amount allowed as a deduction under this section for the taxable year (or would be allowed as such a deduction but for subsection (c)(1)(C)).

"(ii) The trustee is a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

"(iii) No part of the trust assets will be invested in life insurance contracts.

"(iv) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(v) The interest of an individual in the balance in his account is nonforfeitable.

"(vi) Under regulations prescribed by the Secretary, rules similar to the rules of section 401(a)(9) shall apply to the distribution of the entire interest of beneficiaries of such trust.

"(B) TREATMENT OF COMPARABLE ACCOUNTS HELD BY INSURANCE COMPANIES.—For purposes of this section, an account held by an insurance company in the United States shall be treated as a medical savings account (and such company shall be treated as a bank) if—

"(i) such account is part of a health insurance plan that includes a catastrophic health plan (as defined in subsection (c)(2)),

"(ii) such account is exclusively for the purpose of paying the medical expenses of the beneficiaries of such account who are covered under such catastrophic health plan, and

"(iii) the written instrument governing the account meets the requirements of clauses (i), (v), and (vi) of subparagraph (A).

"(2) MEDICAL EXPENSES.—

"(A) IN GENERAL.—The term 'medical expenses' means, with respect to an individual, amounts paid or incurred by such individual for—

"(i) medical care (as defined in section 213), or

"(ii) long-term care (as defined in paragraph (3)),

for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

"(B) HEALTH PLAN COVERAGE MAY NOT BE PURCHASED FROM ACCOUNT.—

"(i) IN GENERAL.—Such term shall not include any amount paid for coverage under a health plan.

"(ii) EXCEPTION.—Clause (i) shall not apply—

"(I) in the case of coverage of an individual under 65 years of age under a catastrophic health plan or under a long-term care insurance plan, or

"(II) in the case of coverage of an individual 65 years of age or older under a medicare supplemental policy or under a long-term care insurance plan or for payment of premiums under part A or part B of title XVIII of the Social Security Act.

"(3) LONG-TERM CARE.—

"(A) IN GENERAL.—The term 'long-term care' means diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services which are required by, and provided to, a chronically ill individual, which have as their primary purpose the direct provision of needed assistance with 1 or more activities of daily living (or the alleviation of the conditions necessitating such assistance) that the individual is certified under subparagraph (B) as being unable to perform, and which are provided in a setting other than an acute care unit of a hospital pursuant to a continuing plan of care prescribed by a physician or registered professional nurse. Such term does not include food or lodging provided in an institutional or other setting, or basic living services associated with the maintenance of a household or participation in community life, such as case management, transportation or legal services, or the performance of home maintenance or household chores.

"(B) CHRONICALLY ILL INDIVIDUAL.—The term 'chronically ill individual' means an individual who is certified by a physician or registered professional nurse as being unable to perform at least 3 activities of daily living without substantial assistance from another individual. For purposes of this paragraph, the term 'activities of daily living' means bathing, dressing, eating, toileting, transferring, and walking.

"(4) TIME WHEN CONTRIBUTIONS DEEMED MADE.—A contribution shall be deemed to be made on the last day of the preceding taxable year if the contribution is made on account of such taxable year and is made not later than the time prescribed by law for filing the return for such taxable year (not including extensions thereof).

"(e) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) IN GENERAL.—Any amount paid or distributed out of a medical savings account shall be included in the gross income of the individual for whose benefit such account was established unless such amount is used exclusively to pay the medical expenses of such individual.

"(2) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid during a taxable year to a medical savings account to the extent that such contribution exceeds the amount allowable as a deduction under subsection (a) if—

"(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

"(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (B) shall be included in the gross income of the individual for the taxable year in which it is received.

"(3) PENALTY FOR DISTRIBUTIONS NOT USED FOR MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a medical savings account which is not used to pay the medical expenses of the individual for whose benefit the account was established shall be increased by 10 percent of the amount of such payment or distribution which is includible in gross income under paragraph (1).

"(B) ACCOUNT BALANCE LIMITATION.—If—

"(i) the tax imposed by this chapter is required to be increased under subparagraph (A) by reason of a distribution, and

"(ii) after such distribution, the aggregate balance of all medical savings accounts established for the benefit of the individual, is less than the amount of the deductible under the catastrophic health plan covering such individual

subparagraph (A) shall be applied by substituting '50 percent' for '10 percent'.

"(4) ROLLOVERS.—Paragraph (1) shall not apply to any amount paid or distributed out of a medical savings account to the individual for whose benefit the account is maintained if the entire amount received (including money and any other property) is paid into another medical savings account for the benefit of such individual not later than the 60th day after the day on which he received the payment or distribution.

"(5) PENALTY FOR MANDATORY DISTRIBUTIONS NOT MADE FROM ACCOUNT.—

"(A) IN GENERAL.—If during any taxable year—

"(i) there is a payment of a mandatory distribution expense incurred by a beneficiary of a medical savings account, and

"(ii) the person making such payment is not reimbursed for such payment with a distribution from such account before the 60th day after such payment

the taxpayer's tax imposed by this chapter for such taxable year shall be increased by 100 percent of the excess of the amount of such payment over the amount of reimbursement made before such 60th day.

"(B) MANDATORY DISTRIBUTION EXPENSE.—For purposes of subparagraph (A), the term 'mandatory distribution expense' means—

"(i) any expense incurred which may be counted towards a deductible, or for a copayment or coinsurance, under the catastrophic health plan covering such beneficiary, and

"(ii) in the case of a beneficiary who has attained age 65, any expense for coverage described in subsection (d)(2)(B)(ii)(II) and any expense incurred which may be counted toward a deductible, or for a copayment or coinsurance, under title XVIII of the Social Security Act.

"(f) TAX TREATMENT OF ACCOUNTS.—

"(1) EXEMPTION FROM TAX.—Any medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

"(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

"(A) IN GENERAL.—If, during any taxable year of the individual for whose benefit the medical savings account was established, such individual engages in any transaction prohibited by section 4975 with respect to the account, the account ceases to be a medical savings account as of the first day of that taxable year.

"(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, paragraph (1) of subsection (e) shall be applied as if there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day) and no portion of such distribution were used to pay medical expenses.

"(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the individual for whose benefit a medical savings account was established uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed to that individual and not used to pay medical expenses.

"(g) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

"(1) the assets of such account are held by a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

"(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (d).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

"(h) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations."

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (17) the following new paragraph:

"(18) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220."

(c) DISTRIBUTIONS FROM MEDICAL SAVINGS ACCOUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUCTION.—Section 213 of such Code is amended by adding at the end thereof the following new subsection:

"(g) COORDINATION WITH MEDICAL SAVINGS ACCOUNTS.—The amount otherwise taken into account under subsection (a) as expenses paid for medical care shall be reduced by the amount (if any) of the distributions from any medical savings account of the taxpayer during the taxable year which is not includible in gross income by reason of being used for medical care."

(d) EXCLUSION OF EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS FROM EMPLOYMENT TAXES.—

(1) SOCIAL SECURITY TAXES.—

(A) Subsection (a) of section 3121 of such Code is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting "; or", and by inserting after paragraph (21) the following new paragraph:

"(22) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220."

(B) Subsection (a) of section 209 of the Social Security Act is amended by striking "or" at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting "; or", and by inserting after paragraph (18) the following new paragraph:

"(19) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220 of the Internal Revenue Code of 1986."

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end thereof the following new paragraph:

"(10) EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—The term 'compensation' shall not include any payment made to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220."

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking "or" at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting "; or", and by inserting after paragraph (16) the following new paragraph:

"(17) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220."

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking "or" at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting "; or", and by inserting after paragraph (20) the following new paragraph:

"(21) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220."

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting "medical savings accounts," after "accounts," in the heading of such section,

(2) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

"(2) a medical savings account (within the meaning of section 220(d)),",

(3) by striking "or" at the end of paragraph (1) of subsection (a), and

(4) by adding at the end thereof the following new subsection:

"(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings account (within the meaning of section 220(d)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount excludable from gross income under section 220 for such taxable year. For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(e)(2) applies shall be treated as an amount not contributed."

(f) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (relating to prohibited transactions) is amended—

(1) by adding at the end of subsection (c) the following new paragraph:

"(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2)(A) to such account.", and

(2) by inserting "or a medical savings account described in section 220(d)" in subsection (e)(1) after "described in section 408(a)".

(g) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement account or annuities) is amended—

(1) by inserting "or on medical savings accounts" after "annuities" in the heading of such section, and

(2) by adding at the end of subsection (a) the following: "The person required by section 220(h) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause."

(h) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

"Sec. 220. Medical savings accounts.

"Sec. 221. Cross reference."

(2) The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4973 and inserting the following:

"Sec. 4973. Tax on excess contributions to individual retirement accounts, medical savings accounts, certain 403(b) contracts, and certain individual retirement annuities."

(3) The table of sections for subchapter B of chapter 68 of such Code is amended by inserting "or on medical savings accounts" after "annuities" in the item relating to section 6693.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

Subtitle D—Anti-Fraud

PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

SEC. 2301. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1996, the Attorney General shall establish a program—

(1) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

(2) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(3) in consultation with the Inspector General of the Department of Health and Human Services, to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH THIRD PARTY INSURERS.—In carrying out the program established under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data with representatives of private sponsors of health benefit plans and other providers of health insurance.

(d) REGULATIONS.—

(1) IN GENERAL.—The Attorney General shall by regulation establish standards to carry out the program under subsection (a).

(2) INFORMATION STANDARDS.—

(A) IN GENERAL.—Such standards shall include standards relating to the furnishing of information by health insurers (including self-insured health benefit plans), providers, and others to enable the Attorney General to carry out the program (including coordination with law enforcement agencies under subsection (b) and third party insurers under subsection (c)).

(B) CONFIDENTIALITY.—Such standards shall include procedures to assure that such information is provided and utilized in a manner that protects the confidentiality of the information and the privacy of individuals receiving health care services.

(C) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information to the Attorney General under the program under this section, with respect to the Attorney General's performance of duties under the program, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act, with respect to the performance of such a contract.

SEC. 2302. AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.

In addition to any other amounts authorized to be appropriated to the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such sums as may be necessary to enable the Attorney General to conduct investigations of allegations of health care fraud and otherwise carry out the program established under section 2301 in a fiscal year.

SEC. 2303. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE TRUST FUND.

(a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Anti-Fraud and Abuse Trust Fund" (in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this part and section 1128A(f)(3) of the Social Security Act.

(b) MANAGEMENT.—

(1) IN GENERAL.—The Trust Fund shall be managed by the Attorney General through a Managing Trustee designated by the Attorney General.

(2) INVESTMENT OF FUNDS.—It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in the trustee's judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month, except that where such average is not a multiple of ⅛ of 1 percent, the rate of interest on such obligations shall be the multiple of ⅛ of 1 percent nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where the Trustee determines that the purchase of such other obligations is in the public interest.

(3) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(4) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(5) The receipts and disbursements of the Attorney General in the discharge of the functions of the Attorney General shall not be included in the totals of the budget of the United States Government. For purposes of part C of the Balanced Budget and Emergency Deficit Control Act of 1985, the Attorney General and the Trust Fund shall be treated in the same manner as the Federal Retirement Thrift Investment Board and the Thrift Savings Fund, respectively. The United States is not liable for any obligation or liability incurred by the Trust Fund.

(c) USE OF FUNDS.—Of the amounts in the Trust Fund—

(1) not less than 60 percent shall be used to support educational activities to prevent the occurrence of violations of anti-fraud and abuse laws, including the issuance of advisory opinions under section 1129 and 1877(i) of the Social Security Act (as added by part 4) and fraud alerts, seminars for providers, and program updates; and

(2) any amounts remaining after use for activities under paragraph (1) shall be used to assist the Attorney General in carrying out the all-payor fraud and abuse control program established under section 2301(a) in the fiscal year involved.

(d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES INTO TRUST FUND.—Section 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a–7a(f)(3)) is amended by striking "as miscellaneous receipts of the Treasury of the United States" and inserting "in the Anti-Fraud and Abuse Trust Fund established under section 2303(a) of the Affordable Health Care Now Act of 1994".

(e) USE OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-SHARING.—Section 1128A(f) of the Social Security Act (42 U.S.C. 1320a–7a(f)) is amended in the matter preceding paragraph (1) by striking "Secretary and disposed of as follows:" and inserting the following: "Secretary. If the person against whom such a penalty or assessment was assessed collected a payment from an individual for providing to the individual the service that is the subject of the penalty or assessment, the Secretary shall pay a portion of the amount recovered to the individual in the nature of restitution in an amount equal to the payment so collected. The Secretary shall dispose of any remaining amounts recovered under this section as follows:".

PART 2—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 2311. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO FRAUD.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

"(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service on or after the date of the enactment of this paragraph, or with respect to any act or omission on or after such date in a program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) of such Act (42 U.S.C. 1320a-7(b)(3)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

SEC. 2312. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) of the Social Security Act (42 U.S.C. 1320a-7(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

"(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

"(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.".

SEC. 2313. REVISIONS TO CRIMINAL PENALTIES.

(a) CLARIFICATION OF DISCOUNT EXCEPTION TO ANTI-KICKBACK PROVISIONS.—Section 1128B(b)(3)(A) of the Social Security Act (42 U.S.C. 1320a-7b(b)(3)(A)) is amended—

(1) by inserting "(regardless of its timing or availability)" after "in price"; and

(2) by striking "program;" and inserting "program and is not paid in the form of currency or coin;".

(b) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or service, if—

"(A) the item or service is provided through an organization described in section 1877(b)(3), or

"(B) the item or service is provided through such an organization on behalf of another entity (including but not limited to a self-insured employer or indemnity plan) that assumes financial risk for the provision of the item or service.".

(c) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN PROTECTED FINANCIAL RELATIONSHIPS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)), as amended by subsection (b), is further amended—

(1) by striking "and" at the end of subparagraph (E);

(2) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(G) any amount in a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in section 1877(a)(2), if section 1877(a)(1) does not apply to that amount or financial relationship.".

SEC. 2315. REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

(a) CLARIFICATION OF COVERAGE OF RADIOLOGY OR DIAGNOSTIC SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraph (D).

(b) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—Section 1877(b) of such Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

"(4) SHARED FACILITY SERVICES.—

"(A) IN GENERAL.—In the case of a shared facility service of a shared facility—

"(i) that is furnished—

"(I) personally by the referring physician who is a shared facility physician or personally by an individual directly employed by such a physician,

"(II) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

"(III) to a patient of a shared facility physician; and

"(ii) that is billed by the referring physician.

"(B) SHARED FACILITY RELATED DEFINITIONS.—

"(i) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

"(ii) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

"(iii) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician who has a financial relationship under a shared facility arrangement with the facility.

"(iv) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

"(I) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

"(II) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

"(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.".

(c) REVISION TO RURAL PROVIDER EXCEPTION.—Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2)) is amended by striking "substantially all" and inserting "not less than 75 percent (as determined in accordance with regulations of the Secretary)".

(d) CLARIFICATION OF REFERRALS BY NEPHROLOGISTS.—Section 1877(h)(5)(C) of such Act (42 U.S.C. 1395nn(H)(5)(C)) is amended—

(1) by striking "and a request" and inserting "a request";

(2) by inserting after "radiation therapy," the following: "and a request by a nephrologist for items or services related to renal dialysis,"; and

(3) by striking "or radiation oncologist" and inserting "radiation oncologist, or nephrologist".

(e) REVISION OF REPORTING REQUIREMENTS.—Section 1877(f) of such Act (42 U.S.C. 1395nn(f)) is amended—

(1) by striking "Each entity" and all that follows through paragraph (2) and inserting the following: "The Secretary may require each entity (other than a physician or physician group practice) providing designated health services to provide the Secretary with the following information concerning the entity's ownership, investment, and compensation arrangements:

"(1) the designated health services provided by the entity; and

"(2) the names and unique physician identifier numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)) or with a compensation interest (as described in subsection (a)(2)(B)) in the entity, or whose immediate relatives have such an ownership, investment, or compensation interest in the entity."; and

(2) by striking the fifth sentence.

(f) EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) of such Act (42 U.S.C. 1395nn(b)(3)) is amended—

(1) by striking "or" at the end of subparagraph (C);

(2) by striking the period at the end of subparagraph (D) and inserting a comma; and

(3) by adding at the end the following new subparagraphs:

"(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)); or

"(F) which meets State regulatory requirements applicable to health maintenance organizations and which—

"(i) provides designated health services directly or through contractual arrangements with providers;

"(ii) assumes financial risk for the provision of services or provides services on behalf of another individual or entity (including but not limited to a self-insured employer, indemnity plan, physician, or physician group) that assumes financial risk for the provision of the item or service; and

"(iii) subjects the services to a program of utilization review offered by an organization described in a preceding subparagraph, an organization meeting State regulatory requirements applicable to utilization review, or an organization accredited to perform utilization review considered appropriate by the Secretary.".

(g) PREEMPTION OF STATE LAW.—Section 1877(g) of such Act (42 U.S.C. 1395nn(g)) is amended by adding at the end the following new paragraph:

"(6) PREEMPTION OF STATE LAW.—The provisions of this section shall supersede any State law to the extent State law prohibits a physician from making a referral, or an entity from presenting a bill, for the furnishing of a service which is not subject to the restrictions applicable under paragraph (1).".

(h) REVISION OF EFFECTIVE DATE EXCEPTION PROVISION.—Section 13562(b)(2) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking subparagraphs (A) and (B) and inserting the following:

"(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

"(B) section 1877(b)(4) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply;

"(C) the requirements of section 1877(c)(2) of the Social Security Act (as amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(D) section 1877(e)(3) of the Social Security Act (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of the Social Security Act (as amended by this Act) shall not apply; and

"(F) section 1877(h)(4)(B) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act).".

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to referrals made on or after January 1, 1995, except that the amendments made by subsection (h) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993.

SEC. 2316. MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) STUDY ON COSTS OF PEER REVIEW CONTRACTS FOR MEDICARE HMOS.—The Comptroller General shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of the Social Security Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary of Health and Human Services to assess the quality of services provided by such eligible organizations.

(b) REPORT TO CONGRESS.—Not later than July 1, 1997, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subsection (a).

SEC. 2317. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this part shall take effect January 1, 1996.

PART 3—AMENDMENTS TO CRIMINAL LAW

SEC. 2321. PENALTIES FOR HEALTH CARE FRAUD.

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

"(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

"(1) to defraud any health care plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be guilty of a felony, and fined under this title or imprisoned not more than 5 years, or both.

"(b) In determining the amount or scope of any penalty or assessment, the court shall take into account:

"(1) the nature of the false or fraudulent claims and the circumstances under which they are presented;

"(2) the degree of culpability and history of prior offenses by the convicted health care provider;

"(3) the extent to which restitution is paid; and

"(4) such other matters as justice may require.

"(c) A principal is liable for penalties and assessments under this section for the acts of the principal's agents acting within the scope of the agency.

"(d) For purposes of this section, the term 'health care plan' means a Federally-funded public program or private program for the delivery of or payment for health care items or services.".

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud.".

SEC. 2322. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(c)(1) In special circumstances and in the Attorney General's sole discretion, the Attorney General may make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution under section 1347.

"(2) A person is not eligible for a payment under paragraph (1) if—

"(A) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment.

"(B) the person knowingly participated in the offense;

"(C) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

"(i) in a criminal, civil, or administrative proceeding;

"(ii) in a congressional, administrative or General Accounting Office report, hearing, audit or investigation; or

"(iii) by the news media, unless the person is the original source of the information; or

"(D) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

"(3) For the purposes of paragraph (2)(C)(iii), the term 'original source' means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

"(4) Neither the failure of the Attorney General to authorize a payment under paragraph (1) nor the amount authorized shall be subject to judicial review.".

SEC. 2323. BROADENING APPLICATION OF MAIL FRAUD STATUTE.

Section 1341 of title 18, United States Code, is amended—

(1) by inserting "or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier," after "Postal Service,"; and

(2) by inserting "or such carrier" after "causes to be delivered by mail".

PART 4—ADVISORY OPINIONS

SEC. 2331. AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ISSUE ADVISORY OPINIONS UNDER TITLE XI.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

"ADVISORY OPINIONS

"SEC. 1129. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as provided in this section.

"(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

"(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

"(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

"(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

"(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section 1128B(b).

"(5) Whether an arrangement, activity or proposed arrangement or proposed activity violates any other provision of this Act.

"(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

"(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

"(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

"(d) EFFECT OF ADVISORY OPINIONS.—

"(1) Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

"(2) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

"(e) REGULATIONS.—The Secretary within 180 days of the date of enactment, shall issue regulations establishing a system for the issuance of advisory opinions. Such regulations shall provide for—

"(1) the procedure to be followed by a party applying for an advisory opinion;

"(2) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

"(3) the interval in which the Secretary shall respond;

"(4) the reasonable fee to be charged to the party requesting an advisory opinion; and

"(5) the manner in which advisory opinions will be made available to the public.

"(f) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed 30 days.".

SEC. 2332. AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ISSUE ADVISORY OPINIONS RELATING TO PHYSICIAN OWNERSHIP AND REFERRAL.

Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended by the addition of the following new subsection:

"(i) ADVISORY OPINIONS.—

"(1) IN GENERAL.—The Secretary shall issue advisory opinions on whether an arrangement or proposed arrangement will result in a prohibited referral within the meaning of this section.

"(2) EFFECT OF ADVISORY OPINIONS.—

"(A) Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

"(B) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of this section.

"(3) REGULATIONS.—The Secretary within one hundred and eighty days of the date of enactment, shall issue regulations establishing a system for the issuance of advisory opinions. Such regulations shall provide for—

"(A) the procedure to be followed by a party applying for an advisory opinion;

"(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

"(C) the interval in which the Secretary shall respond;

"(D) the reasonable fee to be charged to the party requesting an advisory opinion; and

"(E) the manner in which advisory opinions will be made available to the public.

"(4) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed thirty days.".

SEC. 2333. EFFECTIVE DATE.

Unless otherwise specified, the amendments made by this part shall be effective upon the enactment of this Act.

Subtitle E—Increased Medicare Beneficiary Choice; Additional Medicare Reforms

PART 1—INCREASED MEDICARE BENEFICIARY CHOICE

SEC. 2401. REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS UNDER MEDICARE.

(a) USE OF METROPOLITAN STATISTICAL AREAS TO DETERMINE ADJUSTED AVERAGE PER CAPITA COST.—Section 1876(a)(4) of such Act (42 U.S.C. 1395mm(a)(4)) is amended by striking "in a geographic area served by an eligible organization or in a similar area" and inserting "in the metropolitan statistical area (as defined by the Office of Management and Budget) in which the individual resides, or in the entire portion of the State in which the individual resides which is not located in a metropolitan statistical area in the case of an individual who does not reside in a metropolitan statistical area".

(b) DETERMINATION OF MODEL ADDITIONAL HEALTH BENEFIT PACKAGES.—Section 1876(g) of such Act (42 U.S.C. 1395mm(g)) is amended by inserting after paragraph (3) the following new paragraph:

"(4) The Secretary shall develop the following model packages of additional health benefits (referred to in paragraph (3)(B)) which an eligible organization may provide (at its option) under paragraph (2):

"(A) Coverage for catastrophic illness (subject to a limit on out-of-pocket expenditures).

"(B) Coverage for prescription drugs.

"(C) Coverage for preventive services.".

(c) REVISION OF MEMBERSHIP LIMITATION.—Section 1876(f) of the Social Security Act (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1), by striking "one-half" and inserting "25 percent"; and

(2) in paragraph (2)(A), by striking "50 percent" and inserting "75 percent".

(d) ENROLLMENT PERIODS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.—

(1) UNIFORM OPEN ENROLLMENT PERIOD.—Section 1876(c)(3)(A)(i) of such Act (42 U.S.C. 1395mm(c)(3)(A)(i)) is amended by striking "must have" and all that follows through "and including" and inserting the following: "shall have open enrollment during an annual uniform open enrollment period established by the Secretary for all eligible organizations, together with".

(2) OPEN ENROLLMENT FOR CERTAIN DISENROLLED INDIVIDUALS.—Section 1876(c)(3)(A)(ii)(I) of such Act (42 U.S.C. 1395mm(c)(3)(A)(ii)(I)) is amended by adding at the end the following: "Each eligible organization with a risk-sharing contract under this section shall have an open enrollment period for individuals residing in the organization's service area who disenroll from another eligible organization with a risk-sharing contract under this section on the grounds that the individual's primary care physician is no longer a member of the organization's provider network or for cause (in accordance with such standards, and as demonstrated through an appeals process that meets such requirements, as the Secretary may establish).

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into on or after the date of the enactment of this Act.

SEC. 2402. EXPANSION AND REVISION OF MEDICARE SELECT POLICIES.

(a) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—

(1) IN GENERAL.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 (hereafter referred to as "OBRA-1990") is hereby repealed.

(2) CONFORMING AMENDMENT.—Section 4358 of OBRA-1990 is amended by redesignating subsection (d) as subsection (c).

(b) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) of the Social Security Act (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

"(1)(A) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

"(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

"(ii) in the case of a policy described in subparagraph (C)(i)—

"(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

"(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

"(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those standards if the policy meets the requirements of subparagraph (B).

"(B) A policy meets the requirements of this subparagraph if—

"(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

"(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network,

"(iii) the network offers sufficient access,

"(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

"(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

"(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

"(bb) out of area coverage under the policy,

"(cc) the policy's coverage of emergency services and urgently needed care, and

"(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

"(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

"(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

"(C)(i) A policy described in this subparagraph—

"(I) is offered by an eligible organization (as defined in section 1876(b)),

"(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

"(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

"(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).".

(c) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) of the Social Security Act (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking "(1) Each" and inserting "(1)(A) Except as provided in subparagraph (B), each";

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new subparagraph:

"(B)(i) Except as provided in clause (ii), in the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy.

"(ii) If an individual described in clause (i) moves to a geographic area where an issuer described in clause (i), or where an affiliate of such issuer, is issuing medicare supplemental policies, such individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

"(iii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.".

(d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of the Social Security Act (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking "(2)" and inserting "(2)(A)";

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as so redesignated—

(A) by striking "paragraph (1)(E)(i)" and inserting "paragraph (1)(B)(v)(I), and

(B) by striking "paragraph (1)(E)(ii)" and inserting "paragraph (1)(B)(v)(II)";

(4) by striking "the previous sentence" and inserting "this subparagraph"; and

(5) by adding at the end the following new subparagraph:

"(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(e) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the "NAIC") makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the "1994 NAIC Model Regulation").

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in paragraph (1), the Secretary of Health and Human Services (in this subsection as the "Secretary") shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the "1994 Federal Regulation").

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1994 NAIC Model Regulation or the 1994 Federal Regulation; or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1994 NAIC Model Regulation or the 1994 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered, the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2403. INCLUDING NOTICE OF AVAILABLE HEALTH MAINTENANCE ORGANIZATIONS IN ANNUAL NOTICE TO BENEFICIARIES.

Section 1804 of the Social Security Act (42 U.S.C. 1395b-2) is amended—

(1) by striking "and" at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting ", and"; and

(3) by inserting after paragraph (3) the following new paragraph:

"(4) with respect to the area in which the individual receiving the notice resides, a description of the eligible organizations under section 1833(a)(1) or section 1876 and the carriers offering a medicare supplemental policy described in section 1882(t)(1) which serve the area in which the individual receiving the notice resides.".

SEC. 2404. LEGISLATIVE PROPOSAL ON ENROLLING MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a proposal for legislation which provides for the enrollment of medicare beneficiaries in private health insurance plans (including medisave coverage described in section 1102(e)).

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term "medicare beneficiary" means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) CONTENTS OF THE PROPOSAL.—A proposal for legislation submitted under subsection (a) shall—

(1) provide for an appropriate methodology by which the Secretary shall make payment to private health insurance plans for the enrollment of medicare beneficiaries;

(2) provide individuals the opportunity to remain enrolled in such a plan without an interruption in coverage upon becoming medicare beneficiaries; and

(3) provide medicare beneficiaries with the opportunity to enroll in a private health insurance plan.

SEC. 2405. OPTIONAL INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN PRIVATE HEALTH PLANS.

(a) INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—Notwithstanding title XVIII of the Social Security Act, the Secretary shall provide for a monthly payment as provided under subsection (b)(1) to a private health insurance plan on behalf of enrolled medicare beneficiaries who choose to enroll in such a plan.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term "medicare beneficiary" means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) PAYMENT SPECIFIED.—

(1) FEDERAL PAYMENT.—

(A) IN GENERAL.—The amount of payment specified in this paragraph for an individual who is enrolled in a private health insurance plan is the lesser of—

(i) the applicable rate specified in section 1876(a)(1)(C) of the Social Security Act (but at 100 percent, rather than 95 percent, of the applicable amount); or

(ii) the monthly premium charged the individual for coverage under the private health insurance plan.

(B) SOURCE OF PAYMENT.—The payment to a private health insurance plan under this paragraph for individuals entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, with the allocation to be determined by the Secretary.

(2) INDIVIDUAL'S SHARE.—If the monthly premium for the private plan in which the individual is enrolled is greater than the amount specified under paragraph (1)(A)(i), the individual shall be responsible for paying to the plan the difference between the monthly premium charged the individual for coverage under the plan and the amount specified in paragraph (1)(A)(i).

(c) PAYMENTS UNDER THIS SECTION AS SOLE MEDICARE BENEFITS.—Payments made under this section shall be instead of the amounts that would otherwise be payable, pursuant to sections 1814(b) and 1833(a) of the Social Security Act, for services furnished to medicare beneficiaries.

(d) INCLUSION IN ANNUAL NOTICE TO BENEFICIARIES.—Section 1804 of the Social Security Act (42 U.S.C. (42 U.S.C. 1395b-2), as amended by section 2403, is amended

(1) by striking "and" at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ", and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) a description of the option provided pursuant to section 2405 of the Affordable Health Care Now Act of 1994 for payment to be made by the Secretary on the individual's behalf for enrollment in a private health insurance plan.".

PART 2—MEDICARE PART B PREMIUM; OTHER MEDICARE PAYMENT CHANGES

SEC. 2411. EXTENSION OF CURRENT RULES FOR COMPUTING MEDICARE PART B PREMIUM.

Section 1839(e) of the Social Security Act (42 U.S.C. 1395r(e)) is amended—

(1) in paragraph (1)(A), by striking "January 1999" and inserting "January 2005"; and

(2) in paragraph (2), by striking "January 1998" and inserting "January 2004".

SEC. 2412. INCREASE IN MEDICARE PART B PREMIUM FOR INDIVIDUALS WITH HIGH INCOME.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new part:

"PART VIII—MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

"Sec. 59B. Medicare part B premium tax.

"SEC. 59B. MEDICARE PART B PREMIUM TAX.

"(a) IMPOSITION OF TAX.—In the case of an individual to whom this section applies for the taxable year, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax for such taxable year equal to the aggregate of the Medicare part B premium taxes for each of the months during such year that such individual is covered by Medicare part B.

"(b) INDIVIDUALS TO WHOM SECTION APPLIES.—This section shall apply to any individual for any taxable year if—

"(1) such individual is covered under Medicare part B for any month during such year, and

"(2) the modified adjusted gross income of the taxpayer for such taxable year exceeds the threshold amount.

"(c) MEDICARE PART B PREMIUM TAX FOR MONTH.—

"(1) IN GENERAL.—The Medicare part B premium tax for any month is ⅔ the amount equal to the excess of—

"(A) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

"(B) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

"(2) PHASEIN OF TAX.—If the modified adjusted gross income of the taxpayer for any taxable years exceeds the threshold amount by less than $50,000, the Medicare part B premium tax for any month during such taxable year shall be an amount which bears the same ratio to the amount determined under paragraph (1) (without regard to this paragraph) as such excess bears to $50,000. The preceding sentence shall not apply to any individual whose threshold amount is zero.

"(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(A) except as otherwise provided in this paragraph, $100,000,

"(B) $125,000 in the case of a joint return, and

"(C) zero in the case of a taxpayer who—

"(i) is married at the close of the taxable year but does not file a joint return for such year, and

"(ii) does not live apart from his spouse at all times during the taxable year.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 135, 911, 931, and 933, and

"(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) MEDICARE PART B COVERAGE.—An individual shall be treated as covered under Medicare part B for any month if a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part for the month.

"(4) MARRIED INDIVIDUAL.—The determination of whether an individual is married shall be made in accordance with section 7703."

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

"Part VIII. Medicare Part B Premiums For High-Income Individuals."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months after December 1994 in taxable years ending after December 31, 1994.

SEC. 2413. IMPROVED EFFICIENCY THROUGH CONSOLIDATION OF ADMINISTRATION OF PARTS A AND B.

(a) IN GENERAL.—The Secretary of Health and Human Services shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act) including over a 5-year period.

(b) COMBINATION OF INTERMEDIARY AND CARRIER FUNCTIONS.—In taking such steps, the Secretary shall contract with a single entity that combines the fiscal intermediary and carrier functions in each area except where the Secretary finds that special regional or national contracts are appropriate.

(c) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this section.

SEC. 2414. EXTENSION OF MEDICARE SECONDARY PAYMENT PROVISIONS.

(a) EXTENSION OF DATA MATCH.—

(1) Section 1862(b)(5)(C)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(5)(C)(iii)) is amended by striking "1998" and inserting "2004".

(2) Section 6103(l)(12)(F) of the Internal Revenue Code of 1986 is amended—

(A) in clause (i), by striking "1998" and inserting "2004",

(B) in clause (ii)(I), by striking "1997" and inserting "2003", and

(C) in clause (ii)(II), by striking "1998" and inserting "2004".

(b) EXTENSION OF MEDICARE SECONDARY PAYER TO DISABLED BENEFICIARIES.—Section 1862(b)(1)(B)(iii) of such Act (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended by striking "1998" and inserting "2004".

(c) EXTENSION OF PERIOD FOR END STAGE RENAL DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended in the second sentence by striking "1998" and inserting "2004".

Subtitle F—Health Care Antitrust Improvements

SEC. 2501. PROTECTION FROM ANTITRUST LAWS FOR CERTAIN COMPETITIVE AND COLLABORATIVE ACTIVITIES.

(a) PROTECTIONS DESCRIBED.—An activity relating to the provision of health care services shall receive the following protection from the antitrust laws:

(1) If the activity is within a safe harbor designated by the Attorney General under section 2502, the safe harbor shall be a defense to all antitrust claims, except for claims for injunctive relief asserted by the Attorney General or the Chair of the Federal Trade Commission in extraordinary circumstances.

(2) If the activity is specified in and in compliance with the terms of a certificate of review issued by the Attorney General under section 2503 and the activity occurs while the certificate is in effect, the certificate shall be a defense to antitrust claims, other than claims for injunctive relief.

(b) AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.—

(1) IN GENERAL.—If any person brings an action alleging a claim under the antitrust laws and the activity on which the claim is based is found by the court to be protected from such laws under subsection (a), the court shall, at the conclusion of the action—

(A) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(B) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(2) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant to paragraph (1) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

SEC. 2502. DESIGNATION OF SAFE HARBORS.

(a) IN GENERAL.—

(1) DESIGNATION BY ATTORNEY GENERAL.—The Attorney General, in consultation with the Secretary of Health and Human Services and the Chair, shall develop and designate pursuant to paragraph (C) safe harbors for purposes of section 2501(a)(1) relating to—

(A) each category of activities referred to in paragraph (2); and

(B) such other categories of activities as the Attorney General may designate in accordance with the process described in this section.

(2) REQUIRED CATEGORIES OF ACTIVITIES SUBJECT TO SAFE HARBORS.—The categories of activities referred to in this paragraph are as follows:

(A) JOINT PURCHASING OF HEALTH CARE SERVICES.—Providing the terms under which consumers of health care services (patients or others acting on their behalf) may jointly negotiate and purchase health care services.

(B) SMALL HOSPITAL MERGERS.—Providing for small hospitals lawfully to merge under the antitrust laws without undue delay or review, taking into account the special needs and circumstances of rural health care markets.

(C) NETWORK FORMATION AND OPERATION.—Permitting activities related to the startup and operation of collaborations between State-licensed providers through partial or full integration, including multi-provider networks, hospital networks, physician-hospital organizations, and other efforts to provide health care services more efficiently.

(D) ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—Permitting standard setting and enforcement activities by medical self-regulatory entities (such as hospital boards and medical societies) to promote health care quality, except that a safe harbor under this paragraph may not provide protection for any activity undertaken for financial gain or for anticompetitive reasons.

(E) PROVISION OF INFORMATION TO BUYERS AND CONSUMERS.—Permitting health care providers collectively to supply non-price medical information to buyers and consumers relating to the type, quality and efficiency of treatment, including joint views on procedures that should be covered by purchasers and medical protocols, except that a safe harbor under this subparagraph may not provide protection for any collective refusals to deal or collective attempts at coercion.

(F) PARTICIPATION IN SURVEYS.—Providing the terms under which health care providers may lawfully participate in written surveys of prices of services, reimbursements received, employee compensation, and other relevant areas.

(G) HIGH-TECHNOLOGY AND TERTIARY CARE JOINT VENTURES.—Permitting activities of health care joint ventures to purchase or use new or existing high technology or costly equipment, or to provide advanced tertiary care services.

(H) MARKET POWER SCREENS.—Providing market power screens at appropriate levels below which combinations of health care providers are too small to pose a realistic antitrust threat. There may be different levels for different activities and markets, taking into account the special needs of rural health care markets.

(I) JOINT PURCHASING ARRANGEMENTS.—Providing the terms under which health care providers may make joint purchases of products and services.

(J) GOOD FAITH NEGOTIATIONS.—Providing the terms under which health care providers may engage in discussions relating to legitimate collaborative activities contemplated by the safe harbors.

(b) PROCESS FOR DESIGNATION OF ADDITIONAL CATEGORIES OF ACTIVITIES.—

(1) SOLICITATION OF PROPOSALS.—Not later than 30 days after the date of the enactment of this Act, the Attorney General shall publish a notice in the Federal Register soliciting proposals for safe harbors.

(2) REVIEW OF PROPOSED SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary and the Chair) shall review the proposed safe harbors submitted under paragraph (1) and include a description of the safe harbors in the report under subsection (d).

(3) ADDITIONAL SAFE HARBORS.—After submitting the report under subsection (d), the Attorney General (in consultation with the Secretary and the Chair) may from time to time add additional safe harbors in accordance with the procedures described in this subsection.

(c) EFFECTIVE DATE OF SAFE HARBORS.—

(1) PUBLICATION.—Not later than 180 days after the date of the enactment of this Act, the Attorney General shall publish in the Federal Register for public comment the safe harbors proposed for designation under this section. Not later than 180 days after publishing such proposed safe harbors in the Federal Register, the Attorney General shall issue final rules establishing such safe harbors.

(2) EFFECTIVE DATE.—The safe harbors established under the final rules issued under paragraph (1) shall take effect 90 days after issuance, unless disapproved by the Congress.

(d) REPORT ON PROPOSED SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary and the Chair) shall submit a report to Congress describing the proposals from subsections (a) and (b)(1) to be included in the publication of safe harbors described in subsection (c)(1) and the proposals from subsection (b)(1) that are not to be so included, together with explanations therefor.

(e) MODIFICATION OR REMOVAL OF SAFE HARBORS.—The Attorney General (in consultation with the Secretary and the Chair) may modify or remove a safe harbor following notice and comment upon a determination that the safe harbor does not meet the criteria of subsection (f).

(f) CRITERIA FOR SAFE HARBORS.—In establishing safe harbors under this section, the Attorney General shall take into account the following:

(1) The extent to which a competitive or collaborative activity will accomplish any of the following:

(A) An increase in access to health care services.

(B) The enhancement of the quality of health care services.

(C) The establishment of cost efficiencies that will be passed on to consumers, including economies of scale and reduced transaction and administrative costs.

(D) An increase in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(E) An improvement in the utilization of health care resources or the reduction in the inefficient duplication of the use of such resources.

(2) Whether the designation of an activity as a safe harbor will result in the following outcomes:

(A) Health plans and other health care insurers, consumers of health care services, and health care providers will be better able to negotiate payment and service arrangements which will reduce costs to consumers.

(B) Taking into consideration the characteristics of the particular purchasers and providers involved, competition will not be unduly restricted.

(C) Equally efficient and less restrictive alternatives do not exist to meet the criteria described in paragraph (1).

(D) The activity will not unreasonably foreclose competition by denying competitors a necessary element of competition.

SEC. 2503. CERTIFICATES OF REVIEW.

(a) ESTABLISHMENT OF PROGRAM.—In consultation with the Secretary, the Attorney General shall (not later than 180 days after the date of the enactment of this Act) issue certificates of review in accordance with this section for providers of health care services and advise and assist any person with respect to applying for such a certificate of review.

(b) PROCEDURES FOR APPLICATION FOR CERTIFICATE.—

(1) SUBMISSION OF APPLICATION.—

(A) FORM; CONTENT.—To apply for a certificate of review, a person shall submit to the Attorney General a written application which—

(i) specifies the activities relating to the provision of health care services which satisfy the criteria described in section 2502(e) and which will be included in the certificate; and

(ii) is in a form and contains any information, including information pertaining to the overall market in which the applicant operates, required by rule or regulation promulgated under section 2506.

(B) FILING FEE.—The Attorney General may require a filing fee to be submitted with the application to cover the cost of publication and the cost of review required by this section. The amount of the filing fee shall be determined on a sliding scale established by the Attorney General (based on the monetary size of the transaction involved), except that such fee may not exceed $5,000.

(2) PUBLICATION OF NOTICE IN FEDERAL REGISTER.—Within 10 days after an application submitted under paragraph (1) is received by the Attorney General, the Attorney General shall publish in the Federal Register a notice that announces that an application for a certificate of review has been submitted, identifies each person submitting the application, and describes the conduct for which the application is submitted.

(3) ESTABLISHMENT OF PROCEDURES FOR ISSUANCE OF CERTIFICATE.—In consultation with the Chair and the Secretary, the Attorney General shall establish procedures to be used in applying for and in determining whether to approve an application for a certificate of review under this title. Under such procedures the Attorney General, in consultation with the Secretary, shall approve an application if the Attorney General determines that the activities to be covered under the certificate will satisfy the criteria described in section 2502(f) for safe harbors designated under such section and that the benefits of the issuance of the certificate will outweigh any disadvantages that may result from reduced competition. If the Attorney General, with the concurrence of the Secretary, determines that the requirements for a certificate are met, the Attorney General shall issue to the applicant a certificate of review. The certificate of review shall specify—

(i) the health care market activities to which the certificate applies,

(ii) the person to whom the certificate of review is issued, and

(iii) any terms and conditions the Attorney General or the Secretary deems necessary to assure compliance with the applicable procedures described in paragraph (3).

(4) TIMING FOR DECISION ON APPLICATION.—Within 90 days after the Attorney General receives an application for a certificate of review, the Attorney General shall determine whether to grant or deny the certificate.

(5) NOTIFICATION OF DECISION.—The Attorney General shall notify the applicant of the Attorney General's determination and if the application is denied, the reasons for the denial.

(6) FRAUDULENT PROCUREMENT.—A certificate of review shall be void ab initio with respect to any health care market activities for which the certificate was procured by fraud.

(c) AMENDMENT AND REVOCATION OF CERTIFICATES.—

(1) NOTIFICATION OF CHANGES.—Any applicant who receives a certificate of review—

(A) shall promptly report to the Attorney General any change relevant to the matters specified in the certificate; and

(B) may submit to the Attorney General an application to amend the certificate to reflect the effect of the change on the conduct specified in the certificate.

(2) AMENDMENT TO CERTIFICATE.—An application for an amendment to a certificate of review shall be treated as an application for the issuance of a certificate. The effective date of an amendment shall be the date on which the application for the amendment is received by the Attorney General.

(3) REVOCATION.—

(A) GROUNDS FOR REVOCATION.—In accordance with this paragraph, the Attorney General, in consultation with the Secretary, may revoke in whole or in part a certificate of review issued under this section. There shall be considered as grounds for the revocation of a certificate the fact that—

(i) after the expiration of the 2-year period beginning on the date a person's certificate is issued, the activities of the person have not substantially accomplished the purposes for the issuance of the certificate;

(ii) the person has failed to comply with any of the terms or conditions imposed under the certificate by the Attorney General or the Secretary under subsection (b)(4); or

(iii) the activities covered under the certificate no longer satisfy the criteria set forth in section 2502(f).

(B) REQUEST FOR COMPLIANCE INFORMATION.—If the Attorney General or the Secretary has reason to believe that any of the grounds for revocation of a certificate of review described in subparagraph (A) may apply to a person holding the certificate, the Attorney General shall request such information from such person as the Attorney General or the Secretary deems necessary to resolve the matter of compliance. Failure to comply with such request shall be grounds for revocation of the certificate under this paragraph.

(C) PROCEDURES FOR REVOCATION.—If the Attorney General or the Secretary determines that any of the grounds for revocation of a certificate of review described in subparagraph (A) apply to a person holding the certificate, or that such person has failed to comply with a request made under subparagraph (B), the Attorney General shall give written notice of the determination to such person. The notice shall include a statement of the circumstances underlying, and the reasons in support of, the determination. In the 60-day period beginning 30 days after the notice is given, the Attorney General shall revoke the certificate or modify it as the Attorney General or the Secretary deems necessary to cause the certificate to apply only to activities that meet the criteria set forth in section 2502(f).

(D) INVESTIGATION AUTHORITY.—For purposes of carrying out this paragraph, the Attorney General may conduct investigations in the same manner as the Attorney General conducts investigations under section 3 of the Antitrust Civil Process Act, except that no civil investigative demand may be issued to a person to whom a certificate of review is issued if such person is the target of such investigation.

(d) REVIEW OF DETERMINATIONS.—

(1) AVAILABILITY OF REVIEW FOR CERTAIN ACTIONS.—If the Attorney General denies, in whole or in part, an application for a certificate of review or for an amendment to a certificate, or revokes or modifies a certificate pursuant to paragraph (3), the applicant or certificate holder (as the case may be) may, within 30 days of the denial or revocation, bring an action in the United States District Court for the District of Columbia to set aside the determination on the ground that such determination is clearly erroneous.

(2) NO OTHER REVIEW PERMITTED.—Except as provided in paragraph (1), no action by the Attorney General, the Chair, or the Secretary pursuant to this subtitle shall be subject to judicial review.

(3) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an application for a certificate of review or for an amendment to a certificate, or revokes or amends a certificate, neither the negative determination nor the statement of reasons therefore shall be admissible in evidence, in any administrative or judicial proceeding, concerning any claim under the antitrust laws.

(e) PUBLICATION OF DECISIONS.—The Attorney General shall publish a notice in the Federal Register on a timely basis of each decision made with respect to an application for a certificate of review under this section or the amendment or revocation of such a certificate, in a manner that protects the confidentiality of any proprietary information relating to the application.

(f) ANNUAL REPORTS.—Every person to whom a certificate of review is issued shall submit to the Attorney General an annual report, in such form and at such time as the Attorney General may require, that contains any necessary updates to the information required under subsection (b) and a description of the activities of the holder under the certificate during the preceding year.

(g) RESTRICTIONS ON DISCLOSURE OF INFORMATION.—

(1) WAIVER OF DISCLOSURE REQUIREMENTS UNDER ADMINISTRATIVE PROCEDURE ACT.—Information submitted by any person in connection with the issuance, amendment, or revocation of a certificate of review shall be exempt from disclosure under section 552 of title 5, United States Code.

(2) RESTRICTIONS ON DISCLOSURE OF COMMERCIAL OR FINANCIAL INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), no officer or employee of the United States shall disclose commercial or financial information submitted in connection with the issuance, amendment, or revocation of a certificate of review if the information is privileged or confidential or if disclosure of the information would cause harm to the person who submitted the information.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply with respect to information disclosed—

(i) upon a request made by the Congress or any committee of the Congress,

(ii) in a judicial or administrative proceeding, subject to appropriate protective orders,

(iii) with the consent of the person who submitted the information,

(iv) in the course of making a determination with respect to the issuance, amendment, or revocation of a certificate of review, if the Attorney General deems disclosure of the information to be necessary in connection with making the determination,

(v) in accordance with any requirement imposed by a statute of the United States, or

(vi) in accordance with any rule or regulation promulgated under subsection (i) permitting the disclosure of the information to an agency of the United States or of a State on the condition that the agency will disclose the information only under the circumstances specified in clauses (i) through (v).

(3) PROHIBITION AGAINST USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—Any information disclosed in an application for a certificate of review under this section shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing whether a person is entitled to the protections provided by such a certificate.

SEC. 2504. NOTIFICATIONS PROVIDING REDUCTION IN CERTAIN PENALTIES UNDER ANTITRUST LAW FOR HEALTH CARE JOINT VENTURES.

(a) NOTIFICATIONS DESCRIBED.—

(1) SUBMISSION OF NOTIFICATION BY VENTURE.—Any party to a health care joint venture, acting on such venture's behalf, may, not later than 90 days after entering into a written agreement to form such venture or not later than 90 days after the date of the enactment of this Act, whichever is later, file with the Attorney General a written notification disclosing—

(A) the identities of the parties to such venture,

(B) the nature and objectives of such venture, and

(C) such additional information as the Attorney General may require by regulation.

(2) FILING FEE.—The Attorney General may require a filing fee to be submitted with the notification to cover the cost of publication and the cost of administering this section, except that the amount of such fee shall not exceed $250.

(3) SUBMISSION OF ADDITIONAL INFORMATION.—

(A) REQUEST OF ATTORNEY GENERAL.—At any time after receiving a notification filed under paragraph (1), the Attorney General may require the submission of additional information or documentary material relevant to the proposed health care joint venture.

(B) PARTIES TO VENTURE.—Any party to a health care joint venture may submit such additional information on the venture's behalf as may be appropriate to ensure that the venture will receive the protections provided under subsection (b).

(C) REQUIRED SUBMISSION OF INFORMATION ON CHANGES TO VENTURE.—A health care joint venture for which a notification is in effect under this section shall submit information on any change in the membership of the venture not later than 90 days after such change occurs.

(4) PUBLICATION OF NOTIFICATION.—

(A) INFORMATION MADE PUBLICLY AVAILABLE.—Not later than 30 days after receiving a notification with respect to a venture under paragraph (1), the Attorney General shall publish in the Federal Register a notice with respect to the venture that identifies the parties to the venture and generally describes the purpose and planned activity of the venture. Prior to its publication, the contents of the notice shall be made available to the parties to the venture.

(B) RESTRICTION ON DISCLOSURE OF OTHER INFORMATION.—All information and documentary material submitted pursuant to this section and all information obtained by the Attorney General in the course of any investigation or case with respect to a potential violation of the antitrust laws by the health care joint venture (other than information and material described in subparagraph (A)) shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies except in a judicial proceeding in which such information and material is subject to any protective order.

(5) WITHDRAWAL OF NOTIFICATION.—Any person who files a notification pursuant to this section may withdraw such notification before a publication by the Attorney General pursuant to paragraph (4).

(6) NO JUDICIAL REVIEW PERMITTED.—Any action taken or not taken by the Attorney General with respect to notifications filed pursuant to this subsection shall not be subject to judicial review.

(b) PROTECTIONS FOR VENTURES SUBJECT TO NOTIFICATION.—

(1) IN GENERAL.—

(A) PROTECTIONS DESCRIBED.—Except as provided in subsection (c), the provisions of paragraphs (2), (3), (4), and (5) shall apply with respect to any action under the antitrust laws challenging conduct within the scope of a notification which is in effect pursuant to subsection (a)(1).

(B) Timing of protections.—The protections described in this subsection shall apply to the venture that is the subject of a notification under subsection (a)(1) as of the earlier of—

(i) the date of the publication in the Federal Register of the notice published with respect to the notification; or

(ii) if such notice is not published during the period required under subsection (a)(4), the expiration of the 30-day period that begins on the date the Attorney General receives any necessary information required to be submitted under subsection (a)(1) or any additional information required by the Attorney General under subsection (a)(3)(A).

(2) Applicability of rule of reason standard.—In any action under the antitrust laws, the conduct of any person which is within the scope of a notification filed under subsection (a) shall not be deemed illegal per se, but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including, but not limited to, effects on competition in relevant markets.

(3) Limitation on recovery to actual damages and interest.—Notwithstanding section 4 of the Clayton Act, any person who is entitled to recovery under the antitrust laws for conduct that is within the scope of a notification filed under subsection (a) shall recover the actual damages sustained by such person and interest calculated at the rate specified in section 1961 of title 28, United States Code, for the period beginning on the earliest date for which injury can be established and ending on the date of judgment, unless the court finds that the award of all or part of such interest is unjust under the circumstances.

(4) Award of attorney's fees and costs of suit.—

(A) In general.—In any action under the antitrust laws brought against a health care joint venture for conduct that is within the scope of a notification filed under subsection (a), the court shall, at the conclusion of the action—

(i) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(ii) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(B) Offset in cases of bad faith.—The court may reduce an award made pursuant to subparagraph (A) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

(5) Restrictions on admissibility of information.—

(A) In general.—Any information disclosed in a notification submitted under subsection (a)(1) and the fact of the publication of a notification by the Attorney General under subsection (a)(4) shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing whether a party to a health care joint venture is entitled to the protections described in this subsection.

(B) Actions of Attorney General.—No action taken by the Attorney General pursuant to this section shall be admissible into evidence in any judicial or administrative proceeding for the purpose of supporting or answering any claim under the antitrust laws.

(c) Exception for Certain Activities.—

(1) Activities described.—The protections described in subsection (b) shall not apply to conduct which constitutes price-fixing, bid-rigging, or market allocation, unless such conduct is related to procompetitive aspects of a health care joint venture (as determined in accordance with the process described in paragraph (2)).

(2) Process.—If conduct of a health care joint venture which is subject to a notification under subsection (a)(1) is challenged for price-fixing, bid-rigging, or market allocation, any party to the joint venture shall be entitled to show the procompetitive aspects of such conduct. The protections described in subsection (b) shall not apply to the conduct if the party is unable to show that the conduct is not mere price-fixing, bid-rigging, or market allocation.

SEC. 2505. REVIEW AND REPORTS ON SAFE HARBORS, CERTIFICATES OF REVIEW, AND NOTIFICATIONS.

(a) In General.—The Attorney General, in consultation with the Secretary and the Chair, shall periodically review the safe harbors designated under section 2502, the certificates of review issued under section 2503, and notification received under section 2504, and—

(1) with respect to the safe harbors, issue modifications to such safe harbors in such manner as the Attorney General considers appropriate in accordance with the requirements of section 2502, which modifications shall take effect 90 days after issuance, unless disapproved by the Congress; and

(2) with respect to the certificates of review and notifications, submit a report to Congress on the issuance of such certificates and receipt of notifications, including a description of the effect of such certificates and notifications on increasing access to high quality health care services at reduced costs.

(b) Recommendations for Legislation.—The Attorney General shall include in the reports submitted under subsection (a)(2) any recommendations of the Attorney General for legislation to improve the programs for the issuance of certificates of review and receipt of notifications established under this subtitle.

SEC. 2506. RULES, REGULATIONS, AND GUIDELINES.

(a) Safe Harbors, Certificates, and Notifications.—The Attorney General, in consultation with the Secretary and the Chair, shall promulgate such rules, regulations, and guidelines as are necessary to carry out sections 2502, 2503, and 2504.

(b) Guidance for Providers.—

(1) In general.—To promote greater certainty regarding the application of the antitrust laws to activities in the health care market, the Attorney General, in consultation with the Secretary and the Chair, shall (not later than 1 year after the date of the enactment of this Act), taking into account the criteria used to designate safe harbors under section 2502 and grant certificates of review under section 2503, publish guidelines—

(A) to define or provide assistance in determining relevant geographic and product markets for health care services and providers of health care services;

(B) to further collaborative activities which may be helpful to enhance services in underserved and geographically disadvantaged areas such as rural markets and inner cities;

(C) to assist collaboration between providers (such as hospital networks, physician-hospital organizations, and other groups of providers) which will help provide health care services more efficiently;

(D) to further activities by which public health clinics (including community health centers and migrant health centers under title III of the Public Health Service Act) may participate in networks and other collaborative activities in order to enhance services in underserved areas;

(E) to assist providers of health care services in analyzing whether the activities of such providers may be subject to a safe harbor under section 2502;

(F) to provide clarification for activities in the general subject matter areas described in the safe harbors in section 2502, but which fall outside the safe harbors; and

(G) to describe specific types of activities which would meet the requirements for issuance of a certificate of review under section 2503, and summarizing the factual and legal bases on which the activities would meet the requirements.

(2) Periodic update.—The Attorney General shall periodically update the guidelines published under paragraph (1) as the Attorney General considers appropriate.

(3) Waiver of administrative procedure act.—Section 553 of title 5, United States Code, shall not apply to the issuance of guidelines under paragraph (1).

SEC. 2507. ESTABLISHMENT OF HHS OFFICE OF HEALTH CARE COMPETITION POLICY.

(a) In General.—There is established within the Department of Health and Human Services an Office to be known as the Office of Health Care Competition Policy (hereafter in this section referred to as the "Office"). The Office shall be headed by a director, who shall be appointed by the Secretary.

(b) Duties.—The Office shall coordinate the responsibilities of the Secretary under this subtitle and otherwise assist the Secretary in developing policies relating to the competitive and collaborative activities of providers of health care services.

SEC. 2508. DEFINITIONS.

In this subtitle:

(1) The term "antitrust laws"—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) The term "Chair" means the Chair of the Federal Trade Commission.

(3) The term "health benefit plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, or a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974) which provides benefits with respect to health care services.

(4) The term "health care joint venture" means a joint venture of 2 or more persons formed for the purpose of providing health care services, including attempts to enter into or perform a contract or agreement to provide such services.

(5) The term "health care services" means any services for which payment may be made

under a health benefit plan, including services related to the delivery or administration of such services.

(6) The term "medical self-regulatory entity" means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

(7) The term "person" includes a State or unit of local government.

(8) The term "provider of health care services" means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(9) The term "Secretary" means the Secretary of Health and Human Services.

(10) The term "specialty group" means a medical specialty or subspecialty in which a provider of health care services may be licensed to practice by a State (as determined by the Secretary in consultation with the certification boards for such specialties and subspecialties).

(11) The term "standard setting and enforcement activities" means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

Subtitle G—Encouraging Enforcement Activities of Medical Self-Regulatory Entities

PART 1—APPLICATION OF THE CLAYTON ACT TO MEDICAL SELF-REGULATORY ENTITIES

SEC. 2601. ANTITRUST EXEMPTION FOR MEDICAL SELF-REGULATORY ENTITIES.

(a) IN GENERAL.—(1) Except as provided in paragraph (2), no damages, interest on damages, cost of suit, or attorney's fee may be recovered under section 4, 4A, or 4C of the Clayton Act (15 U.S.C. 15, 15a, 15c), or under any State law similar to such section, from any medical self-regulatory entity (including its members, officers, employees, consultants, and volunteers or committees thereof) as a result of engaging in standard setting or enforcement activities that are—

(A) designed to promote the quality of health care provided to patients, and

(B) not conducted for purposes of financial gain.

(2) Paragraph (1) shall not prohibit the recovery of actual damages, interest on damages, the cost of suit, or a reasonable attorney's fee under section 4 or 4A of the Clayton Act (15 U.S.C. 15, 15a), or under any State law similar to such section, by a State or the United States from a medical self-regulatory entity (including its members, officers, employees, consultants, and volunteers or committees thereof) for injury sustained as a result of engaging in the conduct described in such paragraph.

(b) FEES.—In any action under section 4, 4C, or 16 of the Clayton Act (15 U.S.C. 15, 15c, 26), or under a similar State law, brought against any medical self-regulatory entity (including its members, officers, employees, consultants, and volunteers or committees thereof) as a result of engaging in conduct described in subsection (a)(1), the court shall award the cost of suit, including a reasonable attorney's fee, to a substantially prevailing defendant.

SEC. 2602. DEFINITIONS.

For purposes of this subtitle:

(1) The term "medical self-regulatory entity" means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff.

(2) The term "standard setting and enforcement activities" means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the quality of health care provided by a medical professional.

PART 2—CONSULTATION BY FEDERAL AGENCIES

SEC. 2611. CONSULTATION WITH MEDICAL SELF-REGULATORY ENTITIES RESPECTING MEDICAL PROFESSIONAL GUIDELINES AND STANDARDS.

Any Federal agency engaged in the establishment of medical professional standards shall consult with appropriate medical societies or associations, specialty boards, or recognized accrediting agencies, if available, in carrying out medical professional standard setting and guidelines or standards relating to the practice of medicine.

Subtitle H—Reform of Clinical Laboratory Requirements for Simple Tests

SEC. 2701. ELIMINATING CLIA REQUIREMENT FOR CERTIFICATE OF WAIVER FOR SIMPLE LABORATORY EXAMINATIONS AND PROCEDURES.

(a) IN GENERAL.—Section 353 of the Public Health Service Act (42 U.S.C. 263a) is amended—

(1) in subsection (b), by inserting before the period at the end the following: "or unless the laboratory is exempt from the certificate requirement under subsection (d)(2)";

(2) by amending paragraph (2) of subsection (d) to read as follows:

"(2) EXEMPTION FROM CERTIFICATE REQUIREMENT FOR LABORATORIES PERFORMING ONLY SIMPLE EXAMINATIONS AND PROCEDURES.—A laboratory which performs only laboratory examinations and procedures described in paragraph (3) is not required to have in effect a certificate under this section.";

(3) by striking paragraph (4) of subsection (d); and

(4) in subsection (m)(1), by striking ", except that the Secretary" and all that follows and inserting a period.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first month beginning after the date of the enactment of this Act.

SEC. 2702. AMENDMENT RELATED TO SIMPLE LABORATORY EXAMINATIONS.

Section 353(d) of the Public Health Service Act (42 U.S.C. 263) is amended by striking paragraph (3) and inserting the following:

"(3) EXAMINATIONS AND PROCEDURES.—The examinations and procedures identified in paragraph (2) are simple laboratory examinations and procedures which have an insignificant risk of an erroneous result and include those which—

"(A) have been approved by the Food and Drug Administration for home use,

"(B) employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible,

"(C) the Secretary has determined pose no reasonable risk of serious harm to the patient if performed incorrectly, or

"(D)(i) are performed by or under the direction or supervision of or in collaboration with a doctor of medicine or osteopathy licensed to practice medicine or osteopathy in the State in which the laboratory is located, or by an individual qualified to direct, supervise, or perform examinations and procedures under State laws or such standards as the Secretary may establish; and

"(ii) the patient is available for clinical observation; and

"(iii) prompt results are needed to evaluate, diagnose, and treat the patient or to avoid additional burdens on the patient that could result from not performing the test.

"(4) DEFINITION.—As used in this section, the term 'simple laboratory examinations and procedures' includes dipstick tests for total and allergen-specific IgE; microscopic examination of nasal smears (for cells and bacteria); mono spot tests; testing for theophylline using the Accu-Level method; microscopic urinalysis; vaginal wet mount; KOH prep, scabies prep; rapid strep antigen; nonautomated qualitative and quantitative semen analysis; pin worm; prostate smears; synovial fluid analysis for inflammation and infection; post coital test; fern test; occult blood; Gram stain; qualitative drug screen; pulse oximetry; hemoglobin (by hand-held hemoglobinometer); ASO, CRP, RF, and mono screen; sickle cell screen; white blood cell count by manual chamber count; peripheral blood smears; sputum eosinophil; urine culture colony; urine sensitivities; microscopic examination of hair morphology; molluscum smear; fungal cultures, including dermatophyte test medium; Tzank smear; Darkfield examination; agglutination pregnancy test; urethral gram stains, and centrifigal hematology, including white blood cell count, hematocrit, differential, and platelet count.".

SEC. 2703. AMENDMENT RELATED TO STUDY.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Centers for Disease Control and Prevention, shall use existing appropriations to conduct the study required by section 4 of the Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. 263a note). The Secretary shall report the results of such study to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Labor and Human Resources of the Senate not later than May 1, 1996.

(b) SUNSET.—If the results of the study described in subsection (a) are not reported to the committees of Congress by May 1, 1996, section 353 of the Public Health Service Act shall not be in effect after May 1, 1996.

SEC. 2704. AMENDMENTS RELATED TO THE CLINICAL LABORATORY IMPROVEMENT ADVISORY COMMITTEE.

The Secretary of Health and Human Services shall revise the membership of the Clinical Laboratory Improvement Advisory Committee established by the Secretary in regulations to implement section 353 of the Public Health Service Act (subpart T of part 493 of title 42 Code of Federal Regulations) to contain, in the membership which does not include ex-officio members or officers or employees of the Federal Government, a number of practicing physicians which is proportionate to the number of physician laboratories regulated under such section 353. For purposes of this section, the term "practicing physician" means a licensed doctor of medicine or osteopathy who spends at least 80 percent of the physician's professional time in direct patient care and who directs an in-office clinical laboratory for the physician's patients.

Subtitle I—Miscellaneous Provisions

SEC. 2801. REQUIREMENT THAT CERTAIN AGENCIES PREFUND GOVERNMENT HEALTH BENEFITS CONTRIBUTIONS FOR THEIR ANNUITANTS.

(a) DEFINITIONS.—For the purpose of this section—

(1) the term "agency" means any agency or other instrumentality within the executive branch of the Government, the receipts and disbursements of which are not generally included in the totals of the budget of the United States Government submitted by the President;

(2) the term "health benefits plan" means, with respect to an agency, a health benefits plan, established by or under Federal law, in which employees or annuitants of such agency may participate;

(3) the term "health-benefits coverage" means coverage under a health benefits plan";

(4) an individual shall be considered to be an "annuitant of an agency" if such individual is entitled to an annuity, under a retirement system established by or under Federal law, by virtue of—

(A) such individual's service with, and separation from, such agency; or

(B) being the survivor of an annuitant under subparagraph (A) or of an individual who died while employed by such agency; and

(5) the term "Office" means the Office of Personnel Management.

(b) PREFUNDING REQUIREMENT.—

(1) IN GENERAL.—Effective as of October 1, 1994, each agency (or February 1, 1995, in the case of the agency with the greatest number of employees, as determined by the Office) shall be required to prepay the Government contributions which are or will be required in connection with providing health-benefits coverage for annuitants of such agency.

(2) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section. The regulations shall be designed to ensure at least the following:

(A) Amounts paid by each agency shall be sufficient to cover the amounts which would otherwise be payable by such agency (on a "pay-as-you-go" basis), on or after the applicable effective date under paragraph (1), on behalf of—

(i) individuals who are annuitants of the agency as of such effective date; and

(ii) individuals who are employed by the agency as of such effective date, or who become employed by the agency after such effective date, after such individuals have become annuitants of the agency (including their survivors).

(B)(i) For purposes of determining any amounts payable by an agency—

(I) this section shall be treated as if it had taken effect at the beginning of the 20-year period which ends on the effective date applicable under paragraph (1) with respect to such agency; and

(II) in addition to any amounts payable under subparagraph (A), each agency shall also be responsible for paying any amounts for which it would have been responsible, with respect to the 20-year period described in subclause (I), in connection with any individuals who are annuitants or employees of the agency as of the applicable effective date under paragraph (1).

(ii) Any amounts payable under this subparagraph for periods preceding the applicable effective date under paragraph (1) shall be payable in equal installments over the 20-year period beginning on such effective date.

(c) FASB STANDARDS.—Regulations under subsection (b) shall be in conformance with the provisions of standard 106 of the Financial Accounting Standards Board, issued in December 1990.

(d) CLARIFICATION.—Nothing in this section shall be considered to permit or require duplicative payments on behalf of any individuals.

(e) DRAFT LEGISLATION.—The Office shall prepare and submit to Congress any draft legislation which may be necessary in order to carry out this section.

SEC. 2802. INELIGIBILITY OF ALIENS FOR SSI AND MEDICAID.

(a) IN GENERAL.—Notwithstanding any other provision of law and except as provided in subsections (b) and (c), no alien shall be eligible for any program referred to in subsection (d).

(b) EXCEPTIONS.—

(1) REFUGEE EXCEPTION.—Subsection (a) shall not apply to an alien admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act until 6 years after the date of such alien's arrival into the United States.

(2) AGED EXCEPTION.—Subsection (a) shall not apply to an alien who—

(A) has been lawfully admitted to the United States for permanent residence;

(B) is over 75 years of age; and

(C) has resided in the United States for at least 5 years.

(3) CURRENT RESIDENT EXCEPTION.—Subsection (a) shall not apply to the eligibility of an alien for a program referred to in subsection (d) until 1 year after the date of the enactment of this Act if, on such date of enactment, the alien is residing in the United States and is eligible for the program.

(c) PROGRAMS FOR WHICH ALIENS MAY BE ELIGIBLE.—The limitation under subsection (a) shall not apply to medical assistance with respect to emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act).

(d) PROGRAMS FOR WHICH ALIENS ARE INELIGIBLE.—The programs referred to in this subsection are the following:

(1) The program of medical assistance under title XIX of the Social Security Act, except emergency services as provided in subsection (c).

(2) The supplemental security income program under title XVI of the Social Security Act.

(e) NOTIFICATION OF ALIENS.—Any Federal agency that administers a program referred to in subsection (d) shall, directly or through the States, notify each alien receiving benefits under the program whose eligibility for the program is or will be terminated by reason of this section.

SEC. 2803. LIMITATION ON SSI BENEFITS FOR DRUG AND ALCOHOL ADDICTS.

(a) IN GENERAL.—

(1) LIMITATION DESCRIBED.—Section 1614(a) of the Social Security Act (42 U.S.C. 1382c(a)) is amended by adding at the end the following:

"(5)(A) The Secretary shall identify all recipients of benefits under this title by reason of disability whose disability is a result of addiction to illegal drugs.

"(B) The Secretary shall periodically, on a random basis, test each recipient identified under subparagraph (A) to determine whether the recipient is using illegal drugs.

"(C)(i) Notwithstanding any other provision of this title, any individual who is determined under subparagraph (B) to be using illegal drugs, or who refuses to submit to testing as provided for under subparagraph (B), shall not be eligible for benefits under this title for a period of at least 1 year.

"(ii) The period of ineligibility under clause (i) shall terminate (after the last day of such 1-year period) if the individual has 2 tests (at least 2 months apart and not paid for through Federal funds) which establish that the recipient is not using illegal drugs.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to quarters beginning after the expiration of the 6-month period that begins on the date of the enactment of this Act.

(b) REPRESENTATIVE PAYEE REFORMS.—

(1) AUTHORITY OF GOVERNMENT AGENCIES TO BECOME PAID REPRESENTATIVE PAYEES.—Section 1631(a)(2)(D)(ii) of such Act (42 U.S.C. 1383(a)(2)(D)(ii)) is amended by adding at the end the following: "The term 'qualified organization' also includes any government agency that meets the requirements of items (aa) and (bb) of subclause (II).".

(2) MAXIMUM FEE PAYABLE TO REPRESENTATIVE PAYEES.—Section 1631(a)(2)(D)(i) of such Act (42 U.S.C. 1383(a)(2)(D)(i)) is amended by striking "the lesser of—" and all that follows and inserting "10 percent of the monthly benefit involved.".

TITLE III—LONG-TERM CARE

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Subtitle A—Tax Treatment of Long-term Care Insurance

SEC. 3001. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Subpart E of part I of subchapter L of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 818 the following new section:

"SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

"(a) GENERAL RULE.—For purposes of this part, a long-term care insurance contract shall be treated as an accident or health insurance contract.

"(b) LONG-TERM CARE INSURANCE CONTRACT.—

"(1) IN GENERAL.—For purposes of this part, the term 'long-term care insurance contract' means any insurance contract issued if—

"(A) the only insurance protection provided under such contract is coverage of qualified long-term care services and benefits incidental to such coverage,

"(B) the maximum benefit under the policy for expenses incurred for any day does not exceed $200,

"(C) such contract does not cover expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

"(D) such contract is guaranteed renewable,

"(E) such contract does not have any cash surrender value, and

"(F) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

"(2) SPECIAL RULES.—

"(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be treated as described in paragraph (1)(A) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

"(B) CONTRACT MAY COVER MEDICARE REIMBURSABLE EXPENSES WHERE MEDICARE IS SECONDARY PAYOR.—Paragraph (1)(C) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

"(C) REFUNDS OF PREMIUMS.—Paragraph (1)(F) shall not apply to any refund of premiums on surrender or cancellation of the contract.

"(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which—

"(A) are required by a chronically ill individual in a qualified facility, and

"(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

"(2) CHRONICALLY ILL INDIVIDUAL.—

"(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

"(i)(I) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in subparagraph (B)) for a period of at least 90 days due to a loss of functional capacity, or

"(II) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subclause (I), or

"(ii) having a similar level of disability due to cognitive impairment.

"(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

"(i) MOBILITY.—The process of walking or wheeling on a level surface which may include the use of an assistive device such as a cane, walker, wheelchair, or brace.

"(ii) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

"(iii) TOILETING.—The act of going to the toilet room for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes or the ability to voluntarily control bowel and bladder function, or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

"(iv) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

"(v) EATING.—The process of getting food from a plate or its equivalent into the mouth.

"(3) QUALIFIED FACILITY.—The term 'qualified facility' means—

"(A) a nursing, rehabilitative, hospice, or adult day care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility, or similar institution)—

"(i) which is licensed under State law, or

"(ii) which is a certified facility for purposes of title XVIII or XIX of the Social Security Act, or

"(B) an individual's home if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a facility described in subparagraph (A).

"(4) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is to provide needed assistance with any of the activities of daily living described in paragraph (2)(B).

"(5) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

"(d) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—This section shall not apply in determining whether section 4980B (relating to failure to satisfy continuation coverage requirements of group health plans) applies.

"(e) INFLATION ADJUSTMENT OF $200 BENEFIT LIMIT.—

"(1) IN GENERAL.—In the case of a calendar year after 1994, the $200 amount contained in subsection (b)(1)(B) shall be increased for such calendar year by the medical care cost adjustment for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

"(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(B) such component for August of 1993."

(b) RESERVES.—Clause (iii) of section 807(d)(3)(A) is amended by inserting "(other than a long-term care insurance contract within the meaning of section 818A)" after "contract".

(c) CLERICAL AMENDMENT.—The table of sections for such subpart E is amended by inserting after the item relating to section 818 the following new item:

"Sec. 818A. Treatment of long-term care insurance or plans."

SEC. 3002. EXCLUSION FOR BENEFITS PROVIDED UNDER LONG-TERM CARE INSURANCE; INCLUSION OF EMPLOYER-PROVIDED COVERAGE.

(a) IN GENERAL.—Subsection (a) of section 104 of the Internal Revenue Code of 1986 (relating to compensation for injuries or sickness) is amended by striking "and" at the end of paragraph (4), by striking the period at the end of paragraph (5) and inserting ", and", and by inserting after paragraph (4) the following new paragraph:

"(6) benefits under a long-term care insurance contract (as defined in section 818A(b))."

(b) INCLUSION OF EMPLOYER-PROVIDED COVERAGE.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by adding at the end thereof the following sentence: "The preceding sentence shall not apply to any plan providing coverage for long-term care services."

SEC. 3003. QUALIFIED LONG-TERM SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended by striking "or" at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

"(C) for qualified long-term care services (as defined in section 818A(c)), or".

(b) DEDUCTION FOR LONG-TERM CARE EXPENSES FOR PARENT OR GRANDPARENT.—Section 213 of such Code (relating to deduction for medical expenses) is amended by adding at the end the following new subsection:

"(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE EXPENSES.—For purposes of subsection (a), the term 'dependent' shall include any parent or grandparent of the taxpayer for whom the taxpayer has expenses for long-term care services described in section 818A(c), but only to the extent of such expenses."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) of such Code (as redesignated by subsection (a)) is amended by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)".

(2)(A) Paragraph (1) of section 213(d) of such Code is amended by adding at the end thereof the following new flush sentence:

"In the case of a long-term care insurance contract (as defined in section 818A), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D)."

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

"(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

"(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any long-term care insurance contract (as defined in section 818A) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

"In the case of an individual with an attained age before the close of the taxable year of:	**The limitation is:**
40 or less	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	1,600
More than 70	2,000.

"(B) INDEXING.—

"(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, each dollar amount contained in paragraph (1) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

"(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(II) such component for August of 1991."

(3) Paragraph (6) of section 213(d) of such Code is amended—

(A) by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)", and

(B) by striking "paragraph (1)(C)" in subparagraph (A) and inserting "paragraph (1)(D)".

(4) Paragraph (7) of section 213(d) of such Code is amended by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)".

SEC. 3004. EFFECTIVE DATE.

The amendments made by this subtitle shall apply to taxable years beginning after December 31, 1994.

Subtitle B—Establishment of Federal Standards for Long-term Care Insurance

SEC. 3101. ESTABLISHMENT OF FEDERAL STANDARDS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—The Public Health Service Act is amended—

(1) by redesignating title XXVII (42 U.S.C. 300cc et seq.) as title XXVIII; and

(2) by inserting after title XXVI the following new title:

"TITLE XXVII—LONG-TERM CARE INSURANCE STANDARDS

"PART A—PROMULGATION OF STANDARDS AND MODEL BENEFITS

"SEC. 2701. STANDARDS.

"(a) APPLICATION OF STANDARDS.—

"(1) NAIC.—The Secretary shall request that the National Association of Insurance Commissioners (hereinafter in this title referred to as the 'NAIC')—

"(A) develop specific standards that incorporate the requirements of this title; and

"(B) report to the Secretary on such standards,

by not later than 12 months after enactment of this title. If the NAIC develops such model standards that incorporate the requirements of this title within such period and the Secretary finds that such standards implement the requirements of this title, such standards shall be the standards applied under this title.

"(2) DEFAULT.—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Secretary shall promulgate, within 12 months after such deadline, a regulation that provides standards that incorporate the requirements of this title and such standards shall apply as provided for in this title.

"(3) RELATION TO STATE LAW.—Nothing in this title shall be construed as preventing a State from applying standards that provide greater protection to policyholders of long-term care insurance policies than the standards promulgated under this title, except that such State standards may not be inconsistent or in conflict with any of the requirements of this title.

"(b) DEADLINE FOR APPLICATION OF STANDARDS.—

"(1) IN GENERAL.—Subject to paragraph (2), the date specified in this subsection for a State is—

"(A) the date the State adopts the standards established under subsection (a)(1); or

"(B) the date that is 1 year after the first day of the first regular legislative session that begins after the date such standards are first established under subsection (a)(2);

whichever is earlier.

"(2) STATE REQUIRING LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

"(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

"(B) having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1994. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(c) ITEMS INCLUDED IN STANDARDS.—The standards promulgated under subsection (a) shall include—

"(1) minimum Federal standards for long-term care insurance consistent with the provisions of this title;

"(2) standards for the enhanced protection of consumers with long-term care insurance;

"(3) procedures for the modification of the standards established under paragraph (1) in a manner consistent with future laws to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program; and

"(4) other activities determined appropriate by Congress.

"(d) CONSULTATION.—In establishing standards and models of benefits under this section, the Secretary shall provide for and consult with an advisory committee to be chosen by the Secretary, and composed of—

"(1) three individuals who are representatives of carriers;

"(2) three individuals who are representatives of consumer groups;

"(3) three representatives who are representatives of providers of long-term care services;

"(4) three other individuals who are not representatives of carriers or of providers of long-term care services and who have expertise in the delivery and financing of such services; and

"(5) the Secretary of Veterans Affairs.

"(e) DUTIES.—The advisory committee established under subsection (d) shall—

"(1) recommend the appropriate inflationary index to be used with respect to the inflation protection benefit portion of the standards;

"(2) recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy;

"(3) recommend appropriate standards for benefits under section 2715(c); and

"(4) perform such other activities as determined appropriate by the Secretary.

"(f) ADMINISTRATIVE PROVISIONS.—The following provisions of section 1886(e)(6) of the Social Security Act shall apply to the advisory committee chosen under subsection (d) in the same manner as such provisions apply under such section:

"(1) Subparagraph (C) (relating to staffing and administration).

"(2) Subparagraph (D) (relating to compensation of members).

"(3) Subparagraph (F) (relating to access to information).

"(4) Subparagraph (G) (relating to use of funds).

"(5) Subparagraph (H) (relating to periodic GAO audits).

"(6) Subparagraph (J) (relating to requests for appropriations).

"PART B—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

"SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.

"(a) IN GENERAL.—

"(1) REGULATORY PROGRAM.—No long-term care policy (as defined in section (2721)) may be issued, sold, or offered for sale as a long-term care insurance policy in a State on or after the date specified in section 2701(b) unless—

"(A) the Secretary determines that the State has established a regulatory program that—

"(i) provides for the application and enforcement of the standards established under section 2701(a); and

"(ii) complies with the requirements of subsection (b);

by the date specified in section 2701(b), and the policy has been approved by the State commissioner or superintendent of insurance under such program; or

"(B) if the State has not established such a program, or if the State's regulatory program has been decertified, the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 2701(a) by the date specified in section 2701(b).

For purposes of this subsection, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

"(2) REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review regulatory programs described in paragraph (1)(A) to determine if they continue to provide for the application and enforcement of the standards and procedures established under section 2701(a) and (b). If the Secretary determines that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under paragraph (1)(B) with respect to certifying policies in the State and shall exercise full authority under section 2701 for carriers, agents, or associations or its subsidiary in the State plans in the State.

"(b) ADDITIONAL REQUIREMENTS FOR APPROVAL OF STATE REGULATORY PROGRAMS.—For purposes of subsection (a)(1)(A)(ii), the requirements of this subsection for a State regulatory program are as follows:

"(1) ENFORCEMENT.—The enforcement under the program—

"(A) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards; and

"(B) shall provide for notice in the annual report required under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

"(2) PROCESS.—The enforcement process under each State regulatory program shall provide for—

"(A) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the standards;

"(B) responding on a timely basis to such complaints;

"(C) the investigation of—

"(i) those complaints which have a reasonable probability of validity, and

"(ii) such other alleged violations of the standards as the program finds appropriate; and

"(D) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty as provided for in section 2718) in the case of a carrier, agent, or association or its subsidiary determined to have violated the standards.

"(3) CONSUMER ACCESS TO COMPLIANCE INFORMATION.—

"(A) IN GENERAL.—A State regulatory program must provide for consumer access to complaints filed with the State commissioner or superintendent of insurance with respect to long-term care insurance policies.

"(B) CONFIDENTIALITY.—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

"(4) PROCESS FOR APPROVAL OF PREMIUMS.—

"(A) IN GENERAL.—Each State regulatory program shall—

"(i) provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care insurance policies; and

"(ii) establish a policy for receipt and consideration of public comments before approving such a premium increase or decrease.

"(B) CONDITIONS FOR APPROVAL.—No premium increase shall be approved (or deemed approved) under subparagraph (A) unless the proposed increase is accompanied by an actuarial memorandum which—

"(i) includes a description of the assumptions that justify the increase;

"(ii) contains such information as may be required under the Standards; and

"(iii) is made available to the public.

"(C) APPLICATION.—Except as provided in subparagraph (D), this paragraph shall not apply to a group long-term care insurance policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such group policy.

"(D) EXCEPTION.—Subparagraph (C) shall not apply to—

"(i) group conversion policies;

"(ii) the group continuation feature of a group policy if the insurer separately rates employee and continuation coverages; and

"(iii) group policies where the function of the employer is limited solely to collecting premiums (through payroll deductions or dues checkoff) and remitting them to the insurer.

"(E) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the NAIC from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

"(5) ANNUAL REPORTS.—Each State regulatory program shall provide for annual reports to be submitted to the Secretary on the implementation and enforcement of the standards in the State, including information concerning violations in excess of 30 days.

"(6) ACCESS TO OTHER INFORMATION.—The State regulatory program must provide for consumer access to actuarial memoranda provided under paragraph (4).

"(7) DEFAULT.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the enforcement activities described in subsection (c).

"(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

"(1) IN GENERAL.—The Secretary shall exercise authority under this section in the case of a State that does not have a regulatory program approved under this section.

"(2) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

"(A) for individuals and entities to file written, signed complaints respecting alleged violations of the requirements of this title;

"(B) for responding on a timely basis to such complaints; and

"(C) for the investigation of—

"(i) those complaints that have a reasonable probability of validity; and

"(ii) such other alleged violations of the requirements of this title as the Secretary determines to be appropriate.

In conducting investigations under this subsection, agents of the Secretary shall have reasonable access necessary to enable such agents to examine evidence of any carrier, agent, or association or its subsidiary being investigated.

"(3) HEARINGS.—

"(A) IN GENERAL.—Prior to imposing an order described in paragraph (4) against a carrier, agent, or association or its subsidiary under this section for a violation of the requirements of this title, the Secretary shall provide the carrier, agent, association or subsidiary with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary by regulation) of the date of the notice, a hearing respecting the violation.

"(B) CONDUCT OF HEARING.—Any hearing requested under subparagraph (A) shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

"(C) AUTHORITY IN HEARINGS.—In conducting hearings under this paragraph—

"(i) agents of the Secretary and administrative law judges shall have reasonable access necessary to enable such agents and judges to examine evidence of any carrier, agent, or association or its subsidiary being investigated; and

"(ii) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subparagraph and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

"(D) ISSUANCE OF ORDERS.—If an administrative law judge determines in a hearing under this paragraph, upon the preponderance of the evidence received, that a carrier, agent, or association or its subsidiary named in the complaint has violated the requirements of this title, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier, agent, association, or subsidiary an order described in paragraph (4).

"(4) CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.—

"(A) IN GENERAL.—Subject to the provisions of subparagraphs (B) through (F), an order under this paragraph—

"(i) shall require the agent, association or its subsidiary, or a carrier—

"(I) to cease and desist from such violations; and

"(II) to pay a civil penalty in an amount not to exceed $15,000 in the case of each agent, and not to exceed $25,000 for each association or its subsidiary or a carrier for each such violation; and

"(ii) may require the agent, association or its subsidiary, or a carrier to take such other remedial action as is appropriate.

"(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this paragraph by reason of any violation if the carrier, agent, or association or its subsidiary establishes to the satisfaction of the Secretary that—

"(i) such violation was due to reasonable cause and was not intentional and was not due to willful neglect; and

"(ii) such violation is corrected within the 30-day period beginning on the earliest date the carrier, agent, association, or subsidiary knew, or exercising reasonable diligence could have known, that such a violation was occurring.

"(C) Waiver by Secretary.—In the case of a violation under this title that is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed under subparagraph (A)(i)(II) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

"(D) Administrative appellate review.—The decision and order of an administrative law judge under this paragraph shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this paragraph.

"(E) Judicial review.—A carrier, agent, or association or its subsidiary or any other individual adversely affected by a final order issued under this paragraph may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

"(F) Enforcement of orders.—If a carrier, agent, or association or its subsidiary fails to comply with a final order issued under this paragraph against the carrier, agent, association or subsidiary after opportunity for judicial review under subparagraph (E), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

"(d) Demonstration Grant Program.—

"(1) In general.—The Secretary may award grants to States for the establishment of demonstration programs to improve the enforcement within such States of long-term care insurance standards applicable under this title.

"(2) Application.—To be eligible to receive a grant under paragraph (1), a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the program for which the State intends to use the amounts provided under the grant.

"(3) Minimum amount of grants.—The amount of a grant awarded under this subsection shall not be less than $100,000.

"(4) Evaluation.—A State that receives a grant under this subsection shall comply with such evaluation procedures as the Secretary shall by regulation establish. The Secretary shall utilize such evaluations to conduct an overall evaluation of the results of the demonstration programs established under this section.

"(5) Authorization of appropriations.—There are authorized to be appropriated to carry out this subsection, $5,000,000 for each of the fiscal years 1996 through 2000.

"SEC. 2712. REGULATION OF SALES PRACTICES.

"(a) Duty of Good Faith and Fair Dealing.—

"(1) In general.—Each agent (as defined in section 2733) or association that is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

"(2) Prohibited practices.—An agent or association is considered to have violated paragraph (1) if the agent or association engages in any of the following practices:

"(A) Twisting.—

"(i) In general.—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or insurers for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

"(ii) Policy replacement form.—With respect to any person who elects to replace or effect a change in a long-term care insurance policy, the individual that is selling such policy shall ensure that such person completes a policy replacement form developed by the NAIC. A copy of such form shall be provided to such person and additional copies shall be delivered by the selling individual to the old policy issuer and the new issuer and kept on file for inspection by the State regulatory agency.

"(B) High pressure tactics.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through force, fright, threat or undue pressure, whether explicit or implicit.

"(C) Cold lead advertising.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

"(D) Others.—Engaging in such other practices determined inappropriate under guidelines issued by the NAIC.

"(b) Financial Standards.—The NAIC shall develop recommended financial minimum standards (including both income and asset criteria) for the purpose of advising individuals considering the purchase of a long-term care insurance policy.

"(c) Prohibition of Sale or Issuance to Medicaid Beneficiaries.—An agent, an association, or a carrier may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under title XIX of the Social Security Act.

"(d) Prohibition of Sale or Issuance of Duplicate Service Benefit Policies.—An agent, association or its subsidiary, or a carrier may not sell or issue a service-benefit long-term care insurance policy to an individual—

"(1) knowing that the policy provides for coverage that duplicates coverage already provided in another service-benefit long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy); or

"(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage—

"(A) does not duplicate other coverage in effect under a service-benefit long-term care insurance policy; or

"(B) will replace another service-benefit long-term care insurance policy.

In this subsection, the term 'service-benefit long-term care insurance policy' means a long-term care insurance policy which provides for benefits based on the type and amount of services furnished.

"(e) Prohibition Based on Eligibility for Other Benefits.—A carrier may not sell or issue a long-term care insurance policy that reduces, limits or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

"(f) Provision of Outline of Coverage.—No agent, association or its subsidiary, or carrier may sell or offer for a sale a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) without providing to the purchaser or potential purchaser (or representative) an outline of coverage that complies with the standards established under section 2701(a).

"(g) Penalties.—Any agent who sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, and, in addition, is subject to a civil money penalty of not to exceed $15,000 for each such violation. Any association or its subsidiary or carrier that sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be fined in accordance with title 18, United States Code, and in addition, is subject to a civil money penalty of not to exceed $25,000 for each violation.

"(h) Agent Training and Certification Requirements.—The NAIC, shall establish requirements for long-term care insurance agent training and certification that—

"(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care insurance policies; and

"(2) specify procedures for certifying agents who have completed such training and who are as qualified to sell or offer for sale long-term care insurance policies.

"SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

"(a) Refund of Premiums.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 2717, the carrier shall refund directly to the applicant, or in the case of an employer to whomever remits the premium, and not by delivery by the agent, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy (or certificate).

"(b) Mailing of Policy.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall provide the applicant, or in the case of a group plan the employer, the policy (or certificate) of insurance not later than 30 days after the date of the approval.

"(c) Information on Denials of Claims.—If a claim under a long-term care insurance policy is denied, the carrier shall, within 30 days of the date of a written request by the policyholder or certificate holder (or representative)—

"(1) provide a written explanation of the reasons for the denial; and

"(2) make available all medical and patient records directly relating to such denial.

Except as provided in subsection (e) of section 2715, no claim under such a policy may be denied on the basis of a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

"(d) Reporting of Information.—A carrier that issues one or more long-term care insurance policies shall periodically (not less often than annually) report, in a form and in a manner determined by the NAIC, to the Commissioner, superintendent or director of insurance of each State in which the policy is delivered, and shall make available to the Secretary, upon request, information in a form and manner determined by the NAIC concerning—

"(1) the long-term care insurance policies of the carrier that are in force;

"(2) the most recent premiums for such policies and the premiums imposed for such policies since their initial issuance;

"(3) the lapse rate, replacement rate, and rescission rates by policy;

"(4) the names of that 10 percent of its agents that—

"(A) have the greatest lapse and replacement rate; and

"(B) have produced at least $50,000 of long-term care insurance sales in the previous year; and

"(5) the claims denied (expressed as a number and as a percentage of claims submitted) by policy.

Information required under this subsection shall be reported in a format specified in the standards established under section 2701(a). For purposes of paragraph (3), there shall be included (but reported separately) data concerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

"(e) Standards on Compensation for Sale of Policies.—

"(1) In general.—A carrier that issues one or more long-term care insurance policies may provide a commission or other compensation to an agent or other representative for the sale of such a policy only if the first year commission or other first year compensation to be paid does not exceed 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year, or if the first year commission or other compensation to be paid does not exceed 50 percent of the premium paid on the first year policy, until the NAIC promulgates mandatory standards concerning compensation for the sale of such policies.

"(2) Subsequent years.—The commission or other compensation provided for the sale of long-term care insurance policies in years subsequent to the first year of the policy shall be the same as that provided in the second subsequent year and shall be provided for no fewer than 5 subsequent years.

"(3) Limitation.—No carrier shall provide compensation to its agents for the sale of a long-term care insurance policy and no agent shall receive compensation greater than the renewal compensation payable by the replacing carrier on renewal policies if an existing policy is replaced.

"(4) Compensation defined.—As used in this subsection, the term 'compensation' includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy, including but not limited to deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

"SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE, AND BASIS FOR CANCELLATION OF POLICIES.

"(a) In General.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation or fraud.

"(b) Continuation and Conversion Rights for Group Policies.—

"(1) In general.—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

"(2) Basis for continuation.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facility, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

"(3) Basis for conversion.—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

"(A) whose coverage under the group policy would otherwise be terminated for any reason; and

"(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

"(4) Treatment of substantial equivalence.—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

"(5) Group replacement of policies.—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

"(c) Standards for Issuance.—

"(1) In general.—

"(A) Guarantee.—An agent, association or carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual, or eligible individual in the case of a group plan, if such individual meets the minimum medical underwriting requirements of such policy.

"(B) Premium for converted policy.—If a group policy from which conversion is made is a replacement for a previous group policy, the premium for the converted policy shall be calculated on the basis of the insured's age at the inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

"(2) Upgrade for current policies.—The NAIC shall establish standards, including those providing guidance on medical underwriting and age rating, with respect to the access of individuals to policies offering upgraded benefits.

"(d) Effect of Incapacitation.—

"(1) In general.—

"(A) Prohibition.—Except as provided in paragraph (2), a long-term care insurance policy in effect as of the effective date of the standards established under section 2701(a) may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care provider, independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

"(B) Reinstatement.—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the insurer is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a period of not less than 5 months after termination and shall allow for the collection of past due premium.

"(2) Permitted cancellation.—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

"(A) the period of such nonpayment is in excess of 30 days; and

"(B) notice of intent to cancel is provided to the policyholder or designated representative of the policy holder not less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

"SEC. 2715. BENEFIT STANDARDS.

"(a) Use of Standard Definitions and Terminology, Uniform Format, and Standard Benefits.—Each long-term care insurance policy shall, with respect to services, providers or facilities, pursuant to standards established under section 2701(a)—

"(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with respect to definitions and terminology used for long-term care services and providers;

"(2) use a uniform format for presenting the outline of coverage under such a policy; and

"(3) provide coverage for at least one standard benefits package (of those developed by the NAIC) that shall include the limitations on the amount of payments per day and the lengths of covered stays for nursing facility and home health care services;

as prescribed under guidelines issued by the NAIC and periodically updated.

"(b) Disclosure.—

"(1) Outline of coverage.—

"(A) Requirement.—Each carrier that sells or offers for sale a long-term care insurance policy shall provide an outline of coverage under such policy that meets the applicable standards established pursuant to section 2701(a), complies with the requirements of subparagraph (B), and is in a uniform format as prescribed in guidelines issued by the NAIC and periodically updated.

"(B) Contents.—The outline of coverage for each long-term care insurance policy shall include at least the following:

"(i) A description of the principal benefits and coverage under the policy.

"(ii) A statement of the principal exclusions, reductions, and limitations contained in the policy.

"(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

"(iv) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern, except that such summary shall substantially and accurately reflect the contents of the policy or the master policy.

“(v) A description of the terms, specified in section 2717, under which a policy or certificate may be returned and premium refunded.

“(vi) Information on national average costs for nursing facility and home health care and information (in graphic form) on the relationship of the value of the benefits provided under the policy to such national average costs and State average costs, where available.

“(vii) A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.

“(2) Certificates.—A certificate issued pursuant to a group long-term care insurance policy shall include—

“(A) a description of the principal benefits and coverage provided in the policy;

“(B) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

“(C) a statement that the group master policy determines governing contractual provisions.

“(3) Long-term care as part of life insurance.—In the case of a long-term care insurance policy issued as a part of, or a rider on, a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

“(A) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

“(B) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person; and

“(C) any exclusions, reductions, and limitations on benefits of long-term care.

“(4) Additional information.—The NAIC shall develop recommendations with respect to informing consumers of the long-term economic viability of carriers issuing long-term care insurance policies.

“(c) Limiting Conditions on Benefits; Minimum Benefits.—

“(1) In general.—A long-term care insurance policy may not condition or limit eligibility—

“(A) for benefits for a type of services to the need for or receipt of any other services;

“(B) for any benefit on the medical necessity for such benefit;

“(C) for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC; or

“(D) for residential care (if covered under the policy) only—

“(i) to care provided in facilities which provide a higher level of care; or

“(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

“(2) Home health care or community-based services.—If a long-term care insurance policy provides benefits for the payment of specified home health care or community-based services, the policy—

“(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

“(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or licensed or certified home care worker, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC;

“(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

“(D) must provide, at a minimum, benefits for personal care services (including home health aide and home care worker services as defined by the NAIC) home health services, adult day care, and respite care in an individual's home or in another setting in the community, or any of these benefits on a respite care basis.

“(3) Nursing facility services.—If a long-term care insurance policy provides benefits for the payment of specified nursing facility services, the policy must provide such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act or until such time as subsequently provided for by the NAIC in establishing uniform language and definitions under section 2715(a)(1)) in the State.

“(4) Per diem policies.—

“(A) Definition.—For purposes of this title, the term ‘per diem long-term care insurance policy’ means a long-term care insurance policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

“(B) Limitation.—No per diem long-term care insurance policy (or certificate) may condition or otherwise exclude benefit payments based on the receipt of any type of nursing facility, home health care or community-based services.

“(d) Prohibition of Discrimination.—A long-term care insurance policy may not treat benefits under the policy in the case of an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other cognitive or mental impairment differently from an individual having another medical condition for which benefits may be made available.

“(e) Limitation on Use of Preexisting Condition Limits.—

“(1) Initial issuance.—

“(A) In general.—Subject to subparagraph (B), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the issuance of the policy.

“(B) 6-month limit.—

“(i) In general.—No long-term care insurance policy or certificate issued under this title shall utilize a definition of ‘preexisting condition’ that is more restrictive than the following: The term ‘preexisting condition’ means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured individual.

“(ii) Prohibition on exclusion of coverage.—No long-term care insurance policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of the coverage of the insured individual.

“(2) Replacement policies.—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

“(f) Eligibility for Benefits.—

“(1) Long-term care policies.—Each long-term care insurance policy shall—

“(A) describe the level of benefits available under the policy; and

“(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive, or mental impairment required in order to receive benefits under the policy.

“(2) Functional assessment.—In order to submit a claim under any long-term care insurance policy, each claimant shall have a professional functional assessment of his or her physical, cognitive, and mental abilities. Such initial assessment shall be conducted by an individual or entity, meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and that such individual meets any applicable State licensure and certification requirements. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy. For purposes of this paragraph and paragraph (4), the term ‘control’ means the direct or indirect possession of the power to direct the management and policies of a person. Control is presumed to exist, if any person directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent of the voting securities of another person.

“(3) Claims review.—Except as provided in paragraph (4), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

“(4) Appeals process.—

“(A) In general.—Each long-term care insurance policy shall provide for a timely and independent appeals process, meeting standards established by the NAIC, for individuals who dispute the results of the claims review, conducted under paragraph (3), of the claimant's functional assessment, conducted under paragraph (2).

“(B) Independent assessment.—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's physical, cognitive or mental abilities.

“(C) Conduct.—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

“(i) by an individual who has a direct or indirect significant or controlling interest in, or direct affiliation or relationship with, the issuer of the policy;

“(ii) by an entity that provides services to the policyholder or certificateholder for which benefits are available under the long-term care insurance policy; or

“(iii) by an individual or entity in control of, or controlled by, the issuer of the policy.

“(5) Standard assessments.—Not later than 2 years after the date of enactment of this title, the advisory committee established under section 2701(d) shall recommend uniform needs assessment mechanisms for the determination of eligibility for benefits under such assessments.

“(g) Inflation Protection.—

"(1) OPTION TO PURCHASE.—A carrier may not offer a long-term care insurance policy unless the carrier also offers to the proposed policyholder, including each group policyholder, the option to purchase a policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not offer to a policyholder an inflation protection feature that is less favorable to the policyholder than one of the following:

"(A) With respect to policies that provide for automatic periodic increases in benefits, the policy provides for an annual increase in benefits in a manner so that such increases are computed annually at a rate of not less than 5 percent.

"(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous period was not declined. The amount of any such additional benefit may not be less than the difference between—

"(i) the existing policy benefit; and

"(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and extending until the year in which the offer of increase is made.

"(C) With respect to service benefit policies, the policy covers a specified percentage of the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

"(2) EXCEPTION.—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

"(3) REQUIRED INFORMATION.—Carriers shall include the following information in or together with the outline of coverage provided under this title:

"(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison shall show benefit levels over not less than a 20-year period.

"(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

"(4) CONTINUATION OF PROTECTION.—Inflation protection benefit increases under this subsection under a policy that contains such protection shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

"(5) CONSTANT PREMIUM.—An offer of inflation protection under this subsection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

"(6) REJECTION.—Inflation protection under this subsection shall be included in a long-term care insurance policy unless a carrier obtains a written rejection of such protection signed by the policyholder.

"SEC. 2716. NONFORFEITURE.

"(a) IN GENERAL.—Each long-term care insurance policy (or certificate) shall provide that if the policy lapses after the policy has been in effect for a minimum period (specified under the standards under section 2701(a)), the policy will provide, without payment of any additional premiums, nonforfeiture benefits as determined appropriate by the NAIC.

"(b) ESTABLISHMENT OF STANDARDS.—The standards under section 2701(a) shall provide that the percentage or amount of benefits under subsection (a) must increase based upon the policyholder's equity in the policy.

"SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

"(a) CONTESTABILITY.—A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or material misrepresentation relating to the issuance of the policy unless notice of such fraud or material misrepresentation is provided within a time period to be determined by the NAIC.

"(b) RIGHT TO RETURN.—Each applicant for a long-term care insurance policy shall have the right to return the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

"SEC. 2718. CIVIL MONEY PENALTY.

"(a) CARRIER.—Any carrier, association or its subsidiary that sells or offers for sale a long-term care insurance policy and that—

"(1) fails to make a refund in accordance with section 2713(a);

"(2) fails to transmit a policy in accordance with section 2713(b);

"(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

"(4) provides a commission or compensation in violation of section 2713(e);

"(5) fails to provide an outline of coverage in violation of section 2715(b)(1); or

"(6) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $25,000 for each such violation.

"(b) AGENTS.—Any agent that sells or offers for sale a long-term care insurance policy and that—

"(1) fails to make a refund in accordance with section 2713(a);

"(2) fails to transmit a policy in accordance with section 2713(b);

"(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

"(4) fails to provide an outline of coverage in violation of section 2715(b)(1); or

"(5) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $15,000 for each such violation.

"PART C—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND ENDORSEMENTS

"SEC. 2721. LONG-TERM CARE INSURANCE POLICY DEFINED.

"(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance policy, rider or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

"(1) group and individual annuities and life insurance policies, riders or certificates that provide directly, or that supplement long-term care insurance; and

"(2) a policy, rider or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

"(b) ISSUANCE.—Long-term care insurance policies may be issued by—

"(1) carriers;

"(2) fraternal benefit societies;

"(3) nonprofit health, hospital, and medical service corporations;

"(4) prepaid health plans;

"(5) health maintenance organizations; or

"(6) any similar organization to the extent they are otherwise authorized to issue life or health insurance.

"(c) POLICIES EXCLUDED.—The term 'long-term care insurance policy' shall not include any insurance policy, rider or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance, such term shall not include life insurance policies, riders or certificates that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

"(d) APPLICATIONS.—Notwithstanding any other provision of this title, this title shall apply to any product advertised, marketed or offered as a long-term insurance policy, rider or certificate.

"SEC. 2722. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

"Not later than 1 year after the date of enactment of this title the NAIC shall issue guidelines that shall apply to organizations and associations, other than employers and labor organizations that do not accept compensation, and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association. Such guidelines shall include at minimum the following:

"(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations may not function primarily as sales agents for insurance companies.

"(2) Organizations and associations shall provide objective information regarding long-term care insurance policies sold or endorsed by such organizations and associations to ensure that members of such organizations and associations have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

"(3) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the manner in which such policies and the insurance company issuing such policies were selected. If the organization or association and the insurance company have interlocking directorates, the organization or association shall disclose such fact to their members.

"(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or association receives) from the endorsement or sale of the policy to its members.

"(5) The Boards of Directors of organizations and associations selling or endorsing long-term care insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.

"PART D—MISCELLANEOUS PROVISIONS

"SEC. 2731. FUNDING FOR LONG-TERM CARE INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE.

"(a) IN GENERAL.—The Secretary, acting through the Public Health Service, may award grants to States, and national organizations with demonstrated experience in long-term care insurance, for the establishment of programs to provide information, counseling, and assistance relating to the procurement of adequate and appropriate long-term care insurance.

"(b) APPLICATION.—To be eligible to receive a grant under subsection (a), a State or national organization shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the program for which the State or organization intends to use the amounts provided under the grant.

"(c) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated for grants to States under subsection (a), $10,000,000 for each of the fiscal years 1996 through 1998.

"(2) NATIONAL ORGANIZATIONS.—There are authorized to be appropriated for grants to national organizations under subsection (a), $1,000,000 for each of the fiscal years 1996 through 1998.

"SEC. 2732. DEFINITIONS.

"As used in this title:

"(1) AGENT.—The term 'agent' means—

"(A) prior to 2 years after the date of enactment of this Act, an individual who sells or offers for sale a long-term care insurance policy subject to the requirements of this title and is licensed or required to be licensed under State law for such purpose; and

"(B) after the date referred to in subparagraph (A), an individual who meets the training and certification requirements established under section 2712(f).

"(2) ASSOCIATION.—The term 'association' includes the association and its subsidiaries.

"(3) CARRIER.—The term 'carrier' means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insured carrier, a reinsurance carrier, and a multiple employer welfare arrangement (a combination of employers associated for the purpose of providing health benefit plan coverage for their employees).".

(b) CONFORMING AMENDMENTS.—

(1) Sections 2701 through 2714 of the Public Health Service Act (42 U.S.C. 300cc through 300cc–15) are redesignated as sections 2801 through 2814, respectively.

(2) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are amended by striking "2701" each place that such appears and inserting "2801".

Subtitle C—Protection of Assets Under Medicaid Through Use of Qualified Long-term Care Insurance

SEC. 3201. PROTECTION OF ASSETS THROUGH USE OF QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by sections 1601(a) and 1701(a), is amended—

(1) by redesignating section 1933 as section 1934; and

(2) by inserting after section 1932 the following new section:

"SPECIAL RULES FOR ASSET DISREGARD IN THE CASE OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS

"SEC. 1933. (a) IN GENERAL.—Each State plan under this title may provide, subject to subsection (d), that in determining the eligibility of an individual for medical assistance under the plan with respect to such services there shall be disregarded some or all of the individual's assets which are attributable (as determined under subsection (c)(2)) to coverage under a qualified long-term care insurance contract (as defined in subsection (b)).

"(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT DEFINED.—In this section, the term 'qualified long-term care insurance contract' means, with respect to a State, a long-term care insurance contract (as defined in section 818A(b) of the Internal Revenue Code of 1986) which—

"(1) provides such protection against the costs of receiving long-term care services as the State may require by law;

"(2) provides that benefits under the contract shall be paid without regard to eligibility for medical assistance under this title; and

"(3) meets such other requirements (such as requirements relating to premiums, disclosure, minimum benefits, rights of conversion, and standards for claims processing) as the State may determine to be appropriate.

"(c) OTHER DEFINITIONS.—In this section:

"(1) LONG-TERM CARE SERVICES.—The term 'long-term care services' means nursing facility services, home health care services, and home and community-based services, and includes such other similar items and services described in section 1905(a) as a State may specify.

"(2) ATTRIBUTION RULES.—An individual's assets are considered to be 'attributable' to a qualified long-term care insurance contract to the extent specified under the State plan. Such a plan shall provide for at least one of the following:

"(A) All assets are considered attributable if the insurance contract provides coverage for at least a specified period of coverage (of not less than 3 years and of not more than 6 years) for long-term care services.

"(B) An amount of assets, up to the dollar limitation on benefits for long-term care services under the contract, is considered attributable to the contract.

"(d) LIMITATION.—In no case shall this section result in (1) the total Federal payments to the State for the quarter under this title (including payments attributable to this section), exceeding (2) the total Federal payments that the Secretary estimates would have been paid under this title to the State for the quarter if the State did not provide for the determination of eligibility in accordance with subsection (a).".

(b) CONFORMING AMENDMENT.—Section 1902(a)(17)(A) of such Act (42 U.S.C. 1396a(a)(17)(A)) is amended by inserting "and section 1932" after "objectives of this title".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply (except as provided under paragraph (2)) to payments to States under title XIX of the Social Security Act for calendar quarters beginning on or after one year after the date of the enactment of this Act, without regard to whether regulations to implement such amendment are promulgated by such date.

(2) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle D—Studies

SEC. 3301. FEASIBILITY OF ENCOURAGING HEALTH CARE PROVIDERS TO DONATE SERVICES TO HOMEBOUND PATIENTS.

The Comptroller General of the United States shall conduct a study on the feasibility of encouraging health care providers to donate their services to homebound patients. Such study shall include an examination of the effects of qualifying such services as a charitable contribution.

SEC. 3302. FEASIBILITY OF TAX CREDIT FOR HEADS OF HOUSEHOLDS WHO CARE FOR ELDERLY FAMILY MEMBERS IN THEIR HOMES.

The Comptroller General of the United States shall conduct a study on the feasibility of providing heads of households who care for elderly family members in their homes with a tax credit. Such study shall estimate the cost of such a tax credit which would apply to expenses incurred in the custodial care of such an elderly family member to the extent such expenses exceed 5 percent of adjusted gross income.

SEC. 3303. CASE MANAGEMENT OF CURRENT LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the feasibility of encouraging or requiring the use of a single designated public or nonprofit agency (such as an area agency on aging) to coordinate, through case management, the provision of long-term care benefits under current Federal, State, and local programs in a geographic area.

(b) REPORT.—The Secretary shall submit to Congress a report on the study conducted under subsection (a) by not later than 1 year after the date of the enactment of this Act.

Such report shall include such recommendations regarding changes in legislation to encourage or require the use (described in subsection (a)) of an agency to coordinate long-term care benefits as may be appropriate.

Subtitle E—Volunteer Service Credit Demonstration Projects

SEC. 3401. AMENDMENT TO THE OLDER AMERICANS ACT OF 1965.

(a) IN GENERAL.—Part B of title IV of the Older Americans Act of 1965 (42 U.S.C. 3034–3035r) is amended by adding at the end the following:

"SEC. 429K. VOLUNTEER SERVICE CREDIT DEMONSTRATION PROJECTS.

"(a) REQUIREMENTS.—The Commissioner shall—

"(1) establish and operate (directly, or through the State agency on aging or one or more area agencies on aging) a volunteer service credit demonstration project in all or part of each State;

"(2) establish criteria for selecting individuals to whom volunteer services will be provided under volunteer service credit demonstration projects operated under paragraph (1);

"(3) recruit and train (directly or through State agencies on aging or area agencies on aging) individuals who volunteer to provide services through such projects;

"(4) establish a minimum standard for each service to be provided by volunteers through such projects;

"(5) monitor services provided by volunteers through such projects to ensure that standards established under paragraph (4) are met; and

"(6) maintain (directly or through State agencies on aging or area agencies on aging) with respect to each individual who provides services through a volunteer service credit demonstration project operated under paragraph (1) a separately identifiable account showing the number of hours such individual provided such services.

"(b) DEFINITION.—For purposes of subsection (a), the term 'volunteer service credit demonstration project' means a demonstration project through which homemaker services, respite care for families, adult day care, and educational, transportation, and home-delivery services are provided by—

"(1) volunteer older individuals for the benefit of older individuals or low-income children; or

"(2) volunteer individuals of any age for the benefit of older individuals;

in return for the receipt of similar services under any such demonstration project (that is established under this section) at a time at which such volunteers are older individuals in need of such services.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 1995.

AMENDMENT TO H.R. 3600, AS REPORTED TO BE OFFERED BY REPRESENTATIVE PETRI

Strike all after the enacting clause and insert in lieu thereof the text of H.R. 4469 (as introduced).

Amendment To H.R. 3600 Offered By Mr. Rowland of Georgia

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUBTITLES.

(a) SHORT TITLE.—This Act may be cited as the "Bipartisan Health Care Reform Act of 1994".

(b) TABLE OF TITLES AND SUBTITLES IN ACT.—The following are the titles and subtitles contained in this Act:

TITLE I—ASSURING AVAILABILITY AND CONTINUITY OF HEALTH COVERAGE

Subtitle A—Insurance Reforms
Subtitle B—Benefits
Subtitle C—Employer Responsibilities
Subtitle D—Definitions; General Provisions

TITLE II—REMOVAL OF FINANCIAL BARRIERS TO ACCESS

Subtitle A—Tax Deductibility for Individuals and Self-Employed
Subtitle B—Low-Income Subsidies and Medicaid Reform
Subtitle C—Report and Recommendations on Health Coverage and Access

TITLE III—ACCESS IMPROVEMENTS

Subtitle A—Expanding Access in Underserved Areas
Subtitle B—Improved Access in Rural Areas
Subtitle C—Academic Health Centers
Subtitle D—United States-Mexico Border Health Commission

TITLE IV—HEALTH CARE QUALITY ENHANCEMENT

Subtitle A—Performance Measures for Quality Assurance
Subtitle B—Primary Care Provider Education
Subtitle C—Other Medical Education Grants and Programs

TITLE V—MARKET INCENTIVES TO CONTAINING COSTS

Subtitle A—Facilitating Establishment of Health Plan Purchasing Organization (HPPOs) and Health Risk Pools
Subtitle B—Preemption of State Benefit Mandates and Anti-Managed Care Laws
Subtitle C—Malpractice Reform
Subtitle D—Paperwork Reduction and Administrative Simplication
Subtitle E—Antitrust
Subtitle F—Fraud and Abuse
Subtitle G—Billing for Laboratory Services

TITLE VI—MEDICARE AND MEDICAID

Subtitle A—Increased Medicare Beneficiary Choice; Improved Program Efficiency
Subtitle B—Savings in Medicare and Medicaid

TITLE VII—INCENTIVES TO PURCHASE LONG-TERM CARE INSURANCE

Subtitle A—Establishment of Federal Standards for Long-term Care Insurance
Subtitle B—Tax Treatment of Long-term Care Insurance

TITLE VIII—MISCELLANEOUS SAVINGS PROVISIONS

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TITLE I—ASSURING AVAILABILITY AND CONTINUITY OF HEALTH COVERAGE

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Subtitle A—Insurance Reform

PART 1—GUARANTEED ACCESS TO HEALTH COVERAGE

SEC. 1001. GUARANTEED OFFER BY CARRIERS.

(a) In General.—Each carrier that offers health insurance coverage in the individual or small group market in a service area shall make available, to each qualifying individual or small employer (covered in such market) in the service area—

(1) qualified standard coverage consistent with section 1102, and

(2) subject to subsection (b), qualified high-deductible coverage consistent with section 1103.

(b) High-Deductible Coverage.—.

(1) Exception to offer requirement for health maintenance organizations.—The requirements of subsection (a)(2) shall not apply with respect to a health insurance coverage that—

(A) is provided by a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), or

(B) is not provided by such an organization but is provided by an organization recognized under State law as a health maintenance organization or managed care organization or a similar organization regulated under State law for solvency.

(2) Option to offer medisave coverage.—The offer of high-deductible coverage under subsection (a)(2) may be accompanied by the contribution by an employer to a medical savings account (in accordance with section 7705 of the Internal Revenue Code of 1986).

(c) Establishment of Service Areas.—

(1) In general.—Each carrier shall establish one or more service areas with respect to qualified insurance coverage it provides in a State.

(2) Nondiscrimination.—The establishment of such service areas shall be subject to approval of the appropriate regulatory authority and shall not be established in a discriminatory manner.

(3) Coverage of area.—With respect to each service area, the carrier shall provide for coverage of benefits for items and services furnished throughout the service area.

(d) Family Coverage Option.—The offer of coverage under this section with respect to an individual shall include the option of coverage of family members of the individual.

(e) Limitation on Carriers.—A carrier may not require an employer under a group health plan to impose or otherwise to impose through a waiting period for health coverage under a plan or similar requirement a limitation or condition on health coverage or benefits based on the health status of an individual, claims experience of an individual, receipt of health care by an individual, medical history of an individual, receipt of public subsidies by an individual, or lack of evidence of insurability of an individual.

SEC. 1002. GUARANTEED ISSUE BY CARRIERS.

(a) In General.—Subject to subsections (b) and (c) and section 1003, each carrier that offers health insurance coverage in the individual and small group market in a service area—

(1) must accept every small employer in the service area that applies for such coverage during an enrollment period provided under section 1005; and

(2) must accept for enrollment under such coverage every qualifying individual (and family member of such an individual) who applies for enrollment during an enrollment period provided under section 1005 and may not place any restriction on the eligibility of an individual to enroll so long as such individual is a qualifying individual.

(b) Special Rules for Managed Care Arrangements.—In the case of coverage offered by an carrier or under a group health plan that provides benefits through a managed care arrangement, the carrier or plan may—

(1) limit the employers that may apply for such coverage to those with qualifying individuals residing in the service area in which the coverage is provided;

(2) limit the individuals who may be enrolled under such coverage to those who reside in such service area; and

(3) within such service area, deny such coverage to such employers or individuals if the organization demonstrates to the applicable regulatory authority that—

(A) it will not have the capacity to deliver services adequately to enrollees of any additional groups or additional enrollees because of its obligations to existing group contract holders and enrollees, and

(B) it is applying this paragraph uniformly to all employers and individuals without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

(c) Special Rule for Financial Capacity Limits.—In the case of coverage offered by any carrier, the carrier may deny coverage to a small employer or individual if the carrier demonstrates to the applicable regulatory authority that—

(1) it does not have the financial reserves necessary to underwrite additional coverage, and

(2) it is applying this subsection uniformly to all employers and individuals without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

SEC. 1003. GUARANTEED RENEWAL.

(a) Limitation on Termination by Carriers.—Subject to subsection (c), a carrier may deny, cancel, or not renew health coverage of a qualifying individual or eligible employer only on the basis of—

(1) nonpayment of premiums,

(2) fraud or misrepresentation, or

(3) subject to subsection (b), because the carrier is ceasing to provide any health insurance coverage in the individual and small group markets a State, or, in the case of a health maintenance organization, in a geographic area.

(b) Limitations on Market Exit by Carriers.—

(1) Notice, etc.—Subsection (a)(3) shall not apply to a carrier ceasing to provide health insurance coverage unless—

(A) such termination of coverage takes effect at the end of a contract year, and

(B) the carrier provides notice of such termination to employers and individuals covered at least 30 days before the date of an annual open enrollment period established with respect to the employer or individual under section 1005

(3) Limitation on reentry in individual and small group market.—If a carrier ceases to offer or provide health insurance coverage in an area with respect to the individual or small group market, the insurer may not offer such health insurance coverage in the area in such market until 5 years after the date of the termination.

(c) Rule for Multiemployer Plans.—A multiemployer plan and a certified multiple employer health plan may not cancel coverage or deny renewal of coverage under such a plan with respect to an employer other than—

(1) for nonpayment of contributions,

(2) for fraud or other misrepresentation by the employer, or

(3) because the plan is ceasing to provide any coverage in a geographic area.

SEC. 1004. PROHIBITING PREEXISTING CONDITION EXCLUSIONS.

(a) In General.—Except as provided in this section, a carrier or group health plan providing qualified health coverage may not exclude health coverage with respect to services related to treatment of a condition based on the fact that the condition existed before the effective date of coverage of the individual.

(b) Limitation on Duration of Exclusion to 6 Months; Crediting of Previous Coverage.—

(1) In general.—Subject to paragraph (2), the period of an exclusion under subsection (a) may not exceed 6 months beginning on the date of coverage.

(2) Crediting of previous coverage.—A carrier or group health plan providing qualified health coverage shall provide that if a covered individual is in a period of continuous coverage (as defined in paragraph (4)) as of the date of initial coverage, any period of exclusion of coverage with respect to a preexisting condition (as defined in paragraph (3)) for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

(3) Preexisting condition defined.—In this subsection, the term "preexisting condition" means, with respect to health coverage, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(4) Period of continuous coverage.—In this subsection, subject to paragraphs (5) and (6), the term "period of continuous coverage" means the period beginning on the date an individual has health coverage (or coverage under a public plan providing medical benefits) and ends on the date the individual does not have such coverage for a continuous period of more than 3 months.

(5) Exceptions for children.—A child who is covered at the time of birth or adoption is considered to be in a period of continuous coverage as of the date of birth or adoption.

(6) Transitional amnesty at time of initial enrollment.—For purposes of this paragraph, each individual who—

(A) has health coverage as of the first day of an amnesty period described in section 1105(a)(1) shall be considered to have had a period of continuous coverage during the previous 6 months, or

(B) does not have health coverage as of the first day of such an amnesty period but obtains such coverage during the period, shall be considered to have had a period of continuous coverage during the 6 months preceding the effective date of the coverage.

(c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—The exclusion of coverage shall not apply if the exclusion relates to pregnancy.

(d) APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization that provides health insurance coverage shall not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwithstanding that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provisions of this part so long as such exclusion is applied consistent with the provisions of this part.

SEC. 1005. ASSURING CHOICE OF COVERAGE THROUGH OPEN ENROLLMENT.

(a) OPEN ENROLLMENT PERIODS.—

(1) AMNESTY PERIODS.—

(A) INITIAL PERIOD.—There shall be an initial amnesty and open enrollment period, with respect to individuals who are residents of a State, during the 60-day period beginning on January 1, 1997.

(B) CONTINUOUS OPEN ENROLLMENT FOR FULLY SUBSIDIZED INDIVIDUALS.—There shall be an individual amnesty and continuous open enrollment period, with respect to an individual at any time the individual is eligible for the full amount of the premium assistance under part A of title XXI of the Social Security Act and does not have qualified health coverage.

(C) NEWLY ELIGIBLE FOR SUBSIDIES.—There shall be an individual amnesty and open enrollment period, with respect to an individual not described in subparagraph (B) at the time the individual first becomes eligible for premium assistance under part A of title XXI of the Social Security Act, during the 60-day period beginning on the first date the individual becomes so eligible.

(2) OTHER OPEN ENROLLMENT PERIODS.—Each carrier and each group health plan providing health coverage (and each health plan purchasing organization under subtitle A of title V) in the individual and small group market shall provide for at least one period (of not less than 30 days) each year during which qualifying individuals and eligible employers may obtain qualified health coverage from the carrier or group. Such period shall be in addition to the amnesty periods under paragraph (1).

(b) SPECIAL ENROLLMENT PERIODS.—

(1) NEWLY ELIGIBLE IN AN AREA.—For each qualifying individual, at the time the individual moves outside the service area of coverage provided by a carrier to the individual, there shall be an open enrollment period (of not less than 30 days) during which the individual may enroll in health insurance coverage.

(2) FAMILY OR EMPLOYMENT CHANGES.—In the case of a qualifying individual who—

(A) through marriage, divorce, birth or adoption of a child, or similar circumstances, experience a change in family composition, or

(B) experience a change in employment status (including a significant change in the terms and conditions of employment or the terms and conditions of employment of a spouse),

the individual shall have a period (of at least 30 days) in which the individual is permitted to change the individual or family basis of coverage or the health coverage in which the individual is enrolled. The circumstances under which such special enrollment periods are required and the duration of such periods shall be specified by the Secretary.

(3) ENROLLMENT DUE TO LOSS OF PREVIOUS COVERAGE.—In the case of a qualifying individual who—

(A) had health coverage at the time of the individual's initial enrollment period,

(B) stated at the time of the initial enrollment period that having other health coverage was the reason for declining enrollment, and

(C) lost the other health coverage as a result of the termination of the coverage, termination or reduction of employment, or other reason, except termination at the option of the individual,

there shall be a special enrollment period during the 30-day period beginning on the date of termination of the other coverage.

(4) EXCEPTION FOR COURT ORDERS.—If a court has ordered that coverage be provided for a spouse or child of an employee under a covered employee's group health plan, there shall be a special enrollment period during the 30-day period beginning on the date of issuance of the court order.

(5) ENROLLMENT OF FAMILY MEMBERS.—There shall be an open enrollment period with respect to family members of an individual (including children of a spouse) during the 30-day period beginning on the date of the marriage or of the date of the birth or adoption of a child, if family coverage is available as of such date.

(c) PERIOD OF COVERAGE.—

(1) OPEN ENROLLMENT PERIODS.—In the case of a qualifying individual who enrolls under health coverage during a general enrollment period under subsection (a), the coverage shall begin on the first day of the first month beginning at least 15 days after the end of such period.

(2) SPECIAL ENROLLMENT PERIODS.—

(A) IN GENERAL.—In the case of a qualifying individual who enrolls under health coverage during a special enrollment period under subsection (b), coverage shall begin on such date (not later than the first day of the first month that begins at least 15 days after the date of enrollment) as the Secretary shall specify, consistent with this paragraph.

(B) COVERAGE OF FAMILY MEMBERS.—The Secretary shall provide for coverage of family members to begin as soon as possible on or after the date of the event that gives rise to the special enrollment period (or, in the case of birth or adoption, as of the date of birth or adoption).

PART 2—PROVISION OF BENEFITS

SEC. 1011. STANDARDS FOR MANAGED CARE ARRANGEMENTS.

(a) APPLICATION OF REQUIREMENTS.—Each group health plan, and each carrier providing health insurance coverage, that provides for health care through a managed care arrangement (as defined in section 1903) shall comply with the applicable requirements of this section.

(b) SCOPE OF ARRANGEMENTS WITH PROVIDERS.—

(1) ACCESS TO CARE.—The entity providing for a managed care arrangement with respect to health coverage shall enter into such agreements with health care providers (including primary and specialty providers, such as providers for children) or have such other arrangements as may be necessary to assure that covered individuals have reasonably prompt access through the entity's provider network to all items and services contained in the package of benefits for which coverage is provided (including access to emergency services on a 24-hour basis where medically necessary), in a manner that assures the continuity of the provision of such items and services. Such access shall take into account the diverse needs of enrollees and proximity to the workplaces or residences of enrollees.

(2) ACCESS TO CENTERS OF EXCELLENCE.—

(A) IN GENERAL.—The entity providing for a managed care arrangement under health coverage shall demonstrate that covered individuals (including individuals with chronic diseases) have access through the entity's provider network to specialized treatment expertise. Such entity may demonstrate such access through contracts with centers of excellence described in subparagraph (B).

(B) DESIGNATION OF CENTERS OF EXCELLENCE.—The Secretary shall establish a process for the designation of facilities, including children's hospitals and other pediatric facilities, as centers of excellence for purposes of this paragraph. A facility may not be designated unless the facility is determined—

(i) to provide specialty care,

(ii) to deliver care for complex cases requiring specialized treatment and for individuals with chronic diseases, and

(iii) to meet other requirements that may be established by the Secretary relating to specialized education and training of health professionals, participation in peer-reviewed research, or treatment of patients from outside the geographic area of the facility.

(3) CHOICE OF PERSONAL PHYSICIAN.—The entity providing for a managed care arrangement under health coverage shall permit each enrollee to choose a personal physician from among participating physicians and change that selection as appropriate.

(c) PROVISION OF EMERGENCY CARE SERVICES.—

(1) IN GENERAL.—The entity providing for a managed care arrangement under health coverage must cover medically necessary emergency care services provided to covered individuals (including trauma services, such as those provided by designated trauma centers), without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the entity to provide items or services to covered individuals and, in the case of services furnished for the treatment of an emergency medical condition (as defined in section 1867(e)(1) of the Social Security Act), without regard to prior authorization.

(2) DESIGNATED TRAUMA CENTERS DEFINED.—In paragraph (1), the term "designated trauma center"—

(A) has the meaning given such term in section 1231 of the Public Health Service Act, and

(B) includes (for years prior to 2001) a trauma center that—

(i) is located in a State that has not designated trauma centers under section 1213 of such Act, and

(ii) the Secretary finds meets the standards under such section to be a designated trauma center.

(d) DUE PROCESS STANDARDS RELATING TO PROVIDER NETWORKS.—

(1) STANDARDS FOR SELECTION OF PROVIDERS FOR NETWORK.—

(A) ESTABLISHMENT.—The entity providing for a managed care arrangement under health coverage shall establish standards (including competitive criteria for quality, efficiency, credentialing, and services) to be used by the entity for contracting with health care providers with respect to the entity's provider network. Such standards shall be established in consultation with providers who are members of the network.

(B) DISTRIBUTION OF INFORMATION.—Descriptive information regarding these standards and criteria shall be made available to enrollees, providers who are members of the network, and prospective enrollees and prospective participating providers, including notice of when applications for participation will be accepted.

(C) NOTICE OF DENIALS.—The entity shall provide written notice of any denial of an application to participate in the provider network.

(2) NOTICE REQUIREMENT.—

(A) IN GENERAL.—The entity may not terminate or refuse to renew an agreement with a provider to participate in the entity's provider network unless the entity provides written notification to the provider of the entity's decision to terminate or refuse to renew the agreement. The notification shall include a statement of the reasons for the entity's decision, consistent with the standards established under paragraph (1).

(B) TIMING OF NOTIFICATION.—The entity shall provide the notification required under subparagraph (A) at least 45 days prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of a covered individual.

(3) REVIEW PROCESS.—

(A) IN GENERAL.—The entity shall provide a process under which the provider may request a review of the entity's decision to terminate or refuse to renew the provider's participation agreement. Such review shall be conducted by a group of individuals the majority of whom are health care providers who are members of the entity's provider network or employees of the entity, and who are members of the same profession as the provider who requests the review.

(B) COUNSEL.—If the provider requests in advance, the entity shall permit an attorney representing the provider to be present at the provider's review.

(C) REVIEW ADVISORY.—The findings and conclusions of a review under this paragraph shall be advisory and non-binding.

(4) ADVISORY COMMITTEE.—The entity shall establish an advisory committee of participating physicians with whom it consults, on an advisory basis, on the termination of physicians who have been participating in the provider network. In making recommendations to the entity, such an advisory committee may consider such features of the physician's practice, relating to case mix and age of patients, as may lead the physician to have higher than expected treatment costs for the patients of the physician who are enrollees.

(5) CONSTRUCTION.—Nothing in this subsection shall be construed to affect any other provision of law that provides an appeals process or other form of relief to a provider of health care services.

(e) REFERENCE TO PREEMPTION OF STATE LAWS RESTRICTING UTILIZATION REVIEW PROGRAMS.—For preemption of States laws restricting utilization review programs, see section 5103.

SEC. 1012. UTILIZATION REVIEW.

(a) REQUIRING REVIEW TO MEET STANDARDS.—A group health plan or insurer providing health insurance coverage may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets the standards established by the Secretary under this section.

(b) ESTABLISHMENT OF STANDARDS BY SECRETARY.—The Secretary shall establish standards for utilization review programs, consistent with subsection (b), and shall periodically review and update such standards to reflect changes in the delivery of health care services. The Secretary shall establish such standards in consultation with appropriate parties.

(c) REQUIREMENTS FOR STANDARDS.—Under the standards established under subsection (a)—

(1) individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage;

(2) negative determinations of the medical necessity or appropriateness of services or the site at which services are furnished may be made only by clinically qualified personnel;

(3) the utilization review program shall provide for a process under which an enrollee or provider may obtain timely review of a denial of coverage, including upon request a review conducted by the medical director of the carrier or plan or a physician designated by the carrier or plan;

(4) utilization review shall be conducted in accordance with uniformly applied standards that are based on currently available medical evidence; and

(5) providers shall participate in the development of the utilization review program.

(d) PREEMPTION.—For provision preempting State laws relating to utilization review, see subtitle B of title V.

SEC. 1013. REQUIREMENTS FOR ARRANGEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.

(a) REQUIREMENT.—

(1) IN GENERAL.—Subject to subsection (d), each group health plan and each carrier providing qualified health coverage shall, with respect to at least one essential community provider (as defined in subsection (c)) within each class of such a provider (as described in paragraph (2)) located within the service area with respect to the plan or coverage, enter into a written provider participation agreement (described in subsection (b)) with the provider.

(2) CLASS DEFINED.—For purposes of the paragraph (1), providers described in each paragraph of subsection (c) shall constitute a separate "class" of providers.

(b) PARTICIPATION AGREEMENT.—A participation agreement between a group health plan or carrier and an essential community provider under this subsection shall provide that the plan or carrier agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers with a participation agreement with the plan or carrier with respect to the scope of services for which payment is made by the plan or carrier to the provider.

(c) ESSENTIAL COMMUNITY PROVIDERS DESCRIBED.—In this section, an "essential community provider" means any of the following:

(1) CERTAIN MEDICARE DISPROPORTIONATE SHARE HOSPITALS.—A hospital—

(A) described in section 1886(d)(5)(F)(i)(II) of the Social Security Act;

(B) described in section 1886(d)(5)(F)(iv)(I) of such Act with a disproportionate patient percentage (as defined in section 1886(d)(5)(F)(vi) of such Act) greater than 20.2; or

(C) that would be described in subparagraph (A) or (B) if—

(i) the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act), or

(ii) in the case of a hospital whose inpatients are predominantly individuals under 18 years of age, if the hospital were a subsection (d) hospital with more than 100 beds.

(2) SOLE COMMUNITY HOSPITALS.—A sole community hospital (as described in section 1886(d)(5)(D)(iii) of such Act).

(3) MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—A medicare-dependent, small rural hospital (as described in section 1886(d)(5)(G)(iii) of such Act), or a hospital that would be a medicare-dependent, small rural hospital if the hospital were a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act).

(4) FEDERALLY QUALIFIED HEALTH CENTERS.—A Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act) or an entity that would be such a center but for its failure to meet the requirement described in section 329(f)(2)(G)(i) of the Public Health Service Act or the requirement described in section 330(e)(3)(G)(i) of such Act (relating to the composition of the entity's governing board).

(5) RURAL HEALTH CLINICS.—A rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act).

(6) LOCAL HEALTH DEPARTMENTS.—A health department of a unit of State or local government which provides health services directly to individuals.

(d) SUNSET.—The requirement of subsection (a) shall not apply to health coverage provided after December 31, 1999.

SEC. 1014. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Chapter 79 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 7705. MEDICAL SAVINGS ACCOUNTS.

"(a) GENERAL RULE.—For purposes of this title, the term 'medical savings account' means a trust created or organized in the United States for the exclusive benefit of an individual or his beneficiaries, but only if the written instrument creating the trust meets the following requirements:

"(1) Except in the case of a rollover contribution described in subsection (d)(3), no contribution will be accepted unless—

"(A) it is in cash, and

"(B) such individual is an eligible employee for the period for which such contribution is made.

"(2) The trustee is a bank (as defined in section 408(n)), insurance company (as defined in section 816), or such other person who demonstrates to the satisfaction of the Secretary that the manner in which such other person will administer the trust will be consistent with the requirements of this section.

"(3) No part of the trust funds will be invested in life insurance contracts.

"(4) The interest of an individual in the balance of the account is nonforfeitable.

"(5) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(b) ELIGIBLE EMPLOYEE.—For purposes of this section—

"(1) IN GENERAL.—The term 'eligible employee' means any employee who has high-deductible coverage (as defined in section 1103 of the Bipartisan Health Care Reform Act of 1994) offered by the employer.

"(2) EXCEPTION.—An employee shall be treated as not being an eligible employee for any calendar year if, for any month during such year, it is reasonably expected that such employee—

"(A) will have adjusted gross income that is less than 100 percent of the income official poverty line (as determined by the Director of the Office of Management and Budget) for a family of the size involved; or

"(B) is an AFDC recipient or SSI recipient.

"(3) DEFINITIONS.—For purposes of paragraph (2)—

"(A) AFDC RECIPIENT.—The term 'AFDC recipient' means, for a month, an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV, of the Social Security Act for the month.

"(B) SSI RECIPIENT.—The term 'SSI recipient' means, for a month, an individual—

"(i) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

"(ii) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93-66 for the month,

"(iii) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month, or

"(iv) who is treated under section 1619(b) of the Social Security Act as receiving supplemental security income benefits in a month for purposes of title XIX of such Act.

"(c) TAX TREATMENT OF ACCOUNTS.—

"(1) ACCOUNT TAXED AS GRANTOR TRUST.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the account beneficiary of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

"(B) TREATMENT OF CAPITAL LOSSES.—With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall be allowed only to the extent of capital gains from such assets for such taxable year. Any capital loss which is disallowed under the preceding sentence shall be treated as a capital loss from the sale or exchange of such an asset in the next taxable year. For purposes of this subparagraph, all medical savings accounts of the account beneficiary shall be treated as 1 account.

"(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

"(A) IN GENERAL.—If, during any taxable year of the account beneficiary, such beneficiary engages in any transaction prohibited by section 4975 with respect to the account, the account shall cease to be a medical savings account as of the first day of such taxable year.

"(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, subsection (d) shall be applied as if—

"(i) there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day), and

"(ii) no portion of such distribution were used to pay qualified medical expenses.

"(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the account beneficiary uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed and not used to pay qualified medical expenses.

"(d) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary or of the spouse or dependents (as defined in section 152) of such beneficiary shall be included in the gross income of such beneficiary to the extent such amount does not exceed the excess of—

"(i) the aggregate contributions to such account which were not includible in gross income by reason of section 106(2), over

"(ii) the aggregate prior payments or distributions from such account which were includible in gross income under this paragraph.

"(B) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all medical savings accounts of the account beneficiary shall be treated as 1 account,

"(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by chapter 1 on the account beneficiary for any taxable year in which there is a payment or distribution from a medical savings account of such beneficiary which is includible in gross income under paragraph (1) shall be increased by 100 percent of the amount which is so includible.

"(B) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 65.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains age 65.

"(C) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

"(3) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

"(A) IN GENERAL.—Paragraph (1) shall not apply to any amount paid or distributed from a medical savings account to the account beneficiary to the extent the amount received is paid into a medical savings account for the benefit of such beneficiary not later than the 60th day after the day on which he receives the payment or distribution.

"(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in his gross income because of the application of this paragraph.

"(4) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care to the extent of the amount of such payment or distribution which is excludable from gross income solely by reason of paragraph (1)(A).

"(e) DEFINITIONS.—For purposes of this section—

"(1) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' means any expense for medical care (as defined in section 213(d)); except that such term shall not include any amount paid for insurance.

"(2) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual for whose benefit the medical savings account is maintained.

"(f) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

"(1) the assets of such account are held by a bank (as defined in section 408(n)), insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

"(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (a).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

"(g) REPORTS.—The trustee of a medical savings account shall keep such records and make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by such regulations."

(b) INCOME AND EMPLOYMENT TAX TREATMENT OF EMPLOYER CONTRIBUTIONS.—

(1) EMPLOYER PAYMENTS EXCLUDED FROM GROSS INCOME.—The text of section 106 of such Code is amended to read as follows:

"Gross income of an employee does not include—

"(1) employer-provided coverage under an accident or health plan, and

"(2) employer contributions to any medical savings account (as defined in section 7705) of an eligible employee, but only to the extent that the amount contributed does not exceed the excess of premium for standard coverage over the premium for high-deductible coverage (as such terms are defined in section 1903 of the Bipartisan Health Care Reform Act of 1994)."

(2) EMPLOYER PAYMENTS EXCLUDED FROM EMPLOYMENT TAX BASE.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 of such Code is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting "; or", and by inserting after paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2)."

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking "or" at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting "; or", and by inserting after paragraph (19) the following new paragraph:

"(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2) of the Internal Revenue Code of 1986."

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

"(10) Medical savings account contributions.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2)."

(C) Unemployment tax.—Subsection (b) of section 3306 of such Code is amended by striking "or" at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting "; or", and by inserting after paragraph (16) the following new paragraph:

"(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2)."

(D) Withholding tax.—Subsection (a) of section 3401 of such Code is amended by striking "or" at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting "; or", and by inserting after paragraph (20) the following new paragraph:

"(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(2)."

(c) Technical Amendments.—

(1) Tax on prohibited transactions.—Section 4975 of such Code (relating to prohibited transactions) is amended—

(A) by adding at the end of subsection (c) the following new paragraph:

"(4) Special rule for medical savings accounts.—An individual for whose benefit a medical savings account (within the meaning of section 7705) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 7705(c)(2)(A) to such account.", and

(B) by inserting "or a medical savings account described in section 7705" in subsection (e)(1) after "described in section 408(a)".

(2) Failure to provide reports on medical savings accounts.—Section 6693 of such Code (relating to failure to provide reports on individual retirement account or annuities) is amended—

(A) by inserting "**OR ON MEDICAL SAVINGS ACCOUNTS**" after "**ANNUITIES**" in the heading of such section, and

(B) by adding at the end of subsection (a) the following: "The person required by section 7705(g) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause."

(3) Clerical amendments.—

(A) The table of sections for chapter 79 of such Code is amended by adding at the end the following:

"Sec. 7705. Medical savings accounts."

(B) The table of sections for subchapter B of chapter 68 of such Code is amended by inserting "or on medical savings accounts" after "annuities" in the item relating to section 6693.

(d) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

PART 3—FAIR RATING PRACTICES

SEC. 1021. USE OF FAIR RATING PRACTICES.

(a) Use of Fair Rating Practices.—The premium rate established by a carrier for health insurance coverage in the individual and small group market may not vary within a benefit design except by the following:

(1) Age.—By age, based on classes of age established by the Secretary, in consultation with the NAIC, consistent with subsection (b).

(2) Geographic area.—By geographic area, as identified by a State consistent with subsection (c).

(3) Family size.—Family size, based on the following 4 classes of family coverage: individual, individual with one or more children, married couple without children, and married couple with children.

(b) Limitation on Variation by Age.—

(1) In general.—Any variation in premium rates by age under subsection (a)(1) may not result in the ratio of the highest age rate to the lowest age rate exceeding the limiting ratio described in paragraph (2).

(2) Limiting ratio.—For purposes of paragraph (1), the limiting ratio described in this paragraph is—

(A) 4-to-1, for premiums for months in 1997,

(B) 3.67-to-1, for premiums for months in 1998,

(C) 3.33-to-1, for premiums for months in 1999, and

(D) 3-to-1, for premiums for months in 2000 and any succeeding year.

(3) Preemption.—For preemption of State laws relating to establishment of premium rates, see section 5105.

(c) Geographic Area Variations.—For purposes of subsection (a)(2), a State—

(1) may not identify an area that divides a 3-digit zip code, a county or all portions of a metropolitan statistical area within the State, and

(2) may, upon agreement with one or more adjacent States, identify multi-state geographic areas consistent with paragraph (1).

(d) Premium Rating in Group Health Plans.—The premium rate established under a group health plan for health insurance coverage may not vary within a benefit design except by the factors described in subsection (a) and subject to the limitation specified in subsection (b).

(e) Actuarial Certification.—Each carrier that offers health insurance coverage in a State shall file annually with the State commissioner of insurance a written statement by a member of the American Academy of Actuaries (or other individual acceptable to the commissioner) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the insurer and methods used by the insurer in establishing premium rates for applicable health insurance coverage—

(1) the carrier is in compliance with the applicable provisions of this section, and

(2) the rating methods are actuarially sound.

Each such carrier shall retain a copy of such statement for examination at its principal place of business.

SEC. 1022. COORDINATION WITH PREMIUM ASSISTANCE CERTIFICATE PROGRAM.

Each carrier or group health plan providing qualified health coverage shall accept and apply (as a reduction against premiums otherwise imposed) any premium certificate issued under a State premium assistance program under part A of title XXI of the Social Security Act.

SEC. 1023. ESTABLISHMENT OF RISK ADJUSTMENT MECHANISMS.

(a) Establishment of Standards.—

(1) Development of models.—

(A) In general.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, one or more model risk adjustment systems (each in this section referred to as a "risk adjustment mechanism") under which premiums applicable to health insurance coverage in the individual and small group market would be adjusted to take into account such factors as may be appropriate to predict the future need and use of services by covered individuals in the market. Such factors may include the age, gender, geographic residence, health status, socio-economic status, or other demographic characteristics of individuals enrolled in such plans.

(B) Review and application.—If the NAIC develops such models within such period, the Secretary shall review such models to determine if they provide for an effective risk adjustment mechanism. Such review shall be completed within 90 days after the date the models are developed. Unless the Secretary determines within such period that such a model is not an effective risk adjustment mechanism, such remaining models shall serve as the models under this section, with such amendments as the Secretary deems necessary.

(2) Contingency.—If the NAIC does not develop such models within such period or the Secretary determines that all such models do not provide for an effective risk adjustment mechanism, the Secretary shall specify, within 15 months after the date of the enactment of this Act, models to carry out this section.

(b) Implementation of Risk Adjustment Mechanisms.—Each State shall establish and maintain one or more risk adjustment mechanisms that are consistent with a model established under subsection (a) by not later than January 1, 1997. A State may establish and maintain such a mechanism jointly with one or more other States.

(c) Construction.—Nothing in this section shall be construed to prohibit risk adjustment, reinsurance, or allocation of risk arrangements relating to health insurance coverage, whether on a State or multi-State basis, not required under this section.

PART 4—CONSUMER PROTECTIONS

SEC. 1031. REQUIREMENT FOR PROVISION OF INFORMATION.

(a) Carriers.—Each carrier that offers health insurance coverage to small employers (or eligible employees of small employers) or qualifying individuals must disclose to such prospective enrollees, to brokers, and to health plan purchasing organizations the information that the Secretary may specify relating to the performance of the carrier in providing such coverage, consistent with any quality measures established under section 4002.

(b) Group Health Plans.—Each group health plan that provides health coverage must disclose to enrollees and potential enrollees information, similar to the information described in subsection (a), relating to performance of the plan in providing such coverage, consistent with any quality measures established under section 4002.

SEC. 1032. PROHIBITION OF IMPROPER INCENTIVES.

(a) Limitation on Financial Incentives.—No carrier that provides health insurance coverage may vary the commission or financial or other remuneration to a person based on the claims experience or health status of individuals enrolled by or through the person.

(b) NONDISCRIMINATION IN AGENT COMPENSATION.—A carrier—

(1) may not vary or condition the compensation provided to an agent or broker related to the sale or renewal of health insurance coverage because of the health status or claims experience of any individuals enrolled with the carrier through the agent or broker; and

(2) may not terminate, fail to renew, or limit its contract or agreement of representation with an agent or broker for any reason related to the health status or claims experience of any individuals enrolled with the carrier through the agent or broker.

(c) PROHIBITION OF TIE-IN ARRANGEMENTS.—No carrier that offers health insurance coverage may require the purchase of any other insurance or product as a condition for the purchase of such coverage.

SEC. 1033. WRITTEN POLICIES AND PROCEDURES RESPECTING ADVANCE DIRECTIVES.

An insurer and a group health plan offering health coverage shall meet the requirements of section 1866(f) of the Social Security Act (relating to maintaining written policies and procedures respecting advance directives), insofar as such requirements would apply to the insurer or plan if the insurer or plan were an eligible organization.

PART 5—STANDARDS AND CERTIFICATION; ENFORCEMENT; PREEMPTION; GENERAL PROVISIONS

SEC. 1051. ESTABLISHMENT OF STANDARDS.

(a) ROLE OF NAIC.—

(1) IN GENERAL.—The Secretary shall request the NAIC to develop, within 9 months after the date of the enactment of this Act, model regulations that specify standards with respect the requirements of this subtitle.

(2) REVIEW OF STANDARDS.—If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirements, such standards shall serve as the standards under this part, with such amendments as the Secretary deems necessary.

(b) CONTINGENCY.—If the NAIC does not develop such model regulations within such period or the Secretary determines that such regulations do not specify standards that meet the requirements described in subsection (a), the Secretary shall specify, within 15 months after the date of the enactment of this Act, standards to carry out those requirements.

SEC. 1052. APPLICATION OF STANDARDS TO CARRIERS THROUGH STATES.

(a) APPLICATION OF STANDARDS.—

(1) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in paragraph (2), a report on steps the State is taking to implement and enforce the standards established under section 1051 with respect to carriers and health insurance coverage offered not later than such deadline.

(2) DEADLINE FOR REPORT.—The deadline under this paragraph is 1 year after the date the standards are established under section 1051.

(b) FEDERAL ROLE.—

(1) NOTICE OF DEFICIENCY.—If the Secretary determines that a State has failed to submit a report by the deadline specified under subsection (a) or finds that the State has not implemented and provided adequate enforcement of the standards under such subsection, the Secretary shall notify the State and provide the State a period of 60 days in which to submit such report or to implement and enforce such standards under such subsection.

(2) IMPLEMENTATION OF ALTERNATIVE.—

(A) IN GENERAL.—If, after such 60-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of such standards in the State as the Secretary determines to be appropriate.

(B) EFFECTIVE PERIOD.—Such implementation and enforcement shall take effect with respect to carriers, and health insurance coverage offered or renewed, on or after 3 months after the date of the Secretary's finding under the previous sentence, and until the date the Secretary finds that such a failure has been corrected.

SEC. 1053. APPLICATION TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Subject to subsection (b), section 1051 and 1052 shall apply to group health plans providing health coverage in the same manner as they apply to carriers providing health insurance coverage.

(b) SUBSTITUTION OF FEDERAL OFFICIALS.—For purposes of subsection (a), any reference in section 1051 or 1052 to—

(1) a State or the Secretary of Health and Human Services is deemed a reference to the Secretary of Labor, and

(2) any reference to a carrier or health insurance coverage is deemed a reference to a group health plan and health coverage, respectively.

SEC. 1054. ENFORCEMENT.

(a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR EMPLOYERS AND GROUP HEALTH PLANS.—

(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of this title insofar as they relate to group health plans or employers shall be deemed to be provisions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor under this subtitle pursuant to paragraph (1), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

(b) ENFORCEMENT BY EXCISE TAX FOR CARRIERS.—

(1) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding at the end thereof the following new section:

"SEC. 4980C. FAILURE OF CARRIER TO COMPLY WITH HEALTH INSURANCE STANDARDS.

"(a) IMPOSITION OF TAX.—

"(1) IN GENERAL.—There is hereby imposed a tax on the failure of an insurer to comply with the requirements applicable to the insurer under parts 1 through 4 of subtitle A and subtitle B of title I of the Bipartisan Health Care Reform Act of 1994.

"(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by a carrier in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an carrier.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each individual to which such failure relates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

"(2) LIMITATION.—The amount of the tax imposed by subsection (a) for a carrier with respect to health insurance coverage shall not exceed 25 percent of the amounts received for such coverage during the period such failure persists.

"(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the carrier.

"(d) EXCEPTIONS.—

"(1) CORRECTIONS WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) by reason of any failure if—

"(A) such failure was due to reasonable cause and not to willful neglect, and

"(B) such failure is corrected within the 30-day period beginning on the earliest date the insurer knew, or exercising reasonable diligence would have known, that such failure existed.

"(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of such tax would be excessive relative to the failure involved.

"(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance coverage' and 'carrier' have the respective meanings given such terms in section 1903 of the Bipartisan Health Care Reform Act of 1994."

(2) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end thereof the following new items:

"Sec. 4980C. Failure of carrier to comply with health insurance standards."

SEC. 1055. LIMITATION ON SELF INSURANCE FOR SMALL EMPLOYERS.

(a) IN GENERAL.—A single employer plan (as defined in section 1213 of the Employee Retirement Income Security Act of 1974) may not offer health coverage other than through a carrier unless the plan has at least 100 eligible employees.

(b) REFERENCE TO SMALL EMPLOYER POOLING ARRANGEMENTS.—For provisions providing for small employer pooling arrangements, see section 5011.

PART 6—MULTIPLE EMPLOYER HEALTH BENEFITS PROTECTIONS

SEC. 1071. LIMITED EXEMPTION FROM CERTAIN RESTRICTIONS ON ERISA PREEMPTION OF STATE LAW FOR HEALTH PLANS MAINTAINED BY MULTIPLE EMPLOYERS SUBJECT TO CERTAIN FEDERAL STANDARDS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

"PART 7—MULTIPLE EMPLOYER HEALTH PLANS

"SEC. 701. DEFINITIONS.

"For purposes of this part—

"(1) INSURER.—The term 'insurer' means an insurance company, insurance service, or insurance organization, licensed to engage in the business of insurance by a State.

"(2) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the dependents of its employees, are or were covered under such arrangement in connection with the employment of the employees.

"(3) EXCESS/STOP LOSS COVERAGE.—The term 'excess/stop loss coverage' means, in connection with a multiple employer welfare arrangement, a contract under which an insurer provides for payment with respect to claims under the arrangement, relating to participants or beneficiaries individually or otherwise, in excess of an amount or amounts specified in such contract.

"(4) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

"(5) SPONSOR.—The term 'sponsor' means, in connection with a multiple employer welfare arrangement, the association or other entity which establishes or maintains the arrangement.

"(6) STATE INSURANCE COMMISSIONER.—The term 'State insurance commissioner' means the insurance commissioner (or similar official) of a State.

"(7) DOMICILE STATE.—The term 'domicile State' means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for a certification under this part, most individuals to be covered under the arrangement are located, except that, in any case in which information contained in the latest annual report of the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different State.

"(8) FULLY INSURED.—Coverage under a multiple employer welfare arrangement is 'fully insured' if one or more insurers, health maintenance organizations, similar organizations regulated under State law for solvency, or any combination thereof are liable under one or more insurance policies or contracts for all benefits under the arrangement (irrespective of any recourse they may have against other parties).

"(9) CERTIFIED MULTIPLE EMPLOYER HEALTH PLAN.—The term 'certified multiple employer health plan' means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of certification under this part.

"SEC. 702. CERTIFIED MULTIPLE EMPLOYER HEALTH PLANS RELIEVED OF CERTAIN RESTRICTIONS ON PREEMPTION OF STATE LAW AND TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.

"(a) IN GENERAL.—Subject to subsection (b), a multiple employer welfare arrangement under which coverage is not fully insured and with respect to which there is in effect a certification granted by the Secretary under this part (or with respect to which there is pending a complete application for such an certification and the Secretary determines that provisional protection under this part is appropriate)—

"(1) shall be treated for purposes of subtitle A and the preceding parts of this subtitle as an employee welfare benefit plan, irrespective of whether such arrangement is an employee welfare benefit plan, and

"(2) shall be exempt from section 514(b)(6)(A)(ii).

"(b) BENEFITS MUST CONSIST OF MEDICAL CARE.—Subsection (a) shall apply to a multiple employer welfare arrangement only if the benefits provided thereunder consist solely of medical care described in section 607(1) (disregarding such incidental benefits as the Secretary shall specify by regulation).

"(c) RESTRICTION ON COMMENCEMENT OF NEW ARRANGEMENTS.—A multiple employer welfare arrangement providing benefits which consist of medical care described in section 607(1) which has not commenced operations as of January 1, 1995, may commence operations only if a certification granted to the arrangement under this part is in effect (or there is pending with respect to the arrangement a complete application for such a certification and the Secretary determines that provisional protection under this part is appropriate).

"SEC. 703. CERTIFICATION PROCEDURE.

"(a) IN GENERAL.—The Secretary shall grant a certification described in section 702(a) to a multiple employer welfare arrangement if—

"(1) an application for such certification with respect to such arrangement, identified individually or by class, has been duly filed in complete form with the Secretary in accordance with this part,

"(2) such application demonstrates compliance with the requirements of section 704 with respect to such arrangement, and

"(3) the Secretary finds that such certification is—

"(A) administratively feasible,

"(B) not adverse to the interests of the individuals covered under the arrangement, and

"(C) protective of the rights and benefits of the individuals covered under the arrangement.

"(b) NOTICE AND HEARING.—Before granting a certification under this section, the Secretary shall publish notice in the Federal Register of the pendency of the certification, shall require that adequate notice be given to interested persons, including the State insurance commissioner of each State in which covered individuals under the arrangement are, or are expected to be, located, and shall afford interested persons opportunity to present views. The Secretary may not grant an certification under this section unless the Secretary affords an opportunity for a hearing and makes a determination on the record with respect to the findings required under subsection (a)(3). The Secretary shall, to the maximum extent practicable, make a final determination with respect to any application filed under this section in the case of a newly established arrangement within 90 days after the date which the Secretary determines is the date on which such application is filed in complete form.

"SEC. 704. ELIGIBILITY REQUIREMENTS.

"(a) APPLICATION FOR CERTIFICATION.—

"(1) IN GENERAL.—A certification may be granted by the Secretary under this part only on the basis of an application filed with the Secretary in such form and manner as shall be prescribed in regulations of the Secretary. Any such application shall be signed by the operating committee and the sponsor of the arrangement.

"(2) FILING FEE.—The arrangement shall pay to the Secretary at the time of filing an application under this section a filing fee in the amount of $5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the certification procedures under this part.

"(3) INFORMATION INCLUDED.—An application filed under this section shall include, in a manner and form prescribed in regulations of the Secretary, at least the following information:

"(A) IDENTIFYING INFORMATION.—The names and addresses of—

"(i) the sponsor, and

"(ii) the members of the operating committee of the arrangement.

"(B) STATES IN WHICH ARRANGEMENT INTENDS TO DO BUSINESS.—The States in which individuals covered under the arrangement are to be located and the number of such individuals expected to be located in each such State.

"(C) BONDING REQUIREMENTS.—Evidence provided by the operating committee that the bonding requirements of section 412 will be met as of the date of the application.

"(D) PLAN DOCUMENTS.—A copy of the documents governing the arrangement (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits and coverage that will be provided to individuals covered under the arrangement.

"(E) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the arrangement and contract administrators and other service providers.

"(F) FUNDING REPORT.—A report setting forth information determined as of a date within the 120-day period ending with the date of the application, including the following:

"(i) RESERVES.—A statement, certified by the operating committee of the arrangement, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 707 are or will be met in accordance with regulations which the Secretary shall prescribe.

"(ii) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the arrangement for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the arrangement. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

"(iii) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the arrangement and a projection of the assets, liabilities, income, and expenses of the arrangement for the 12-month period referred to in clause (ii). The income statement shall identify separately the arrangement's administrative expenses and claims.

"(iv) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the arrangement.

"(v) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

"(b) OTHER REQUIREMENTS.—A complete application for a certification under this part shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

"(1) SPONSOR.—

"(A) IN GENERAL.—Except in a case to which subparagraph (B) applies, the sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 3 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care described in section 607(1), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members.

"(B) SPECIAL RULE FOR EMPLOYERS IN THE SAME TRADE OR BUSINESS.—In the case of an arrangement under which all participating employers are engaged in a common type of trade or business, the sponsor is the operating committee of the arrangement.

"(2) OPERATING COMMITTEE.—The arrangement is operated, pursuant to a trust agreement, by an operating committee which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the operating committee has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the committee are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the committee if they constitute not more than 25 percent of the membership of the committee and they do not provide services to the arrangement other than on behalf of the sponsor. The committee has sole authority to approve applications for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

"(3) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the arrangement include a written instrument, meeting the requirements of an instrument required under section 5022(a)(1), which—

"(A) provides that the committee serves as the named fiduciary required for plans under section 5022(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

"(B) provides that the sponsor is to serve as plan sponsor (referred to in section 3(16)(B)),

"(C) incorporates the requirements of section 707, and

"(D) provides that, effective upon the granting of a certification under this part—

"(i) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

"(ii) all individuals thereafter commencing coverage under the arrangement must be—

"(I) active or retired owners, officers, directors, or employees of, or partners in, participating employers, or

"(II) the beneficiaries of individuals described in subclause (I).

"(4) CONTRIBUTION RATES.—The contribution rates referred to in subsection (a)(3)(F)(ii) are adequate.

"(5) REGULATORY REQUIREMENTS.—Such other requirements as the Secretary may prescribe by regulation as necessary to carry out the purposes of this part.

"(c) TREATMENT OF PARTY SEEKING CERTIFICATION WHERE PARTY IS SUBJECT TO DISQUALIFICATION.—

"(1) IN GENERAL.—In the case of any application for a certification under this part with respect to a multiple employer welfare arrangement, if the Secretary determines that the sponsor of the arrangement or any other person associated with the arrangement is subject to disqualification under paragraph (2), the Secretary may deny the certification with respect to such arrangement.

"(2) DISQUALIFICATION.—A person is subject to disqualification under this paragraph if such person—

"(A) has intentionally made a material misstatement in the application for certification;

"(B) has obtained or attempted to obtain a certification under this part through misrepresentation or fraud;

"(C) has misappropriated or converted to such person's own use, or improperly withheld, money held under a plan or any multiple employer welfare arrangement;

"(D) is prohibited (or would be prohibited if the arrangement were a plan) from serving in any capacity in connection with the arrangement under section 411,

"(E) has failed to appear without reasonable cause or excuse in response to a subpoena, examination, warrant, or any other order lawfully issued by the Secretary compelling such response,

"(F) has previously been subject to a determination under this part resulting in the denial, suspension, or revocation of a certification under this part on similar grounds, or

"(G) has otherwise violated any provision of this title with respect to a matter which the Secretary determines of sufficient consequence to merit disqualification for purposes of this part.

"(d) FRANCHISE NETWORKS.—In the case of a multiple employer welfare arrangement established and maintained by a franchisor for a franchise network consisting of its franchisees, such franchisor shall be treated as the sponsor referred to in the preceding provisions of this section, such network shall be treated as an association referred to in such provisions, and each franchisee shall be treated as a member (of the association and the sponsor) referred to in such provisions, if all participating employers are such franchisees and the requirements of subsection (b)(1) with respect to a sponsor are met with respect to the network.

"(e) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In applying the preceding provisions of this section in the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but for the failure to meet any requirement of section 3(40)(C)—

"(1) paragraphs (1) and (2) of subsection (b) and subparagraphs (A), (B), and (D) of paragraph (3) of subsection (b) shall be disregarded, and

"(2) the joint board of trustees shall be considered the operating committee of the arrangement.

"(f) CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

"(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple employer welfare arrangement are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer, subsection (b)(3)(D) shall be disregarded.

"(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are 'related' if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

"SEC. 705. ADDITIONAL REQUIREMENTS APPLICABLE TO CERTIFIED MULTIPLE EMPLOYER HEALTH PLANS.

"(a) NOTICE OF MATERIAL CHANGES.—In the case of any certified multiple employer health plan, descriptions of material changes in any information which was required to be submitted with the application for the certification granted under this part shall be filed in such form and manner as shall be prescribed in regulations of the Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

"(b) REPORTING REQUIREMENTS.—Under regulations of the Secretary, the requirements of sections 102, 103, and 104 shall apply with respect to any multiple employer welfare arrangement which is or has been a certified multiple employer health plan in the same manner and to the same extent as such requirements apply to employee welfare benefit plans, irrespective of whether such certification continues in effect. The annual report required under section 103 for any plan year in the case of any such multiple employer welfare arrangement shall also include information described in section 704(a)(3)(F) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year.

"(c) ENGAGEMENT OF QUALIFIED ACTUARY.—The operating committee of each multiple employer welfare arrangement which is or has been a certified multiple employer health plan shall engage, on behalf of all covered individuals, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

"(1) are in the aggregate reasonably related to the experience of the arrangement and to reasonable expectations, and

"(2) represent such actuary's best estimate of anticipated experience under the arrangement.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

"(d) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted to a multiple employer welfare arrangement under this part shall not be effective unless written notice of such certification is filed with the State insurance commissioner of each State in which at least 5 percent of the individuals covered under the arrangement are located. For purposes of this paragraph, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed. The Secretary may by regulation provide in specified cases for the application of the preceding sentence with lesser percentages in lieu of such 5 percent amount.

"SEC. 706. DISCLOSURE TO PARTICIPATING EMPLOYERS BY ARRANGEMENTS PROVIDING MEDICAL CARE.

"(a) IN GENERAL.—A multiple employer welfare arrangement providing benefits consisting of medical care described in section 607(1) shall issue to each participating employer—

"(1) a document equivalent to the summary plan description required of plans under part 1,

"(2) information describing the contribution rates applicable to participating employers, and

"(3) a statement indicating—

"(A) that the arrangement is not a licensed insurer under the laws of any State,

"(B) whether coverage under the arrangement is fully insured,

"(C) if coverage under the arrangement if not fully insured, (i) whether the arrangement is (or has ceased to be) an certified multiple employer health plan, and (ii) if such an arrangement is an certified multiple employer health plan, that such arrangement is treated as an employee welfare benefit plan under this title.

"(b) TIME FOR DISCLOSURE.—Such information shall be issued to employers within such reasonable period of time before becoming participating employers as may be prescribed in regulations of the Secretary.

"SEC. 707. MAINTENANCE OF RESERVES.

"(a) IN GENERAL.—Each multiple employer welfare arrangement which is or has been an certified multiple employer health plan and under which coverage is not fully insured shall establish and maintain reserves, consisting of—

"(1) a reserve for unearned contributions,

"(2) a reserve for payment of claims reported and not yet paid and claims incurred but not yet reported, and for expected administrative costs with respect to such claims, and

"(3) a reserve, in an amount recommended by the qualified actuary, for any other obligations of the arrangement.

"(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—The total of the reserves described in subsection (a)(2) shall not be less than an amount equal to 25 percent of expected incurred claims and expenses for the plan year.

"(c) REQUIRED MARGIN.—In determining the amounts of reserves required under this section in connection with any multiple employer welfare arrangement, the qualified actuary shall include a margin for error and other fluctuations taking into account the specific circumstances of such arrangement.

"(d) ADDITIONAL REQUIREMENTS.—The Secretary may provide such additional requirements relating to reserves and excess/stop loss coverage as the Secretary considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any arrangement or any class of arrangements.

"(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COVERAGE.—The Secretary may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such arrangement or arrangements.

"(f) ALTERNATIVE MEANS OF COMPLIANCE.—The Secretary may permit an arrangement to substitute, for all or part of the reserves required under subsection (a), such security, guarantee, or other financial arrangement as the Secretary determines to be adequate to enable the arrangement to fully meet all its financial obligations on a timely basis.

"SEC. 708. CORRECTIVE ACTIONS.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—A multiple employer welfare arrangement with respect to which there is or has been in effect a certification granted under this part shall continue to meet the requirements of section 707, irrespective of whether such certification continues in effect. The operating committee of such arrangement shall determine semiannually whether the requirements of section 707 are met. In any case in which the committee determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination and so notifies the committee, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the end of the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with section 707. Not later than 10 days after receiving from the actuary recommendations for corrective actions, the committee shall notify the Secretary (in such form and manner as the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the committee has taken or plans to take in response to such recommendations. The committee shall thereafter report to the Secretary, in such form and frequency as the Secretary may specify to the committee, regarding corrective action taken by the committee until the requirements of section 707 are met.

"(b) TERMINATION.—

"(1) NOTICE OF TERMINATION.—In any case in which the operating committee of a multiple employer welfare arrangement which is or has been an certified multiple employer health plan determines that there is reason to believe that the arrangement will terminate, the committee shall so inform the Secretary, shall develop a plan for winding up the affairs of the arrangement in connection with such termination in a manner which will result in timely payment of all benefits for which the arrangement is obligated, and shall submit such plan in writing to the Secretary. Actions required under this paragraph shall be taken in such form and manner as may be prescribed in regulations of the Secretary.

"(2) ACTIONS REQUIRED IN CONNECTION WITH TERMINATION.—In any case in which—

"(A) the Secretary has been notified under subsection (a) of a failure of a multiple employer welfare arrangement which is or has been an certified multiple employer health plan to meet the requirements of section 707 and has not been notified by the operating committee of the arrangement that corrective action has restored compliance with such requirements, and

"(B) the Secretary determines that the continuing failure to meet the requirements of section 707 can be reasonably expected to result in a continuing failure to pay benefits for which the arrangement is obligated,

the operating committee of the arrangement shall, at the direction of the Secretary, terminate the arrangement and, in the course of the termination, take such actions as the Secretary may require as necessary to ensure that the affairs of the arrangement will be, to the maximum extent possible, wound up in a manner which will result in timely payment of all benefits for which the arrangement is obligated.

"SEC. 709. EXPIRATION, SUSPENSION, OR REVOCATION OF CERTIFICATION.

"(a) EXPIRATION AND RENEWAL OF CERTIFICATION.—A certification granted to a multiple employer welfare arrangement under this part shall expire 3 years after the date on which the certification is granted. A certification which has expired may be renewed by means of application for a certification in accordance with section 704.

"(b) SUSPENSION OR REVOCATION OF CERTIFICATION BY SECRETARY.—The Secretary may suspend or revoke a certification granted to a multiple employer welfare arrangement under this part—

"(1) for any cause that may serve as the basis for the denial of an initial application for such a certification under section 704, or

"(2) if the Secretary finds that—

"(A) the arrangement, or the sponsor thereof, in the transaction of business while under the certification, has used fraudulent, coercive, or dishonest practices, or has demonstrated incompetence, untrustworthiness, or financial irresponsibility,

"(B) the arrangement, or the sponsor thereof, is using such methods or practices in the conduct of its operations, so as to render its further transaction of operations hazardous or injurious to participating employers, or covered individuals,

"(C) the arrangement, or the sponsor thereof, has refused to be examined in accordance with this part or to produce its accounts, records, and files for examination in accordance with this part, or

"(D) any of the officers of the arrangement, or the sponsor thereof, has refused to give information with respect to the affairs of the arrangement or the sponsor or to perform any other legal obligation relating to such an examination when required by the Secretary in accordance with this part.

Any such suspension or revocation under this subsection shall be effective only upon a final decision of the Secretary made after notice and opportunity for a hearing is provided in accordance with section 710.

"(c) SUSPENSION OR REVOCATION OF CERTIFICATION UNDER COURT PROCEEDINGS.—A certification granted to a multiple employer welfare arrangement under this part may be suspended or revoked by a court of competent jurisdiction in an action by the Secretary brought under paragraph (2), (5), or (6) of section 502(a), except that the suspension or revocation under this subsection shall be effective only upon notification of the Secretary of such suspension or revocation.

"(d) NOTIFICATION OF PARTICIPATING EMPLOYERS.—All participating employers in a multiple employer welfare arrangement shall be notified of the expiration, suspension, or revocation of a certification granted to such arrangement under this part, by such persons and in such form and manner as shall be prescribed in regulations of the Secretary, not later than 20 days after such expiration or after receipt of notice of a final decision requiring such suspension or revocation.

"(e) PUBLICATION OF EXPIRATIONS, SUSPENSIONS, AND REVOCATIONS.—The Secretary shall publish all expirations of, and all final decisions to suspend or revoke, certifications granted under this part.

"SEC. 710. REVIEW OF ACTIONS OF THE SECRETARY.

"(a) IN GENERAL.—Any decision by the Secretary which involves the denial of an application by a multiple employer welfare arrangement for a certification under this part or the suspension or revocation of such a certification shall contain a statement of the specific reason or reasons supporting the Secretary's action, including reference to the specific terms of the certification and the statutory provision or provisions relevant to the determination.

"(b) DENIALS OF APPLICATIONS.—In the case of the denial of an application for a certification under this part, the Secretary shall send a copy of the decision to the applicant by certified or registered mail at the address specified in the records of the Secretary. Such decision shall constitute the final decision of the Secretary unless the arrangement, or any party that would be prejudiced by the decision, files a written appeal of the denial within 30 days after the mailing of such decision. The Secretary may affirm, modify, or reverse the initial decision. The decision on appeal shall become final upon the mailing of a copy by certified or registered mail to the arrangement or party that filed the appeal.

"(c) SUSPENSIONS OR REVOCATIONS OF CERTIFICATION.—In the case of the suspension or revocation of a certification granted under this part, the Secretary shall send a copy of the decision to the arrangement by certified or registered mail at its address, as specified in the records of the Secretary. Upon the request of the arrangement, or any party that would be prejudiced by the suspension or revocation, filed within 15 days of the mailing of the Secretary's decision, the Secretary shall schedule a hearing on such decision by written notice, sent by certified or registered mail to the arrangement or party requesting such hearing. Such notice shall set forth—

"(1) a specific date and time for the hearing, which shall be within the 10-day period commencing 20 days after the date of the mailing of the notice, and

"(2) a specific place for the hearing, which shall be in the District of Columbia or in the State and county thereof (or parish or other similar political subdivision thereof) in which is located the arrangement's principal place of business.

The decision as affirmed or modified in such hearing shall constitute the final decision of the Secretary, unless such decision is reversed in such hearing."

(b) CONFORMING AMENDMENT TO DEFINITION OF PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 1002(16)(B)) is amended by adding at the end the following new sentence: "Such term also includes the sponsor (as defined in section 701(5)) of a multiple employer welfare arrangement which is or has been a certified multiple employer health plan (as defined in section 701(9)).".

(c) ALTERNATIVE MEANS OF DISTRIBUTION OF SUMMARY PLAN DESCRIPTIONS.—Section 110 of such Act (29 U.S.C. 1030) is amended by adding at the end the following new subsection:

"(c) The Secretary shall prescribe, as an alternative method for distributing summary plan descriptions in order to meet the requirements of section 104(b)(1) in the case of multiple employer welfare arrangements providing benefits consisting of medical care described in section 607(1), a means of distribution of such descriptions by participating employers.".

(d) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 608 the following new items:

"PART 7—MULTIPLE EMPLOYER HEALTH PLANS

"Sec. 701. Definitions.
"Sec. 702. Certified multiple employer health plans relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.
"Sec. 703. Certification procedure.
"Sec. 704. Eligibility requirements.
"Sec. 705. Additional requirements applicable to certified multiple employer health plans.
"Sec. 706. Disclosure to participating employers by arrangements providing medical care.
"Sec. 707. Maintenance of reserves.
"Sec. 708. Corrective actions.
"Sec. 709. Expiration, suspension, or revocation of certification.
"Sec. 710. Review of actions of the secretary.".

SEC. 1072. CLARIFICATION OF SCOPE OF PREEMPTION RULES.

(a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting ", but only, in the case of an arrangement which provides medical care described in section 607(1) and with respect to which a certification under part 7 is not in effect," before "to the extent not inconsistent with the preceding sections of this title".

(b) CROSS-REFERENCE.—Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

"(E) For additional rules relating to certification from subparagraph (A)(ii) of multiple employer welfare arrangements providing medical care, see part 7.".

SEC. 1073. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting "for any plan year of any such plan, or any fiscal year of any such other arrangement," after "single employer", and by inserting "during such year or at any time during the preceding 1-year period" after "common control";

(2) in clause (iii), by striking "common control shall not be based on an interest of less than 25 percent" and inserting "an interest of greater than 25 percent may not be required as the minimum interest necessary for common control", and by striking "and" at the end,

(3) by redesignating clause (iv) as clause (v), and

(4) by inserting after clause (iii) the following new clause:

"(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, at the time the determination under clause (i) is made, the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 95 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement.".

SEC. 1074. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

"(i) under or pursuant to one or more collective bargaining agreements,".

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

"(C) Clause (i) of subparagraph (A) shall apply only if—

"(i) the plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

"(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement, or

"(II) pay a commission or any other type of compensation to a person that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement,

"(ii) not less than 85 percent of the covered individuals under the plan or other arrangement are individuals who—

"(I) are employed within a bargaining unit covered by at least one of the collective bargaining agreements with a participating employer (or are covered on the basis of an individual's employment in such a bargaining unit), or

"(II) are present or former employees of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (or are covered on the basis of such present or former employment),

"(iii) the plan or other arrangement does not provide benefits to individuals (other than individuals described in clause (ii)(II)) who work outside the standard metropolitan statistical area in which the sponsoring employee organization represents employees (or to individuals (other than individuals described in clause (ii)(II)) on the basis of such work by others), except that in the case of a sponsoring employee organization that represents employees who work outside of any standard metropolitan statistical area, this clause shall be applied by reference to the State in which the sponsoring organization represents employees,

"(iv) the employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary—

"(I) that the plan or other arrangement meets the requirements of clauses (i), (ii), and (iii), and

"(II) if, for any year, 10 percent or more of the covered individuals under the plan are individuals not described in subclause (I) or (II) of clause (ii), the total number of covered individuals and the total number of covered individuals not so described.

"(D)(i) Clause (i) of subparagraph (A) shall not apply to a plan or other arrangement that is established or maintained pursuant to one or more collective bargaining agreements which the National Labor Relations Boards determines to have been negotiated or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)).

"(ii)(I) Whenever a State insurance commissioner has reason to believe that this subparagraph is applicable to part or all of a plan or other arrangement, the State insurance commissioner may file a petition with the National Labor Relations Board for a determination under clause (i), along with sworn written testimony supporting the petition.

"(II) The Board shall give any such petition priority over all other petitions and cases, other than other petitions under subclause (I) or cases given priority under section 10 of the National Labor Relations Act (29 U.S.C. 160).

"(III) The Board shall determine, upon the petition and any response, whether, on the facts before it, the plan or other arrangement was negotiated, created, or otherwise agreed to in a manner or through conduct which violates section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)). Such determination shall constitute a final determination for purposes of this subparagraph and shall be binding in all Federal or State actions with respect to the status of the plan or other arrangement under this subparagraph.

"(IV) A person aggrieved by the determination of the Board under subclause (III) may obtain review of the determination in any United States court of appeals in the circuit in which the collective bargaining at issue occurred. Commencement of proceedings under this subclause shall not, unless specifically ordered by the court, operate as a stay of any State administrative or judicial action or proceeding related to the status of the plan or other arrangement, except that in no case may the court stay, before the completion of the review, an order which prohibits the enrollment of new individuals into coverage under a plan or arrangement.".

SEC. 1075. EMPLOYEE LEASING HEALTH CARE ARRANGEMENTS.

(a) Employee Leasing Health Care Arrangement Defined.—Section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

"(43) Employee Leasing Health Care Arrangement.—

"(A) In general.—Subject to subparagraph (B), the term 'employee leasing health care arrangement' means any labor leasing arrangement, staff leasing arrangement, extended employee staffing or supply arrangement, or other arrangement under which—

"(i) one business or other entity (hereinafter in this paragraph referred to as the 'lessee'), under a lease or other arrangement entered into with any other business or other entity (hereinafter in this paragraph referred to as the 'lessor'), receives from the lessor the services of individuals to be performed under such lease or other arrangement, and

"(ii) benefits consisting of medical care described in section 607(1) are provided to such individuals or such individuals and their dependents as participants and beneficiaries.

"(B) Exception.—Such term does not include an arrangement described in subparagraph (A) if, under such arrangement, the lessor retains, both legally and in fact, a complete right of direction and control within the scope of employment over the individuals whose services are supplied under such lease or other arrangement, and such individuals perform a specified function for the lessee which is separate and divisible from the primary business or operations of the lessee.".

(b) Treatment of Employee Leasing Health Care Arrangements as Multiple Employer Welfare Arrangements.—Section 3(40) of such Act (29 U.S.C. 1002(40)) (as amended by the preceding provisions of this title) is further amended by adding at the end the following new subparagraph:

"(E) The term 'multiple employer welfare arrangement' includes any employee leasing health care arrangement.".

(c) Special Rules for Employee Leasing Health Care Arrangements.—

(1) In general.—Part 7 of subtitle B of title I of such Act (as added by the preceding provisions of this Act) is amended by adding at the end the following new section:

"SEC. 712. SPECIAL RULES FOR EMPLOYEE LEASING HEALTH CARE ARRANGEMENTS.

"(a) In General.—The requirements of paragraphs (1), (2), and (3) of section 704(b) shall be treated as satisfied in the case of a multiple employer welfare arrangement that is an employee leasing health care arrangement if the application for certification includes information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

"(1) 3-year tenure.—The lessor has been in operation for not less than 3 years.

"(2) Solicitation restrictions.—Employee leasing services provided under the arrangement are not solicited, advertised, or marketed through licensed insurance agents or brokers acting in such capacity.

"(3) Creation of employment relationship.—

"(A) Disclosure statement.—Written notice is provided to each applicant for employment subject to coverage under the arrangement, at the time of application for employment and before commencing coverage under the arrangement, stating that the employer is the lessor under the arrangement.

"(B) Informed consent.—Each such applicant signs a written statement consenting to the employment relationship with the lessor.

"(C) Informed recruitment of lessee's employees.—In any case in which the lessor offers employment to an employee of a lessee under the arrangement, the lessor informs each employee in writing that his or her acceptance of employment with the lessor is voluntary and that refusal of such offer will not be deemed to be resignation from or abandonment of current employment.

"(4) Requisite employer-employee relationship under arrangement.—Under the employer-employee relationship with the employees of the lessor—

"(A) the lessor retains the ultimate authority to hire, terminate, and reassign such employees,

"(B) the lessor is responsible for the payment of wages, payroll-related taxes, and employee benefits, without regard to payment by the lessee to the lessor for its services,

"(C) the lessor maintains the right of direction and control over its employees, except to the extent that the lessee is responsible for supervision of the work performed consistent with the lessee's responsibility for its product or service, and

"(D) in accordance with section 301(a) of the Labor Management Relations Act, 1947 (29 U.S.C. 185(a)), the lessor retains in the absence of an applicable collective bargaining agreement, the right to enter into arbitration and to decide employee grievances, and

"(E) no owner, officer, or director of, or partner in, a lessee is an employee of the lessor, and not more than 10 percent of the individuals covered under the arrangement consist of owners, officers, or directors of, or partners in, such a lessee (or any combination thereof).

"(b) Definitions.—For purposes of this section—

"(1) Lessor.—The term 'lessor' means the business or other entity from which services of individuals are obtained under an employee leasing health care arrangement.

"(2) Lessee.—The term 'lessee' means a business or other entity which receives the services of individuals provided under an employee leasing health care arrangement.".

(2) Clerical amendment.—The table of contents in section 1 of such Act (as amended by the preceding provisions of this title) is further amended by inserting after the item relating to section 710 the following new item:

"Sec. 712. Employee leasing health care arrangements.".

SEC. 1076. ENFORCEMENT PROVISIONS RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND EMPLOYEE LEASING HEALTH CARE ARRANGEMENTS.

(a) Enforcement of Filing Requirements.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking "subsection (c)(2) or (i) or (l)" and inserting "paragraph (2) or (4) of subsection (c) or subsection (i) or (l)"; and

(2) by adding at the end of subsection (c) the following new paragraph:

"(4) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of such person's failure or refusal to file the information required to be filed with the Secretary under section 101(e).".

(b) Actions by States in Federal Court.—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(1) in paragraph (5), by striking "or" at the end;

(2) in paragraph (6), by striking the period and inserting ", or"; and

(3) by adding at the end the following:

"(7) by a State official having authority under the law of such State to enforce the laws of such State regulating insurance, to enjoin any act or practice which violates any provision of part 7 which such State has the power to enforce under part 7.".

(c) Criminal Penalties for Certain Willful Misrepresentations.—Section 501 of such Act (29 U.S.C. 1131) is amended—

(1) by inserting "(a)" after "Sec. 501."; and

(2) by adding at the end the following new subsection:

"(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

"(1) being an certified multiple employer welfare arrangement (as defined in section 701(9)),

"(2) being an employee leasing health care arrangement under a certification granted under part 7, or

"(3) having been established or maintained under or pursuant to a collective bargaining agreement,

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.".

(d) Cease Activities Orders.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

"(m)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of a multiple employer welfare arrangement providing benefits consisting of medical care described in section 607(1) that—

"(A) is not licensed, registered, or otherwise approved under the insurance laws of the States in which the arrangement offers or provides benefits, or

"(B) is not operating in accordance with the terms of a certification granted by the Secretary under part 7,

a district court of the United States shall enter an order requiring that the arrangement cease activities.

"(2) Paragraph (1) shall not apply in the case of a multiple employer welfare arrangement if the arrangement shows that—

"(A) coverage under it is fully insured, within the meaning of section 701(8),

"(B) it is licensed, registered, or otherwise approved in each State in which it offers or provides benefits, except to the extent that such State does not require licensing, registration, or approval of multiple employer welfare arrangements under which all coverage is fully insured, and

"(C) with respect to each such State, it is operating in accordance with applicable State insurance laws that are not superseded under section 514.

"(3) The court may grant such additional equitable or remedial relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the arrangement.".

(e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by adding at the end (after and below paragraph (2)) the following new sentence: "The terms of each multiple employer welfare arrangement to which this section applies and which provides benefits consisting of medical care described in section 607(1) shall require the operating committee or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the arrangement.".

SEC. 1077. FILING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS PROVIDING HEALTH BENEFITS.

Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection:

"(e)(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1995) and no later than February 15 of each year (in the case of an arrangement in operation since the beginning of such year), unless, as of the date by which such filing otherwise must be made, such arrangement provides no benefits consisting of medical care described in section 607(1).

"(2) Each registration statement—

"(A) shall be filed in such form, and contain such information concerning the multiple employer welfare arrangement and any persons involved in its operation (including whether coverage under the arrangement is fully insured), as shall be provided in regulations which shall be prescribed by the Secretary, and

"(B) if coverage under the arrangement is not fully insured, shall contain a certification that copies of such registration statement have been transmitted by certified mail to—

"(i) in the case of an arrangement which is an certified multiple employer health plan (as defined in section 701(9)), the State insurance commissioner of the domicile State of such arrangement, or

"(ii) in the case of an arrangement which is not an certified multiple employer health plan, the State insurance commissioner of each State in which the arrangement is located.

"(3) The person or persons responsible for filing the annual registration statement are—

"(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or

"(B) in the case of a multiple employer welfare arrangement for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually responsible for the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.

"(4) Any agreement entered into under section 506(c) with a State as the primary domicile State with respect to any multiple employer welfare arrangement shall provide for simultaneous filings of reports required under this subsection with the Secretary and with the State insurance commissioner of such State.".

SEC. 1078. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

"(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

"(1) STATE ENFORCEMENT.—

"(A) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the provisions of this title applicable to multiple employer welfare arrangements which are or have been certified multiple employer health plans (as defined in section 701(9)). The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

"(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

"(C) CONCURRENT AUTHORITY OF THE SECRETARY.—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

"(D) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular multiple employer welfare arrangement, as the primary domicile State to which authority has been delegated pursuant to such agreements.

"(2) ASSISTANCE TO STATES.—The Secretary shall—

"(A) provide enforcement assistance to the States with respect to multiple employer welfare arrangements, including, but not limited to, coordinating Federal and State efforts through the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

"(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act,

"(C) assist the States in obtaining from the Office of Regulations and Interpretations timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

"(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.".

SEC. 1079. EFFECTIVE DATE; TRANSITIONAL RULES.

(a) EFFECTIVE DATE.—The amendments made by this part shall take effect January 1, 1996, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this title before the effective date thereof.

(b) TRANSITIONAL RULES.—If the sponsor of a multiple employer welfare arrangement which, as of January 1, 1996, provides benefits consisting of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(1)) files with the Secretary of Labor an application for a certification under part 7 of subtitle B of title I of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement during the 18-month period following such date. If the Secretary determines, at any time after the date of enactment of this Act, that any such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such Act of a multiple employer welfare arrangement would be detrimental to the interests of individuals covered under such arrangement, such exclusion shall cease as of the date of the determination. Any determination made by the Secretary under this subsection shall be in the Secretary's sole discretion.

PART 7—SIMPLIFYING FILING OF REPORTS FOR EMPLOYERS COVERED UNDER MULTIPLE EMPLOYER WELFARE ARRANGEMENTS PROVIDING FULLY INSURED COVERAGE CONSISTING OF MEDICAL CARE

SEC. 1081. SINGLE ANNUAL FILING FOR ALL PARTICIPATING EMPLOYERS.

(a) IN GENERAL.—Section 110 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1030), as amended by section 5021(c) of this subtitle, is amended by adding at the end the following new subsection:

"(d) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are participating employers under a multiple employer welfare arrangement under which all coverage consists of medical care (described in section 607(1)) and is fully insured (as defined in section 701(9)).''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. The Secretary of Labor shall prescribe the alternative method referred to in section 110(d) of the Employee Retirement Income Security Act of 1974, as added by such amendment, within 90 days after the date of the enactment of this Act.

Subtitle B—Benefits

SEC. 1101. QUALIFIED HEALTH COVERAGE.

In this Act, the term "qualified health coverage" means health coverage that—

(1) provides—

(A) at least standard coverage consistent with section 1102, or

(B) at least high-deductible coverage consistent with section 1103; and

(2) meets other requirements of subtitle A applicable to the coverage and the carrier or group health plan providing the coverage.

SEC. 1102. STANDARD COVERAGE.

(a) IN GENERAL.—Health insurance coverage is considered to provide standard coverage consistent with this subsection if—

(1) benefits under such coverage are provided within at least each of the required categories of benefits described in paragraph (1) of subsection (b) and consistent with such subsection;

(2) the actuarial value of the benefits meets the requirements of subsection (c),

(3) the benefits comply with the minimum requirements specified in subsection (d), and

(4) the benefits do not violate the anti-discrimination rules described in section 1105.

(b) REQUIRED CATEGORIES OF COVERED BENEFITS.—

(1) IN GENERAL.—The categories of covered benefits described in this paragraph are the types of benefits specified in subparagraphs (A), (B), (C), (D), and (F) of paragraph (1), and subparagraphs (E) and (F) of paragraph (2), of section 8904(a) of title 5, United States Code (relating to types of benefits required to be in health insurance offered to Federal employees).

(2) COVERAGE OF TREATMENTS IN APPROVED RESEARCH TRIALS.—

(A) IN GENERAL.—Coverage of the routine medical costs (as defined in subparagraph (B)) associated with the delivery of treatments shall be considered to be medically appropriate only if the treatment is part of an approved research trial (as defined in subparagraph (C)).

(B) ROUTINE MEDICAL COSTS DEFINED.—In subparagraph (A), the term "routine medical costs" means the cost of health services required to provide treatment according to the design of the trial, except those costs normally paid for by other funding sources (as defined by the Secretary). Such costs do not include the cost of the investigational agent, devices or procedures themselves, the costs of any nonhealth services that might be required for a person to receive the treatment, or the costs of managing the research.

(C) APPROVED RESEARCH TRIAL DEFINED.—In subparagraph (A), the term "approved research trial" means a trial—

(i) conducted for the primary purpose of determining the safety, effectiveness, efficacy, or health outcomes of a treatment, compared with the best available alternative treatment, and

(ii) approved by the Secretary.

A trial is deemed to be approved under clause (ii) if it is approved by the National Institutes of Health, the Food and Drug Administration (through an investigational new drug exemption), the Department of Veterans Affairs, or by a qualified nongovernmental research entity (as identified in guidelines issued by one or more of the National Institutes of Health).

(3) COVERAGE OF OFF-LABEL USE.—An off-label use for a drug that has been found to be safe and effective under section 505 of the Federal Food, Drug, and Cosmetic Act shall be covered if the medical indication for which it is used is listed in one of the following 3 compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

(c) STANDARD ACTUARIAL VALUE.—

(1) IN GENERAL.—The actuarial value of the benefits under standard coverage in a fair rating area (as identified under section 1021(c)) meets the requirements of this subsection if such value is equivalent to the standard actuarial value described in paragraph (2) for the area, as adjusted for inflation under paragraph (4). The actuarial value of benefits under standard coverage shall be determined using the standardized population and set of standardized utilization and cost factors described in paragraph (3).

(2) STANDARD ACTUARIAL VALUE DESCRIBED.—The standard actuarial value described in this paragraph for coverage in a geographic area is the actuarial value of benchmark coverage during 1994 in such area. Such actuarial value shall be determined using the standardized population and set of standardized utilization and cost factors described in paragraph (3).

(3) ADJUSTMENTS FOR STANDARDIZED POPULATION, STANDARDIZED UTILIZATION AND COST FACTORS, AND GEOGRAPHIC AREA.—The adjustment under this paragraph—

(A) for a standardized population shall be made by not taking into account individuals 65 years of age or older, employees of the United States Postal Service, and retirees; and

(B)(i) except as provided in clause (ii), for a geographic area shall be made in a manner that reflects the ratio of the actuarial value of benchmark coverage in such geographic area (as adjusted under subparagraph (A)) to such actuarial value for such benchmark coverage for the United States as a whole, taking into account standardized actuarial utilization and cost factors, and

(ii) in the case of a group health plan operating in more than one geographic area, the ratio described in clause (i) shall be determined in accordance with regulations promulgated by the Secretary.

At the election of a group health plan under subparagraph (B)(ii), the ratio under such subparagraph shall be 1.

(4) ADJUSTMENT FOR INFLATION.—

(A) IN GENERAL.—The adjustment under this paragraph for a year (beginning with 1995) is the FEHBP national rolling increase percentage for the year involved, compounded by such increase for each preceding year after 1994.

(B) FEHBP NATIONAL ROLLING INCREASE PERCENTAGE.—For purposes of this paragraph, the term "FEHBP national rolling increase percentage" means, for a year, the 5-year average of the annual national percentage increase in the premiums for health plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code) for the period ending with the previous year. Such increase shall be determined by the Secretary in consultation with the Director of Office of Personnel Management based on the best information available.

(d) MINIMUM REQUIREMENTS WITHIN A CATEGORY.—Benefits offered in the standard plan within any category shall be not less than the narrowest scope and shortest duration of benefits so offered within that category, in an approved health benefits plan under chapter 89 of title 5, United States Code (relating to Federal Employees Health Benefits Program).

(e) NO COVERAGE OF SPECIFIC TREATMENT, PROCEDURES, OR CLASSES REQUIRED.—Nothing in this section (or section 1103) may be construed to require the coverage of any specific procedure or treatment or class of service in health coverage under this Act or through regulation.

(f) CONSTRUCTION.—Nothing in this section (or section 1103) shall be construed as requiring coverage to include benefits for items and services that are not medically necessary or appropriate.

SEC. 1103. HIGH-DEDUCTIBLE COVERAGE.

Health insurance coverage is considered to provide high-deductible coverage consistent with this section if—

(1) benefits under such coverage comply with requirements described in section 1102(b) and 1102(d);

(2) the deductible amount is the amount established under section 1104(b)(1);

(3) benefits under the coverage in any year are covered only to the extent expenses incurred for items and services included in the coverage for the year exceed the deductible amount specified in paragraph (2);

(4) the actuarial value of the coverage (as determined under rules consistent with section 1102(c)) is equivalent to 80 percent of the actuarial value established under such section for standard coverage; and

(5) the benefits do not violate the anti-discrimination rules described in section 1105.

SEC. 1104. ACTUARIAL VALUATION OF BENEFITS.

(a) IN GENERAL.—The Secretary, in consultation with the National Association of Insurance Commissioners and the American Academy of Actuaries, shall establish (and may from time to time modify) procedures by which health insurance benefits are valued for purposes of this subtitle.

(b) DEDUCTIBLE; MODEL BENEFIT PACKAGES.—The Secretary, in consultation with the National Association of Insurance Commissioners and the American Academy of Actuaries, shall establish—

(1) the deductible amount for high-deductible coverage for the purposes of section 1103(2) such that the actuarial value of high-deductible coverage described in section 1103 is 20 percent less than the actuarial value of standard coverage described in section 1102; and

(2) model benefit packages that may be treated, for purposes of this title, as meeting the requirements for standard or high-deductible coverage under sections 1102 and 1103, respectively, and which shall include model cost sharing arrangements for fee-for-service options, managed care options, and point-of-service options.

SEC. 1105. ANTI-DISCRIMINATION RULE.

A carrier and a group health plan providing health coverage may not establish a limitation on benefits covered in a manner that has the effect of differentiating with respect to different serious illnesses or conditions or limiting the duration of or reimbursement for such an illness or condition.

SEC. 1106. FAMILY COVERAGE OPTION; SUPPLEMENTAL COVERAGE.

(a) FAMILY COVERAGE OPTION.—Each carrier and group health plan that offers health insurance coverage shall provide for an option under which children under 26 years of age (without regard to whether they are full-time students or disabled) will be treated (with respect to family coverage) as family members. The carrier or plan may impose an additional premium for such option.

(b) CONSTRUCTION.—Nothing in this title shall be construed as limiting the benefits that may be offered as part of a group health plan or health insurance coverage.

SEC. 1107. LEVEL PLAYING FIELD FOR PROVIDERS.

(a) IN GENERAL.—Nothing in this subtitle may be construed to require or prohibit the use of a particular class of provider, among the providers that are legally authorized to provide such treatment.

(b) COVERAGE OF CERTAIN OTHER PROVIDERS.—

(1) IN GENERAL.—For purposes of this subtitle, benefits under standard coverage shall include the following:

(A) Coverage provided at an individual's home by a Christian Science practitioner or Christian Science nurse.

(B) Coverage provided in a Christian Science Sanitorium (as defined in section 1861(y) of the Social Security Act), including coverage provided by a Christian Science practitioner.

(2) QUALIFICATIONS OF PROVIDERS.—A Christian Science practitioner or Christian Science nurse is qualified for purposes of paragraph (1) if the practitioner or nurse is listed as such a practitioner or nurse by the First Church of Christ, Scientist, in Boston, Massachusetts.

Subtitle C—Employer Responsibilities

SEC. 1201. REQUIRING EMPLOYERS TO OFFER OPTION OF COVERAGE.

(a) IN GENERAL.—Subject to subsections (c) and (d), each employer shall make available with respect to each qualifying employee health coverage under a group health plan (whether fully-insured or self-insured) which meets the following requirements (and the applicable requirements of subtitle A):

(1) ANNUAL OFFERING.—The employee may elect health coverage for the employee and family members on an annual basis for each plan year and at such other times as may be specified by the Secretary of Labor, in a manner consistent with the standards established to carry out section 1105.

(2) CHOICE OF COVERAGE.—

(A) IN GENERAL.—Subject to subsection (c), such coverage is provided for at least—

(i) a competing choice of qualified standard coverage (consistent with section 1102), including at least one option (either a fee-for-service option or a point-of-service option) that permits covered individuals an unrestricted choice of the lawful providers for which benefits are made available; and

(ii) high-deductible coverage (consistent with section 1103).

(B) COVERAGE FLOOR.—Any such coverage (other than coverage for supplemental benefits) shall include benefits the actuarial value of which is not less than the actuarial value of high-deductible coverage if such coverage is consistent with the requirements specified in paragraph (1), (3), and (4) of section 1102(a).

(C) DISCLOSURE FOR CERTAIN COVERAGE.—If an employer offers coverage the actuarial value of which is more than the actuarial value for high-deductible coverage but less than such value for standard coverage, the employer must disclose to the employees detailed information on how the coverage offered compares to the standard and high-deductible coverage offered by the employer.

(D) USE OF STANDARDIZED FACTORS.—For purposes of this paragraph, actuarial value of coverage shall be determined using the standardized population and standardized utilization and cost factors described in section 1102(c)(4).

(E) FAMILY COVERAGE OPTION.—The offer of coverage under this section with respect to a qualifying employee shall include the option of coverage of family members of the employee.

(3) PAYROLL WITHHOLDING.—The employee electing such coverage may elect to have any premiums owed by the employee collected through payroll deduction.

(4) NONDISCRIMINATION IN CONTRIBUTIONS BASED ON PRICE OF COVERAGE SELECTED.—

(A) IN GENERAL.—The employer may not vary the amount of any employer contribution, within a class of family coverage, with respect to such coverage, on the basis of the total premium price of the coverage selected.

(B) SPECIAL RULES.—In applying subparagraph (A)—

(i) the "total premium price" shall include, in the case of high-deductible coverage, amounts paid by an employer into a medical savings account (established under section 7705 of the Internal Revenue Code of 1986); and

(ii) if the employee selects health coverage the premium for which is less than the amount of the employer contribution, the employer shall pay the amount of such difference to the employee (or, at the employee's option in the case of an employee who has high-deductible coverage, to such a medical savings account).

(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring the amount of contributions to be the same for employees in different geographic areas or classes of family coverage.

(b) NO EMPLOYER MANDATE.—Subject to subsection (a)(4) (relating to equal contribution rule), an employer is not required under this section to make any contribution to the cost of health coverage.

(c) GRANDFATHER FOR EXISTING CONTRACTS.—

(1) IN GENERAL.—The requirement of subsection (a)(2) shall not apply to a group health plan for a plan year if—

(A) the group health plan is in effect in the plan year in which July 1, 1994, occurs, and

(B) the employer makes (or offers to make), in such plan year and the plan year involved, a contribution to the plan on behalf of each employee who is eligible to participate in the plan.

(2) SUNSET.—Paragraph (1) shall only apply to a group health plan until the expiration of a contract in effect on the date of the enactment of this Act or, if earlier, January 1, 2000.

(d) SPECIAL RULES.—

(1) EMPLOYERS CONTRACTING WITH VOLUNTARY PURCHASING ARRANGEMENTS, ETC.—An employer is deemed to have satisfied the requirements of subsection (a) with respect to an employee if the employer enters into a contract with a health plan purchasing organization (established under subtitle A of title V), a small employer pooling arrangement (described in section 5011), a multiemployer plan providing health benefits, or a certified multiple employer health plan (as defined in section 701(9) of the Employee Retirement Income Security Act of 1974) to offer coverage with respect to the employee.

(2) EXCLUSION OF NEW EMPLOYERS AND CERTAIN SMALL EMPLOYERS.—Subsection (a) shall not apply to any small employer for any plan year if, as of the beginning of such plan year—

(A) such employer (including any predecessor thereof) has been an employer for less than 1 year,

(B) such employer has no more than 2 qualifying employees, or

(C) no more than 2 qualifying employees of the employer are not covered under any group health plan.

(3) EXCLUSION OF FAMILY MEMBERS.—Under such procedures as the Secretary may prescribe, any relative of an employer may be, at the election of the employer, excluded from consideration as an qualifying employee for purposes of applying the requirements of subsection (a). In the case of an employer that is not an individual, an employee who is a relative of a key employee (as defined in section 416(i)(1) of the Internal Revenue Code of 1986) of the employer may, at the election of the key employee, be considered a relative excludable under this paragraph.

(e) CONSTRUCTION ON RANGE OF COVERAGE OFFERINGS.—Nothing in this section shall be construed—

(1) as limiting the number of standard and high-deductible coverage options that an employer may offer to an employee,

(2) as preventing employers from offering supplemental benefits (as defined in section 1101(f)), or

(3) as preventing an employer from providing for contributions to a medical savings account in connection with the offering of high-deductible coverage, subject to subsection (a)(4) and the requirements of section 7705 of the Internal Revenue Code of 1986.

SEC. 1202. NONDISCRIMINATION UNDER GROUP HEALTH PLANS.

(a) APPLICATION OF RULES SIMILAR TO MEDICARE NONDISCRIMINATION RULES.—Subject to paragraph (2), the provisions of paragraphs (1)(A), (1)(D), (1)(E), (3)(A), and (3)(C) of section 1862(b) of the Social Security Act shall apply to an individual eligible for low-income assistance under subtitle A of title II in relation to an employer in the same manner as such provisions apply to an individual age 65 or over who is entitled to benefits under title XVIII of such Act under section 226(a) of such Act in relation to such employer.

(b) RULES OF APPLICATION.—In applying subsection (a)—

(1) in applying clauses (ii) and (iii) of section 1862(b)(1)(A) of the Social Security Act, any reference to "20 or more employees" is deemed a reference to "5 or more employees";

(2) clause (iv) of section 1862(b)(1)(A) of such Act shall not apply; and

(3) any reference to title XVIII of such Act is deemed a reference to assistance under title XXI of such Act (as added by subtitle A of title II of this Act).

(c) ENFORCEMENT.—

(1) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to excise taxes on qualified pension, etc. plans) is amended by inserting after section 5000 the following new section:

"SEC. 5000A. EMPLOYER REQUIREMENTS.

"(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any employer to comply with the requirements of section 1201 and section 1202 of the Bipartisan Health Care Reform Act of 1994.

"(b) AMOUNT OF TAX.—The amount of tax imposed by subsection (a) shall be equal to $100 for each day for each individual for which such a failure occurs.

"(c) LIMITATION ON TAX.—

"(1) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

"(A) such failure was due to reasonable cause and not to willful neglect, and

"(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the 1st date any of the individuals on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

"(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.".

(2) CLERICAL AMENDMENT.—The table of sections for such chapter 47 is amended by adding at the end the following new item:

"Sec. 5000A. Employer requirements.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 1997.

SEC. 1203. EFFECTIVE DATES.

Except as otherwise provided, the requirements of sections 1201 and 1202 shall apply to plan years beginning after December 31, 1996.

Subtitle D—Definitions; General Provisions

SEC. 1901. GENERAL DEFINITIONS.

For purposes of this Act:

(1) APPLICABLE REGULATORY AUTHORITY.—The term "applicable regulatory authority" means, with respect to a carrier operating in a State—

(A) the State insurance commissioner, or

(B) the Secretary, in the case described in section 1052(b).

(2) FAMILY MEMBER.—

(A) IN GENERAL.—Individuals are considered to be members of a family if—

(i) they are married, or

(ii) they have a legal parent-to-child relationship (whether by natural birth or adoption), if the child is—

(I) under 19 years of age,

(II) is under 25 years of age and a full-time student, or

(III) an unmarried dependent regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22.

(B) SPECIAL RULES.—Family members—

(i) include an adopted child and a recognized natural child;

(ii) include a stepchild or foster child with respect to an individual but only if the child lives with the individual in a regular parent-child relationship; and

(iii) include such other children as the Secretary may specify, but shall not include an emancipated minor.

(3) PRISONER.—The term "prisoner" means, as specified by the Secretary, an individual during a period of imprisonment under Federal, State, or local authority after conviction as an adult.

(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(5) STATE.—The term "State" means the 50 States and the District of Columbia

SEC. 1902. DEFINITIONS RELATING TO EMPLOYMENT.

(a) APPLICATION OF ERISA DEFINITIONS.—Except as otherwise provided in this Act, terms used in this Act shall have the meanings applicable to such terms under section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002).

(b) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) COUNTABLE EMPLOYEE.—The term "countable employee" means, with respect to an employer for a month, any employee other than an employee whose normal work week is less than 10 hours.

(2) LARGE EMPLOYER.—The term "large employer" means an employer that is not a small employer (as defined in paragraph (4)).

(3) QUALIFYING EMPLOYEE.—

(A) IN GENERAL.—The term "qualifying employee" means, with respect to an employer for a month, any employee other than—

(i) a part-time, seasonal, or temporary employee (as defined in subparagraph (B)); or

(ii) an employee who is a child described in section 1901(2)(A)(ii).

(B) PART-TIME, SEASONAL, OR TEMPORARY EMPLOYEE DEFINED.—For purposes of subparagraph (A), the term "part-time, seasonal, or temporary employee" means any of the following employees with respect to a month:

(i) CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal work week is reasonably expected as of the 1st day of such month to be less than 20 hours.

(ii) SEASONAL OR TEMPORARY EMPLOYEES.—Any employee who is not reasonably expected as of the 1st day of such month to be employed by the employer for a period of 120 consecutive days during any 365-day period that includes such 1st day.

(iii) DELAY FOR CERTAIN PART-TIME EMPLOYEES.—Any employee whose normal work week is reasonably expected as of the 1st day of such month to be at least 20 hours, but less than 35 hours, and the normal work week of the employee during the preceding 3 months was less than 20 hours.

(4) SMALL EMPLOYER.—The term "small employer" means, with respect to a calendar year, an employer that normally employs more than 1 but less than 100 countable employees on a typical business day. For the purposes of this paragraph, the term "employee" includes a self-employed individual. For purposes of determining if an employer is a small employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

SEC. 1903. DEFINITIONS RELATING TO HEALTH COVERAGE, PLANS, AND CARRIERS.

Except as otherwise provided, for purposes of this Act:

(1) BENCHMARK COVERAGE.—The term "benchmark coverage" means the standard option of the Blue Cross-Blue Shield plan offered under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code, as in effect during 1994.

(2) CARRIER.—The term "carrier" means a licensed insurance company, an entity offering prepaid hospital or medical services, and a health maintenance organization offering such services to an employer, and includes a similar organization regulated under State law for solvency.

(3) CERTIFIED MULTIPLE EMPLOYER HEALTH PLAN.—The term "certified multiple employer health plan" means a multiple employer welfare arrangement treated as an employee welfare benefit plan by reason of an certification under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by part 6 of this subtitle).

(4) CLASS OF FAMILY COVERAGE.—The term "class of family coverage" means the 4 classes described in section 1021(a)(3).

(5) GROUP HEALTH PLAN.—The term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance coverage under paragraph (7)(B).

(6) HEALTH COVERAGE.—The term "health coverage" means health insurance coverage provided by a carrier or medical care provided under a group health plan.

(7) HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "health insurance coverage" means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by a carrier.

(B) EXCEPTION.—Such term does not include any of the following (or any combination of the following):

(i) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

(ii) Medicare supplemental health insurance.

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers' compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) A hospital or fixed indemnity policy.

(ix) Coverage provided exclusively to individuals who are not eligible individuals.

(8) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" includes, as defined in standards established under section 1103, a an organization that provides health insurance coverage which meets specified standards and under which health services are offered to be provided on a prepaid, at-risk basis primarily through a defined set of providers.

(9) HEALTH PLAN PURCHASING ORGANIZATION.—The term "health plan purchasing organization" means an organization established under subtitle A of title V.

(10) INDIVIDUAL MARKET.—The term "individual market" means the insurance market offered to individuals seeking health insurance coverage for standard coverage or high-deductible coverage on behalf of themselves (and their dependents) and not seeking coverage on the basis of employment, membership in a organization, or through any group purchasing arrangement.

(11) MANAGED CARE ARRANGEMENTS.—

(A) MANAGED CARE ARRANGEMENT.—The term "managed care arrangement" means, with respect to an arrangement under a group health plan or under health insurance coverage, providers who have entered into an agreement under the arrangement under which such providers are obligated to provide items and services covered under the arrangement to individuals covered under the plan or who have such coverage.

(B) PROVIDER NETWORK.—The term "provider network" means, with respect to a group health plan or health insurance coverage, providers who have entered into an agreement described in subparagraph (A) under a managed care arrangement.

(12) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—The term "multiple employer welfare arrangement" shall have the meaning applicable under section 3(40) of the Employee Retirement Income Security Act of 1974.

(13) NAIC.—The term "NAIC" means the National Association of Insurance Commissioners.

(14) OPTIONS.—

(A) FEE-FOR-SERVICE OPTION.—Standard coverage is considered to provide a "fee-for-service option" if benefits with respect to the covered items and services in the coverage are made available for such items and services provided through any lawful provider of such covered items and services.

(B) MANAGED CARE OPTION.—Standard coverage is considered to provide a "managed care option" if benefits with respect to the covered items and services in the coverage are made available exclusively through a managed care arrangement, except in the case of emergency services and as otherwise required under law.

(C) POINT-OF-SERVICE OPTION.—Standard coverage is considered to provide a "point-of-service option" if the benefits with respect to covered items and services in the coverage are made available principally through a managed care arrangement, with the choice of the enrollee to obtain such benefits for items and services provided through any lawful provider of such covered items and services. The coverage may provide for different cost sharing schedules based on whether the items and services are provided through such an arrangement or outside such an arrangement.

(15) QUALIFIED HEALTH COVERAGE.—The term "qualified health coverage" has the meaning given such term in section 1101.

(16) SMALL GROUP MARKET.—The term "small group market" means the insurance market offered to small employers seeking health insurance coverage on behalf of their employees (and their dependents).

(17) STANDARD COVERAGE.—The term "standard coverage" means coverage provided consistent with section 1102.

(18) STATE COMMISSIONER OF INSURANCE.—The term "State commissioner of insurance" includes a State superintendent of insurance.

SEC. 1904. DEFINITIONS RELATING TO RESIDENCE AND IMMIGRATION STATUS.

Except as otherwise provided, for purposes of this Act:

(1) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term "alien permanently residing in the United States under color of law" means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following (such status not having changed):

(A) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

(B) An alien who is granted asylum under section 208 of such Act.

(C) An alien whose deportation is withheld under section 243(h) of such Act.

(D) An alien whose deportation is suspended pursuant to section 244 of such Act.

(E) An alien who is granted conditional entry pursuant to section 203(a)(7) of such Act as in effect before April 1, 1980.

(F) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

(E) An alien who is within a class of aliens lawfully present in the United States pursuant to any other provision of such Act, if (i) the Attorney General determines that the continued presence of such class of aliens serves a humanitarian or other compelling public interest, and (ii) the Secretary determines that such interest would be further served by treating each such alien within such class as an "legal permanent resident" for purposes of this Act or who has been granted extended voluntary departure as a member of a nationality group.

(F) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

(G) An alien within such other classification of permanent resident aliens as the Secretary may establish by regulation.

(2) LONG-TERM NONIMMIGRANT.—The term "long-term nonimmigrant" means a nonimmigrant described in subparagraph (E), (H), (I), (K), (L), (N), (O), (Q), or (R) of section 101(a)(15) of the Immigration and Nationality Act.

(3) QUALIFYING INDIVIDUAL.—The term "qualifying individual" means, an individual who is a resident of the United States, who is not a prisoner, and is—

(A) a citizen or national of the United States;

(B) an alien permanently residing in the United States under color of law (as defined in paragraph (1)); or

(C) a long-term nonimmigrant (as defined in paragraph (2)).

SEC. 1905. EFFECTIVE DATES.

The requirements of this title shall apply with respect to—

(1) group health plans for plan years beginning on or after January 1, 1997, and

(2) carriers (with respect to coverage other than under a group health plan) as of January 1, 1997.

TITLE II—REMOVAL OF FINANCIAL BARRIERS TO ACCESS

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Subtitle A—Tax Deductibility for Individuals and Self-Employed

SEC. 2101. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED AND MADE PERMANENT.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking "25 percent" and inserting "the applicable percentage".

(b) DEDUCTION MADE PERMANENT; APPLICABLE PERCENTAGE.—Paragraph (6) of section 162(l) of such Code is amended to read as follows:

"(6) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

In the case of taxable years beginning in calendar year:	The applicable percentage is:
1996, 1997, or 1998	25 percent
1999	50 percent
2000 or thereafter ...	100 percent."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 2102. DEDUCTION FOR HEALTH INSURANCE COSTS OF INDIVIDUALS WHO ARE NOT SELF-EMPLOYED.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. HEALTH INSURANCE COSTS OF INDIVIDUALS WHO ARE NOT SELF-EMPLOYED.

"(a) IN GENERAL.—In the case of an individual who is not a self-employed individual (as defined in section 401(c)(1)), there shall be allowed as a deduction an amount equal to 25 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

"(b) COORDINATION WITH DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.—The amount which would (but for this paragraph) be allowed as a deduction under subsection (a) for the taxable year shall be reduced (but not below zero) by the amount (if any) allowed as a deduction under section 162(l) for such taxable year.

"(c) OTHER COVERAGE.—Subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer.

"(d) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a)."

(b) DEDUCTION ALLOWED WHETHER OR NOT TAXPAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by adding at the end the following new paragraph:

"(16) HEALTH INSURANCE COSTS.—The deduction allowed by section 220."

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

"Sec. 220. Health insurance costs of individuals who are not self-employed.

"Sec. 221. Cross reference."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

Subtitle B—Low Income Subsidies and Medicaid Reform

SEC. 2100. DESCRIPTION OF TRANSITION FROM CURRENT MEDICAID SYSTEM TO NEW ACUTE CARE LOW-INCOME ASSISTANCE PROGRAM.

This subtitle provides for a transition from the current medicaid system to a new system of acute care low-income assistance through the following:

(1) IMMEDIATE MEDICAID REFORMS.—During 1995, 1996, and 1997, States are permitted to enroll medicaid recipients under coordinated care arrangements, but are restricted from eliminating eligibility categories currently in effect.

(2) SUBSTITUTION OF NEW PREMIUM AND COST-SHARING ASSISTANCE PROGRAM FOR AFDC AND NON-CASH BENEFICIARIES.—Beginning January 1, 1998—

(A) States are required to establish a new premium assistance program under title XXI of the Social Security Act, and

(B) with respect to AFDC and non-cash medicaid beneficiaries and other low-income individuals—

(i) States are required to provide for premium assistance for standard benefits through that program and additional benefits through a supplemental benefits grant program, and

(ii) States will no longer provide such individuals with medicaid coverage for standard acute care services.

PART 1—PREMIUM SUBSIDY AND SUPPLEMENTAL BENEFIT PROGRAMS FOR LOW-INCOME INDIVIDUALS

SEC. 2101. STATE PREMIUM SUBSIDY PROGRAMS.

(a) MEDICAID STATE PLAN REQUIREMENT.—

(1) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6111(1), is amended by inserting after paragraph (61) the following new paragraph:

"(62) provide for a State program furnishing premium subsidies for low-income individuals in accordance with part A of title XXI.".

(2) EFFECTIVE DATE.—The requirement of section 1902(a)(62) of the Social Security Act shall apply to Federal financial participation for calendar quarters beginning on or after January 1, 1998.

(b) REQUIREMENTS FOR STATE PREMIUM SUBSIDY PROGRAMS FOR LOW-INCOME INDIVIDUALS.—Such Act is further amended by adding at the end the following new title:

"TITLE XXI—STATE PREMIUM AND COST-SHARING SUBSIDY PROGRAMS FOR LOW-INCOME INDIVIDUALS; STATE SUPPLEMENTAL BENEFITS PROGRAMS; FINANCING FAILSAFE MECHANISM

"PART A—STATE PREMIUM AND COST-SHARING SUBSIDY PROGRAMS

"SEC. 2101. ESTABLISHMENT OF STATE PROGRAMS.

"(a) IN GENERAL.—As a requirement under section 1902(a)(62), effective January 1, 1998, each State shall establish and maintain a premium and cost-sharing subsidy program (in this title referred to as a 'State subsidy program') that provides for—

"(1) premium assistance described in section 2103 to premium subsidy eligible individuals described in section 2102 in accordance with this part, and

"(2) State maintenance-of-effort contributions in accordance with section 2108.

"(b) AVAILABILITY OF FUNDS.—Each State with a State subsidy program approved under this part is entitled, for calendar quarters beginning on or after January 1, 1998, to payment under section 2106.

"(c) APPROVAL OF STATE PROGRAMS.—The Secretary may not approve a State subsidy program unless the State has submitted a detailed description of the form and manner in which it will carry out the program and the Secretary finds that the program meets the applicable requirements of this part.

"(d) DESIGNATION OF STATE AGENCY.—A State may designate any appropriate State agency to administer the state subsidy program.

"SEC. 2102. ELIGIBILITY.

"(a) ASSISTANCE.—

"(1) PREMIUM SUBSIDY.—Each premium subsidy eligible individual (as defined in subsection (b)) is entitled to premium assistance under section 2103(a)(1).

"(2) COST-SHARING SUBSIDY.—Each cost-sharing subsidy eligible individual (as defined in subsection (c)) is entitled to cost-sharing assistance described in section 2103(a)(2).

"(b) PREMIUM SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—

"(1) IN GENERAL.—In this title, subject to the succeeding provisions of this section and part C, the term 'premium subsidy eligible individual' means a individual who has been determined under section 2104 to have family modified adjusted income below the following applicable percentage of the applicable poverty line (for a family of the size involved):

"Calendar year:	Applicable applicable percentage:
1998	100
1999	115
2000	130
2001	145
2002	160
2003	175
2004	200

"(2) SPECIAL RULE FOR CHILDREN.—In this title, subject to the succeeding provisions of this section and part C, the term 'premium subsidy eligible individual' includes a child under 18 years of age who has been determined under section 2104 to have family modified adjusted income below the following applicable percentage of the applicable poverty line (for a family of the size involved):

"Calendar year:	Applicable applicable percentage:
1998	140
1999	150
2000	160
2001	170
2002	180
2003	200
2004	240

"(3) SPECIAL RULE FOR PREGNANT WOMEN.—In this title, subject to the succeeding provisions of this section and part C, the term 'premium subsidy eligible individual' includes a pregnant woman who has been determined under section 2104 to have family modified adjusted income below the following applicable percentage of the applicable poverty line (for a family of the size involved):

"Calendar year:	Applicable applicable percentage:
1998	140
1999	150
2000	160
2001	170
2002	180
2003	200
2004	240

"(4) ADJUSTMENT OF PERCENTAGES BASED ON FAILSAFE MECHANISM.—The percentages specified in paragraphs (1), (2), and (3) are subject to adjustment under part C of this title.

"(c) COST-SHARING SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—

"(1) IN GENERAL.—In this title, subject to the succeeding provisions of this section and part C, the term 'cost-sharing subsidy eligible individual' means an individual who has been determined under section 2104 to have family modified adjusted income below 100 percent of the applicable poverty line (for a family of the size involved).

"(2) ADJUSTMENT OF PERCENTAGE BASED ON FAILSAFE MECHANISM.—The percentage specified in paragraph (1) shall in no case be greater than the percentage specified in subsection (b).

"(d) EXCLUSION OF CERTAIN INDIVIDUALS.—

"(1) IN GENERAL.—The terms 'premium subsidy eligible individual' and 'cost-sharing subsidy eligible individual' do not include, with respect to a month, any of the following individuals:

"(A) MEDICARE BENEFICIARY.—An individual who is entitled to benefits under part A or B of title XVIII for the month.

"(B) SSI RECIPIENT.—An individual who is an SSI recipient (as defined in paragraph (3)) for the month.

"(C) INMATES.—An individual who as of the first day of the month is an inmate of a public institution (except as a patient of a medical institution).

"(D) CERTAIN ALIENS.—An individual who is neither a citizen or national of the United

States or an alien permanently residing in the United States under color of law (as defined in paragraph (2).

"(E) NONRESIDENTS.—An individual who is not residing in the United States.

"(2) ALIEN PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW.—The term 'alien permanently residing in the United States under color of law' means an alien lawfully admitted for permanent residence (within the meaning of section 101(a)(20) of the Immigration and Nationality Act), and includes any of the following:

"(A) An alien who is admitted as a refugee under section 207 of the Immigration and Nationality Act.

"(B) An alien who is granted asylum under section 208 of such Act.

"(C) An alien whose deportation is withheld under section 243(h) of such Act.

"(D) An alien who is admitted for temporary residence under section 210, 210A, or 245A of such Act.

"(E) An alien who has been paroled into the United States under section 212(d)(5) of such Act for an indefinite period or who has been granted extended voluntary departure as a member of a nationality group.

"(F) An alien who is the spouse or unmarried child under 21 years of age of a citizen of the United States, or the parent of such a citizen if the citizen is over 21 years of age, and with respect to whom an application for adjustment to lawful permanent residence is pending.

"(3) SSI RECIPIENT.—In this subsection, the term 'SSI recipient' means, for a month, an individual—

"(A) with respect to whom supplemental security income benefits are being paid under title XVI for the month,

"(B) who is receiving a supplemental payment under section 1616 or under section 212 of Public Law 93–66 for the month,

"(C) who is receiving monthly benefits under section 1619(a) (whether or not pursuant to section 1616(c)(3)) for the month, or

"(D) who is treated under section 1619(b) as receiving supplemental security income benefits in a month for purposes of title XIX.

"(e) PROTECTION OF CURRENT BENEFICIARIES.—The term 'premium subsidy eligible individual' also includes, with respect to a State as of December 31, 1997, an individual who—

"(1) is not excluded under subsection (d),

"(2) is entitled to receive medical assistance under the State plan under title XIX (and for which Federal financial participation was available) as of December 31, 1997, and

"(3) would remain eligible for medical assistance under the State plan under title XIX but for amendments made by the Bipartisan Health Care Reform Act of 1994.

"SEC. 2103. PREMIUM AND COST-SHARING ASSISTANCE.

"(a) IN GENERAL.—

"(1) PREMIUM ASSISTANCE.—The premium assistance under a State subsidy program shall be in the form of a premium reduction certificate with an amount equal to the premium assistance computed under subsection (b). A carrier providing health insurance coverage or a group health plan that is tendered such a certificate with respect to an individual shall reduce the amount of the premium by the amount of the certificate. For purposes of this part, VA health coverage (as defined in section 1801(2) of title 38, United States Code) provided by the Department of Veterans Affairs shall be considered to be health insurance coverage provided by a carrier.

"(2) COST-SHARING ASSISTANCE.—The cost-sharing assistance under a State subsidy program shall be in the form of a cost-sharing reduction certificate (or other means). A carrier providing health insurance coverage or a group health plan that is tendered such a certificate with respect to an individual shall reduce the cost-sharing otherwise imposed with respect to health coverage to amounts that are nominal (as specified by the State, consistent with the regulations established to carry out section 1916(a)(3)).

"(3) CONSOLIDATED AND ELECTRONIC CERTIFICATES.—Nothing in this section shall be construed as preventing a State from—

"(A) in the case of an individual who is both a premium subsidy eligible individual and a cost-sharing eligible individual, from consolidating the premium and cost-sharing certificates of the individual, and

"(B) providing premium and cost-sharing certificates through electronic or other means.

"(b) AMOUNT OF PREMIUM ASSISTANCE.—

"(1) IN GENERAL.—Except as provided in paragraph (4), the amount of premium assistance for a month for a premium subsidy eligible individual is the lesser of—

"(A) the premium assistance amount determined under paragraph (2); or

"(B) the amount of the premium for qualified standard health coverage provided the individual,

reduced by the amount of any contribution made by an employer with respect to coverage of the individual.

"(2) PREMIUM ASSISTANCE AMOUNT DETERMINED.—

"(A) IN GENERAL.—The premium assistance amount determined under this paragraph is an amount equal to the subsidy percentage specified in paragraph (3) multiplied by 1/12 of the lesser of—

"(i) the annual premium for qualified standard health coverage provided the individual, or

"(ii) the weighted average annual premium for the individual's class of enrollment (determined in accordance with subparagraph (B)) for standard health insurance coverage offered in the geographic area (identified under 1021(c) of the Bipartisan Health Care Reform Act of 1994) in the individual and small group market in which the individual resides.

"(B) DETERMINATION OF WEIGHTED AVERAGE ANNUAL PREMIUM.—For purposes of subparagraph (A)(ii), the weighted average annual premium for a class of enrollment for coverage described in subparagraph (A)(i) shall be based on the number of families and individuals covered in the class and area involved.

"(C) CLASS OF ENROLLMENT.—In this title, the term 'class of enrollment' means the classes described in section 1021(a)(3) of the Bipartisan Health Care Reform Act of 1994.

"(3) SUBSIDY PERCENTAGE.—For purposes of paragraph (2), the term 'subsidy percentage' means 100 percent reduced (but not below zero) by the number of percentage points (rounded to the nearest whole number) by which such individual's family income (expressed as a percent) exceeds 100 percent of the poverty line.

"(c) PAYMENTS OF ASSISTANCE.—

"(1) PREMIUM ASSISTANCE.—

"(A) IN GENERAL.—The State issuing a premium assistance certificate shall, upon tender to the State of such certificate by the carrier or group health plan providing coverage, pay the carrier or plan the amount of the certificate.

"(B) TIMING OF PAYMENTS.—Payments under this paragraph shall commence in the first month during which the individual obtains qualified standard health coverage and is determined under section 2104 to be a premium subsidy eligible individual.

"(C) TREATMENT OF SURPLUSES AND DEFICITS.—If the premium for coverage is greater than the amount of the premium assistance for an individual, the individual is responsible for payment of any difference. If the premium for coverage is less than the amount of the premium assistance for an individual, the difference shall not be paid to the individual or the carrier or plan but shall revert to the Federal Government.

"(2) COST-SHARING ASSISTANCE.—

"(A) IN GENERAL.—The State issuing a cost-sharing assistance certificate shall, upon presentation to the State of evidence of such certificate by the carrier or group health plan providing coverage and evidence of cost-sharing amounts otherwise incurred for which a reduction is available under the certificate, pay the carrier or plan the amount of the reduction certificate.

"(B) TIMING OF PAYMENTS.—Payments under this paragraph shall commence in the first month during which the individual obtains qualified standard health coverage and is determined under section 2104 to be a premium subsidy eligible individual.

"(3) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium or cost-sharing assistance paid based on an eligibility determination error to the extent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

"SEC. 2104. ELIGIBILITY DETERMINATIONS.

"(a) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State subsidy programs with respect to determining eligibility for premium and cost-sharing assistance, including requirements with respect to—

"(1) application procedures;

"(2) information verification procedures;

"(3) timeliness of eligibility determinations;

"(4) procedures for applicants to appeal adverse decisions; and

"(5) any other matters determined appropriate by the Secretary.

"(b) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under subsection (a) shall include the following requirements:

"(1) FREQUENCY OF APPLICATIONS.—A State program shall provide that an individual may file an application for assistance with an agency designated by the State at any time, in person.

"(2) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under subsection (c).

"(3) DISTRIBUTION OF APPLICATIONS.—A State program shall distribute applications for assistance through employers, health plan purchasing organizations, and appropriate public agencies.

"(4) CONVENIENT LOCATION TO SUBMIT APPLICATIONS.—A State program shall provide convenient locations for premium subsidy eligible individuals to apply for premium and cost-sharing assistance.

"(4) REQUIREMENT TO SUBMIT REVISED APPLICATION.—A State program shall, in accordance with regulations promulgated by the Secretary, require individuals to submit revised applications during a year to reflect changes in estimated family incomes, including changes in employment status of family members, during the year. The State shall revise the amount of any premium and cost-sharing assistance based on such a revised application.

"(5) AFDC APPLICANTS.—A State program shall include a procedure under which individuals applying for benefits under title IV shall have an opportunity to apply for assistance under this part in connection with such application.

"(6) VERIFICATION.—A State program shall provide for verification of the information supplied in applications under this part. Such verification may include examining return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

"(c) ADMINISTRATION OF STATE PROGRAMS.—

"(1) IN GENERAL.—The Secretary shall establish standards for States operating programs under this part which ensure that such programs are operated in a uniform manner with respect to application procedures, data processing systems, and such other administrative activities as the Secretary determines to be necessary.

"(2) APPLICATION FORMS.—The Secretary shall develop an application form for assistance which shall—

"(A) be simple in form and understandable to the average individual;

"(B) require the provision of information necessary to make a determination as to whether an individual is a premium or cost-sharing subsidy eligible individual including a declaration of estimated income by the individual based, at the election of the individual—

"(i) on multiplying by a factor of 4 the individual's family income for the 3-month period immediately preceding the month in which the application is made, or

"(ii) on estimated income for the entire year for which the application is submitted; and

"(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

"(3) OUTREACH ACTIVITIES.—A State operating a program under this part shall conduct such outreach activities as the Secretary determines appropriate.

"(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM AND COST-SHARING ASSISTANCE.—A determination by a State that an individual is a premium or cost-sharing subsidy eligible individual shall be effective for the calendar year for which such determination is made unless a revised application submitted under subsection (b)(4) indicates that an individual is no longer eligible for premium or cost-sharing assistance.

"(e) PENALTIES FOR MATERIAL MISREPRESENTATIONS.—

"(1) IN GENERAL.—Any individual who knowingly makes a material misrepresentation of information in an application for assistance under this part shall be liable to the Federal Government for the amount any premium assistance and cost-sharing assistance received by an individual on the basis of a misrepresentation and interest on such amount at a rate specified by the Secretary, and shall, in addition, be liable to the Federal Government for $2,000 or, if greater, 3 times the amount any premium assistance and cost-sharing assistance provided on the basis of a misrepresentation.

"(2) COLLECTION OF PENALTY AMOUNTS.—A State which receives an application for assistance with respect to which a material misrepresentation has been made shall collect the penalty amount required under paragraph (1) and submit 50 percent of such amount to the Secretary in a timely manner.

"SEC. 2105. END-OF-YEAR RECONCILIATION FOR PREMIUM ASSISTANCE.

"(a) IN GENERAL.—

"(1) REQUIREMENT TO FILE STATEMENT.—An individual who received premium assistance under this part from a State for any month in a calendar year shall file with the State an income reconciliation statement to verify the individual's family income for the year. Such a statement shall be filed at such time, and contain such information, as the State may specify in accordance with regulations promulgated by the Secretary.

"(2) NOTICE OF REQUIREMENT.—A State shall provide a written notice of the requirement under paragraph (1) at the end of the year to an individual who received premium assistance under this part from such State in any month during the year.

"(b) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—

"(1) IN GENERAL.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to an individual, the State shall compute the amount of premium assistance that should have been provided under this part with respect to the individual for the year involved.

"(2) OVERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was greater than the amount computed under paragraph (1), the excess amount shall be treated as an underpayment of a tax imposed by chapter 1 of the Internal Revenue Code of 1986 and paid by the Secretary of the Treasury to the taxpayer involved.

"(3) UNDERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was less than the amount computed under paragraph (1), the amount of the difference shall be treated as an overpayment of tax imposed by such chapter, or in the event the taxpayer involved is entitled to a refund of such a tax, subject to the provisions of section 6402(d) of such Code.

"(c) VERIFICATION.—Each State may use such information as it has available to verify income of individuals with applications filed under this part, including return information disclosed to the State for such purpose under section 6103(l)(15) of the Internal Revenue Code of 1986.

"(d) PENALTIES FOR FAILURE TO FILE.—In the case of an individual who is required to file a statement under this section in a year who fails to file such a statement by such date as the Secretary shall specify in regulations, the entire amount of the premium assistance provided in such year shall be considered an excess amount under subsection (b)(2) and such individual shall not be eligible for premium assistance under this part until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the individual establishes, to the satisfaction of the State under such rules, good cause for the failure to file the statement on a timely basis.

"(e) PENALTIES FOR FALSE INFORMATION.—Any individual who provides false information in a statement filed under subsection (a) is subject to the same penalties as are provided under section 2104(e) for a misrepresentation of material fact described in such section.

"(f) NO RECONCILIATION FOR COST-SHARING REDUCTIONS.—No reconciliation statement is required under this section with respect to cost-sharing assistance.

"SEC. 2106. PAYMENTS TO STATES.

"(a) IN GENERAL.—

"(1) PAYMENTS FOR PREMIUM AND COST-SHARING ASSISTANCE.—Subject to paragraph (3) and section 2151, the Secretary shall provide for payment to each State operating a State subsidy program in an amount equal to—

"(A) the sum of—

"(i) the amount of premium assistance paid on behalf of premium subsidy eligible individuals, and

"(ii) the amount of the cost-sharing assistance paid on behalf of cost-sharing subsidy eligible individuals; less

"(B) the amount of any maintenance-of-effort payments that the State has failed to pay under section 2108.

Such payments shall be made at such time and in such form as provided in regulations promulgated by the Secretary, based on the form and manner in which payments are made under section 1903.

"(2) MATCHING PAYMENTS FOR ADMINISTRATIVE EXPENSES.—

"(A) IN GENERAL.—Subject to section 2151 and subparagraphs (B) and (C), the Secretary shall pay to each State operating a State subsidy program, for each quarter beginning with the quarter commencing January 1, 1998, an amount equal to 50 percent of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State subsidy program.

"(B) LIMITATION.—The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subparagraph (A) shall not exceed 1.5 percent of the total expenditures under the State subsidy program in the quarter.

"(C) EXCEPTION FOR FAILURE TO ESTABLISH AND MAINTAIN RISK ADJUSTMENT MECHANISM.—No amounts are payable to a State under subparagraph (A) if the State has failed to establish and maintain a risk adjustment mechanism in accordance with section 1023(b) of the Bipartisan Health Care Reform Act of 1994.

"(3) LIMITATION.—The total amount of payments made under paragraph (1) with respect to a State for all quarters in a year may not exceed the amount of the limitation that would be imposed under section 2135 with respect to Federal payments to the State for the quarter if any reference in such section to supplemental benefits were treated as a reference to core benefits.

"(4) STATE ENTITLEMENT.—This subsection constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide payments to States under this part in accordance with this subsection.

"(b) FUNDING.—The amount paid to States under subsection (a) shall be paid by the Secretary from the Health Care Assurance Trust Fund (established under section 2107).

"(c) AUDITS.—The Secretary shall conduct regular audits of the activities under the State programs conducted under this part.

"SEC. 2107. HEALTH CARE ASSURANCE TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Assurance Trust Fund' (in this section referred to as the 'Trust Fund'), consisting of such amounts as may be appropriated or credited to it under this section.

"(b) TRANSFERS TO THE TRUST FUND.—

"(1) IN GENERAL.—There are hereby appropriated to the Trust Fund—

"(A) the amount determined by the Secretary, after consultation with the Secretary of Health and Human Services, to be equal to the sum of—

"(i) the decrease in Federal expenditures under title XIX of the Social Security Act by reason of the provisions of, and the amendments made by, the Bipartisan Health Care Reform Act of 1994, and

"(ii) any reduction in payments to States under such title by reason of the State maintenance-of-effort requirement under section 2108, and

"(C) amounts equivalent to the following amounts received in the Treasury:

"(i) Criminal fines imposed and collected, and amounts resulting from the forfeiture of property, in cases involving a Federal health care offense (as defined in section 1128D of the Social Security Act).

"(ii) Penalties and damages imposed and collected under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

"(iii) Administrative penalties and assessments imposed and collected under section 1128A of the Social Security Act (except as otherwise provided by law).

"(2) Transfers from other trust funds.—The Secretary of Health and Human Services shall transfer each fiscal year to the Trust Fund from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund the amount which the Secretary estimates is equal to the decrease in expenditures in each such trust fund attributable to the provisions of title VI of the Bipartisan Health Care Reform Act of 1994.

"(3) Transfers from certain recovered amounts and gifts.—The Secretary of Health and Human Services shall transfer each fiscal year to the Trust Fund—

"(A) the portion of amounts recovered under section 1128A(a) with respect to a qualified health coverage or qualified long-term care policy which is not repaid to the plan or policy, or

"(B) any money gifts or bequests made to or on behalf of the United States for allocation to the Trust Fund.

"(c) Expenditures.—Amounts in the Trust Fund are appropriated to the Secretary to carry out the health insurance premium assistance program and the cost-sharing grant program established under part B of title XIX of the Social Security Act, and to the extent any such amount is not expended during any fiscal year, such amount shall be available for such purpose for subsequent fiscal years.

"SEC. 2108. REQUIREMENT OF STATE MAINTENANCE-OF-EFFORT PAYMENTS.

"(a) In General.—As a condition of payment of amounts to a State under section 2106, each State shall provide for payments to the Secretary, in a form, manner, and time specified by the Secretary, of the maintenance of effort amount computed under subsection (b)(1) for the State. The Secretary shall permit payment of such amounts as an offset against the amounts otherwise payable to the State under section 2106.

"(b) Maintenance of Effort Amount.—The maintenance of effort amount computed under this paragraph for a State for a quarter in a year is equal to the product of—

"(1) the amount that would be computed as the limit on Federal expenditures under section 2106(a)(3) for the State for the quarter if the FEHBP State rolling increase percentage (as defined in section 2136(b)(2)) were substituted for the FEHBP national rolling increase percentage in section 2135(a)(2)(B) and 2135(b)(1); and

"(2) the Federal-to-State conversion factor (specified under section 2135(b)(3)).

"(c) Crediting.—Payments made under this section shall be deposited by the Secretary to the credit of the Bipartisan Health Insurance Trust Fund.

"SEC. 2109. DEFINITIONS AND DETERMINATIONS OF INCOME.

"For purposes of this part:

"(1) Qualified standard health plan.—The term 'qualified standard health plan' has the meaning given such term in section ____ of the Bipartisan Health Care Reform Act of 1994.

"(2) Determinations of income.—

"(A) Family income.—The term 'family income' means, with respect to an individual who—

"(i) is not a dependent (as defined in subparagraph (B)) of another individual, the sum of the modified adjusted gross incomes (as defined in subparagraph (D)) for the individual, the individual's spouse, and dependents of the individual; or

"(ii) is a dependent of another individual, the sum of the modified adjusted gross incomes for the other individual, the other individual's spouse, and dependents of the other individual.

"(B) Dependent.—The term 'dependent' shall have the meaning given such term under paragraphs (1) or (2) of section 152(a) of the Internal Revenue Code of 1986.

"(C) Special rule for foster children.—For purposes of subparagraph (A), a child who is placed in foster care by a State agency shall not be considered a dependent of another individual.

"(D) Modified adjusted gross income.—The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

"(i) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code, and

"(ii) increased by—

"(I) the amount of interest received or accrued by the individual during the taxable year which is exempt from tax,

"(II) the amount of the social security benefits (as defined in section 86(d) of such Code) received during the taxable year to the extent not included in gross income under section 86 of such Code,

"(III) the amount of aid to families with dependent children received during the taxable year under part A of title IV to the extent not included in gross income under such Code, and

"(IV) the amount of any supplemental security income benefits provided under title XVI.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

"(3) Medical consumer price index.—The term 'medical consumer price index' means the medical care services component of the consumer price index (for urban consumers) as determined by the Bureau of Labor Statistics.

"(4) Poverty line.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) that—

"(A) in the case of a family of less than five individuals, is applicable to a family of the size involved; and

"(B) in the case of a family of more than four individuals, is applicable to a family of four persons.

"(5) Pregnant woman.—The term 'pregnant woman' means a woman described in section 1902(l)(1)(A).

"(6) Premium.—Any reference to the term 'premium' includes a reference to premium equivalence for self-insured plans.

"(7) State.—The term 'State' means each of the 50 States and the District of Columbia.

"Part B—State Supplemental Benefits Programs

"SEC. 2131. ESTABLISHMENT OF STATE SUPPLEMENTAL BENEFITS PROGRAMS.

"(a) In General.—Each State shall establish a State supplemental benefits program (in this title referred to as the 'State supplemental benefits program') that provides supplemental medical benefits for supplemental benefit eligible individuals.

"(b) Availability of Funds.—Each State with a State supplemental benefits program approved under this part is entitled, for calendar quarters beginning on or after January 1, 1998, to payment under section 2136.

"(c) Approval of State Programs.—The Secretary may not approve a State supplemental benefits program unless the State has submitted a detailed description of the form and manner in which it will carry out the program and the Secretary finds that the program meets the applicable requirements of this part.

"SEC. 2132. ELIGIBILITY.

"(a) In General.—In this part, the term 'supplemental benefit eligible individual' means an individual who, as of the time of provision of supplemental medical benefits, is—

"(1) a premium subsidy eligible individual (as defined in section 2102(b)), or

"(2) a pregnant woman or child who would be eligible for medical assistance under section 1902(l) or otherwise but for the elimination of coverage under such section.

"(b) Protection of Current Beneficiaries.—The term 'supplemental benefit eligible individual' also includes, with respect to a State as of December 31, 1997, an individual who—

"(1) is not described in section 2102(d),

"(2) is entitled to receive medical assistance under the State plan under title XIX (and for which Federal financial participation was available) as of December 31, 1997, and

"(3) would remain eligible for medical assistance under the State plan under title XIX but for amendments made by the Bipartisan Health Care Reform Act of 1994.

"(c) Construction.—Nothing in this part shall be construed to create an entitlement for supplemental benefit eligible individuals. The provisions of section 2105 (relating to reconciliation) shall not apply to any assistance provided under this part.

"SEC. 2133. SCOPE AND PROVISION OF BENEFITS; BENEFITS ADMINISTRATION.

"(a) In General.—The supplemental medical benefits that may be made available under a State supplemental benefits program may include benefits included in the supplemental medical benefits group described in section 1932(b)(2).

"(b) Coverage of Benefits.—

"(1) In general.—Each State supplemental benefits program shall include, in the document submitted to the Secretary describing the program, a description of—

"(A) the methods and standards used to select the types, and the amount, duration, and scope, of supplemental medical benefits included in the program and to assure access to, and the quality of, services included in such benefits;

"(B) the nondiscriminatory manner or basis under which such benefits are to be made available to and allocated among supplemental benefits eligible individuals;

"(C) the manner in which such benefits are coordinated with each other and with benefits provided under qualified health plans for supplemental benefits eligible individuals; and

"(D) the manner in which the program will not duplicate benefits available under health insurance plans or other health benefit programs for which supplemental benefit eligible individuals may qualify.

"(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—Nothing in paragraph (1) shall be construed as preventing a State supplemental benefits program from varying the benefits available under the program based on individual needs.

"(3) LIMITATION ON USE OF FUNDS FOR ABORTIONS.—None of the funds appropriated to carry out this title shall be expended for any abortion except where the procedure is necessary to save the life of the mother or where the pregnancy is the result of an act of rape or incest.

"(c) PAYMENT METHODS.—Benefits under a program may be made available in the form of direct provision of services, reimbursement of providers, prepayment to providers or health plans on a capitation basis, reimbursement of supplemental benefit eligible individuals for expenses incurred for expenses included in supplemental medical benefits, or a combination of these methods.

"(d) ADMINISTRATION.—

"(1) STATE AGENCY.—Each State supplemental benefits program shall designate the State agency designated under section 2101(d) to administer the State premium and cost-sharing assistance program under part A.

"(2) ADMINISTRATIVE EXPENDITURES.—Each State supplemental benefits program shall contain assurances that not more than 3 percent of expenditures under the program for all quarters in any fiscal year shall be for administrative costs.

"(3) COORDINATION.—The State supplemental benefits program shall specify how the program—

"(A) will be integrated with the State medicaid plan, titles V and XX of the Social Security Act, part A of this title, and any other Federal or State programs that provide services or assistance targeted to supplemental benefit eligible individuals, and

"(B) will be coordinated with qualified health plans.

"(e) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—Each State supplemental benefits program shall furnish to the Secretary—

"(1) such reports, and cooperate with such audits, as the Secretary determines are needed concerning the State's administration of program under this part, including the processing of any claims under the plan, and

"(2) such data and information as the Secretary may require in order to carry out the Secretary's responsibilities.

"(f) USE OF STATE FUNDS FOR MATCHING.—Each State supplemental benefits program shall provide assurances satisfactory to the Secretary that Federal funds will not be used to provide for the State share of expenditures under this part.

"SEC. 2134. PAYMENTS TO STATES.

"(a) MATCHING PAYMENTS.—Subject to sections 2133(d)(2), 2135(a), 2136, and 2151, for each quarter beginning with the quarter commencing January 1, 1996, the Secretary, in accordance with the Cash Management Improvement Act, shall authorize payment to each State with an approved State supplemental benefits program under this part, an amount equal to the sum of—

"(1) the Federal medical assistance percentage (as defined in section 1905(b)) of amount demonstrated by State to have been expended under the program during the quarter for supplemental medical benefits for supplemental benefit eligible individuals; and

"(2) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the program.

This subsection constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide payments to States under this part in accordance with this subsection.

"(b) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

"(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of the total sum to be expended in such quarter, and such other information as the Secretary may find necessary.

"(2) From the allotment available therefore, the Secretary shall provide for payment of the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid.

"(c) FUNDING.—The amount paid to States under subsection (a) shall be paid by the Secretary from amounts made available under the Health Care Assurance Trust Fund established under section 2107.

"(d) AUDITS.—The Secretary shall conduct regular audits of the activities under the State programs conducted under this title.

"SEC. 2135. LIMITATION ON PAYMENTS TO STATES.

"(a) LIMITATION.—

"(1) COMPUTATION OF BASELINE FOR CALENDAR YEAR.—The baseline under this paragraph for 1997 is the product of—

"(A) ¼ of the State's per capita Federal supplemental allotment (determined under subsection (b)) for 1994, increased (on a compounded basis) by the FEHBP national rolling increase percentage for 1995, 1996, and 1997, and

"(B) the average monthly number of AFDC recipients and non-cash medicaid beneficiaries in the State in 1997.

"(2) LIMITATION.—

"(A) IN GENERAL.—Subject to section 2151 and paragraph (3), the total amount of payments that may be made to a State under section 2134 for a quarter in a year (beginning with 1998) is ¼ of the product described in this subparagraph (or paragraph (1)) for the previous year, increased by the supplemental benefit factor under subparagraph (B) for the year.

"(B) SUPPLEMENTAL BENEFIT FACTOR DESCRIBED.—For purposes of subparagraph (A), the 'supplemental benefit factor' for a year for a State is equal to the sum of—

"(i) FEHBP national rolling increase factor (described in paragraph (2)) for the year,

"(ii) the annual percentage increase in the population of the State (as estimated by the Secretary), and

"(iii)(I) 1 percentage point for the first 4 quarters in which this paragraph applies,

"(II) .67 percentage points for the next 4 quarters,

"(III) .33 percentage points for the next 4 quarters, and

"(IV) 0 percentage points thereafter.

"(2) FEHBP NATIONAL ROLLING INCREASE PERCENTAGE.—For purposes of this section, the term 'FEHBP national rolling increase percentage' means, for a year, the 5-year average of the annual national percentage increase in the premiums for health plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code) for the period ending with the previous year. Such increase shall be determined by the Secretary in consultation with the Director of Office of Personnel Management based on the best information available and shall be adjusted to take into account the age distribution in the Federal workforce and to disregard any changes due to changes in the benefit package under such chapter after 1994.

"(3) ADJUSTMENT FOR AVAILABILITY OF ADDITIONAL FUNDS.—If the Secretary determines for a year that the total amount of the Federal payments under section 2134 for a year for all the States is less than the sum of the limitations for the year for all the States established under paragraph (1), the limitation for each State under this subsection shall be increased in a pro-rata manner by such an amount as will not result in such total Federal payments under section 2134 exceeding the sum of such limits for all the States for the year.

"(b) PER CAPITA FEDERAL SUPPLEMENTAL ALLOTMENT DEFINED.—

"(1) IN GENERAL.—For purposes of subsection (a)(1), the 'per capita Federal supplemental allotment' for a State for a year is equal to the base per capita allotment (described in paragraph (2)), increased by the FEHBP national rolling increase percentage (as defined in subsection (a)(4)) for the year involved.

"(2) BASE PER CAPITA ALLOTMENT.—The 'base per capita allotment' described in this paragraph, for a State, is—

"(A) the baseline Federal medicaid supplemental expenditures (as defined in paragraph (3)) for the State, divided by

"(B) the number of AFDC recipients and non-cash medicaid beneficiaries enrolled in the State medicaid plan under title XIX in 1994, as determined under paragraph (4).

"(3) DETERMINATION OF BASELINE FEDERAL MEDICAID EXPENDITURES.—

"(A) IN GENERAL.—For purposes of paragraph (2)(A), the 'baseline medicaid supplemental expenditures' for a State is the amount of Federal payments made under section 1903(a)(1) under the State medicaid plan under title XIX with respect to medical assistance furnished for items and services included in the supplemental medical benefits group (described in section 1932(b)(2)) for AFDC recipients and non-cash medicaid beneficiaries for all calendar quarters in 1994.

"(B) DISPROPORTIONATE SHARE PAYMENTS NOT INCLUDED.—In applying subparagraph (A), payments attributable to section 1923 shall not be counted in the amount of payments.

"(C) TREATMENT OF DISALLOWANCES.—The amount determined under this paragraph shall take into account amounts (or an estimate of amounts) disallowed.

"(4) DETERMINATION OF NUMBER OF AFDC RECIPIENTS AND NON-CASH MEDICAID BENEFICIARIES.—For purposes of paragraph (2)(B), the number of AFDC recipients and non-cash medicaid beneficiaries for a State for 1994 shall be determined based on actual reports submitted by the State to the Secretary. In the case of individuals who were not recipients or beneficiaries for the entire fiscal year, the number shall take into account only the portion of the year in which they were such recipients. The Secretary may audit such reports.

"(5) APPLICATION TO PARTICULAR ITEMS AND SERVICES.—For purposes of this subsection, in determining the per capita Federal supplemental allotment for a category of items and services (within the supplemental medical benefits group) furnished in a State, there shall be counted only that proportion of such expenditures (determined only with respect to medical assistance furnished to AFDC recipients and non-cash medicaid beneficiaries) that were attributable to items and services included in the group (taking into account any limitation on amount, duration, or scope of items and services included in such package).

"SEC. 2136. STATE MAINTENANCE OF EFFORT REQUIREMENT.

"(a) IN GENERAL.—Payment to a State under section 2134 for a quarter (beginning after 1996) is conditioned upon the State making expenditures for supplemental benefits under this part for AFDC recipients and non-cash beneficiaries equal to at least the maintenance of effort amount computed under subsection (b).

"(b) MAINTENANCE OF EFFORT AMOUNT.—

"(1) IN GENERAL.—The maintenance of effort amount computed under this subsection for a State for a quarter in a year is equal to the product of—

"(A) the amount that would be computed as the minimum limitation under section 2135 for the State for the quarter (determined without regard to subsection (a)(5)) if the FEHBP State rolling increase percentage (as defined in paragraph (2)) were substituted for the FEHBP national rolling increase percentage in section 2135(a)(2)(B) and 2135(b)(1); and

"(B) the Federal-to-State conversion factor (specified under paragraph (3)).

"(2) FEHBP STATE ROLLING INCREASE PERCENTAGE.—For purposes of this section, the term 'FEHBP State rolling increase percentage' means, for a year with respect to a State, the 5-year average of the annual percentage increase in the premiums for health plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code) for the period ending with the previous year, based upon health plans offered in the State. Such increase shall be determined by the Secretary in consultation with the Director of Office of Personnel Management based on the best information available and shall be adjusted to take into account the age distribution in the Federal workforce (in relation to the State workforce) and to disregard any changes due to changes in the benefit package under such chapter after 1994.

"(3) FEDERAL-TO-STATE CONVERSION FACTOR.—For purposes of paragraph (1), the 'Federal-to-State conversion factor' for a State is equal to the ratio of—

"(A) 1 minus the Federal medical assistance percentage for the State for 1994, to

"(B) such Federal medical assistance percentage.

"PART C—FINANCING FAILSAFE MECHANISM

"SEC. 2151. FINANCING FAILSAFE MECHANISM.

"(a) PURPOSE.—

"(1) IN GENERAL.—The purpose of this section is to ensure that the amount of the additional targeted expenditures provided under the Bipartisan Health Care Reform Act of 1994 do not exceed the amount of the health care expenditure reductions achieved under such Act and, thus, do not result in an increase in the Federal deficit.

"(2) ADDITIONAL TARGETED EXPENDITURES DEFINED.—In this section, the term 'additional targeted expenditures' means the following:

"(A) PREMIUM AND COST-SHARING SUBSIDIES AND SUPPLEMENTAL BENEFITS.—Payments to States under parts A and B of this title.

"(B) TAX EXPENDITURES FOR PREMIUM DEDUCTIONS, ETC..—Reductions in revenues attributable to the amendments made to section 162 of the Internal Revenue Code of 1986 (by section 2101 of the Bipartisan Health Care Reform Act of 1994) and the addition of section 220 to such Code (as added by section 2202 of this Act).

"(3) HEALTH CARE EXPENDITURE REDUCTIONS.—In this section, the term 'health care expenditure reductions' means net reductions in Federal payments under titles XVIII and XIX resulting from the amendments by the Bipartisan Health Care Reform Act of 1994.

"(4) CONTINGENCY.—Any direct payment authority provided under part A or B to premium and cost-sharing assistance or supplemental medical benefits is subject to the operation of this section.

"(b) DETERMINATION OF UNFINANCED HEALTH SPENDING.—

"(1) CURRENT HEALTH SPENDING ESTIMATE.—

"(A) FISCAL YEARS THROUGH 2004.—Not later than the date that is 60 days after the date of enactment of this Act, the President shall issue an executive order setting forth the current health spending estimate for fiscal year 1995 and for each subsequent fiscal year through 2004, which shall consist of estimates (for each year) projecting what Federal outlays or revenues would have been if this Act had not been enacted, for the following:

"(i) total Federal outlays under titles XVIII and XIX of the Social Security Act (including administrative costs and offsetting receipts); and

"(ii) revenue losses attributable to section 162(l) of the Internal Revenue Code of 1986.

"(B) FISCAL YEARS AFTER 2004.—For each fiscal year following fiscal year 2004, the current health spending estimate is the estimate set forth in the executive order for fiscal year 2004, modified by an annual adjustment factor set forth in such order.

"(2) PRESIDENT TO TRANSMIT HEALTH REFORM ESTIMATES.—

"(A) ESTIMATES FOR UPCOMING FISCAL YEAR AND CURRENT YEAR.—By January 31 before the beginning of each fiscal year (beginning with fiscal year 1997), the President shall transmit to Congress a report that includes a health reform estimate (as specified in paragraph (3)) with respect to the upcoming fiscal year and the current fiscal year.

"(B) DETERMINATIONS FOR PRIOR FISCAL YEAR.—By January 31 before the beginning of each fiscal year (beginning with fiscal year 1998), the President shall transmit to Congress a report that includes determinations for the fiscal year which ended the prior September, with respect to the items specified in the health reform estimate (as specified in paragraph (3)).

"(3) HEALTH REFORM ESTIMATE.—

"(A) IN GENERAL.—The health reform estimate is a calculation, for the applicable fiscal year, of—

"(i) updated projections for the applicable fiscal year for each item set forth in the current health estimate (as set forth in paragraph (1)); plus

"(ii) the health reform outlays set forth in subparagraph (B); minus

"(iii) the net health reform revenues set forth in subparagraph (C).

"(B) HEALTH REFORM OUTLAYS.—Health reform outlays equal total outlays under parts A and B (including administrative costs) projected for the fiscal year.

"(C) NET HEALTH REFORM REVENUES.— Net health reform revenues equal total revenue losses projected for the applicable fiscal year due to the amendments made to section 162 of the Internal Revenue Code of 1986 (by section 2101 of the Bipartisan Health Care Reform Act of 1994) and the addition of section 220 to such Code (as added by section 2202 of this Act).

"(4) DETERMINATION OF UNFINANCED HEALTH SPENDING AND EXCESS HEALTH FINANCING.—

"(A) IN GENERAL.—Each health reform estimate required by this subsection shall be accompanied by a comparison of such estimate with the current health spending estimate for the applicable fiscal year.

"(B) DEFICIT.—If the applicable health reform estimate exceeds the applicable current health spending estimate, the President shall report the amount of the excess as unfinanced health spending for the applicable fiscal year.

"(C) EXCESS.—If the applicable health reform estimate is less than the applicable current health spending estimate, the President shall report such difference as excess health financing for the applicable fiscal year.

"(d) OFFSETTING UNFINANCED HEALTH SPENDING.—

"(1) REQUIREMENT TO FULLY OFFSET UNFINANCED HEALTH SPENDING.—If the President's report includes a determination of unfinanced health spending pursuant to subsection (c)(4) for the upcoming fiscal year, the current fiscal year, or the fiscal year which ended the prior October, such determination shall be accompanied by an executive order effective on October 1 of that calendar year which fully offsets in the fiscal year beginning October 1 the sum of such unfinanced health spending (for the upcoming fiscal year, the current fiscal year, and the prior fiscal year) in the manner provided in this subsection. Such executive order shall be accompanied by such regulations as are required under subsection (d)(4).

"(2) OFFSETS.—The offsets required by this subsection shall be accomplished through a combination of—

"(A) reducing the applicable percentages specified in the tables under section 2102(b), and

"(B) reducing the limitation on payments to each State under section 2135 by an equal percentage.

"(3) PROPORTIONAL REDUCTION.—The President shall apply the offset mechanisms described in subparagraphs (A) and (B) of paragraph (2) proportionally so as to result in a reduction in Federal expenditures under part A and part B of this title in the same ratio as the ratio of the total amount of Federal payments that are estimated would otherwise be made under part A to such amount under part B for the fiscal year involved. The reduction in percentages under paragraphs (1), (2), and (3) of section 2102(b) shall be done in a pro-rata manner reflecting the percentages specified in the tables in such respective paragraphs.

"(4) CONSULTATION.—In making the determinations required by this subsection, the President shall consult with the Director of the Office of Management and Budget, the Secretary of the Treasury, and the Director of the Congressional Budget Office.

"(e) APPLICATION OF EXCESS HEALTH FINANCING.—

"(1) INCREASE IN APPLICABLE PERCENTAGES.—If the President's report includes a determination of excess health financing pursuant to subsection (c)(4) for a fiscal year, such determination shall be accompanied by an executive order effective on October 1 of that calendar year which provides for an increase in the fiscal year beginning October 1 in the applicable percentages provided under paragraphs (1), (2), and (3) of section 2102(b) in the manner provided in this subsection. Such executive order shall be accompanied by such regulations as are required under subsection (d)(4).

"(2) PROPORTIONAL INCREASE.—The President the increase described in paragraph (1) shall apply under paragraphs (1), (2), and (3) of section 2102(b) in a pro-rata manner reflecting the percentages specified in the tables in such respective paragraphs.

"(3) CONSULTATION.—In making the determinations required by this subsection, the President shall consult with the Director of the Office of Management and Budget, the Secretary of the Treasury, and the Director of the Congressional Budget Office.

"(f) GAO AUDIT OF REDUCTIONS.—If the President has issued an executive order under subsection (d)(1), the General Accounting Office shall report to Congress, as soon thereafter as possible following the date of transmittal of the President's report, an analysis of whether the executive order has fully complied with the requirements of this section.".

(b) APPLICATION OF SAVE PROVISIONS.—Section 1137(b) of the Social Security Act (42 U.S.C. 1320b-7(b)) is amended—

(1) by striking "and" at the end of paragraph (4),

(2) by striking the period at the end of paragraph (5) and inserting "; and", and

(3) by adding at the end the following:

"(6) a State premium and cost-sharing assistance program under part A of title XXI.".

PART 2—IMMEDIATE MEDICAID REFORMS

SEC. 2111. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CONTRACTING FOR COORDINATED CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—

(1) PAYMENT PROVISIONS.—Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended to read as follows:

"(m)(1) No payment shall be made under this title to a State with respect to expenditures incurred by such State for payment to an entity which is at risk (as defined in section 1932(a)(4)) for services provided by such entity to individuals eligible for medical assistance under the State plan under this title, unless the entity is a risk contracting entity (as defined in section 1932(a)(3)) and the State and such entity comply with the applicable provisions of section 1932.

"(2) No payment shall be made under this title to a State with respect to expenditures incurred by such State for payment for services provided to an individual eligible for medical assistance under the State plan under this title if such payment by the State is contingent upon the individual receiving such services from a specified health care provider or subject to the approval of a specified health care provider, unless the entity receiving payment is a primary care case management entity (as defined in section 1932(a)(2)) and the State and such entity comply with the applicable provisions of section 1932.".

(2) REQUIREMENTS FOR COORDINATED CARE SERVICES.—Title XIX of such Act (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

"REQUIREMENTS FOR COORDINATED CARE SERVICES

"SEC. 1932. (a) DEFINITIONS.—For purposes of this title—

"(1) PRIMARY CARE CASE MANAGEMENT PROGRAM.—The term 'primary care case management program' means a program operated by a State agency under which such State agency enters into contracts with primary care case management entities for the provision of health care items and services which are specified in such contracts and the provision of case management services to individuals who are—

"(A) eligible for medical assistance under the State plan,

"(B) enrolled with such primary care case management entities, and

"(C) entitled to receive such specified health care items and services and case management services only as approved and arranged for, or provided, by such entities.

"(2) PRIMARY CARE CASE MANAGEMENT ENTITY.—The term 'primary care case management entity' means a health care provider which—

"(A) must be a physician, group of physicians, a Federally qualified health center, a rural health clinic, a community health authority (under section 1934), or an entity employing or having other arrangements with physicians operating under a contract with a State to provide services under a primary care case management program,

"(B) receives payment on a fee for service basis (or, in the case of a Federally qualified health center or a rural health clinic, on a reasonable cost per encounter basis) for the provision of health care items and services specified in such contract to enrolled individuals,

"(C) receives an additional fixed fee per enrollee for a period specified in such contract for providing case management services (including approving and arranging for the provision of health care items and services specified in such contract on a referral basis) to enrolled individuals, and

"(D) is not an entity that is at risk (as defined in paragraph (4)) for such case management services.

"(3) RISK CONTRACTING ENTITY.—The term 'risk contracting entity' means an entity which has a contract with the State agency (or a health insuring organization described in subsection (n)(2)) under which the entity—

"(A) provides or arranges for the provision of health care items or services which are specified in such contract to individuals eligible for medical assistance under the State plan, and

"(B) is at risk (as defined in paragraph (4)) for part or all of the cost of such items or services furnished to individuals eligible for medical assistance under such plan.

"(4) AT RISK.—The term 'at risk' means an entity which—

"(A) has a contract with the State agency under which such entity is paid a fixed amount for providing or arranging for the provision of health care items or services specified in such contract to an individual eligible for medical assistance under the State plan and enrolled with such entity, regardless of whether such items or services are furnished to such individual, and

"(B) is liable for all or part of the cost of furnishing such items or services, regardless of whether such cost exceeds such fixed payment.

"(b) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

"(1) ORGANIZATION.—A risk contracting entity meets the requirements of this section only if such entity—

"(A)(i) is a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as determined by the Secretary pursuant to section 1312 of such Act; or

"(ii) is described in subparagraph (C), (D), (E), (F), or (G) of subsection (e)(4);

"(B) is a Federally qualified health center, a rural health clinic, or a community health authority (under section 1934) which has made adequate provision against the risk of insolvency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical assistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency; or

"(C) is an entity which meets all applicable State licensing requirements and has made adequate provision against the risk of insolvency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical assistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency.

"(2) GUARANTEES OF ENROLLEE ACCESS.—A risk contracting entity meets the requirements of this section only if—

"(A) the geographic locations, hours of operation, patient to staff ratios, and other relevant characteristics of such entity are sufficient to afford individuals eligible for medical assistance under the State plan access to such entities that is at least equivalent to the access to health care providers that would be available to such individuals if such individuals were not enrolled with such entity;

"(B) such entity has reasonable and adequate hours of operation, including 24-hour availability of—

"(i)(I) treatment for an unforeseen illness, injury, or condition of an individual eligible for medical assistance under the State plan and enrolled with such entity; or

"(II) referral to other health care providers for such treatment; and

"(ii) other information, as determined by the Secretary or the State; and

"(C) such entity complies with such other requirements relating to access to care as the Secretary or the State may impose.

"(3) CONTRACT WITH STATE AGENCY.—A risk contracting entity meets the requirements of this section only if such entity has a written contract with the State agency which provides—

"(A) that the entity will comply with all applicable provisions of this section, that the State has the right to penalize the entity for failure to comply with such requirements and to terminate the contract in accordance with subsection (j), and that the entity will be subject to penalties imposed by the Secretary under subsection (i) for failure to comply with such requirements;

"(B) for a payment methodology based on experience rating or another actuarially sound methodology approved by the Secretary, which guarantees (as demonstrated by such models or formulas as the Secretary may approve) that—

"(i) payments to the entity under the contract shall not exceed an amount equal to 100 percent of the costs (which shall include administrative costs and which may include costs for inpatient hospital services that would have been incurred in the absence of such contract) that would have been incurred by the State agency in the absence of the contract; and "(ii) the financial risk for inpatient hospital services is limited to an extent established by the State;

"(C) that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain—

"(i) to the ability of the entity (or a subcontractor) to bear the risk of potential financial losses; or

"(ii) to services performed or determinations of amounts payable under the contract;

"(D) that in the entity's enrollment, reenrollment, or disenrollment of individuals eligible for medical assistance under the State plan and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of such individuals' health status or requirements for health care services;

"(E)(i) individuals eligible for medical assistance under the State plan who have enrolled with the entity are permitted to terminate such enrollment without cause as of the beginning of the first calendar month (or in the case of an entity described in subsection (e)(4), as of the beginning of the first enrollment period) following a full calendar month after a request is made for such termination;

"(ii) that when an individual has relocated outside the entity's service area, and the entity has been notified of the relocation, services (within reasonable limits) furnished by a health care provider outside the service area will be reimbursed either by the entity or by the State agency; and

"(iii) for written notification of each such individual's right to terminate enrollment, which shall be provided at the time of such individual's enrollment, and, in the case of a child with special health care needs as defined in subsection (e)(1)(B)(ii), at the time the entity identifies such a child;

"(F) in the case of services immediately required to treat an unforeseen illness, injury, or condition, of an individual eligible for medical assistance under the State plan and enrolled with the entity—

"(i) that such services shall not be subject to a preapproval requirement; and

"(ii) where such services are furnished by a health care provider other than the entity, for reimbursement of such provider either by the entity or by the State agency;

"(G) for disclosure of information in accordance with subsection (h) and section 1124;

"(H) that any physician incentive plan operated by the entity meets the requirements of section 1876(i)(8);

"(I) for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients;

"(J) that the entity will comply with the requirement of section 1902(w) with respect to each enrollee;

"(K) that the entity will implement a grievance system, inform enrollees in writing about how to use such grievance system, ensure that grievances are addressed in a timely manner, and report grievances to the State at intervals to be determined by the State;

"(L) that contracts between the entity and each subcontractor of such entity will require each subcontractor—

"(i) to cooperate with the entity in the implementation of its internal quality assurance program under paragraph (4) and adhere to the standards set forth in the quality assurance program, including standards with respect to access to care, facilities in which patients receive care, and availability, maintenance, and review of medical records;

"(ii) to cooperate with the Secretary, the State agency and any contractor to the State in monitoring and evaluating the quality and appropriateness of care provided to enrollees as required by Federal or State laws and regulations; and

"(iii) where applicable, to adhere to regulations and program guidance with respect to reporting requirements under section 1905(r);

"(M) that, where the State deems it necessary to ensure the timely provision to enrollees of the services listed in subsection (f)(2)(C)(ii), the State may arrange for the provision of such services by health care providers other than the entity and may adjust its payments to the entity accordingly;

"(N) that the entity and the State will comply with guidelines and regulations issued by the Secretary with respect to procedures for marketing and information that must be provided to individuals eligible for medical assistance under the State plan;

"(O) that the entity must provide payments to hospitals for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital, in accordance with paragraphs (2) and (3) of section 1902(s);

"(P) that the entity shall report to the State, at such time and in such manner as the State shall require, on the rates paid for hospital services (by type of hospital and type of service) furnished to individuals enrolled with the entity;

"(Q) detailed information regarding the relative responsibilities of the entity and the State, for providing (or arranging for the provision of), and making payment for, the following items and services:

"(i) immunizations;

"(ii) the purchase of vaccines;

"(iii) lead screening and treatment services;

"(iv) screening and treatment for tuberculosis;

"(v) screening and treatment for, and preventive services related to, sexually transmitted diseases, including HIV infection;

"(vi) screening, diagnostic, and treatment services required under section 1905(r);

"(vii) family planning services;

"(viii) services prescribed under—

"(I) an Individual Education Plan or Individualized Family Service Plan under part B or part H of the Individuals with Disabilities Education Act; and

"(II) any other individual plan of care or treatment developed under this title or title V;

"(ix) transportation needed to obtain services to which the enrollee is entitled under the State plan or pursuant to an individual plan of care or treatment described in subclauses (I) and (II) of clause (viii); and

"(x) such other services as the Secretary may specify;

"(R) detailed information regarding the procedures for coordinating the relative responsibilities of the entity and the State to ensure prompt delivery of, compliance with any applicable reporting requirements related to, and appropriate record keeping with respect to, the items and services described in subparagraph (Q); and

"(S) such other provisions as the Secretary may require.

"(4) INTERNAL QUALITY ASSURANCE.—A risk contracting entity meets the requirements of this section only if such entity has in effect a written internal quality assurance program which includes a systematic process to achieve specified and measurable goals and objectives for access to, and quality of, care, which—

"(A) identifies the organizational units responsible for performing specific quality assurance functions, and ensures that such units are accountable to the governing body of the entity and that such units have adequate supervision, staff, and other necessary resources to perform these functions effectively,

"(B) if any quality assurance functions are delegated to other entities, ensures that the risk contracting entity remains accountable for all quality assurance functions and has mechanisms to ensure that all quality assurance activities are carried out,

"(C) includes methods to ensure that physicians and other health care professionals under contract with the entity are licensed or certified as required by State law, or are otherwise qualified to perform the services such physicians and other professionals provide, and that these qualifications are ensured through appropriate credentialing and recredentialing procedures,

"(D) provides for continuous monitoring of the delivery of health care, through—

"(i) identification of clinical areas to be monitored, including immunizations, prenatal care, services required under section 1905(r), and other appropriate clinical areas, to reflect care provided to enrollees eligible for medical assistance under the State plan,

"(ii) use of quality indicators and standards for assessing the quality and appropriateness of care delivered, and the availability and accessibility of all services for which the entity is responsible under such entity's contract with the State,

"(iii) use of epidemiological data or chart review, as appropriate, and patterns of care overall,

"(iv) patient surveys, spot checks, or other appropriate methods to determine whether—

"(I) enrollees are able to obtain timely appointments with primary care providers and specialists, and

"(II) enrollees are otherwise guaranteed access and care as provided under paragraph (2),

"(v) provision of written information to health care providers and other personnel on the outcomes, quality, availability, accessibility, and appropriateness of care, and

"(vi) implementation of corrective actions,

"(E) includes standards for timely enrollee access to information and care which at a minimum shall incorporate standards used by the State or professional or accreditation bodies for facilities furnishing perinatal and neonatology care and other forms of specialized medical and surgical care,

"(F) includes standards for the facilities in which patients receive care,

"(G) includes standards for managing and treating medical conditions prevalent among such entity's enrollees eligible for medical assistance under the State plan,

"(H) includes mechanisms to ensure that enrollees eligible for medical assistance under the State plan receive services for which the entity is responsible under the contract which are consistent with standards established by the applicable professional societies or government agencies,

"(I) includes standards for the availability, maintenance, and review of medical records consistent with generally accepted medical practice,

"(J) provides for dissemination of quality assurance procedures to health care providers under contract with the entity, and

"(K) meets any other requirements prescribed by the Secretary or the State.

"(5) TRANSITIONAL AGREEMENTS WITH ESSENTIAL COMMUNITY PROVIDERS.—A risk contracting entity meets the requirements of this section only if such entity complies with the requirements of section 1013 of the Bipartisan Health Care Reform Act of 1994 (subject to the sunset contained in subsection (j) of such section).

"(c) GENERAL REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT PROGRAMS.—A primary care case management program implemented by a State under this section shall—

"(1) provide that each primary care case management entity participating in such program has a written contract with the State agency,

"(2) include methods for selection and monitoring of participating primary care case management entities to ensure—

"(A) that the geographic locations, hours of operation, patient to staff ratio, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance under the State plan access to such entities that is at least equivalent to the access to health care providers that would be available to such individuals if such individuals were not enrolled with such entity,

"(B) that such entities and their professional personnel are licensed as required by State law and qualified to provide case management services, through methods such as ongoing monitoring of compliance with applicable requirements and providing information and technical assistance, and

"(C) that such entities—

"(i) provide timely and appropriate primary care to such enrollees consistent with standards established by applicable professional societies or governmental agencies, or such other standards prescribed by the Secretary or the State, and

"(ii) where other items and services are determined to be medically necessary, give timely approval of such items and services and referral to appropriate health care providers,

"(3) provide that no preapproval shall be required for emergency health care items or services, and

"(4) permit individuals eligible for medical assistance under the State plan who have enrolled with a primary care case management entity to terminate such enrollment without cause not later than the beginning of the first calendar month following a full calendar month after the request is made for such termination.

"(d) EXEMPTIONS FROM STATE PLAN REQUIREMENTS.—A State plan may permit or require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity without regard to the requirements set forth in the following paragraphs of section 1902(a):

"(1) Paragraph (1) (concerning statewideness).

"(2) Paragraph (10)(B) (concerning comparability of benefits), to the extent benefits not included in the State plan are provided.

"(3) Paragraph (23) (concerning freedom of choice of provider), except with respect to services described in section 1905(a)(4)(C) and except as required under subsection (e).

"(e) STATE OPTIONS WITH RESPECT TO ENROLLMENT AND DISENROLLMENT.—

"(1) MANDATORY ENROLLMENT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a State plan may require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity only if the individual is permitted a choice within a reasonable service area (as defined by the State)—

"(i) between or among 2 or more risk contracting entities,

"(ii) among a risk contracting entity and a primary care case management program, or

"(iii) among primary care case management entities.

"(B) SPECIAL NEEDS CHILDREN.—

"(i) IN GENERAL.—A State may not require a child with special health care needs (as defined in clause (ii)) to enroll with a risk contracting entity or a primary care case management entity.

"(ii) DEFINITION.—For purposes of this subparagraph, the term 'child with special health care needs' refers to an individual eligible for supplemental security income under title XVI, a child described under section 501(a)(1)(D), or a child described in section 1902(e)(3).

"(2) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

"(A) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this section,

"(B) in the next month (or next 2 months) is not eligible for such medical assistance, but

"(C) in the succeeding month is again eligible for such benefits,

the State agency (subject to subsection (b)(3)(E)) may enroll the individual for that succeeding month with such entity, if the entity continues to have a contract with the State agency under this subsection.

"(3) DISENROLLMENT.—

"(A) RESTRICTIONS ON DISENROLLMENT WITHOUT CAUSE.—Except as provided in subparagraph (C), a State plan may restrict the period in which individuals enrolled with risk contracting entities described in paragraph (4) may terminate such enrollment without cause to the first month of each period of enrollment (as defined in subparagraph (B)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

"(B) PERIOD OF ENROLLMENT.—For purposes of this paragraph, the term 'period of enrollment' means—

"(i) a period not to exceed 6 months in duration, or

"(ii) a period not to exceed 1 year in duration, in the case of a State that, on the effective date of this paragraph, had in effect a waiver under section 1115 of requirements under this title under which the State could establish a 1-year minimum period of enrollment with risk contracting entities.

"(C) SPECIAL NEEDS CHILDREN.—A State may not restrict disenrollment of a child with special health care needs (as defined in paragraph (1)(B)(ii)).

"(4) ENTITIES ELIGIBLE FOR DISENROLLMENT RESTRICTIONS.—A risk contracting entity described in this paragraph is—

"(A) a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act,

"(B) an eligible organization with a contract under section 1876,

"(C) an entity that is receiving (and has received during the previous 2 years) a grant of at least $100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act,

"(D) an entity that—

"(i) received a grant of at least $100,000 under section 329(d)(1)(A) or section 330(d)(1) of the Public Health Service Act in the fiscal year ending June 30, 1976, and has been a grantee under either such section for all periods after that date, and

"(ii) provides to its enrollees, on a prepaid capitation or other risk basis, all of the services described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) (and the services described in section 1905(a)(7), to the extent required by section 1902(a)(10)(D)),

"(E) an entity that is receiving (and has received during the previous 2 years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,

"(F) a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

"(i) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

"(ii) which, for all periods after such date, either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services on a prepaid capitation or other risk basis under a contract with the State agency initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract,

"(G) an entity that had contracted with the State agency prior to 1970 for the provision, on a prepaid risk basis, of services (which did not include inpatient hospital services) to individuals eligible for medical assistance under the State plan,

"(H) a program pursuant to an undertaking described in subsection (n)(3) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who—

"(i) are not insured for benefits under part B of title XVIII or eligible for medical assistance under the State plan, and

"(ii) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity,

"(I) an entity that, on the date of enactment of this provision, had a contract with the State agency under a waiver under section 1115 or 1915(b) and was not subject to a requirement under this title to permit disenrollment without cause, or

"(J) an entity that has a contract with the State agency under a waiver under section 1915(b)(5).

"(f) STATE MONITORING AND EXTERNAL REVIEW.—

"(1) STATE GRIEVANCE PROCEDURE.—A State contracting with a risk contracting entity or a primary care case management entity under this section shall provide for a grievance procedure for enrollees of such entity with at least the following elements:

"(A) A toll-free telephone number for enrollee questions and grievances.

"(B) Periodic notification of enrollees of their rights with respect to such entity or program.

"(C) Periodic sample reviews of grievances registered with such entity or program or with the State.

"(D) Periodic survey and analysis of enrollee satisfaction with such entity or program, including interviews with individuals who disenroll from the entity or program.

"(2) STATE MONITORING OF QUALITY AND ACCESS.—

"(A) RISK CONTRACTING ENTITIES.—A State contracting with a risk contracting entity under this section shall provide for ongoing monitoring of such entity's compliance with the requirements of subsection (b), including compliance with the requirements of such entity's contract under subsection (b)(3), and shall undertake appropriate followup activities to ensure that any problems identified are rectified and that compliance with the requirements of subsection (b) and the requirements of the contract under subsection (b)(3) is maintained.

"(B) PRIMARY CARE CASE MANAGEMENT ENTITIES.—A State electing to implement a primary care case management program shall provide for ongoing monitoring of the program's compliance with the requirements of subsection (c) and shall undertake appropriate followup activities to ensure that any problems identified are rectified and that compliance with subsection (c) is maintained.

"(C) SERVICES.—

"(i) IN GENERAL.—The State shall establish procedures (in addition to those required under subparagraphs (A) and (B)) to ensure that the services listed in clause (ii) are available in a timely manner to an individual enrolled with a risk contracting entity or a primary care case management entity. Where necessary to ensure the timely provision of such services, the State shall arrange for the provision of such services by health care providers other than the risk contracting entity or the primary care case management entity in which an individual is enrolled.

"(ii) SERVICES LISTED.—The services listed in this clause are—

"(I) prenatal care;

"(II) immunizations;

"(III) lead screening and treatment;

"(IV) prevention, diagnosis and treatment of tuberculosis, sexually transmitted diseases (including HIV infection), and other communicable diseases; and

"(V) such other services as the Secretary may specify.

"(iii) REPORT.—The procedures referred to in clause (i) shall be described in an annual report to the Secretary provided by the State.

"(3) EXTERNAL INDEPENDENT REVIEW.—

"(A) IN GENERAL.—Except as provided in paragraph (4), a State contracting with a risk contracting entity under this section shall provide for an annual external independent review of the quality and timeliness of, and access to, the items and services specified in such entity's contract with the State agency. Such review shall be conducted by a utilization control and peer review organization with a contract under section 1153 or another organization unaffiliated with the State government or with any risk contracting entity and approved by the Secretary.

"(B) CONTENTS OF REVIEW.—An external independent review conducted under this paragraph shall include the following:

"(i) A review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of quality of care and inappropriate utilization (including overutilization) and treatment.

"(ii) A review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine trends in quality and appropriateness of care.

"(iii) Notification of the entity and the State when the review under this paragraph indicates inappropriate care, treatment, or utilization of services (including overutilization).

"(iv) Other activities as prescribed by the Secretary or the State.

"(C) AVAILABILITY.—The results of each external independent review conducted under this paragraph shall be available to the public consistent with the requirements for disclosure of information contained in section 1160.

"(4) DEEMED COMPLIANCE WITH EXTERNAL INDEPENDENT QUALITY OF CARE REVIEW REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary may deem the State to have fulfilled the requirement for independent external review of quality of care with respect to an entity which has been accredited by an organization described in subparagraph (B) and approved by the Secretary.

"(B) ACCREDITING ORGANIZATION.—An accrediting organization described in this subparagraph must—

"(i) exist for the primary purpose of accrediting coordinated care organizations;

"(ii) be governed by a group of individuals representing health care providers, purchasers, regulators, and consumers (a minority of which shall be representatives of health care providers);

"(iii) have substantial experience in accrediting coordinated care organizations, including an organization's internal quality assurance program;

"(iv) be independent of health care providers or associations of health care providers;

"(v) be a nonprofit organization; and

"(vi) have an accreditation process which meets requirements specified by the Secretary.

"(5) FEDERAL MONITORING RESPONSIBILITIES.—The Secretary shall review the external independent reviews conducted pursuant to paragraph (3) and shall monitor the effectiveness of the State's monitoring and followup activities required under subparagraph (A) of paragraph (2). If the Secretary determines that a State's monitoring and followup activities are not adequate to ensure that the requirements of paragraph (2) are met, the Secretary shall undertake appropriate followup activities to ensure that the State improves its monitoring and followup activities.

"(g) PARTICIPATION OF CERTAIN PROVIDERS.—Each risk contracting entity shall meet the requirements of section 1013 of the Bipartisan Health Care Reform Act of 1994 in the same manner as they would apply to a group health plan (when such section becomes effective).

"(h) TRANSACTIONS WITH PARTIES IN INTEREST.—

"(1) IN GENERAL.—Each risk contracting entity which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General of the United States a description of transactions between the entity and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

"(A) Any sale or exchange, or leasing of any property between the entity and such a party.

"(B) Any furnishing for consideration of goods, services (including management services), or facilities between the entity and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

"(C) Any lending of money or other extension of credit between the entity and such a party.

The State or the Secretary may require that information reported with respect to a risk contracting entity which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the risk contracting entity and such entity.

"(2) AVAILABILITY OF INFORMATION.—Each risk contracting entity shall make the information reported pursuant to paragraph (1) available to its enrollees upon reasonable request.

"(i) REMEDIES FOR FAILURE TO COMPLY.—

"(1) IN GENERAL.—If the Secretary determines that a risk contracting entity or a primary care case management entity—

"(A) fails substantially to provide services required under section 1905(r), when such an entity is required to do so, or provide medically necessary items and services that are required to be provided to an individual enrolled with such an entity, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(B) imposes premiums on individuals enrolled with such an entity in excess of the premiums permitted under this title;

"(C) acts to discriminate among individuals in violation of the provision of subsection (b)(3)(D), including expulsion or refusal to reenroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the entity whose medical condition or history indicates a need for substantial future medical services;

"(D) misrepresents or falsifies information that is furnished—

"(i) to the Secretary or the State under this section; or

"(ii) to an individual or to any other entity under this section; or

"(E) fails to comply with the requirements of section 1876(i)(8),

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in paragraph (2).

"(2) ADDITIONAL REMEDIES.—The remedies described in this paragraph are—

"(A) civil money penalties of not more than $25,000 for each determination under paragraph (1), or, with respect to a determination under subparagraph (C) or (D)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(C), $15,000 for each individual not enrolled as a result of a practice described in such paragraph, or

"(B) denial of payment to the State for medical assistance furnished by a risk contracting entity or a primary care case management entity under this section for individuals enrolled after the date the Secretary notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(j) Termination of Contract by State.—Any State which has a contract with a risk contracting entity or a primary care case management entity may terminate such contract if such entity fails to comply with the terms of such contract or any applicable provision of this section.

"(k) Fair Hearing.—Nothing in this section shall affect the rights of an individual eligible to receive medical assistance under the State plan to obtain a fair hearing under section 1902(a)(3) or under applicable State law.

"(l) Disproportionate Share Hospitals.—Nothing in this section shall affect any requirement on a State to comply with section 1923.

"(m) Referral Payments.—For 1 year following the date on which individuals eligible for medical assistance under the State plan in a service area are required to enroll with a risk contracting entity or a primary care case management entity, Federally qualified health centers and rural health centers located in such service area or providing care to such enrollees, shall receive a fee for educating such enrollees about the availability of services from the risk contracting entity or primary care case management entity with which such enrollees are enrolled.

"(n) Special Rules.—

"(1) Nonapplicability of certain provisions to certain risk contracting entities.—

In the case of any risk contracting entity which—

"(A)(i) is an individual physician or a physician group practice of less than 50 physicians, and

"(ii) is not described in paragraphs (A) and (B) of subsection (b)(1), and

"(B) is at risk only for the health care items and services directly provided by such entity,

paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4) of subsection (b), and paragraph (3) of subsection (f), shall not apply to such entity.

"(2) Exception from definition of risk contracting entity.—For purposes of this section, the term 'risk contracting entity' shall not include a health insuring organization which was used by a State before April 1, 1986, to administer a portion of the State plan of such State on a statewide basis.

"(3) New jersey.—The rules under section 1903(m)(6) as in effect on the day before the effective date of this section shall apply in the case of an undertaking by the State of New Jersey (as described in such section 1903(m)(6)).

"(o) Continuation of Certain Coordinated Care Programs.—The Secretary may provide for the continuation of any coordinated care program operating under section 1115 or 1915 without requiring compliance with any provision of this section which conflicts with the continuation of such program and without requiring any additional waivers under such sections 1115 and 1915 if the program has been successful in assuring quality and containing costs (as determining by the Secretary) and is likely to continue to be successful in the future.

"(p) Guidelines, Regulations, and Model Contract.—

"(1) Guidelines and regulations on solvency.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines and regulations concerning solvency standards for risk contracting entities and subcontractors of such risk contracting entities. Such guidelines and regulations shall take into account characteristics that may differ among risk contracting entities including whether such an entity is at risk for inpatient hospital services.

"(2) Guidelines and regulations on marketing.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines and regulations concerning—

"(A) marketing undertaken by any risk contracting entity or any primary care case management program to individuals eligible for medical assistance under the State plan, and

"(B) information that must be provided by States or any such entity to individuals eligible for medical assistance under the State plan with respect to—

"(i) the options and rights of such individuals to enroll with, and disenroll from, any such entity, as provided in this section, and

"(ii) the availability of services from any such entity (including a list of services for which such entity is responsible or must approve and information on how to obtain services for which such entity is not responsible). In developing the guidelines and regulations under this paragraph, the Secretary shall address the special circumstances of children with special health care needs (as defined in subsection (e)(1)(B)(ii)) and other individuals with special health care needs.

"(3) Model contract.—The Secretary shall develop a model contract to reflect the requirements of subsection (b)(3) and such other requirements as the Secretary determines appropriate.".

(b) Waivers From Requirements on Coordinated Care Programs.—Section 1915(b) of such Act (42 U.S.C. 1396n) is amended—

(1) in the matter preceding paragraph (1), by striking "as may be necessary" and inserting ", and section 1932 as may be necessary";

(2) in paragraph (1), by striking "a primary care case management system or";

(3) by striking "and" at the end of paragraph (3);

(4) by striking the period at the end of paragraph (4) and inserting ", and"; and

(5) by inserting after paragraph (4) the following new paragraph:

"(5) to permit a risk contracting entity (as defined in section 1932(a)(3)) to restrict the period in which individuals enrolled with such entity may terminate such enrollment without cause in accordance with section 1932(e)(3)(A).".

(c) State Option To Guarantee Medicaid Eligibility.—Section 1902(e)(2) of such Act (42 U.S.C. 1396a(e)(2)) is amended—

(1) in subparagraph (A), by striking all that precedes "(but for this paragraph)" and inserting "In the case of an individual who is enrolled—

"(i) with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) or with a risk contracting entity (as defined in section 1932(a)(3)), or

"(ii) with any risk contracting entity (as defined in section 1932(a)(3)) in a State that, on the effective date of this provision, had in effect a waiver under section 1115 of requirements under this title under which the State could extend eligibility for medical assistance for enrollees of such entity, or

"(iii) with an eligible organization with a contract under section 1876,

and who would",

(2) in subparagraph (B), by striking "organization or" each place it appears, and

(3) by adding at the end the following new subparagraph:

"(C) The State plan may provide, notwithstanding any other provision of this title, that an individual shall be deemed to continue to be eligible for benefits under this title until the end of the month following the month in which such individual would (but for this paragraph) lose such eligibility because of excess income and resources, if the individual is enrolled with a risk contracting entity or primary care case management entity (as those terms are defined in section 1932(a)).".

(d) Enhanced Match Related To Quality Review.—Section 1903(a)(3)(C) of such Act (42 U.S.C. 1396b(a)(3)(C)) is amended—

(1) by striking "organization or by" and inserting "organization, by"; and

(2) by striking "section 1152, as determined by the Secretary," and inserting "section 1152, as determined by the Secretary, or by another organization approved by the Secretary which is unaffiliated with the State government or with any risk contracting entity (as defined in section 1932(a)(3)),".

(e) Accumulation of Reserves by Certain Entities.—Any organization referred to in section 329, 330, or 340, of the Public Health Service Act which has contracted with a State agency as a risk contracting entity under section 1932(g)(3)(A) of the Social Security Act may accumulate reserves with respect to payments made to such organization under section 1932(g)(3)(C) of such Act.

(f) Conforming Amendments.—

(1) Section 1128(b)(6)(C)(i) of such Act (42 U.S.C. 1320a-7(b)(6)(C)(i)) is amended by striking "health maintenance organization" and inserting "risk contracting entity".

(2) Section 1902(a)(23) of such Act (42 U.S.C. 1396a(a)(23)) is amended by striking "primary care-case management system (described in section 1915(b)(1)), a health maintenance organization," and inserting "primary care case management program (as defined in section 1932(a)(1)), a risk contracting entity (as defined in section 1932(a)(3)),".

(3) Section 1902(a)(30)(C) of such Act (42 U.S.C. 1396a(a)(30)(C)) is amended by striking "use a utilization" and all that follows through "with the results" and inserting "provide for independent review and quality assurance of entities with contracts under section 1932, in accordance with subsection (f) of such section 1932, with the results".

(4) Section 1902(a)(57) of such Act (42 U.S.C. 1396a(a)(57)) is amended by striking "or health maintenance organization (as defined in section 1903(m)(1)(A))" and inserting "risk contracting entity, or primary care case management entity (as defined in section 1932(a))".

(5) Section 1902(a) of such Act (42 U.S.C. 1396a), as amended by sections 6001(a) and 6011(b), is amended—

(A) by striking "and" at the end of paragraph (63);

(B) by striking the period at the end of paragraph (64) and inserting "; and"; and

(C) by adding at the end the following new paragraphs:

"(65) at State option, provide for a primary care case management program in accordance with section 1932; and

"(66) at State option, provide for a program under which the State contracts with risk contracting entities in accordance with section 1932.".

(6) Section 1902(p)(2) of such Act (42 U.S.C. 1396a(p)(2)) is amended by striking "health maintenance organization (as defined in section 1903(m))" and inserting "risk contracting entity (as defined in section 1932(a)(3))".

(7) Section 1902(w) of such Act (42 U.S.C. 1396a(w)) is amended—

(A) in paragraph (1), by striking “section 1903(m)(1)(A)” and inserting “section 1932(a)(3)”, and

(B) in paragraph (2)(E)—

(i) by striking “health maintenance organization” and inserting “risk contracting entity”, and

(ii) by striking “organization” and inserting “entity”.

(8) Section 1903(k) of such Act (42 U.S.C. 1396b(k)) is amended by striking “health maintenance organization which meets the requirements of subsection (m) of this section” and inserting “risk contracting entity which meets the requirements of section 1932”.

(9) Section 1903(w)(7)(A)(viii) of such Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking “health maintenance organizations (and other organizations with contracts under section 1903(m))” and inserting “risk contracting entities with contracts under section 1932”.

(10) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding clause (i), by inserting “(which may be on a prepaid capitation or other risk basis)” after “payment”.

(11) Section 1916(b)(2)(D) of such Act (42 U.S.C. 1396o(b)(2)(D)) is amended by striking “health maintenance organization (as defined in section 1903(m))” and inserting “risk contracting entity (as defined in section 1932(a)(3))”.

(12) Section 1925(b)(4)(D)(iv) of such Act (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended—

(A) in the heading, by striking “hmo” and inserting “risk contracting entity”,

(B) by striking “health maintenance organization (as defined in section 1903(m)(1)(A))” and inserting “risk contracting entity (as defined in section 1932(a)(3)”, and

(C) by striking “health maintenance organization in accordance with section 1903(m)” and inserting “risk contracting entity in accordance with section 1932”.

(13) Paragraphs (1) and (2) of section 1926(a) of such Act (42 U.S.C. 1396r–7(a)) are each amended by striking “health maintenance organizations under section 1903(m)” and inserting “risk contracting entities under section 1932”.

(14) Section 1927(j)(1) of such Act is amended by striking “* * * Health Maintenance Organizations, including those organizations that contract under section 1903(m)” and inserting “risk contracting entities (as defined in section 1932(a)(3))”.

(g) Effective Date.—The amendments made by this section shall become effective with respect to calendar quarters beginning on or after January 1, 1995.

SEC. 2112. CONTINUATION OF STATE MEDICAID ELIGIBILITY CATEGORIES.

(a) In General.—Section 1902(a) of the Social Security Act (42 U.S.C. 1369a(a)), as amended by sections 6111(1) and 2101(a)(1), is amended—

(1) by striking “and” at the end of paragraph (62);

(2) by striking the period at the end of paragraph (63) and inserting “; and ”; and

(3) by adding at the end the following new paragraph:

“(64) subject to section 1932(c), provide for the continuation through December 31, 1997, of eligibility for medical assistance under section 1902(a)(10)(A) of any class or category of individuals eligible for medical assistance under such section during fiscal year 1994.”.

(b) Effective Date.—The amendments made by subsection (a) shall apply to payments for calendar quarters beginning on or after January 1, 1995.

PART 3—INTEGRATION OF AFDC AND NON-CASH MEDICAID BENEFICIARIES INTO STATE PREMIUM SUBSIDY PROGRAM

SEC. 2121. DIVISION OF MEDICAID BENEFITS INTO 2 GROUPS; REQUIREMENT FOR INTEGRATION OF AFDC RECIPIENTS AND NON-CASH MEDICAID BENEFICIARIES INTO STATE PREMIUM SUBSIDY PROGRAMS.

(a) In General.—Title XIX of the Social Security Act, as amended by section 2111(a)(2), is amended by redesignating section 1933 as section 1934 and by inserting after section 1932 the following new section:

“TRANSITIONAL MEDICAID REFORM RULES FOR BENEFITS FOR ACUTE MEDICAL SERVICES FOR AFDC RECIPIENTS AND NON-CASH MEDICAID BENEFICIARIES

“Sec. 1933. (a) Application of Section.—This section applies with respect to medical assistance for acute medical services (as defined in subsection (f)) under State plans under this title for calendar quarters during 1995, 1996, and 1997 to AFDC recipients and non-cash medicaid categorical beneficiaries. To the extent this section applies, it supersedes provisions of this title (and other applicable law) to the contrary.

“(b) Division of Acute Medical Service Benefits.—The Secretary shall divide the class of benefits for acute medical services into—

“(1) a group of those benefits with respect to such services typically included in the services covered under a qualified standard health plan (in this section referred to as ‘core benefits’), and

“(2) a group of benefits with respect to such services (in this section referred to as ‘supplemental medical benefits’).

“(c) Sunset in Medical Assistance.—For calendar quarters beginning on or after January 1, 1998, with respect to any individual who is AFDC recipient or non-cash medicaid beneficiary and who is a premium subsidy eligible individual under part A of title XXI—

“(1) the individual is not entitled to receive medical assistance for core benefits under the State plan, and

“(2) Federal financial participation under section 1903(a) shall not be paid to the State to the extent that expenditures for such assistance.

“(d) State Maintenance of Effort Required.—

“(1) In general.—Payment to a State under section 1903(a) for a quarter (beginning after 1997) is conditioned upon the State making expenditures under this title for core benefits for AFDC recipients and non-cash beneficiaries equal to at least the maintenance of effort amount computed under paragraph (2).

“(2) Maintenance of effort amount.—The maintenance of effort amount computed under this paragraph for a State for a quarter in a year is equal to the product of—

“(A) the amount that would be computed as the per capita core benefits expenditure limit under subsection (c)(2) for the State for the quarter if the FEHBP State rolling increase percentage (as defined in section 2136(b)(2)) were substituted for the FEHBP national rolling increase percentage in section 2135(a)(2)(B) and 2135(b)(1); and

“(B) the Federal-to-State conversion factor (specified under section 2135(b)(3)).

“(e) Reference to Payments Under New State Supplementary Medical Benefits Program.—For payments to States for operation of State supplementary benefit programs, see part B of title XXI.

“(f) Definitions.—In this section:

“(1) Acute medical services.—“The term ‘acute medical services’ means items and services described in section 1905(a) other than the following:

“(A) Nursing facility services (as defined in section 1905(f)).

“(B) Intermediate care facility for the mentally retarded services (as defined in section 1905(d)).

“(C) Personal care services (as described in section 1905(a)(24)).

“(D) Private duty nursing services (as referred to in section 1905(a)(8)).

“(E) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915.

“(F) Home and community care furnished to functionally disabled elderly individuals under section 1929.

“(G) Community supported living arrangements services under section 1930.

“(H) Case-management services (as described in section 1915(g)(2)).

“(I) Home health care services (as referred to in section 1905(a)(7)), clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in a previous subparagraph.

“(J) Hospice care.

“(2) AFDC recipient.—The term ‘AFDC recipient’ means an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV.

“(3) Non-cash medicaid beneficiary.—The term ‘non-cash medicaid beneficiary’ means an individual described in section 1902(a)(10)(A) who is not an AFDC recipient or an SSI recipient.

“(4) SSI recipient.—The term ‘SSI recipient’ means, for a month, an individual—

“(A) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act for the month,

“(B) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93–66 for the month,

“(C) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month, or

“(D) who is treated under section 1619(b) of the Social Security Act as receiving supplemental security income benefits in a month for purposes of title XIX of such Act.

“(5) State.—This section shall only apply with respect to the 50 States and the District of Columbia.”.

SEC. 2122. 25 PERCENT REDUCTION IN AMOUNT OF PAYMENT ADJUSTMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) In General.—Section 1923 of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

“(h) Reduction in Federal Financial Participation for Disproportionate Share Adjustments.—Notwithstanding any other provision of this section, the amount of payments under section 1903(a) with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year shall not exceed the following percent of the amount otherwise determined under subsection (f):

“(1) For fiscal years 1997 and 1998, 75 percent.

“(2) For fiscal years 1999 and 2000, 70 percent.

"(3) For fiscal years 2001 and thereafter 2004, 65 percent.".

(b) CONFORMING AMENDMENT.—Section 1923(c) of such Act (42 U.S.C. 1396r-4(c)) is amended in the matter preceding paragraph (1) by striking "(f) and (g)" and inserting "(f), (g), and (h)".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to quarters in fiscal years beginning on or after October 1, 1996.

Subtitle C—Report and Recommendations on Health Coverage and Access

SEC. 2201. OBJECTIVE OF FULL ACCESS AND COVERAGE.

It is an objective of this Act to assure by 2002 that—

(1) all eligible individuals in the United States have access to private or public health coverage, and

(2) at least 95 percent of such individuals have such coverage.

SEC. 2202. REPORT AND RECOMMENDATIONS ON ACHIEVEMENT OF OBJECTIVE FOR HEALTH COVERAGE AND ACCESS.

(a) STUDY.—The Secretary shall monitor and evaluate the extent to which eligible individuals in the United States have access to health coverage and have health coverage.

(b) REPORT.—Not later than January 31, 2002, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). The Secretary shall include in the report a determination of whether the objective described in section 2201 has been met.

(c) RECOMMENDATIONS.—If the Secretary determines that such objective has not been met, the Secretary shall include in the report such recommendations as may be appropriate to achieve the objective at the earliest possible date.

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Subtitle A—Expanding Access in Underserved Areas

SEC. 3001. COMMUNITY HEALTH AUTHORITIES DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by sections 2111(a) and 2121(a), is amended—

(1) by redesignating section 1934 as section 1935; and

(2) by inserting after section 1933 the following new section:

"COMMUNITY HEALTH AUTHORITIES DEMONSTRATION PROJECTS

"SEC. 1934. (a) IN GENERAL.—In order to test the effectiveness of various innovative health care delivery approaches through the operation of community health authorities, the Secretary shall operate a program under which States establish projects to demonstrate the effectiveness of such approaches in providing access to cost-effective preventive and primary care and related services for various areas and populations, including low-income residents of medically underserved areas or for medically underserved populations. A State may operate more than one such project.

"(b) SELECTION OF STATE PROJECTS.—

"(1) IN GENERAL.—A State is eligible to participate in the program, and establish a demonstration project, under this section only if—

"(A) the State submits to the Secretary an application, at such time and in such form as the Secretary may require, for participation in the program; and

"(B) the Secretary finds that—

"(i) the application contains assurances that the State will support the development of a community health authority that meets the requirements of this section,

"(ii) the community health authority will meet the requirements for such an authority under subsection (c),

"(iii) the State provides sufficient assurances that the demonstration project of a community health authority meets (or, when operational, will meet) the requirements of subsection (d), and

"(iv) the State will comply with the requirements of subsections (g) and (h).

"(2) CONTENTS OF APPLICATION.—Each application submitted under paragraph (1) for a demonstration project shall include at least the following:

"(A) A description of the proposed community health authority and of the area or population that the authority will serve.

"(B) A demonstration that the CHA will serve at least one geographic area or population group that is designated as medically underserved under section 330 of the Public Health Service Act or as having a shortage of health professionals under section 332 of such Act.

"(C) An assessment of the area's or population's need for services and an assurance that the services of the CHA will be responsive to those needs.

"(D) A list of the items and services to be furnished by the CHA under the project, broken down by those items and services that are treated as medical assistance under the State plan under this title and other items and services that will be provided by the CHA (either directly or through coordination with other entities).

"(E) An assurance that the CHA has entered into (or plans to enter into) written participation agreements with a sufficient number of providers to enable the CHA to furnish all of such items and services to enrolled individuals.

"(F) An assurance that the State plan under this title will provide payment to the authority in accordance with subsection (e).

"(G) Evidence of support and assistance from other State agencies with responsibility for providing or supporting the provision of preventive and primary care services to underserved and at-risk populations.

"(H) A proposed budget for the CHA.

"(3) PERIOD OF APPROVAL.—Each project approved under this section shall be approved for a period of not less than 3 years, subject to renewal for subsequent periods unless such approval is withdrawn for cause by the Secretary or at the request of the State.

"(c) COMMUNITY HEALTH AUTHORITY (CHA) DEFINED.—In this section, the terms 'community health authority' and 'CHA' mean a nonprofit entity that meets the following requirements:

"(1) The entity serves (or will serve at the time it becomes operational under a project) a geographic area or population group that includes those designated—

"(A) under section 330 of the Public Health Service Act as medically underserved, or

"(B) under section 332 of such Act as a health professions shortage area.

"(2) The entity enrolls—

"(A) individuals and families who are medicaid-eligible;

"(B) within the limits of its available resources and capacity, other individuals who have incomes below 200 percent of the Federal official poverty level; and

"(C) within the limits of its available resources and capacity, other individuals and families who are able to pay the costs of enrollment.

"(3) Through its participating providers, the entity provides or, through contracts, arranges for the provision of (or, by the time it become operational, will so provide or arrange for the provision of) at least preventive services, primary care services, inpatient and outpatient hospital services, and any other service provided by a participating provider for which payment may be made under the State plan under this title to enrolled individuals.

"(4) The entity must include (to the maximum extent practicable) as participating providers any of the following providers that furnish services provided by (or arranged by) the entity that are located in or serve the area or population to be covered:

"(A) Federally-qualified health centers.

"(B) Rural health clinics.

"(C) Local public health agencies that furnish such services.

"(D) A hospital (or other provider of inpatient or outpatient hospital services) which has a participation agreement in effect with the State under its plan under this title, which is located in or serving the area or population to be served.

"(5) The entity may include as participating providers other providers (which may include private physicians or group practice offices, other community clinics, limited service providers (such as prenatal clinics), and health professionals teaching programs (such as area health educational centers)) and take other appropriate steps, to the extent needed to assure that the network is reasonable in size and able to provide (or arrange for the provision of) the services it proposes to furnish to its enrollees.

"(6) The entity must maintain written agreements with each participating provider under which the provider agrees to participate in the CHA and agrees to accept payment from the CHA as payment in full for services furnished to individuals enrolled with the CHA.

"(7) Under the written agreements described in paragraph (6), if a majority of the board of directors of the entity has determined that a participating provider is failing to meet any of the requirements of the participation agreement, the board may terminate the provider's participation agreement in accordance with the following requirements:

"(A) Subject to subparagraph (B), prior to any termination of a provider's participation agreement, the provider shall be entitled to 30 days prior notice, a reasonable opportunity to correct any deficiencies, and an opportunity for a full and fair hearing conducted by the entity to dispute the reasons for termination. The provider shall be entitled to appeal the board of directors' decision directly to a committee consisting of representatives of all of the entity's participating providers.

"(B) If a majority of the board of directors of the entity determines that the continued participation of a provider presents an immediate threat to the health and safety of patients or a substantial risk of improper diversion of funds, the board may suspend the provider's participation agreement (including the receipt of funds under the agreement) for a period of up to 60 days. During this period, the entity shall take steps to ensure that patients who were assigned to or cared for by the suspended provider are appropriately assigned or referred to alternative participating providers. The suspended provider shall be entitled to a hearing within the period of the suspension to show cause why the suspension should be lifted and its participation agreement restored. If dissatisfied with the board's decision, the provider shall be entitled to appeal the decision directly to a committee consisting of representatives of all of the entity's participating providers.

"(C) For all other disputes between the entity and its participating providers (including disputes over the amounts due or interim rates to be paid to a provider), the entity shall provide an opportunity for a full and fair hearing.

"(8) The entity must be governed by a board of directors that includes representatives of the participating providers and, as appropriate, other health professionals, civic or business leaders, elected officials, and residents of the area or population served. Not less than 51 percent of such board shall be composed of individuals who are enrolled in the CHA and who are representatives of the community served.

"(d) DEMONSTRATION PROJECT REQUIREMENTS.—The requirements of this subsection, with respect to a demonstration project of a CHA under this section, are as follows:

"(1)(A) All services furnished by the CHA under the project shall be available and accessible to all enrolled individuals and, except as provided in subparagraph (B), must be available without regard to an individual's ability to pay for such services.

"(B) A CHA shall prepare a schedule of discounts to be applied to the payment of premiums by individuals who are not medicaid-eligible individuals which shall be adjusted on the basis of the individual's ability to pay.

"(2) The CHA shall take appropriate steps to emphasize the provision of preventive and primary care services, and shall ensure that each enrolled individual is assigned to a primary care physician (to the greatest extent appropriate and feasible), except that the CHA shall establish a process through which an enrolled individual may be assigned to another primary care physician for good cause shown.

"(3) The CHA must make reasonable efforts to reduce the unnecessary or inappropriate use of hospital or other high-cost services through an emphasis on preventive and primary care services, the implementation of utilization review or other appropriate methods.

"(4) The State must regularly provide the CHA with information on other medical, health, and related benefits that may be available to individuals enrolled with the CHA under programs other than the State plan under this title, and the CHA must provide its enrolled individuals with enrollment information and other non-cash assistance to assist them in obtaining such benefits.

"(5) The State and the CHA must meet such financial standards and requirements and reporting requirements as the Secretary specifies and must prepare and submit to the Secretary an annual independent financial audit conducted in accordance with requirements specified by the Secretary.

"(6) In collaboration with the State, the CHA must adopt and use community-oriented, patient-responsive quality assurance and control systems in accordance with requirements specified by the Secretary. Such systems must include at least an ongoing quality assurance program that measures consumer satisfaction with the care provided under the network, stresses improved health outcomes, and operates a community health status improvement process that identifies and investigates community health problems and implements measures designed to remedy them.

"(e) CAPITATION PAYMENTS.—

"(1) IN GENERAL.—Under a demonstration project under this section, the State shall enter into an annual contract with the CHA under which the State shall make monthly payments to the CHA for covered services furnished through the CHA to individuals entitled to medical assistance under this title in the amount specified in paragraph (2). Payment shall be made at the beginning of each month on the basis of estimates of the amounts payable and amounts subsequently paid are subject to adjustment to reflect the amounts by which previous payments were greater or less than the amount of payments that should have been made.

"(2) AMOUNT OF CAPITATION PAYMENT.—The amount of a monthly payment under paragraph (1) during a contract year, shall be not less than 1/12 of the product of—

"(A)(i) the average per capita amounts expended under this title under the State plan for covered services to be furnished under the demonstration project for similar Medicaid-eligible individuals for the most recent 12-month period ending before the date of the enactment of this section, increased by (ii) the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) during the period that begins upon the expiration of such 12-month period and ends upon the expiration of the most recent 12-month period ending before the first month of the contract year for which complete financial data on such index is available, and

"(B) the number of Medicaid-eligible individuals enrolled under the project as of the 15th day of the month prior to the first month of the contract year (or, in the case of the first year for which a contract is in effect under this subsection, the CHA's reasonable estimate of the number of such individuals who will be enrolled in the project as of the 15th day of such month).

"(f) ADDITIONAL STATE ASSISTANCE FOR PLANNING, DEVELOPMENT, AND OPERATIONS.—

"(1) IN GENERAL.—Subject to paragraph (2), in addition to the payments under subsection (e), demonstration projects approved under this section are eligible to have approved expenditures described in paragraph (3) treated, for purposes of section 1903(a)(7), as expenditures found necessary by the Secretary for the proper and efficient administration of the State plan under this title.

"(2) SPECIAL RULES.—

"(A) LIMITATION WITH RESPECT TO ANY COMMUNITY HEALTH AUTHORITY.—The total amount of expenditures with respect to any CHA that may be treated as expenditures for medical assistance under paragraph (1) for any 12-month period shall not exceed $250,000.

"(B) Limitation on number of years.—The number of 12-month periods for which expenditures are treated as expenditures for medical assistance under paragraph (1) for a CHA shall not exceed—

"(i) 2 for expenditures for planning and development assistance, described in paragraph (3)(A), and

"(ii) 2 for expenditures for operational assistance, described in paragraph (3)(B).

"(C) NO RESULTING REDUCTION IN AMOUNTS PROVIDED UNDER PHSA GRANTS.—No grant to a CHA or one of its participating providers under the Public Health Service Act or this Act may be reduced on the ground that activities of the CHA that are considered approved expenditures under paragraph (3) are activities for which the CHA or the participating providers received funds under such Act.

"(3) APPROVED EXPENDITURES.—The approved expenditures described in this paragraph are as follows:

"(A) PLANNING AND DEVELOPMENT.—Expenditures for planning and development with respect to a CHA, including—

"(i) developing internal management, legal and financial and clinical, information, and reporting systems for the CHA, and carrying out other operating activities of the CHA;

"(ii) recruiting, training and compensating management staff of the CHA and, as appropriate and necessary, management and clinical staff of any participating provider;

"(iii) purchasing essential equipment and acquiring, modernizing, expanding, or (if cost-effective) renovating facilities for the CHA and for participating providers (including amortization costs and payment of interest on loans); and

"(iv) entering into arrangements to obtain or participate in emerging medical technologies, including telemedicine.

"(B) OPERATIONS.—Expenditures in support of the operations of a CHA, including—

"(i) the ongoing management of the CHA, including daily program administration, recordkeeping and reporting, assurance of proper financial management (including billings and collections) and oversight of program quality;

"(ii) developing and operating systems to enroll eligible individuals in the CHA;

"(iii) data collection, in collaboration with the State medicaid agency and the State health department, designed to measure changes in patient access to care, the quality of care furnished, and patient health status, and health care outcomes;

"(iv) ongoing community outreach and community education to all residents of the area or population served, to promote the enrollment of eligible individuals and the appropriate utilization of health services by such individuals;

"(v) the establishment of necessary reserves or purchase of stop-loss coverage; and

"(vi) activities relating to health professions training, including residency training at participating provider sites.

"(g) ADDITIONAL REQUIREMENTS.—

"(1) MANDATORY ENROLLMENT OF MEDICAID-ELIGIBLE INDIVIDUALS.—Notwithstanding any provision of section 1903(m), a State participating in a demonstration project under this section may, until December 31, 1997, require that each medicaid-eligible resident in the service area of a CHA operating under the project is not eligible to receive any medical assistance under the State plan that may be obtained through enrollment with the CHA unless the individual receives such assistance through enrollment with the CHA.

"(2) CONTINUED ENTITLEMENT TO ADDITIONAL BENEFITS.—In the case of a medicaid-eligible individual enrolled with a CHA under a demonstration project under this section, the individual shall remain entitled to medical assistance for services which are not covered services under the project, until December 31, 1997.

"(3) HMO-RELATED REQUIREMENTS.—A CHA under this section shall be deemed to meet the requirements of section 1903(m) (subject to paragraph (1)) in the same manner as an entity listed under section 1903(m)(2)(G).

"(4) OUTSTATIONING ELIGIBILITY WORKERS.—Under the project, the State may (in addition to meeting the requirements of section 1902(a)(55)) provide for, or pay the reasonable costs of, stationing eligibility workers at appropriate service sites under the project, and may permit medicaid-eligible individuals to be enrolled under the State plan at such a CHA or at such a site.

"(5) PURCHASE OF STOP-LOSS COVERAGE.—The State shall ensure that the CHA has purchased stop-loss coverage to protect against default on its obligations under the project. If an entity otherwise qualified to serve as a CHA is prohibited under State law from purchasing such coverage, the State shall waive the application of such law to the extent necessary to permit the entity to purchase such coverage.

"(h) EVALUATION AND REPORTING.—

"(1) CHA.—Each CHA in a State with a demonstration project approved under this section shall prepare and submit to the State an annual report on its activities during the previous year.

"(2) STATE.—Taking into account the reports submitted pursuant to paragraph (1), each State with a demonstration project approved under this section shall prepare and submit to the Secretary an annual evaluation of its activities and services under this section. Such evaluation shall include an analysis of the effectiveness of the project in providing cost-effective health care to enrolled individuals.

"(3) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this section, the Secretary shall submit to Congress a report on the demonstration projects conducted under this section. Such report shall include an analysis of the effectiveness of such projects in providing cost-effective health care for the areas or populations served.

"(i) COLLABORATION IN ADMINISTRATION.—In carrying out this section, the Secretary shall assure the highest possible level of collaboration between the Health Care Financing Administration and the Public Health Service. Such collaboration may include (if appropriate and feasible) any of the following:

"(1) The provision by the Public Health Service of new or increased grant support to eligible entities participating in a CHA, in order to expand the availability of services (particularly preventive and primary care services).

"(2) The placement of health professionals at eligible locations and collaboration with Federally-assisted health professions training programs located in or near the areas served by community health authorities.

"(3) The provision of technical and other nonfinancial assistance.

"(j) DEFINITIONS.—In this section:

"(1) MEDICAID-ELIGIBLE INDIVIDUAL.—The term 'medicaid-eligible individual' means an individual described in section 1902(a)(10)(A) and entitled to medical assistance under the State plan.

"(2) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to a CHA, a provider that has entered into an agreement with the CHA for the provision of covered services under a project under this section.

"(3) PREVENTIVE AND PRIMARY CARE SERVICES.—'Preventive' and 'primary' services include those services described in section 1905(l)(2)(A) and included as Federally-qualified health center services.".

(b) EXCEPTION TO ANTI-KICKBACK LAW.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (D),

(2) by striking the period at the end of subparagraph (E) and inserting "; and", and

(3) by adding at the end the following new subparagraph:

"(F) any remuneration paid, or received, by a Federally qualified health center, rural health clinic, or other entity which is a participating provider under a demonstration project under section 1934 as part of an arrangement for the procurement of goods or services or the referral of patients or the lease or purchase of space or equipment.".

(c) TRANSITION.—A premium subsidy eligible individual may use premium assistance certificates issued under title XXI of the Social Security Act to purchase coverage offered by a community health authority.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar quarters beginning on or after October 1, 1994.

SEC. 3002. HEALTH CENTER PROGRAM AMENDMENTS.

(a) AUTHORIZATION OF GRANTS FOR NETWORK DEVELOPMENT.—

(1) MIGRANT HEALTH CENTERS.—

(A) IN GENERAL.—Section 329 of the Public Health Service Act (42 U.S.C. 254b) is amended by adding at the end the following:

"(j)(1) The Secretary may make a grant, to an entity receiving a grant under this section or to a group of such entities, to support the planning and development of health service networks (as defined in paragraph (3)) which will serve high impact areas, medically underserved areas, or medically underserved populations within the area they serve (or propose to serve).

"(2) A grant under this subsection for the planning and development of a health service network may be used for the following costs:

"(A) The costs of developing the network corporate entity, including planning and needs assessment.

"(B) The costs of developing internal management for the network, as well as costs of developing legal, financial, clinical, information, billing, and reporting systems, and other costs necessary to achieve operational status.

"(C) The costs of recruitment, training, and compensation of management staff of the network and, as appropriate and necessary, the management and clinical staff of any participating provider.

"(D) The costs of developing additional primary health and related service sites, including costs related to purchase of essential equipment, acquisition, modernization, expansion, or, if cost-effective, construction of facilities.

"(3) In this subsection, the term 'health service network' means a nonprofit private entity that—

"(A) through its participating providers (which may provide services directly or through contract) assures the provision of primary health and related services and, as appropriate, supplemental health services to residents of the high impact area or medically underserved area or members of the medically underserved population covered by the network,

"(B) includes, as participating providers, at least all recipients of grants under this section or section 330, 340, or 340A that provide primary health and related services to the residents of the area it serves (or proposes to serve), and that may include, at the entity's option, any other providers of primary health or supplemental health services to residents of the high impact area or medically underserved area or members of the medically underserved population covered by the network, but only if such participating providers agree to provide services without regard to an individual's ability to pay, and

"(C) is governed by individuals a majority of whom are patients, employees, or board members of its participating providers that receive grants under this section or section 330, 340, or 340A.".

(B) CONFORMING CHANGE.—Section 329(h)(1)(A) of such Act (42 U.S.C. 254b(h)(1)(A)) is amended by inserting "and subsection (j)" after "through (e)".

(2) COMMUNITY HEALTH CENTERS.—Section 330 of such Act (42 U.S.C. 254c) is amended by adding at the end the following:

"(l)(1) The Secretary may make a grant, to an entity receiving a grant under this section or to a group of such entities, to support the planning and development of health service networks (as defined in section 329(j)(3)) which will serve high impact areas, medically underserved areas, or medically underserved populations within the area they serve (or propose to serve).

"(2) A grant under this subsection for the planning and development of a health service network may be used for the costs described in section 329(j)(2).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(b) EXTENSION OF AUTHORIZATION OF APPROPRIATIONS.—For extension of authorization of appropriations for migrant health centers and community health centers, see section 3131.

Subtitle B—Improved Access in Rural Areas

PART 1—GRANTS TO ENCOURAGE COMMUNITY RURAL HEALTH NETWORKS

SEC. 3101. ASSISTANCE FOR DEVELOPMENT OF ACCESS PLANS FOR CHRONICALLY UNDERSERVED AREAS.

(a) AVAILABILITY OF FINANCIAL ASSISTANCE TO IMPLEMENT ACTION PLANS TO INCREASE ACCESS.—

(1) IN GENERAL.—The Secretary shall provide grants (in amounts determined in accordance with paragraph (3)) over a 3-year period to an eligible State for the development of plans to increase access to health care services during such period for residents of areas in the State that are designated as chronically underserved areas in accordance with subsection (b).

(2) ELIGIBILITY REQUIREMENTS.—A State is eligible to receive grants under this section if the State submits to the Secretary (at such time and in such form as the Secretary may require) assurances that the State has developed (or is in the process of developing) a plan to increase the access of residents of a chronically underserved area to health care services that meets the requirements of subsection (c), together with such other information and assurances as the Secretary may require.

(3) AMOUNT OF ASSISTANCE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amount of assistance provided to a State under this subsection with respect to any plan during a 3-year period shall be equal to—

(i) for the first year of the period, an amount equal to 100% of the amounts expended by the State during the year to implement the plan described in paragraph (1) (as reported to the Secretary in accordance with such requirements as the Secretary may impose);

(ii) for the second year of the period, an amount equal to 50% of the amounts expended by the State during the year to implement the plan; and

(iii) for the third year of the period, an amount equal to 33% of the amounts expended by the State during the year to implement the plan.

(B) AGGREGATE PER PLAN LIMIT.—The amount of assistance provided to a State under this subsection with respect to any plan may not exceed $100,000 during any year of the 3-year period for which the State receives assistance.

(b) DESIGNATION OF AREAS.—

(1) DESIGNATION BY GOVERNOR.—In accordance with the guidelines developed under paragraph (2), the Governor of a State may designate an area in the State as a chronically underserved area for purposes of this section upon the request of a local official of the area or upon the Governor's initiative.

(2) GUIDELINES FOR DESIGNATION.—

(A) DEVELOPMENT BY SECRETARY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop guidelines for the designation of areas as chronically underserved areas under this section.

(B) FACTORS CONSIDERED IN DEVELOPMENT OF GUIDELINES.—In developing guidelines under paragraph (1), the Secretary shall consider the following factors:

(i) Whether the area (or a significant portion of the area)—

(I) is designated as a health professional shortage area (under section 332(a) of the Public Health Service Act), or meets the criteria for designation as such an area; or

(II) was previously designated as such an area or previously met such criteria for an extended period prior to the designation of the area under this section (in accordance with criteria established by the Secretary).

(ii) The availability and adequacy of health care providers and facilities for residents of the area.

(iii) The extent to which the availability of assistance under other Federal and State programs has failed to alleviate the lack of access to health care services for residents of the area.

(iv) The percentage of residents of the area whose income is at or below the poverty level.

(v) The percentage of residents of the area who are age 65 or older.

(vi) The existence of cultural or geographic barriers to access to health care services in the area, including weather conditions.

(3) REVIEW BY SECRETARY.—No designation under paragraph (1) shall take effect under this section unless the Secretary—

(A) has been notified of the proposed designation; and

(B) has not, within 60 days after the date of receipt of the notice, disapproved the designation.

(4) PERIOD OF DESIGNATION.—A designation under this section shall be effective during a period specified by the Governor of not longer than 3 years. The Governor may extend the designation for additional 3-year periods, except that a State may not receive assistance under subsection (a)(3) for amounts expended during any such additional periods.

(c) REQUIREMENTS FOR STATE ACCESS PLANS.—A State plan to increase the access of residents of chronically underserved areas to health care services meets the requirements of this section if the Secretary finds that the plan was developed with the participation of health care providers and facilities and residents of the area that is the subject of the plan, together with such other requirements as the Secretary may impose.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for assistance under this section $10,000,000 for each of the first 3 fiscal years beginning after the date on which the Secretary develops guidelines for the designation of areas as chronically underserved areas under subsection (b)(2).

SEC. 3102. TECHNICAL ASSISTANCE GRANTS FOR NETWORKS.

(a) IN GENERAL.—The Secretary shall make funds available under this section to provide technical assistance (including information regarding eligibility for other Federal programs) and advice for entities described in subsection (b) seeking to establish or enhance a community rural health network in an underserved rural area.

(b) ENTITIES ELIGIBLE TO RECEIVE FUNDS.—The following entities are eligible to receive funds for technical assistance under this section:

(1) An entity receiving a grant under section 3103.

(2) A State or unit of local government.

(3) An entity providing health care services (including health professional education services) in the area involved.

(c) USE OF FUNDS.—

(1) IN GENERAL.—Funds made available under this section may be used—

(A) for planning a community health network and the submission of the plan for the network to the Secretary under section 3103(c) (subject to the limitation described in paragraph (2));

(B) to provide assistance in conducting community-based needs and prioritization, identifying existing regional health resources, and developing networks, utilizing existing local providers and facilities where appropriate;

(C) to provide advice on obtaining the proper balance of primary and secondary facilities for the population served by the network;

(D) to provide assistance in coordinating arrangements for tertiary care;

(E) to provide assistance in recruitment and retention of health care professionals;

(F) to provide assistance in coordinating the delivery of emergency services with the provision of other health care services in the area served by the network;

(G) to provide assistance in coordinating arrangements for mental health and substance abuse treatment services; and

(H) to provide information regarding the area or proposed network's eligibility for Federal and State assistance for health care-related activities, together with information on funds available through private sources.

(2) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in paragraph (1) may not exceed $50,000 and may not be available for a period of time exceeding 1 year.

(d) USE OF RURAL HEALTH OFFICES.—In carrying out this section with respect to entities in rural areas, the Secretary shall make funds available through—

(1) not more than 10 regional centers acting as clearinghouses for the distribution of such funds;

(2) State Offices of Rural Health, or any combination of such centers and Offices.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 for each of fiscal years 1996 through 2000 to carry out this section. Amounts appropriated under this section shall be available until expended.

SEC. 3103. DEVELOPMENT GRANTS FOR NETWORKS.

(a) IN GENERAL.—The Secretary shall provide financial assistance to eligible entities in order to provide for the development and implementation of community rural health networks.

(b) ELIGIBLE ENTITIES.—

(1) IN GENERAL.—An entity is eligible to receive financial assistance under this section only if the entity—

(A) is (i) based in a rural area or (ii) is described in paragraph (2), (3), or (4) of section 3102(b),

(B) is undertaking to develop and implement a community rural health network in an underserved rural area (or underserved rural areas) with the active participation of at least 3 health care providers or facilities in the area, and

(C) has consulted with the local governments of the area to be served by the network and with individuals who reside in the area.

(2) COORDINATION WITH PROVIDERS OUTSIDE OF AREA PERMITTED.—Nothing in this section shall be construed as preventing an entity that coordinates the delivery of services in an underserved rural area with an entity outside the area from qualifying for financial assistance under this section, or as preventing an entity consisting of a consortia of members located in adjoining States from qualifying for such assistance.

(3) PERMITTING ENTITIES NOT RECEIVING FUNDING FOR DEVELOPMENT OF PLAN TO RECEIVE FUNDING FOR IMPLEMENTATION.—An entity that is eligible to receive financial assistance under this section may receive assistance to carry out activities described in subsection (c)(1)(B) notwithstanding that the entity does not receive assistance to carry out activities described in subsection (c)(1)(A).

(c) USE OF FUNDS.—

(1) IN GENERAL.—Financial assistance made available to eligible entities under this section may be used only—

(A) for the development of a community health network and the submission of the plan for the network to the Secretary; and

(B) after the Secretary approves the plan for the network, for activities to implement the network, including (but not limited to)—

(i) establishing information systems, including telecommunications,

(ii) recruiting health care providers,

(iii) providing services to enable individuals to have access to health care services, including transportation and language interpretation services (including interpretation services for the hearing-impaired), and

(iv) establishing and operating a community health advisor program described in paragraph (2).

(2) COMMUNITY HEALTH ADVISOR PROGRAM.—

(A) PROGRAM DESCRIBED.—In paragraph (1), a "community health advisor program" is a program under which community health advisors carry out the following activities:

(i) Collaborating efforts with health care providers and related entities to facilitate the provision of health services and health-related social services.

(ii) Providing public education on health promotion and disease prevention and efforts to facilitate the use of available health services and health-related social services.

(iii) Providing health-related counseling.

(iv) Making referrals for available health services and health-related social services.

(v) Improving the ability of individuals to use health services and health-related social services under Federal, State, and local programs through assisting individuals in establishing eligibility under the programs.

(vi) Providing outreach services to inform the community of the availability of the services provided under the program.

(B) COMMUNITY HEALTH ADVISOR DEFINED.—In subparagraph (A), the term "community health advisor" means, with respect to a community health advisor program, an individual—

(i) who has demonstrated the capacity to carry out one or more of the activities carried out under the program; and

(ii) who, for not less than one year, has been a resident of the community in which the program is to be operated.

(3) LIMITATIONS ON ACTIVITIES FUNDED.—Financial assistance made available under this section may not be used for any of the following:

(A) For a telecommunications system unless such system is coordinated with, and does not duplicate, a system existing in the area.

(B) For construction or remodeling of health care facilities.

(4) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in paragraph (1)(A) may not exceed $50,000 and may not be made available for a period of time exceeding 1 year.

(d) APPLICATION.—

(1) IN GENERAL.—No financial assistance shall be provided under this section to an entity unless the entity has submitted to the Secretary, in a time and manner specified by the Secretary, and had approved by the Secretary an application.

(2) INFORMATION TO BE INCLUDED.—Each such application shall include—

(A) a description of the community rural health network, including service area and capacity, and

(B) a description of how the proposed network will utilize existing health care facilities in a manner that avoids unnecessary duplication.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for each of fiscal years 1996 through 2000 to carry out this section. Amounts appropriated under this section shall be available until expended.

(2) INTEGRATION OF OTHER AUTHORIZATIONS.—In order to provide for the authorization of appropriations under paragraph (1), notwithstanding any other provision of law, no funds are authorized to be appropriated to carry out the following programs in fiscal years after fiscal year 1994:

(A) The rural health transition grant program (under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987).

(B) The rural health outreach program (for which appropriations were annually provided under the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Acts).

(3) ANNUAL LIMIT ON ASSISTANCE TO GRANTEE.—The amount of financial assistance provided to an entity under this section during a year may not exceed $250,000.

SEC. 3104. DEFINITIONS.

For purposes of this part:

(1) COMMUNITY RURAL HEALTH NETWORK.—The term "community rural health network" means a formal cooperative arrangement between participating hospitals, physicians, and other health care providers which—

(A) is located in an underserved rural area;

(B) furnishes health care services to individuals residing in the area; and

(C) is governed by a board of directors selected by participating health care providers and residents of the area.

(2) RURAL AREA.—The term "rural area" has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(4) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(5) UNDERSERVED RURAL AREA.—The term "underserved rural area" means a rural area designated—

(A) as a health professional shortage area under section 332(a) of the Public Health Service Act; or

(B) as a chronically underserved area under section 3101.

PART 2—INCENTIVES FOR HEALTH PROFESSIONALS TO PRACTICE IN RURAL AREAS

Subpart A—National Health Service Corps Program

SEC. 3111. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:"

SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

"(a) GENERAL RULE.—Gross income shall not include any qualified loan repayment.

"(b) QUALIFIED LOAN REPAYMENT.—For purposes of this section, the term 'qualified loan repayment' means any payment made on behalf of the taxpayer by the National Health Service Corps Loan Repayment Program under section 338B(g) of the Public Health Service Act.".

(b) CONFORMING AMENDMENT.—Paragraph (3) of section 338B(g) of the Public Health Service Act is amended by striking "Federal, State, or local" and inserting "State or local".

(c) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 137 and inserting the following:

"Sec. 137. National Health Service Corps loan repayments.

"Sec. 138. Cross references to other Acts.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made under section 338B(g) of the Public Health Service Act after the date of the enactment of this Act.

SEC. 3112. MODIFICATION IN CRITERIA FOR DESIGNATION AS HEALTH PROFESSIONAL SHORTAGE AREA.

(a) CONSIDERATIONS REGARDING MEDICARE AND MEDICAID PROGRAMS AS MEANS OF PAYMENT.—Section 332(b) of the Public Health Service Act (42 U.S.C. 254e(b)) is amended by adding at the end the following paragraph:

"(4) With respect to determining the need for health services through the indicators of need under paragraphs (1) and (2), consideration of the following:

"(A) The number of individuals in the population involved whose means of payment for health services is the program under title XVIII of the Social Security Act.

"(B) The number of individuals in the population whose means of payment for health services is the program under title XIX of such Act.

"(C) The number of individuals in the population who are uninsured with respect to health policies or plans.

"(D) The percentage of the population constituted by the aggregate number of individuals under subparagraphs (A) through (C).

"(E) In the case of community-based physicians who provide primary health services and who are accepting additional patients whose means of payment is through the program established in title XVIII or XIX of the Social Security Act, the percentage constituted by the ratio of the number of such physicians to the number of individuals in the population.".

(b) Relevance of Travel Times Within Frontier Areas.—Section 332(a) of the Public Health Service Act (42 U.S.C. 245e(a)) is amended by adding at the end the following new paragraph:

"(4) With respect to meeting the criteria under paragraph (1)(A) for an area to be designated as a health professional shortage area, the Secretary shall, in the case of a frontier area, make the determination of whether the frontier area is a rational area for the delivery of health services without regard to—

"(A) the travel time between population centers in the frontier area; or

"(B) the travel time to contiguous area resources in the frontier area.".

(c) Agency Recommendations for Improvements.—Not later than July 1, 1995, the Secretary of Health and Human Services shall submit to the Congress a report specifying the recommendations of the Secretary for improving the manner of determining the extent to which a geographic area has a need for assignments of members of the National Health Service Corps, and for equitably allocating such assignments among the geographic areas with a need for such assignments.

(d) Effective Date.—This section shall take effect on October 1, 1994, or upon the date of the enactment of this Act, whichever occurs later.

SEC. 3113. OTHER PROVISIONS REGARDING NATIONAL HEALTH SERVICE CORPS.

(a) Scholarship and Loan Repayment Programs.—

(1) Authorization of appropriations.—Section 338H(b)(1) of the Public Health Service Act (42 U.S.C. 254q(b)(1)) is amended—

(A) by striking "and" after "1991,"; and

(B) by striking "through 2000." and inserting "through 1999, $175,000,000 for fiscal year 1996, $180,000,000 for fiscal year 1997, $185,000,000 for fiscal year 1998, $190,000,000 for fiscal year 1999, and $195,000,000 for fiscal year 2000.".

(2) Allocation for participation of nurses in scholarship program.—Section 338H(b)(2) of the Public Health Service Act (42 U.S.C. 254q(b)(2)) is amended by adding at the end the following subparagraph:

"(C) Of the amounts appropriated under paragraph (1) for fiscal year 1995 and subsequent fiscal years, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program, the total number who are being educated as nurses or are serving as nurses, respectively, is increased to 20 percent.".

(b) Increase in Number of Mental Health Professionals in Shortage Areas.—

(1) In general.—Section 338H(b) of the Public Health Service Act (42 U.S.C. 254q(b)) is amended by adding at the end the following paragraph:

"(3) Mental health professionals.—In providing contracts under this subpart for scholarships and loan repayments, the Secretary shall ensure that an appropriate number of mental health professionals is assigned under section 333 for health professional shortage areas.".

(2) Applicability.—With respect to contracts for scholarships and loan repayments under subpart III of part D of title III of the Public Health Service Act, the amendment made by subsection (a) applies with respect to contracts entered into on or after October 1, 1994.

Subpart B—Incentives Under Other Programs

SEC. 3121. EXTENSION OF ADDITIONAL PAYMENT UNDER MEDICARE FOR PHYSICIANS' SERVICES FURNISHED IN FORMER SHORTAGE AREAS.

(a) In General.—Section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)) is amended by striking "area," and inserting "area (or, in the case of an area for which the designation as a health professional shortage area under such section is withdrawn, in the case of physicians' services furnished to such an individual during the 3-year period beginning on the effective date of the withdrawal of such designation),".

(b) Effective Date.—The amendment made by subsection (a) shall apply to physicians' services furnished in an area for which the designation as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act is withdrawn on or after January 1, 1995.

SEC. 3122. REFINEMENT OF GEOGRAPHIC ADJUSTMENT FACTOR FOR MEDICARE PHYSICIANS' SERVICES.

(a) Deadline for Initial Review and Revision.—Section 1848(e)(1)(C) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(C)) is amended by adding at the end the following: "The first such review and revision shall apply to services furnished on or after January 1, 1995.".

(b) Authority To Adjust Index Value for Input Component Under Certain Circumstances.—(1) Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)) is amended—

(A) in subparagraph (A), by striking "(B) and (C)" and inserting "(B), (C), and (D)";

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following:

"(C) Special adjustment to correct for unique local circumstances.—The Secretary may adjust the value assigned to an input component of an index in a fee schedule area if the Secretary determines that the value that would otherwise apply in such area does not accurately reflect the relative costs of such input for such area because of unique local circumstances.".

(2) Section 1848(i)(1)(D) of the Social Security Act (42 U.S.C. 1395w-4(i)(1)(D)) is amended by inserting "(including any adjustment under subparagraph (C) thereof)" after "subsection (e)".

(c) Report on Review Process.—Not later than April 1, 1996, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall study and report to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on—

(1) the data necessary to review and revise the indices established under section 1848(e)(1)(A) of the Social Security Act, including—

(A) the shares allocated to physicians' work effort, practice expenses (other than malpractice expenses), and malpractice expenses;

(B) the weights assigned to the input components of such shares; and

(C) the index values assigned to such components;

(2) any limitations on the availability of data necessary to review and revise such indices at least every three years;

(3) ways of addressing such limitations, with particular attention to the development of alternative data sources for input components for which current index values are based on data collected less frequently than every three years; and

(4) the costs of developing more accurate and timely data sources.

(d) Study on Low-Volume Adjustment in Isolated Areas.—(1) Not later than July 1, 1996, the Physician Payment Review Commission shall study and report to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on the feasibility and desirability of providing for a special adjustment to the index value of the medical equipment and supplies input component of the index used under section 1848(e) of the Social Security Act with respect to services described in paragraph (2).

(2) Services described in this paragraph are services—

(A) furnished by a physician who practices in an isolated area;

(B) requiring the presence of expensive medical equipment and supplies in the physician's office; and

(C) with respect to which the cost per service of operating the equipment is increased because of the low volume of patients of such physician.

SEC. 3123. DEVELOPMENT OF MODEL STATE SCOPE OF PRACTICE LAW.

(a) In General.—The Secretary of Health and Human Services shall develop and publish a model law that may be adopted by States to increase the access of individuals residing in underserved rural areas to health care services by expanding the services which non-physician health care professionals may provide in such areas.

(b) Deadline.—The Secretary shall publish the model law developed under subsection (a) not later than 1 year after the date of the enactment of this Act.

PART 3—ASSISTANCE FOR INSTITUTIONAL PROVIDERS

Subpart A—Community and Migrant Health Centers

SEC. 3131. COMMUNITY AND MIGRANT HEALTH CENTERS.

(a) Migrant Health Centers.—Section 329(h)(1)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(1)(A)) is amended—

(1) by striking "and" after "1991,"; and

(2) by inserting before the period the following: ", $75,000,0000 for fiscal year 1996, $80,000,0000 for fiscal year 1997, $85,000,0000 for fiscal year 1998, $90,000,0000 for fiscal year 1999, and $95,000,0000 for fiscal year 2000".

(b) Community Health Centers.—Section 330(g)(1)(A) of the Public Health Service Act (42 U.S.C. 254c(g)(1)(A)) is amended—

(1) by striking "and" after "1991,"; and

(2) by inserting before the period the following: ", $650,000,0000 for fiscal year 1996, $675,000,0000 for fiscal year 1997, $700,000,0000 for fiscal year 1998, $725,000,0000 for fiscal year 1999, and $750,000,0000 for fiscal year 2000".

Subpart B—Emergency Medical Systems

SEC. 3141. EMERGENCY MEDICAL SERVICES.

(a) Establishment of Federal Office.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in the heading for the title, by striking "**TRAUMA CARE**" and inserting "**EMERGENCY MEDICAL AND TRAUMA CARE SERVICES**";

(2) in the heading for part A, by striking "General" and all that follows and inserting "General Authorities and Duties"; and

(3) by amending section 1201 to read as follows:

"SEC. 1201. ESTABLISHMENT OF OFFICE OF EMERGENCY MEDICAL AND TRAUMA CARE SERVICES.

"(a) In General.—The Secretary shall establish an office to be known as the Office of Emergency Medical and Trauma Care Services, which shall be headed by a director appointed by the Secretary. The Secretary shall carry out this title acting through the Director of such Office.

"(b) General Authorities and Duties.—With respect to emergency medical services (including trauma care), the Secretary shall—

"(1) conduct and support research, training, evaluations, and demonstration projects;

"(2) foster the development of appropriate, modern systems of such services through the sharing of information among agencies and individuals involved in the study and provision of such services;

"(3) foster the development of regional systems for the provision of such services;

"(4) sponsor workshops and conferences;

"(5) as appropriate, disseminate to public and private entities information obtained in carrying out paragraphs (1) through (4);

"(6) provide technical assistance to State and local agencies;

"(7) coordinate activities of the Department of Health and Human Services; and

"(8) as appropriate, coordinate activities of such Department with activities of other Federal agencies.

"(c) Certain Requirements.—With respect to emergency medical services (including trauma care), the Secretary shall ensure that activities under subsection (b) are carried out regarding—

"(1) maintaining an adequate number of health professionals with expertise in the provision of the services, including hospital-based professionals and prehospital-based professionals;

"(2) developing, periodically reviewing, and revising as appropriate, in collaboration with appropriate public and private entities, guidelines for the provision of such services (including, for various typical circumstances, guidelines on the number and variety of professionals, on equipment, and on training);

"(3) the appropriate use of available technologies, including communications technologies; and

"(4) the unique needs of underserved inner-city areas and underserved rural areas.

"(d) Grants, Cooperative Agreements, and Contracts.—In carrying out subsections (b) and (c), the Secretary may make grants and enter into cooperative agreements and contracts.

"(e) Definitions.—For purposes of this part:

"(1) The term 'hospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at a medical facility.

"(2) The term 'prehospital-based professional' means a health professional (including an allied health professional) who has expertise in providing one or more emergency medical services and who normally provides the services at the site of the medical emergency or during transport to a medical facility.".

(b) State Offices of Emergency Medical Services; Demonstration Program Regarding Telecommunications.—Part A of title XII of the Public Health Service Act (42 U.S.C. 300d et seq.), as amended by section 601(b) of Public Law 103-183 (107 Stat. 2238), is amended—

(1) by redesignating sections 1202 and 1203 as sections 1203 and 1204, respectively;

(2) by inserting after section 1201 the following section:

"SEC. 1202. STATE OFFICES OF EMERGENCY MEDICAL SERVICES.

"(a) Program of Grants.—The Secretary may make grants to States for the purpose of improving the availability and quality of emergency medical services through the operation of State offices of emergency medical services.

"(b) Requirement of Matching Funds.—

"(1) In general.—The Secretary may not make a grant under subsection (a) unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such subsection, to provide non-Federal contributions toward such costs in an amount that—

"(A) for the first fiscal year of payments under the grant, is not less than $1 for each $3 of Federal funds provided in the grant;

"(B) for any second fiscal year of such payments, is not less than $1 for each $1 of Federal funds provided in the grant; and

"(C) for any third fiscal year of such payments, is not less than $3 for each $1 of Federal funds provided in the grant.

"(2) Determination of amount of non-Federal contribution.—

"(A) Subject to subparagraph (B), non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(B) The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

"(i) for the first fiscal year of payments under the grant, 100 percent or less of the non-Federal contributions required in paragraph (1) will be provided in the form of in-kind contributions;

"(ii) for any second fiscal year of such payments, not more than 50 percent of such non-Federal contributions will be provided in the form of in-kind contributions; and

"(iii) for any third fiscal year of such payments, such non-Federal contributions will be provided solely in the form of cash.

"(c) Certain Required Activities.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that activities carried out by an office operated pursuant to such subsection will include—

"(1) coordinating the activities carried out in the State that relate to emergency medical services;

"(2) activities regarding the matters described in paragraphs (1) through (4) section 1201(b); and

"(3) identifying Federal and State programs regarding emergency medical services and providing technical assistance to public and nonprofit private entities regarding participation in such programs.

"(d) Requirement Regarding Annual Budget for Office.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, for any fiscal year for which the State receives such a grant, the office operated pursuant to subsection (a) will be provided with an annual budget of not less than $50,000.

"(e) Certain Uses of Funds.—

"(1) Restrictions.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that—

"(A) if research with respect to emergency medical services is conducted pursuant to the grant, not more than 10 percent of the grant will be expended for such research; and

"(B) the grant will not be expended to provide emergency medical services (including providing cash payments regarding such services).

"(2) Establishment of office.—Activities for which a State may expend a grant under subsection (a) include paying the costs of establishing an office of emergency medical services for purposes of such subsection.

"(f) Reports.—The Secretary may not make a grant under subsection (a) unless the State involved agrees to submit to the Secretary reports containing such information as the Secretary may require regarding activities carried out under this section by the State.

"(g) Requirement of Application.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section."; and

(3) in section 1204 (as redesignated by paragraph (1) of this subsection)—

(A) by redesignating subsection (c) as subsection (d); and

(B) by inserting after subsection (b) the following new subsection:

"(c) Demonstration Program Regarding Telecommunications.—

"(1) Linkages for rural facilities.—Projects under subsection (a)(1) shall include demonstration projects to establish telecommunications between rural medical facilities and medical facilities that have expertise or equipment that can be utilized by the rural facilities through the telecommunications.

"(2) Modes of communication.—The Secretary shall ensure that the telecommunications technologies demonstrated under paragraph (1) include interactive video telecommunications, static video imaging transmitted through the telephone system, and facsimiles transmitted through such system.".

(c) Funding.—Section 1232 of the Public Health Service Act (42 U.S.C. 300d-32) is amended by striking subsections (a) and (b) and inserting the following:

"(a) Emergency Medical Services Generally.—For the purpose of carrying out section 1201 other than with respect to trauma care, and for the purpose of carrying out section 1204(c), there are authorized to be appropriated $2,000,000 for each of the fiscal years 1996, 1997, and 1998.

"(b) State Offices.—For the purpose of carrying out section 1202, there are authorized to be appropriated $3,000,000 for each of the fiscal years 1996, 1997, and 1998.".

SEC. 3142. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d-51 et seq.) is amended by adding at the end the following new section:

"SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL VICTIMS OF MEDICAL EMERGENCIES.

"(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

"(b) APPLICATION AND PLAN.—

"(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

"(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

"(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

"(B) demonstrate that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

"(C) demonstrate that there is a lack of facilities available and equipped to deliver advanced levels of medical care in the geographic areas to be served;

"(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

"(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are effectively meeting the emergency medical needs of the populations they serve;

"(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

"(G) demonstrate that the State, in utilizing the grant proceeds, will—

"(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received; and

"(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

"(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan; and

"(I) contain such other information as the Secretary may determine appropriate.

"(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

"(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

"(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

"(d) STATE ADMINISTRATION AND USE OF GRANT.—

"(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

"(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

"(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

"(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

"(f) REPORTS.—

"(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

"(A) a description of the manner in which the grant proceeds were utilized;

"(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

"(C) such other information as the Secretary may require.

"(2) TERMINATION OF FUNDING.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

"(g) DEFINITION.—As used in this section, the term 'rural areas' means geographic areas that are located outside of standard metropolitan statistical areas, as identified by the Secretary.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, $15,000,000 for each of the fiscal years 1996, 1997, and 1998.".

Subpart C—Assistance to Rural Providers Under Medicare

SEC. 3151. AMENDMENTS TO ESSENTIAL ACCESS COMMUNITY HOSPITAL (EACH) PROGRAM UNDER MEDICARE.

(a) INCREASING NUMBER OF PARTICIPATING STATES.—Section 1820(a)(1) of the Social Security Act (42 U.S.C. 1395i–4(a)(1)) is amended by striking "7" and inserting "9".

(b) TREATMENT OF INPATIENT HOSPITAL SERVICES PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

(1) IN GENERAL.—Section 1820(f)(1)(F) of such Act (42 U.S.C. 1395i–4(f)(1)(F)) is amended to read as follows:

"(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care to patients requiring stabilization before discharge or transfer to a hospital, except that the facility may not provide any inpatient hospital services—

"(i) to any patient whose attending physician does not certify that the patient may reasonably be expected to be discharged or transferred to a hospital within 72 hours of admission to the facility; or

"(ii) consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A)), unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.".

(2) LIMITATION ON AVERAGE LENGTH OF STAY.—Section 1820(f) of such Act (42 U.S.C. 1395i–4(f)) is amended by adding at the end the following new paragraph:

"(4) LIMITATION ON AVERAGE LENGTH OF INPATIENT STAYS.—The Secretary may terminate a designation of a rural primary care hospital under paragraph (1) if the Secretary finds that the average length of stay for inpatients at the facility during the previous year in which the designation was in effect exceeded 72 hours. In determining the compliance of a facility with the requirement of the previous sentence, there shall not be taken into account periods of stay of inpatients in excess of 72 hours to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.".

(3) CONFORMING AMENDMENT.—Section 1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is amended by striking "such services" and all that follows and inserting "the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital.".

(4) GAO REPORTS.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit reports to Congress on—

(A) the application of the requirements under section 1820(f) of the Social Security Act (as amended by this subsection) that rural primary care hospitals provide inpatient care only to those individuals whose attending physicians certify may reasonably be expected to be discharged within 72 hours after admission and maintain an average length of inpatient stay during a year that does not exceed 72 hours; and

(B) the extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited the ability of such hospitals to provide needed services.

(c) DESIGNATION OF HOSPITALS.—

(1) PERMITTING DESIGNATION OF HOSPITALS LOCATED IN URBAN AREAS.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i–4) is amended—

(i) by striking paragraph (1) of subsection (e) and redesignating paragraphs (2) through (6) as paragraphs (1) through (5);

(ii) in subsection (e)(1)(A) (as redesignated by subparagraph (A))—

(I) by striking "is located" and inserting "except in the case of a hospital located in an urban area, is located",

(II) by striking ", (ii)" and inserting "or (ii)", and

(III) by striking "or (iii)" and all that follows through "section,"; and

(iii) in subsection (i)(1)(B), by striking "paragraph (3)" and inserting "paragraph (2)".

(B) NO CHANGE IN MEDICARE PROSPECTIVE PAYMENT.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(i) in clause (iii)(III), by inserting "located in a rural area and" after "that is", and

(ii) in clause (v), by inserting "located in a rural area and" after "in the case of a hospital".

(2) PERMITTING HOSPITALS LOCATED IN ADJOINING STATES TO PARTICIPATE IN STATE PROGRAM.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i-4) is amended—

(i) by redesignating subsection (k) as subsection (l); and

(ii) by inserting after subsection (j) the following new subsection:

"(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN PARTICIPATING STATES.—Notwithstanding any other provision of this section—

"(1) for purposes of including a hospital or facility as a member institution of a rural health network, a State may designate a hospital or facility that is not located in the State as an essential access community hospital or a rural primary care hospital if the hospital or facility is located in an adjoining State and is otherwise eligible for designation as such a hospital;

"(2) the Secretary may designate a hospital or facility that is not located in a State receiving a grant under subsection (a)(1) as an essential access community hospital or a rural primary care hospital if the hospital or facility is a member institution of a rural health network of a State receiving a grant under such subsection; and

"(3) a hospital or facility designated pursuant to this subsection shall be eligible to receive a grant under subsection (a)(2).".

(B) CONFORMING AMENDMENTS.—(i) Section 1820(c)(1) of such Act (42 U.S.C. 1395i-4(c)(1)) is amended by striking "paragraph (3)" and inserting "paragraph (3) or subsection (k)".

(ii) Paragraphs (1)(A) and (2)(A) of section 1820(i) of such Act (42 U.S.C. 1395i-4(i)) are each amended—

(I) in clause (i), by striking "(a)(1)" and inserting "(a)(1) (except as provided in subsection (k))", and

(II) in clause (ii), by striking "subparagraph (B)" and inserting "subparagraph (B) or subsection (k)".

(d) SKILLED NURSING SERVICES IN RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(3) of such Act (42 U.S.C. 1395i-4(f)(3)) is amended by striking "because the facility" and all that follows and inserting the following: "because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital.".

(e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—Section 1814(l)(2) of such Act (42 U.S.C. 1395f(l)(2)) is amended by striking "January 1, 1993" and inserting "January 1, 1996".

(f) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in paragraph (1), by striking "during a year before 1993" and inserting "during a year before the prospective payment system described in paragraph (2) is in effect"; and

(B) in paragraph (2), by striking "January 1, 1993," and inserting "January 1, 1996,".

(2) NO USE OF CUSTOMARY CHARGE IN DETERMINING PAYMENT.—Section 1834(g)(1) of such Act (42 U.S.C. 1395m(g)(1)) is amended by adding at the end the following new flush sentence: "The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.".

(g) CLARIFICATION OF PHYSICIAN STAFFING REQUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(1)(H) of such Act (42 U.S.C. 1395i-4(f)(1)(H)) is amended by striking the period and inserting the following: ", except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).".

(h) TECHNICAL AMENDMENTS RELATING TO PART A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILLNESS.—(1) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)) is amended—

(A) by striking "inpatient hospital services" the first place it appears and inserting "inpatient hospital services or inpatient rural primary care hospital services";

(B) by striking "inpatient hospital services" the second place it appears and inserting "such services"; and

(C) by striking "and inpatient rural primary care hospital services".

(2) Sections 1813(a) and 1813(b)(3)(A) of such Act (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking "inpatient hospital services" each place it appears and inserting "inpatient hospital services or inpatient rural primary care hospital services".

(3) Section 1813(b)(3)(B) of such Act (42 U.S.C. 1395e(b)(3)(B)) is amended by striking "inpatient hospital services" and inserting "inpatient hospital services, inpatient rural primary care hospital services".

(4) Section 1861(a) of such Act (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by striking "inpatient hospital services" and inserting "inpatient hospital services, inpatient rural primary care hospital services"; and

(B) in paragraph (2), by striking "hospital" and inserting "hospital or rural primary care hospital".

(i) AUTHORIZATION OF APPROPRIATIONS.—Section 1820(l) of such Act (42 U.S.C. 1395i-4(l)), as redesignated by subsection (c)(2)(A), is amended by striking "1990, 1991, and 1992" and inserting "1990 through 2000".

(j) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 3152. RURAL EMERGENCY ACCESS CARE HOSPITALS DESCRIBED.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

"(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

"(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

"(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

"(C) The facility is in danger of closing due to low inpatient utilization rates and negative operating losses, and the closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

"(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

"(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

"(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

"(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

"(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

"(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part time, off-site basis.

"(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

"(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital:

"(A) An appropriate medical screening examination (as described in section 1867(a)).

"(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).".

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) of such Act (42 U.S.C. 1395dd(e)(5)) is amended by striking "1861(mm)(1))" and inserting "1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))".

SEC. 3153. COVERAGE OF AND PAYMENT FOR SERVICES.

(a) Coverage Under Part B.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking "and" at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).".

(b) Payment Based on Payment for Outpatient Rural Primary Care Hospital Services.—

(1) In general.—Section 1833(a)(6) of the Social Security Act (42 U.S.C. 1395l(a)(6)) is amended by striking "services," and inserting "services and rural emergency access care hospital services,".

(2) Payment methodology described.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(A) in the heading, by striking "Services" and inserting "Services and rural emergency access care hospital services"; and

(B) in paragraph (1), by striking "during a year before 1993" and inserting "during a year before the prospective payment system described in paragraph (2) is in effect";

(C) in paragraph (1), by adding at the end the following: "The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.";

(D) in paragraph (2), by striking "January 1, 1993," and inserting "January 1, 1996,"; and

(E) by adding at the end the following new paragraph:

"(3) Application of methods to payment for rural emergency access care hospital services.—The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.".

SEC. 3154. EFFECTIVE DATE.

The amendments made by this subpart shall apply to fiscal years beginning on or after October 1, 1994.

Subpart D—Demonstration Projects to Encourage Primary Care and Rural-Based Graduate Medical Education

SEC. 3161. STATE AND CONSORTIUM DEMONSTRATION PROJECTS.

(a) In General.—

(1) Participation of states and consortia.—The Secretary shall establish and conduct a demonstration project to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice under which the Secretary shall make payments in accordance with subsection (d)—

(A) to not more than 10 States for the purpose of testing and evaluating mechanisms to meet the goals described in section 3162; and

(B) to not more than 10 health care training consortia for the purpose of testing and evaluating mechanisms to meet such goals.

(2) Exclusion of consortia in participating states.—A consortia may not receive payments under the demonstration project under paragraph (1)(B) if any of its members is located in a State receiving payments under the project under paragraph (1)(A).

(b) Applications.—

(1) In general.—Each State and consortium desiring to conduct a demonstration project under this section shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require to assure that the State or consortium will meet the goals described in section 3162. In the case of an application of a State, the application shall include—

(A) information demonstrating that the State has consulted with interested parties with respect to the project, including State medical associations, State hospital associations, and medical schools located in the State;

(B) an assurance that no hospital conducting an approved medical residency training program in the State will lose more than 10 percent of such hospital's approved medical residency positions in any year as a result of the project; and

(C) an explanation of a plan for evaluating the impact of the project in the State.

(2) Approval of applications.—A State or consortium that submits an application under paragraph (1) may begin a demonstration project under this subsection—

(A) upon approval of such application by the Secretary; or

(B) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

(3) Notice and comment.—A State or consortium shall issue a public notice on the date it submits an application under paragraph (1) which contains a general description of the proposed demonstration project. Any interested party may comment on the proposed demonstration project to the State or consortium or the Secretary during the 30-day period beginning on the date the public notice is issued.

(c) Specific Requirements for Participants.—

(1) Requirements for states.—Each State participating in the demonstration project under this subtitle shall use the payments provided under subsection (d) to test and evaluate either of the following mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice:

(A) Use of alternative weighting factors.—

(i) In general.—The State may make payments to hospitals in the State for direct graduate medical education costs in amounts determined under the methodology provided under section 1886(h) of the Social Security Act, except that the State shall apply weighting factors that are different than the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(ii) Use of payments for primary care residents.—In applying different weighting factors under clause (i), the State shall ensure that the amount of payment made to hospitals for costs attributable to primary care residents shall be greater than the amount that would have been paid to hospitals for costs attributable to such residents if the State had applied the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(B) Payments for medical education through consortium.—The State may make payments for graduate medical education costs through payments to a health care training consortium (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium) that is established in the State but that is not otherwise participating in the demonstration project.

(2) Requirements for consortium.—

(A) In general.—In the case of a consortium participating in the demonstration project under this subtitle, the Secretary shall make payments for graduate medical education costs through a health care training consortium whose members provide medical residency training (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium).

(B) Use of payments.—

(i) In general.—Each consortium receiving payments under subparagraph (A) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice, and may use such funds for the operation of the consortium.

(ii) Payments to participating programs.—The consortium shall ensure that the majority of the payments received under subparagraph (A) are directed to consortium members for primary care residency programs, and shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the consortium's payment amount under the project. Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

(d) Allocation of Portion of Medicare GME Payments for Activities Under Project.—Notwithstanding any provision of title XVIII of the Social Security Act, the following rules apply with respect to each State and each health care training consortium participating in the demonstration project established under this section during a year:

(1) In the case of a State—

(A) the Secretary shall reduce the amount of each payment made to hospitals in the State during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(B) the Secretary shall pay the State an amount equal to the Secretary's estimate of the sum of the reductions made during the year under subparagraph (A) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(2) In the case of a consortium—

(A) the Secretary shall reduce the amount of each payment made to hospitals who are members of the consortium during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(B) the Secretary shall pay the consortium an amount equal to the Secretary's estimate of the sum of the reductions made during the year under subparagraph (A) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(e) Additional Grant for Planning and Evaluation.—

(1) In general.—The Secretary may award grants to States and consortia participating in the demonstration project under this section for the purpose of developing and evaluating such projects. A State or consortia may conduct such an evaluation or contract with a private entity to conduct the evaluation. Each State and consortia desiring to

receive a grant under this paragraph shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for grants under this paragraph for fiscal years 1996 through 2000.

(f) DURATION.—A demonstration project under this section shall be conducted for a period not to exceed 5 years. The Secretary may terminate a project if the Secretary determines that the State or consortium conducting the project is not in substantial compliance with the terms of the application approved by the Secretary.

(g) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—Each State or consortium participating in the demonstration project shall submit to the Secretary a final evaluation within 360 days of the termination of the State or consortium's participation and such interim evaluations as the Secretary may require.

(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this subtitle begins, and annually thereafter for each year in which such a project is conducted, the Secretary shall submit a report to Congress which evaluates the effectiveness of the State and consortium activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(h) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project under this subtitle shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

SEC. 3162. GOALS FOR PROJECTS.

The goals referred to in this section for a State or consortium participating in the demonstration project under this subtitle are as follows:

(1) The training of an equal number of physician and non-physician primary care providers.

(2) The recruiting of residents for graduate medical education training programs who received a portion of undergraduate training in a rural area.

(3) The allocation of not less than 50 percent of the training spent in a graduate medical residency training program at sites at which acute care inpatient hospital services are not furnished.

(4) The rotation of residents in approved medical residency training programs among practices that serve residents of rural areas.

(5) The development of a plan under which, after a 5-year transition period, not less than 50 percent of the residents who begin an initial residency period in an approved medical residency training program shall be primary care residents.

SEC. 3163. DEFINITIONS.

In this subpart:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term "approved medical residency training program" has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act.

(2) HEALTH CARE TRAINING CONSORTIUM.—The term "health care training consortium" means a State, regional, or local entity consisting of at least one of each of the following:

(A) A hospital operating an approved medical residency training program at which residents receive training at ambulatory training sites located in rural areas.

(B) A school of medicine or osteopathic medicine.

(C) A school of allied health or a program for the training of physician assistants (as such terms are defined in section 799 of the Public Health Service Act).

(D) A school of nursing (as defined in section 853 of the Public Health Service Act).

(3) PRIMARY CARE.—The term "primary care" means family practice, general internal medicine, general pediatrics, and obstetrics and gynecology.

(4) RESIDENT.—The term "resident" has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

(5) RURAL AREA.—The term "rural area" has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

PART 4—HOSPITAL AFFILIATED PRIMARY CARE CENTER

SEC. 3171. HOSPITAL-AFFILIATED PRIMARY CARE CENTERS.

(a) DEFINITIONS.—For purposes of this section:

(1) COMMUNITY HOSPITAL.—The term "community hospital" means a public general hospital, owned and operated by a State, county or local unit of government, or a private community hospital that—

(A) has less than 50 beds; and

(B) primarily serves a medically underserved population as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254c(b)(3)) or a health professional shortage area as defined in section 322(a)(1) of such Act (42 U.S.C. 254c(a)(1).

(2) HOSPITAL-AFFILIATED PRIMARY CARE CENTER.—The term "hospital-affiliated primary care center" (referred to in this section as a "primary care center") means a distinct administrative unit of a community hospital, located in, or adjacent to, the hospital, that—

(A) delivers primary health services as defined in section 330(b)(1) of such Act (42 U.S.C. 354c(b)(1)) to a catchment area determined by the hospital and approved by the Secretary; and

(B) provides referrals to providers of supplemental health services as defined in section 330(b)(2) of such Act (42 U.S.C. 354c(b)(2)).

(3) PRIMARY CARE GROUP PRACTICE.—

(A) The term "primary care group practice" means any combination of 3 or more primary care physicians who are—

(i) organized to provide primary health services in a manner that is consistent with the needs of the population served;

(ii) located in, or adjacent to, the community hospital;

(iii) who have admitting privileges at the community hospital; and

(iv)(I) who are salaried by the hospital such that a majority of the members of the group practice is full time in the primary care center; or

(II) who are organized into a legal entity (partnership, corporation, or professional association) that has a contract approved by the Secretary with the community hospital to provide primary health services.

(B) SPECIAL RULE FOR HPSAS AND NEAR-HPSAS.—In the case of a group that is located in an area that—

(i) is designated as a primary care health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e); or

(ii) would meet the requirements for designation as a primary care health professional shortage area if there were 25 percent fewer physicians in the area;

the requirement that a group practice have 3 or more primary care physicians may be met by substituting a nurse practitioner or a physician assistant for 1 member of the group.

(C) SPECIAL RULE FOR FRONTIER AREAS.—In the case of a group that is located in a frontier area, subparagraph (A) shall be applied by substituting "two" for "three" in the matter preceding clause (i).

(D) OTHER REQUIREMENTS FOR GROUP.—

(i) physicians in specialties other than primary care specialties may become members of a primary care group practice as needed, but may not be used to satisfy the requirement of subsection (b)(2)(D); and

(ii) nonphysician providers, particularly physician assistants, certified nurse midwives, and nurse practitioners, shall be used where practicable in concert with the physicians of a primary care group practice.

(4) FRONTIER AREA.—The term "frontier area" means a county in which there are 6 or fewer individuals residing per square mile.

(5) PRIMARY CARE PHYSICIAN.—The term "primary care physician" means a physician in the specialty of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.

(6) PRIMARY CARE RESIDENT.—The term "primary care resident" means a graduate physician in training, whose training program is approved by appropriate certifying bodies and is in a primary care specialty.

(b) ESTABLISHMENT OF GRANT PROGRAM.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall make grants to community hospitals to assist such hospitals in planning, developing, and operating primary care services in medically underserved areas. In making such grants, the Secretary shall avoid duplication of efforts in areas where existing community health centers, migrant health centers, rural emergency access care hospitals, federally qualified health centers, and other facilities are adequate to meet the needs of the medically underserved population.

(2) ELIGIBILITY FOR GRANTS.—In order to be eligible for a grant under this subsection, a community hospital shall submit an application that contains or is supported by assurances, satisfactory to the Secretary, that—

(A) the services of the primary care center will be delivered through a primary care group practice;

(B) to the extent practicable, primary health services in the community hospital will be delivered only through the primary care center;

(C) qualified personnel trained in triage will be placed in the emergency room, the outpatient department, and the primary care center to screen and direct patients to the appropriate location for care;

(D) each patient of the primary care center will have an identified member of the group practice responsible for continuous management of the patient, including emergency services and referrals of the patients for inpatient or outpatient services;

(E) to the extent practicable, excess facilities and equipment in or owned by the community hospital will be covered for use in the primary care center;

(F) the hospital and the primary care center will avoid unnecessary duplication of facilities and equipment, except that the primary care center may install appropriate support equipment for routine primary health services;

(G) the primary care center will be maintained as a separate and distinct cost and revenue center for accounting purposes;

(H) the primary care center will be operated in accordance with all of the requirements specified for community health centers in section 330(e)(3) of the Public Health Service Act (other than subparagraph (G));

(I) the hospital has an advisory committee that—

(i) is composed of individuals, a majority of whom are health consumers in the catchment area of the hospital; and

(ii) meets at least 6 times a year to review the operations of the primary care center and develop recommendations to the governing board of the hospital about the operation of the center and the types of services to be provided;

(J) the primary care center will maintain an information program for its patients that fully discloses—

(i) the covered professional services and referral capabilities offered by the primary care center; and

(ii) the method by which patients of the primary care center may resolve grievances about billing for covered professional services and the quality of such services.

(3) OTHER REQUIREMENTS.—

(A) USE OF PRIMARY CARE RESIDENTS.—(i) Primary health services may be delivered by primary care residents if such services are delivered under the supervision of a member of the group practice.

(ii)(I) Medical and other health science students may receive primary care training in the primary care center, except that no full-time member of the group practice may also spend full time in the teaching of residents and students.

(II) The Secretary shall issue regulations to assure that teaching does not detract significantly from the actual delivery of service in the primary care center.

(B) COSTS OF PRIMARY CARE CENTERS.—(i) Only costs clearly associated with the provision of services in the primary care setting may be assigned to a primary care center.

(ii) Inpatient-related costs may not be included in the costs of operating a primary care center.

(iii) Costs associated with the education and training of residents, medical, and other health science students may not be included in the costs of operating a primary care center, except that salaries and other costs associated with the delivery of services by residents may be included in such costs as long as such costs are prorated based on the actual percentage of time spent by the resident in the primary care center.

(C) ADVISORY COMMITTEE.—(i) The advisory committee referred to in paragraph (2)(I) shall participate in the development of an application for a grant under this section and the development of any grant renewal application.

(ii) The Secretary may not approve the application for a grant under this subsection unless the application has been approved by the advisory committee.

(4) USE OF GRANTS.—(A) A grant under this subsection may be used to cover costs associated with (i) planning, (ii) developing (including modernization and renovation of space), and (iii) operating, primary care centers.

(B) Not more than 25 percent of any grant may be used for the purposes specified in subparagraph (A)(ii).

(c) TECHNICAL ASSISTANCE.—The Secretary shall, upon request, provide technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management) to a community hospital to assist it in developing plans for, and in operating, a primary care center. Funds appropriated under this section may be used to carry out the purposes of this section.

(d) RETENTION OF EARNED INCOME.—The Secretary shall establish, by regulation, a plan to allow primary care centers to retain earned income from the operation of the center if the income is used to—

(1) expand or improve the services of the center;

(2) expand the population eligible to utilize the services of the center;

(3) make managerial or physical improvements to the center; or

(4) establish a reserve fund for conversion to a prepaid reimbursement methodology.

(e) USE OF APPROPRIATIONS.—For a fiscal year after 1995, not more than 35 percent of the excess of the amount appropriated for such fiscal year under section 330(g)(1)(A) of the Public Health Service Act (42 U.S.C. 254c(g)(1)(A)) over the amount appropriated under such section for fiscal year 1995 may be used by the Secretary for the purpose of making grants under subsection (b).

Subtitle C—Academic Health Centers

SEC. 3201. STUDY OF PAYMENTS FOR MEDICAL EDUCATION AT SITES OTHER THAN HOSPITALS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the feasibility and desirability of making payments to facilities that are not hospitals for the direct and indirect costs of graduate medical education attributable to residents trained at such facilities. In conducting the study, the Secretary shall evaluate new payment methodologies—

(1) under which each entity which incurs costs of graduate medical education shall receive reimbursement for such costs; and

(2) which would encourage the training of primary care physicians.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress a report on the study conducted under subsection (a), and shall include in the report such recommendations as the Secretary considers appropriate.

Subtitle D—United States-Mexico Border Health Commission

SEC. 3301. AGREEMENT TO ESTABLISH BINATIONAL COMMISSION.

The President is authorized and encouraged to conclude an agreement with Mexico to establish a binational commission to be known as the United States-Mexico Border Health Commission.

SEC. 3302. DUTIES.

It should be the duty of the Commission—

(1) to conduct a comprehensive needs assessment in the United States-Mexico border area for the purposes of identifying, evaluating, preventing, and resolving health problems that affect the general population of the area;

(2) to implement the actions recommended by the needs assessment by—

(A) assisting in the coordination of the efforts of public and private entities to prevent and resolve such health problems,

(B) assisting in the coordination of the efforts of public and private entities to educate such population concerning such health problems, and

(C) assisting in the development and implementation of programs to prevent and resolve such health problems and (where necessary) to educate such population concerning such health programs; and

(3) to formulate recommendations to the Governments of the United States and Mexico concerning a fair and reasonable method by which the government of one country would reimburse a public or private entity in the other country for the cost of a health care service that the entity furnishes to a citizen of the first country who is unable, through insurance or otherwise, to pay for the service.

SEC. 3303. OTHER AUTHORIZED FUNCTIONS.

In addition to the duties described in section 3302, the Commission should be authorized to perform the following additional functions as the Commission determines to be appropriate:

(1) To conduct or sponsor investigations, research, or studies designed to identify, study, and monitor health problems that affect the general population in the United States-Mexico border area.

(2) To provide financial, technical, or administrative assistance to public or private entities who act to prevent, resolve, or educate such population concerning such health problems.

SEC. 3304. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT OF UNITED STATES SECTION.—The United States section of the Commission should be composed of 13 members. The section should consist of the following members:

(1) The Secretary of Health and Human Services or such individual's delegate.

(2) The commissioners of health from the States of Texas, New Mexico, California, and Arizona or such individuals' delegates.

(3) 2 individuals from each of the States of Texas, New Mexico, California, and Arizona who are nominated by the chief executive officer of one of such States and are appointed by the President from among individuals who have demonstrated ties to community-based organizations and have a demonstrated interest in health issues of the United States-Mexico border area.

(b) COMMISSIONER.—The Commissioner of the United States section of the Commission should be the Secretary of Health and Human Services or such individual's delegate to the Commission. The Commissioner should be the leader of the section.

SEC. 3305. REGIONAL OFFICES.

The Commission should establish no fewer than 2 regional border offices in locations selected by the Commission.

SEC. 3306. REPORTS.

Not later than February 1 of each year that occurs more than 1 year after the date of the establishment of the Commission, the Commission should submit an annual report to both the United States Government and the Government of Mexico regarding all activities of the Commission during the preceding calendar year.

SEC. 3307. DEFINITIONS.

For purposes of this subtitle:

(1) COMMISSION.—The term "Commission" means the United States-Mexico Border Health Commission authorized in section 3301.

(2) HEALTH PROBLEM.—The term "health problem" means a disease or medical ailment or an environmental condition that poses the risk of disease or medical ailment. The term includes diseases, ailments, or risks of disease or ailment caused by or related to environmental factors, control of animals and rabies, control of insect and rodent vectors, disposal of solid and hazardous waste, and control and monitoring of air and water quality.

(3) UNITED STATES-MEXICO BORDER AREA.—The term "United States-Mexico border area" means the area located in the United

States and Mexico within 100 kilometers of the border between the United States and Mexico.

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Sec. 4208. Nurse allied health project grants and contracts.
Sec. 4209. Nurse practitioner and nurse midwife programs.

Subtitle A—Performance Measures for Quality Assurance

SEC. 4001. HEALTH QUALITY ADVISORY COUNCIL.

(a) ESTABLISHMENT.—The Secretary shall provide for the establishment of an advisory council to be known as the "Health Quality Advisory Council" (in this subtitle referred to as the "Council").

(b) DUTIES.—

(1) INITIAL PERFORMANCE MEASURES.—

(A) DEVELOPMENT.—The Council shall develop an initial set of performance measures to be used to assess the quality of health plans. The performance measures shall include measures that provide information with respect to a health plan on the following subjects:

(i) Outcomes of care for specified medical conditions.

(ii) Health status of enrollees.

(iii) Health promotion activities.

(iv) Prevention of diseases, disorders, disabilities, injuries, and other adverse health conditions.

(v) Risk management and reduction.

(vi) Consumer satisfaction with the plan, services, providers, and care provided.

(B) RECOMMENDATIONS.—Not later than the date that is 9 months from the date of the enactment of this Act, the Council shall recommend to the Secretary the initial set of measures developed under subparagraph (A), along with a recommended schedule for phasing in the assessment of health plans using the measures.

(2) UPDATING MEASURES.—The Council shall make recommendations to the Secretary with respect to updating, as additional health care data with respect to health plans becomes valid and available, any set of performance measures selected by the Secretary under section 4002.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Council shall be voting members, other than officials designated under paragraph (3)(B) as ex officio members of the Council.

(2) APPOINTED MEMBERS.—The Secretary shall appoint to the Council 9 appropriately qualified individuals who are not officers or employees of the United States. Members appointed under this paragraph shall include—

(A) individuals distinguished in the field of health outcomes;

(B) representatives of health plans;

(C) health care providers; and

(D) consumers of health care.

(3) EX OFFICIO MEMBERS.—The Secretary shall designate as ex officio members of the Council the Director of the National Institutes of Health, the Director of the Centers for Disease Control, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), and the Chief Medical Officer of the Department of Veterans Affairs.

(d) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council appointed under subsection (c)(2) shall serve for a term of 3 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (c)(2), the Secretary shall appoint 3 members to serve for a term of 3 years, 3 members to serve for a term of 2 years, and 3 members to serve for a term of 1 year.

(3) SERVICE BEYOND TERM.—A member of the Council appointed under subsection (c)(2) may continue to serve after the expiration of the term of the member until a successor is appointed.

(e) VACANCIES.—If a member of the Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

(f) CHAIR.—The Secretary shall, from among the members of the Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Council.

(g) MEETINGS.—The Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Administrator or the chair.

(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

(1) APPOINTED MEMBERS.—Members of the Council appointed under subsection (c)(2) shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS-18 of the General Schedule.

(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Council may not receive compensation for service on the Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

(i) STAFF.—The Secretary shall provide to the Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

(j) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the Council shall continue in existence until otherwise provided by law.

SEC. 4002. ASSESSMENT OF HEALTH PLANS USING PERFORMANCE MEASURES.

(a) SELECTION OF INITIAL PERFORMANCE MEASURES.—

(1) EVALUATION OF RECOMMENDATIONS.—If the Council recommends an initial set of performance measures and an implementation schedule to the Secretary not later than the deadline in section 4001(b)(1)(B), the Secretary shall evaluate the set and schedule to determine whether they will provide for effective measurement of the quality of health plans. The Secretary shall complete such evaluation not later than the date that is 90 days from the date on which the Secretary receives the recommendations of the Council.

(2) MODIFICATION.—Prior to the initiation of the rule making under paragraph (3), the Secretary may modify the recommended set of performance measures, or the implementation schedule with respect to the set, as the Secretary determines appropriate from the evaluation under paragraph (1).

(3) RULE MAKING.—After notice and opportunity for public comment, the Secretary shall promulgate a rule that—

(A) establishes an initial set of performance measures and a schedule for phasing in the assessment of health plans using the measures;

(B) specifies the amount and nature of the data that health plans will be required to transmit under subsection (b) in order to permit States to conduct assessments under the subsection; and

(C) specifies the frequency with which, and the method by which, such data will be required to be transmitted.

(b) ASSESSMENT OF COMPLIANCE BY STATES.—

(1) DATA TRANSMISSION.—A health plan shall transmit to a State the data determined to be necessary by the Secretary under subsection (a)(3).

(2) ASSESSMENT.—Each State shall assess the completeness, accuracy, and validity of the data supplied by each health plan offered in the State. A State may satisfy this requirement by entering into a contract or other agreement with any appropriate individual or entity.

(3) ENSURING COMPLIANCE.—A State may take appropriate action to ensure compliance by health plans offered in the State with the requirements of paragraph (1). Such action may include the imposition of a penalty on a health plan that transmits incomplete, false, or misleading data to the State.

(4) PUBLICATION OF RESULTS.—Each health plan shall publish a report on the performance measures as required and shall send the report to employers, brokers, health plan purchasing organizations, and consumers in its service area.

(c) UPDATING MEASURES.—The Secretary, after receiving the recommendations of the Council and after notice and opportunity for public comment, may update a set of performance measures or an implementation schedule established under this section.

Subtitle B—Primary Care Provider Education

SEC. 4101. AREA HEALTH EDUCATION CENTERS.

Section 746(i)(1)(A) of the Public Health Service Act (42 U.S.C. 293j(i)(1)(A)) is amended by striking "through 1995" and inserting "through 1994 and $30,000,000 for each of the fiscal years 1995 through 1999".

SEC. 4102. PUBLIC HEALTH AND PREVENTIVE MEDICINE.

Section 765(a) of the Public Health Service Act (42 U.S.C. 294c(a)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4103. FAMILY MEDICINE.

Section 747(d)(1) of the Public Health Service Act (42 U.S.C. 293k(d)(1)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4104. GENERAL INTERNAL MEDICINE AND PEDIATRICS.

Section 748(c) of the Public Health Service Act (42 U.S.C. 293l(c)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4105. PHYSICIAN ASSISTANTS.

Section 750(d)(1) of the Public Health Service Act (42 U.S.C. 293n(d)(1)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4106. ALLIED HEALTH PROJECT GRANTS AND CONTRACTS.

Section 767(d) of the Public Health Service Act (42 U.S.C. 294e(d)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4107. NURSE PRACTITIONER AND NURSE MIDWIFE PROGRAMS.

Section 822(d) of the Public Health Service Act (42 U.S.C. 296m(d)) is amended by striking "and 1994" and inserting "through 1999".

Subtitle C—Other Medical Education Grants and Programs

SEC. 4201. SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS OF NATIONAL HEALTH SERVICE CORPS.

Section 338H(b)(1) of the Public Health Service Act (42 U.S.C. 254q(b)(1)) is amended—

(1) by striking "and" after "1991,"; and

(2) by striking "through 2000." and inserting "through 1994, $150,000,000 for fiscal year 1995, $175,000,000 for fiscal year 1996, $200,000,000 for fiscal year 1997, $225,000,000 for fiscal year 1998, and $250,000,000 for fiscal year 1999.".

SEC. 4202. AREA HEALTH EDUCATION CENTERS.

Section 746(i)(1)(A) of the Public Health Service Act (42 U.S.C. 293j(i)(1)(A)) is amended by striking "through 1995" and inserting "through 1994 and $30,000,000 for each of the fiscal years 1995 through 1999".

SEC. 4203. PUBLIC HEALTH AND PREVENTIVE MEDICINE.

Section 765(a) of the Public Health Service Act (42 U.S.C. 294c(a)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4204. FAMILY MEDICINE.

Section 747(d)(1) of the Public Health Service Act (42 U.S.C. 293k(d)(1)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4205. GENERAL INTERNAL MEDICINE AND PEDIATRICS.

Section 748(c) of the Public Health Service Act (42 U.S.C. 293l(c)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4206. PHYSICIAN ASSISTANTS.

Section 750(d)(1) of the Public Health Service Act (42 U.S.C. 293n(d)(1)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4207. ALLIED HEALTH PROJECT GRANTS AND CONTRACTS.

Section 767(d) of the Public Health Service Act (42 U.S.C. 294e(d)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4208. NURSE ALLIED HEALTH PROJECT GRANTS AND CONTRACTS.

Section 767(d) of the Public Health Service Act (42 U.S.C. 294e(d)) is amended by striking "through 1995" and inserting "through 1999".

SEC. 4209. NURSE PRACTITIONER AND NURSE MIDWIFE PROGRAMS.

Section 822(d) of the Public Health Service Act (42 U.S.C. 296m(d)) is amended by striking "and 1994" and inserting "through 1999".

TITLE V—MARKET INCENTIVES TO CONTAINING COSTS

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Subtitle A—Facilitating Establishment of Health Plan Purchasing Organization (HPPOs) and Health Risk Pools

PART 1—HEALTH PLAN PURCHASING ORGANIZATIONS

SEC. 5001. ESTABLISHMENT AND ORGANIZATION.

(a) IN GENERAL.—Health plan purchasing organizations (each in this part referred to as a "purchasing organization") may be established in accordance with this part. Each purchasing organization shall be chartered under State law and operated as a not-for-profit corporation. A carrier may not form, underwrite, or possess a majority vote of a purchasing organization, but may administer such an organization.

(b) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each purchasing organization shall be governed by a Board of Directors. Such Board shall initially be appointed under procedures established by the State in which it operates. Subsequently, the Board shall be elected by the members of the organization in accordance with paragraph (3). Such Board shall be composed of individuals who are small employers (or representatives of small employers), eligible employees of small employers (or representatives of such employees), and qualifying individuals in the area in which the organization operates.

(2) MEMBERSHIP.—A purchasing organization shall accept all small employers and eligible employees and other individuals who are in the individual or small employer market sector within the area served by the organization as members if such employers, employees, or individuals request such membership.

(3) VOTING.—Members of a purchasing organization shall have voting rights consistent with the rules established under the bylaws governing the organization.

(c) DUTIES OF PURCHASING ORGANIZATIONS.—

(1) IN GENERAL.—Subject to paragraph (2), each purchasing organization shall—

(A) market health insurance coverage to members throughout the entire area served by the organization;

(B) enter into agreements under section 5002 with carriers offering qualified health coverage under this subtitle;

(C) enter into agreements with small employers under section 5003;

(D) enroll individuals with carriers offering qualified health coverage, only in accordance with section 5004; and

(E) carry out other functions provided for under this part.

(2) LIMITATION ON ACTIVITIES.—A purchasing organization shall not—

(A) perform any activity (including review, approval, or enforcement) relating to payment rates for providers;

(B) perform any activity (including certification or enforcement) relating to compliance of carriers (and health coverage provided by carriers) with the requirements of subtitle A of title I;

(C) assume financial risk in relation to any such carrier; or

(D) perform other activities identified by the State as being inconsistent with the performance of its duties under paragraph (1).

(3) CHARACTERISTICS OF SERVICE AREA.—

(A) IN GENERAL.—A purchasing organization need not serve areas that are contiguous, but the geographic boundaries of such areas shall be consistent with the boundaries established under section 1021 for geographic areas used in establishing premium rates in the individual and small group market sectors.

(B) SERVICE OF ENTIRE METROPOLITAN STATISTICAL AREA.—If a purchasing organization serves a part of a metropolitan statistical area the organization shall serve the entire area.

(d) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

(1) that a purchasing organization be established in each area of a State in which it operates; and

(2) that there be only one purchasing organization established with respect to any area.

SEC. 5002. AGREEMENTS TO OFFER QUALIFIED HEALTH COVERAGE.

(a) AGREEMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (3), each purchasing organization for an area shall enter into an agreement under this section with each carrier that desires to provide qualified health coverage to be made available through the purchasing organization (consistent with any procedures established by the State).

(2) TERMINATION OF AGREEMENT.—An agreement under paragraph (1) shall remain in effect for a 12-month period, except that the purchasing organization may terminate an agreement under paragraph (1) if the carrier's license or certification under State law is terminated or for other good cause shown.

(3) LIMITATION ON RENEWAL OF AGREEMENTS.—Subsequent to the 12-month period described in paragraph (2), a purchasing organization may—

(A) refuse to enter into a subsequent agreement with a carrier if the organization determines that the number of enrollees or the premium for coverage is too low, and

(B) if a previous agreement with a carrier was terminated for good cause and the organization determines appropriate actions have not been taken to correct the problems, refuse to enter into a subsequent agreement with the carrier.

(b) RECEIPT OF PREMIUMS ON BEHALF OF CARRIERS.—

(1) IN GENERAL.—Under an agreement under this section between a purchasing organization and a carrier—

(A) premiums shall be payable, and

(B) payment of premiums may be made by individuals (or employers on their behalf) directly to the purchasing organization for the benefit of the carrier.

(2) TIMING OF PAYMENT OF PREMIUMS.—Premiums may be payable on a monthly basis (or, at the option of an eligible employee or individual, on a quarterly basis). The purchasing organization may provide for reasonable penalties and grace periods for late payment.

(3) CARRIERS RETAIN RISK OF NONPAYMENT.—Nothing in this subsection shall be construed as placing upon a purchasing organization any risk associated with the failure of individuals and employers to make prompt payment of premiums (other than the portion of the premium representing the purchasing organization administrative fee under section 5005). Each small employer and qualifying individual who enrolls with a carrier providing qualified health coverage through the purchasing organization is liable to the carrier for premiums.

(c) FORWARDING OF PREMIUMS.—

(1) IN GENERAL.—If, under an agreement under subsection (a), premium payments for qualified health coverage are made to the purchasing organization, the purchasing organization shall forward to the carrier the amount of the premiums.

(2) PAYMENTS.—Payments shall be made by the purchasing organization under this subsection within a period of days (specified by the Secretary and not to exceed 7 days) after receipt of the premium from the small employer of the eligible employee or the qualifying individual, as the case may be.

SEC. 5003. PROVISION OF INFORMATION.

(a) IN GENERAL.—Each purchasing organization for an area shall make available to small employers that employ individuals in the area and to qualifying individuals who reside in the area—

(1) information provided to the purchasing organization by the State or carriers, and

(2) the opportunity to enter into an agreement with the organization for the purchase of qualified health coverage.

(b) FORWARDING INFORMATION AND PAYROLL DEDUCTIONS.—As part of an agreement entered into under this section, a small employer shall forward the information and make the payroll deductions required under section 1201(a).

SEC. 5004. ENROLLING ELIGIBLE EMPLOYEES AND QUALIFYING INDIVIDUALS FOR QUALIFIED HEALTH COVERAGE THROUGH A PURCHASING ORGANIZATION.

A purchasing organization shall offer, on behalf of each carrier with which an agreement was entered into under section 5002 and in accordance with the enrollment procedures of such carriers and the open enrollment periods provided under 1005, enrollment for the coverage only to—

(1) all eligible employees employed by small employers in the area served by the purchasing organization; and

(2) all qualifying individuals residing in such area.

SEC. 5005. RESTRICTION ON CHARGES.

(a) IN GENERAL.—A purchasing organization may impose an administrative fee with respect to an eligible employee or qualifying individual enrolled for qualified health coverage offered through the purchasing organization.

(b) FEE.—A purchasing organization that elects to impose a fee under subsection (a) shall ensure that such fee is set as a percentage of the premium for each such coverage option, is imposed uniformly with respect to all coverage options offered through the organization, and is disclosed explicitly as an addition to the premium.

SEC. 5006. STATE REPORT ON ESTABLISHMENT OF PURCHASING ORGANIZATIONS.

(a) IN GENERAL.—Not later than January 1, 2000, each State shall conduct a review of access of residents of the State who are not employees of large employers or medicare beneficiaries to obtaining standard health insurance coverage through a purchasing organization.

(b) RESPONSE.—If the State determines, based on such review, that such residents are unable to obtain such coverage through such an organization, the State shall take such actions as the State determines appropriate to ensure public or private entities provide access to such an organization by such residents.

PART 2—SMALL EMPLOYER POOLING ARRANGEMENTS

SEC. 5011. SMALL EMPLOYER POOLING ARRANGEMENTS.

(a) REQUIREMENTS FOR SEPAS APPLICABLE WHERE SIGNIFICANT NUMBER OF SMALL EMPLOYERS PARTICIPATE.—In any case in which coverage is provided for the current plan year under a multiple employer health plan and more than 10 percent of the participating employers in the arrangement are small employers (as defined in section 1902), the entity sponsoring such arrangement shall ensure that such arrangement is maintained for such year in the form of a small employer pooling arrangement.

(b) REQUIREMENTS FOR SMALL EMPLOYER POOLING ARRANGEMENTS.—For purposes of this title, an arrangement is maintained in the form of a small employer pooling arrangement for any applicable fiscal year, if—

(1) the benefits under the arrangement consist solely of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (disregarding such incidental benefits as the Secretary of Labor shall specify by regulations),

(2) the general requirements of subsection (c) are met with respect to the arrangement, and

(3) the following requirements are met with respect to the arrangement:

(A) in the case of an arrangement under which all coverage is fully-insured, the requirements of subsection (d) are met with respect to carriers providing coverage under the arrangement, or

(B) in the case of an arrangement under which some or all coverage is not fully-insured, the arrangement constitutes an exempted multiple employer health plan, and the requirements of subsection (e) are met with respect to the arrangement.

(c) GENERAL REQUIREMENTS.—The general requirements of this subsection with respect to a multiple employer welfare arrangement are the following:

(1) REQUIRED COVERAGE.—The coverage provided under the arrangement consists of at least the forms of health coverage required to be offered by employers under section 1201(a)(2).

(2) APPLICABILITY OF CERTAIN HEALTH INSURANCE MARKETPLACE REFORMS.—The coverage provided under the arrangement complies with the requirements of sections 1003 through 1005.

(3) EMPLOYEE AND INDIVIDUAL ELIGIBILITY.—Under the arrangement, each eligible employee and each qualifying individual with respect to each participating employer is made eligible for coverage required under this section.

(d) REQUIREMENTS FOR ARRANGEMENTS PROVIDING SELF-INSURED COVERAGE.—

(1) IN GENERAL.—The requirements of this subsection with respect to a multiple employer welfare arrangement under which some or all coverage is not fully-insured are (in addition to the requirements for exempted multiple employer welfare arrangements under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (added by this Act)) the following:

(A) the arrangement meets the requirements of section 1002 (relating to guaranteed issue), irrespective of the type coverage provided, as if the arrangement were a carrier,

(B) the arrangement meets the requirements of sections 1021 and 1022 (relating to premiums), as if the arrangement were a carrier, and

(C) the arrangement participates in any risk adjustment mechanisms established under section 1024, and

(D) under the arrangement, with respect to all participating employers as of the beginning of each plan year, the total number of eligible employees is not less than 100.

(2) REQUIRED SCOPE OF ELIGIBILITY FOR PARTICIPATING EMPLOYERS.

(A) IN GENERAL.—Under the terms of the written instruments governing the arrangement, all restrictions on the eligibility of employers to be participating employers in the arrangement are specifically set forth and consist solely of criteria described in subparagraph (B), and all employers with respect to whom such criteria are met may be participating employers. No such restrictions under the arrangement shall be considered enforceable unless they are so specified.

(B) CRITERIA FOR RESTRICTIONS ON PARTICIPATING EMPLOYERS.—The terms of the arrangement shall define restrictions on eligibility of employers to be participating employers only by reference to one or more of the following criteria:

(i) Participating employers are restricted to those located in one or more specified geographic locations.

(ii) Participating employers are restricted to those who are (or whose owners, officers, or employees are) members of one or more trade associations, industry associations, professional associations, or chambers of commerce (or similar business groups).

(iii) Participating employers are restricted to those who are otherwise related by specified supply contracts, franchise arrangements, or common ownership interests.

(iv) Participating employers are restricted to employers whose employees are covered under one or more specified collective bargaining agreements.

(e) REFERENCE TO LIMITATION ON SELF-INSURANCE BY SMALL EMPLOYERS.—For restriction on self-insurance by small employers, see section 1055.

PART 3—ENCOURAGEMENT OF MULTIPLE EMPLOYER ARRANGEMENTS PROVIDING BASIC HEALTH BENEFITS

SEC. 5021. ELIMINATING COMMONALITY OF INTEREST OR GEOGRAPHIC LOCATION REQUIREMENT FOR TAX EXEMPT TRUST STATUS.

(a) IN GENERAL.—Paragraph (9) of section 501(c) of the Internal Revenue Code of 1986 (relating to exempt organizations) is amended—

(1) by inserting "(A)" after "(9)"; and

(2) by adding at the end the following:

"(B) Any determination of whether a multiple employer health plan (as defined in section 701(10) of the Employee Retirement Income Security Act of 1974) or an insured multiple employer health plan (as defined in section 701(11) of such Act) is a voluntary employees' beneficiary association meeting the requirements of this paragraph shall be made without regard to any determination of commonality of interest or geographic location if—

"(i) such plan provides at least standard coverage (consistent with section 1102 of the Bipartisan Health Care Reform Act of 1994), and

"(ii) in the case of an insured multiple employer health plan, it meets the requirements enforceable under section 514(b)(6)(B)(i) of the Employee Retirement Income Security Act of 1974 to the extent not preempted by section 5104 of the Bipartisan Health Care Reform Act of 1994.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to determinations made on or after January 1, 1996.

PART 4—TAX EXEMPTION FOR HIGH RISK POOLS

SEC. 5031. TAX EXEMPTION FOR HIGH RISK INSURANCE POOLS.

(a) IN GENERAL.—Subsection (c) of section 501 of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

"(27) In the case of taxable years beginning before January 1, 1997, any corporation, association, or similar legal entity which is created by any State or political subdivision thereof to establish a risk pool to provide health insurance coverage to any person unable to obtain health insurance coverage in the private insurance market because of health conditions and no part of the net earnings of which inures to the benefit of any private shareholder, member, or individual."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1989.

Subtitle B—Preemption of State Benefit Mandates and Anti-Managed Care Laws

SEC. 5101. PREEMPTION FROM STATE BENEFIT MANDATES.

Effective as of January 1, 1997, no State shall establish or enforce any law or regulation that—

(1) requires the offering, as part of health insurance coverage, of any services, category of care, or services of any class or type of provider; or

(2) specifies the individuals to be provided health insurance coverage or the duration of such coverage.

SEC. 5102. PREEMPTION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.

(a) LIMITATION ON RESTRICTIONS ON NETWORK PLANS.—Effective as of January 1, 1997—

(1) a State may not prohibit or limit a carrier or group health plan providing health coverage from including incentives for enrollees to use the services of participating providers;

(2) a State may not prohibit or limit such a carrier or plan from limiting coverage of services to those provided by a participating provider;

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers by such a carrier or plan with respect to health coverage;

(4) a State may not prohibit or limit such a carrier or plan from limiting the number of participating providers;

(5) a State may not prohibit or limit such a carrier or plan from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers; and

(6) a State may not prohibit or limit the corporate practice of medicine.

(b) DEFINITIONS.—In this section:

(1) MANAGED CARE COVERAGE.—The term "managed care coverage" means health coverage to the extent the coverage is provided through a managed care arrangement (as defined in section 1903(11)(A)) that meets the applicable requirements of such section.

(2) PARTICIPATING PROVIDER.—The term "participating provider" means an entity or individual which provides, sells, or leases health care services as part of a provider network (as defined in section 1903(11)(B)).

(c) REFERENCE TO STANDARDS FOR MANAGED CARE ARRANGEMENTS.—For requirements relating to managed care arrangements, see section 1011.

SEC. 5103. PREEMPTION OF STATE LAWS RESTRICTING UTILIZATION REVIEW PROGRAMS.

(a) IN GENERAL.—Effective January 1, 1997, no State law or regulation shall prohibit or regulate activities under a utilization review program (as defined in subsection (b)).

(b) UTILIZATION REVIEW PROGRAM DEFINED.—In this section, the term "utilization review program" means a system of reviewing the medical necessity and appropriateness of patient services (which may include inpatient and outpatient services) using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

SEC. 5104. PROHIBITION OF PROVISIONS PROHIBITING EMPLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.

No provision of State or local law shall apply that prohibits 2 or more employers from obtaining coverage under an insured multiple employer health plan.

SEC. 5105. PREEMPTION RELATING TO DIFFERENT INSURANCE STANDARDS.

A State may not establish or enforce standards for health insurance coverage made available in the individual and small group markets that are different from the standards established under title I.

SEC. 5106. GAO STUDY ON MANAGED CARE.

(a) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effectiveness of the use of managed care in the delivery of health services.

(b) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under subsection (a) and shall include in the report such recommendations as may be appropriate.

Subtitle C—Malpractice Reform

PART 1—UNIFORM STANDARDS FOR MALPRACTICE CLAIMS

SEC. 5201. APPLICABILITY.

Except as provided in section 5221, this part shall apply to any medical malpractice liability action brought in a Federal or State court, and to any medical malpractice claim subject to an alternative dispute resolution system, that is initiated on or after January 1, 1996.

SEC. 5202. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 5212(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section 5222(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in any Federal court under section 1332 of title 28, United States Code, during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system referred to in paragraph (1) that applied in the State whose law applies in such action.

(3) CLAIMS AGAINST UNITED STATES.—

(A) ESTABLISHMENT OF PROCESS FOR CLAIMS.—The Attorney General shall establish an alternative dispute resolution process for the resolution of tort claims consisting of medical malpractice liability claims brought against the United States under chapter 171 of title 28, United States Code. Under such process, the resolution of a claim shall occur after the completion of the administrative claim process applicable to the claim under section 2675 of such title.

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A) may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process established by the Attorney General under such subparagraph.

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is "initially resolved" under an alternative dispute resolution system if—

(1) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

(2) if the ADR determines that the defendant is liable, the ADR reaches a decision on the amount of damages assessed against the defendant.

(c) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice liability claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

(2) DEADLINE FOR FILING ACTION.—A medical malpractice liability action may not be brought by a party unless—

(A) the party has filed the notice of intent required by paragraph (1); and

(B) the party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term "court of competent jurisdiction" means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court. The previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (c)(1).

SEC. 5203. OPTIONAL APPLICATION OF PRACTICE GUIDELINES.

(a) DEVELOPMENT AND CERTIFICATION OF GUIDELINES.—Each State may develop, for certification by the Secretary, a set of specialty clinical practice guidelines, based on recommended guidelines developed by the Agency for Health Care Policy and Research.

(b) PROVISION OF HEALTH CARE UNDER GUIDELINES.—Notwithstanding any other provision of law, in any medical malpractice liability action arising from the conduct of a health care provider or health care professional, if such conduct was in accordance with a guideline developed by the State in which the conduct occurred and certified by the Secretary under subsection (a), the guideline—

(1) may be introduced by any party to the action (including a health care provider, health care professional, or patient); and

(2) if introduced, shall establish a rebuttable presumption that the conduct was in accordance with the appropriate standard of medical care, which may only be overcome by the presentation of clear and convincing evidence on behalf of the party against whom the presumption operates.

SEC. 5204. TREATMENT OF NONECONOMIC AND PUNITIVE DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant and the members of the claimant's family for losses resulting from the injury which is the subject of a medical malpractice liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(b) NO AWARD OF PUNITIVE DAMAGES AGAINST MANUFACTURER OF MEDICAL PRODUCT.—In the case of a medical malpractice liability action in which the plaintiff alleges a claim against the manufacturer of a medical product, no punitive or exemplary damages may be awarded against such manufacturer.

(c) JOINT AND SEVERAL LIABILITY FOR NONECONOMIC DAMAGES.—The liability of each defendant for noneconomic damages shall be several only and shall not be joint, and each defendant shall be liable only for the amount of noneconomic damages allocated to the defendant in direct proportion to the defendant's percentage of responsibility (as determined by the trier of fact).

(d) USE OF PUNITIVE DAMAGE AWARDS FOR OPERATION OF ADR SYSTEMS IN STATES.—

(1) IN GENERAL.—The total amount of any punitive damages awarded in a medical malpractice liability action shall be paid to the State in which the action is brought (or, in a case brought in Federal court, in the State in which the health care services that caused the injury that is the subject of the action were provided), and shall be used by the State solely to implement and operate the State alternative dispute resolution system certified by the Secretary under section 5222 (except as provided in paragraph (2)).

(2) USE OF REMAINING AMOUNTS FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVITIES.—If the amount of punitive damages paid to a State under paragraph (1) for a year is greater than the State's costs of implementing and operating the State alternative dispute resolution system during the year, the balance of such punitive damages paid to the State shall be used solely to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

(A) licensing or certifying health care professionals and health care providers in the State; and

(B) carrying out programs to reduce malpractice-related costs for providers volunteering to provide services in medically underserved areas.

(3) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to paragraph (1) to supplement and not to replace amounts spent by the State for implementing and operating the State alternative dispute resolution system or carrying out the activities described in paragraph (2).

SEC. 5205. PERIODIC PAYMENTS FOR FUTURE LOSSES.

(a) IN GENERAL.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but may be permitted to make such payments on a periodic basis. The periods for such payments shall be determined by the court, based upon projections of when such expenses are likely to be incurred.

(b) WAIVER.—A court may waive the application of subsection (a) with respect to a defendant if the court determines that it is not in the best interests of the plaintiff to receive payments for damages on such a periodic basis.

SEC. 5206. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(1) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to section 5202(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim under the alternative dispute resolution system), but only if—

(A) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action is less than the amount of damages awarded to the party under the ADR system; and

(B) in the case of an action in which the party that contested the ruling is the defendant, the amount of damages assessed against the party under the action is greater than the amount of damages assessed under the ADR system.

(2) EXCEPTIONS.—Paragraph (1) shall not apply if—

(A) the party contesting the ruling made under the previous alternative dispute resolution system shows that—

(i) the ruling was procured by corruption, fraud, or undue means,

(ii) there was partiality or corruption under the system,

(iii) there was other misconduct under the system that materially prejudiced the party's rights, or

(iv) the ruling was based on an error of law;

(B) the party contesting the ruling made under the alternative dispute resolution system presents new evidence before the trier of fact that was not available for presentation under the ADR system;

(C) the medical malpractice liability action raised a novel issue of law; or

(D) the court finds that the application of such paragraph to a party would constitute an undue hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(3) LIMIT ON ATTORNEY'S FEES PAID.—Attorneys' fees that are required to be paid under paragraph (1) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency fee agreement, the amount of attorneys' fees for purposes of the preceding sentence shall not exceed the reasonable value of those services.

(4) RECORDS.—In order to receive attorneys' fees under paragraph (1), counsel of record in the medical malpractice liability action involved shall maintain accurate, complete records of hours worked on the action, regardless of the fee arrangement with the client involved.

(b) CONTINGENCY FEE DEFINED.—As used in this section, the term "contingency fee" means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 5207. UNIFORM STATUTE OF LIMITATIONS.

(a) IN GENERAL.—No medical malpractice claim may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of such claim was discovered, but in no event may such a claim be initiated after the expiration of the 4-year period that begins on the date on which the alleged injury that is the subject of such claim occurred.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, a medical malpractice claim may not be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of such claim was discovered or should reasonably have been discovered, but in no event may such a claim be initiated after the date on which the minor attains 12 years of age.

SEC. 5208. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IN GENERAL.—In the case of a medical malpractice claim relating to services provided during labor or the delivery of a baby, if the health care professional or health care provider against whom the claim is brought did not previously treat the claimant for the pregnancy, the trier of fact may not find that such professional or provider committed malpractice and may not assess damages against such professional or provider unless the malpractice is proven by clear and convincing evidence.

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another professional.

SEC. 5209. UNIFORM STANDARD FOR DETERMINING LIABILITY IN ACTIONS BASED ON NEGLIGENCE.

(a) STANDARD OF REASONABLENESS.—Except as provided in subsection (b), a defendant in a medical malpractice liability action may not be found to have committed malpractice unless the defendant's conduct at the time of providing the health care services that are the subject of the action was not reasonable.

(b) ACTIONS BROUGHT UNDER STRICT LIABILITY.—Subsection (a) shall not apply with respect to a medical malpractice action if (in accordance with applicable State law) the theory of liability upon which the action is based is a theory of strict liability.

SEC. 5210. JURISDICTION OF FEDERAL COURTS.

Nothing in this part shall be construed to establish any jurisdiction over any medical malpractice liability action in the district courts of the United States on the basis of sections 1331 or 1337 of title 28, United States Code.

SEC. 5211. PREEMPTION.

(a) IN GENERAL.—The provisions of this part shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this part shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this part, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this part.

(b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this part shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground in inconvenient forum.

PART 2—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS (ADR)

SEC. 5221. BASIC REQUIREMENTS.

(a) IN GENERAL.—A State's alternative dispute resolution system meets the requirements of this section if the system—

(1) applies to all medical malpractice liability claims under the jurisdiction of the courts of that State;

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

(5) with respect to a State system that consists of multiple dispute resolution procedures—

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or

provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator for Health Care Policy and Research of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of part 1 (other than section 5202) shall apply with respect to claims brought under a State alternative dispute resolution system or the alternative Federal system in the same manner as such provisions apply with respect to medical malpractice liability actions brought in the State.

SEC. 5222. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) IN GENERAL.—Not later than October 1 of each year (beginning with 1995), the Secretary, in consultation with the Attorney General, shall determine whether a State's alternative dispute resolution system meets the requirements of this part for the following calendar year.

(2) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection for a calendar year if the Secretary determines under paragraph (1) that the system meets the requirements of section 5221, including the requirement described in section 5204 that punitive damages awarded under the system are paid to the State for the uses described in such section.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1995, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 5221(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims brought under the system shall be heard and resolved by arbitrators appointed by the Secretary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year, the State shall make a payment to the United States (at such time and in such manner as the Secretary may require) in an amount equal to 110 percent of the costs incurred by the United States during the year as a result of the application of the system with respect to the State.

SEC. 5223. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this part and the alternative Federal system established under section 5222(b).

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

(A) the effect of the alternative dispute resolution systems on the cost of health care within each State,

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within the State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which medical malpractice liability claims shall be resolved on a no-fault basis.

PART 3—DEFINITIONS

SEC. 5231. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM.—The term "alternative dispute resolution system" means a system that is enacted or adopted by a State to resolve medical malpractice claims other than through a medical malpractice liability action.

(2) CLAIMANT.—The term "claimant" means any person who brings a health care liability action and, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such an action is brought.

(3) CLEAR AND CONVINCING EVIDENCE.—The term "clear and convincing evidence" is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

(4) ECONOMIC DAMAGES.—The term "economic damages" means damages paid to compensate an individual for losses for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(5) HEALTH CARE PROFESSIONAL.—The term "health care professional" means any individual who provides health care services in a State and who is required by State law or regulation to be licensed or certified by the State to provide such services in the State.

(6) HEALTH CARE PROVIDER.—The term "health care provider" means any organization or institution that is engaged in the delivery of health care services in a State that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(7) INJURY.—The term "injury" means any illness, disease, or other harm that is the subject of a medical malpractice claim.

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term "medical malpractice liability action" means any civil action brought pursuant to State law in which a plaintiff alleges a medical malpractice claim against a health care provider or health care professional, but does not include any action in which the plaintiff's sole allegation is an allegation of an intentional tort.

(9) MEDICAL MALPRACTICE CLAIM.—The term "medical malpractice claim" means any claim relating to the provision of (or the failure to provide) health care services or the use of a medical product, without regard to the theory of liability asserted, and includes any third-party claim, cross-claim, counterclaim, or contribution claim in a medical malpractice liability action.

(10) MEDICAL PRODUCT.—

(A) IN GENERAL.—The term "medical product" means, with respect to the allegation of a claimant, a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) if—

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect to the safety of the formulation or performance of the aspect of such drug or device which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term "medical product" shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(11) NONECONOMIC DAMAGES.—The term "noneconomic damages" means damages paid to compensate an individual for losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary losses, but does not include punitive damages.

(12) PUNITIVE DAMAGES.—The term "punitive damages" means compensation, in addition to compensation for actual harm suffered, that is awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

(13) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(14) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

Subtitle D—Paperwork Reduction and Administrative Simplification

SEC. 5301. PREEMPTION OF STATE "QUILL AND PEN" LAWS.

(a) IN GENERAL.—Any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form is deemed to be satisfied if the records are maintained in an electronic form that meets standards established by the Secretary under subsection (b).

(b) SECRETARIAL AUTHORITY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall issue regulations to carry out subsection (a). The regulations shall provide for an electronic substitute that is in the form of a unique identifier (assigned to each authorized individual) that serves the functional equivalent of a signature. The regulations may provide for such exceptions to subsection (a) as the Secretary determines to be necessary to prevent fraud and abuse, to prevent the illegal distribution of controlled substances, and in such other cases as the Secretary deems appropriate.

(c) EFFECTIVE DATE.—Subsection (a) shall take effect on the first day of the first month that begins more than 30 days after the date the Secretary issues the regulations referred to in subsection (b).

SEC. 5302. CONFIDENTIALITY OF ELECTRONIC HEALTH CARE INFORMATION.

(a) PROMULGATION OF REQUIREMENTS.—

(1) IN GENERAL.—The Secretary shall promulgate, and may modify from time to time, requirements to facilitate and ensure the uniform, confidential treatment of individually identifiable health information in electronic environments.

(2) DEFINITION.—For purposes of this subtitle, the term "individually identifiable health information" means information that—

(A) relates in any way to—

(i) the past, present, or future physical or mental health or condition or functional status of an individual;

(ii) the provision of health care to an individual; or

(iii) payment for the provision of such care; and

(B) identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(3) ITEMS TO BE INCLUDED.—The requirements under this subsection—

(A) shall provide for the preservation of confidentiality and privacy rights during the processes of electronic health care claims processing and payment;

(B) shall apply to the collection, storage, handling, and transmission (including initial and subsequent disclosures) of individually identifiable health care data in electronic form by all carriers, group health plans, and multiple employer welfare arrangements providing health coverage, public third-party payers, providers, and all other entities involved in the collection, storage, handling, or transmission of such information;

(C) may not apply to public health reporting required under State or Federal law;

(D) shall delineate protocols for securing electronic storage, processing, and transmission of individually identifiable health information;

(E) shall specify fair information practices that—

(i) create a proper balance between what individually identifiable health information an individual is expected to divulge to a record-keeping organization and what information the individual may obtain from such an organization;

(ii) minimize the extent to which individually identifiable health information is used against an individual; and

(iii) create and define obligations respecting the uses and disclosures that may be made of such information;

(F) shall require publication of a list of data banks containing individually identifiable health information;

(G) shall establish appropriate protections for highly sensitive individually identifiable health information (such as data concerning mental health, substance abuse, and communicable and genetic diseases);

(H) shall encourage the use of alternative dispute resolution mechanisms (where appropriate) to resolve disputes concerning the use and disclosure of individually identifiable health information;

(I) shall provide for the deletion of individually identifiable health information that is no longer needed to carry out the purpose for which the information was collected, or a related purpose; and

(J) shall specify an effective date for the requirements.

(4) CONSULTATION WITH WORKING GROUP.—In promulgating and modifying requirements under this subsection, the Secretary shall consult with a working group of knowledgeable individuals representing all interested parties (including carriers, group health plans, and multiple employer welfare arrangements, public third-party payers, providers, consumers, employers, information managers, and technical experts).

(5) DEADLINE.—The Secretary shall first promulgate requirements under this subsection by not later than 12 months after the date of the enactment of this Act.

(b) APPLICATION OF REQUIREMENTS.—

(1) STATE ENFORCEMENT OF SIMILAR REQUIREMENTS.—The requirements promulgated under subsection (a) shall not apply to individually identifiable health information in a State if—

(A) the State has applied to the Secretary for a determination that the State has in effect a law that provides for the application of requirements with respect to such information (and enforcement provisions with respect to such requirements) consistent with the requirements promulgated under subsection (a) and the enforcement provisions of subsection (d); and

(B) the Secretary determines that the State has such a law in effect.

(2) APPLICATION TO CURRENT INFORMATION.—The Secretary shall specify the extent to which (and manner in which) the requirements promulgated under subsection (a) shall apply to individually identifiable health information created or received before the effective date of the requirements.

(c) DEFENSE FOR PROPER DISCLOSURES.—An individual or entity that establishes that the individual or entity has disclosed individually identifiable health information in accordance with the requirements promulgated under subsection (a) has established a defense in an action brought under subsection (d) for improper disclosure of such information.

(d) PENALTIES FOR VIOLATIONS.—An individual or entity that receives, stores, handles, transmits, or discloses individually identifiable health information in violation of the requirements promulgated under this section shall be liable in a civil action to any person aggrieved by such violation for compensatory damages, appropriate equitable relief, and attorneys' fees (if appropriate), in accordance with regulations of the Secretary.

SEC. 5303. STANDARDIZATION OF ELECTRONIC RECEIPT AND TRANSMISSION OF CLAIMS AND ELIGIBILITY INFORMATION.

(a) GOALS.—The Secretary shall establish national goals, and time frames for such goals, respecting the progress to be made by the health care industry in eliminating unnecessary paperwork, and achieving appropriate standardization, consistent with the requirements promulgated under section 5302, in the areas of electronic—

(A) receipt and transmission of health care claims; and

(B) verification of eligibility for health coverage.

(b) CONTINGENT REQUIREMENTS.—If the Secretary determines that the health care industry has failed to meet the goals established under subsection (a) in the time frames established under such subsection, the Secretary shall promulgate (and may, from time to time, modify) standards and requirements to achieve such goals.

(c) CONSULTATION.—The Secretary shall conduct activities under this section in consultation with the American National Standards Institute, carriers, group health plans, and multiple employer welfare arrangements providing health coverage, public third-party payers, providers, and others.

SEC. 5304. USE OF UNIFORM HEALTH CLAIMS FORMS AND IDENTIFICATION NUMBERS.

(a) GOALS.—The Secretary shall establish national goals, and time frames for such goals, respecting the progress to be made by the health care industry in achieving uniformity—

(1) in the format and content of basic paper claims forms for health care coverage;

(2) in the use of common identification numbers for individuals, and common identification numbers for providers, to be used for all health-related purposes.

(b) CONTINGENT REQUIREMENTS.—If the Secretary determines that the health care industry has failed to meet the goals established under subsection (a) in the time frames established by the Secretary under such subsection, the Secretary shall promulgate (and may, from time to time, modify) standards and requirements to achieve such goals.

(c) CONSULTATION.—The Secretary shall conduct activities under this section in consultation with the Workgroup for Electronic Data Interchange and with carriers, group health plans, and multiple employer welfare arrangements providing health coverage, public third-party payers, providers, and others.

SEC. 5305. PRIORITY AMONG CARRIERS, GROUP HEALTH PLANS, AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

(a) GOALS.—The Secretary shall establish national goals, and time frames for such goals, respecting the progress to be made by the health care industry in achieving uniformity in the rules for determining the liability of carriers, group health plans, and multiple employer welfare arrangements when health benefits with respect to an individual are payable by 2 or more such parties.

(b) CONTINGENT REQUIREMENTS.—If the Secretary determines that the health care industry has failed to meet the goals established under subsection (a) in the time frames established by the Secretary under such subsection, the Secretary shall promulgate (and may, from time to time, modify) rules described in such subsection.

(c) CONSULTATION.—The Secretary shall conduct activities under this section in consultation with carriers, group health plans, and multiple employer welfare arrangements.

SEC. 5306. EXCHANGE OF INFORMATION AMONG CARRIERS, GROUP HEALTH PLANS, AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

(a) GOALS.—The Secretary shall establish national goals, and time frames for such goals, respecting the progress to be made by the health care industry in achieving uniformity with respect to the exchange of information among carriers, group health plans, and multiple employer welfare arrangements when health benefits with respect to an individual may be payable by 2 or more such parties.

(b) CONTINGENT REQUIREMENTS.—If the Secretary determines that the health care industry has failed to meet the goals established under subsection (a) in the time frames established by the Secretary under such subsection, the Secretary shall promulgate (and may, from time to time, modify) requirements concerning the exchange among carriers, group health plans, and multiple employer welfare arrangements (and annual updating) of appropriate information (which may include requirements for the use of common identification numbers and for the listing of all individuals having health care coverage).

(c) CONSULTATION.—The Secretary shall conduct activities under this section in consultation with carriers, group health plans, and multiple employer welfare arrangements.

SEC. 5307. FAILURE TO SATISFY CERTAIN HEALTH PLAN REQUIREMENTS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to taxes on group health plans), as amended by section 1002(c)(1), is amended by adding at the end the following new section:

"SEC. 5000B. FAILURE TO SATISFY CERTAIN HEALTH PLAN REQUIREMENTS.

"(a) GENERAL RULE.—There is hereby imposed, on any administrator of a health plan, a tax on any failure to comply with an applicable requirement of sections 5303 through 5306 of the Bipartisan Health Care Reform Act of 1994.

"(b) AMOUNT OF TAX.—The amount of tax imposed by subsection (a) which an administrator fails to comply with a requirement described in that subsection shall be equal to $100 for each such failure.

"(c) LIMITATIONS ON TAX.—

"(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person liable for tax did not know, and by exercising reasonable diligence would not have known, that the failure existed.

"(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

"(A) the failure was due to reasonable cause and not to willful neglect, and

"(B) the failure is corrected during the 30-day period beginning on the 1st date the person liable for the tax knew, or by exercising reasonable diligence would have known, that the failure existed.

"(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of that tax would be excessive relative to the failure involved.".

(b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of section 275(a) of that Code (relating to nondeductibility of certain taxes) is amended by inserting "47," after "46,".

(c) CLERICAL AMENDMENTS.—The table of sections for chapter 47 of that Code, as amended by section 1002(c)(2), is amended by adding at the end the following new item:

"5000B. Failure to satisfy certain health plan requirements.".

SEC. 5308. DEFINITION.

For purposes of this subtitle, the term "provider" means a physician, hospital, pharmacy, laboratory, or other person licensed or otherwise authorized under applicable State laws to furnish health care items or services.

Subtitle E—Antitrust

SEC. 5401. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF HEALTH PLANS.

(a) IN GENERAL.—The Attorney General shall provide for the development and publication of explicit guidelines on the application of antitrust laws to the activities of health plans. The guidelines shall be designed to facilitate development and operation of plans, consistent with the antitrust laws.

(b) REVIEW PROCESS.—The Attorney General shall establish a review process under which the administrator or sponsor of a health plan (or organization that proposes to administer or sponsor a health plan) may submit a request to the Attorney General to obtain a prompt opinion (but in no event later than 90 days after the Attorney General receives the request) from the Department of Justice on the plan's conformity with the Federal antitrust laws.

(c) DEFINITIONS.—In this section—

(1) the term "antitrust laws"—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, and

(B) includes any State law similar to the laws referred to in subparagraph (A); and

(2) the term "health plan" means any contract or arrangement under which an entity bears all or part of the cost of providing health care items and services, including a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, but does not include—

(A) coverage only for accident, dental, vision, disability, or long term care, medicare supplemental health insurance, or any combination thereof,

(B) coverage issued as a supplement to liability insurance,

(C) workers' compensation or similar insurance, or

(D) automobile medical-payment insurance.

SEC. 5402. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary, shall issue in accordance with this section a certificate of public advantage to each eligible health care collaborative activity that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such activity, and the parties to such activity, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such activity if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

(1) STANDARDS TO BE MET.—The Attorney General shall issue a certificate to an eligible health care collaborative activity if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the activity outweigh the reduction in competition (if any) that is likely to result from the activity, and

(B) such reduction in competition is necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the activity is likely —

(i) to maintain or to increase the quality of health care by providing new services not currently offered in the relevant market,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs, that cannot be achieved by the provision of available services and facilities in the relevant market,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care collaborative activity and the entities responsible for making payments to such providers to negotiate societally optimal payment and service arrangements,

(ii) the effects of the health care collaborative activity on premiums and other charges imposed by the entities described in clause (i), and

(iii) the availability of equally efficient, less restrictive alternatives to achieve the benefits that are intended to be achieved by carrying out the activity.

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care collaborative activity (in the case of an activity in existence as of the time of the application) and implementation plan for the collaborative activity.

(d) ELIGIBLE HEALTH CARE COLLABORATIVE ACTIVITY.—To be an eligible health care collaborative activity for purposes of this section, a health care collaborative activity shall submit to the Attorney General an application that complies with the rules in effect under subsection (c) and that includes—

(1) an agreement by the parties to the activity that the activity will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the activity,

(2) an agreement that the activity will submit to the Attorney General annually a report that describes the operations of the activity and information regarding the impact of the activity on health care and on competition in health care, and

(3) an agreement that the parties to the activity will notify the Attorney General and the Secretary of the termination of the activity not later than 30 days after such termination occurs.

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 90 days after an eligible health care collaborative activity submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 90-day period, the Attorney General may extend the time for issuance for good cause.

(f) REVOCATION OF CERTIFICATE.—Whenever the Attorney General finds that a health care collaborative activity with respect to which a certificate is in effect does not meet the standards specified in subsection (b), the Attorney General shall revoke such certificate.

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an application for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

(2) to attempt to enter into any health care collaborative activity with respect to which such a certificate is in effect.

(i) DEFINITIONS.—In this section:

(1) The term "antitrust laws" has the meaning given it in section 5401(c)(1).

(2) The term "certificate" means a certificate of public advantage authorized to be issued under subsection (a).

(3) The term "health care collaborative activity" means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of sharing in the provision and coordination of health care services and that involves substantial integration and financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

(4) The term "health care services" includes services related to the delivery or administration of health care services.

(5) The term "liable" means liable for any civil or criminal violation of the antitrust laws.

(6) The term "provider of health care services" means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

SEC. 5403. STUDY OF IMPACT ON COMPETITION.

The Attorney General, in consultation with the Chairman of the Federal Trade Commission, annually shall submit to the Congress a report as part of the annual budget oversight proceedings concerning the Antitrust Division of the Department of Justice. The report shall enable the Congress to determine how enforcement of antitrust laws is affecting the formation of efficient, cost-saving joint ventures and if the certificate of public advantage procedure set forth in section 5402 has resulted in undesirable reduction in competition in the health care marketplace. The report shall include an evaluation of the factors set forth in paragraphs (2)(A) and (2)(B) of section 5402(b).

Subtitle F—Fraud and Abuse

PART 1—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

SEC. 5501. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1996, the Attorney General shall establish a program—

(1) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

(2) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, and

(3) in consultation with the Inspector General of the Department of Health and Human Services, to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers.

(c) COORDINATION WITH THIRD PARTY INSURERS.—In carrying out the program established under subsection (a), the Attorney General shall consult with, and arrange for the sharing of data with representatives of private sponsors of health benefit plans and other providers of health insurance.

(d) REGULATIONS.—

(1) IN GENERAL.—The Attorney General shall by regulation establish standards to carry out the program under subsection (a).

(2) INFORMATION STANDARDS.—

(A) IN GENERAL.—Such standards shall include standards relating to the furnishing of information by health insurers (including self-insured health benefit plans), providers, and others to enable the Attorney General to carry out the program (including coordination with law enforcement agencies under subsection (b) and third party insurers under subsection (c)).

(B) CONFIDENTIALITY.—Such standards shall include procedures to assure that such information is provided and utilized in a manner that protects the confidentiality of the information and the privacy of individuals receiving health care services.

(C) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information to the Attorney General under the program under this section, with respect to the Attorney General's performance of duties under the program, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act, with respect to the performance of such a contract.

SEC. 5502. AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.

In addition to any other amounts authorized to be appropriated to the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such sums as may be necessary to enable the Attorney General to conduct investigations of allegations of health care fraud and otherwise carry out the program established under section 5501 in a fiscal year.

SEC. 5503. ESTABLISHMENT OF ANTI-FRAUD AND ABUSE TRUST FUND.

(a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Anti-Fraud and Abuse Trust Fund" (in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this part and section 1128A(f)(3) of the Social Security Act.

(b) MANAGEMENT.—

(1) IN GENERAL.—The Trust Fund shall be managed by the Attorney General through a Managing Trustee designated by the Attorney General.

(2) INVESTMENT OF FUNDS.—It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in the trustee's judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and

shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month, except that where such average is not a multiple of ⅛ of 1 percent, the rate of interest on such obligations shall be the multiple of ⅛ of 1 percent nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where the Trustee determines that the purchase of such other obligations is in the public interest.

(3) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(4) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(5) The receipts and disbursements of the Attorney General in the discharge of the functions of the Attorney General shall not be included in the totals of the budget of the United States Government. For purposes of part C of the Balanced Budget and Emergency Deficit Control Act of 1985, the Attorney General and the Trust Fund shall be treated in the same manner as the Federal Retirement Thrift Investment Board and the Thrift Savings Fund, respectively. The United States is not liable for any obligation or liability incurred by the Trust Fund.

(c) USE OF FUNDS.—Of the amounts in the Trust Fund—

(1) not less than 60 percent shall be used to support educational activities to prevent the occurrence of violations of anti-fraud and abuse laws, including the issuance of advisory opinions under section 1129 and 1877(i) of the Social Security Act (as added by part 4) and fraud alerts, seminars for providers, and program updates; and

(2) any amounts remaining after use for activities under paragraph (1) shall be used to assist the Attorney General in carrying out the all-payor fraud and abuse control program established under section 5501(a) in the fiscal year involved.

(d) DEPOSIT OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES INTO TRUST FUND.—Section 1128A(f)(3) of the Social Security Act (42 U.S.C. 1320a-7a(f)(3)) is amended by striking "as miscellaneous receipts of the Treasury of the United States" and inserting "in the Anti-Fraud and Abuse Trust Fund established under section 5503(a) of the Bipartisan Health Care Reform Act of 1994".

(e) USE OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE PENALTIES TO REPAY BENEFICIARIES FOR COST-SHARING.—Section 1128A(f) of the Social Security Act (42 U.S.C. 1320a-7a(f)) is amended in the matter preceding paragraph (1) by striking "Secretary and disposed of as follows:" and inserting the following: "Secretary. If the person against whom such a penalty or assessment was assessed collected a payment from an individual for providing to the individual the service that is the subject of the penalty or assessment, the Secretary shall pay a portion of the amount recovered to the individual in the nature of restitution in an amount equal to the payment so collected. The Secretary shall dispose of any remaining amounts recovered under this section as follows:".

PART 2—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 5511. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO FRAUD.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7(a)) is amended by adding at the end the following new paragraph:

"(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service on or after the date of the enactment of this paragraph, or with respect to any act or omission on or after such date in a program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a-7(b)(1)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) of such Act (42 U.S.C. 1320a-7(b)(3)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

SEC. 5512. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) of the Social Security Act (42 U.S.C. 1320a-7(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

"(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

"(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.".

SEC. 5513. REVISIONS TO CRIMINAL PENALTIES.

(a) CLARIFICATION OF DISCOUNT EXCEPTION TO ANTI-KICKBACK PROVISIONS.—Section 1128B(b)(3)(A) of the Social Security Act (42 U.S.C. 1320a-7b(b)(3)(A)) is amended—

(1) by inserting "(regardless of its timing or availability)" after "in price"; and

(2) by striking "program;" and inserting "program and is not paid in the form of currency or coin;".

(b) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or service, if—

"(A) the item or service is provided through an organization described in section 1877(b)(3), or

"(B) the item or service is provided through such an organization on behalf of another entity (including but not limited to a self-insured employer or indemnity plan) that assumes financial risk for the provision of the item or service.".

(c) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN PROTECTED FINANCIAL RELATIONSHIPS.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)), as amended by subsection (b), is further amended—

(1) by striking "and" at the end of subparagraph (E);

(2) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(G) any amount in a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in section 1877(a)(2), if section 1877(a)(1) does not apply to that amount or financial relationship.".

(d) EXEMPTION FROM ANTI-KICKBACK PENALTIES FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED PERSONS.—

(1) IN GENERAL.—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)), as amended by subsections (b) and (c), is further amended—

(A) by striking "and" at the end of subparagraph (F);

(B) by striking the period at the end of subparagraph (G) and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(F) any remuneration paid by or to a recipient or subrecipient of Federal grant funds under or in connection with an arrangement for the procurement of goods or services by the recipient or subrecipient, the referral of patients, or the lease or purchase of space or equipment, if—

"(i) the arrangement is in writing and signed by the parties;

"(ii) the arrangement will result in the savings of Federal grant funds or increased revenues to the recipient or subrecipient that will be used to increase the availability or accessibility of services to a medically underserved population served by the recipient or subrecipient or an improvement in the quality of services to such population, except that the recipient or subrecipient may seek a prior determination from the Public Health Service that this requirement is met and, if the recipient or subrecipient does so, Public Health Service approval shall be conclusive and binding on the Federal Government;

"(iii) the arrangement will not result in private inurement to any current employees or members of the Board of Directors of the recipient or subrecipient, or to agents of the recipient or subrecipient who were involved in recommending or negotiating the arrangement;

"(iv) with respect to an arrangement under which a recipient or subrecipient is procuring goods or services, the provider of the goods or services is the only provider able to supply such goods or services, or the recipient or subrecipient has engaged in a competitive process to procure the goods or services that meets the requirements for competition under Federal grant awards;

"(v) with respect to an arrangement for a referral of patients, the arrangement will assure that all patients covered or affected by the arrangement are advised that they may request a referral to any person or entity of their choosing, subject to appropriate contractual limitations under which the recipient or subrecipient may operate as a health plan or as a contract health plan provider and such limitations as the patient may be under as an enrollee of a health plan;

"(vi) with respect to an arrangement for a referral of patients, the arrangement will not interfere with the discretion of health professionals to refer patients in a manner they believe will most appropriately deal with a patient's particular circumstances, subject to appropriate contractual limitations under which the recipient or subrecipient may operate as a health plan or as a contract health plan provider and such limitations as the patient may be under as an enrollee of a health plan; and

"(vii) with respect to an arrangement that does not meet the requirements of any of the preceding clauses, the recipient or subrecipient of Federal grant funds involved has applied to the Secretary for approval of the arrangement and the Secretary, after consultation with the Inspector General of the Department of Health and Human Services, has approved the arrangement based upon a finding that the arrangement will produce a substantial benefit to a medically underserved population that outweighs the arrangement's failure to fully satisfy all of the above requirements.

In this subparagraph, a 'recipient' means a public or nonprofit private entity that receives a grant or cooperative agreement under the Public Health Service Act or title V, and a 'subrecipient' means a public or nonprofit private entity that performs substantive work under a grant or cooperative agreement under the Public Health Service Act or title V to a recipient.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect after the expiration of the 6-month period that begins on the date of the enactment of this Act.

SEC. 5515. REVISIONS TO LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

(a) CLARIFICATION OF COVERAGE OF RADIOLOGY OR DIAGNOSTIC SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraph (D).

(b) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—Section 1877(b) of such Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

"(4) SHARED FACILITY SERVICES.—

"(A) IN GENERAL.—In the case of a shared facility service of a shared facility—

"(i) that is furnished—

"(I) personally by the referring physician who is a shared facility physician or personally by an individual directly employed by such a physician,

"(II) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

"(III) to a patient of a shared facility physician; and

"(ii) that is billed by the referring physician.

"(B) SHARED FACILITY RELATED DEFINITIONS.—

"(i) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

"(ii) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

"(iii) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician who has a financial relationship under a shared facility arrangement with the facility.

"(iv) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

"(I) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

"(II) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

"(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.".

(c) REVISION TO RURAL PROVIDER EXCEPTION.—Section 1877(d)(2) of such Act (42 U.S.C. 1395nn(d)(2)) is amended by striking "substantially all" and inserting "not less than 75 percent (as determined in accordance with regulations of the Secretary)".

(d) CLARIFICATION OF REFERRALS BY NEPHROLOGISTS.—Section 1877(h)(5)(C) of such Act (42 U.S.C. 1395nn(H)(5)(C)) is amended—

(1) by striking "and a request" and inserting "a request";

(2) by inserting after "radiation therapy," the following: "and a request by a nephrologist for items or services related to renal dialysis,"; and

(3) by striking "or radiation oncologist" and inserting "radiation oncologist, or nephrologist".

(e) REVISION OF REPORTING REQUIREMENTS.—Section 1877(f) of such Act (42 U.S.C. 1395nn(f)) is amended—

(1) by striking "Each entity" and all that follows through paragraph (2) and inserting the following: "The Secretary may require each entity (other than a physician or physician group practice) providing designated health services to provide the Secretary with the following information concerning the entity's ownership, investment, and compensation arrangements:

"(1) the designated health services provided by the entity; and

"(2) the names and unique physician identifier numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)) or with a compensation interest (as described in subsection (a)(2)(B)) in the entity, or whose immediate relatives have such an ownership, investment, or compensation interest in the entity."; and

(2) by striking the fifth sentence.

(f) EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) of such Act (42 U.S.C. 1395nn(b)(3)) is amended—

(1) by striking "or" at the end of subparagraph (C);

(2) by striking the period at the end of subparagraph (D) and inserting a comma; and

(3) by adding at the end the following new subparagraphs:

"(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)); or

"(F) which meets State regulatory requirements applicable to health maintenance organizations and which—

"(i) provides designated health services directly or through contractual arrangements with providers;

"(ii) assumes financial risk for the provision of services or provides services on behalf of another individual or entity (including but not limited to a self-insured employer, indemnity plan, physician, or physician group) that assumes financial risk for the provision of the item or service; and

"(iii) subjects the services to a program of utilization review offered by an organization described in a preceding subparagraph, an organization meeting State regulatory requirements applicable to utilization review, or an organization accredited to perform utilization review considered appropriate by the Secretary.".

(g) PREEMPTION OF STATE LAW.—Section 1877(g) of such Act (42 U.S.C. 1395nn(g)) is amended by adding at the end the following new paragraph:

"(6) PREEMPTION OF STATE LAW.—The provisions of this section shall supersede any State law to the extent State law prohibits a physician from making a referral, or an entity from presenting a bill, for the furnishing of a service which is not subject to the restrictions applicable under paragraph (1).".

(h) REVISION OF EFFECTIVE DATE EXCEPTION PROVISION.—Section 13562(b)(2) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking subparagraphs (A) and (B) and inserting the following:

"(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act);

"(B) section 1877(b)(4) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply;

"(C) the requirements of section 1877(c)(2) of the Social Security Act (as amended by this Act) shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(D) section 1877(e)(3) of the Social Security Act (as amended by this Act) shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act (as in effect on the day before the date of the enactment of this Act);

"(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of the Social Security Act (as amended by this Act) shall not apply; and

"(F) section 1877(h)(4)(B) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act).".

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to referrals made on or after January 1, 1995, except that the amendments made by subsection (h) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993.

SEC. 5516. MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) STUDY ON COSTS OF PEER REVIEW CONTRACTS FOR MEDICARE HMO'S.—The Comptroller General shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of the Social Security Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary of Health and Human Services to assess the quality of services provided by such eligible organizations.

(b) REPORT TO CONGRESS.—Not later than July 1, 1997, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subsection (a).

SEC. 5517. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this part shall take effect January 1, 1996.

PART 3—AMENDMENTS TO CRIMINAL LAW

SEC. 5521. PENALTIES FOR HEALTH CARE FRAUD.

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

"(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

"(1) to defraud any health care plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be guilty of a felony, and fined under this title or imprisoned not more than 5 years, or both.

"(b) In determining the amount or scope of any penalty or assessment, the court shall take into account:

"(1) the nature of the false or fraudulent claims and the circumstances under which they are presented;

"(2) the degree of culpability and history of prior offenses by the convicted health care provider;

"(3) the extent to which restitution is paid; and

"(4) such other matters as justice may require.

"(c) A principal is liable for penalties and assessments under this section for the acts of the principal's agents acting within the scope of the agency.

"(d) For purposes of this section, the term 'health care plan' means a Federally-funded public program or private program for the delivery of or payment for health care items or services.".

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud.".

SEC. 5522. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following new subsection:

"(c)(1) In special circumstances and in the Attorney General's sole discretion, the Attorney General may make a payment of up to $10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution under section 1347.

"(2) A person is not eligible for a payment under paragraph (1) if—

"(A) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment.

"(B) the person knowingly participated in the offense;

"(C) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

"(i) in a criminal, civil, or administrative proceeding;

"(ii) in a congressional, administrative or General Accounting Office report, hearing, audit or investigation; or

"(iii) by the news media, unless the person is the original source of the information; or

"(D) when, in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

"(3) For the purposes of paragraph (2)(C)(iii), the term 'original source' means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

"(4) Neither the failure of the Attorney General to authorize a payment under paragraph (1) nor the amount authorized shall be subject to judicial review.".

SEC. 5523. BROADENING APPLICATION OF MAIL FRAUD STATUTE.

Section 1341 of title 18, United States Code, is amended—

(1) by inserting "or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier," after "Postal Service,"; and

(2) by inserting "or such carrier" after "causes to be delivered by mail".

PART 4—ADVISORY OPINIONS

SEC. 5531. AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ISSUE ADVISORY OPINIONS UNDER TITLE XI.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

"ADVISORY OPINIONS

"SEC. 1129. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as provided in this section.

"(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

"(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

"(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

"(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

"(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section 1128B(b).

"(5) Whether an arrangement, activity or proposed arrangement or proposed activity violates any other provision of this Act.

"(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

"(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

"(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

"(d) EFFECT OF ADVISORY OPINIONS.—

"(1) Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

"(2) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

"(e) REGULATIONS.—The Secretary within 180 days of the date of enactment, shall issue regulations establishing a system for the issuance of advisory opinions. Such regulations shall provide for—

"(1) the procedure to be followed by a party applying for an advisory opinion;

"(2) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

"(3) the interval in which the Secretary shall respond;

"(4) the reasonable fee to be charged to the party requesting an advisory opinion; and

"(5) the manner in which advisory opinions will be made available to the public.

"(f) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed 30 days.".

SEC. 5532. AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ISSUE ADVISORY OPINIONS RELATING TO PHYSICIAN OWNERSHIP AND REFERRAL.

Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended by the addition of the following new subsection:

"(i) ADVISORY OPINIONS.—

"(1) IN GENERAL.—The Secretary shall issue advisory opinions on whether an arrangement or proposed arrangement will result in a prohibited referral within the meaning of this section.

"(2) EFFECT OF ADVISORY OPINIONS.—

"(A) Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

"(B) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of this section.

"(3) REGULATIONS.—The Secretary within one hundred and eighty days of the date of enactment, shall issue regulations establishing a system for the issuance of advisory opinions. Such regulations shall provide for—

"(A) the procedure to be followed by a party applying for an advisory opinion;

"(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

"(C) the interval in which the Secretary shall respond;

"(D) the reasonable fee to be charged to the party requesting an advisory opinion; and

"(E) the manner in which advisory opinions will be made available to the public.

"(4) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed thirty days.".

SEC. 5533. EFFECTIVE DATE.

Unless otherwise specified, the amendments made by this part shall be effective upon the enactment of this Act.

PART 5—PAYMENTS FOR STATE HEALTH CARE FRAUD CONTROL UNITS

SEC. 5541. ESTABLISHMENT OF STATE FRAUD UNITS.

(a) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL UNIT.—The Governor of each State shall, consistent with State law, establish and maintain in accordance with subsection (b) a State agency to act as a Health Care Fraud and Abuse Control Unit for purposes of this part.

(b) DEFINITION.—In this section, a "State Fraud Unit" means a Health Care Fraud and Abuse Control Unit designated under subsection (a) that the Attorney General certifies meets the requirements of this part.

SEC. 5542. REQUIREMENTS FOR STATE FRAUD UNITS.

(a) IN GENERAL.—The State Fraud Unit must—

(1) be a single identifiable entity of the State government;

(2) be separate and distinct from any State agency with principal responsibility for the administration of any Federally-funded or mandated health care program;

(3) meet the other requirements of this section.

(b) SPECIFIC REQUIREMENTS DESCRIBED.—The State Fraud Unit shall—

(1) be a Unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations;

(2) if it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, (A) assure its referral of suspected criminal violations to the appropriate authority or authorities in the State for prosecution, and (B) assure its assistance of, and coordination with, such authority or authorities in such prosecutions; or

(3) have a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which provide effective coordination of activities between the Fraud Unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to any Federally-funded or mandated health care programs.

(c) STAFFING REQUIREMENTS.—The Fraud Unit must—

(1) employ attorneys, auditors, investigators and other necessary personnel; and

(2) be organized in such a manner and provide sufficient resources as is necessary to promote the effective and efficient conduct of Fraud Unit activities.

(d) COOPERATIVE AGREEMENTS; MEMORANDA OF UNDERSTANDING.—The Fraud Unit must have cooperative agreements with—

(1) Federally-funded or mandated health care programs;

(2) similar Fraud Units in other States, as exemplified through membership and participation in the National Association of Medicaid Fraud Control Units or its successor; and

(3) the Attorney General of the United States.

(e) REPORTS.—The Fraud Unit shall submit to the Attorney General an application and an annual report containing such information as the Attorney General determines to be necessary to determine whether the Fraud Unit meets the requirements of this section.

(f) FUNDING SOURCE; PARTICIPATION IN ALL-PAYER PROGRAM.—The Fraud Unit may receive funding for its activities from such sources as the State considers appropriate. The Fraud Unit shall participate in the all-payer fraud and abuse control program established under section 5501.

SEC. 5543. SCOPE AND PURPOSE.

The Fraud Unit shall carry out the following activities:

(1) The Fraud Unit shall conduct a statewide program for the investigation and prosecution (or referring for prosecution) of violations of all applicable state laws regarding any and all aspects of fraud in connection with any aspect of the administration and provision of health care services and activities of providers of such services under any Federally-funded or mandated health care programs;

(2) The Fraud Unit shall have procedures for reviewing complaints of the abuse or neglect of patients of facilities (including patients in residential facilities and home health care programs) that receive payments under any Federally-funded or mandated health care programs, and, where appropriate, to investigate and prosecute such complaints under the criminal laws of the State or for referring the complaints to other State agencies for action.

(3) The Fraud Unit shall provide for the collection, or referral for collection to the appropriate agency, of overpayments that are made under any Federally-funded or mandated health care program and that are discovered by the Fraud Unit in carrying out its activities.

SEC. 5544. PAYMENTS TO STATES.

(a) IN GENERAL.—

(1) MATCHING PAYMENTS TO STATES.—Subject to subsection (c), for each year for which a State has a Fraud Unit approved under section 5542(b) in operation the Attorney General shall pay to the State for each quarter in a fiscal year an amount equal to the applicable percentage of the sums expended during the quarter by the Fraud Unit.

(2) TIME OF PAYMENT.—The Attorney General shall make a payment under paragraph (1) for a quarter by not later than 30 days after the end of the quarter.

(b) APPLICABLE PERCENTAGE DEFINED.—

(1) IN GENERAL.—In subsection (a), the "applicable percentage" with respect to a State for a fiscal year is—

(A) 90 percent, for quarters occurring during the first 3 years for which the Fraud Unit is in operation; or

(B) 75 percent, for any other quarters.

(2) TREATMENT OF STATES WITH MEDICAID FRAUD CONTROL UNITS.—In the case of a State with a State medicaid fraud control in operation prior to or as of the date of the enactment of this Act, in determining the number of years for which the State's Fraud Unit under this part has been in operation, there shall be included the number of years for which such State medicaid fraud control unit was in operation.

(c) LIMIT ON PAYMENT.—Notwithstanding subsection (a), the total amount of payments made to a State under this section for a fiscal year may not exceed—

(1) for fiscal year 1996, 4 times the amount paid to the State under section 1903(a)(6) of the Social Security Act during the first quarter of 1995; and

(2) for each succeeding fiscal year, the amount determined under this subsection in the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the year.

Subtitle G—Billing for Laboratory Services

SEC. 5601. EASING RESTRICTIONS ON BILLING FOR LABORATORY AND OTHER SERVICES.

(a) IN GENERAL.—The Public Health Service Act is amended—

(1) by redesignating title XXVII (42 U.S.C. 300cc et seq.) as title XXVIII; and

(2) by inserting after title XXVI the following new title:

"TITLE XXVII—RESTRICTIONS ON BILLING

"SEC. 2701. PROHIBITION.

"(a) BILLING OF OTHERS FOR ANCILLARY HEALTH SERVICES.—Except as provided in section 2702, it shall be unlawful for any person (including any individual or entity) who furnishes ancillary health services (as defined in section 2705(1)) to present or cause to be presented, a claim, bill, or demand for payment to any person other than the patient receiving such services.

"(b) BILLING OF RECIPIENT OF SERVICES.—Except as provided in section 2702, it shall be unlawful for any physician, or the agent of any physician, to present, or cause to be presented, a claim, bill, or demand for payment for ancillary health services to any recipient of such services unless the services covered by the claim, bill, or demand were furnished—

"(1) personally by, or under the supervision of, the referring physician;

"(2) personally by, or under the supervision of, a physician who is a member of the same group practice as the referring physician; or

"(3) personally by individuals who are employed by such physician or group practice and who are personally supervised by the physician or by another physician in the group practice.

"(c) GENERAL EXCEPTION FOR SERVICES UNDER MEDICARE.—This section does not apply with respect to any ancillary health services for which payment may be made under title XVIII of the Social Security Act.

"SEC. 2702. EXCEPTIONS.

"Notwithstanding the provisions of section 2701, a person who furnishes ancillary health services to an individual may present, or cause to be presented, for payment for actual services rendered a claim, bill, or demand to—

"(1) an immediate family member of the recipient of the services or any other person legally responsible for the debts or care of the recipient of the services;

"(2) a third party payor designated by the recipient of the services;

"(3) a health maintenance organization, or other health plan providing coverage through a managed care arrangement, in which the recipient of the services is enrolled;

"(4) a hospital or skilled nursing facility where the recipient of the services was an inpatient or outpatient at the time the services were provided;

"(5) an employer where the recipient of the services is an employee of such employer and the employer is responsible for payment for the services;

"(6) a governmental agency or specified agent, on behalf of the recipient of the services;

"(7) a substance abuse program where the clients of such a program were the recipient of the services;

"(8) a clinic or other health care provider that has been designated (or that is operated by an organization that has been designated) as tax-exempt pursuant to section 501(c)(3) of the Internal Revenue Code of 1986 whose purpose is the promotion of public health, if the services rendered relate to testing for sexually transmitted disease, acquired immune deficiency syndrome, pregnancy, pregnancy termination, or other conditions where the Secretary has determined that compliance with section 2701 could seriously compromise the recipient's need for confidentiality;

"(9) a person engaged in bona fide research studies;

"(10) the party requesting the ancillary health services where Federal, State, or local law requires that the identity of the recipient be kept confidential;

"(11) another person furnishing the same ancillary health services for which payment is sought (hereafter referred to in this paragraph as the 'requesting party') where the person presenting, or causing to be presented, the claim, bill, or demand for payment furnished the services at the request of the requesting party, except that the requesting party may not be a facility owned or operated by the physician requesting the ancillary health service; and

"(12) an entity approved to receive such claims, bills or demands by the Secretary in regulations.

The persons described in paragraphs (1) through (12) who have received a claim, bill, or demand for payment for such ancillary health services may present, or cause to be presented, such claim, bill, or demand to the responsible party.

"SEC. 2703. SANCTIONS.

"(a) PAYMENT.—No payment may be made for a service that is provided in violation of section 2701.

"(b) COLLECTION OF AMOUNTS.—

"(1) LIABILITY ON COLLECTION.—If a person collects any amounts that were billed in violation of section 2701(a), such person shall be liable for, and shall refund on a timely basis to the individual whom such amounts were collected, any amounts so collected.

"(2) COLLECTION BY PHYSICIAN.—If a physician collects any amounts from a recipient of services, or from another person on behalf of the recipient of services (including a third-party payor) that were billed in violation of section 2701(b), such physician shall be liable for, and shall refund on a timely basis to the recipient or person, any amounts so collected.

"(c) REPEATED CLAIMS.—Any person that presents, or causes to be presented, on a repeated basis, a bill or a claim that such person knows, or should have known, is for a service for which payment may not be made under subsection (a), or for which a refund has not been made under subsection (b), shall be subject to a civil money penalty of not more than $5,000 for each such bill or claim. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and subsection (b)) shall apply to a civil money penalty assessed under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under such section 1128A(a).

"(d) SUSPENSION OF LABORATORY CERTIFICATION.—If the Secretary finds, after reasonable notice and opportunity for a hearing, that a laboratory which holds a certificate pursuant to section 353 has violated section 2701, the Secretary may suspend, revoke or limit such certification in accordance with the procedures established in section 353(k).

"(e) EXCLUSION FROM OTHER PROGRAMS.—

"(1) AUTHORITY.—The Secretary may exclude from participation in any program under title XVIII of the Social Security Act, any individual or entity that the Secretary determines has violated section 2701 and may direct that such individual and entity be excluded from participation in any State health care program receiving Federal funds.

"(2) APPLICATION OF OTHER LAW.—The provisions of section 1128(e) of the Social Security Act shall apply to any exclusion under paragraph (1) in the same manner as such provisions apply to a proceeding under such section 1128.

"SEC. 2704. REGULATIONS.

"The Secretary shall by regulation impose such other requirements as may be necessary to implement the purposes of this title.

"SEC. 2705. DEFINITIONS.

"As used in this title:

"(1) ANCILLARY HEALTH SERVICES.—The term 'ancillary health services' means—

"(A) clinical laboratory services;

"(B) diagnostic x-ray tests and other diagnostic imaging services including CT and magnetic resonance imaging services;

"(C) other diagnostic tests;

"(D) durable medical equipment; and

"(E) physical therapy services.

"(2) GROUP PRACTICES.—The term 'group practice' means a group of 2 or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

"(A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel;

"(B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group;

"(C) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and

"(D) which meets such other standards as the Secretary may impose by regulation.

In the case of a faculty practice plan associated with a hospital with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group (as well as perform other tasks, such as research), the definition of such term shall be limited with respect to the services provided outside of the faculty practice plan.

"(3) IMMEDIATE FAMILY MEMBER.—The term 'immediate family member' shall include spouses, natural and adoptive parents, natural and adoptive children, natural and adopted siblings, stepparents, stepchildren and stepsiblings, fathers-in-law, mothers-in-law, brothers-in-law, sisters-in-law, sons-in-law and daughters-in-law, grandparents and grandchildren, and such additional family members as may be specified in regulations adopted by the Secretary.

"(4) PHYSICIAN.—The term 'physician' means—

"(A) a doctor of medicine or osteopathy legally authorized to practice medicine and perform surgery by the State in which such individual performs such function or action;

"(B) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry in the State in which such individual performs such functions;

"(C) a doctor of podiatric medicine;

"(D) a doctor of optometry; or

"(E) a chiropractor.

"(5) THIRD PARTY PAYOR.—The term 'third party payor' means any health care insurer, including any hospital services corporation, health services corporation, medical expense indemnity corporation, mutual insurance company, or self-insured corporation, that provides coverage for health or health-related items or service.".

(b) CONFORMING AMENDMENTS.—

(1) Sections 2701 through 2714 of the Public Health Service Act (42 U.S.C. 300cc through 300cc–15) are redesignated as sections 2801 through 2814, respectively.

(2)(A) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289) are amended by striking out "2701" each place that such appears and inserting in lieu thereof "2801".

(B) Section 305(i) of such Act (42 U.S.C. 242c(i)) is amended by striking out "2711" each place that such appears and inserting in lieu thereof "2811".

SEC. 5602. EFFECTIVE DATE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act, as added by section 5601(a), shall become effective December 31, 1994.

(b) REGULATIONS.—Not later than July 1, 1995, the Secretary of Health and Human Services shall promulgate such regulations as may be appropriate to carry out such title.

TITLE VI—MEDICARE AND MEDICAID

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Subtitle A—Increased Medicare Beneficiary Choice; Improved Program Efficiency

PART 1—INCREASED MEDICARE BENEFICIARY CHOICE

SEC. 6001. REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS UNDER MEDICARE.

(a) USE OF METROPOLITAN STATISTICAL AREAS TO DETERMINE ADJUSTED AVERAGE PER CAPITA COST.—Section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) is amended by striking "in a geographic area served by an eligible organization or in a similar area" and inserting "in the metropolitan statistical area (as defined by the Office of Management and Budget) in which the individual resides, or in the entire portion of the State in which the individual resides which is not located in a metropolitan statistical area in the case of an individual who does not reside in a metropolitan statistical area".

(b) DETERMINATION OF MODEL ADDITIONAL HEALTH BENEFIT PACKAGES.—Section 1876(g) of such Act (42 U.S.C. 1395mm(g)) is amended by inserting after paragraph (3) the following new paragraph:

"(4) The Secretary shall develop the following model packages of additional health benefits (referred to in paragraph (3)(B)) which an eligible organization may provide (at its option) under paragraph (2):

"(A) Coverage for catastrophic illness (subject to a limit on out-of-pocket expenditures).

"(B) Coverage for prescription drugs.

"(C) Coverage for preventive services.".

(c) REVISION OF MEMBERSHIP LIMITATION.—Section 1876(f) of such Act (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1), by striking "one-half" and inserting "25 percent"; and

(2) in paragraph (2)(A), by striking "50 percent" and inserting "75 percent".

(d) ENROLLMENT PERIODS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.—

(1) UNIFORM OPEN ENROLLMENT PERIOD.—Section 1876(c)(3)(A)(i) of such Act (42 U.S.C. 1395mm(c)(3)(A)(i)) is amended by striking "must have" and all that follows through "and including" and inserting the following: "shall have open enrollment during an annual uniform open enrollment period established by the Secretary for all eligible organizations, together with".

(2) OPEN ENROLLMENT FOR CERTAIN DISENROLLED INDIVIDUALS.—Section 1876(c)(3)(A)(ii)(I) of such Act (42 U.S.C. 1395mm(c)(3)(A)(ii)(I)) is amended by adding at the end the following: "Each eligible organization with a risk-sharing contract under this section shall have an open enrollment period for individuals residing in the organization's service area who disenroll from another eligible organization with a risk-sharing contract under this section on the grounds that the individual's primary care physician is no longer a member of the organization's provider network or for cause (in accordance with such standards, and as demonstrated through an appeals process that meets such requirements, as the Secretary may establish).

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into on or after the date of the enactment of this Act.

SEC. 6002. EXPANSION AND REVISION OF MEDICARE SELECT POLICIES.

(a) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—

(1) IN GENERAL.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 (hereafter referred to as "OBRA-1990") is hereby repealed.

(2) CONFORMING AMENDMENT.—Section 4358 of OBRA-1990 is amended by redesignating subsection (d) as subsection (c).

(b) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) of the Social Security Act (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

"(1)(A) If a medicare supplemental policy meets the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

"(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

"(ii) in the case of a policy described in subparagraph (C)(i)—

"(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

"(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

"(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those standards if the policy meets the requirements of subparagraph (B).

"(B) A policy meets the requirements of this subparagraph if—

"(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

"(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network,

"(iii) the network offers sufficient access,

"(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

"(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

"(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

"(bb) out of area coverage under the policy,

"(cc) the policy's coverage of emergency services and urgently needed care, and

"(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

"(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

"(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

"(C)(i) A policy described in this subparagraph—

"(I) is offered by an eligible organization (as defined in section 1876(b)),

"(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

"(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

"(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).".

(c) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) of the Social Security Act (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking "(1) Each" and inserting "(1)(A) Except as provided in subparagraph (B), each";

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new subparagraph:

"(B)(i) Except as provided in clause (ii), in the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy.

"(ii) If an individual described in clause (i) moves to a geographic area where an issuer described in clause (i), or where an affiliate of such issuer, is issuing medicare supplemental policies, such individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

"(iii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.".

(d) CIVIL MONEY PENALTY.—Section 1882(t)(2) of the Social Security Act (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking "(2)" and inserting "(2)(A)";

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as so redesignated—

(A) by striking "paragraph (1)(E)(i)" and inserting "paragraph (1)(B)(v)(I)", and

(B) by striking "paragraph (1)(E)(ii)" and inserting "paragraph (1)(B)(v)(II)";

(4) by striking "the previous sentence" and inserting "this subparagraph"; and

(5) by adding at the end the following new subparagraph:

"(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(e) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the "NAIC") makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the "1994 NAIC Model Regulation").

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in paragraph (1), the Secretary of Health and Human Services (in this subsection as the "Secretary") shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the "1994 Federal Regulation").

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1994 NAIC Model Regulation or the 1994 Federal Regulation; or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1994 NAIC Model Regulation or the 1994 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered, the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6003. INCLUDING NOTICE OF AVAILABLE HEALTH MAINTENANCE ORGANIZATIONS IN ANNUAL NOTICE TO BENEFICIARIES.

Section 1804 of the Social Security Act (42 U.S.C. 1395b-2) is amended—

(1) by striking "and" at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting ", and"; and

(3) by inserting after paragraph (3) the following new paragraph:

"(4) with respect to the area in which the individual receiving the notice resides, a description of the eligible organizations under section 1833(a)(1) or section 1876 and the carriers offering a medicare supplemental policy described in section 1882(t)(1) which serve the area in which the individual receiving the notice resides.".

SEC. 6004. LEGISLATIVE PROPOSAL ON ENROLLING MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop and submit to Congress a proposal for legislation which provides for the enrollment of medicare beneficiaries in private health insurance plans.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term "medicare beneficiary" means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) CONTENTS OF THE PROPOSAL.—A proposal for legislation submitted under subsection (a) shall—

(1) provide for an appropriate methodology by which the Secretary shall make payment to private health insurance plans for the enrollment of medicare beneficiaries;

(2) provide individuals the opportunity to remain enrolled in such a plan without an interruption in coverage upon becoming medicare beneficiaries; and

(3) provide medicare beneficiaries with the opportunity to enroll in a private health insurance plan.

SEC. 6005. OPTIONAL INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN PRIVATE HEALTH PLANS.

(a) INTERIM ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—Notwithstanding title XVIII of the Social Security Act, the Secretary shall provide for a monthly payment as provided under subsection (b)(1) to a private health insurance plan on behalf of enrolled medicare beneficiaries who choose to enroll in such a plan.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term "medicare beneficiary" means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) PAYMENT SPECIFIED.—

(1) FEDERAL PAYMENT.—

(A) IN GENERAL.—The amount of payment specified in this paragraph for an individual who is enrolled in a private health insurance plan is the lesser of—

(i) the applicable rate specified in section 1876(a)(1)(C) of the Social Security Act (but at 100 percent, rather than 95 percent, of the applicable amount); or

(ii) the monthly premium charged the individual for coverage under the private health insurance plan.

(B) SOURCE OF PAYMENT.—The payment to a private health insurance plan under this paragraph for individuals entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, with the allocation to be determined by the Secretary.

(2) INDIVIDUAL'S SHARE.—If the monthly premium for the private plan in which the individual is enrolled is greater than the amount specified under paragraph (1)(A)(i), the individual shall be responsible for paying to the plan the difference between the monthly premium charged the individual for coverage under the plan and the amount specified in paragraph (1)(A)(i).

(c) PAYMENTS UNDER THIS SECTION AS SOLE MEDICARE BENEFITS.—Payments made under this section shall be instead of the amounts that would otherwise be payable, pursuant to sections 1814(b) and 1833(a) of the Social Security Act, for services furnished to medicare beneficiaries.

(d) INCLUSION IN ANNUAL NOTICE TO BENEFICIARIES.—Section 1804 of the Social Security Act (42 U.S.C. 1395b-2), as amended by section 6003, is amended

(1) by striking "and" at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ", and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) a description of the option provided pursuant to section 6005 of the Bipartisan Health Care Reform Act of 1994 for payment to be made by the Secretary on the individual's behalf for enrollment in a private health insurance plan.".

PART 2—IMPROVED PROGRAM EFFICIENCY

SEC. 6011. IMPROVED EFFICIENCY THROUGH CONSOLIDATION OF ADMINISTRATION OF PARTS A AND B.

(a) IN GENERAL.—The Secretary of Health and Human Services shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act) including over a 5-year period.

(b) COMBINATION OF INTERMEDIARY AND CARRIER FUNCTIONS.—In taking such steps, the Secretary shall contract with a single entity that combines the fiscal intermediary and carrier functions in each area except where the Secretary finds that special regional or national contracts are appropriate.

(c) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this section.

PART 3—NOTICE OF ADVANCE DIRECTIVE RIGHTS

SEC. 6021. PROVIDING NOTICE OF RIGHTS REGARDING MEDICAL CARE TO INDIVIDUALS ENTERING MEDICARE.

(a) IN GENERAL.—Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended—

(1) in paragraph (2), by striking "and" at the end;

(2) in paragraph (3), by striking the period at the end and inserting ", and"; and

(3) by inserting after paragraph (3) the following new paragraph:

"(4) a description of an individual's rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in section 1866(f)(3)).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to notices provided under section 1804 of the Social Security Act on or after January 1 of the first year beginning after the date of the enactment of this Act.

Subtitle B—Savings in Medicare and Medicaid

PART 1—SAVINGS RELATING TO MEDICARE PART A

SEC. 6101. REDUCTION IN UPDATE FOR PAYMENTS FOR INPATIENT HOSPITAL SERVICES.

Section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) in subclause (XII)—

(A) by striking "fiscal year 1997" and inserting "for each of the fiscal years 1997 through 2000", and

(B) by striking "0.5 percentage point" and inserting "2.0 percentage points"; and

(2) in subclause (XIII), by striking "fiscal year 1998" and inserting "fiscal year 2005".

SEC. 6102. REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) PPS HOSPITALS.—

(1) REDUCTION IN BASE PAYMENT RATES.—Section 1886(g)(1)(A) of the Social Security Act (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: "In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Bipartisan Health Care Reform Act of 1994) and shall reduce by 10.41 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the Health Security Act).".

(2) REDUCTION IN UPDATE.—Section 1886(g)(1) of such Act (42 U.S.C. 1395ww(g)(1)) is amended—

(A) in subparagraph (B)(i)—

(i) by striking "and (II)" and inserting "(II)", and

(ii) by striking the semicolon at the end and inserting the following: ", and (III) an annual update factor established for the prospective payment rates applicable to discharges in a fiscal year which (subject to reduction under subparagraph (C)) will be based upon such factor as the Secretary determines appropriate to take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality;";

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following new subparagraph:

"(C)(i) With respect to payments attributable to portions of cost reporting periods or discharges occurring during each of the fiscal years 1996 through 2005, the Secretary shall include a reduction in the annual update factor established under subparagraph (B)(i)(III) for discharges in the year equal to the applicable update reduction described in clause (ii) to adjust for excessive increases in capital costs per discharge for fiscal years prior to fiscal year 1992 (but in no event may such reduction result in an annual update factor less than zero).

"(ii) In clause (i), the term 'applicable update reduction' means, with respect to the update factor for a fiscal year—

"(I) 4.9 percentage points; or

"(II) if the annual update factor for the previous fiscal year was less than the applicable update reduction for the previous year, the sum of 4.9 percentage points and the difference between the annual update factor for the previous year and the applicable update reduction for the previous year.".

(b) PPS-EXEMPT HOSPITALS.—Section 1861(v)(1) of such Act (42 U.S.C. 1395x(v)(1)) is further amended by adding at the end the following new subparagraph:

"(T) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to the capital-related costs of inpatient hospital services furnished by a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)), the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during each of the fiscal years 1996 through 2005.".

PART 2—SAVINGS RELATING TO MEDICARE PART B

SEC. 6111. ESTABLISHMENT OF CUMULATIVE EXPENDITURE GOALS FOR PHYSICIAN SERVICES.

(a) USE OF CUMULATIVE PERFORMANCE STANDARD.—Section 1848(f)(2) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)) is amended—

(1) in subparagraph (A)—

(A) in the heading, by striking "IN GENERAL" and inserting "FISCAL YEARS 1991 THROUGH 1994.—",

(B) in the matter preceding clause (i), by striking "a fiscal year (beginning with fiscal year 1991)" and inserting "fiscal years 1991, 1992, 1993, and 1994", and

(C) in the matter following clause (iv), by striking "subparagraph (B)" and inserting "subparagraph (C)";

(2) in subparagraph (B), by striking "subparagraph (A)" and inserting "subparagraphs (A) and (B)";

(3) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(4) by inserting after subparagraph (A) the following new subparagraph:

"(B) FISCAL YEARS BEGINNING WITH FISCAL YEAR 1995.—Unless Congress otherwise provides, the performance standard rate of increase, for all physicians' services and for each category of physicians' services, for a fiscal year beginning with fiscal year 1995 shall be equal to the performance standard rate of increase determined under this paragraph for the previous fiscal year, increased by the product of—

"(i) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services or for the category of physicians' services, respectively, under this part for portions of calendar years included in the fiscal year involved,

"(ii) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

"(iii) 1 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians' services or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

"(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services or of the category of physicians' services, respectively, in the fiscal year (compared with the previous fiscal year) which are estimated to result from changes in law or regulations affecting the percentage increase described in clause (i) and which is not taken into account in the percentage increase described in clause (i),

minus 1, multiplied by 100, and reduced by the performance standard factor (specified in subparagraph (C)).".

(b) TREATMENT OF DEFAULT UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3)(B) of such Act (42 U.S.C. 1395w–4(d)(3)(B)) is amended—

(A) in clause (i)—

(i) in the heading, by striking "IN GENERAL" and inserting "1992 THROUGH 1996", and

(ii) by striking "for a year" and inserting "for 1992, 1993, 1994, 1995, and 1996"; and

(B) by adding after clause (ii) the following new clause:

"(iii) YEARS BEGINNING WITH 1997.—

"(I) IN GENERAL.—The update for a category of physicians' services for a year beginning with 1997 provided under subparagraph (A) shall be increased or decreased by the same percentage by which the cumulative percentage increase in actual expenditures for such category of physicians' services for such year was less or greater, respectively, than the performance standard rate of increase (established under subsection (f)) for such category of services for such year.

"(II) CUMULATIVE PERCENTAGE INCREASE DEFINED.—In subclause (I), the 'cumulative percentage increase in actual expenditures' for a year shall be equal to the product of the adjusted increases for each year beginning with 1995 up to and including the year involved, minus 1 and multiplied by 100. In the previous sentence, the 'adjusted increase' for a year is equal to 1 plus the percentage increase in actual expenditures for the year.''.

(2) Conforming amendment.—Section 1848(d)(3)(A)(i) of such Act (42 U.S.C. 1395w-4(d)(3)(A)(i)) is amended by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''.

(c) Use of Real GDP to Adjust for Volume and Intensity.—Section 1848(f)(2)(B)(iii) of such Act (42 U.S.C. 1395w-4(f)(2)(B)(iii)), as added by subsection (a), is amended to read as follows:

''(iii) 1 plus the average per capita growth in the real gross domestic product (divided by 100) for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for the category of services consisting of primary care services), and''.

(d) Repeal of Restriction on Maximum Reduction.—Section 1848(d)(3)(B)(ii) of such Act (42 U.S.C. 1395w-4(d)(3)(B)(ii)) is amended—

(1) in the heading, by inserting ''IN CERTAIN YEARS'' after ''ADJUSTMENT'';

(2) in the matter preceding subclause (I), by striking ''for a year'';

(3) in subclause (I), by adding ''and'' at the end;

(4) in subclause (II), by striking '', and'' and inserting a period; and

(5) by striking subclause (III).

(e) Repeal of Performance Standard Factor.—

(1) In general.—Section 1842(f)(2) of such Act, as amended by subsection (a)(3), is amended by striking subparagraph (C) and redesignating subparagraph (D) as subparagraph (C).

(2) Conforming amendment.—Section 1842(f)(2)(B) of such Act, as added by subsection (a), is amended in the matter following clause (iv) by striking ''1, multiplied by 100'' and all that follows through ''subparagraph (C))'' and inserting ''1 and multiplied by 100''.

(f) Reduction in Conversion Factor for Physician Fee Schedule for 1995.—Section 1848(d)(1) of the Social Security Act (42 U.S.C. 1395w-4(d)(1)) is amended—

(1) in subparagraph (A), by inserting after ''subparagraph (B)'' the following: '', and, in the case of 1995, specified in subparagraph (C)'';

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

''(C) Special provision for 1995.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph for 1995 is—

''(i) in the case of physicians' services included in the category of primary care services (as defined in subsection (j)(1)), the conversion factor established under this subsection for 1994 adjusted by the update established under paragraph (3) for 1995; and

''(ii) in the case of any other physicians' services, the conversion factor established under this subsection for 1994 reduced by 3 percent and adjusted by the update established under paragraph (3) for 1995.''.

SEC. 6112. IMPOSITION OF COINSURANCE ON LABORATORY SERVICES.

(a) In General.—Paragraphs (1)(D) and (2)(D) of section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) are each amended—

(1) by striking ''(or 100 percent'' and all that follows through ''the first opinion))''; and

(2) by striking ''100 percent of such negotiated rate'' and inserting ''80 percent of such negotiated rate''.

(b) Effective Date.—The amendments made by subsection (a) shall apply to tests furnished on or after January 1, 1995.

SEC. 6113. INCREASE IN MEDICARE PART B PREMIUM FOR INDIVIDUALS WITH HIGH INCOME.

(a) In General.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new part:

''PART VIII—MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

''Sec. 59B. Medicare part B premium tax.

''SEC. 59B. MEDICARE PART B PREMIUM TAX.

''(a) Imposition of Tax.—In the case of an individual to whom this section applies for the taxable year, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax for such taxable year equal to the aggregate of the Medicare part B premium taxes for each of the months during such year that such individual is covered by Medicare part B.

''(b) Individuals to Whom Section Applies.—This section shall apply to any individual for any taxable year if—

''(1) such individual is covered under Medicare part B for any month during such year, and

''(2) the modified adjusted gross income of the taxpayer for such taxable year exceeds the threshold amount.

''(c) Medicare Part B Premium Tax for Month.—

''(1) In general.—The Medicare part B premium tax for any month is the applicable percentage (as defined in paragraph (2)) of the amount equal to the excess of—

''(A) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

''(B) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

''(2) Phase-in of tax.—If the modified adjusted gross income of the taxpayer for any taxable years exceeds the threshold amount by—

''(A) less than $25,000, the applicable percentage under this paragraph is 33⅓ percent;

''(B) at least $25,000, but less than $50,000, the applicable percentage under this paragraph is 66⅔ percent,

''(C) at least $50,000, but less than $75,000, the applicable percentage under this paragraph is 65/75 (expressed as a percent), or

''(D) at least $75,000, the applicable percentage under this paragraph is 100 percent.

''(d) Other Definitions and Special Rules.—For purposes of this section—

''(1) Threshold amount.—The term 'threshold amount' means—

''(A) except as otherwise provided in this paragraph, $75,000,

''(B) $100,000 in the case of a joint return, and

''(C) zero in the case of a taxpayer who—

''(i) is married at the close of the taxable year but does not file a joint return for such year, and

''(ii) does not live apart from his spouse at all times during the taxable year.

''(2) Modified adjusted gross income.—The term 'modified adjusted gross income' means adjusted gross income—

''(A) determined without regard to sections 135, 911, 931, and 933, and

''(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

''(3) Medicare part B coverage.—An individual shall be treated as covered under Medicare part B for any month if a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part for the month.

''(4) Married individual.—The determination of whether an individual is married shall be made in accordance with section 7703.''.

(b) Clerical Amendment.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

''Part VIII. Medicare Part B Premiums For High-Income Individuals.''.

(c) Effective Date.—The amendments made by this section shall apply to months after December 1995 in taxable years ending after December 31, 1995.

SEC. 6114. EXTENSION OF 25 PERCENT PART B PREMIUM.

Section 1839(e) of the Social Security Act (42 U.S.C. 1395r(e)) is amended—

(1) in paragraph (1)(A), by striking ''after after December 1995 and prior to January 1999'' and inserting ''after December 1995'';

(2) by striking ''(1)(A)'' and inserting ''(1)'';

(3) by striking paragraph (2); and

(4) by redesignating subparagraph (B) of paragraph (1) as paragraph (2) (and redesignating the clauses of such subparagraph accordingly).

SEC. 6115. REDUCTION IN HOSPITAL OUTPATIENT SERVICES THROUGH ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.

(a) In General.—Section 1833(a)(2)(B) of the Social Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended by striking ''section 1886)—'' and all that follows and inserting the following: ''section 1886), an amount equal to a prospectively determined payment rate established by the Secretary that provides for payments for such items and services to be based upon a national rate adjusted to take into account the relative costs of furnishing such items and services in various geographic areas, except that for items and services furnished during cost reporting periods (or portions thereof) in years beginning with 1996, such amount shall be equal to 95 percent of the amount that would otherwise have been determined;''.

(b) Establishment of Prospective Payment System.—Not later than July 1, 1995, the Secretary of Health and Human Services shall establish the prospective payment system for hospital outpatient services necessary to carry out section 1833(a)(2)(B) of the Social Security Act (as amended by subsection (a)).

(c) Effective Date.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

PART 3—SAVINGS RELATING TO MEDICARE PARTS A AND B

SEC. 6121. REDUCTION IN HOME HEALTH SERVICES THROUGH ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.

(a) In General.—Section 1833(a)(2)(A) of the Social Security Act (42 U.S.C. 1395l(a)(2)(A)) is amended by striking ''section 1861(s)(10)(A), the lesser of—'' and all that follows and inserting the following: ''section 1861(s)(10)(A), an amount equal to a prospectively determined payment rate established by the Secretary that provides for payments for such services to be based upon a national rate adjusted to take into account the relative costs of furnishing such services in various geographic areas, except that for services furnished during cost reporting periods (or portions thereof) in years beginning with 1996, such amount shall be equal to 95 percent of the amount that would otherwise have been determined;".

(b) ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.—Not later than July 1, 1995, the Secretary of Health and Human Services shall establish the prospective payment system for home health services necessary to carry out section 1833(a)(2)(A) of the Social Security Act (as amended by subsection (a)).

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

SEC. 6122. MEDICARE SECONDARY PAYER.

(a) DELAY IN SUNSET OF DATA MATCHING REQUIREMENTS.—(1) Section 1862(b)(5)(C)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(5)(C)(iii)) is amended by striking "1998" and inserting "2005".

(2) Section 6103(l)(12)(F) of the Internal Revenue Code of 1986 is amended—

(A) in clause (i), by striking "1998" and inserting "2005",

(B) in clause (ii)(I), by striking "1997" and inserting "2004", and

(C) in clause (ii)(II), by striking "1998" and inserting "2005".

(b) EXTENSION OF MEDICARE SECONDARY PAYER TO DISABLED BENEFICIARIES.—Section 1862(b)(1)(B)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended by striking "1998" and inserting "2005".

(c) EXTENSION OF COVERAGE FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the second sentence, by striking "October 1, 1998" and inserting "October 1, 1995"; and

(2) by adding at the end the following: "Effective for items and services furnished on or after October 1, 1995, and before October 1, 2005 (with respect to periods beginning on or after April 1, 1994), clauses (i) and (ii) shall be applied by substituting '24-month' for '12-month' each place it appears.".

PART 4—SAVINGS IN MEDICAID

SEC. 6131. ELIMINATION OF MEDICAID PEDIATRIC IMMUNIZATION PROGRAM.

Effective as if included in the enactment of the 13621 of the Omnibus Budget Reconciliation Act of 1993, title XIX of the Social Security Act is amended as follows:

(1) Section 1902(a) (42 U.S.C. 1396a(a)) is amended by striking paragraph (62).

(2) Section 1928 (42 U.S.C. 1396s) is repealed.

(3) Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by inserting "or" at the end of paragraph (12),

(B) by striking the semicolon at the end of paragraph (13) and inserting a period, and

(C) by striking paragraphs (14) and (15).

(4) Section 1902(a)(32) (42 U.S.C. 1396a(a)(32)) is amended—

(A) by adding "and" at the end of subparagraph (B),

(B) by striking "; and" at the end of subparagraph (C) and inserting a period, and

(C) by striking subparagraph (D).

(5) Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (11)(B)—

(ii) by inserting "and" before "(ii)", and

(iii) by striking "to the individual under section 1903, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services" and inserting "to him under section 1903";

(B) in paragraph (11)(C), by striking ", including the provision of information and education on pediatric vaccinations and the delivery of immunization services," and

(C) in paragraph (43)(A), by striking "and the need for age-appropriate immunizations against vaccine-preventable diseases".

(6) Section 1905(r)(1) (42 U.S.C. 1396d(r)(1)) is amended—

(A) in subparagraph (A)(i), by striking "and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines"; and

(B) in subparagraph (B)(iii), by striking "(according to the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines)".

SEC. 6132. 25 PERCENT REDUCTION IN AMOUNT OF PAYMENT ADJUSTMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) IN GENERAL.—Section 1923 of the Social Security Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

"(h) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION FOR DISPROPORTIONATE SHARE ADJUSTMENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision of this section, the amount of payments under section 1903(a) with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year shall not the applicable percentage of the amount otherwise determined under subsection (f)

"(2) APPLICABLE PERCENTAGE DEFINED.—In paragraph (1), the applicable percentage for a fiscal year is as follows:

"(A) For each of the fiscal years 1997 and 1998, 75 percent.

"(B) For fiscal year 1999, 70 percent.

"(C) For fiscal year 2000 and each succeeding fiscal year, 65 percent.".

(b) CONFORMING AMENDMENT.—Section 1923(c) of such Act (42 U.S.C. 1396r-4(c)) is amended in the matter preceding paragraph (1) by striking "(f) and (g)" and inserting "(f), (g), and (h)".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to quarters in fiscal years beginning on or after October 1, 1995.

SEC. 6133. DENIAL OF MEDICAID ELIGIBILITY FOR CERTAIN ALIENS.

(a) IN GENERAL.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)(1)) is amended—

(1) in paragraph (1)—

(A) by striking "paragraph (2)" and inserting "paragraphs (2) and (3)", and

(B) by striking "who is not lawfully admitted" and all that follows and inserting a period;

(2) in paragraph (2), by striking "described in paragraph (1)"; and

(3) by adding at the end the following new paragraph:

"(4) The limitation on payments provided under paragraph (1) shall not apply with respect to medical assistance furnished to an alien—

"(A) who is 75 years of age or older;

"(B) in the case of an alien who has qualified for conditional entry pursuant to section 207 or 208 of the Immigration and Nationality Act, during the 5-year period beginning on the date such alien enters the United States; or

"(C) in the case of any other alien, during the 1-year period beginning on the date such alien enters the United States.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance furnished during quarters beginning on or after the expiration of the 1-year period that begins on the date of the enactment of this Act, without regard to whether or not regulations to carry out such amendments have been promulgated by such date.

SEC. 6134. ELIMINATION OF MEDICALLY NEEDY PROGRAM FOR INDIVIDUALS NOT IN AN INSTITUTION.

(a) IN GENERAL.—Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)) is amended by inserting "such assistance is restricted to individuals in institutions and" after ", then".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to calendar quarters beginning on or after January 1, 1998.

TITLE VII—INCENTIVES TO PURCHASE LONG-TERM CARE INSURANCE

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Subtitle A—Establishment of Federal Standards for Long-term Care Insurance

SEC. 7001. ESTABLISHMENT OF FEDERAL STANDARDS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—The Public Health Service Act is amended—

(1) by redesignating title XXVII (42 U.S.C. 300cc et seq.) as title XXVIII; and

(2) by inserting after title XXVI the following new title:

"TITLE XXVII—LONG-TERM CARE INSURANCE STANDARDS

"PART A—PROMULGATION OF STANDARDS AND MODEL BENEFITS

"SEC. 2701. STANDARDS.

"(a) APPLICATION OF STANDARDS.—

"(1) NAIC.—The Secretary shall request that the National Association of Insurance Commissioners (hereinafter in this title referred to as the 'NAIC')—

"(A) develop specific standards that incorporate the requirements of this title; and

"(B) report to the Secretary on such standards,

by not later than 12 months after enactment of this title. If the NAIC develops such model standards that incorporate the requirements of this title within such period and the Secretary finds that such standards implement the requirements of this title, such standards shall be the standards applied under this title.

"(2) DEFAULT.—If the NAIC does not promulgate the model standards under paragraph (1) by the deadline established in that paragraph, the Secretary shall promulgate, within 12 months after such deadline, a regulation that provides standards that incorporate the requirements of this title and such standards shall apply as provided for in this title.

"(3) RELATION TO STATE LAW.—Nothing in this title shall be construed as preventing a State from applying standards that provide greater protection to policyholders of long-term care insurance policies than the standards promulgated under this title, except that such State standards may not be inconsistent or in conflict with any of the requirements of this title.

"(b) DEADLINE FOR APPLICATION OF STANDARDS.—

"(1) IN GENERAL.—Subject to paragraph (2), the date specified in this subsection for a State is—

"(A) the date the State adopts the standards established under subsection (a)(1); or

"(B) the date that is 1 year after the first day of the first regular legislative session that begins after the date such standards are first established under subsection (a)(2);

whichever is earlier.

"(2) STATE REQUIRING LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

"(A) requiring State legislation (other than legislation appropriating funds) in order for the standards established under subsection (a) to be applied; but

"(B) having a legislature which is not scheduled to meet within 1 year following the beginning of the next regular legislative session in which such legislation may be considered;

the date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1995. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(c) ITEMS INCLUDED IN STANDARDS.—The standards promulgated under subsection (a) shall include—

"(1) minimum Federal standards for long-term care insurance consistent with the provisions of this title;

"(2) standards for the enhanced protection of consumers with long-term care insurance;

"(3) procedures for the modification of the standards established under paragraph (1) in a manner consistent with future laws to expand existing Federal or State long-term care benefits or establish a comprehensive Federal or State long-term care benefit program; and

"(4) other activities determined appropriate by Congress.

"(d) CONSULTATION.—In establishing standards and models of benefits under this section, the Secretary shall provide for and consult with an advisory committee to be chosen by the Secretary, and composed of—

"(1) three individuals who are representatives of carriers;

"(2) three individuals who are representatives of consumer groups;

"(3) three representatives who are representatives of providers of long-term care services;

"(4) three other individuals who are not representatives of carriers or of providers of long-term care services and who have expertise in the delivery and financing of such services; and

"(5) the Secretary of Veterans Affairs.

"(e) DUTIES.—The advisory committee established under subsection (d) shall—

"(1) recommend the appropriate inflationary index to be used with respect to the inflation protection benefit portion of the standards;

"(2) recommend the uniform needs assessment mechanism to be used in determining the eligibility of individuals for benefits under a policy;

"(3) recommend appropriate standards for benefits under section 2715(c); and

"(4) perform such other activities as determined appropriate by the Secretary.

"(f) ADMINISTRATIVE PROVISIONS.—The following provisions of section 1886(e)(6) of the Social Security Act shall apply to the advisory committee chosen under subsection (d) in the same manner as such provisions apply under such section:

"(1) Subparagraph (C) (relating to staffing and administration).

"(2) Subparagraph (D) (relating to compensation of members).

"(3) Subparagraph (F) (relating to access to information).

"(4) Subparagraph (G) (relating to use of funds).

"(5) Subparagraph (H) (relating to periodic GAO audits).

"(6) Subparagraph (J) (relating to requests for appropriations).

"PART B—ESTABLISHMENT AND IMPLEMENTATION OF LONG-TERM CARE INSURANCE POLICY STANDARDS

"SEC. 2711. IMPLEMENTATION OF POLICY STANDARDS.

"(a) IN GENERAL.—

"(1) REGULATORY PROGRAM.—No long-term care policy (as defined in section (2721)) may be issued, sold, or offered for sale as a long-term care insurance policy in a State on or after the date specified in section 2701(b) unless—

"(A) the Secretary determines that the State has established a regulatory program that—

"(i) provides for the application and enforcement of the standards established under section 2701(a); and

"(ii) complies with the requirements of subsection (b);

by the date specified in section 2701(b), and the policy has been approved by the State commissioner or superintendent of insurance under such program; or

"(B) if the State has not established such a program, or if the State's regulatory program has been decertified, the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 2701(a) by the date specified in section 2701(b).

For purposes of this subsection, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

"(2) REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review regulatory programs described in paragraph (1)(A) to determine if they continue to provide for the application and enforcement of the standards and procedures established under section 2701(a) and (b). If the Secretary determines that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under paragraph (1)(B) with respect to certifying policies in the State and shall exercise full authority under section 2701 for carriers, agents, or associations or its subsidiary in the State plans in the State.

"(b) ADDITIONAL REQUIREMENTS FOR APPROVAL OF STATE REGULATORY PROGRAMS.—For purposes of subsection (a)(1)(A)(ii), the requirements of this subsection for a State regulatory program are as follows:

"(1) ENFORCEMENT.—The enforcement under the program—

"(A) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of non-compliance with such standards; and

"(B) shall provide for notice in the annual report required under paragraph (5) to the Secretary of cases where such compliance is not secured within such 30-day period.

"(2) PROCESS.—The enforcement process under each State regulatory program shall provide for—

"(A) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the standards;

"(B) responding on a timely basis to such complaints;

"(C) the investigation of—

"(i) those complaints which have a reasonable probability of validity, and

"(ii) such other alleged violations of the standards as the program finds appropriate; and

"(D) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty as provided for in section 2718) in the case of a carrier, agent, or association or its subsidiary determined to have violated the standards.

"(3) CONSUMER ACCESS TO COMPLIANCE INFORMATION.—

"(A) IN GENERAL.—A State regulatory program must provide for consumer access to complaints filed with the State commissioner or superintendent of insurance with respect to long-term care insurance policies.

"(B) CONFIDENTIALITY.—The access provided under subparagraph (A) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

"(4) PROCESS FOR APPROVAL OF PREMIUMS.—

"(A) IN GENERAL.—Each State regulatory program shall—

"(i) provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care insurance policies; and

"(ii) establish a policy for receipt and consideration of public comments before approving such a premium increase or decrease.

"(B) CONDITIONS FOR APPROVAL.—No premium increase shall be approved (or deemed approved) under subparagraph (A) unless the proposed increase is accompanied by an actuarial memorandum which—

"(i) includes a description of the assumptions that justify the increase;

"(ii) contains such information as may be required under the Standards; and

"(iii) is made available to the public.

"(C) APPLICATION.—Except as provided in subparagraph (D), this paragraph shall not apply to a group long-term care insurance policy issued to a group described in section 4(E)(1) of the NAIC Long Term Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines developed by the NAIC, provide notice to policyholders and certificate holders of any premium change under such group policy.

"(D) EXCEPTION.—Subparagraph (C) shall not apply to—

"(i) group conversion policies;

"(ii) the group continuation feature of a group policy if the insurer separately rates employee and continuation coverages; and

"(iii) group policies where the function of the employer is limited solely to collecting premiums (through payroll deductions or dues checkoff) and remitting them to the insurer.

"(E) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the NAIC from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care insurance policies.

"(5) ANNUAL REPORTS.—Each State regulatory program shall provide for annual reports to be submitted to the Secretary on the implementation and enforcement of the standards in the State, including information concerning violations in excess of 30 days.

"(6) ACCESS TO OTHER INFORMATION.—The State regulatory program must provide for consumer access to actuarial memoranda provided under paragraph (4).

"(7) DEFAULT.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the enforcement activities described in subsection (c).

"(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

"(1) IN GENERAL.—The Secretary shall exercise authority under this section in the case of a State that does not have a regulatory program approved under this section.

"(2) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

"(A) for individuals and entities to file written, signed complaints respecting alleged violations of the requirements of this title;

"(B) for responding on a timely basis to such complaints; and

"(C) for the investigation of—

"(i) those complaints that have a reasonable probability of validity; and

"(ii) such other alleged violations of the requirements of this title as the Secretary determines to be appropriate.

In conducting investigations under this subsection, agents of the Secretary shall have reasonable access necessary to enable such agents to examine evidence of any carrier, agent, or association or its subsidiary being investigated.

"(3) HEARINGS.—

"(A) IN GENERAL.—Prior to imposing an order described in paragraph (4) against a carrier, agent, or association or its subsidiary under this section for a violation of the requirements of this title, the Secretary shall provide the carrier, agent, association or subsidiary with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary by regulation) of the date of the notice, a hearing respecting the violation.

"(B) CONDUCT OF HEARING.—Any hearing requested under subparagraph (A) shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

"(C) AUTHORITY IN HEARINGS.—In conducting hearings under this paragraph—

"(i) agents of the Secretary and administrative law judges shall have reasonable access necessary to enable such agents and judges to examine evidence of any carrier, agent, or association or its subsidiary being investigated; and

"(ii) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subparagraph and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

"(D) ISSUANCE OF ORDERS.—If an administrative law judge determines in a hearing under this paragraph, upon the preponderance of the evidence received, that a carrier, agent, or association or its subsidiary named in the complaint has violated the requirements of this title, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier, agent, association, or subsidiary an order described in paragraph (4).

"(4) CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.—

"(A) IN GENERAL.—Subject to the provisions of subparagraphs (B) through (F), an order under this paragraph—

"(i) shall require the agent, association or its subsidiary, or a carrier—

"(I) to cease and desist from such violations; and

"(II) to pay a civil penalty in an amount not to exceed $15,000 in the case of each agent, and not to exceed $25,000 for each association or its subsidiary or a carrier for each such violation; and

"(ii) may require the agent, association or its subsidiary, or a carrier to take such other remedial action as is appropriate.

"(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this paragraph by reason of any violation if the carrier, agent, or association or its subsidiary establishes to the satisfaction of the Secretary that—

"(i) such violation was due to reasonable cause and was not intentional and was not due to willful neglect; and

"(ii) such violation is corrected within the 30-day period beginning on the earliest date the carrier, agent, association, or subsidiary knew, or exercising reasonable diligence could have known, that such a violation was occurring.

"(C) WAIVER BY SECRETARY.—In the case of a violation under this title that is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed under subparagraph (A)(i)(II) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

"(D) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this paragraph shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this paragraph.

"(E) JUDICIAL REVIEW.—A carrier, agent, or association or its subsidiary or any other individual adversely affected by a final order issued under this paragraph may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

"(F) ENFORCEMENT OF ORDERS.—If a carrier, agent, or association or its subsidiary fails to comply with a final order issued under this paragraph against the carrier, agent, association or subsidiary after opportunity for judicial review under subparagraph (E), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

"SEC. 2712. REGULATION OF SALES PRACTICES.

"(a) DUTY OF GOOD FAITH AND FAIR DEALING.—

"(1) IN GENERAL.—Each agent (as defined in section 2733) or association that is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

"(2) PROHIBITED PRACTICES.—An agent or association is considered to have violated paragraph (1) if the agent or association engages in any of the following practices:

"(A) TWISTING.—

"(i) IN GENERAL.—Knowingly making any misleading representation (including the inaccurate completion of medical histories) or incomplete or fraudulent comparison of any long-term care insurance policy or insurers for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

"(ii) POLICY REPLACEMENT FORM.—With respect to any person who elects to replace or effect a change in a long-term care insurance policy, the individual that is selling such policy shall ensure that such person completes a policy replacement form developed by the NAIC. A copy of such form shall be provided to such person and additional copies shall be delivered by the selling individual to the old policy issuer and the new issuer and kept on file for inspection by the State regulatory agency.

"(B) HIGH PRESSURE TACTICS.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through force, fright, threat or undue pressure, whether explicit or implicit.

"(C) COLD LEAD ADVERTISING.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

"(D) OTHERS.—Engaging in such other practices determined inappropriate under guidelines issued by the NAIC.

"(b) FINANCIAL STANDARDS.—The NAIC shall develop recommended financial minimum standards (including both income and asset criteria) for the purpose of advising individuals considering the purchase of a long-term care insurance policy.

"(c) PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.—An agent, an association, or a carrier may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance under title XIX of the Social Security Act.

"(d) PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE SERVICE BENEFIT POLICIES.—An agent, association or its subsidiary, or a carrier may not sell or issue a service-benefit long-term care insurance policy to an individual—

"(1) knowing that the policy provides for coverage that duplicates coverage already provided in another service-benefit long-term care insurance policy held by such individual (unless the policy is intended to replace such other policy); or

"(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage—

"(A) does not duplicate other coverage in effect under a service-benefit long-term care insurance policy; or

"(B) will replace another service-benefit long-term care insurance policy.

In this subsection, the term 'service-benefit long-term care insurance policy' means a long-term care insurance policy which provides for benefits based on the type and amount of services furnished.

"(e) PROHIBITION BASED ON ELIGIBILITY FOR OTHER BENEFITS.—A carrier may not sell or issue a long-term care insurance policy that reduces, limits or coordinates the benefits provided under the policy on the basis that the policyholder has or is eligible for other long-term care insurance coverage or benefits.

"(f) PROVISION OF OUTLINE OF COVERAGE.—No agent, association or its subsidiary, or carrier may sell or offer for a sale a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) without providing to the purchaser or potential purchaser (or representative) an outline of coverage that complies with the standards established under section 2701(a).

"(g) PENALTIES.—Any agent who sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, and, in addition, is subject to a civil money penalty of not to exceed $15,000 for each such violation. Any association or its subsidiary or carrier that sells, offers for sale, or issues a long-term care insurance policy in violation of this section may be fined in accordance with title 18, United States Code, and in addition, is subject to a civil money penalty of not to exceed $25,000 for each violation.

"(h) AGENT TRAINING AND CERTIFICATION REQUIREMENTS.—The NAIC, shall establish requirements for long-term care insurance agent training and certification that—

"(1) specify requirements for training insurance agents who desire to sell or offer for sale long-term care insurance policies; and

"(2) specify procedures for certifying agents who have completed such training and who are as qualified to sell or offer for sale long-term care insurance policies.

"SEC. 2713. ADDITIONAL RESPONSIBILITIES FOR CARRIERS.

"(a) REFUND OF PREMIUMS.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance pursuant to subsection 2717, the carrier shall refund directly to the applicant, or in the case of an employer to whomever remits the premium, and not by delivery by the agent, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy (or certificate).

"(b) MAILING OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall provide the applicant, or in the case of a group plan the employer, the policy (or certificate) of insurance not later than 30 days after the date of the approval.

"(c) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the carrier shall, within 30 days of the date of a written request by the policyholder or certificate holder (or representative)—

"(1) provide a written explanation of the reasons for the denial; and

"(2) make available all medical and patient records directly relating to such denial.

Except as provided in subsection (e) of section 2715, no claim under such a policy may be denied on the basis of a failure to disclose a condition at the time of issuance of the policy if the application for the policy failed to request information respecting the condition.

"(d) REPORTING OF INFORMATION.—A carrier that issues one or more long-term care insurance policies shall periodically (not less often than annually) report, in a form and in a manner determined by the NAIC, to the Commissioner, superintendent or director of insurance of each State in which the policy is delivered, and shall make available to the Secretary, upon request, information in a form and manner determined by the NAIC concerning—

"(1) the long-term care insurance policies of the carrier that are in force;

"(2) the most recent premiums for such policies and the premiums imposed for such policies since their initial issuance;

"(3) the lapse rate, replacement rate, and rescission rates by policy;

"(4) the names of that 10 percent of its agents that—

"(A) have the greatest lapse and replacement rate; and

"(B) have produced at least $50,000 of long-term care insurance sales in the previous year; and

"(5) the claims denied (expressed as a number and as a percentage of claims submitted) by policy.

Information required under this subsection shall be reported in a format specified in the standards established under section 2701(a). For purposes of paragraph (3), there shall be included (but reported separately) data concerning lapses due to the death of the policyholder. For purposes of paragraph (4), there shall not be included as a claim any claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

"(e) STANDARDS ON COMPENSATION FOR SALE OF POLICIES.—

"(1) IN GENERAL.—A carrier that issues one or more long-term care insurance policies may provide a commission or other compensation to an agent or other representative for the sale of such a policy only if the first year commission or other first year compensation to be paid does not exceed 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year, or if the first year commission or other compensation to be paid does not exceed 50 percent of the premium paid on the first year policy, until the NAIC promulgates mandatory standards concerning compensation for the sale of such policies.

"(2) SUBSEQUENT YEARS.—The commission or other compensation provided for the sale of long-term care insurance policies in years subsequent to the first year of the policy shall be the same as that provided in the second subsequent year and shall be provided for no fewer than 5 subsequent years.

"(3) LIMITATION.—No carrier shall provide compensation to its agents for the sale of a long-term care insurance policy and no agent shall receive compensation greater than the renewal compensation payable by the replacing carrier on renewal policies if an existing policy is replaced.

"(4) COMPENSATION DEFINED.—As used in this subsection, the term 'compensation' includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy, including but not limited to deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

"SEC. 2714. RENEWABILITY STANDARDS FOR ISSUANCE, AND BASIS FOR CANCELLATION OF POLICIES.

"(a) IN GENERAL.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium, material misrepresentation or fraud.

"(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

"(1) IN GENERAL.—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

"(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facility, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

"(3) BASIS FOR CONVERSION.—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

"(A) whose coverage under the group policy would otherwise be terminated for any reason; and

"(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

"(4) TREATMENT OF SUBSTANTIAL EQUIVALENCE.—In determining under this subsection whether benefits are substantially equivalent, consideration should be given to the difference between managed care and non-managed care plans.

"(5) GROUP REPLACEMENT OF POLICIES.—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

"(c) STANDARDS FOR ISSUANCE.—

"(1) IN GENERAL.—

"(A) GUARANTEE.—An agent, association or carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual, or eligible individual in the case of a group plan, if such individual meets the minimum medical underwriting requirements of such policy.

"(B) PREMIUM FOR CONVERTED POLICY.—If a group policy from which conversion is made is a replacement for a previous group policy, the premium for the converted policy shall be calculated on the basis of the insured's age at the inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

"(2) UPGRADE FOR CURRENT POLICIES.—The NAIC shall establish standards, including those providing guidance on medical underwriting and age rating, with respect to the access of individuals to policies offering upgraded benefits.

"(d) EFFECT OF INCAPACITATION.—

"(1) IN GENERAL.—

"(A) PROHIBITION.—Except as provided in paragraph (2), a long-term care insurance policy in effect as of the effective date of the standards established under section 2701(a) may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care provider, independent of the issuer of the policy, to be cognitively or mentally incapacitated so as to not make payments in a timely manner.

"(B) REINSTATEMENT.—A long-term care policy shall include a provision that provides for the reinstatement of such coverage, in the event of lapse, if the insurer is provided with proof of cognitive or mental incapacitation. Such reinstatement option shall remain available for a period of not less than 5 months after termination and shall allow for the collection of past due premium.

"(2) PERMITTED CANCELLATION.—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

"(A) the period of such nonpayment is in excess of 30 days; and

"(B) notice of intent to cancel is provided to the policyholder or designated representative of the policyholder not less than 30 days prior to such cancellation, except that notice may not be provided until the expiration of 30 days after a premium is due and unpaid.

Notice under this paragraph shall be deemed to have been given as of 5 days after the mailing date.

"SEC. 2715. BENEFIT STANDARDS.

"(a) USE OF STANDARD DEFINITIONS AND TERMINOLOGY, UNIFORM FORMAT, AND STANDARD BENEFITS.—Each long-term care insurance policy shall, with respect to services, providers or facilities, pursuant to standards established under section 2701(a)—

"(1) use uniform language and definitions, except that such language and definitions may take into account the differences between States with respect to definitions and terminology used for long-term care services and providers;

"(2) use a uniform format for presenting the outline of coverage under such a policy; and

"(3) provide coverage for at least one standard benefits package (of those developed by the NAIC) that shall include the limitations on the amount of payments per day and the lengths of covered stays for nursing facility and home health care services;

as prescribed under guidelines issued by the NAIC and periodically updated.

"(b) DISCLOSURE.—

"(1) OUTLINE OF COVERAGE.—

"(A) REQUIREMENT.—Each carrier that sells or offers for sale a long-term care insurance policy shall provide an outline of coverage under such policy that meets the applicable standards established pursuant to section 2701(a), complies with the requirements of subparagraph (B), and is in a uniform format as prescribed in guidelines issued by the NAIC and periodically updated.

"(B) CONTENTS.—The outline of coverage for each long-term care insurance policy shall include at least the following:

"(i) A description of the principal benefits and coverage under the policy.

"(ii) A statement of the principal exclusions, reductions, and limitations contained in the policy.

"(iii) A statement of the terms under which the policy (or certificate) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

"(iv) A statement, in bold face type on the face of the document in language that is understandable to an average individual, that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern, except that such summary shall substantially and accurately reflect the contents of the policy or the master policy.

"(v) A description of the terms, specified in section 2717, under which a policy or certificate may be returned and premium refunded.

"(vi) Information on national average costs for nursing facility and home health care and information (in graphic form) on the relationship of the value of the benefits provided under the policy to such national average costs and State average costs, where available.

"(vii) A statement of the percentage limit on annual premium increases that is provided under the policy pursuant to this section.

"(2) CERTIFICATES.—A certificate issued pursuant to a group long-term care insurance policy shall include—

"(A) a description of the principal benefits and coverage provided in the policy;

"(B) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

"(C) a statement that the group master policy determines governing contractual provisions.

"(3) LONG-TERM CARE AS PART OF LIFE INSURANCE.—In the case of a long-term care insurance policy issued as a part of, or a rider on, a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

"(A) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

"(B) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person; and

"(C) any exclusions, reductions, and limitations on benefits of long-term care.

"(4) ADDITIONAL INFORMATION.—The NAIC shall develop recommendations with respect to informing consumers of the long-term economic viability of carriers issuing long-term care insurance policies.

"(c) LIMITING CONDITIONS ON BENEFITS; MINIMUM BENEFITS.—

"(1) IN GENERAL.—A long-term care insurance policy may not condition or limit eligibility—

"(A) for benefits for a type of services to the need for or receipt of any other services;

"(B) for any benefit on the medical necessity for such benefit;

"(C) for benefits furnished by licensed or certified providers in compliance with conditions which are in addition to those required for licensure or certification under State law, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC; or

"(D) for residential care (if covered under the policy) only—

"(i) to care provided in facilities which provide a higher level of care; or

"(ii) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State.

"(2) HOME HEALTH CARE OR COMMUNITY-BASED SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified home health care or community-based services, the policy—

"(A) may not limit such benefits to services provided by registered nurses or licensed practical nurses;

"(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or licensed or certified home care worker, except that if no State licensure or certification laws exists, in compliance with qualifications developed by the NAIC;

"(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act; and

"(D) must provide, at a minimum, benefits for personal care services (including home health aide and home care worker services as defined by the NAIC) home health services, adult day care, and respite care in an individual's home or in another setting in the community, or any of these benefits on a respite care basis.

"(3) NURSING FACILITY SERVICES.—If a long-term care insurance policy provides benefits for the payment of specified nursing facility services, the policy must provide such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act or until such time as subsequently provided for by the NAIC in establishing uniform language and definitions under section 2715(a)(1)) in the State.

"(4) PER DIEM POLICIES.—

"(A) DEFINITION.—For purposes of this title, the term 'per diem long-term care insurance policy' means a long-term care insurance policy (or certificate under a group long-term care insurance policy) that provides for benefit payments on a periodic basis due to cognitive impairment or loss of functional capacity without regard to the expenses incurred or services rendered during the period to which the payments relate.

"(B) LIMITATION.—No per diem long-term care insurance policy (or certificate) may condition or otherwise exclude benefit payments based on the receipt of any type of nursing facility, home health care or community-based services.

"(d) PROHIBITION OF DISCRIMINATION.—A long-term care insurance policy may not treat benefits under the policy in the case of an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any organic or inorganic mental illness, or with mental retardation or any other cognitive or mental impairment differently from an individual having another medical condition for which benefits may be made available.

"(e) LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.—

"(1) INITIAL ISSUANCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the issuance of the policy.

"(B) 6-MONTH LIMIT.—

"(i) IN GENERAL.—No long-term care insurance policy or certificate issued under this title shall utilize a definition of 'preexisting condition' that is more restrictive than the following: The term 'preexisting condition' means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured individual.

"(ii) PROHIBITION ON EXCLUSION OF COVERAGE.—No long-term care insurance policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of the coverage of the insured individual.

"(2) REPLACEMENT POLICIES.—If a long-term care insurance policy replaces another long-term care insurance policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

"(f) ELIGIBILITY FOR BENEFITS.—

"(1) LONG-TERM CARE POLICIES.—Each long-term care insurance policy shall—

"(A) describe the level of benefits available under the policy; and

"(B) specify in clear, understandable terms, the level (or levels) of physical, cognitive, or mental impairment required in order to receive benefits under the policy.

"(2) FUNCTIONAL ASSESSMENT.—In order to submit a claim under any long-term care insurance policy, each claimant shall have a professional functional assessment of his or her physical, cognitive, and mental abilities. Such initial assessment shall be conducted by an individual or entity, meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and that such individual meets any applicable State licensure and certification requirements. The individual or entity conducting such assessment may not control, or be controlled by, the issuer of the policy. For purposes of this paragraph and paragraph (4), the term 'control' means the direct or indirect possession of the power to direct the management and policies of a person. Control is presumed to exist, if any person directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent of the voting securities of another person.

"(3) CLAIMS REVIEW.—Except as provided in paragraph (4), each long-term care insurance policy shall be subject to final claims review by the carrier pursuant to the terms of the long-term care insurance policy.

"(4) APPEALS PROCESS.—

"(A) IN GENERAL.—Each long-term care insurance policy shall provide for a timely and independent appeals process, meeting standards established by the NAIC, for individuals who dispute the results of the claims review, conducted under paragraph (3), of the claimant's functional assessment, conducted under paragraph (2).

"(B) INDEPENDENT ASSESSMENT.—An appeals process under this paragraph shall include, at the request of the claimant, an independent assessment of the claimant's physical, cognitive or mental abilities.

"(C) CONDUCT.—An independent assessment under subparagraph (B) shall be conducted by an individual or entity meeting the qualifications established by the NAIC to assure the professional competence and credibility of such individual or entity and any applicable State licensure and certification requirements and may not be conducted—

"(i) by an individual who has a direct or indirect significant or controlling interest in, or direct affiliation or relationship with, the issuer of the policy;

"(ii) by an entity that provides services to the policyholder or certificateholder for which benefits are available under the long-term care insurance policy; or

"(iii) by an individual or entity in control of, or controlled by, the issuer of the policy.

"(5) STANDARD ASSESSMENTS.—Not later than 2 years after the date of enactment of this title, the advisory committee established under section 2701(d) shall recommend uniform needs assessment mechanisms for the determination of eligibility for benefits under such assessments.

"(g) INFLATION PROTECTION.—

"(1) OPTION TO PURCHASE.—A carrier may not offer a long-term care insurance policy unless the carrier also offers to the proposed policyholder, including each group policyholder, the option to purchase a policy that provides for increases in benefit levels, with benefit maximums or reasonable durations that are meaningful, to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. A carrier may not offer to a policyholder an inflation protection feature that is less favorable to the policyholder than one of the following:

"(A) With respect to policies that provide for automatic periodic increases in benefits, the policy provides for an annual increase in benefits in a manner so that such increases are computed annually at a rate of not less than 5 percent.

"(B) With respect to policies that provide for periodic opportunities to elect an increase in benefits, the policy guarantees that the insured individual will have the right to periodically increase the benefit levels under the policy without providing evidence of insurability or health status so long as the option for the previous period was not declined. The amount of any such additional benefit may not be less than the difference between—

"(i) the existing policy benefit; and

"(ii) such existing benefit compounded annually at a rate of at least 5 percent for the period beginning on the date on which the existing benefit is purchased and extending until the year in which the offer of increase is made.

"(C) With respect to service benefit policies, the policy covers a specified percentage of the actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

"(2) EXCEPTION.—The requirements of paragraph (1) shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

"(3) REQUIRED INFORMATION.—Carriers shall include the following information in or together with the outline of coverage provided under this title:

"(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. Such comparison shall show benefit levels over not less than a 20-year period.

"(B) Any expected premium increases or additional premiums required to pay for any automatic or optional benefit increases, whether the individual who purchases the policy obtains the inflation protection initially or whether such individual delays purchasing such protection until a future time.

"(4) CONTINUATION OF PROTECTION.—Inflation protection benefit increases under this subsection under a policy that contains such protection shall continue without regard to an insured's age, claim status or claim history, or the length of time the individual has been insured under the policy.

"(5) CONSTANT PREMIUM.—An offer of inflation protection under this subsection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

"(6) REJECTION.—Inflation protection under this subsection shall be included in a long-term care insurance policy unless a carrier obtains a written rejection of such protection signed by the policyholder.

"SEC. 2716. NONFORFEITURE.

"(a) IN GENERAL.—Each long-term care insurance policy (or certificate) shall provide that if the policy lapses after the policy has been in effect for a minimum period (specified under the standards under section 2701(a)), the policy will provide, without payment of any additional premiums, nonforfeiture benefits as determined appropriate by the NAIC.

"(b) ESTABLISHMENT OF STANDARDS.—The standards under section 2701(a) shall provide that the percentage or amount of benefits under subsection (a) must increase based upon the policyholder's equity in the policy.

"SEC. 2717. LIMIT OF PERIOD OF CONTESTABILITY AND RIGHT TO RETURN.

"(a) CONTESTABILITY.—A carrier may not cancel or renew a long-term care insurance policy or deny a claim under the policy based on fraud or material misrepresentation relating to the issuance of the policy unless notice of such fraud or material misrepresentation is provided within a time period to be determined by the NAIC.

"(b) RIGHT TO RETURN.—Each applicant for a long-term care insurance policy shall have the right to return the policy (or certificates) within 30 days of the date of its delivery (and to have the premium refunded) if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

"SEC. 2718. CIVIL MONEY PENALTY.

"(a) CARRIER.—Any carrier, association or its subsidiary that sells or offers for sale a long-term care insurance policy and that—

"(1) fails to make a refund in accordance with section 2713(a);

"(2) fails to transmit a policy in accordance with section 2713(b);

"(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

"(4) provides a commission or compensation in violation of section 2713(e);

"(5) fails to provide an outline of coverage in violation of section 2715(b)(1); or

"(6) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $25,000 for each such violation.

"(b) AGENTS.—Any agent that sells or offers for sale a long-term care insurance policy and that—

"(1) fails to make a refund in accordance with section 2713(a);

"(2) fails to transmit a policy in accordance with section 2713(b);

"(3) fails to provide, make available, or report information in accordance with subsections (c) or (d) of section 2713;

"(4) fails to provide an outline of coverage in violation of section 2715(b)(1); or

"(5) issues a policy without obtaining certain information in violation of section 2715(f);

is subject to a civil money penalty of not to exceed $15,000 for each such violation.

"PART C—LONG-TERM CARE INSURANCE POLICIES, DEFINITION AND ENDORSEMENTS

"SEC. 2721. LONG-TERM CARE INSURANCE POLICY DEFINED.

"(a) IN GENERAL.—As used in this section, the term 'long-term care insurance policy' means any insurance policy, rider or certificate advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis, for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes—

"(1) group and individual annuities and life insurance policies, riders or certificates that provide directly, or that supplement long-term care insurance; and

"(2) a policy, rider or certificates that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

"(b) ISSUANCE.—Long-term care insurance policies may be issued by—

"(1) carriers;

"(2) fraternal benefit societies;

"(3) nonprofit health, hospital, and medical service corporations;

"(4) prepaid health plans;

"(5) health maintenance organizations; or

"(6) any similar organization to the extent they are otherwise authorized to issue life or health insurance.

"(c) POLICIES EXCLUDED.—The term 'long-term care insurance policy' shall not include any insurance policy, rider or certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With respect to life insurance, such term shall not include life insurance policies, riders or certificates that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

"(d) APPLICATIONS.—Notwithstanding any other provision of this title, this title shall apply to any product advertised, marketed or offered as a long-term insurance policy, rider or certificate.

"SEC. 2722. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

"Not later than 1 year after the date of enactment of this title the NAIC shall issue guidelines that shall apply to organizations and associations, other than employers and labor organizations that do not accept compensation, and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association. Such guidelines shall include at minimum the following:

"(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations may not function primarily as sales agents for insurance companies.

"(2) Organizations and associations shall provide objective information regarding long-term care insurance policies sold or endorsed by such organizations and associations to ensure that members of such organizations and associations have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

"(3) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the manner in which such policies and the insurance company issuing such policies were selected. If the organization or association and the insurance company have interlocking directorates, the organization or association shall disclose such fact to their members.

"(4) Organizations and associations selling or endorsing long-term care insurance policies shall disclose in marketing literature provided to their members concerning such policies the nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support that the organization or association receives) from the endorsement or sale of the policy to its members.

"(5) The Boards of Directors of organizations and associations selling or endorsing long-term care insurance policies, if such organizations and associations have a Board of Directors, shall review and approve such insurance policies, the compensation arrangements and the marketing materials used to promote sales of such policies.

"PART D—MISCELLANEOUS PROVISIONS

"SEC. 2731. DEFINITIONS.

"As used in this title:

"(1) AGENT.—The term 'agent' means—

"(A) prior to 2 years after the date of enactment of this Act, an individual who sells or offers for sale a long-term care insurance policy subject to the requirements of this title and is licensed or required to be licensed under State law for such purpose; and

"(B) after the date referred to in subparagraph (A), an individual who meets the training and certification requirements established under section 2712(f).

"(2) ASSOCIATION.—The term 'association' includes the association and its subsidiaries.

"(3) CARRIER.—The term 'carrier' means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insured carrier, a reinsurance carrier, and a multiple employer welfare arrangement (a combination of employers associated for the purpose of providing health benefit plan coverage for their employees).".

(b) CONFORMING AMENDMENTS.—

(1) Sections 2701 through 2714 of the Public Health Service Act (42 U.S.C. 300cc through 300cc–15) are redesignated as sections 2801 through 2814, respectively.

(2) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are amended by striking "2701" each place that such appears and inserting "2801".

Subtitle B—Tax Treatment of Long-term Care Insurance

SEC. 7101. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Subpart E of part I of subchapter L of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 818 the following new section:

"SEC. 818A. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

"(a) GENERAL RULE.—For purposes of this part, a long-term care insurance contract shall be treated as an accident or health insurance contract.

"(b) LONG-TERM CARE INSURANCE CONTRACT.—

"(1) IN GENERAL.—For purposes of this part, the term 'long-term care insurance contract' means any insurance contract issued if—

"(A) the only insurance protection provided under such contract is coverage of qualified long-term care services and benefits incidental to such coverage,

"(B) the maximum benefit under the policy for expenses incurred for any day does not exceed $200,

"(C) such contract does not cover expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

"(D) such contract is guaranteed renewable,

"(E) such contract does not have any cash surrender value, and

"(F) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

"(2) SPECIAL RULES.—

"(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be treated as described in paragraph (1)(A) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

"(B) CONTRACT MAY COVER MEDICARE REIMBURSABLE EXPENSES WHERE MEDICARE IS SECONDARY PAYOR.—Paragraph (1)(C) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

"(C) REFUNDS OF PREMIUMS.—Paragraph (1)(F) shall not apply to any refund of premiums on surrender or cancellation of the contract.

"(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which—

"(A) are required by a chronically ill individual in a qualified facility, and

"(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

"(2) CHRONICALLY ILL INDIVIDUAL.—

"(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

"(i)(I) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in subparagraph (B)) for a period of at least 90 days due to a loss of functional capacity, or

"(II) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subclause (I), or

"(ii) having a similar level of disability due to cognitive impairment.

"(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

"(i) MOBILITY.—The process of walking or wheeling on a level surface which may include the use of an assistive device such as a cane, walker, wheelchair, or brace.

"(ii) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

"(iii) TOILETING.—The act of going to the toilet room for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes or the ability to voluntarily control bowel and bladder function, or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

"(iv) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

"(v) EATING.—The process of getting food from a plate or its equivalent into the mouth.

"(3) QUALIFIED FACILITY.—The term 'qualified facility' means—

"(A) a nursing, rehabilitative, hospice, or adult day care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility, or similar institution)—

"(i) which is licensed under State law, or

"(ii) which is a certified facility for purposes of title XVIII or XIX of the Social Security Act, or

"(B) an individual's home if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a facility described in subparagraph (A).

"(4) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is to provide needed assistance with any of the activities of daily living described in paragraph (2)(B).

"(5) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

"(d) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—This section shall not apply in determining whether section 4980B (relating to failure to satisfy continuation coverage requirements of group health plans) applies.

"(e) INFLATION ADJUSTMENT OF $200 BENEFIT LIMIT.—

"(1) IN GENERAL.—In the case of a calendar year after 1994, the $200 amount contained in subsection (b)(1)(B) shall be increased for such calendar year by the medical care cost adjustment for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

"(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(B) such component for August of 1993."

(b) CLERICAL AMENDMENT.—The table of sections for such subpart E is amended by inserting after the item relating to section 818 the following new item:

"Sec. 818A. Treatment of long-term care insurance or plans."

SEC. 7102. EXCLUSION FOR BENEFITS PROVIDED UNDER LONG-TERM CARE INSURANCE; INCLUSION OF EMPLOYER-PROVIDED COVERAGE.

(a) IN GENERAL.—Subsection (a) of section 104 of the Internal Revenue Code of 1986 (relating to compensation for injuries or sickness) is amended by striking "and" at the end of paragraph (4), by striking the period at the end of paragraph (5) and inserting ", and", and by inserting after paragraph (4) the following new paragraph:

"(6) benefits under a long-term care insurance contract (as defined in section 818A(b))."

(b) INCLUSION OF EMPLOYER-PROVIDED COVERAGE.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by adding at the end thereof the following sentence: "The preceding sentence shall not apply to any plan providing coverage for long-term care services."

SEC. 7103. QUALIFIED LONG-TERM SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended by striking "or" at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

"(C) for qualified long-term care services (as defined in section 818A(c)), or".

(b) DEDUCTION FOR LONG-TERM CARE EXPENSES FOR PARENT OR GRANDPARENT.—Section 213 of such Code (relating to deduction for medical expenses) is amended by adding at the end the following new subsection:

"(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE EXPENSES.—For purposes of subsection (a), the term 'dependent' shall include any parent or grandparent of the taxpayer for whom the taxpayer has expenses for long-term care services described in section 818A(c), but only to the extent of such expenses."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) of such Code (as redesignated by subsection (a)) is amended by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)".

(2)(A) Paragraph (1) of section 213(d) of such Code is amended by adding at the end thereof the following new flush sentence:

"In the case of a long-term care insurance contract (as defined in section 818A), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D)."

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

"(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

"(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any long-term care insurance contract (as defined in section 818A) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

"In the case of an individual with an attained age before the close of the taxable year of:	**The limitation is:**
40 or less	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	1,600
More than 70	2,000.

"(B) INDEXING.—

"(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, each dollar amount contained in paragraph (1) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

"(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(II) such component for August of 1991."

(3) Paragraph (6) of section 213(d) of such Code is amended—

(A) by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)", and

(B) by striking "paragraph (1)(C)" in subparagraph (A) and inserting "paragraph (1)(D)".

(4) Paragraph (7) of section 213(d) of such Code is amended by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)".

SEC. 7104. EXCLUSION FROM GROSS INCOME FOR AMOUNTS OTHERWISE INCLUDIBLE ON THE SURRENDER OR CANCELLATION OF ANY LIFE INSURANCE POLICY WHICH ARE USED FOR LONG-TERM CARE INSURANCE PREMIUMS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

"SEC. 137. AMOUNTS RECEIVED ON CANCELLATION, ETC., OF LIFE INSURANCE CONTRACTS AND USED TO PAY PREMIUMS FOR QUALIFIED LONG-TERM CARE INSURANCE.

"No amount which would (but for this section) be includible in the gross income of an individual shall be included in gross income on the whole or partial surrender, cancellation, or exchange of any life insurance contract during the taxable year if—

"(1) such individual has attained age 65 on or before the date of the transaction, and

"(2) the amount otherwise includible in gross income is used during such year to pay premiums for any qualified long-term care insurance policy (as defined in section 2721(a) of the Public Health Service Act) for the benefit of such individual or the spouse of such individual if such spouse has attained age 65 on or before the date of the transaction.".

(b) CLERICAL AMENDMENT.—The table of sections for such part III is amended by striking the last item and inserting the following new items:

"Sec. 137. Amounts received on cancellation, etc., of life insurance contracts and used to pay premiums for qualified long-term care insurance.

"Sec. 138. Cross references to other Acts.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 7105. EFFECTIVE DATE.

The amendments made by this subtitle shall apply to taxable years beginning after December 31, 1995.

Subtitle C—Studies

SEC. 7201. FEASIBILITY OF ENCOURAGING HEALTH CARE PROVIDERS TO DONATE SERVICES TO HOMEBOUND PATIENTS.

The Comptroller General of the United States shall conduct a study on the feasibility of encouraging health care providers to donate their services to homebound patients. Such study shall include an examination of the effects of qualifying such services as a charitable contribution.

SEC. 7202. FEASIBILITY OF TAX CREDIT FOR HEADS OF HOUSEHOLDS WHO CARE FOR ELDERLY FAMILY MEMBERS IN THEIR HOMES.

The Comptroller General of the United States shall conduct a study on the feasibility of providing heads of households who care for elderly family members in their homes with a tax credit. Such study shall estimate the cost of such a tax credit which would apply to expenses incurred in the custodial care of such an elderly family member to the extent such expenses exceed 5 percent of adjusted gross income.

SEC. 7203. CASE MANAGEMENT OF CURRENT LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the feasibility of encouraging or requiring the use of a single designated public or non-profit agency (such as an area agency on aging) to coordinate, through case management, the provision of long-term care benefits under current Federal, State, and local programs in a geographic area.

(b) REPORT.—The Secretary shall submit to Congress a report on the study conducted under subsection (a) by not later than 1 year after the date of the enactment of this Act. Such report shall include such recommendations regarding changes in legislation to encourage or require the use (described in subsection (a)) of an agency to coordinate long-term care benefits as may be appropriate.

SEC. 7204. SUBACUTE CARE STUDY.

(a) STUDY.—The Secretary of Health and Human Services shall—

(1) define the level and type of care that should constitute subacute care;

(2) determine the appropriateness of furnishing subacute care in different settings by evaluating the quality of care and patient outcomes;

(3) determine the cost and effectiveness of providing subacute care under the medicare program under title XVIII of the Social Security Act to individuals who are eligible for benefits under part A of such title;

(4) determine the extent to which hospital DRG prospective payment rates under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) are appropriate for the less restrictive institutional settings that provide subacute care; and

(5) study the relationships between institutions and their payment methodologies in order to develop ways in which to maximize the continuity of care for each patient episode in which subacute care is furnished.

(b) REPORT.—Not later than October 1, 1996, the Secretary shall submit to the Congress a report on the matters described in subsection (a).

SEC. 7205. STUDY OF LONG-TERM CARE INSURANCE.

(a) REPORT.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall report to Congress on alternatives for extending access to long-term care through the private insurance market. The Secretary shall specifically study the cost of current policies, their effectiveness in providing care and their availability to the general population.

(b) RECOMMENDATIONS.—The Secretary shall recommend any changes in Federal law which may be necessary to increase access to long-term care for all Americans through the private insurance market. In conducting this study, the Secretary shall consult with the National Association of Insurance Commissioners and other private entities with expertise in private health insurance and long-term care.

TITLE VIII—MISCELLANEOUS SAVINGS PROVISIONS

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Sec. 8001. Requirement that certain agencies prefund government health benefits contributions for their annuitants.
Sec. 8002. Ineligibility of aliens for SSI and medicaid.
Sec. 8003. Limitation on SSI benefits for drug and alcohol addicts.

SEC. 8001. REQUIREMENT THAT CERTAIN AGENCIES PREFUND GOVERNMENT HEALTH BENEFITS CONTRIBUTIONS FOR THEIR ANNUITANTS.

(a) DEFINITIONS.—For the purpose of this section—

(1) the term "agency" means any agency or other instrumentality within the executive branch of the Government, the receipts and disbursements of which are not generally included in the totals of the budget of the United States Government submitted by the President;

(2) the term "health benefits plan" means, with respect to an agency, a health benefits plan, established by or under Federal law, in which employees or annuitants of such agency may participate;

(3) the term "health-benefits coverage" means coverage under a health benefits plan";

(4) an individual shall be considered to be an "annuitant of an agency" if such individual is entitled to an annuity, under a retirement system established by or under Federal law, by virtue of—

(A) such individual's service with, and separation from, such agency; or

(B) being the survivor of an annuitant under subparagraph (A) or of an individual who died while employed by such agency; and

(5) the term "Office" means the Office of Personnel Management.

(b) PREFUNDING REQUIREMENT.—

(1) IN GENERAL.—Effective as of October 1, 1994, each agency (or February 1, 1995, in the case of the agency with the greatest number of employees, as determined by the Office) shall be required to prepay the Government contributions which are or will be required in connection with providing health-benefits coverage for annuitants of such agency.

(2) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section. The regulations shall be designed to ensure at least the following:

(A) Amounts paid by each agency shall be sufficient to cover the amounts which would otherwise be payable by such agency (on a "pay-as-you-go" basis), on or after the applicable effective date under paragraph (1), on behalf of—

(i) individuals who are annuitants of the agency as of such effective date; and

(ii) individuals who are employed by the agency as of such effective date, or who become employed by the agency after such effective date, after such individuals have become annuitants of the agency (including their survivors).

(B)(i) For purposes of determining any amounts payable by an agency—

(I) this section shall be treated as if it had taken effect at the beginning of the 20-year period which ends on the effective date applicable under paragraph (1) with respect to such agency; and

(II) in addition to any amounts payable under subparagraph (A), each agency shall also be responsible for paying any amounts for which it would have been responsible, with respect to the 20-year period described in subclause (I), in connection with any individuals who are annuitants or employees of the agency as of the applicable effective date under paragraph (1).

(ii) Any amounts payable under this subparagraph for periods preceding the applicable effective date under paragraph (1) shall be payable in equal installments over the 20-year period beginning on such effective date.

(c) FASB STANDARDS.—Regulations under subsection (b) shall be in conformance with the provisions of standard 106 of the Financial Accounting Standards Board, issued in December 1990.

(d) CLARIFICATION.—Nothing in this section shall be considered to permit or require duplicative payments on behalf of any individuals.

(e) DRAFT LEGISLATION.—The Office shall prepare and submit to Congress any draft legislation which may be necessary in order to carry out this section.

SEC. 8002. INELIGIBILITY OF ALIENS FOR SSI AND MEDICAID.

(a) IN GENERAL.—Notwithstanding any other provision of law and except as provided in subsections (b) and (c), no alien shall be eligible for any program referred to in subsection (d).

(b) EXCEPTIONS.—

(1) REFUGEE EXCEPTION.—Subsection (a) shall not apply to an alien admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act until 6 years after the date of such alien's arrival into the United States.

(2) AGED EXCEPTION.—Subsection (a) shall not apply to an alien who—

(A) has been lawfully admitted to the United States for permanent residence;

(B) is over 75 years of age; and

(C) has resided in the United States for at least 5 years.

(3) CURRENT RESIDENT EXCEPTION.—Subsection (a) shall not apply to the eligibility of an alien for a program referred to in subsection (d) until 1 year after the date of the enactment of this Act if, on such date of enactment, the alien is residing in the United States and is eligible for the program.

(c) PROGRAMS FOR WHICH ALIENS MAY BE ELIGIBLE.—The limitation under subsection (a) shall not apply to medical assistance with respect to emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act).

(d) PROGRAMS FOR WHICH ALIENS ARE INELIGIBLE.—The programs referred to in this subsection are the following:

(1) The program of medical assistance under title XIX of the Social Security Act, except emergency services as provided in subsection (c).

(2) The supplemental security income program under title XVI of the Social Security Act.

(e) NOTIFICATION OF ALIENS.—Any Federal agency that administers a program referred to in subsection (d) shall, directly or through the States, notify each alien receiving benefits under the program whose eligibility for the program is or will be terminated by reason of this section.

SEC. 8003. LIMITATION ON SSI BENEFITS FOR DRUG AND ALCOHOL ADDICTS.

(a) IN GENERAL.—

(1) LIMITATION DESCRIBED.—Section 1614(a) of the Social Security Act (42 U.S.C. 1382c(a)) is amended by adding at the end the following:

"(5)(A) The Secretary shall identify all recipients of benefits under this title by reason of disability whose disability is a result of addiction to illegal drugs.

"(B) The Secretary shall periodically, on a random basis, test each recipient identified under subparagraph (A) to determine whether the recipient is using illegal drugs.

"(C)(i) Notwithstanding any other provision of this title, any individual who is determined under subparagraph (B) to be using illegal drugs, or who refuses to submit to testing as provided for under subparagraph (B), shall not be eligible for benefits under this title for a period of at least 1 year.

"(ii) The period of ineligibility under clause (i) shall terminate (after the last day of such 1-year period) if the individual has 2 tests (at least 2 months apart and not paid for through Federal funds) which establish that the recipient is not using illegal drugs.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to quarters beginning after the expiration of the 6-month period that begins on the date of the enactment of this Act.

(b) REPRESENTATIVE PAYEE REFORMS.—

(1) AUTHORITY OF GOVERNMENT AGENCIES TO BECOME PAID REPRESENTATIVE PAYEES.—Section 1631(a)(2)(D)(ii) of such Act (42 U.S.C. 1383(a)(2)(D)(ii)) is amended by adding at the end the following: "The term 'qualified organization' also includes any government agency that meets the requirements of items (aa) and (bb) of subclause (II).".

(2) MAXIMUM FEE PAYABLE TO REPRESENTATIVE PAYEES.—Section 1631(a)(2)(D)(i) of such Act (42 U.S.C. 1383(a)(2)(D)(i)) is amended by striking "the lesser of—" and all that follows and inserting "10 percent of the monthly benefit involved.".

TITLE IX—DEPARTMENT OF VETERANS AFFAIRS

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SEC. 9001. BENEFITS AND ELIGIBILITY THROUGH DEPARTMENT OF VETERANS AFFAIRS MEDICAL SYSTEM.

(a) DVA AS A PARTICIPANT IN HEALTH CARE REFORM.—

(1) IN GENERAL.—Title 38, United States Code, is amended by inserting after chapter 17 the following new chapter:

"CHAPTER 18—ELIGIBILITY AND BENEFITS UNDER ENROLLMENT-BASED SYSTEM

"SUBCHAPTER I—GENERAL

"1801. Definitions.

"SUBCHAPTER II—ENROLLMENT

"1811. Enrollment: veterans.
"1812. Enrollment: CHAMPVA eligibles.
"1813. Enrollment: family members.

"SUBCHAPTER III—BENEFITS

"1821. Benefits for VA enrollees.
"1822. Chapter 17 benefits.
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"1834. Health Plan Fund.
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"SUBCHAPTER I—GENERAL

"§ 1801. Definitions

"For purposes of this chapter:

"(1) The term 'qualified health coverage' has the meaning given such term in section 1101 of the Bipartisan Health Care Reform Act of 1994.

"(2) The term 'VA health coverage' means qualified health coverage provided by the Secretary under section 7341 of this title.

"(3) The term 'VA enrollee' means an individual enrolled under subchapter II of this chapter with VA health coverage.

"(4) The term 'standard coverage' has the meaning given such term in section 1102 of the Bipartisan Health Care Reform Act of 1994.

"SUBCHAPTER II—ENROLLMENT

"§ 1811. Enrollment: veterans

"Each veteran residing in the United States may enroll to obtain VA health coverage. A veteran who wants to receive the standard coverage through the Department shall enroll to obtain VA health coverage.

"§ 1812. Enrollment: CHAMPVA eligibles

"(a) ELIGIBILITY.—An individual described in subsection (b) who resides in the United States may enroll to obtain VA health coverage.

"(b) APPLICABILITY.—This section applies to the following individuals who are not otherwise eligible for medical care under chapter 55 of title 10 (CHAMPUS):

"(1) The surviving spouse or child of a veteran who (A) died as a result of a service-connected disability, or (B) at the time of death had a total disability permanent in nature, resulting from a service-connected disability.

"(2) The surviving spouse or child of a person who died in the active military, naval, or air service in the line of duty and not due to such person's own misconduct.

"(c) DEFINITION OF CHILD.—For purposes of this section, the term 'child' means a child described in section 1901(2)(B) of the Bipartisan Health Care Reform Act of 1994.

"§ 1813. Enrollment: family members

"(a) ELIGIBILITY.—The Secretary shall authorize the Secretary to enroll members of the family of an enrollee under section 1811 or 1812 of this title. The enrollee shall have the option of enrolling to obtain VA health coverage as an individual or with family members. If the enrollee chooses to enroll to obtain VA health coverage with family members, all such family members must be so enrolled.

"(b) REQUIRED PAYMENTS.—Any family member with VA health coverage shall (except as provided in section 1831(c)(2)(B) of this title) be subject to payment of premiums, deductibles, copayments, and coinsurance in accordance with the Bipartisan Health Care Reform Act of 1994.

"(c) ENROLLMENT ELIGIBILITY TO SURVIVE DEATH OF VETERAN.—An individual with VA health coverage pursuant to subsection (a) as a member of the family of a veteran enrolled under section 1811 of this title shall not lose eligibility to obtain such coverage by reason of the death of that veteran.

"(d) MEMBERS OF FAMILY.—For purposes of this section, the members of the family of an enrollee are those individuals (other than the enrollee) included within the term 'family' as defined in section 1901(2) of the Bipartisan Health Care Reform Act of 1994.

"SUBCHAPTER III—BENEFITS

"§ 1821. Benefits for VA enrollees

"The Secretary shall ensure that each individual enrolled with VA health coverage is provided the items and services in standard coverage under the Bipartisan Health Care Reform Act of 1994.

"§ 1822. Chapter 17 benefits

"(a) CARE AND SERVICES NOT INCLUDED IN STANDARD COVERAGE.—In the case of care and services that may be provided under chapter 17 of this title that are not included in standard coverage, the Secretary shall provide to any veteran (whether or not enrolled with qualified health coverage) the care and services authorized under that chapter in accordance with the terms and conditions applicable to that veteran and that care under that chapter.

"(b) VETERANS WHO ARE NOT ELIGIBLE TO ENROLL UNDER THE BIPARTISAN HEALTH CARE REFORM ACT OF 1994.—In the case of a veteran who is not eligible for enrollment under this chapter, the Secretary shall provide to the veteran the care and services that may be provided under chapter 17 of this title through any facility of the department, whether or not the facility is operating pursuant to VA health coverage.

"(c) PRESERVATION OF SPECIALIZED DVA TREATMENT CAPACITIES.—In carrying out subsection (a), the Secretary shall ensure that the Department maintains the capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that affords those veterans reasonable access to care and services for those specialized needs. The Secretary shall ensure that overall capacity of the Department to provide such specialized services is not reduced below the capacity of the Department, nationwide, to provide those services, as of the date of the enactment of this chapter. Nothing in this subsection precludes the Secretary from expanding the number or type of facilities or programs that provide treatment and rehabilitation services for the specialized needs of such veterans, including provision of specialized services on an outpatient basis.

"(d) ANNUAL REPORT.—Not later than March 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing the actions the Secretary has taken to carry out subsection (c) during the preceding fiscal year. Each such report shall include a statement of the number of veterans to whom the Department provided specialized services that are covered by the report and the expense of providing those services, and a description of the alternatives available in the private sector for the provision of those services to veterans.

"§ 1823. Supplemental benefits packages and policies

"VA health coverage may include supplemental health benefits packages and supplemental cost sharing policies consistent with the Bipartisan Health Care Reform Act of 1994. However, such coverage may not include a supplemental health benefits package to a veteran that provides coverage for services that the Department is required to provide to that veteran under chapter 17 of this title.

"§ 1824. Limitation regarding veterans who elect not to enroll to obtain VA health coverage

"(a) REIMBURSEMENT REQUIRED.—A veteran who is residing in an area in which the Department offers VA health coverage and who elects not to enroll to obtain such coverage may be provided the items and services in standard coverage through VA health coverage offered in that area only if (except as provided in subsection (b)) the plan is reimbursed for the cost of the care provided.

(b) EXCEPTION.—The Secretary may not impose on or collect from a veteran described in subsection (a) a cost-share charge of any kind in the case of treatment for a service-connected disability that (as determined by the Secretary) requires a specialized treatment capacity for which the Department has particular expertise.

"§ 1825. Limitation on use of funds for abortions

"None of the funds appropriated to carry out this title shall be expended for any abortion except when it is made known to the Secretary that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

"SUBCHAPTER IV—FINANCIAL MATTERS

"§ 1831. Premiums, copayments, etc.

"(a) EXEMPTION OF CERTAIN VETERANS.—Subject to subsection (f), in the case of a veteran described in subsection (b) who is a VA enrollee, there may not be imposed or collected from the veteran a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge) for items and services in standard coverage that are provided to the veteran by the Secretary within a VA plan provider network.

"(b) VETERANS EXEMPT FROM CHARGES.—The veterans referred to in subsection (a) are the following:

"(1) Any veteran with a service-connected disability rated at 10 percent or greater.

"(2) Any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty.

"(3) Any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section.

"(4) Any veteran who is a former prisoner of war.

"(5) Any veteran of the Mexican border period or World War I.

"(6) Any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

"(c) OTHER ENROLLEES.—(1) In the case of a VA enrollee who is not described in subsection (b), the Secretary shall (except as provided in paragraph (2)) charge premiums and shall establish copayments, deductibles, and coinsurance amounts.

"(2) The Secretary may not collect from an enrollee a premium in the case of—

"(A) an individual with VA health coverage by reason of eligibility under section 1812 of this title; or

"(B) an individual with VA health coverage by reason of eligibility under section 1813 of this title and who is described in paragraph (1) of section 1713(a) of this title.

"(3) The Secretary may not charge a copayment, deductible, or other coinsurance amount in the case of care for any disease covered under section 1710(e)(1) of this title.

"(d) ESTABLISHMENT OF RATES.—The premium rate, and the rates for deductibles and copayments, applicable under VA health coverage shall be established by such coverage based on rules applicable to all health coverage offered in the geographic area in which such VA health coverage is offered.

"(e) DUTIES OF EMPLOYERS.—The obligations (including obligations with respect to payment of premiums) under the Bipartisan Health Care Reform Act of 1994 of an employer with respect to employees with VA health coverage, and with respect to such a plan, shall be the same as those that apply with respect to other employees and other health coverage.

"(f) ACCEPTANCE OF PREMIUM CERTIFICATES.—In the case of a veteran who has been issued a premium certificate or voucher under the Bipartisan Health Care Reform Act of 1994, the Secretary may require the veteran to tender the certificate to the Secretary as a condition of enrollment and the Secretary may accept the certificate.

"§ 1832. Recovery of cost of certain care and services

"(a) RECOVERY FROM THIRD PARTIES.—In the case of an individual provided care or services through VA health coverage who has coverage under any supplemental health insurance policy, including a Medicare supplemental health insurance plan, the Secretary has the right to recover or collect charges for care or services (as determined by the Secretary, but not including care or services for a service-connected disability) from the party providing that coverage to the extent that the individual (or the provider of the care or services) would be eligible to receive payment for such care or services from such party if the care or services had not been furnished by a department or agency of the United States.

"(b) PROCEDURES.—The provisions of subsections (b) through (f) of section 1729 of this title shall apply with respect to claims by the United States under subsection (a) in the same manner as they apply to claims under subsection (a) of that section.

"§ 1833. Health Coverage Fund

"(a) ESTABLISHMENT OF FUND.—There is hereby established in the Treasury a revolving fund to be known as the 'Department of Veterans Affairs Health Coverage Fund'.

"(b) CREDITING OF AMOUNTS TO FUND.—There shall be credited to the revolving fund any amount received by the Department by reason of the furnishing of health care under VA health coverage and any amount received by the Department by reason of the enrollment of an individual with VA health coverage (including amounts received as premiums, premium certificates or vouchers, copaymentsor coinsurance, and deductibles), any amount received as a third-party reimbursement, and any amount received as a reimbursement from other health coverage for care furnished to one of its enrollees.

"(c) CREDITING TO TREASURY.—Any amounts deposited to the revolving fund that are attributable to amounts received by the Department as a premium, including a premium certificate or voucher, by reason of the enrollment with VA health coverage of a veteran described in section 1831(b) of this title shall be covered into the General Fund of the Treasury.

"(d) AMOUNTS NOT PERMITTED TO BE RETAINED.—Notwithstanding subsection (b), the Department may not retain amounts received for care furnished to a VA enrollee in a case in which the costs of such care have been covered by appropriations. Such amounts shall be deposited in the General Fund of the Treasury.

"(e) AVAILABILITY OF FUNDS.—Amounts in the revolving fund are hereby made available for all expenses, both direct and indirect, related to the delivery through VA health coverage of the items and services in standard coverage and any supplemental benefits package or policy offered through such coverage.".

(b) PRESERVATION OF EXISTING BENEFITS FOR FACILITIES NOT OFFERING SERVICES THROUGH QUALIFIED HEALTH COVERAGE.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1704 the following new section:

"§ 1705. Facilities not offering qualified health coverage; veterans not eligible to enroll to obtain coverage

"The provisions of this chapter shall apply with respect to the furnishing of care and services—

"(1) by any facility of the Department that (A) is not offering qualified health coverage under the Bipartisan Health Care Reform Act of 1994, and (B) is not located in a State (or portion of a State) that is a single payer area; and

"(2) by any facility of the Department (whether or not offering qualified health coverage under the Bipartisan Health Care Reform Act of 1994) in the case of a veteran who is not an eligible for enrollment under chapter 18 of this title.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1704 the following new item:

"1705. Facilities not offering qualified health coverage; veterans not eligible to enroll to obtain coverage.".

SEC. 9002. ORGANIZATION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES AS FACILITIES OFFERING QUALIFIED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 73 of title 38, United States Code, is amended—

(1) by redesignating subchapter IV as subchapter V; and

(2) by inserting after subchapter III the following new subchapter:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"§ 7341. Organization of health care facilities as facilities offering qualified health coverage

"(a) Except as provided in section 7342 of this title, the Secretary shall organize Department plans and facilities as plans and facilities offering qualified health coverage under the Bipartisan Health Care Reform Act of 1994 subject to adjustment under subsection (g). The Secretary shall prescribe regulations establishing standards for the operation of Department health care facilities as facilities offering qualified health coverage under the Bipartisan Health Care Reform Act of 1994. In prescribing those standards, the Secretary shall assure that they conform, to the maximum extent practicable, to the requirements for qualified health coverage generally set forth in the Bipartisan Health Care Reform Act of 1994.

"(b) Within a geographic area or region, health care facilities of the Department located within that area or region may be organized to operate as a single entity offering qualified health coverage encompassing all Department facilities within that area or region or may be organized to operate as several entities offering qualified health coverage.

"(c) Within a geographic area or region other than a State (or portion of a State) that operates as a single payer area, any health insurance purchasing cooperative, or similar entity that offer health insurance plans shall offer as an option to eligible individuals enrollment to obtain VA health coverage that is offered in that area or region.

"(d) Any health insurance program that is provided for Federal employees shall include enrollment to obtain VA health coverage as enrollment options for eligible individuals. Premiums shall be paid for VA health coverage under any such insurance program based upon enrollment with that plan in the same manner as to any other health coverage.

"(e)(1) In establishing and operating standard health coverage, the Secretary, in consultation with the Comptroller General, shall take appropriate steps to ensure the financial solvency and stability of the VA health coverage and of contractors and subcontractors providing services pursuant to section 7343 of this title.

"(2) In carrying out paragraph (1), the Secretary may purchase from commercial sources insurance to insure the Department against the financial risks involved in the offering of VA health coverage.

"(3) Notwithstanding any other provision of law, there shall be no requirements applicable to the offering of VA health coverage with respect to the maintenance of a reserve fund, requirements to reinsure, or payments into any other financial integrity fund other than as established pursuant to paragraph (1).

"(f) In carrying out responsibilities under the Bipartisan Health Care Reform Act of 1994, a State (or a State-established entity)—

"(1) may not impose any standard or requirement on VA health coverage that is inconsistent with this section or any regulation prescribed under this section or other Federal laws regarding the operation of this section; and

"(2) may not deny certification of VA health coverage under the Bipartisan Health Care Reform Act of 1994 on the basis of a conflict between a rule of a State (or State-established entity) and this section or regulations prescribed under this section or other Federal laws regarding the operation of this section.

"(g) Notwithstanding any provision of the Bipartisan Health Care Reform Act of 1994 or this subchapter, any reference in this subchapter to 'qualified health coverage' under such Act shall be considered a reference to coverage of a standardized package of benefits established by the Secretary with an actuarial value not less than the actuarial value of qualified health coverage under such Act.

"§ 7342. Operation of health care facilities within States operating as single payer areas

"(a) In a State (or portion of a State) that operates as a single payer system, Department health care facilities in that State (or portion of a State) shall serve as providers to individuals residing in that State (or portion of a State) who would be eligible to enroll under chapter 18 of this title to obtain VA health coverage if they were residing in an area where qualified health coverage was offered under the Bipartisan Health Care Reform Act of 1994. Such facilities may provide those individuals any covered service in standard coverage.

"(b) A Department facility providing care to residents of a single payer area pursuant to subsection (a) shall be reimbursed for that care on the same basis as any other provider furnishing the same services in that area.

"(c) A veteran described in section 1831(b) of this title shall be exempt from any otherwise applicable charges for such care. Any other individual provided care pursuant to subsection (a) shall be subject to all applicable requirements respecting copayments, deductibles, and coinsurance. Notwithstanding the preceding sentence, section 1831(c)(3) of this title shall apply to any such charge.

"§ 7343. Health care resource agreements

"(a)(1) In accordance with policies established under subsection (b), an official specified in paragraph (2) may, without regard to any law or regulation specified in paragraph (3), enter into agreements with health care plans, with insurers, and with health care providers, and with any other entity or individual, to furnish or obtain any health-care resource.

"(2) An official specified in this paragraph is any of the following:

"(A) The head official offering VA health coverage.

"(B) The director of a Department health care facility that is providing service through VA health coverage.

"(C) The director of a Department health care facility that is operating in a State (or portion of a State) that is operating under a single payer system.

"(3) A law or regulation specified in this paragraph is any of the following:

"(A) Section 1703 of this title.

"(B) Any other law or regulation pertaining to—

"(i) competitive procedures;

"(ii) acquisition procedures or policies (other than contract dispute settlement procedures); or

"(iii) bid protests.

"(4) For purposes of this subsection, the term 'health-care resource' has the meaning given that term in section 8152 of this title.

"(b) Policies established by the Secretary under subsection (a) shall include appropriate provisions to ensure that procurements under that subsection are carried out in a manner consistent with (1) Federal acquisition policies regarding nondiscrimination, equal opportunity, business integrity, and safeguarding against fraud and abuse, and (2) the goal of a streamlined process for the acquisition of health-care resources.

"(c) Any proceeds to the Government received from an agreement under subsection (a) shall be credited to the Department of Veterans Affairs Health Coverage Fund established under section 1834 of this title and to funds that have been allotted to the facility that furnished the resource involved.

"§ 7344. Administrative and personnel flexibility

"(a) In order to carry out this subchapter, the Secretary may—

"(1) subject to section 1822(c) of this title, carry out administrative reorganizations of the Department without regard to those provisions of section 510 of this title following subsection (a) of that section; and

"(2) when the Secretary finds it is cost-effective or necessary in order to provide health care services in a timely manner—

"(A) enter into contracts for procurement of any commercially available item at a cost of under $100,000 without regard to any provision of law or regulation (i) requiring competitive procedures; (ii) mandating or giving priority to any source of supply; or (iii) pertaining to protests; and

"(B) enter into contracts without regard to section 8110(c) of this title for the performance of services previously performed by employees of the Department.

"(b)(1) The Secretary may establish alternative personnel systems or procedures for personnel at facilities offering qualified health coverage under this title, or for personnel at facilities operating in a State (or portion of a State) that is operating under a single payer system, whenever the Secretary considers such action necessary, except that the Secretary shall provide for preference eligibles (as defined in section 2108 of title 5) in a manner comparable to the preference for such eligibles under subchapter I of chapter 33, and subchapter I of chapter 35, of such title.

"(2) In establishing alternative personnel systems or procedures under this subsection, the Secretary shall include the following:

"(A) A system that ensures that applicants for employment and employees are appointed, promoted, and assigned on the basis of merit and fitness.

"(B) An equal employment opportunity program.

"(C) Compensation systems which will be used to set rates of pay that are competitive with rates of pay paid by health-care providers other than the Department and that take into consideration the difficulty, responsibility, and qualification requirements of the work performed.

"(D) A formal performance appraisal system.

"(E) A system to address unacceptable conduct and performance by employees, including a general statement of violations, sanctions, and procedures which shall be made known to all employees, and a dispute resolution procedure.

"(F) A formal policy regarding the accrual and use of sick leave and annual leave.

"(c) The Secretary may carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department offering qualified health coverage.

"§ 7345. Veterans Health Care Transition Fund

"(a) For each of fiscal years 1995 and 1996, the Secretary of the Treasury shall credit to a special fund (in this section referred to as the 'Fund') of the Treasury an amount equal to—

"(1) $1,200,000,000 for fiscal year 1995; and

"(2) $800,000,000 for fiscal year 1996.

"(b) Amounts in the Fund shall be available to the Secretary only for VA health coverage authorized under this chapter. Such amounts are available without fiscal year limitation for costs of commencing the offering of VA health coverage, including consulting services, equipment, marketing, and other costs, minor construction, and (subject to section 8104 of this title) major construction.

"(c) The Secretary shall submit to Congress, no later than March 1, 1996, a report concerning the operation of the Department of Veterans Affairs health care system in preparing for, and operating under, national health care reform under the Bipartisan Health Care Reform Act of 1994 during fiscal years 1995 and 1996. The report shall include a discussion of—

"(1) the adequacy of amounts in the Fund for the offering of VA health coverage;

"(2) the quality of care provided by such plans; and

"(3) the ability of such plans to attract patients.

"§ 7346. Funding provisions: grants and other sources of assistance

"The Secretary may apply for and accept, if awarded, any grant or other source of funding that is intended to meet the needs of special populations and that but for this section is unavailable to facilities of the Department or to qualified health coverage offered by the Government if funds obtained through the grant or other source of funding will be used through a facility of the Department offering qualified health coverage.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by striking out the item relating to the heading for subchapter IV and inserting in lieu thereof the following:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"7341. Organization of health care facilities as facilities offering qualified health coverage
"7342. Operation of health care facilities within States operating as single payer areas.
"7343. Health care resource agreements.
"7344. Administrative and personnel flexibility.
"7345. Veterans Health Coverage Transition Fund.
"7346. Funding provisions: grants and other sources of assistance.

"SUBCHAPTER V—RESEARCH CORPORATIONS".

SEC. 9003. ELIGIBILITY FOR CHAPTER 17 CARE.

(a) NURSING HOME CARE—Section 1710(a)(1) of title 38, United States Code, is amended by inserting "(or, in the case of a veteran described in subparagraph (A) or (D) below, shall furnish nursing home care)" after "may furnish nursing home care".

(b) OUTPATIENT CARE FOR ENROLLED VETERANS.—Paragraph (1) of section 1712(a) of such title is amended—

(1) by striking out "and" at the end of subparagraph (C);

(2) by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon; and

(3) by adding at the end the following:

"(E) to any veteran described in section 1831(b) of this title who is enrolled under section 1811 of this title and the Bipartisan Health Care Reform Act of 1994 with VA health coverage (as defined in section 1801 of this title), for any disability to the extent that care and treatment of that disability is not included within standard coverage (as defined in section 1801 of this title);".

(c) OBVIATE-THE-NEED OUTPATIENT CARE.—(1) Paragraph (2) of such section is amended by striking out "The Secretary" and all that follows through "this subsection—" and inserting in lieu thereof "Except as provided in subsection (b) of this section, the Secretary shall furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed—".

(2) Paragraph (4) of such section is amended by striking out "medical services for a purpose described in paragraph (5) of this subsection" and inserting in lieu thereof ", to the extent that facilities are available, such medical services as the Secretary determines are needed".

(3) Such section is further amended—

(A) by striking out paragraph (5); and

(B) by redesignating paragraphs (6) and (7) as paragraphs (5) and (6), respectively.

(d) CONFORMING AMENDMENTS.—(1) Section 1701(6)(A)(i) of such title is amended by striking out "(except under the conditions described in section 1712(a)(5)(A) of this title)".

(2) Section 1701(6)(B)(i)(II) of such title is amended by striking "section 1712(a)(5)(B)" and inserting in lieu thereof "section 1712".

(3) Section 1703(a)(2)(B) of such title is amended by striking out "for a purpose described in section 1712(a)(5)(B) of this title" and inserting in lieu thereof "to complete treatment incident to hospital, nursing home, or domiciliary care that has been provided by the Department".

(4) Section 1712A(b)(1) of such title is amended by striking out "section 1712(a)(5)(B)" and inserting in lieu thereof "section 1703(a)(2)(B)".

SEC. 9004. AUTHORITY TO PROVIDE HEALTH CARE FOR HERBICIDE AND RADIATION EXPOSURE.

(a) AUTHORIZED INPATIENT CARE.—Section 1710(e) of title 38, United States Code, is amended to read as follows:

"(e)(1)(A) Subject to paragraph (4), a herbicide-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for any disease specified in subparagraph (B).

"(B) The diseases referred to in subparagraph (A) are those for which the National Academy of Sciences, in a report issued in accordance with section 2 of the Agent Orange Act of 1991, has determined—

"(i) that there is sufficient evidence to conclude that there is a positive association between occurrence of the disease in humans and exposure to a herbicide agent;

"(ii) that there is evidence which is suggestive of an association between occurrence of the disease in humans and exposure to a herbicide agent, but such evidence is limited in nature; or "(iii) that available studies are insufficient to permit a conclusion about the presence or absence of an association between occurrence of the disease in humans and exposure to a herbicide agent.

"(2) A radiation-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for—

"(A) any disease listed in section 1112(c)(2) of this title; and

"(B) any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

"(3) Subject to paragraph (4), a veteran who the Secretary finds may have been exposed while serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War to a toxic substance or environmental hazard is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability which becomes manifest before October 1, 1996, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

"(4) Hospital and nursing home care may not be provided under or by virtue of paragraph (1) after September 30, 1996, or, in the case of a veteran described in paragraph (3), after September 30, 1998.

"(5) For purposes of this subsection and section 1712 of this title—

"(A) the term 'herbicide-exposed veteran' means a veteran (i) who served on active duty in the Republic of Vietnam during the Vietnam era, and (ii) who the Secretary finds may have been exposed during such service to a herbicide agent;

"(B) the term 'herbicide agent' has the meaning given that term in section 1116(a)(4) of this title; and

"(C) the term 'radiation-exposed veteran' has the meaning given that term in section 1112(c)(4) of this title.".

(b) AUTHORIZED OUTPATIENT CARE.—Section 1712 of such title is amended—

(1) in subsection (a)(1) (as amended by section 9003(b)), by adding at the end the following:

"(F) during the period before October 1, 1996, to any herbicide-exposed veteran for any disease listed in section 1710(e)(1)(B) of this title; and

"(G) to any radiation-exposed veteran for any disease covered under section 1710(e)(1)(C) of this title."; and

(2) in subsection (i)(3)—

(A) by striking out "(A)"; and

(B) by striking out ", or (B)" and all that follows through "title".

(c) SAVINGS PROVISION.—The provisions of sections 1710(e) and 1712(a) of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, shall apply with respect to hospital care, nursing home care, and medical services in the case of any veteran furnished care or services before such date of enactment on the basis of presumed exposure to a substance or radiation under the authority of those provisions.

SEC. 9005. EXTENSION OF AUTHORITY TO PROVIDE PRIORITY OUTPATIENT HEALTH CARE FOR EXPOSURE TO ENVIRONMENTAL HAZARDS.

Section 1712(a)(1)(D) of title 38, United States Code, is amended by striking out "December 31, 1994, for any disability" and inserting in lieu thereof "October 1, 1998, for any disability which becomes manifest before October 1, 1996,".

SEC. 9006. REPORT ON WAIVING COST-SHARING FOR CERTAIN MEDICAL CARE FOR DEPENDENTS OF PERSIAN GULF VETERANS WHO MAY HAVE BEEN EXPOSED TO ENVIRONMENTAL HAZARDS.

(a) REPORT.—The Secretary of Veterans Affairs shall submit to Congress a report on the desirability and the feasibility of waiving any requirement for cost-sharing in the case of medical care described in subsection (b) that is provided through VA health coverage under chapter 18 of title 38, United States Code (as added by section 9001), to an individual who is a VA enrollee enrolled under family-member eligibility under section 1813 of that chapter.

(b) PERSIAN GULF WAR ILLNESS.—Medical care referred to in subsection (a) is medical care provided to a family member of a veteran described in subparagraph (C) of section 1710(e)(1) of title 38, United States Code, for any disease or disability occurring in that family member which the Secretary finds may be related to the service of the veteran in the Southwest Asia theater of operations during the Persian Gulf War.

(c) MATTERS TO BE CONSIDERED.—In preparing the report under subsection (a), the Secretary shall consider relevant studies, including those that have been (or that are being) conducted by the Department of Veterans Affairs, the Department of Defense, the National Institutes of Health, the National Academy of Sciences, and private health care providers.

(d) SUBMISSION OF REPORT.—The report under subsection (a) shall be submitted not later than 60 days after the date of the enactment of this Act.

SEC. 9007. STUDY OF THE EFFECT OF TELEMEDICINE ON THE DELIVERY OF VA HEALTH CARE SERVICES.

(a) IN GENERAL.—During each of fiscal years 1995 through 1997, the Secretary of Veterans Affairs shall carry out a study of the effect of telemedicine on the delivery, accessibility, and quality of health care services available to individuals who are eligible for enrollment in a Department of Veterans Affairs health care plan.

(b) REPORTS.—Not later than 120 days after the date of the enactment of this Act and annually thereafter through 1998, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report, including descriptions of the telemedicine applications benefiting veterans, relating to the study conducted under subsection (a).

(c) CONSULTATION.—Each study under subsection (a) shall be carried out in consultation with the Secretary of Health and Human Services, the Secretary of Defense, the Chair of the White House Information Infrastructure Task Force, and the Director of High Performance Computing and Communications in the Executive Office of the President.

SEC. 9008. LEGISLATIVE PROPOSAL ON VA HEALTH COVERAGE FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary, in consultation with the Secretary of Veterans Affairs, shall develop and submit to Congress a proposal for legislation which provides for obtaining VA health coverage for medicare beneficiaries who are veterans.

(2) MEDICARE BENEFICIARY.—For purposes of this section, the term "medicare beneficiary" means an individual who is eligible for benefits under part A of title XVIII of the Social Security Act and is enrolled under part B of such title.

(b) CONTENTS OF THE PROPOSAL.—A proposal for legislation submitted under subsection (a) shall—

(1) provide for an appropriate methodology by which the Secretary shall make payment to the Secretary of Veterans Affairs for the enrollment of medicare beneficiaries;

(2) provide individuals the opportunity to remain enrolled to obtain VA health coverage without an interruption in coverage upon becoming medicare beneficiaries; and

(3) provide medicare beneficiaries who are veterans with the opportunity to enroll to obtain VA health coverage as an individual or with family members.

TITLE X—AUTOMOBILE INSURANCE COORDINATION

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Sec. 10001. Definitions.
Sec. 10002. Provision of automobile insurance medical services through health plans.
Sec. 10003. Payment for automobile insurance medical services.
Sec. 10004. Payment facilitation.
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SEC. 10001. DEFINITIONS.

In this title—

(1) INJURED INDIVIDUAL.—The term "injured individual" means an individual who has a bodily injury or illness sustained in an automobile accident and who is entitled to receive automobile insurance medical services from a health plan.

(2) AUTOMOBILE INSURANCE MEDICAL SERVICES.—The term "automobile insurance medical services" means services and items covered by automobile insurance that are medically necessary or appropriate for treatment of bodily injuries or illnesses sustained in automobile accidents and that are within the scope of the benefits to which an injured individual is entitled under his or her health plan.

(3) AUTOMOBILE INSURANCE CARRIER.—The term "automobile insurance carrier" means an insurance company, employer, or fund that is liable for payment for automobile insurance medical services based either on a direct contractual obligation to an injured individual or an obligation on behalf of a person responsible for causation of an injured individual's bodily injury or illness.

(4) HEALTH PLAN.—The term "health plan" means a plan or organization that pays for the services of health care providers and is subject to Federal or State regulation.

SEC. 10002. PROVISION OF AUTOMOBILE INSURANCE MEDICAL SERVICES THROUGH HEALTH PLANS.

(a) IN GENERAL.—An individual enrolled in a health plan shall receive automobile insurance medical services exclusively through the provision (or arrangement for the provision) of such services by the health plan. Such services shall be subject to all quality, cost containment, and anti-fraud and abuse provisions that apply generally to medical services provided by or through health plans.

(b) ALTERNATIVE PERMITTED.—

(1) BY AGREEMENT.—Subsection (a) shall not prevent an individual and an automobile insurance carrier from agreeing that treatment for bodily injury or illness sustained in an automobile accident shall be provided other than by or through the health plan in which the individual is enrolled. Notice of any such agreement shall be filed with the injured individual's health plan. Upon receipt of such notice, the health plan shall be absolved of all responsibility for payment of any services covered by the agreement.

(2) MEDICARE AND MEDICAID.—Subsection (a) shall not prevent a State from requiring automobile insurance carrier to make direct payment to health care providers for automobile insurance medical services that are covered both by (A) medicare or medicaid, and (B) and automobile insurance contract that is required by law and provides for direct payment of medical services regardless of fault. Payment for automobile insurance medical services in such circumstances shall be made to the extent of the automobile insurance carrier's liability under the applicable contract, in accordance with fee schedules prescribed under section 10003(d), and such services shall be subject to all quality, cost containment, and anti-fraud and abuse provisions that apply generally to medical services provided by or through health plans.

SEC. 10003. PAYMENT FOR AUTOMOBILE INSURANCE MEDICAL SERVICES.

(a) PAYMENT TO HEALTH PLANS.—Each automobile insurance carrier that is liable for payment for automobile insurance medical services provided to an injured individual by a health plan shall make payment to the health plan for such services to the extent of its obligations under the applicable automobile insurance contract. Any federally funded health care plan shall have first priority, over the right of any other person, to receive payment pursuant to any obligation under an automobile insurance policy covering automobile insurance medical services.

(b) REIMBURSEMENT FOR COST SHARING.—Each automobile insurance carrier shall remain liable, to the extent of its obligations under the applicable automobile insurance contract, for reimbursement of any deductibles or coinsurance paid by an injured individual for automobile insurance medical services.

(c) LIMITATION OF LIABILITY.—Except with respect to payments to health plans as required by subsection (a) and to reimbursement of deductibles and coinsurance in accordance with subsection (b), nothing in this title or any other provision of law shall require an automobile insurance carrier or any person insured by such a carrier to make any payment to a health plan, health care provider, or any other person for (1) automobile insurance medical services, or (2) other health care services or items used to treat an injury or illness sustained in an automobile accident that are not medically necessary or appropriate.

(d) USE OF FEE SCHEDULES.—

(1) IN GENERAL.—Irrespective of the type of health plan providing automobile insurance medical services, payment by automobile insurance carriers for such services shall be made to the plan in accordance with any fee schedule or schedules established for health care services generally. Each State shall develop or approve a fee schedule applicable to payment for any automobile insurance medical services that are not covered by a generally applicable fee schedule or schedules.

(2) ALTERNATIVE PAYMENT METHODOLOGIES.—Fee schedules shall not be required in any case in which an automobile insurance carrier and a health plan have agreed on an alternative payment arrangement.

(e) REIMBURSEMENT FOR PAYMENTS MADE.—Nothing in this title or any other provision of law shall impair the right of a health plan or automobile insurance carrier to seek reimbursement from any person liable for a bodily injury or illness sustained in an automobile accident for payments made for automobile insurance medical services to treat such injury or illness.

(f) RIGHTS TO COVERAGE FOR ADDITIONAL TREATMENT.—Subject to the provisions of subsection (c), nothing in this title shall impair any rights with respect to medically necessary or appropriate services and items to which an individual injured in an automobile accident is entitled that are not automobile insurance medical services as defined in this title.

SEC. 10004. PAYMENT FACILITATION.

(a) IN GENERAL.—In each State, an efficient and effective system shall be established for prompt payment for automobile insurance medical services by automobile insurance carriers to health plans. Such systems shall require automobile insurance carriers and health plans to interface effectively, including through the use of cost-effective computer data programs, in order to specify the automobile insurance carrier or carriers liable for payment for automobile insurance medical services. Such systems also shall include mechanisms for resolution, including arbitration, of any issues or disputes that may arise in connection with such payment. The results of the resolution of issues and disputes under the mechanisms prescribed pursuant to this subsection, including the use of any fee schedule under section 10003(d), shall be admissible in evidence only for purposes of recovery under section 10003(e).

(b) SANCTIONS.—In each State, appropriate sanctions shall be prescribed for the failure of a health plan, an automobile insurance carrier, or any other person to comply with the requirements established pursuant to subsection (a). Such sanctions shall include a penalty for late payment, which shall be imposed on any automobile insurance carrier that delays payment to a health plan after the amount of reimbursement is established pursuant to the procedures prescribed under subsection (a).

SEC. 10005. CONSTRUCTION.

(a) COORDINATION WITH OTHER PROVISIONS OF THIS ACT.—The provisions of this title shall be construed to be consistent with and shall be implemented in accordance with the other provisions of this Act.

(b) EFFECT ON WORKERS' COMPENSATION LAW.—Nothing in this title shall affect rights or obligations under workers' compensation law.

AMENDMENT IN THE NATURE OF A SUBSTITUTE TO BE OFFERED BY REPRESENTATIVE STEARNS OF FLORIDA

Strike out all after the enacting clause and insert in lieu thereof the text of H.R. 4550 (as introduced.).

EXTENSIONS OF REMARKS

ENTITLEMENTS

HON. LEE H. HAMILTON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. HAMILTON. Mr. Speaker, I would like to insert my Washington report for Wednesday, August 10, 1994 into the CONGRESSIONAL RECORD.

ENTITLEMENTS

When constituents tell me their concern about our growing national debt, they sometimes ask why, after the recent defense reductions, the elimination of 100,000 federal jobs, and the renewed efforts to trim wasteful projects, is the budget deficit still $200 billion in 1994? Much of the answer lies in the growth of federal entitlement programs, which have increased from $36 billion in 1965 to more than $800 billion this year.

WHAT ARE ENTITLEMENTS?

Entitlements are federal benefits established by law to be provided to any person who meets the eligibility requirements. They include need-based benefits such as food stamps, Aid to Families with Dependent Children (AFDC), and Supplemental Security Income, as well as work-related benefits, such as Social Security, veterans' benefits, unemployment compensation, and farm payments. The Congressional Budget Office estimates that entitlements will cost $803 billion in 1994—over half of all federal spending—and predicts they will grow by another $300 billion by 1999. Among the 400 or so entitlements, the largest are Social Security ($318 billion), and Medicare ($160 billion), and Medicaid ($86 billion). Two striking facts about entitlements are their huge costs and that, while they do prevent poverty, most entitlement spending is not for the poor.

GROWTH OF SPENDING

One way of dividing up the federal budget is into discretionary spending and entitlements. Discretionary spending is spending that Congress must specifically vote to approve each year, and it includes defense spending as well as a variety of domestic programs such as the national park system, the FBI, federal highways, and medical research. In recent years Congress and the President have done a fairly good job of reining in discretionary spending. Once growing rapidly, total discretionary spending is now basically flat. Tight caps through 1998 will allow virtually no growth.

We are not doing nearly so well with entitlements. Basically all of the growth in federal spending in recent years has come from entitlements—and they have grown rapidly. Because entitlements are not directly controlled through the annual appropriations process, they can grow without congressional approval as more individuals become eligible for the programs and as benefit costs rise. Most of the entitlement growth comes from federal health insurance programs—Medicare and Medicaid. They are the two fastest growing federal programs, and will account for more than half of all entitlement growth through 1997.

Largely because of the expected entitlement growth, the deficit is projected to rise again in 1997 and exceed $300 billion six years after that. An example helps show the importance of curbing entitlement growth: If all welfare recipients returned to work now and the AFDC and food tamp programs no longer cost anything, the savings would be lost in a year due to growth in other entitlements.

WHAT HAS BEEN TRIED?

Congress has taken some steps to rein in entitlements. Last year it passed a deficit reduction package curtailing entitlement spending by some $80 billion over the next five years. The largest share of savings comes from reduced payments to hospitals and physicians, as well as trimming federal employees' retirement costs. Similar cutbacks were made in the 1990 deficit reduction act. After-tax benefits for relatively better-off Social Security beneficiaries were also trimmed. Congress has also enacted pay-as-you-go requirements for all new entitlement programs: Any new entitlement program must be paid for by cutting some other spending or finding revenues to pay for it. But since this only applies to new programs and not to increases in existing entitlements, it has had limited impact on entitlement growth.

ADDITIONAL STEPS

Various approaches have been proposed for better restraining entitlement spending. One approach would be to place spending caps on entitlements. Because the caps Congress placed on discretionary spending in 1990 have worked reasonably well, some have suggested also placing caps on entitlements—which would mean putting an overall ceiling on the amount that could be spent each year on entitlements. But recent attempts to cap entitlements have failed to pass Congress because of concerns about how caps would be implemented. For example, once the cap is reached, would benefits be reduced or would new applicants be denied access to the programs? Would exceeded caps in one program require across-the-board cuts in all programs? Caps can help put a brake on spending, but they do not solve the real problem of making specific policy changes in specific entitlements to reduce future costs.

A second approach would be to apply need-based criteria to more entitlement programs. Although some entitlements such as welfare (AFDC) are means tested—which means that only those below a certain income receive benefits—most entitlements are not. In 1991 nearly one quarter of all federal entitlements dollar went to households with incomes over $50,000.

A third way to trim entitlements is to look program by program for ways to trim costs. This is what is happening to some extent with the current debate over health care reform, as ways are sought to curb future Medicare and Medicaid increases. Evaluating each program according to its own merits and cost makes good sense but is difficult to do because of the popularity of some of the programs. In July I supported a bill that will help Congress monitor the total costs of entitlement spending and that requires the President and Congress to address spending that exceeds budget targets. This will formalize and strengthen steps that now exist in a presidential Executive Order. In addition, later this year the President's Bipartisan Commission on entitlements will report their findings and make recommendations for reform. This report should open up discussion about individual programs and present realistic options for curbing entitlements.

CONCLUSION

One of our top priorities as a nation should be getting the federal budget deficit under control, and to a large extent that means getting entitlements—particularly federal health insurance costs—under control. The projections of entitlement growth and the resulting burden placed on our economy are indisputable. Making the difficult choices will not be easy, but they are essential for the long-term economic strength of our country. An entitlement system that provides affordable benefits when we need them is important, but we must also save and invest more for the future of ourselves and our children.

TRIBUTE TO THE LATE KATE REED ESTES

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. HALL of Texas. Mr. Speaker, I am honored to have the privilege today to pay tribute to the late Kate Reed Estes of Trenton, TX. Kate was born June 28, 1917, in Trenton, died on June 29, 1994, and in the intervening years enjoyed a rich and rewarding life. She was known throughout North Texas for her two loves, politics and jazz music. She was very special to me and to my family.

Kate Reed Estes was the daughter of Burgher Reed and Lucille Morrow Reed. Her father was one of the five founding fathers of REA in Fannin County, and her family was close to the late Speaker of the House of Representatives, Sam Rayburn. A lifelong Democrat and Democratic party leader, Kate was a former employee of mine during my tenure in the Texas Senate. She also worked for and supported the late Congressman Ray Roberts. Her professional and political skills were invaluable in my office, and I appreciated very much her years of service. Above all, she was loyal. She loved her home, her city of Trenton, the United Methodist Church, and all of Fannin County. Kate knew so many people. Each friend was a part of her, and all of us considered her as family.

Kate held the distinction of being the only female jazz pianist ever to play with the One O'Clock Lab Band at North Texas State University. She also was the first woman to graduate from the jazz department at North Texas State. She was a professional musician and a former member of American Federation of Musicians. As a jazz musician she played with

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

such greats as Tennessee Ernie Ford, Frankie Carle, Gene Hall, and Leon Breeden. She also played for Arthur Godfrey and Cactus Pryor and played at almost every major club in Texas at one time or another.

As a retired public school teacher, political leader, and jazz musician, Kate was an inspiration to those who were fortunate to know her. She was a good friend and will be greatly missed by all those whose lives she touched.

COMMEMORATING THE 50TH ANNIVERSARY OF THE HALYARD MISSION

HON. JIM KOLBE

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. KOLBE. Mr. Speaker, today marks the 50th anniversary of one of the most courageous rescues of American servicemembers in our Nation's history, and I want to take this opportunity to pay tribute to those involved in the Halyard Mission—the largest rescue of American lives from behind enemy lines in American history.

Hundreds of American servicemembers from the Office of Strategic Services and the U.S. Army Air Force were shot down in Nazi-occupied Yugoslavia during their return from raids on Axis communications facilities and the Ploesti oil complex in Romania—Hitler's most important source of oil during World War II. But instead of being captured by Axis forces, the American airmen were escorted to safe haven by Yugoslavian Chetniks.

The Chetniks were members of a Yugoslavian resistance force, led by Gen. Draza Mihailovich, who orchestrated one of the largest rescue missions, of World War II. After providing safe haven for American and Allied airmen, Mihailovich made it possible for three waves of C–47's to rescue all 432 airmen by use of makeshift, secret airstrips a mere 80 miles from Belgrade.

It is important that this day be remembered, and I appreciate the efforts of the National Committee of American Airmen Rescued by General Mihailovich, Inc., who have worked diligently to inform the public about the Halyard Mission and the contribution of General Mihailovich.

Mr. Speaker, this year has been marked with numerous celebrations for our World War II veterans, and I want to be sure that the survivors and rescuers of the Halyard Mission are remembered.

CRIME BILL

HON. RON PACKARD

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. PACKARD. Mr. Speaker, Americans are outraged by the crime wave gripping our Nation—evidence of the social meltdown in our communities. At the core of the pessimism is the feeling that our country is suffering a moral and spiritual decline. The answer to our crime problem lies in the restoration of the family; the revival of the work ethic; and most important, the renewal of moral conduct.

However, the $33 billion crime bill now before us denies us the right to fill the very spiritual void which is responsible for our crime. crisis. It makes it virtually impossible to impart to our young people the such basic values as the Ten Commandments.

The $630 million Family and Community Endeavor Schools Grant Program, more commonly known as FACE, funds crime prevention programs designed to reach the most vulnerable members of our communities—our kids. The bill's language states that none of the money may be used for religious worship or instruction. This means that teaching kids the Ten Commandments is prohibited.

When we see 14 year olds selling drugs to 12 year olds; 16 year olds stealing from 14 year olds; and 18 year olds killing 16 year olds; I think that teaching things like 'Thou Shall Not Kill' 'Thou Shall Not Steal'; and 'Thou Shall Love Your Neighbor as Thyself' is critical.

Our children need to understand that values are important; respect for others is paramount; and community participation is vital. If we fail to teach these lessons we doom the future of this country to the fatal grip of lawlessness and violence.

TRIBUTE TO CAMP DUDLEY

HON. GERALD B.H. SOLOMON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. SOLOMON. Mr. Speaker, I rise to pay tribute to an institution which this summer celebrates its 110th Anniversary as the oldest camp for boys in the United States—Camp Dudley in Westport, NY, on Lake Champlain. I am personally acquainted with Camp Dudley since two of my sons attended camp there in the 1970's and since my friend Dr. William J. Schmidt, is retiring after 20 years of dedicated service as Dudley's director.

Camp Dudley was founded by Sumner F. Dudley in 1885 and as a nonprofit institution has been affiliated with the YMCA of the United States. Dudley is truly a national camp which is committed to imparting the value "the other fellow first" to the more than 16,375 boys of all races and creeds who have attended over those years. On this historic occasion it is my pleasure to have been personally invited to address the celebration of this 110th anniversary and to pay tribute to Willie and Lois Schmidt as they depart to resume their careers in education. I also take this occasion to extend to Dr. Wheaton Griffin, the newly appointed director, and to his wife Eileen my very best wishes for the future success of this important institution.

Members of the House, please join me in saluting this fine institution and its 110th year of outstanding character building service to so many young children who have gone on to be solid American citizens.

75TH ANNIVERSARY OF THE JEWISH BIG BROTHER & BIG SISTER ASSOCIATION OF GREATER BOSTON

HON. BARNEY FRANK

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. FRANK of Massachusetts. Mr. Speaker, on November 4 of this year, the Jewish Big Brother & Big Sister Association of Greater Boston will celebrate its 75th anniversary. This valuable organization, which has served thousands of needy children over the years of its existence, is the oldest organization of its kind in Massachusetts, and one of the oldest in the country.

When it was founded, the association did not have extensive resources, but the founders had a great commitment and dedication to bringing disadvantaged, parentless youngsters into the mainstream of society. Initially, the program—one of the 13 original Big Brother groups which established the national association—focused on the needs of delinquent boys. Over the years, in addition to broadening its focus to include the challenges faced by young girls, the Jewish Big Brother & Big Sister Association of Greater Boston expanded its services to include family advocacy, crisis intervention, college scholarships, and family discussion groups. Throughout its 75 years, the Association has consistently provided troubled youth with positive role models and mentors, and it now serves some 200 children a year, primarily those living in single parent families.

Mr. Speaker, this lengthy history of contributing to the community by encouraging young people to excel to the best of their ability both academically and socially is obviously valuable in and of itself. But, the organization also provides a valuable collateral benefit to its adult volunteers. Offering adults who wish to give something back to their community the chance to engage in the rewarding work of fostering positive growth in young people often leads the volunteers to find more meaning in their own lives. This combined impact makes the work of the Jewish Big Brother & Big Sister Association of Greater Boston doubly important. For its valuable contributions over the last 75 years and for demonstrating that the spirit of volunteerism is alive and well today, I ask my colleagues to join me in recognizing the Association's service to the community and in looking ahead to the next 75 years.

WORLD WAR II/PELELIEU

HON. ROBERT A. UNDERWOOD

OF GUAM

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. UNDERWOOD. Mr. Speaker, for the last few weeks, you and most of our colleagues have been witnesses to the efforts I have made in order to bring attention to a largely neglected aspect of the Second World War, the battles of the Pacific. Amid feelings of neglect from islanders who suffered during the war and widespread sympathy, support and concern among our Nation's veterans, I would like to cite yet another example of a World War II battle which will remain not properly recognized—Pelelieu.

Located in the Pacific, southwest of Guam and 500 miles southeast of the Philippines, the island of Pelelieu, by any other standard, would be considered no more than a puny little dot in our normally complex and ever-changing scheme of things. Now a part of the Republic of Palau, this beautiful but small island ordinarily would have been inhabited by fewer than 600 native Palauans. Nevertheless, more than 40,000 people were amassed here 50 years ago, struggling in inhumane conditions within the island's limited living space, in order to fight for control over a Japanese airstrip.

At the close of the Marianas campaign, a substantial part of the Navy set out toward the Palau Islands, a major Japanese naval stronghold. On September 15, 1944, Admiral Nimitz struck Pelelieu. The Marines of the 3d Amphibious Corps met tough resistance from the Japanese defensive forces. When the smoke cleared, more than 12,000 soldiers were left dead and the once lush islands were reduced to bare limestone. Needless to say, American forces eventually took the islands, Imperial Japanese command was demolished and the destiny of Palau was changed forever.

However, the Palauans were still determined to regain their birthrights. The strains of occupation and the ravages of war did not break their spirit. The survivors were able to recover their culture and control of their natural resources during the ensuing years. In 1947, the islands became part of the U.N. Trust Territory of the Pacific Islands under U.S. administration. After two referendums, a constitution was adopted in 1981 and elections were held later that year. The islands became internally self-governing and a Compact of Free Association with the United States was signed in 1982. This Compact provided for an option for full independence or an alteration of its status with the United States at any time based upon approval of such changes through plebiscite.

As we celebrate the 50th anniversary of World War II in Palau, an international conference will record, for Palauans and for the world, the historical, political economic, environmental, educational, and cultural effects of the Second World War in Palau and the Pacific. Presenters will include Palauan war survivors, local planning experts, and international scholars. The conference will be held in Koror, Palau from the 6th through the 9th of this coming September. The National Museum of Palau should be congratulated for sponsoring this combination of scholarship and commemoration of a great historical drama.

The Palauan Islands are now the last Trust Territory in the world and they are scheduled to become a fully independent nation in free association with the United States this coming October 1st; that is a fitting testimony to the commemoration of the 50th anniversary of World War II in Palau.

A TRIBUTE TO GENERAL AND MRS. RUSSELL SUTTON

HON. JERRY LEWIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. LEWIS of California. Mr. Speaker, I would like to bring to your attention the fine work and outstanding public service of two extraordinary individuals, Brigadier General and Mrs. Russell Sutton, of Twentynine Palms, CA. Since June 1992, General and Mrs. Sutton have developed and championed a remarkably close relationship between the Marine Corps Air Ground Combat Center at Twentynine Palms and the city of Twentynine Palms and other communities in the Morongo Basin. After a distinguished military career spanning 30 years, General Sutton is retiring and will be presented with the Distinguished Service Medal at his retirement ceremony by General Mundy, Commandant of the U.S. Marine Corps.

General Sutton was born in Nashville, TN, and graduated from the University of Alabama with a MS degree in physical education, and was commissioned a second lieutenant in the Marine Corps in 1964. During the course of his long and distinguished career, General Sutton has been promoted extensively while serving tours of duty in Vietnam, the United Kingdom, Malta, Korea, and Thailand, as well as numerous locations throughout the United States.

General Sutton has been widely decorated during his career, having received a Bronze Star medal with Combat V and three gold stars; Purple Heart with gold star; Defense Meritorious Medal; Meritorious Service Medal; Joint Service Commendation Medal; Navy Commendation Medal with Combat V; and the Combat Action Ribbon.

Sutton was named commanding general of the Marine Corps Air Ground Combat Center in June 1992. During his command, he has made significant contributions to personnel at the combat center as well as citizens of the local community. Major successful efforts have also been made toward improving military training, the quality of life, environmental affairs, family services, and community relations.

Since arriving in Twentynine Palms, General Sutton and his wife, Linda, have worked together as a team playing an extraordinary role in building bridges and strengthening ties between the combat center and the local community. Their active involvement with the local chamber of commerce, Pioneer Days, and other worthwhile local charities and activities has been well received by people both on and off the base.

According to the local newspaper, the Twentynine Palms Desert Trail, "With Brig. General Sutton at the helm of the Combat Center, relationships between the community and the base are undoubtedly bright. Both the general and his wife should be commended for recognizing and being leaders in the whole community—not just the military side, but the civilian side as well."

Mr. Speaker, I ask that you join me, our colleagues, and the Sutton's many dear friends in recognizing their outstanding work and selfless contributions. During their time in Twentynine Palms, General and Mrs. Sutton have touched the lives of many people in our community and it is only fitting that the House honor them both today.

MARY DENOVA IS HONORED

HON. HERB KLEIN

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. KLEIN. Mr. Speaker, it is with great pleasure that I rise today to join the congregation of the Church of the Blessed Sacrament in honoring Mary Tolomeo DeNova. Mrs. DeNova is a lifetime resident of Paterson, NJ, and a dedicated member of this community.

Born on September 11, 1907, Mary DeNova has seen the city of Paterson take shape before her eyes. In her first Home on 138 East 18th Street, her parents Dominic and Catherine Tolomeo raised 12 children. Their already crowded two-family house became a welcome stop for Italian immigrants from the providence of Salerno. She fondly recalls the era of trolley cars, when her parents' home was festive, food seemed to be plentiful, and the table was always adorned with homemade wine.

After finishing her formal education in the Paterson public schools at the age of 14, Mary began to work in the factories so prevalent in the Riverside section of Paterson. One such place, owned by Max, Sam, and Izzy Bornstein, was where a long and loving relationship began. It was at the silk mill that she met the foreman, Tony DeNova, to whom she was later married at St. Anthony's Church by Father Valenti in 1928.

Mr. and Mrs. DeNova raised their three sons in Riverside. After World War II, the family bought and managed a corner store in which Mrs. DeNova worked for 41 years. She has a sense of compassion for the community which did not go unnoticed; her sons called her Welfare Mary for her ability to know who was down and out and make sure that they received what they needed.

In addition to her 11 grandchildren and 11 great grandchildren, Mrs. DeNova has been involved in a countless number of clubs and organizations, including a Charter Member of School No. 18, Riverside Vets Leisure Club, Passaic County Democratic Club, Catholic Council of Women, Blessed Sacrament Rosary Society, Blessed Sacrament Leisure Club, All Wags A.C. Auxiliary, the 5th Avenue Democratic Club, and many more. In fact, Mary still treks to her spot at the polls every election day, including primaries, making sure Democrats get a fair shake.

Mary has seen many mayors and many priests come and go, but Father Richard Rusconi, the priest at Blessed Sacrament, and Mayor William J. Pascrell, Jr., a parishioner, could not be more proud of their longtime friend. The history of Paterson, NJ, cannot be written without including the life and times of Mary DeNova. I am very honored to ask my colleagues to pay tribute to Mrs. DeNova, and I wish her the best of luck in the future.

IDEA IMPROVEMENT ACT OF 1994

HON. CASS BALLENGER

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. BALLENGER. Mr. Speaker, today, I am introducing the IDEA Improvement Act of 1994, a bill that makes various amendments to the Individuals with Disabilities Education Act [IDEA].

In putting this bill together, my colleagues and I received a great deal of input from parents, teachers, administrators, legal advocates, and other special education experts. We did not try to represent one particular group's point of view, but instead, have tried to find a solid, reasoned approach that will play a constructive role in improving the education of children with disabilities.

To accomplish the best for these children, this bill carefully balances three priorities: increasing student achievement and accountability; increasing parents' involvement in their children's education; and, encouraging informal dispute resolution.

We need an increased emphasis on student achievement because we know that, too often, special education is more process oriented than results oriented. We need increased parental involvement because parents care the most about their child's well-being and must be a full partner in the educational process. And finally, we need to encourage informal dispute resolution so that special education is focused on successfully educating children, not fighting costly legal battles.

Our legislation includes the following key provisions:

It focuses on measuring educational achievement and ensuring that special education services are targeted to support the student's academic performance;

It gives parents the opportunity to be involved in more school meetings relating to their child's education;

It helps parents be better informed about their child's disabilities and how the special education system works;

It offers voluntary mediation to help settle disputes between parents and schools without costly litigation;

It establishes agreements between State agencies to define payment responsibilities for special education and related services;

It encourages special education programs to coordinate with programs like Even Start and Head Start that offer family literacy services; and,

It allows a judge to reduce parental attorney's fees if the parent did not first try to informally resolve the dispute.

Over the last year, there has been a lot of discussion about the complex issues surrounding the IDEA. Discussion is fine, my colleagues and I believe it is time to move this discussion to a more specific level and put some concrete proposals on the table.

We don't assume to have all the solutions for the problems that have been identified with the IDEA, but today we are making an honest attempt to face these issues with specific proposals. In that spirit, we look forward to continued input from our colleagues and also from the parents, teachers, and administrators that deal with the IDEA on a daily basis.

IDEA IMPROVEMENT ACT OF 1994

HON. WILLIAM F. GOODLING

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. GOODLING. Mr. Speaker, today, I am pleased to join as an original cosponsor of the IDEA Improvement Act of 1994 which is being introduced by Representative CASS BALLENGER.

Over the last year, my Republican colleagues and I on the Subcommittee on Select Education and Civil Rights have heard from parents, teachers, administrators, and State officials about the successes and challenges within special education under the Individuals with Disabilities Education Act [IDEA]. In examining these issues, three themes have emerged that we believe need attention: increasing the achievement of students with disabilities in school; helping parents be more involved in their children's education; and, finding ways to avoid costly and adversarial litigation.

Opportunities for individuals with disabilities have opened up significantly over the last several years. Unless the quality of education disabled students receive also improves, many of these students won't have the skills and confidence they need to take advantage of these new opportunities. The changes in this bill will hopefully place a greater focus on quality education and achievement for children with disabilities.

We also include provisions that strengthen the role of parents in their children's education. One provision of particular interest to me would encourage special education programs to coordinate with programs like Even Start and Head Start that offer family literacy services. A significant number of children being served by special education have a disability related to their difficulty in learning to read. If one or both of the child's parents also suffer from difficulty in reading, then it will be doubly hard for them to help their child overcome their reading difficulty. By improving coordination between special education and family literacy programs in specific circumstances, we can encourage more effective strategies to assist disabled children and their parents.

I believe both the mediation proposal and the requirement that parents try to work out disputes before filing a formal complaint in order to have attorney fees reimbursed are important provisions to encourage disputes to be resolved in an informal manner that avoids unnecessary and costly litigation.

I am also very pleased that we have written this bill in a way that helps move IDEA in a positive direction, but does not create new federal mandates or require excessive Federal intervention in the ways schools operate their special education programs.

I want to express my thanks to Mr. BALLENGER for introducing this valuable legislation, and I look forward to working with him to see that these provisions are included as improvement to the Individuals with Disabilities Education Act.

DR. LOIS GIBSON—AMERICAN SUCCESS STORY

HON. WALTER R. TUCKER III

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. TUCKER. Mr. Speaker, I rise today to salute an American success story, and Women's History Month honoree, Dr. Lois Gibson.

Mr. Speaker, each year, the Mayor's Commission on the Status of Women recognizes women in the Jacksonville community that have made a lasting contribution. One of only five women selected this year is, Dr. Lois Gibson.

Mr. Speaker, Dr. Gibson is special to me because she is the mother of my district administrator, Audrey Gibson. Each honoree was presented with a watercolor poster depicting the 1994 honorees, by Mayor Ed Austin and Betty Davis. The theme of the dinner which was held at the Omni Hotel on March 1, was to Celebrate Women: Builders of Dreams. Besides Mayor Austin and Mrs. Davis, others in the dinner program were Susan Main, Girl Scout Troop No. 374, Anne Witherspoon, Christine Tyler, Madeline Seals-Taylor, and Dr. Bertice Berry. Dr. Berry is an award-winning lecturer, stand-up comedienne, and now host of her own syndicated talk show.

Dr. Gibson is the 12th African-American to be selected by the Mayor's Commission on the Status of Women. The other African-American women so honored were: Willye F. Dennis, Mary White Bocker, Mary Singleton, Marva Williams, I.E. Williams, Sally Mathis, Florida Dwight, Gertrude Peele and Janet Johnson.

Dr. Gibson is a native of Jacksonville, FL. She graduated from Stanton Senior High School. She obtained her nursing diploma from Grady Memorial Hospital, her B.S.N. degree from Tuskegee Institute, her master's from Boston University, and an Ed.D from Nova University.

Mr. Speaker, Dr. Gibson has been a member of 14 professional affiliations, including the American Nurses Association, Florida Nurses Association, and Sigma Theta Tau National Honor Society for Nursing Educators. She is very involved in civic and religions activities. She is a past president of Delta Sigma Theta Sorority, Inc., Chi Eta Phi Nursing Sorority, and the Jacksonville chapter of the Links, Inc. She is also a member of the Jacksonville Women's Network, life member of the National Council of Negro Women, YWCA Board of Directors, Catholic Women's Club, and St. Pius Catholic Church.

While she was dean of nursing at the Florida Community College at Jacksonville, she developed a $3 million proposal for a nursing construction grant to expand the associate degree nursing program. Dr. Gibson has received many awards. A few of them are the Eve Award in Education, the NENW Outstanding Service in the Jacksonville Community Award, and the Northeast Florida Organization of Nursing Educators' Outstanding and Valuable Contribution Award.

Mr. Speaker, Dr. Lois Gibson is truly an American success story and I am proud to associate myself with her.

THE GULF OF MAINE CONSERVATION AND COOPERATION ACT

HON. OLYMPIA J. SNOWE

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Ms. SNOWE. Mr. Speaker, the Gulf of Maine stretches from the Bay of Fundy in Canada to Cape Cod in Massachusetts, and out to Georges Bank. It represents one of the richest marine ecosystems in the United States. It supports over 100 species of birds, 73 species of fish, 26 species of whales, dolphins, and porpoises, and endangered species such as the bald eagle, the roseate tern, the humpback whale, and the sperm whale.

The gulf also provides abundant economic and recreational benefits to the people of the region. Its commercial fishing industry, including aquaculture, produces more than $800 million in revenues annually, and employs 20,000 people. Tourism and recreation in the Gulf of Maine region also generate millions of dollars and employs thousands.

Fortunately, the gulf remains productive, but danger signs are beginning to appear. High levels of toxic contaminants have been detected in the gulf's deep basin sediments, indicating that pollutants are distributed throughout the region. Bacterial contamination has led to the closure of one-third of Maine's shellfish beds. And fish and wildlife habitat is declining.

These problems can be arrested before the gulf's natural resources degrade too far, but it will require cooperation and commitment from the region's citizens, local governments, State and provincial governments, and Federal Governments. The States and provinces wisely recognized that the gulf's resources transcend political boundaries, and the Governors and premiers formed the Gulf of Maine Council on the Marine Environment in 1989 to develop joint solutions to the gulf's environmental and economic problems. Since its creation, the council has developed constructive programs to protect and manage the natural resources of the gulf while enabling the economies of the region to grow.

The missing piece of the effort is the U.S. Government. Agencies like the Commerce Department, the EPA, the Interior Department, and the Army Corps of Engineers already conduct resource management, research, and economic development programs in the region—and these programs often make a positive difference—but these programs can be disconnected and uncoordinated, both within the Federal bureaucracy and without. Consequently, we lost opportunities to pool resources, coordinate, and maximize the effectiveness of our collective efforts in spite of limited budgets.

To help the Federal Government become more involved in this regional cooperative process in the Gulf of Maine, I have introduced a bill, the Gulf of Maine Conservation and Cooperation Act. The bill issues a statement of policy that Federal resource conservation efforts in the region should be maintained and strengthened. It establishes a Gulf of Maine Interagency Task Force consisting of representatives from the Commerce Department, EPA, Interior, and the corps, whose mission is to identify opportunities for interagency cooperation and coordination of activities in order to make efficient use of Federal resources in the gulf region. The bill also requires Federal resource agencies to cooperate and coordinate, to the maximum extent practicable, with the Gulf of Maine Council and the States, and it authorizes Federal financial contributions to the council for joint programs.

The Gulf of Maine Conservation and Cooperation Act does not create any new programs or bureaucracies, promulgate new regulations, or impose new mandates on the States. It does not seek to solve all of the ecological problems of the gulf with one wave of a magic legislative wand. Instead, it seeks only to move the Federal Government in a more constructive direction on issues relating to the health of the Gulf of Maine. It offers a rational, flexible, and inexpensive approach to problem-solving in the gulf, an approach supported by my home State of Maine. I hope my colleagues will support this approach as well.

TRIBUTE TO J. THOMAS RITTER

HON. RICHARD H. LEHMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. LEHMAN. Mr. Speaker, I rise before my colleagues today to pay tribute to J. Thomas Ritter who has retired after 5 years as superintendent of Sequoia and Kings Canyon National Parks and a distinguished career in the premier areas of the National Park Service.

Tom's retirement caps a career that spans 35 years of dedicated service with the National Park Service. Mesa Verde National Park marked the beginning of Tom's park service career. Following that was other seasonal experiences in San Juan National Forest, Glacier National Park, Rocky Mountain National Park and Saguaro National Monument.

His first permanent position was at Lake Mead National Recreation Area, followed by tours at Timpanagos Cave National Monument, Mount McKinley National Park, Anchorage General Office, Glacier Bay National Monument, Voyageurs National Park, the Washington office and finally, Sequoia and Kings Canyon National Park.

I'm proud when Tom says that the greatest time of his career has been working at Sequoia and Kings Canyon National Parks, two jewels in the National Park system that are located in my backyard in my congressional district.

It's to Tom's credit and a tribute to his work that in 1992 he was named Superintendent of the Year for Natural Resources Stewardship for the western region of the Park Service.

And Tom was also the recipient of the Glenn O. Hendrix Award for quality in planning and construction while at Sequoia Kings Canyon. Tom was deeply involved in an era of change at Sequoia and Kings Canyon. The move from Giant Forest to Wuksachi Village, the renovation of the Generals Highway, the wastewater problems and potential closure of Giant Forest are examples of significant issues that he has dealt with exceptionally well.

In addition to dealing with change and inspiring a team approach to management in Sequoia and Kings Canyon, Tom served on numerous service-wide and regional task forces during his 5-year tenure there. His contributions to the Western Region Natural Resources Management and Science Task Force were also valuable.

I want to thank Tom for his stewardship of our Nation's resources and for all his achievements on behalf of park visitors from around the world. He has truly made a difference. For that he will be missed.

THREE CHEERS FOR CAPITALISM

HON. PHILIP M. CRANE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. CRANE. Mr. Speaker, as Congress nears consideration of a Government-run health care system, I believe that Members need to be reminded of the proven inefficiencies of a centrally planned economy. The free market and capitalism have been tested through history and have shown that they are the best method for distributing everything from pins to health care. The United States is the world leader in health care because the Government has been largely absent from the decisionmaking in that service. We have also noted that when the Federal Government becomes involved in a service, like the U.S. Postal Service, performance is subpar compared to free market alternatives, like United Parcel Service.

I am enclosing the September 1993 issue of "Imprimis" in which Malcolm S. Forbes, Jr., describes the free market as the most moral economic system known to mankind. I commend this article to the attention of my colleagues and urge them to heed the advice of Mr. Forbes as we begin debate on health care.

[From Imprimis, September 1993]

THREE CHEERS FOR CAPITALISM

(By Malcolm S. Forbes, Jr.)

Living in the 1990s, we are uniquely able to judge what the American economy has achieved in the 20th century. For this reason, we ought to give three cheers for capitalism. By the term, I mean "democratic capitalism," which is as fundamentally different from the "managed capitalism" of modern-day central planners as it is from the "state capitalism" of old-style fascists, socials, and communists.

Capitalism works better than any of us can conceive. It is also the only truly moral system of exchange. It encourages individuals to freely devote their energies and impulses to peaceful pursuits, to the satisfaction of others' wants and needs, and to constructive action for the welfare of all. The basis for capitalism is not greed. You don't see misers creating Walmarts and Microsofts.

Think about it for a moment. Capitalism is truly miraculous. What other system enables us to cooperate with millions of other ordinary people—whom we will never meet but whom we will gladly provide with goods and services—in an incredible, complex web of commercial transactions? And what other system perpetuates itself, working every day, year in, year out, with no single hand guiding it?

Capitalism is a moral system if only because it is based on trust. When we turn on a light, we assume that there will be electricity. When we drive into a service station, we assume that there will be fuel. When we walk into a restaurant, we assume that there will be food. If we were to make a list of all the basic things that capitalism provides—things that we take for granted—it would fill an encyclopedia.

HOW TO BECOME SUCCESSFUL CAPITALISTS

How do we become successful capitalists? The answer sounds simple, but it is often overlooked in places where you would think they would know better. (I am referring, of course, to government, the media, and our most elite business schools and economics departments.) We succeed as capitalists by offering goods and services that others are willing to buy. Many capitalists do not make correct assumptions about what to offer and fail, but that is as it should be. There is no guarantee of success in any area of life, including business—there is always risk. The particular advantage of capitalism is that failed businesses don't necessarily equal a failed economy; they make way for successful businesses.

But even the most successful businesses can't afford to forget about market principles. AT&T is a case in point. In the 1970s, fiber-optic technology was available, but AT&T decided that it would delay fully converting for perhaps 30 to 40 years. It wanted to fully depreciate its old plants and equipment, and, because it enjoyed a virtual monopoly over its customers, it saw no reason to spend a lot of money on a new long distance calling system. But then an upstart company, MCI, raised a couple billion dollars through the much-maligned "junk bonds" market in order to set up its own fiber-optic network. AT&T had no choice but to keep up with its competition, and, as a result, the U.S. experienced an enormous advance in communications that has put it ahead of its foreign competitors and that has benefited hundreds of millions of consumers.

About twenty-five years ago, the federal government filed an antitrust suit against IBM because it had grown so successful that its name had become virtually synonymous with the computer industry. But the would-be trustbusters underestimated the vitality of an open marketplace. IBM's dominance of mainframe computers, microchips, and software did not prevent the rise of rival companies such as Digital Equipment, Apple Computer, Sun Microsystems, and Microsoft. Today, IBM's very existence is in jeopardy.

Around the same time, John Kenneth Galbraith wrote The New Industrial State, in which he argued that though the Ford Motor Company was no longer the biggest of the auto companies (GM had roughly 50 percent of all sales), Ford was so large that it did not have to pay particular attention to its shareholders or its customers. Apparently, Japanese automakers did not read John Kenneth Galbraith, or the reports of countless other "experts" who claimed that it was impossible to compete against Ford, GM, and Chrysler. They even ignored their own early failures to storm the U.S. market in the 1950s and early 1960s. Finally, after years of trying, Japanese automakers succeeded—and succeeded to an extent that no one could have predicted—in challenging the hegemony of the "giants" in Detroit.

Then there is Sears & Roebuck. What more mundane business could there be than retailing? Yet, around the turn of the century, Sears made retailing truly exciting, reaching out to millions of people with new marketing methods and new products. By the end of the 1940s, it dwarfed all competitors. In the last several decades, however, the company lost its way and became a self-serving, insulated bureaucracy. Now it is closing its doors on numerous stores. Its market share has plunged—and its profits have almost disappeared.

Why, by contrast, has another retail firm, Walmart, achieved its phenomenal success? Not because its founder Sam Walton used to ride around in a pickup truck visiting his stores, though that was good publicity. It was because he recognized the importance of computer technology and had systems devised that help store operators respond to inventory information on a weekly and even daily basis. Sam Walton knew that success, even once it was achieved, was something that couldn't be taken for granted.

What should be clear from each of these examples is that capitalism is not a top-down system—it cannot be mandated or centrally planned. It operates from the bottom up, through individuals—individuals who take risks, who often "don't know any better," who venture into areas where, according to conventional wisdom, they have no business going, who see vast potential where others see nothing.

Often, these individuals literally stumble across ideas that never would have occurred to them if they were forced to work in a top-down system. And they take supposedly "worthless" substances and turn them into infinitely valuable ones. Look at penicillin. Whoever thought that stale bread could be good for anything? The same goes for oil before the invention of the gasoline engine and the automobile and for sand before the invention of glass, fiber-optics, and the microchip.

There is another important thing to remember about capitalism: Failure is not a stigma or a permanent obstacle. It is a spur to learn and try again. Edison invented the light bulb on, roughly, his ten-thousandth attempt. If we had depended on central planners to direct his experiments, we would all be sitting around in the dark today.

OPEN VERSUS MANAGED COMPETITION

This leads to the next question regarding capitalism: What is the market? Central planners don't like the word; they prefer to say, "market forces," as if describing aliens from outer space. But nothing could be further from the truth. The market is people. All of us. We decide what to do and what not to do, where to shop and where not to shop, what to buy and what not to buy. So when central planners trash "market forces," they are really trashing us.

Unfortunately, they are the ones who seem to be calling the shots today on a number of issues that should be left up to the market, i.e., up to us. One such issue is the spiraling costs of health care. Not surprisingly, central planners advocate a top-down approach to reform. With unconscious irony, they call it "managed competition."

But we have already tried managed competition, in fact, it is managed competition that has caused so many problems in the health care industry in the first place. Specifically, the tax code penalizes individuals who want to buy medical insurance by making them pay for it with after-tax dollars, even if they are self-employed. Only 25 percent of their premiums are deductible. But companies may buy health insurance with pre-tax dollars. So they, instead of their employees, have become the primary purchasers of insurance. This drives a wedge between the real customers and the real providers and obscures the real costs of such features of the system as low deductibles. Imagine if every time you went to the supermarket you gave the cash register receipt to your employer, who then submitted it to the insurance company for a claim. What would happen to food prices? They would skyrocket, because you wouldn't care whether a bottle of soda cost $10, $100, or $1,000.

The problem doesn't stop there. Growth in demand and improvements in technology—key ingredients to success in any other business—have instead led to crisis in the health care industry. More people are receiving better treatment than ever before and leading longer, healthier lives, but perversely this has sent costs up rather than down and has overloaded the delivery system.

If we want genuine health care reform, we must return to open competition. The tax code must be revised so that individuals can buy health insurance with pre-tax dollars and set up medical IRAs for their families that can be used to finance routine medical expenses. There is no doubt that a majority of Americans would choose this option. They want to have control over their own health care decisions. Many would choose policies with higher deductibles. Premiums would go down and so would paperwork. Physicians and hospitals would see their patient load come under control and would be induced to offer competitive rates and services. The potential benefits are enormous.

A couple of years ago, Forbes Inc. faced yet another round of steeply rising costs for health care. We wanted to do something that enabled our employees to police those costs in a way we, the employer, were unable to do. So we gave them a stake in the process. We offered them a bonus: They could keep the difference between their claims and $500—and we would double the amount. Thus, if they went through a calendar year without filing any health claims on the insurance company, we would pay them as much as $1000, tax free.

What happened? Suddenly, every employee became cost-conscious. On major medical and dental expenses, claims went down 30 percent. These savings financed the bonuses and our total health care costs went up zero percent last year. This was not because we compelled millions of people to participate in some "managed competition" scheme, but because we let a few hundred individuals make their own health care decisions.

LETTING INDIVIDUALS MAKE THEIR OWN DECISIONS

Letting individuals make their own decisions is what capitalism is all about, but virtually all central planners (now in their heyday under the Clinton administration) and a good many members of the U.S. Congress (Republicans as well as Democrats) fail to realize it. They do not, for example, realize that it is the decisions of individuals that really decide how much tax revenue the government collects and how well the economy prospers. Between 1982 and 1986, the American private sector created well over 18 million new jobs, including a record number of high-paying positions. Of these, 14 million were created by new businesses. But, in 1987, Congress raised the capital gains tax to one of the highest levels in the industrial world. What happened? New business and job creation declined sharply. The nation was hit with a recession. And tax revenues, which were supposed to rise, went down. All this occurred because individuals made the decision not to invest. Today, there is almost $7 trillion of unrealized capital gains that is going begging because of high taxes. If Congress lowered the capital gains rate, it would mean more not less tax revenues. It also would overwhelm any stimulus package Washington could concoct for revitalizing the economy.

Central planners also tend to be big fans of "industrial planning," whereby government picks the "winners" in the marketplace through subsidization of select companies and technologies. They ignore the fact that this will obliterate incentives for companies to remain competitive, breed corruption and special interests, and penalize the small businesses that are the backbone of the economy.

And they want to micromanage the monetary system, knocking down the value of the dollar against the yen or raising it against some other currency in closed-door meetings with bureaucrats from other industrialized nations. They do not realize that one of the most important functions of money is to serve as a constant, reliable measure. A ruler is supposed to be 12 inches long, but they want to change it to 11 or 13 inches whenever it suits their political strategy. You and I might call this a swindle, but in Washington it is called sophisticated economic management.

Even such a simple word as "change" takes on a whole new definition in Washington, meaning change directed from above by well-intended central planners and politicians who think that they "know better" than most people when it comes to making decisions. But, in truth, the most revolutionary sweeping agent of change is capitalism. Look at what has happened in Eastern Europe, the Soviet Union, Latin America, and Asia. When people are free to make their own decisions, they have a stake in the economy, and when they have a stake in the economy, they have a stake in serving others, and when they have a stake in serving others, they have a stake in fighting for freedom.

Capitalism is the real enemy of tyranny. It stands not for accumulated wealth or greed but for human innovation, imagination, and risk-taking. It cannot be measured in mathematical models or quantified in statistical terms, which is why central planners and politicians always underestimate it. As I noted at the outset, it is up to us, then, to give three cheers for capitalism. Who knows? If we cheer loud enough, perhaps even they will listen.

TRIBUTE TO CHARLES COST

HON. JACK REED

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. REED. Mr. Speaker, I rise today to salute a distinguished young man from Rhode Island who has attained the rank of Eagle Scout in the Boy Scouts of America. He is Charles Cost of Troop One in North Scituate, RI, and he is honored this week for his noteworthy achievement.

Not every young American who joins the Boy Scouts earns the prestigious Eagle Scout Award. In fact, only 2.5 percent of all Boy Scouts do. To earn the award, a Boy Scout must fulfill requirements in the areas of leadership, service, and outdoor skills. He must earn 21 merit badges, 11 of which are required from areas such as citizenship in the community, citizenship in the Nation, citizenship in the world, safety, environmental science, and first aid.

As he progresses through the Boy Scout ranks, a Scout must demonstrate participation in increasingly more responsible service projects. He must also demonstrate leadership skills by holding one or more specific youth leadership positions in his patrol and/or troop. This young man has distinguished himself in accordance with these criteria.

For his Eagle Scout project, Charles performed community service in the town of Foster under the direction of the public works director.

Mr. Speaker, I ask you and my colleagues to join me in saluting Eagle Scout Charles Cost. In turn, we must duly recognize the Boy Scouts of America for establishing the Eagle Scout Award and the strenuous criteria its aspirants must meet. This program has through its 84 years honed and enhanced the leadership skills and commitment to public service of many outstanding Americans, two dozen of whom now serve in the House.

It is my sincere belief that Charles Cost will continue his public service and in so doing will further distinguish himself and consequently better his community. I join friends, colleagues, and family who this week salute him.

TRIBUTE TO ANN MARGARET GALLIGAN DENOIA

HON. SAM GEJDENSON

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. GEJDENSON. Mr. Speaker, Ann Margaret Galligan DeNoia, who died on August 3, 1994, at St. Francis Hospital in Hartford, CT, gave real meaning to term "public servant."

Her Irish wit added to the warm personality she brought to her assignments in government at the State and Federal levels over more than three decades.

For 10 years, between 1981 and 1991, she served as executive assistant to Gov. William O'Neill, handling the myriad of duties in an efficient and kindly manner.

Describing her work in its obituary, the Hartford Current noted that "she handled visitors (to the Governor's office) with the charms of a small-time diner waitress but could sternly get rid of the most persistent visitors, too."

Mrs. DeNoia's career included a tenure in the early 1960's on the staff of Abraham A. Ribicoff when he was Secretary of the U.S. Department of Health, Education, and Welfare. She also worked with Mr. O'Neill during his service to Connecticut in the General Assembly and as Lieutenant Governor between 1971 and 1981. For 3 years before her death, she worked for the Connecticut Housing Finance Authority.

She had been active in Democratic Party operations since her teenage years when she started as a volunteer in the campaign of her brother, William Galligan of West Hartford, who ran for the general assembly. Subsequently, she assisted the Democratic entities and programs.

Government produces many good people and some great people. Ann Margaret Galligan DeNoia was one of the great, great individuals to bless government with her presence. Ann was a close personal friend whom I and many others will miss—we share the loss with her husband, Dick.

IN RECOGNITION OF ANGEL FLIGHT, INC.

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. HALL of Texas. Mr. Speaker, I rise today to pay tribute to a singular charitable organization called Angel Flight, Inc. This nonprofit corporation is dedicated to the free air transportation of medical patients, blood, and medical cargoes for those who cannot access such transportation by ordinary commercial means.

Angel Flight is composed of volunteers whose time, talent, money, and aircraft are donated free of charge. In 1993 volunteer pilots produced 300 missions that required over 2,000 hours for a total of 160,000 nautical miles. Areas served include Texas, Arkansas, Oklahoma, Louisiana, Mississippi, Tennessee, Alabama, and Nebraska. The pilot base has increased to more than 250 pilots.

Angel Flight is a member of Air Care Alliance, an organization that supplies information throughout the United States for contacting organizations that provide the services of general aviation pilots and aircraft. A coordinator makes the necessary arrangements for each flight, and users must be qualified by either a physician or social worker.

Some of the medical facilities served include M. D. Anderson Hospital in Houston, Scott & White Hospital in Temple, Wadley Blood Center in Dallas, Cancer Therapy & Research Center in San Antonio, University of Texas Medical Branch in Galveston, Mayo Hospital in Minnesota, and Shrine Hospital in Chicago.

Each pilot must adhere to FAA regulations, provide insurance coverage, and have a minimum of 200 hours of flight time. Angel Flight is financially supported primarily by these volunteer pilots, who donate the use of their airplanes and operating expenses, and by contributions from individuals, service clubs, and other groups. The corporation receives no financial aid from any government entity.

From transporting a cancer patient for an experimental drug treatment to flying a young child to a specialist for a series of cosmetic surgeries, Angel Flight is in the business of helping provide medical care for those in need. Mr. Speaker, during this time when our Nation is focused on quality health care and health care costs, I wish to salute the heroic efforts of these volunteers who are doing their part to provide quality of care for patients at no cost to the taxpayer or government. Their efforts deserve our recognition and our thanks.

A TRIBUTE TO SAM AND YVONNE MARIE ANDERSON—AN AMERICAN SUCCESS STORY

HON. WALTER R. TUCKER III

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. TUCKER. Mr. Speaker, I rise today to salute an American success story, and congratulate Sam Anderson and Yvonne Marie Anderson. Sam and Yvonne are special to me because they are the aunt and uncle of my wife, Robin M. Tucker.

Mr. Speaker, these two exceptional people are to be commended for their work in the field of education. Both being educators, they have given tirelessly of themselves and displayed true dedication to the students of the Los Angeles Unified School District.

Sam Anderson, born in Dallas, TX, came to Los Angeles, and eventually received his B.A. degree from Pepperdine University. His 36 years in the Los Angeles Unified School District/High School Division, included teaching history for 18 years at Jordan High School, and being actively involved with the High School Work Experience Program and Youth Services for the last 12 years.

Yvonne Marie Anderson, hailing from Ft. Worth, TX, attended Woodbury Business College. She was employed for 25 years in the Los Angeles Unified School District/Adult Division at the Jordan/Locke Community Adult School. Mrs. Anderson taught business education for the Employment Preparation Center, was a teacher's advisor for two successive terms and was the business education chairman for three consecutive terms.

Mr. Speaker, Mr. Sam Anderson's commitment to the advancement of high school students and their preparation for the work force, and Mrs. Yvonne Marie Anderson's commitment to the development of adults in preparation for jobs in the business field, along with their active participation in numerous school organizations and educational associations, is to be lauded, for they are truly an American success story, and I am proud to associate myself with them.

LEGISLATION CONCERNING NEGOTIATED RULEMAKING AND THE NEW ENGLAND GROUNDFISH INDUSTRY

HON. OLYMPIA J. SNOWE

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Ms. SNOWE. Mr. Speaker, over the past 6 months, the national press has been full of stories about the decline of the New England groundfish populations. The stories generally follow a similar pattern: The groundfish have been terribly overfished, tough regulations to eliminate overfishing have finally been approved, and the fishermen are resisting them prior to losing their jobs. The stories offer a distinct and clear picture in black and white. But this kind of portrayal, while accurate in some respects, contains a critical flaw: The groundfish issue is actually more muddled. It contains different shades of gray as well as black and white.

Few people in New England will doubt that the groundfish stocks are down and that substantive measures to conserve and rebuild the stocks are in order. The question is not the end but the means. Fishermen think that they know something about the means. As inheritors and practitioners of a 300-year tradition—perhaps the oldest industry in New England—they argue that their experience and knowledge of the fishery resource can yield important insights into the resource that will aid considerably in the development of a fishery management plan for groundfish.

A fishery management plan, amendment 5 to the Northeast Multispecies Fishery Management Plan, has indeed been developed and approved by the New England Fishery Management Council and the Commerce Department, but the fishermen believe that it will unnecessarily put many members of the industry out of work without achieving its conservation objectives. The council held public hearings throughout New England prior to completing amendment 5, but the final amendment incorporates only a few of their recommendations. Its central provision will reduce the number of days that fishermen can fish by 50 percent over 5 years—a provision that was bitterly opposed by the industry during the hearing period.

One thing is certain about amendment 5: A lot of people will lose jobs in Maine and other New England States. But most of the job losses will probably not occur until year 3 of the program, in 1996. In the meantime, there is an opportunity to make every effort to ensure, before the Federal Government forces people out of the fishing industry, that no other, less disruptive set of fishery management alternatives to the controversial provisions of amendment 5 exists.

I have introduced two bills designed to bring the fishermen, the Commerce Department, and other stakeholders to the table to try to find some common ground on less costly management alternatives before it's too late. This process is known as negotiated rulemaking, and it was authorized for Federal agencies under the Negotiated Rulemaking Act of 1990. It provides a collaborative, consensus-based dispute resolution tool that agencies can use to develop potentially controversial regulations. Representatives of all interests with a stake in a particular issue sit down and negotiate with the aid of a facilitator over a set time period. If consensus is reached, the head of the agency can then propose that consensus document as a new rule.

My first bill gives the Secretary of Commerce the explicit authority to use negotiated rulemaking to develop fishery management plans or plan amendments. Under the Magnuson Act, the Secretary can only submit management plans or plan amendments under limited circumstances which preclude his flexibility in using this important tool. Also, negotiated rulemaking is specifically used to develop rules, but fishery management plans are not technically rules. My bill removes these potential obstacles and clears the way for the Secretary to use this dispute resolution tool.

The second bill that I have introduced today directs the Secretary to use negotiated rulemaking in the specific case of the groundfish fishery. Alternative dispute resolution is used more and more commonly in lieu of the traditional adversarial regulatory process. I firmly believe that it needs to be tried in the case of the New England groundfish issue.

My legislation does not approve or disapprove any particular conservation program, or impose particular management measures on the groundfish fishery. It only offers another route for developing conservation measures, a route that may produce measures that yield the necessary conservation gains without causing so much disruption to the economies and coastal communities of our region.

TRIBUTE TO YVONNE J. SETENCICH

HON. RICHARD H. LEHMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. LEHMAN. Mr. Speaker, I rise before my colleagues today to pay tribute to Yvonne J. Setencich, who has served her county well, laboring behind the scenes and working to ensure a better government for all of us.

For 6 years Yvonne has served on the Fresno County grand jury, a tenure that is unprecedented in Fresno County history. Yvonne, who happens to live in Sanger, the small farming community that is my birthplace, capped her career as a member of this government watchdog organization by serving as foreman in 1993–94.

I have known Yvonne for many years, both as a constituent and, more importantly, as a friend, together with her husband, Eli. Although grand jury proceedings are secret, I know her to be a tireless worker, conscientious and organized in the way she goes about the tasks that are before her.

Yvonne has unselfishly given her time and served Fresno County and its citizens with distinction. I am proud to call Yvonne my friend, and I commend her for the years of valuable service she has provided toward a better and more efficient government.

REFORM OF MUSIC LICENSING FEES FOR SMALL BUSINESSES

HON. JACK REED

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. REED. Mr. Speaker, today, along with my colleagues Mr. SENSENBRENNER, Mr. SYNAR, Mr. ROSE, Mr. GEKAS, and Mr. ZELIFF, I am introducing legislation that will help level the playing field between small businesses and music licensing organizations.

Under current law, music licensing organizations such as the American Society of Composers, Authors, and Publishers [ASCAP], Broadcast Music Inc [BMI], and the Society of European Stage Authors and Composers [SESAC] are permitted to collect fees from business people who choose to play music in their establishments, whether it be from television commercial jingles, radio, tapes, or

CD's. This applies to restaurants, shoe stores—even children singing Christmas carols in shopping centers.

The House Judiciary Committee Subcommittee on Intellectual Property and Judicial Administration held a hearing in February to examine the music licensing practices of these societies. One of the witnesses was a constituent of mine, John Deion, who owns the Last Call Saloon in Providence, RI. Mr. Deion joined other small businessmen who aired concerns about the arbitrary nature of the fees, the inability of business owners to determine which organization licenses which work, and the lack of an adequate forum to resolve fee disputes.

My legislation addresses their concerns. Specifically, it does the following:

Expands the current exemption for certain radio or television sets. This has been the most litigated exemption of the Copyright Act and should be clarified to exempt all radios and televisions, provided no charge is made to see or hear the transmission.

Establishes a court-annexed arbitration process for fee disputes. Currently, in order to dispute the amount of the fee, a small business owner must hire an attorney in the state of New York because that is the only place and the only court which hears disputes over music licensing fees. Most business cannot afford to do this.

Requires free on line access to repertoire. Currently, it is difficult to determine which organization licenses which work—a practice that forces business owners to pay all three groups. Individuals should be able to choose to play music from only one music licensing group and only pay fees to one organization instead of all three.

Creates a new exemption for nonprofit educational choral groups who perform for free.

I strongly believe artists deserve compensation for the use of their works. But I also believe that small business owners deserve to operate under a system that is reasonable and fair.

SPECIAL WORDS FOR A VERY SPECIAL CONGRESSMAN

HON. DOUGLAS APPLEGATE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. APPLEGATE. Mr. Speaker, last May a giant of a man and a former member of the House of Representatives passed away at the age of 90, Robert T. Secrest of Cambridge, OH.

Bob Secrest came to Congress in 1933, joined by Jennings Randolph of West Virginia, the last remaining elected official who accompanied Franklin Delano Roosevelt in heralding in the New Deal era.

Bob Secrest was the first Member to leave Congress and join the Armed Forces at the outbreak of World War II, entering the U.S. Navy. Bob Secrest served a total of 20 years in the House during three separate occasions, the only Member of Congress ever to do so. Bob also served on the Federal Trade Commission and was a former member of the Ohio House of Representatives and the Ohio Senate. He also served as the director of the Ohio Department of Commerce.

Mr. Speaker, a good friend of mine from Youngstown, OH, Thomas P. Gilmartin, Sr., an admirer of Robert Secrest, recently sent to me a poem he wrote as a tribute to our former colleague. I would like to take this opportunity to share these thoughtful words with the members of the House:

A TRIBUTE TO BOB SECREST

(By Tom Gilmartin, Sr.)

Bob Secrest tall and straight
Could look anyone in the face and tell them
the way things should be
A decent man through and through
Did his duty with delight
Never ducked from any fight
Veteran-Legislature a statesman too
A gentle man with sparkling eyes
Quick, could think on his feet
Never abusive or mean
Never grumbled or complained
Spoke his mind with humor-wit
Always right with friend or foe
Gee, I'm sorry to see him go.

TRIBUTE TO ALBERT STAEHLE: CREATOR OF SMOKEY BEAR

HON. CARRIE P. MEEK

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mrs. MEEK. Mr. Speaker, this year we are celebrating the 50th anniversary of Smokey Bear. For the past 50 years, Smokey Bear has been a symbol of fire prevention for the U.S. Department of Agriculture Forest Service. He has instilled in generations of Americans the message—Remember—Only you can prevent Forest Fires!—a message of personal responsibility in the fight against carelessly caused wildfires.

The original Smokey Bear was born from the imagination and pen of the late Albert Staehle, considered America's greatest animal illustrator. In 1944, the USDA Forest Service asked Albert Staehle to create a mascot for its wartime fire prevention campaign. After considerable deliberation, he finally settled on a bear. The bear, he felt, could be portrayed as the father of the forest. The bear was fitted with a ranger's hat, blue jeans, a badge, and a bucket of water to put out fires.

Albert Staehle's creation, much to the benefit of our forests, is now the most recognizable animal figure in modern American history. Little did he know at the time that his creation would become a legend and constant reminder of the importance of preserving our precious forests.

During his lifetime, Mr. Staehle created such memorable animal figures as "Butch," the lovable cocker-spaniel who graced the covers of The Saturday Evening Post, Borden's Elsie the Cow and of course, the Forest Service's Smokey Bear. However, his work was not just confined to the animal kingdom. His genius was displayed in a variety of media including posters, magazine advertisements and house organs. He also designed war posters that were considered to be quite striking. His posters were consistent prize winners, in 1938–40 winning the prestigious Kerwin H. Fulton Medal for the Advancement of Art in Outdoor Advertising. He also won awards for his art from the Chicago Outdoor Advertising Association and the Art Directors Club of Philadelphia.

Albert Staehle was born in Munich, Germany, and came to New York when he was 14. He was a third-generation artist. He is the late husband of Marjory Staehle, a resident of the 17th Congressional District of Florida.

Mr. Speaker, until this year, Mr. Staehle has not been given the recognition he deserves for his contribution to the Smokey Bear campaign against forest fires. The American public was unaware and the U.S. Government has overlooked Albert Staehle's contribution.

Mr. Speaker, I applaud the Department of Agriculture Forest Service decision to recognize Albert Staehle for the significant contribution he made to our national heritage.

INTRODUCTION OF H.R. 4927, THE NORTHERN MARIANAS DELEGATE ACT

HON. ROBERT A. UNDERWOOD

OF GUAM

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. UNDERWOOD. Mr. Speaker, today I have introduced H.R. 4927, the Northern Marianas Delegate Act, to provide for a nonvoting Delegate to the House of Representatives to represent the Commonwealth of the Northern Mariana Islands.

The Commonwealth of the Northern Mariana Islands became the newest territory of the United States and an American commonwealth in 1976. This commonwealth is comprised of the northern islands in the Mariana Island chain, the principal islands being Saipan, Tinian, and Rota. Guam is also a part of the Mariana Island chain, and it is fitting that the people of Guam have the honor today to share in the introduction of this bill for our Pacific neighbors, and for our brothers and sisters of Chamoru heritage in the Northern Marianas who share Guam's indigenous identity.

It is important that the Northern Marianas be accorded representation in Congress, not just for fair and just representation of an American community whose interests are affected by the actions of Congress, but more importantly for what the people of Northern Marianas can contribute to the Nation through their Delegate.

The American relationship with the Northern Marianas began just over 50 years ago when American forces fought on the beaches of Saipan and Tinian, and at great human cost, expelled a colonial power that had acquired these islands as part of a Pacific empire. The Americans, in the years to come, established the seeds of democracy that have resulted in this new American commonwealth. This commonwealth, whose roots to America are traced to a violent military encounter in World War II, is the first American soil acquired by conquest in this century. That the people of the Northern Marianas have freely chosen to become a part of the American family is a great credit to the United States; that they do not enjoy full participation in the political process as citizens should be a matter of great concern to all of us.

Today the American citizens who live in the Northern Marianas contribute to the Nation and participate in the life of our Nation in all the same ways that every other American citizen does in his own community. They pay taxes, serve in the military, and work hard for the progress of their communities. They are part of the fabric of our great Nation.

Participation in this American democracy is not based on a particular citizen's tax contribution to the Treasury and it is not based on a preordained size of a community. It is based on a community's commitment to our democratic form of government and our Nation. Our American citizenship has as its foundation a promise of fair and equal treatment by our Government and that promise extends to Congress where fair and equal treatment demands that the Northern Marianas be represented by a Delegate.

The bill that I have introduced today mirrors the legislation which granted Guam and the United States Virgin Islands representation in 1972 and the legislation which granted American Samoa representation in 1980. The Northern Marianas will join the ranks of Delegates representing these islands, Puerto Rico, and the District of Columbia, and the Northern Marianas will add its voice to those who represent American citizens who do not reside in the 50 States, but who do reside in a diverse group of American communities on American soil.

In introducing this bill today I commend the work of the Resident Representative of the Commonwealth of the Northern Mariana Islands, Mr. Juan N. Babauta, and his staff. I also commend the unity of purpose in the leadership of the Northern Marianas expressed by Governor Froilan C. Tenorio in his support of this bill. I hope that the House of Representatives and the Senate will act on this legislation in this session, and I urge my colleagues to cosponsor H.R. 4927, the Northern Marianas Delegate Act.

H.R. 4535, THE UNLISTED TRADING PRIVILEGES ACT OF 1994

HON. CARDISS COLLINS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mrs. COLLINS of Illinois. Mr. Speaker, as an original cosponsor of H.R. 4535, the Unlisted Trading Privileges Act of 1994, I am pleased that this important legislation was passed by the full House under suspension of the rules on August 1, 1994. Unfortunately, due to other pressing congressional business, I was unable to participate in the debate on this bill.

Regional stock exchanges, such as the Chicago exchange in my congressional district, serve a vital role in the present and future strength of our world financial markets. These exchanges are a driving force in providing necessary capital formation for both the American and global economies.

Much of the success of the New York and American exchanges is owed to constant innovation and relentless competition from their regional counterparts. The regional exchanges often have been able to provide cheaper and more efficient transactions, with innovative clearing techniques. These improvements were then adapted by the larger exchanges, benefiting the entire economy.

The Chicago Stock Exchange in particular is important in this regard. It is part of the creative Chicago financial and business community which includes the Chicago Mercantile Exchange and the Chicago Board of Trade and is especially important to the Midwest of our country. The Chicago Stock Exchange is also the largest of the Nation's regional exchanges.

Because of the historical importance of our regional stock exchanges, it is imperative that we in Congress ensure that the most equitable competition exists among all exchanges if we expect the United States to remain the leader in efficient and productive capital formation. A level playing field is necessary to guarantee the new products and services will continually be offered to the American investor.

As you know, H.R. 4535 will help to achieve this goal. The legislation will finally permit regional stock exchanges to trade stocks listed on the New York or American exchanges the moment they become listed and registered on those exchanges.

H.R. 4535 will correct what has long been an outdated provision of the Securities Exchange Act of 1934 that requires regional exchanges to wait up to 60 days for SEC approval to initiate trading in these listed securities while other Wall Street brokerage firms that deal in NYSE listed stocks are able to trade these stocks absent any similar SEC oversight.

H.R. 4535 will also grant the SEC the authority to issue a rulemaking to further explore the granting of unlisted trading privileges in initial public offerings [IPO's] of securities in a company approved for listing on the primary exchanges.

Mr. Speaker, I am extremely pleased that my colleagues in the House supported H.R. 4535 and look forward to similar support from the Senate.

TRIBUTE TO ARMANDO MORA AND LARRY SANDOVAL MEMORIAL SCHOLARSHIP CONCERT TASK FORCE MEMBERS, CITY OF SANTA FE SPRINGS, ANHEUSER-BUSCH, INC., TRIANGLE/BUDWEISER DISTRIBUTING AND SANTA FE SPRINGS NEWS

HON. ESTEBAN EDWARD TORRES

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. TORRES. Mr. Speaker, today, more than ever, we must make available resources for our youth to attend college. All too often, without scholarships and other means of financial assistance, students are unable to pursue a college degree.

For this reason, under the leadership of the city of Santa Fe Springs, Anheuser-Busch, Inc., Triangle/Budweiser Distributing, and the Santa Fe Springs News an effort is underway to raise money for the Armando Mora and Larry Sandoval Memorial Scholarship programs. These scholarship programs provide college scholarships for our local youth. The fundraising vehicle for this project is provided by the city through its Stargaze Concert Series. Artists for the Stargaze Concert Series are the Righteous Brothers, Englebert Humperdinck, and the Temptations.

The scholarship programs are dedicated to the memory of deceased Santa Fe Springs Councilmen Armando Mora and Larry Sandoval. Since the two memorial scholarship programs began, 25 deserving students from Santa Fe High School have received financial assistance. The Armando Mora Scholarship was established in 1986 and the Larry Sandoval Scholarship in 1991.

Youth who have received scholarships include: Tho Huu Lam; Patricia Shultz; Elisabeth Sanchez; Maria Lisa Garcia; Richard Brown; Shelby Lundahl; Quoc Thoung La; Matthew Olsen; Guade Paez; Dyann Renee Collins; Quyen La; Eugenia Mares; Christina Ann Bradberry; Jose L. Garcia, Jr.; Daniel Trejo; Christopher Rublacava; Segio Holling; Jaime Castaneda; Mark Kotsay; and Jeffrey Scott Gibson.

Anheuser-Busch, Inc., and Don Heinmark, president of Triangle/Budweiser Distributing Co., have committed $85,000 over a 5-year period to the Mora/Sandoval Scholarship funds. Ric Trent, publisher of the WAVE Newspaper Group, and Art Aguilar, publisher of the Santa Fe Springs News, have committed more than $75,000 in support for the scholarship fundraising effort and the city of Santa Fe Springs, as the Stargaze Concert promoter, is underwriting concert expenses, including use of the Town Center Plaza for the series.

Other businesses who have joined the city of Santa Fe Springs, Budweiser, the newspapers, and the Chamber of Commerce to support the scholarship program include: W.T. Billard, Inc.; McMaster-Carr Supply; Valverde Construction Co.; Consolidated Disposal; Continental Cablevision; Chris 'n Pitts Restaurants; Presbyterian Intercommunity Hospital; Santa Fe Springs Promenade Shopping Center; Murray's Landscaping; Health First Medical Group; California Industrial Products; Parkhouse Tires; the Santa Fe Springs Lions Club; and PDQ Rentals.

Members of the Armando Mora/Larry Sandoval Scholarship Concert task force are: Sandy Thorstenson, principal of Santa Fe High School; Richard Layne, resident; Rick Mourey, president of W.M.C. Grinding; Judy Boswell, Comp Print; Jeannie Carbajal, Santa Fe Springs News; Ken Okajima, Santa Fe Springs Promenade Shopping Center; Katie Heimark, Triangle/Budweiser; Carlos Sidney, Jr., concerned citizen; Sally Lagos, Norwalk Sheraton Hotel; and Jim Wood, Triangle/Budweiser.

Mr. Speaker, this partnership is a commendable effort by individuals, businesses, and government to support educational opportunities for our youth. I ask my colleagues to join me in applauding this effort and in wishing members of the task force well in their endeavors.

BIPARTISAN LEGISLATIVE ACCOMPLISHMENTS THIS CENTURY

HON. VERNON J. EHLERS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. EHLERS. Mr. Speaker, I have received many requests from my colleagues for the chart I have used to illustrate the vote counts in the House of Representatives on a number of major pieces of legislation passed by Congress this century.

I want to point out that this issue was first brought to our attention in a Dear Colleague from Republican TIM PENNY earlier this week. This chart points out that the bitter partisan path down which we now find ourselves headed is both tragically unnecessary and regrettably uncharacteristic in this deliberative body. It is my sincere hope that we will be able to halt this headlong rush into partisan tyranny on health care so that we will one day be able to proudly add this issue to the list of bipartisan accomplishments of this body.

	Percent House supporting		House vote
	Democrats	Republicans	
Social Security Act (1935)	96	83	372–33
Federal Highway Act (1956)	93	97	388–19
Civil Rights Act (1964)	62	81	290–130
Medicare (1965)	86	47	313–115
Clean Air Act Amendments (1970)	100	99	375–1
Water Pollution Control Act (1972)	99	93	380–14
Health Care (1994?)	83??	2??	

STANDING UP TO GANG VIOLENCE

HON. JIM COOPER

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Mr. COOPER. Mr. Speaker, today, all of us—parents, community leaders, concerned citizens—are in a critical struggle.

We are in a struggle we must win. A struggle for the lives of our very own children.

Tennessee communities like Memphis are being invaded by outside forces—by teen gangs from Los Angeles and from Chicago. These gangs want to pull our children away. They want to pull our children away from our homes, away from our families, away from the safety we want to provide all children.

Today, Memphis has taken an important step to protect our children from this tragedy.

Sara Lewis and everyone involved in this historic Memphis and Shelby County Communitywide Conference on Youth Gangs have sent a clear message: Memphis and Shelby County citizens are going to stand up to gang violence.

I have supported legislation that would help by making gang violence a Federal crime. This measure, like the conference today, is a first step. And, like this conference, it sends a strong message: Tennesseans will unite to fight for the safety of our children.

I congratulate all participants in the Memphis and Shelby County Communitywide Conference on Youth Gangs on their leadership in solving this problem and I join them in the fight. All Tennesseeans, all Americans, must follow their lead. We must continue to stand up for our children by standing up to gang violence.

TRIBUTE TO JUSTICE BLACKMUN

HON. LYNN C. WOOLSEY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 10, 1994

Ms. WOOLSEY. Mr. Speaker, all those who love freedom in America are mourning the retirement of Supreme Court Justice Harry A. Blackmun. He did a great service to this Nation and to the principles of justice and liberty during his tenure on the bench, and his vast knowledge and ideals will be sorely missed.

Sarah Weddington, the winning attorney in the landmark Roe v. Wade case, has written a moving tribute to the great Justice Blackmun. I ask for you to have those words inserted into the RECORD, and I hope that all of my colleagues will take the time to read them.

[From the American University Law Review, Spring 1994]

PARTING PRAISE FOR JUSTICE HARRY A. BLACKMUN

(By Sarah Weddington)

United States Supreme Court Justice Harry A. Blackmun has had a greater impact on the lives of American women than any other person in at least the past half century. For twenty-one years, the 7–2 opinion he authored, Roe v. Wade,[1] has been the epicenter of personal, social, and political change. Because of it, women in the United States have had the right to decide whether to continue or terminate a pregnancy and therefore to determine many other aspects of their lives.

I was reminded of the powerful impact of his opinion recently while in Orlando, Florida to speak to the B'nai B'rith Women Biennial Convention. My remarks included comments about the past and future of the abortion issue and about Justice Blackmun's retirement. Once we feared this moment, but with President Clinton making the appointment, it is predictable that a pro-*Roe* Justice will take that seat. For the near future, I believe abortion will continue to be legal; the question is whether it will be available.

Among those in Orlando who crowded around me afterwards for discussion and future questions was a dark-haired woman with a sparkling personality, a leader in her local young-adult chapter. As she began to talk to me, her eyes filled with tears and her voice choked. She was finally able to lean forward and say in my ear, "Thank you for *Roe v. Wade*. You saved my life." I do not know the specifics of her situation; I do not inquire in front of others about information not volunteered.

As I think of her, other faces that have leaned forward through the years flood back to me. Today I wish that I had a videotape of those people to send to Justice Blackmun as he retires. I wish I could share with him their heart-felt comments about what a positive force *Roe* has been in their lives.

I saw Justice Blackmun for the first time on December 13, 1971, the day of the first *Roe* oral argument and again on October 11, 1972, the second argument. The group of lawyers asking the Court to declare the Texas statute outlawing abortion (except to save the life of the woman) unconstitutional had worked to include arguments that would appeal to each Justice. We were aware that Justice Blackmum had previously been counsel for the Mayo Clinic, an outstanding medical facility in Minnesota. We had no information about what Justice Blackmun's position on the case was likely top be, but he was the Justice we had in mind as we crowded medically related information into the primary brief and organized a separate *amicus curiae* brief signed by leading doctors and medical professors.

The drama of the Supreme Court's consideration of the abortion issue drew key participants in the debate from far and wide. I was a young lawyer of twenty-six arguing my first contested case, a case I wanted desperately to win. My memory of Justice Blackmun is of a kindly, reserved man with greying hair, dark-framed glasses, and a soft voice. His questions were scholarly and inquiring but neither belligerent nor friendly. I was especially alert to his questions during the second hearing because, by then, rumors were flying that Justice Blackmun was writing the opinion, that he had spent part of the 1972 summer at Mayo Clinic researching case issues, and that the Court was preparing to overturn the Texas statute.

On January 22, 1973, Justice Blackmun read the Roe opinion from the Supreme Court bench. It concluded that a woman's fundamental right of personal privacy was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy." It also held that the State of Texas had not proven a compelling reason to regulate abortion. The immediate effect of the decision was to overturn anti-abortion statutes in forty-six of the fifty states. Later I pictured the decisionmaking ability of women expanding exponentially as Justice Blackmun read the words of Roe.

I learned about the decision when a reporter from Washington, D.C. called my Austin office. Moments later I received a three-line telegram from the Court—collect. I don't remember to cost. My phones went crazy: reporters wanted comments, supporters called to celebrate and the curious called to see exactly what the opinion said. Many people tell me that they can still remember exactly where they were and what they were doing when they heard about the decision in Roe v. Wade.

Surely that day Justice Blackmun never expected the Roe opinion to be headline news at the time of his retirement. He, like I, probably thought the basic issue was settled that day in 1973. A year after the decision, I wrote to thank him for his role as draftsman. In his response, Justice Blackmun wrote: "It meant much to have this supportive letter from you at this time. There is always controversy round about us, and this one seems to be particularly deep."[2] How prophetic his words were. With hindsight we now know that defending the decision and its impact would occupy a great deal of judicial time throughout his career.

For example, the issue of financial access to abortion has been before the Supreme Court. In Beal v. Doe,[3] the Court held that Medicaid did not require states to pay for poor women's abortions. In his dissent, Justice Blackmun demonstrated his understanding of the viewpoint of women in poverty:

"The Court concedes the existence of a constitutional right, but denies the realization and enjoyment of that right on the ground that realization and enjoyment are

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Footnotes at end of article.

separate and distinct. For the individual woman concerned, indigent and financially helpless, as the Court's opinions . . . concede her to be, the result is punitive and tragic. Implicit in the Court's holdings is the condescension that she may go elsewhere for her abortion. I find that disingenuous and alarming, almost reminiscent of: "Let them eat cake."[4]

By 1989, the lasting power of Roe seemed tenuous because of Supreme Court appointments made by anti-Roe Presidents Ronald Reagan and George Bush. Justice Blackmun must have felt under siege as he valiantly sought to defend Roe. In Webster v. Reproductive Health Services,[5] the Supreme Court approved new state restrictions on abortion procedures and signaled that it might overturn Roe. Justice Blackmun wrote in dissent:

"I fear for the future. I fear for the liberty and equality of the millions of women who have lived and come of age in the 16 years since Roe was decided."[6]

Many citizens shared his fear. Blackmun, the oldest Justice, and John Paul Stevens were the only Justices defending the original Roe decision, four others were saying, "Let's get rid of Roe," and the remaining three Justices were essentially saying, "We're not ready to overturn Roe, but we are prepared to weaken it." One more anti-Roe Justice could doom the decision. Justice Blackmun had commented that he could not last forever.[7] I believe many voters had Blackmun's comment in mind as they cast their 1992 ballots for the presidential candidate who pledged to protect privacy, Bill Clinton.[8]

Even as this Tribute goes to press, Justice Blackmun will once again participate in deciding a case regarding access. In Madsen v. Women's Health Center Inc.,[9] the Court will review a Florida case involving restrictions placed on clinic picketers who sought to hamper access to an abortion clinic and to disrupt the doctors and patients inside.

At what cost has Justice Blackmun defended privacy and women's right to make choices? He has read over 60,000 pieces of "hate mail" received in the intervening years. He has been picketed, cursed, threatened, and denounced. Even in announcing his retirement, he commented that a Justice can choose when to retire but not the "tag" assigned him or her. "Author of the abortion decision," he once said. "We all pick up tags. I'll carry this one to my grave."[10]

I hope it is a tag that he wears with pride. His opinion, to a significant degree, has been the source of expanded roles for women in such areas as education, employment, and politics since 1973. As Justice Blackmun retires, I wish we could fire a 21-gun salute, the tribute this country extends to its highest and bravest. Then I wish I could give him a videotape of the comments of millions of women, and those who care about them, who thank him for the choices that were theirs, not those of strangers or of government. Their faces have kept me going all these years.

In this issue, various writers laud a diverse collection of characteristics and opinions of Justice Harry A. Blackmun. I write in praise of Justice Blackmun and his opinion in Roe v. Wade. Many prior Justices have been forgotten, but history and especially American women will never forget his work as a U.S. Supreme Court Justice. On behalf of many, I send a hug and a heart-felt "Thank you, we're glad you were there." May your days of retirement pleasures be many, and may you always know and relish the valuable difference you have made in the lives of so many.

FOOTNOTES

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[1] 410 U.S. 113 (1973).

[2] Letter from Justice Harry A. Blackmun to Sarah Weddington, Representative, Texas House of Representatives 1 (Mar. 8, 1974) (on file with "The American University Law Review").

[3] 432 U.S. 438 (1977).

[4] Beal v. Doe, 432 U.S. 438, 462 (1977) (Blackmun, J., dissenting).

[5] 492 U.S. 490 (1989).

[6] Webster v. Reproductive Health Servs., 492 U.S. 490, 538 (1989) (Blackmun, J., dissenting).

[7] Planned Parenthood v. Casey, 112 S. Ct. 2791, 2854 (1992) (Blackmun, J., dissenting).

[8] Mitchell Locin, "With Court Choice, Clinton Gets a Chance to Regain Momentum," Chi. Trib., Apr. 7, 1994, at A15 ("[M]any—particularly women—. . . voted for (Clinton) . . . because they did not want a Republican president to nominate any more justices.").

[9] Operation Rescue v. Women's Health Ctr. Inc., 626 So. 2d 664 (Fla. 1993), cert. granted, Madsen v. Women's Health Ctr. Inc., 114 S. Ct. 907 (1994) (No. 93-880).

[10] "Blackmun Accepts Aftermath of Writing Abortion Opinion," N.Y. Times, Jan. 18, 1983, at A20.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Thursday, August 11, 1994, may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

AUGUST 12

8:30 a.m.
Agriculture, Nutrition, and Forestry
Agricultural Research, Conservation, Forestry and General Legislation Subcommittee
To hold hearings on the Administration's proposed legislation on meat and poultry inspection.
SR-385

10:00 a.m.
Environment and Public Works
Business meeting, to consider pending calendar business.
SD-406

Judiciary
Patents, Copyrights and Trademarks Subcommittee
To hold joint hearings with the House Committee on the Judiciary's Subcommittee on Intellectual Property and Judicial Administration on the implementation of the intellectual property provisions of the General Agreement on Tariffs and Trade (GATT).
2237 Rayburn Building

11:00 a.m.
Foreign Relations
Terrorism, Narcotics and International Operations Subcommittee
To hold a closed briefing on the Moscow Embassy.
S-407, Capitol

CANCELLATIONS

AUGUST 11

8:30 a.m.
Agriculture, Nutrition, and Forestry
Agricultural Research, Conservation, Forestry and General Legislation Subcommittee
To hold hearings on the Administration's proposed legislation on meat and poultry inspection.
SR-332

POSTPONEMENTS

AUGUST 12

2:00 p.m.
Veterans' Affairs
Business meeting, to consider the nomination of Linda Marie Hooks, of Georgia, to be an Assistant Secretary of Veterans Affairs (Acquisition and Facilities), and to mark up pending legislation.
SR-418

SENATE—*Thursday, August 11, 1994*

The Senate met at 9:30 a.m. and was called to order by the Honorable HERB KOHL, a Senator from the State of Wisconsin.

PRAYER

The Chaplain, the Reverend Richard C. Halverson, D.D., offered the following prayer:

Let us pray:

*We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights * * * to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed.* * * *—Declaration of Independence.

God of Abraham, Isaac, and Israel, God of all people, Lord of Heaven and Earth, our Nation was conceived in the hearts and minds of men who believed in a God who created all people and endowed them with "certain unalienable rights." Thomas Jefferson believed that those rights would not be secure if the people no longer believed that they were a gift of God.

The prophet Jeremiah wrote:

For my people have committed two evils; they have forsaken me the fountain of living waters, and hewed them out cisterns, broken cisterns, that can hold no water.—Jeremiah 2:13, KJ.

Forgive our naivete, Lord, that we can build a perfect society without regard for God.

In His name who is the Forgiveness of God incarnate. Amen.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore [Mr. BYRD].

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, August 11, 1994.

To the Senate:

Under the provisions of rule I, section 3, of the Standing Rules of the Senate, I hereby appoint the Honorable HERB KOHL, a Senator from the State of Wisconsin, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. KOHL thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The Chair recognizes the majority leader.

SCHEDULE

Mr. MITCHELL. Mr. President, under a previous agreement, there will be 4 hours for debate on the health care legislation. The time will be divided as follows: The first half hour will be Democratic Senators. Then there will be 2 hours allocated to the Republican side. And then the final 90 minutes, or 1½ hours, will be on the Democratic side. I believe that has been worked out by Senators PACKWOOD and KENNEDY.

Mr. PACKWOOD. It worked out. When I talked with Senator KENNEDY last night, he indicated the Democrats want to run a bunch of speakers on a theme. That was fine. I had no objection.

I just discovered my 10 o'clock speaker may not be here, but I will try to get to him before that. I think we will work it out.

Mr. MITCHELL. Then we will proceed as suggested, 30 minutes on our side, then 2 hours on their side, then the last hour and a half on our side.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, leadership time is reserved.

HEALTH SECURITY ACT

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will now resume consideration of S. 2351, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 2351) to achieve universal health insurance coverage, and for other purposes.

The Senate resumed consideration of the bill.

Mr. MITCHELL. Mr. President, I will yield to Senator KENNEDY, now, to allocate time.

With Senator KENNEDY's concurrence, and in Senator MOYNIHAN's behalf, I yield 10 minutes to the Senator from Michigan.

Mr. RIEGLE. Mr. President, I understand I have been recognized for 10 minutes. I want to try in that period of time to cover many things. First of all, I want to congratulate Senator MOYNIHAN, Senator KENNEDY, and Senator MITCHELL for their extraordinary leadership in bringing this issue forward. It is a very complex issue. It is 14 percent of the American economy in financial terms, but it goes right to the heart of what America is all about.

As we have listened to the debate over the last 2 or 3 days, anyone following it has heard a lot of the technical detail of the various ways to try to improve and strengthen America's health care system to see that everybody has coverage, that it is coverage they can afford, and that—critically important—when they most need it, it is not going to disappear as it often does. We find very often when people get sick, the insurance, one way or another, disappears at the very time they need it most.

So today, I want to just spend a short period of time talking about what I think is really at stake here in this discussion. We all love our country. We have been around, now, over 200 years. We are still a young nation, as nations go. Yet we are the oldest surviving democracy. But there are certain things we need to do, I think, to strengthen our country and to pull us together as a people. Those things, when we stop and think about it, are basic things, like making sure educational opportunity is there for every person; to see to it the job environment is such that people who want to work and need to work have the opportunity to go out and apply their talents and earn a living to support themselves and their families.

In that same vein, health protection, to be able to try to have good health, to restore your health when you are sick, for parents to care for a sick child and to try to heal that child or to care for a sick parent or grandparent, to try to heal them, or to have a spouse in a family who is stricken with cancer or some other problem—when these issues strike, and they do in every family sooner or later, being able to have the health care that we need both to try to prevent serious things from happening, but then to try to deal with those problems when they arise. This strikes right at the very heart of life itself and right at the heart of the family structure, and I think right at the heart of our Nation.

It is ironic. At this time in history, all of the other major industrial nations have managed one way or another to come up with a health care system so everybody in their society has that kind of protection. We want that because it is humane and it is sensible and it is good economics. But we also want it because we cannot really function very well if we have a sort of hit-or-miss system where many people cannot get insurance, many people who have it cannot afford to keep it because it is becoming more expensive, or, as I said before, at the very time when you need the health insurance the most—when someone gets sick—the insurance company withdraws the coverage and

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

says you are no longer insurable. Then you are really in a situation that many people cannot manage by themselves.

I have talked about many of these cases here on the floor. In fact, now, for over 2 years, I have been coming to the floor and I have a little booklet I put together of the faces of families and people in Michigan who illustrate this problem. These are people of all ages and all circumstances who have been devastated by medical circumstances that they could not manage, because either they could not get health care coverage or they could not afford to keep it, or when they needed it most it disappeared out from under them.

One case I want to talk about today just for a moment is the case of a young woman named Cheryl Eichler. I did not know Cheryl Eichler. I met her at one point when we were having a hearing on health care reform in Michigan. She volunteered to come forward as a witness. She was a young woman suffering from Crohn's disease, which is a very painful, difficult, and life-threatening problem. Many Americans have this problem. One of George Bush's sons has this problem, and is struggling with it at this very time.

In any case, Cheryl Eichler was the manager of a 7-Eleven store, earning about $12,000 a year. She had no health insurance coverage through her workplace, and she did not earn enough to be able to buy health insurance on the outside.

Plus, the insurance companies did not want to sell her a policy because she had this Crohn's disease problem. So the day we had our hearing in Michigan, she was actually in the hospital. She left the hospital bed to come in to testify about not just her problem but the problem facing so many people in America who need health care and cannot afford it and, as a result, are in desperate circumstances.

Within a few months of the time that she testified—and she gave magnificent testimony that day—she died at the age of 29. I am convinced that Cheryl Eichler would be alive today if she had gotten the health care she needed when she needed it. Many times she was delayed going to the doctor because she did not have the money to pay for treatment.

Frankly, most places, if you do not have the money to pay, you do not get the treatment, not unless you are on welfare, public assistance, and then you qualify for Medicaid. You should not have to go on welfare in America to get health coverage, if you desperately need it or if your family members need it. That is what happened to Cheryl Eichler. So she is in an early grave. And so many, many people that has happened to over the decades because they were not able to afford the health care that they needed when they needed it.

That does not help America. It does not make us a stronger nation. It is one thing to rally together to fight wars overseas—we have done that many times—or rally to get into the space program and send people to the Moon and bring them back safely, and these are extraordinary national efforts and achievements. But why is it not as important, if not more important, to rally around as a nation—Democrats and Republicans—to try to reform and improve our health care system so everybody in the country has the chance to try to establish good health for themselves and then to be able to maintain it for themselves and the members of their family?

We want people to work. How can you work if you are sick? I mean, we want a healthy nation. We want our people to be strong and well and healthy. That is why we need health care protection that provides both preventive care and then, when people get sick, to try to get them restored as quickly as possible. That is what makes America strong, when our people are strong and when they are not in terrible conditions that overwhelm them financially, as so often is the case with people with these health problems.

I want to just show you one article that ran in the Detroit News some time back about a single parent, working mother, Cynthia Fyfe. She earns not a great amount of money. She gets a little bit of health insurance at the workplace for herself, but none for her son, Anthony, who at the time of this article was 6 years old. You can see a picture of him here. Cute little fellow with glasses on. She has no money to insure her own child.

One way she could get insurance for Anthony is to quit her job and go on welfare. Then she would qualify for Medicaid and Anthony would have health insurance. Is this the way we want to have it in America where somebody that works cannot afford health insurance and their children go uninsured, whereas if that same person would quit their job, go on welfare, then their child will have health insurance?

That does not make any sense. That is not good social policy. That is not helping these people. This little guy right here is America's child. He belongs to us. We ought to care about him. We want him to love his country. We ought to let him know that our country loves him. We do not have to know him to care about him. He is part of our national family, and we ought to cover these children. Why? Because they are important. They are the most important asset we have.

Mr. GREGG. Will the Senator yield?

Mr. RIEGLE. I will when I finish. The most important thing we have are our people and, as these children come along, as precious as they are, do we want to have a situation where if one is stricken with appendicitis, as my little daughter was, or as some other problem that arises that the parent or parents hesitate to go to the doctor or cannot go to the doctor promptly and quickly for the care that child needs? No, that is not what we want. We are not that poverty stricken. We are not Somalia or any other country.

We are in the position to see to it that we meet the health needs of our people. In fact, if we do it, we will save money because we do not avoid these problems. If a person gets sick and becomes far sicker than they need to be, they will eventually get care, but it is the highest cost care and often it is too late and there is a tragedy involved, terrible suffering and hardship for families.

Why do we want to impose that on ourselves? Why do we not have a bigger vision? Why do we not care enough about each other to help create a system in which we can keep these costs down so that people do not keep losing their insurance who now have it or find it so expensive that in order to have it they cannot have anything else in their lives, like money to put aside for a child's college education or buying a house?

And then what about the 40 million people who do not have any insurance at all? What about little Anthony Fyfe here? What about him? Where does he fit into the picture? Right now he does not fit into the picture, although I will say this: In the bill that came out of the Finance Committee, with bipartisan support, there is an amendment in there that I offered which was included to provide health care now for young children in this country under the age of 18 like Anthony Fyfe. It would cover them all, and it would make sure that expectant mothers would also receive proper prenatal care so their children, as they are being born and they are carried during the 9-month term of pregnancy, would be getting the kind of prenatal care and monitoring they need so they can go to full term, so that a baby does not come 6 or 8 weeks premature and maybe cost $100,000 in an infant care ward in the hospital in order to just get up to a normal birth weight.

We can avoid that in many cases if we just provide prenatal care to these expectant mothers.

Why is that not good for America? It is good for America. If we can find the money to fight these foreign wars and to send money off in foreign assistance and to build this huge defense establishment, can we not protect our people? Can we not help our people help themselves? We want people to work. I believe in that, and people want to work. But they cannot work if they are sick, or they cannot work if they have to take time off to go home and attend a sick family member who is sicker than they might be because they did not have health care protection.

Let me just finish by saying this: I think it is time for the Senate and the Congress to rise to this occasion. I know there is a lot of partisanship in this. There is a lot of partisanship in it, and President Clinton, to his great credit, and the First Lady have brought this issue forward. There are a lot of cross-currents, a lot of television ads, so forth, that have been swirling around over the past months. But let us not lose sight of this fact: We are talking about the health and well-being of our country—whether we make our country stronger or whether we leave it in an impaired condition.

It is time for us to act. Let us pass the best bill we can, and let us do it on a bipartisan basis.

Mr. GREGG. Will the Senator yield for a question?

Mr. RIEGLE. Whatever time is left I will be prepared to do it.

The ACTING PRESIDENT pro tempore. The Senator has spoken for 10 minutes.

Mr. GREGG. Mr. President, the Senator mentioned—and it is an important issue—the fact that the child's mother would have to quit work in order to get the care that she felt was necessary for the child. But in reading the CBO report, relative to the Mitchell bill, I noticed the CBO report says that Senator MITCHELL's proposal—I am quoting:

> Senator MITCHELL's proposal would discourage certain low-income people from working more hours or, in some cases, from working at all.

That is a direct quote. Then it goes on to say:

> In the year 2000, the effective marginal rate on labor compensation could increase by as much as 30 to 55 percentage points for workers with family income in the phaseout range. Moreover, those levies would be added to the explicit and implicit marginal taxes that such workers already pay through the income tax, the payroll tax and the phaseout of the earned income tax credit. In the end—

Under the Mitchell bill—

> In the end, some low-wage workers would keep as little as 15 cents of every additional dollar they earn.

It seems to me there is a fundamental flaw here. I recognize what you are trying to get to, and I think it is an appropriate goal. It seems to me the Mitchell bill has some concerns.

Mr. RIEGLE. Mr. President, let me say to the Senator—and I do not know whose time we are on—I invite you—and I know you love the children in New Hampshire as I do the children in Michigan—I urge you to offer a constructive amendment to improve that area of the bill if you think it falls short.

What I hope would not happen, it is very easy to criticize the other fellow's bill whether it is Senator MITCHELL's bill or somebody else's. The problem we face today in America is the system is not working for many of our people. We have an obligation here, not to find fault with the other fellow's plan but to make sure we have a plan that is going to get the job done. And I say let us do that on a bipartisan basis.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator has spoken for 10 minutes. His time is up. Who yields time?

Mr. KENNEDY. Mr. President, I yield 8 minutes to the Senator from Illinois.

The ACTING PRESIDENT pro tempore. Eight minutes has been yielded to the Senator from Illinois [Mr. SIMON].

Mr. SIMON. Mr. President, I have heard twice now speeches saying we are rushing to judgment on this matter of health care. As Senator KENNEDY pointed out on the floor 2 nights ago, I believe it was, this idea was first suggested early in this century by Theodore Roosevelt. We have not exactly been rushing to judgment.

Listen to this speech given by Harry Truman in 1945:

> Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic benefits of sickness. The time has arrived for action to help them attain that opportunity and that protection.

Harry Truman, 49 years ago, and we are still waiting for action. We do not need to wait that long. Frankly, I would love to see the Mitchell bill move much more quickly than it is. I would like to have seen the Clinton bill move much more quickly.

It is very interesting—and the Presiding Officer, Senator KOHL, may be too young to remember these days—that on May 6, 1935, by Executive order, FDR established the WPA. By November of that year, a few months later, 2.6 million Americans were working. He created a totally new program. We are not fashioning anything that dramatically new.

Medicare, within 1 year of its enactment in 1965, had enrolled 19.1 million older Americans.

We are not rushing to judgment. We had, not too long ago, a great flood in the Midwest. It affected Wisconsin a little; it affected Illinois, Missouri, and Iowa much more. Hundreds of thousands of people were affected, and this body responded, as we should, as we responded when Florida and Louisiana had problems.

Thirty-eight million Americans do not have health insurance. Many of them face urgent problems, and we are not responding. We have to respond.

Let me just tell three stories, two from a small town, Troy, IL, where I lived for 26 years. When I was maybe 20 years old, I can remember a man—I have been unable to contact the two families. I did not want to use their names without their permission. But a man I knew, who I thought at that time he was fairly old—he was probably 55 or 60. Since I am 65 now, I am sure I would view him as very young—said to me, "I have cancer. I do not have insurance. I have struggled and worked hard to pay for my house, and if I go ahead and have an operation I might live, I might live another year. But, frankly, it will take the house away from my wife or put a heavy mortgage on it. I have decided to die." And he did.

That would not happen in France. That would not happen in Germany. That would not happen in Great Britain. That would not happen in Italy. Why do we not protect people like that?

A somewhat similar story. A few years later, I was in the State legislature. The man who lived just down the street from me came into my kitchen and said, "I have kidney disease. I am going to have to go through renal dialysis. But if I go through it"—and this was still in its primitive stages then—"If I go through it, I may live a few years longer but I may not. And I am going to deprive my family of our house." And he said, "I've decided to die," almost the same words as the other man used. And he did die. That should not happen in our country.

In Monroe County, when I was in the House of Representatives across the Rotunda here, I used to hold these open office hours, and this man came in who had worked for the State of Illinois, then took a job with a grocery chain, and he had to work there 6 months before he would be eligible for health coverage.

Before the 6 months was up, it was discovered he had a serious heart problem. He and his wife came in and talked to me, and he said, "I can't afford to have heart surgery that the doctor says I need." His wife was with him. She was crying. And she said, "If he doesn't have it, the doctor says he's going to die."

Well, frankly, I was able in that case to contact the Illinois State Medical Society, and we got it worked out. But that is not how we should protect our citizens.

We spend more as a percentage of our gross national product for health insurance and health coverage than any nation, by far—14 percent of $6.5 trillion. That amounts to, if my calculation is correct, $910 billion a year we are spending. Are we getting our money's worth? Well, we are, those of us in the Senate, because all 100 are covered. But 38 million Americans are not covered. We just cannot continue that.

I heard, I believe it was the Senator from Oregon, saying this is a shift of cost to employers. Richard Nixon, not a Democrat, as I recall, suggested a health care plan where employers would pay 75 percent and employees 25 percent. But those are things that we can negotiate. What we should not negotiate is that we are going to cover all Americans.

Our friends on the other side introduced a bill, Senators CHAFEE, DOLE, BOND, HATFIELD, BENNETT, HATCH, DANFORTH, BROWN, GORTON, SIMPSON, STEVENS, COHEN, KASSEBAUM, WARNER, SPECTER, FAIRCLOTH, DOMENICI, LUGAR, GRASSLEY, and DURENBERGER introduced the Chafee bill that said "let's have universal coverage."

Let us not back off on that. This should not be partisan. We ought to protect every American. My friend from Oregon yesterday talked about a hidden payroll tax. I would be willing to vote for a payroll tax. Do not make it hidden. I do not know how we do this. But we ought to cover all Americans. What is wrong with this country when we do not do it?

Mr. President, we ought to act. We ought to do the responsible thing; we ought to do the sensible thing and the compassionate thing, and I hope that we respond to the American people.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. MOYNIHAN. Mr. President, I yield 10 minutes to the distinguished Senator from New Mexico.

The ACTING PRESIDENT pro tempore. The Senator from New Mexico [Mr. BINGAMAN] is recognized for 10 minutes.

Mr. BINGAMAN. I thank the Chair. I thank the Senator from New York for yielding time.

I appreciate the excellent work he has done as chairman of the Finance Committee, and of course the excellent work my own chairman, Senator KENNEDY, has done as chairman of the Labor and Human Resources Committee to put together the bills which made up the basis upon which our majority leader, Senator MITCHELL, has proposed his own legislation.

The first question that I had to deal with in deciding how much of my time and effort to put into this issue of health care reform was: Why should it matter to a Senator from New Mexico? Is it important for my State that something be done in this area?

I began to research the issue. Mr. President, New Mexico is one of those States in which a great many people are not presently covered. We have a low per capita income. The estimate is that about 22 percent of our State does not have health care coverage. That is more than 1 out of 5 people in my State at the present time—350,000 people in a state of 1.6 million. And 36 percent of the people who are not covered are children 18 years of age or less.

Ours is a State of small businesses, and primarily the people who work for those small businesses are the ones who are not covered. I think one of the great misunderstandings that has existed throughout the country is whether or not this was an effort to extend coverage to the very poor. Was this another type of disguised welfare expansion that we were engaged in here? I am satisfied, when you look at the reality of the situation, this is not an effort to extend coverage to the very poor. The very poor have coverage today. The very poor are covered by Medicaid. This is an effort to extend coverage primarily to those working families, those young working families with children who do not have coverage because they are working for relatively low wages. They are working for employers who find it impossible financially for them to provide that coverage.

Again, this is an important issue in my State. It is important because more than 120,000 children in New Mexico do not have health care coverage today.

That is the reason I am on the Senate floor urging my colleagues to move ahead with some type of significant health care reform legislation. We have heard arguments, and will continue to hear them, against our taking action or against our seriously considering the provisions in Senator MITCHELL's bill. One argument is that the Government should stay out of this whole area; it is not Government's problem that 120,000 children in my State have no health care coverage; that it is the private sector's problem; that is someone else's problem; the Government should not be concerned.

Clearly, it is the families' problem first and foremost. But if we have a system which over many decades has not been able to expand coverage to the most vulnerable in our society, those children then, in my view, are a concern of Government. They are a legitimate concern of Government. This is a problem that we can address here in the Congress, and we can do it in a way that does not interject Government more than is necessary, but that does interject Government to the extent necessary, to protect that vulnerable population.

Another argument that we hear is that we as a nation cannot afford to expand coverage. We cannot afford to deal with this problem. I just do not believe that, Mr. President. I work here in the Senate, as my colleagues do, and we vote on bills day after day. We have a defense appropriations bill on the floor today, which, hopefully, we will complete action on tonight. I support that bill. It provides $265 billion in expenditures for our national defense. It is money that needs to be spent. We are not one of the nations that can claim poverty. We have a very rich economy. We have the strongest economy in the world, and clearly we need to look after the health and welfare of the people who keep that economy strong.

Another argument I have heard is that this is too complex a problem for the Congress to deal with in this session of the Congress; we need to put it off. Again, I do not believe this thing will get simpler as we go further on. We need to act now. Clearly, we do not have all the answers. But we have many of the answers. We cannot afford to continue to wait until a perfect solution is at hand, until a solution is at hand that every Senator will agree with.

I believe the opportunity is now. We can get many things right. We will make some mistakes. We will do some things in the legislation that will have unintended consequences. But we will make major mistakes if we do not pass a comprehensive health care reform bill.

Let me mention some of the things I know we can do correctly and do right in this legislation. We can require that coverage is available to everyone in our society regardless of whether that person is sick or has a preexisting condition. We can require that insurance companies maintain coverage and maintain it at a reasonable price so that when illness does strike, the price of coverage, the price of health care, does not go through the ceiling. We can ensure that the average person has the ability to provide coverage without having to pay enormous commissions.

One of the main objections I have heard about Senator MITCHELL's plan is that there is an opportunity for people to buy through a purchasing cooperative and that somehow undermines the free enterprise system. I do not think it hurts the free enterprise system to give people an opportunity to buy another way. If they do not choose to exercise that opportunity, fine. They can continue to buy through their existing carrier, through their existing agent. But giving them that opportunity, to me, seems a very reasonable thing to do.

We can do a better job of controlling costs in health care. We can provide prescription drugs for senior citizens. We can begin to deal with the needs that many of our seniors have for long-term care. We can expand health care delivery into our rural areas, and we can provide coverage for pregnant women and for children in this country. These are not too ambitious a goal for us to take on.

We need to get on with it. If there are necessary amendments, I hope they will be proposed. I certainly expect to propose amendments of my own. I ask my colleagues to seriously consider the amendments I propose, and I pledge to seriously consider any amendment proposed by other Senators. But I do hope that we can proceed to consider this legislation in a serious, nonpartisan way. We can do the best we know how to improve our health care system so that health care is available at a reasonable price to each of our citizens.

I thank you, Mr. President.

I yield the floor.

Mr. PACKWOOD. Mr. President, I yield such time as the Senator from Texas may desire.

The PRESIDING OFFICER (Mr. AKAKA). The Senator from Texas is recognized.

Mr. GRAMM. Mr. President, I thank you for your recognition. I thank our dear colleague from Oregon.

I want to deviate from my speech for a moment to respond to our dear colleague from Illinois. I can hardly believe my ears when the health care system of the United States of America is compared unfavorably to the health care systems of Canada, Great Britain, and Germany. Last year, more heart patients died in Canada waiting to get into the operating room than died on the operating table. People all over the world under government-dominated systems are dying because health care that is readily available in America is not available in those countries.

Since everybody is talking about what we supposedly are going to gain by vastly expanding the role of Government in making health care decisions, I want to start by talking about what we stand to lose.

Mr. KENNEDY. Will the Senator yield?

Mr. GRAMM. I do not yield.

Mr. KENNEDY. On that point?

Mr. GRAMM. I do not yield. I would like to speak, and then I will be very happy at some later point to debate the Senator from Massachusetts at length.

First of all, we have in the United States of America the greatest health care system in the history of the world. In the last 25 years, 90 percent of all the pharmaceuticals, 95 percent of all the medical procedures, 90 percent of the routine miracles that we expect every time we go to the doctor and every time we go to the hospital, have been developed by Americans.

It is very interesting to me that so many of my colleagues, when they think of medical perfection, look to the north, to Canada, and yet I notice that when they and the people they love get sick, they never ever go to Canada to try to get well. Yet, on any given day in America, in any referral hospital—and I would ask my colleagues today to go to nearby Johns Hopkins University, a great medical center—they will find that those referral wards are full of rich or politically powerful Canadians. They are full of people who have had an opportunity to look socialized medicine in the face in Great Britain, or Germany or elsewhere and have found that face to be an ugly, uncaring face, and they have come to the United States of America to get health care. That may not tell some people anything. But it tells me something, and that is we have a lot to lose in this debate as well as a lot to gain.

I am not going to support tearing down the greatest medical care system in the history of the world to rebuild it in the image of the Post Office. And I would like to try in my speech——

(Applause in the gallery.)

Mr. MOYNIHAN. Mr. President, may we have order?

The PRESIDING OFFICER. There will be order in the gallery. If the Senator from Texas will please withhold while I ask the gallery to please refrain from any demonstrations.

Mr. GRAMM. To try in my speech to explain why in fact that is what this debate is about. But let me first go back and talk about the problem, because in our zeal to pass a health care bill—any bill—we, it seems to me, have forgotten what this debate is all about.

First, it is about access to health insurance. And, second, it is about cost. Let me talk about access. The President's original bill, 1,342 pages long, had only 19 pages about access. The President talks incessantly about universal coverage, about insurance that will always be there. But 1,323 pages of the President's bill had nothing to do with that issue. It simply had to do with the Government taking over and running the health care system. But let me talk about access because access is an area where there is a great deal of agreement, and that has all been forgotten in this debate.

First of all, we have had now some two dozen bills introduced, and every one of these bills tries to deal with a problem we call portability. Every one of these bills tries to make it easier for people to change jobs without losing their health insurance.

When we talk about the 37 million Americans last year who did not have health insurance on at least 1 day, over 75 percent of those people, by some studies, did not have health insurance for one reason: They changed jobs. When you change jobs in America, you lose the insurance through the employer you are with, and often you do not get insurance on the new job until you have been there for 30 days.

We can solve 75 percent of the problem of people not having insurance on a provision that, as far as I know, every single Member of the Senate supports: Make it easier for people to change jobs without losing their health insurance. That was in the two bills I introduced, it was in the Dole bill, it is in the Mitchell bill, it is in the Clinton bill, it is in the Gephardt bill, it is in everybody's bill. That is not what we are debating here.

Every bill that has been introduced, as far as I am aware, deals with the problem of permanence. When I was growing up in the late 1950's, my mama got an insurance policy and she paid on that policy for about 4 years. She then had a major ailment. The insurance company paid for the first episode and then promptly canceled her policy. What good is health insurance if you do not have it when you need it? Thank God, that does not happen very much in 1994. But 100 Members of the Senate want to make sure it does not happen—ever—to anybody again. There is no dispute about that issue. That is something we all agree on.

Then what problems remain if you deal with permanence and portability? The next problem has to do with people who are already sick, people who have what are called preexisting conditions.

In listening to the White House, and in listening to some of my colleagues, it sounds as if they believe that by passing laws we can eliminate preexisting conditions. Only God can eliminate preexisting conditions. If the risk of insuring people is high because those people are sick, have been sick, and are likely to be sick in the future, we cannot pass a law changing that. What we can do is try to find a way to distribute those costs.

The other night the President said in his speech: Ask the Republicans if they are willing to give every American health insurance. How can the Congress give the American people anything? We are incapable of giving the American people anything. All we can do is take money away from some people and give it to others. But we are not capable of giving people anything. We do not create wealth here. We redistribute it, we destroy it, and we stifle it, but we do not create it.

There are a lot of ways to deal with preexisting conditions. When the distinguished majority leader talked about this issue, he referred to risk pools for insurance on automobiles. I would rather deal with preexisting conditions by creating a risk pool. For people who have high insurance costs because they are already sick, I would like to try to help them directly. Others want to collectivize all insurance rates. But the point is this: In the dozens of bills that have been introduced, every one of those bills tries to deal with the problem of preexisting conditions. That is not really an issue in this debate.

The final issue with regard to access is how do you help people who do not have private health insurance? There is an incredible anomaly in America today. If you do not work in America, chances are you qualify for Medicaid. But if you do work and make a modest income, you often do not have private health insurance and you are not eligible for Medicaid. We have a system today that treats the people who are riding in the wagon in America better than we treat the people who are pulling the wagon, and we marvel that 62 million people are riding in the wagon. It is amazing to me that we do not have twice that number of people riding in the wagon.

What I would like to do is reform Medicaid and ask for a copayment from Medicaid recipients. Take the average working family and look at the copayments they make when buying health care. Then, on a pro rata basis, based on income, look at the people on Medicaid and require copayments relative to their income. Does it make sense to have people on Medicaid go to the emergency room for a sore throat, when it can cost $150 or $200 a visit? I say no. Instead, they should go to the doctor like everybody else. I think we need a higher copayment to go to the emergency room with a sore throat than to go to the doctor with a sore throat. I want to reform Medicaid and have a modest copayment like most other Americans face. Let the States run the Medicaid Program and use those savings to fund a refundable tax credit so working, low-income people can buy their own private health insurance through the private sector of the economy.

What is the alternative being proposed in President Clinton's bill, in the Gephardt-Clinton bill, and in the Mitchell-Clinton bill? Their alternative is a massive Federal subsidy. Their alternative is to give—as in the Mitchell bill—about 100 to 110 million Americans Federal subsidies. That is almost half the population of the United States. The debate here is: Do we want to do that, and can we afford it?

The Congressional Budget Office, in its study the other day, concluded that when in full force, the Mitchell plan would cost $194.3 billion a year to fund. Here is the question: Can we afford to do that? I noticed the other day we had a report—in fact, it was the day before yesterday. This so-called Entitlement Commission that we have put together came out with its study about the problems we have with the country going bankrupt. Here is what they concluded without considering the Mitchell plan or Clinton plan or anybody else's health care plan:

> If we do not act by 2030—

That is 35 years from now, since we are basically looking into fiscal year 1995.

> this country will be forced to choose between doubling every Federal tax and cutting more than half of every Federal program and entitlement to balance total Federal outlays and revenues.

That is only considering programs under current law. In 1950, the average American family with two children sent $1 out of every $50 it earned to Washington, DC. Today it is sending $1 out of every $4 to Washington, DC.

When fully implemented, the health care bill before us, or the original Clinton plan, or the Gephardt-Clinton plan—they are all basically the same plan, as I will explain—when fully implemented, the average American family with two children is going to be sending one out of every $3 it earns to Washington, DC.

Do we really want to do that, when the country is going bankrupt by what we are already spending? Do we want to start now a program that has the potential of becoming the largest new spending program in the history of the United States of America? Can we really afford to add another burden on the back of the working American family by making them pay part of the health care bills for half the population of the country? I say no. I say we ought to try to help working people get health insurance but do it by cutting existing programs.

Here is my point. If this debate were really about access, we could have a meeting in a room one quarter the size of this Chamber. We could have Democrats and Republicans sit around the same table. We could have the administration represented. And within 2 days we could work out a compromise.

This debate is not about access, and it has never been about access. The White House asks how you can be opposed to this bill and be in favor of Medicare. Medicare was a subsidy to help elderly people buy health care. It was not a program that told them how to consume it or told people how to produce it or set up a separate health care system.

If the issue was about access, we could easily work out a compromise. But this issue is not about access. This issue is about something far more fundamental. This issue is about the role of Government in a free society. This issue is about how to deal with costs. And on this issue, there is a fundamental philosophical division, and it is a very difficult division to compromise on because asking us to compromise on this issue is like asking the bullfighter and the bull to compromise. Here there is a gulf of difference.

What is the problem with cost in American health care? Part of the problem is medical liability. We have some studies that indicate that as much as 20 cents out of every $1 spent on health care goes to try to keep people out of the court house instead of trying to keep people out of the hospital and out of the grave.

What do the bills before us do? The Mitchell bill and the Gephardt bill, as the second iteration of the Clinton bill, not only have no real reform on medical liability, but they go back and overturn actions that the States have already taken.

How many Americans understand that the health care bills before Congress would overturn the actions of 20 State legislatures that have tried to deal with medical liability? Let me read you a quote on this:

> [This] medical liability amendment to the health care bill . . . can only be described as a disaster for the public and a windfall for the trial lawyers. Through their lobbyists and political contributions, the trial lawyers have inserted language that would actually overturn some of the reform the States have worked on for over 20 years by substituting less effective Federal language. The amendment would, if passed, add to the cost of health care while limiting patients' access to the care they need.

Who do you think said that? Do you think that was PHIL GRAMM or BOB DOLE? No. That was George McGovern in today's Wall Street Journal.

Mr. President, if our objective is to deal with cost, what in the world are we doing overriding the actions of 20 States that have tried to deal with medical liability? We would be adding to the cost of health care. That is the kind of provision that is hidden away in these bills which nobody really knows much about.

Now, let me deal with the big issue of cost. Why is the medical market so different than other markets? I can tell you very simply with an analogy. When you go to the hospital today in America, someone else pays 95 percent of your costs. That someone else is generally a third-party-payment health insurance policy. Or maybe it is Medicare, Medicaid, or it maybe the county through its indigent care system. The bottom line is that when an American goes to the hospital today, somebody else pays 95 percent of that American's cost.

When you are spending someone else's money, you do not behave the same way you do when you are spending your own money. If I bought groceries the way I buy health care, I would eat differently and so would my dog.

Imagine for a moment that you had a grocery insurance policy and you paid it once a month, and when you went to the grocery store, 95 percent of all the groceries you put in your market basket would be paid for by that insurance policy. If 85 percent of Americans had that insurance policy for groceries, the grocery store, as we know it today, would not exist. No grocery store in America would sell dog food. Ten or 20 times as many people would work in the grocery store as work in the grocery store today. We would be buying all kinds of specialty items and all kinds of precooked items. Groceries would be exploding in cost. The President would be saying groceries are the right of every American. We would have the committees of this Congress investigating the grocery insurance rip-off. We would be debating in earnest today collectivizing the wholesale and retail distribution for groceries in America. Thank goodness, we do not buy groceries the way we buy health care.

Now, that analogy is a pretty good analogy of health care. I think the President would agree with that analogy. I think probably the distinguished Senator from New York agrees with that analogy.

But where we differ is, how do you fix it? And it is not an easy problem to fix. This is where the fundamental philosophical difference is. The President says to fix it by letting the Government make fundamental decisions about health care.

Under the President's plan, despite all the wonderful, soothing rhetoric which is at great variance with the President's plan, if you do not work for the Federal Government or if you do not work for a giant company that can afford to ransom you out of the Government-mandated health care plan with a 1 percent payroll tax, your private health insurance is canceled. You will be forced to buy health care through a Government-run cooperative, governed by a seven-member board in Washington, DC, that decides how much money is spent on health care, how the money is spent, and what choices you can make. They will set out the parameters for practicing medicine, and will have extraordinary powers to impose taxes on people in States, to change your insurance policy, to reduce reimbursements, and to basically ratchet down through Government to control your access to health care and everybody's access to health care.

Now, we have heard at great length how different these plans are that we are looking at in the House and Senate. In fact, our dear majority leader, when he had his press conference to tell the world about his first bill—which has now been substituted by a second bill, and I understand there is a third bill coming today, and every title of this original bill was changed in the bill we were given yesterday—when he had his press conference to expose his first bill to the world, he did not mention Bill Clinton's name once.

So you get the idea it is a different bill. It is not a different bill. It does the same things in different ways. It tries to limit our freedom of choice in health care.

The way I figure it, a minimum of 80 percent and probably 90 percent of all Americans will have their current health insurance changed by the Mitchell bill. The Mitchell bill tells people what kind of health insurance they can have. It mandates that they buy coverage for benefits that most Americans are not going to want. The alcohol and drug rehabilitation provision, when it was implemented by law in Virginia, sent insurance rates up by 12 percent. Why should an old widower be forced to pay an additional 12 percent for alcohol and drug rehabilitation if he does not want it?

Unlimited care in areas that have traditionally not been covered by insurance policies will send costs through the ceiling. Why should the Government tell us what kind of health insurance we should have in America?

But then you get to the parts of the bill that are even worse. If you have a provision in your health insurance that you want but that the Mitchell bill does not want you to have, there is up to a 66 percent tax on that benefit. How many Americans know that under the bill before us, there are now four different taxes on your private health insurance? And listen to how it tries to control costs. It gave up the original bureaucracy that wrenched down on the health care system. But look at what it substitutes for it. If you have an insurance policy and the cost of your insurance goes up by more than 2 percent in real terms, the Government taxes your policy and the increase with a 25 percent tax.

Now, I ask my colleagues, what is amazing here? It is as if the authors of the bill believe that a person is able to keep their insurance premium from going up.

It is as if, by threatening to penalize the working man and the working woman, somehow they will be able to keep their insurance premiums from going up. Does that make any sense whatsoever?

And if you have a benefit that is important to your family but the Mitchell bill says it is not in the national interest for you to have, the company sponsor has to pay a 35-percent tax on that benefit, and you have to pay taxes at your income tax rate. And so, while the Government does not say you cannot have the benefit, by imposing a 66-percent tax on it, the Government takes away your right to choose.

No matter how you cut it, no matter how you define it, what this debate is about is a conviction held by the President, and by many Democrats in this Chamber that Government control of health care is the only way to deal with rising costs.

What is amazing about their assertion, Mr. President, is that nowhere is there any data given to substantiate the claim. In all the world, not one example is given in 5,000 years of recorded history. I am not aware of a single case where Government control of anything has made it cheaper, has raised the quality, and has broadened the access in real terms when considering the limits imposed to expand that access.

Interestingly enough, there is an alternative that has never failed, and the alternative is competition. Ten years ago, almost every American bought health care through some third party payment system, generally through a private health insurance policy where they paid a monthly premium and they bought fee-for-service medicine and nobody had an interest in controlling cost.

Today, 10 years later, 100 million Americans are buying health care through systems where somebody has an incentive to control cost. Whether it is a health maintenance organization or whether it is a preferred provider organization or whether it is a new innovation called medical savings accounts, we are seeing the evolution in the private market system of cost-conscious alternatives that are holding down costs and that are preserving freedom.

What I want to do is to encourage those innovations. I want to allow people to have a medical savings account tax free. Let them buy a high deductible insurance policy and put their savings into a tax-free medical savings account out of which they could pay the deductibles. But at end of the year they could keep the money they have not spent.

We can expand coverage. We can make the system work better, but we cannot improve the system by lessening the freedom of our people.

People cannot seem to understand why there is so much passion on our side of the aisle about this. Well, my passion comes from the fact that I believe in freedom.

When my momma gets sick, I want her to talk to a doctor and not some Government bureaucrat. I do not want the Government to make decisions for my family, and I do not want them to make decisions for other American families. In the end, Government-run health care fails. In the end, it does not work. And that is hard for some to accept. It is very hard to accept.

But it is going to be impossible to accept a Government-run system when we do not get to make decisions for our families, when we have now some 40 different Government agencies and bureaucracies that are created by this bill that are going to help make the decisions for us, at best, and that are going to make them for us, at worst.

I want to preserve freedom. There has to be a way. There is a way to preserve our freedom and yet help people get and keep good private health insurance.

Let me conclude by saying what I am for and what I am against.

I want to pass a health care bill this year. I think the worst thing we could do is let an issue fester, thereby allowing people who have a political agenda to expand the power of Government and convince people that their solution is the only one. Their solution is to adopt a medical care system that half the world is trying to reject.

Is it not an incredible paradox, when half the world today is trying to get out of Government-run medicine, that we are the only country on the planet that is trying to get into it?

I want to make insurance portable so that you can change jobs without losing it. I want to make insurance permanent so it cannot be canceled if you get sick. I want to deal with medical liability. I want to help working people get good health insurance. And I want to fund it by cutting existing programs and reforming programs like Medicaid. And I am willing to work with anybody at any time, anywhere to do that.

But I am not willing to raise taxes on the American people by another $194 billion a year. I am not willing to do that, and I am not going to do it, and it is not going to be done unless every right I have as a Senator is overridden by the ability of the majority to stop this debate.

I am willing to try to improve the system, but I will not participate in tearing down the greatest health care system in the history of the world and rebuilding it in the image of some Government agency here in Washington, DC.

And how committed am I to that? The media has run around for 3 or 4 days asking, "Are you going to filibuster? Are you willing to filibuster?" I want to legislate. I want to pass a bill to fix what is broken in the system.

But if you are asking me, if I am willing to use every power I have as a Member of the Senate to stop a Government takeover of the health care system, to stop the continual reaching into the pockets and breaking the backs of the working people of this country with a growing tax burden, the answer is, "You bet your life I am." Whatever I can do to stop this, I am going to do. It is vitally important to the future of America.

Here is my concluding point: Why is this so important? This is so important because, if we adopt anything like the Clinton health care plan, we cannot fix it. If we adopt anything like the Clinton health care plan, we are not going to be able to take back all these promises. Once we make all these promises, we will never be able to take them back. We will never be able to pay for them. We will go back and forth between bankrupting the Government and rationing health care. In the end, we will destroy both the economy and the greatest health care system in history.

It is important, if we cannot fix something, that we not break it. And I am going to do everything I can to see that we do not break this system.

I want to work with people. I want to fix what is broken. But there will be no Government takeover of health care on a watch that I share with colleagues who also do not believe that Government is the answer. If the 20th century shows us anything, if anything is proven by the experience of mankind on this planet in the 20th century, it is that big Government does not work; that Government cannot deliver the goods; and that Government will not respect the rights of the individual. And it was true in the worst government on the planet and it is true in the best government on the planet, which is this Government.

So this is a critically important issue. The future of America is going to depend on the outcome of this debate. And we are going to debate it and we are going to fight it out as if the future of America depends on it. It does.

I believe that when the debate is over, when people understand that unions are treated differently for tax purposes than people who are not members of unions; that, in determining whether a State like my State has these employer mandates which are payroll taxes imposed on its employers, health insurance for illegal aliens is included; when people understand that we are overturning medical liability reform, which is critical to controlling cost; when all these amendments are presented and when the American people know all the little special interest provisions in these bills, they are going to reject these bills by overwhelming margins.

Washington is isolated from America. I understand that. If this decision was going to be made in America, I would be absolutely confident. But it is going to be made in Washington, and it scares me to death. But in the end the system works and in the end the Mitchell bill will fail. The Mitchell bill will not fail because there is not a problem in health care. It will fail because the Mitchell-Clinton bill, the Government domination approach, will not solve the problem.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas yields. Who yields time?

Mr. PACKWOOD. I yield to the Senator from Utah such time as he would like.

The PRESIDING OFFICER. The Senator from Utah [Mr. BENNETT] is recognized.

Mr. BENNETT. Mr. President, I will have a more lengthy statement on health care later on when the appropriate time arises for me to give that. But I have something to say today that I think is applicable. I have just a little bit of temerity about saying it because the distinguished scholar who Chairs the Finance Committee is on the floor. I have had the experience of quoting things from America's past in his presence before and have found that he has been called upon to further add to my education and correct me.

Rather than be embarrassed, I have been enlightened by that experience. So I will share again with the Senate an observation from America's past history and say to the distinguished Senator from New York that if I need further enlightenment I will welcome it in the same fashion that I have had it in the past.

One of the documents that I have read from time to time, ever since I was a college student, which I think still has much to teach us, has been the Federalist Papers. The Federalist Papers were basically a political document, written in a political fight. They were tracts, written to convince the good people of New York that they ought to support the ratification of the Constitution. But in the process of going through that, the authors of the Federalist Papers gave us some pearls of wisdom, one of which I will quote here today on the floor, that I think summarizes what we are faced with. From the 62d Federalist, James Madison, the author of that particular document, has this to say about what he calls mutable policy. I am assuming mutable is a 19th century word for something bad. I am not sure exactly what it means. Mr. Madison says this:

> The internal effects of a mutable policy are still more calamitous. It poisons the blessings of liberty itself. It will be of little avail to the people that the laws are made by men of their own choice if the laws be so voluminous that they cannot be read, or so incoherent that they cannot be understood; if they be repealed or revised before they are promulgated, or undergo such incessant changes that no man, who knows what the law is today, can guess what it will be tomorrow. Law is defined to be a rule of action; but how can it be a rule, which is little known, and less fixed?

A quote from Mr. Madison. This strikes a very respondent chord in my mind. He talks about "laws be so voluminous that they cannot be read." I took upon myself the task of reading all 1,400 pages of the majority leader's bill. I must confess I found that it was a wonderful cure for insomnia, and convinced me once again of the wisdom of my decision not to go to law school and therefore not to be trained to talk like that.

I got about 100-and-some-odd pages into the bill when it was changed. "So voluminous they cannot be read, or so incoherent they cannot be understood," and "revised before they are promulgated." I have to start all over again, the first hundred-and-some-odd pages that I read no longer apply because we have a new version. I am going to forgo reading the new version, I will publicly admit, for fear that it, too, will be changed before it is promulgated and incoherent to be not understood. And I will be dependent upon the staff analysis of where it is and what it says.

Enough classical allusions. What are we told in today's paper—that applies to this circumstance in language a little less orotund than that of the Founding Fathers—the Congressional Budget Office has this to say on this same philosophical topic. Referring to the Mitchell bill it says:

> For the proposed system to function effectively, new data would have to be collected.

Stop and think of the implications of that. For it "to function effectively, new data would have to be collected." In other words, the present data does not tell us what is going to happen.

> . . . new procedures and administrative mechanisms developed, and new institutions and administrative capabilities created. In preparing the quantitative estimates presented in this assessment, the Congressional Budget Office has assumed not only that all those things could be done [in other words, they are giving the very best possible odds that this will all work, and that is an assumption] but also that they could be accomplished in the timeframe laid out in the proposal.

There are two assumptions. One that it could be done, and, number two, that it could be done in the timeframe. And

I will get to the timeframe in just a moment.

"There is a significant chance"—there is a phrase pregnant with meaning—

> There is a significant chance that the substantial changes required by this proposal could not be achieved as assumed.

What are we doing here? Taking a significant chance, in the words of the Congressional Budget Office, that these substantial changes required by this proposal could not be achieved as assumed. Are we falling under the condemnation that Mr. Madison gave us, about laws that are "little known and less fixed"?

There is one thing in this bill that is fixed, and that is the trigger. Trigger is not a word that I think Madison would recognize. It comes from a mechanism, perhaps, that was invented since his day. But it is one of the most pernicious concepts that I can think of, where we are saying in this law, if things do not work out the way we hope they will, if things do not work out the way we assume they might, we in 1994 will legislate what will happen in 2002. I can think of nothing more arrogant on the part of this Congress than to say that we know what should be done in 2002 if things do not work out the way we think they might in 1994. I think we need a strong dose of reality and a strong dose of humility, as we approach the enormousness of the task facing us. And we ought to approach this from the standpoint of doing what we think we can do now, based on the best data we have, and trusting to future Congresses to do what they can do based on the data before them as the data become available.

I close with this observation. I serve on the Joint Economic Committee. One day before that committee Dr. Uwe Reinhardt, Princeton University, came before us to talk about health care. He is recognized as one of the great gurus of this debate throughout the country.

I said to him, in effect, why are we convinced that we have to do the whole thing in a single bill in a single Congress? What arrogance there is connected with that. Why do we not say this much we know, therefore this much we can fix and let us fix that and then see what happens and come back in the next Congress with those data before us and fix some more as we move along? That is, to me, the logical way to solve this kind of problem.

He said in effect: Senator, of course that is the logical way to proceed. I agree with you completely. But, he said, those of us who have spent our lives focusing on this issue are convinced that if we do not get it done this year it will be another 30 years before we get a chance to address it.

I said that is absurd. Surely this Congress and future Congresses will not be so irresponsible as to not address this issue in the future.

And he said to me, "Senator, would you commit to address this issue again next year if we don't get it all done this year?"

I said, "Of course, I will."

He said, "Well, if the Senate would commit to do that, then we wouldn't have to do all of this all at once."

So that is my plea, Mr. President. Let us commit to the American people that we will do that which, according to the polls, 65 percent of them want us to do, which is address the issue this year, as well as next year and the year after that and the Congress after that and the Congress after that until, in a series of intelligent, well-informed, proper steps we finally get this problem solved.

To try to say it must be done between now and the time we go on recess, and it must bind future Congresses all the way to the year 2002, and it must be based on a series of assumptions which, according to the Congressional Budget Office, there is a significant chance they will not come to pass is, in my view, irresponsible. And I do not want to be part of that irresponsibility as passionately as I do want to be part of an intelligent solution to this problem.

As I say, I will have more to say about this in a complete statement that I will give later in the week, but I wanted to take advantage of the opportunity in the presence of the chairman of the Finance Committee and the comments in this morning's paper from the Congressional Budget Office to bring these thoughts to the attention of the Senator. I thank the Chair.

Mr. MOYNIHAN. Mr. President, may I congratulate my learned friend from Utah on his citations on the Federalist Papers? Indeed, Madison, Hamilton in particular, and Jay would, if you had said to them our statutes would be what they are today, they would have said they were, indeed, voluminous and incoherent. They would not have anticipated our data processing capacities, and 50 years ago neither did we.

But it is a problem. We are one of the few nations on Earth which allows the citizen to assess his own taxes. It works pretty well. A subject of the Queen is not allowed to decide how much tax he or she owes. The Queen decides. He can sue as much as he wants, but he never wins.

The Tax Code has become near incomprehensible, save for specialists. We have 300,000 pages of Medicare regulations. As we proceed in the manner we are discussing, I think the idea of simplicity needs to be very much—accessibility, not just to insurance but to the information about insurance. If the regulations are incomprehensible, access is, at the very least, dubious. A good point and a timely reminder. Thank you.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Oregon [Mr. PACKWOOD].

Mr. PACKWOOD. Mr. President, I just want to make sure of our time situation. Do we have a unanimous-consent that Senator SPECTER will have an hour at 11 o'clock? I cannot remember.

The PRESIDING OFFICER. There is no consent agreement to that effect.

Mr. MOYNIHAN. Mr. President, may I inquire of Senator WOFFORD, is he ready to speak? He has been very patient. I yield the Senator—I believe the Senator wanted about 5 minutes.

Mr. WOFFORD. Yes.

Mr. MOYNIHAN. I yield the Senator 5 minutes.

The PRESIDING OFFICER. The Chair recognizes the Senator from Pennsylvania [Mr. WOFFORD].

Mr. WOFFORD. Mr. President, it has been good to hear Senator CHAFEE and others on the other side of the aisle reach out in a constructive spirit and with the conviction that this Congress this year can and should come together to find a common sense, common ground for health care reform.

But, Mr. President, I have been alarmed by some of the other voices in this debate. In yesterday morning's Washington Post, one of my Republican colleagues was quoted as saying "health care is too important"—get those words—"health care is too important for this Congress to pass a reform bill now. Instead of acting," he says, "we should commission a study"—a study.

Mr. President, we have had years of studies, mountains of studies. We do not need another study to tell us what is wrong with this system. We need the backbone to fix it, not after the next election, not some time in the next century—now. Health care delayed is health care denied.

To those advocates of delay who say the remedy offered by Senator MITCHELL is too complicated to understand without a study, that the remedy offered by Senator MOYNIHAN on the Finance Committee, now incorporated in great part in the bill we will be considering from Senator MITCHELL, is too complicated to understand without a study, I say study this. This is the Federal employee benefits plan. It is a model of what we are proposing to do to guarantee all Americans the kind of private, affordable coverage, the choice of private health plans, not Government-run plans, your own doctor plans, HMO's, your choice that Members of Congress have arranged for themselves. What is so complicated about that?

When I came to the Senate 3 years ago, I said Congress could not understand the health care problems working families face while we got free medical care from the Office of the Attending Physician. So we fixed that. We now pay the fair market value of that extra service, in addition to having our choice of private health insurance plans. But apparently some of us still do not understand what real families go through, why it is true that health care delayed is health care denied.

If Members of this Congress want more time to study, let them study what it is like to be a middle-class American caught up in the health insurance mess. Let them study what it is like to try to buy insurance on the open market without the help of their employer.

So I am serving notice that if the defenders of the status quo succeed in blocking this, in causing further delay or study, I will offer an amendment that will disqualify every Member of Congress from participating in the Federal Employees Health Benefits Plan until we pass a bill which will do four things:

First, put us on a certain path to universal coverage; second, open the Federal Employees Health Benefits Plan to the American people and to small businesses; third, end insurance discrimination, meaning real portability, meaning an end to preexisting condition exclusions—Senator GRAMM said only God can end a preexisting condition. This Congress in the bill we are seeking can end preexisting condition exclusions—an end to lifetime caps on benefits and an end to discrimination against older Americans; and, fourth, contains real serious, effective measures to control health care costs so we do not increase the deficit.

Mr. President, do you know what would happen to us, to Members of Congress, if we had to deal with the health insurance nightmares that haunt so many Americans? Very soon, each one of us would be getting a letter from our insurance company saying, in effect, after all the doubletalk, "You're out of luck. That insurance you thought you had wasn't real insurance, it was phony."

We would get a letter saying, "You're out of luck, you've reached your lifetime cap on benefits."

"You're out of luck, we won't pay for the services you need because of that preexisting condition you have."

The problem with our present system of health insurance is that so much of it is phony. You pay and pay and then just when you need it, it is not there.

Yesterday, the House overwhelmingly approved a bill that would require Congress to live by the rules it makes concerning workers' rights. The point there is to make Congress understand the consequences of its action. My amendment, if and when it has to be enacted, would force us to understand the consequences of failing to act. I have heard Members of Congress say that doing nothing on health care does not hurt me at all. Well, it should. It should hurt every one of us if we fail to act because it sure is going to hurt the American people and the American economy.

Mr. President, Americans did not start debating health care last week, last month, last year. We have been at this debate for decades.

And when I hear from hard-working men and women in my State about the problems they are having with health care, I remember the words of Martin Luther King at the Lincoln Memorial when he talked about the fierce urgency of now. Now is the time the people need help. Now is the time for the people's representatives to act.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER (Mr. CAMPBELL). The Senator from Oregon.

Mr. MOYNIHAN. Mr. President, I thank the Senator from Pennsylvania for his eloquent and concise statement and his very appropriate threat.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. PACKWOOD. On my time, would the Senator from Pennsylvania yield to a question?

Mr. WOFFORD. Yes.

Mr. PACKWOOD. As I indicated in my opening speech, I spent the better part of a weekend reading this bill about cost containment. I am not sure I have got it figured out yet. But last night I spent time reading this bill—I refer to the Mitchell bill now, not the Finance Committee bill—on risk adjustment between plans. There is nobody that is more informed on health in this body than the Senator from Pennsylvania. It was the main campaign issue when he was elected, and he knows the subject well.

I cannot find anything in the Federal Employees Health Benefit Plan—they have lots of plans. We have a choice of plans—on risk adjustment. Would the Senator briefly explain it, because I do not understand how the risk adjustment in the Mitchell bill works?

Mr. WOFFORD. Mr. President, I say to Senator PACKWOOD, first I wish to make it clear that I am not proposing that the Federal Employees Benefit Plan be the cure-all or the only health reform we are talking about. I am proposing that one of a number of options be the Federal Employees Benefit Plan, that voluntary purchasing cooperatives be one of the options for the American people and for small business particularly, that directly getting your own insurance from Blue Cross/Blue Shield, HMO's, be one of your options, and that your employer may provide that insurance in a variety of ways. One of the ways is the voluntary purchasing cooperatives, the degree to which we have community rating in which we have the whole pool in the community as the pool on which the risk is carried.

Just where that limit is, how many employers, what size and what people are in the community-rated pool we are going to have to discuss and understand and work together on to set the right margin. There are different reasonable approaches to that, which I am looking at with some of my colleagues.

But within the community-rated pool, however we decide it, there is a serious problem of how do you adjust the risks to prevent some plans that are participating in it, some insurance carriers, from having a far greater burden of the higher risks. And if we are going to have community rating, we are going to have to develop, in a constructive fashion, a risk adjustment procedure, and the Mitchell bill proposes one very specific way of doing it.

Mr. PACKWOOD. Well, as I understand the Mitchell bill, it has mandatory cooperatives and it eliminates the Federal Employees Health Benefit program as we know it.

Mr. WOFFORD. Will the Senator yield?

Mr. PACKWOOD. Yes.

Mr. WOFFORD. Did I hear the Senator say there would be mandatory cooperatives?

That horse of mandatory alliances left the field months ago, and neither the Senate Labor Committee nor the Senate Finance Committee has a mandatory alliance. Voluntary purchasing cooperatives.

Mr. PACKWOOD. Mandatory cooperatives appear to be back.

Mr. WOFFORD. I say to the Senator, the horse has not come back on the field that I found.

Mr. PACKWOOD. Well, I thank my good friend. There is the problem. We are on the Finance Committee bill. But we all talk about this bill, S. 2357, the Mitchell bill. That was introduced—14 pounds—last Thursday, I think. Then the night before last, we have this bill. It does not have a number yet. It has not been introduced yet. It has been printed. This is the second Mitchell bill, and with it came a list of sections affected, and it says, "The following sections have been modified" since the initial printing of his bill last week. Every single title in the bill, his original bill, is amended, but we do not know what. All we have is this sheet that gives us numbers. And what you have to do is then go to the new bill and attempt to correspond to the numbers in the old bill, and the numbers do not correspond.

Now, yesterday, we discovered—I was talking to my good friend from New York, Senator MOYNIHAN, about a provision that he and I jointly dislike, which is how many residents medical schools can have and what kind they can have. Senator ROCKEFELLER kindly informed me that that provision was no longer in the second Mitchell bill. I did not know that. I did not know it had been taken out.

Now I discover there is going to be a third bill, or at least a great variety of changes again. I was prepared to make a rather lengthy speech this morning on the 25-percent tax on the so-called high-cost plans. I now hear rumors—I do not know if this is true—that that is out in the new provisions that are coming along. I do not know if they are out or not.

Mr. President, is this the way to legislate? I am telling you something, somebody called my office and talked to me the other day and talked about this first Mitchell bill. They are absolutely enraptured by it. They referred to it as the "War and Peace" of health care legislation. It is not war and peace; they got the wrong medium. The medium is film. This is "Lethal Weapon I".

This is "Lethal Weapon II."

Apparently we are about to have "Lethal Weapon III," and we do not know what is in it.

Well, if that is the way we are going to legislate, I am going to try to be "The Terminator," and we are not going to have these bills. We are not going to legislate 1,400 pages at a time, 14 pounds at a time, changing it every day, trying to figure out what is in it, spending hours and hours and weekends and weekends and staff time and staff time going through this bill trying to dredge out the truly awful parts from the just awful parts, trying to figure out a way to get rid of them, then finding out they may be in it or they may not be out or we are going to be on something different the next day.

Mr. WOFFORD. Will the Senator yield for a question?

Mr. PACKWOOD. No; not now. I am not done yet. The reason I am not going to yield is because Senator SPECTER is due to speak, and he is here. But I am simply asking the Chair—and the Senator from Pennsylvania is as confused as I am when he says the mandatory alliances are out, and I am saying the mandatory co-ops are back yesterday—yesterday. I do not know if they are back today or not. They were out for a while and they were back. That I found. I have not seen the amendments—the revisions. We have not gotten amendments—that are coming today.

But considering that we are affecting one-seventh of the entire economy, considering that if the Clinton bill, as we initially had it passed, if the Congressional Budget Office was right, we would have seen the percentage of our gross domestic product that went for health go from 14 percent of all the money and everything we had to 19.5 percent. To call that progress, to me, redefines the word.

But at this stage, I see my good friend from Pennsylvania is here, and if he is ready, I am prepared to yield to the Senator from Pennsylvania as much time as he might want.

The PRESIDING OFFICER. The Senator from Pennsylvania [Mr. SPECTER] is recognized.

Mr. SPECTER. I thank my distinguished colleague from Oregon for yielding.

I appreciate the time to present my views on the pending health care legislation.

This debate, Mr. President, has been classified as a historic debate, and I believe that is an accurate characterization. There have been frequent references made to the fact that the debate goes back to President Truman's time, and I reflected on that and recollected that when I was a high school debater in 1946, the subject was health care legislation. I consulted with the Congressional Library and found the old high school debate manual from the fall of 1946, where the high school debate topic was "Resolve, that the Federal Government should provide a system of complete medical care available to all citizens at public expense." That was shortly before the time Senator PACKWOOD was in high school—not too much before, but a little before.

I will not read much of this book. But there is a notation here that the annual cost for medical care in the United States is $3.656 billion, which is a long way from the current level of $1 trillion.

I recall debating the subject and getting involved in the questions of medical care and group practice and the needs of the country. I have been an observer of this subject since my high school days, and for the last 14 years in the U.S. Senate I have been an active participant in the ongoing debate through my participation on the Appropriations Subcommittee of Health and Human Services, where for the past 5 years, I have been the ranking Republican working with Senator HARKIN and others on a budget which is now $70 billion a year on discretionary spending.

During my 14 years here, I have had occasion to introduce some 20 bills on health care matters, and have considered this at the top of my own agenda. And certainly it is at the top of the national agenda.

I intend to discuss five major subjects today, Mr. President. The first is the present health care system, its good points and its bad points; second, my legislative proposal, which has been on the table for more than 18 months; third, the proposals offered by President Clinton and Senator MITCHELL; and fourth, the politics of health care in this Chamber and in the Congress today, and the question of the timetable, as to how we ought to proceed.

Mr. President, I believe that while there are needs for reform and needs for correction, we Americans enjoy the best health care system in the world, and the best health care system in the history of the world. I base that on what I have observed and what I have seen in my own family, recalling the days when my father, Harry Specter, was a patient at the Veterans Administration hospital in Wichita, KS, in the late 1930's; and when I saw my mother in the hospital with a gall bladder operation at Mount Sinai in South Philadelphia around 1950; and when I saw the extensive care my brother, Morton Specter, got in Wichita, KS, when he was terminally ill last October.

And I think about my own care that I received a little more than a year ago when I was diagnosed by an MRI, a machine which had not even been in existence for 10 years. In the face of symptoms which doctors could not figure out, I asked for an MRI. I had a little opposition from my doctor, but I got one; they found a golf ball inside my head, and I had an operation. I have had a full recovery and I am very grateful for the kind of medical care we have in this country.

I hear people talk about the Canadian system, and I know that when Canadians have very serious problems they come to the United States. And I hear about the system in England and how there are limitations for people over 60 to get remedial surgery. I hear of other stories of systems around the world. I think that we should not lose sight of the quality of care we have in the United States. But, having said that, I believe there is a need for improvements. There is a need for reform.

I believe that we need to have universal coverage. I agree with President Clinton's objective to have comprehensive health care for all Americans, and not just 95 percent of Americans, but all Americans. I compliment the President for having brought health care to the center stage so that it is receiving the undivided attention of the Congress. That is not quite true, but we are focusing on health care in a very concerted way.

I believe that we need to have coverage for preexisting conditions. I think we spend more money on lawyers fighting about what is preexisting than it would cost to hire the doctors to give the appropriate medical attention.

I think we need to have portability, a fancy word for coverage when people move from one job to another. And I think we need to deal with the problem of spiraling health care costs, which is not sufficiently addressed, in my opinion, by the President's plan or by Senator MITCHELL's plan.

Mr. President, I offered Senate bill 18 on the first day of the 103d Congress, on January 21, 1993. And it is a modest bill by comparison to the Mitchell bill. It is a thin bill. My staff and I worked on it for the better part of 2 years to refine it and come down to what I consider are the essentials of what we ought to enact at the present time.

It differs from the President's proposal and Senator MITCHELL's proposal in that it relies on the market system which has brought the best health care in the world to 86.1 percent of the American people, and it has some limited governmental action. I disagree with those who think the Government should do nothing. It is limited governmental action, but it is not the massive bureaucracy which would be brought into play by the President's plan or by Senator MITCHELL's plan.

I will discuss that in due course. But first, I want to accentuate the positive, and talk about what I think America needs.

This is a matter of overwhelming importance. We are dealing with a health care system which approximates $1 trillion. That is a telephone number. Nobody really knows what that means. We talk about it in terms of 14 percent of the gross national product. Again, that is a constant that is really hard to bring down to Earth. But people do know that almost every day, every man, woman, and child in America has some ache or pain and is concerned about their health, and they see a doctor. The doctor-patient relationship is one of the most important of all relationships.

Early on, the common law gave a privilege to what a patient tells a doctor. And it was second only to the husband-wife privilege where marital communications are sacrosanct, and cannot be inquired into. The law accorded that kind of privilege between the patient and the doctor so that a patient would feel free to tell the doctor exactly what was on the patient's mind, knowing that could not be repeated. The ability to choose one's own doctor, that choice is fundamental and has to be preserved. When a patient goes to a doctor, as I go to my doctor, as Americans go to their doctors every day, there is a confidence that if something can be done, it will be done, because of that personal relationship.

So I think what we need to do is build on the present system. The legislation which I proposed starts off with proposals to cover the Americans who are now not covered, and the first line is to have full deductibility for the self-employed.

As of December 31, 1993, if you are self-employed, you receive no tax deduction for the cost of your insurance premiums. But if you are an employer you can deduct the full amount of your contributions to your employees' health insurance coverage and the beneficiary, the employee, is not taxed at all. That is a unique aspect of our tax laws, and it is designed as a matter of public policy to encourage coverage of health care. That is what has led to so much health coverage, 86.1 percent of the American people.

My legislation would give full deductibility to those who are now not receiving this, the self-employed. It is hard to say how many people would then be covered, but maybe 4, 5, or 6 million. It might be more. We will not know until we try it out.

A second key proposal in my legislation is insurance market reform and small employer purchasing groups, which would enable small business people to get together, pool their purchasing power and get reduced premiums. Here again, there would be substantial additional coverage in America—how many people precisely, again, we do not know for sure; perhaps 6, 7, 8, 9 million people.

I brought these two points to the floor, Mr. President, back on July 29, 1992. I brought these matters to the floor because it seemed to me that we should have been legislating in this field a long time ago. The majority leader came to the floor when we were debating an energy bill, as the Presiding Officer knows, and as we Senators know. But the American people do not understand all of our procedural rules, one being that any Senator can offer an amendment to any bill at any time. But only the majority leader can control the calendar and decide when health care would be brought up.

The majority leader came to the floor and said, "This health care amendment does not belong on an energy bill." I said to the majority leader, "I will agree with you, and I will be glad to take it down voluntarily if the majority leader will give me a date certain when he will take it up." He said he would not do that. I reminded him that he had given a date certain to products liability legislation, which was the day after Labor Day. But he declined to give me a date certain, and it was pretty much a party line vote and my amendment was tabled.

I think, Mr. President, that what we need to do is to take health care reform one step at a time. I call it "trial and correction." I do not call it "trial and error" because I do not think there is an error when you try and you are uncertain as to the outcome, because it is so unpredictable as to precisely what will happen. But those items—full deductibility, insurance market reforms, and group purchasing for the small group market—have been agreed upon in the Congress for a long time. They were not original ideas with ARLEN SPECTER, but I wanted to get them enacted. They were opposed on the basis of "let us not do piecemeal reform because that will defeat comprehensive reform." But had we enacted those provisions in 1992, we would now have some idea as to what they could do, and we would be prepared, in a careful way, to move ahead with other proposals.

My legislation, Senate bill 18, which has been pending for a year and a half, has as its second title "Primary and Preventative Care Service," which provides maternal and infant care coordination, school health care education, and early childhood education.

Title III of my program called for important information to be given to beneficiaries under Medicare and Medicaid. One of the provisions in my legislation on preventative care deals with low birthweight babies. I was amazed, Mr. President, when I saw for the first time a 1-pound baby. I saw that child when I was visiting a health clinic in Pittsburgh and was astounded to find that in a city like Pittsburgh; no city has finer health care delivery than Pittsburgh. Yet, Pittsburgh had the highest infant mortality rate among African-American children. More African-American children died as infants there than in any other city. I saw a 1-pound baby that was as big as the size of my hand, 16 ounces or 18 ounces. It is tough enough coming into this world weighing 8 pounds 10 ounces, as I did. But for those who are born weighing 1 pound, it is a human tragedy for the child carrying those scars for a lifetime, and it is a financial disaster for the country. And it is a multibillion-dollar cost to America not to take care of low birthweight babies.

I have moved ahead on that, Mr. President, working to get the program, Healthy Start, which now receives appropriations through the Labor, Health and Human Services Subcommittee, where I serve as ranking member. We have a program which is in effect—it is not widespread enough, but it is in effect. Within the past 2 weeks, I offered an amendment to the Elementary and Secondary Education Reauthorization bill, which was adopted, providing that schools would be required to inform pregnant young women about prenatal care, modeled after the plan of Dr. Koop, former Surgeon General. We are taking very slow steps, but we ought to be doing a great deal more on prenatal care, which would eliminate the tragedy of premature, 1-pound babies. It would be a multibillion-dollar saving for the United States on preventative health care. That is one of the provisions of Senate bill 18.

Another key provision is title IV which provides for the patient's right to decline medical treatment. Mr. President, we know that statistics demonstrate that more money is spent in the last few hours or days of a person's life on terminal health care costs than is spent in the balance of someone's lifetime. And I had an opportunity to observe that firsthand with my brother, as I have referred to earlier, his terminal health care costs in Wichita last October.

I believe it is very important to make it plain that no person should decide for any other person what kind of terminal health care services that person will get, as that person approaches death. But we have done an insufficient amount in this country to ensure the use of so-called living wills. A living will is a document or permanent record where the person designates what they want by way of terminal health care services as they near death—or in the case of durable power of attorney, a person gives that power to their children or other trusted family or friends. My wife acquainted me with it a long time ago, and we have living wills. It would be an enormous savings if this kind of information was distributed to all people to have the opportunity to make this choice. The amount of savings here, again, is impossible to calculate. My staff and I have tried to get figures on it, and nobody knows what it would save. I think, conservatively, it is in the high billions.

Another title of Senate bill 18—and I am not going to go through the whole bill, but I will make it part of the RECORD.

In fact, I ask unanimous consent that the index to Senate bill 18 be printed in the RECORD at the conclusion of my oral presentation.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. SPECTER. Another key part of cost containment relates to drug clinical trial programs and to medical treatment effectiveness, which sets up a small amount of money set aside on insurance premiums for an analysis of effectiveness of certain treatments and certain drugs, which is not done today. Regrettably, we do not know of any systematic way where there is information available for all doctors and hospitals as to what is effective. This bill sets forth a program in that respect, which would be very, very important for cost containment.

Another provision of the bill would require hospitals and doctors to give a fee schedule. There was recently a celebrated analysis in my State of Pennsylvania on how much less expensive it was to have open-heart surgery in Lancaster as opposed to some of the hospitals in Philadelphia.

And this information, which would be required under my bill, would give consumers an opportunity to make a selection based upon competition and lower costs.

The provisions of my legislation would further require that there be available information on malpractice judgments against doctors or hospitals so that patients would have easily obtainable information on who had been convicted of malpractice among doctors, which hospitals had been found to be guilty of malpractice, so that the consumer would have an opportunity to make an informed judgment as to whether the consumer wanted to go to that hospital or to that doctor.

Another important part of my legislation are the proposals for managed health care, and this is a field which has much to recommend, but is not totally good. But, on balance, I think it is worth implementing to a substantial extent.

The problem with managed health care is whether managers are going to be too restrictive on the kinds of medical care which they will allow those in their program to have. And that is a judgment call. But from what I have seen of managed health care, its benefits substantially outweigh its disadvantages, because it provides for preventive medicine. It provides for regular checkups. It provides for some supervision by the managed health care company on what the doctors would be doing. However, the tough judgment call is to have sufficient supervision without being overly restrictive.

Almost 4 years ago, I had occasion to visit the operations of U.S. Health Care, Inc. at their headquarters in Blue Bell, PA. I was enormously impressed with what I saw. When I have left U.S. Health Care, after visiting with its president, Mr. Leonard Abramson, and others, at the installation, I picked up my car telephone and dictated a letter to Dr. Louis Sullivan, Secretary of Health and Human Services. On a suggestion which Leonard Abramson, president of the U.S. Health Care, had made my letter proposed to the Department of Health and Human Services to take 100,000 Medicare patients and have their care managed by his company without charge and then to contrast that with what would happen to another sample group of 100,000 Medicare patients. Mr. Abramson said that he was confident that his proposal would lead to a 20-percent reduction in costs through managed health care.

Mr. President, I worked with Dr. Sullivan and his Department, and regrettably we could not cut through the mass of redtape because they wanted to give Mr. Abramson and U.S. Health Care a grant. Mr. Abramson did not want the grant. He wanted to run a test program with 100,000 patients under his charge, contrasted with another 100,000. And I am not going to speak at any great length. Each one of these subjects could constitute a lengthy speech.

Mr. President, I ask unanimous consent to print in the RECORD at the conclusion of my comments my letter to Secretary Sullivan, dated October 31, 1990; my follow-up, dated April 8, 1991; Dr. Sullivan's reply to me dated April 19, 1991; and his reply to me dated June 4, 1991.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 2.)

Mr. SPECTER. Mr. President, the upshot was that we could not do much with the Department of Health and Human Services on getting managed care under this test program.

But my own view is that if we were to have managed care to a greater extent in this country, we could save very substantial money. I think it could possibly save up to 20 percent. If we could save 20 percent of the current health care costs of Americans, some $1 trillion, that mathematically would be $200 billion which would be more than enough money to cover the 37 million to 40 million Americans who are now not covered.

My approach is to take health care in America one step at a time, to extend full deductibility, and pick up several million people who would be covered, to have insurance market reform and enable small business to have group payments and see how many more would be covered.

I believe that it is going to be necessary to have certain subsidies for people at the poverty level, and I agree with the generalized approach of a full subsidy at the poverty level, graduated and eliminated as you move to 200 or 250 percent of the poverty level.

But the question as to how we are going to pay for this additional coverage is one which we have to confront directly, and we have not confronted it directly. I believe that by the kinds of proposals that I suggest in Senate bill 18, prenatal care for low birthweight babies, increased use of living wills, and greater use of managed health care, we would see in the course of a reasonably brief period of time very substantial savings which we could use to extend health care coverage to the people who are not covered.

I believe that if you moved ahead with insurance market reform and full deductibility, we might cover a third to one half of the 37 million to 40 million people now not covered. Then with the saving we could cover the remainder of Americans so all people would be covered by health care.

Mr. President, I believe that the American people are looking for answers on the problem of health care reform. Walt Whitman heard America singing. I hear America worried about what is going to happen in Congress on the pending health care legislation.

When President Clinton traveled to Ambridge, PA, in November of last year, I accepted his invitation and went with him and joined him on the speaker's podium and said that I agreed with the President's overall objective of comprehensive health care for all Americans. That was only a few days after he had announced his plan. And I made a qualification that I was not endorsing his plan but I agreed with his overall objective. As a Republican Senator, I was criticized by some of the newspaper editorials for going with a Democratic President to Ambridge and lending him that kind of support.

But I think that on health care, Mr. President, we have to put politics aside as we do on the crime bill which is now pending in the House of Representatives. That is another subject. But it is worth a parenthetical comment. I think the crime bill on balance is good. There are some problems with it, but I think providing for the death penalty, providing for more prisons, providing for more police, and providing for realistic rehabilitation, those are advantages which outweigh the disadvantages.

When some people say we cannot pass the crime bill to give the President the credit, I say this: They are wrong. I do not think we get much credit in Washington for whatever we do. I think if there is any credit going to the President, so be it.

I went with the President, as I say, to Ambridge, PA, and when Mrs. Clinton went to Children's Hospital in Philadelphia in early February I went with her at that time and had a chance to talk to her about Senate bill 18, as I talked to the President about my own ideas in my bill.

She said, "Well, how about the underinsured?" I said: "You've got a good point. We ought to cover the underinsured as well."

I think it is regrettable that we have not sat down in a more bipartisan way, and I hear a lot of concerns about the bickering and the gridlock that goes on in Washington. I read in the Philadelphia Inquirer on Sunday that if health care reform was going to be passed there would be little or no help from Republicans.

Mr. President, I think that is a widespread public perception, but it is inaccurate. When the health care bill came out of Labor and Human Resources, there was bipartisan support. One Republican, Senator JEFFORDS, voted for that bill, and there was Republican support for some of the measures. There was one important matter introduced by Senator BINGAMAN which had a 17-to-0 vote. In the Finance Committee, there have been three Republican Senators, Senators CHAFEE, DANFORTH, and DURENBERGER who have worked in a bipartisan context.

Senator KENNEDY approached me on support for his legislation, and we discussed it at length. I told him what my interests were and what my concerns were. We sent a joint letter on April 6, 1994, to the Congressional Budget Office asking that my bill, S. 18, be costed out so we could see what might be done by incorporating some of the provisions which I have discussed. Regrettably, Mr. President, we never received an answer from the Congressional Budget Office on this point.

This is another long subject which I intended to touch on only very, very briefly.

But for purposes of the record, Mr. President, I ask unanimous consent that the letter that Senator KENNEDY and I sent to the Congressional Budget Office, dated April 6, along with a letter which I sent to the Congressional Budget Office on July 27, 1994, and the reply from the Congressional Budget Office, dated August 1, 1994, and also my letter to the Congressional Budget Office, dated April 2, 1993, and my second letter to him, dated May 3, 1993, and his response to both letters, dated May 17, 1993, be printed in the RECORD.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

U.S. SENATE,
Washington, DC, April 6, 1994.

Mr. ROBERT D. REISCHAUER,
Director, Congressional Budget Office, Washington, DC.

DEAR DIRECTOR REISCHAUER: We are concerned that, in costing comprehensive health reform legislation, the CBO may not be adequately assessing offsetting savings from some proposals directed at reducing health care costs. Such savings are often not factored into actuarial estimates of insurance premiums for a variety of reasons, including difficulty in tracing the impact of the savings on a plan-by-plan basis, short time horizons used in constructing the actuarial estimates, and reduction in health expenditures that may not directly affect spending by the plan itself. Nonetheless, a realistic assessment of such savings is vital to assessing the impact of health reform proposals on both Federal and private spending.

We would appreciate your providing our offices with a costing of a number of important savings proposals, with whatever justification is available to substantiate the estimates. The specific items we would like reviewed include the following proposals from S. 18:

1) Reducing low birth-weight births through expanding access to, and utilization of, prenatal care for high risk women;

2) Reducing "end of life" health care costs through increased utilization of advanced directives and "living wills;"

3) Expanding the utilization of non-physician providers within the Medicare and Medicaid programs; and,

4) Providing disclosure of information to consumers by providers in order to enable consumers to make better comparisons on cost and quality.

We think that items 1 and 2 should certainly be accessible for scoring on savings, and that 3 and 4 ought to be within the ambit of scoring as well.

As set forth in the floor statement for Senate Bill 18 (copy enclosed) and an updated version which has yet to be formally filed (copy enclosed), staff cost estimates suggest that substantial savings could be achieved from many of these proposals.

In addition, we would like you to estimate the independent cost impact of several proposals included in the Administration proposal, including:

Universal availability of preventive services without cost-sharing or deductibles;

Expanded availability of substance abuse treatment services;

Expanded investment in outcomes research and practice guidelines development;

Reform of medical malpractice; and

Reduction in nursing home utilization under Medicaid as the result of availability of home care services.

We would appreciate your careful review of this request and your expedited analysis of these proposals.

Sincerely,

EDWARD M. KENNEDY,
ARLEN SPECTER.

U.S. SENATE,
Washington, DC, July 27, 1994.

ROBERT D. REISCHAUER,
Director, Congressional Budget Office, Washington, DC.

DEAR BOB: I am writing regarding my prior correspondence to you requesting the Congressional Budget Office (CBO) to provide cost estimates of health care reform legislation I have introduced. To date, I have not received a scoring on the specific provisions of my legislation: S. 18, the "Comprehensive Health Care Act of 1993, and S. 631, the "Comprehensive Access and Affordability Health Care Act of 1993."

While I recognize that the CBO has received numerous requests for cost estimates, I am nonetheless, troubled that my longstanding requests have not yet been fulfilled. In view of the impending debate of health care legislation on the Senate floor and concerns with the impact reform legislation will have on the budget, I will be disadvantaged in proceeding with my amendments without CBO cost estimates. I would appreciate, therefore, your prompt attention and response to my request.

To facilitate your analysis, I am again enclosing specific provisions from my legislation which I expect to offer as amendments. They are:

(1) Health Care Cost Containment and Quality Grant Program to provide federal standards and award grants to states to develop health care cost containment information systems similar to Pennsylvania's Health Care Cost Containment Council.

(2) Primary and Preventive Care Services to establish a maternal and infant care federal grant program for prenatal care and early childhood health education programs.

(3) Patient Self Determination Act amendment to improve portability of advance directives and durable power of attorney.

(4) Reimbursement for non-physician providers to allow for direct reimbursement under Medicare and Medicaid programs to nurse practitioners, physician assistants, and certified midwives.

Excepting the first provision, these provisions were provided to you by letter dated April 6, 1994 from Senator Kennedy and me.

Again, it is important that I receive your estimates as soon as possible. If your staff has any questions they should contact Doug Loon or Rebecca Jones of my staff at 224-4254.

Sincerely,

ARLEN SPECTER.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 1, 1994.

Hon. ARLEN SPECTER,
U.S. Senate, Washington, DC.

DEAR SENATOR: Thank you for your letter of July 27, 1994, seeking cost estimates of the health care reform legislation you have introduced. I also acknowledge that you sent an earlier letter requesting estimates of specific provisions in S. 18 and S. 631.

Because heavy demands have been made this year for CBO analysis on a wide range of health plans, we sought guidance and direction from the leadership of both parties on how to establish priorities for these tasks. Working under their recommendations, to date we have analyzed the Administration's health proposal, the Managed Competition Act, and H.R. 1200 creating a single-payer program. We have also completed preliminary analyses of two reported bills—the Health Security Acts reported by the Senate Committee on Finance and the House Committee on Ways and Means.

As you know, in keeping with CBO's statutory charter, our mandated task is to provide cost estimates of those measures reported by committees. At this time, we do not have the capability of responding to all requests for cost analyses of health care proposals. We have had to inform a number of Members in both the Senate and the House that, while it is our intention to be helpful, we must place priority on a limited number of health reform proposals as directed by the leadership.

Consequently, at this time I cannot give you specific dates when responses to your requests can be provided. I realize the importance of your concern, and we will certainly make every effort to accommodate you, given the current constraints on our resources.

Sincerely,

ROBERT D. REISCHAUER.

U.S. SENATE,
Washington, DC, April 2, 1993.

ROBERT D. REISCHAUER,
Director, Congressional Budget Office, Washington, DC.

DEAR MR. REISCHAUER: This letter is to request that the Congressional Budget Office score the cost of Senate bill 631, the "Comprehensive Access and Affordability Health Care Act of 1993" which I introduced on March 23, 1993. A copy of the bill text is enclosed.

Please forward your reply to the attention of Sharon Helfant of my staff and do not hesitate to contact her at 224–4254 regarding any questions or comments.

Thank you for your timely consideration to this matter.

Sincerely,

ARLEN SPECTER.

U.S. SENATE,
Washington, DC, May 3, 1993.

ROBERT D. REISCHAUER,
Director, Congressional Budget Office, Washington, DC.

DEAR MR. REISCHAUER: This letter is regarding my April 2 correspondence to CBO requesting a cost estimate of Senate bill S. 631, the "Comprehensive Access and Affordability Health Care Act of 1993".

To date, I have not received any response. It is very difficult for me to respond to inquiries regarding the cost of my legislation without any response or information—in part or in full—from your office.

As you know, Congress depends upon CBO as a primary source for scoring proposed legislation, and given the high priority of health care reform, I would like to know why you have not responded to a request that was made over one month ago, and when I may expect one.

Thank you for your attention to this matter.

Sincerely,

ARLEN SPECTER.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 17, 1993.

Hon. ARLEN SPECTER,
U.S. Senate, Washington, DC.

DEAR SENATOR: I regret that the Congressional Budget Office was unable to prepare a spending estimate for your bill S. 631, the Comprehensive Access and Affordability Health Care Act of 1993. S. 641 is a major health reform bill and it will be a difficult and time-consuming task to estimate its costs.

Your April 2nd request arrived just as we began the very intensive period when we estimate the savings associated with the Congressional committees' responses to their reconciliation instructions. As you know, the Budget Resolution for 1994 requires committees to submit reconciliation provisions by May 14th in the House and by mid-June in the Senate. Because of the many committee requests in April and May, we have not been able to handle Members' requests for major cost estimating work in the health care area.

While we would like to be able to serve all Members all of the time, our resources are such that during periods of intensive legislative activity, we have to give priority to bills that are being considered by committees. I have asked Charles Seagrave (226–2820), who is in charge of cost estimating in the human resources area, to keep your staff apprised of our progress on estimating major health care reform proposals.

Finally, I regret the difficulties that lack of a CBO cost estimate caused during floor debate and hope that when you need CBO analytical assistance in the future, circumstances are such that we will be able to be fully responsive to your request.

Sincerely,

ROBERT D. REISCHAUER.

Mr. SPECTER. The upshot of the request, Mr. President, is that I never received an answer to any of my requests for scoring.

The people who may be watching on C–SPAN2 do not understand all of our procedures, but before an amendment can be offered on the floor, it has to be scored; that is, there has to be an estimate as to what it would cost so that we do not spend more than is allowed, that there is an offset, and that information has to be provided by the Congressional Budget Office.

I understand that the Congressional Budget Office gets a lot of requests. The thrust of their reply to me was that they did not have time to do it as they had to spend their time on committee bills.

But when I seek to offer an amendment on this very important subject, I am barred from doing so unless I have a Congressional Budget Office response. And when my letter goes out, along with the signature of Senator KENNEDY, who is the chairman of a key committee, you would think there would be a response—but there was not—as to what the scoring is. It was impossible for Senator KENNEDY and me to continue our discussions as to what cooperation I might give and how the ideas I had in S. 18 might have been incorporated at that early stage, long before Senator KENNEDY's committee reported out a bill. So that is part of the problem.

Mr. President, I really seek to accentuate the positive, as I have done here today in talking about what I think ought to be done. But we cannot overlook the legislative proposals which are pending, either on President Clinton's legislative proposal or on the substitute which has now been offered by Senator MITCHELL.

It is my view, and I say this as much as I can in a constructive way, that the legislation offered by President Clinton was much too bureaucratic and massive and too much of a change to provide the right answer for reform of health care in America. I think the same problem is present with Senator MITCHELL's program. It is much too bureaucratic and massive to provide the right answer for America's health care reform needs, contrasted with retaining the present system and targeting the specific problems, as I have suggested in my proposed legislation.

When I read President Clinton's health care proposal last fall, I was amazed by the number of agencies, boards, and commissions which were created in the Clinton health care bill. So I asked my staffer to make me a list of all of the agencies, boards, and commissions. Instead of making a list, my staffer made a chart. And the chart became somewhat famous when Senator DOLE used it in his reply to President Clinton's State of the Union speech last January.

I want to refer to the chart. I have done it before, so I will not do it for too long today. But most people have not seen my chart yet.

This is the Clinton plan, S. 1757, which shows the bureaucracy of President Clinton's health care plan. Every box in red is a new agency board or commission, and there are 105 new boards, agencies, councils, and commissions. The boxes in green are existing agencies which have expanded responsibilities.

I assigned the responsibility to make a list to my staffer, Sharon Helfant. She made the list and she made it in a very careful way through a chart.

Nobody paid much attention to it until Senator DOLE made his speech in his reply to the State of the Union. After that, the White House paid a great deal of attention. They gave it more publicity and popularity than I ever could have or Senator DOLE could have. They said it was a chart of the New York subway system, but the New York subway system is not this complicated.

Then they said it was a Republican plot. So the Washington Post went out and interviewed Sharon Helfant, the person who made the chart. Sharon Helfant told them things I did not know—that she was a Democrat; that she was a big fan of Hillary Clinton; that she had voted for the President; and that when she made up the chart she had taken a piece of paper, 8½ by 11, and had tried to put the chart on it, but it is was too big, so she had to Scotch tape paper together. And that is what you call a well-financed Republican conspiracy.

I do not know if it was coincidence or not, but shortly after Senator DOLE made this chart available in his nationally televised speech, President Clinton's health care proposal started to take a nose dive. Senator DOLE said it was his speech. I disagree with him. I think it was my chart that did it.

But it is plain that when this proposal was put forward, there were many, many people who liked it and wanted to have it adopted. But, as time has passed, there has been a consensus that it is too bureaucratic and simply too much.

That then led health care reform being considered by the Finance Committee and the Committee on Labor and Human Resources, and now Senator MITCHELL has taken on the responsibility of his own health care program.

And John McCann, an intern in my office, and Rebecca Jones of my staff, worked on a chart to put at one glance Senator MITCHELL's health care proposals.

This is the chart on the bill by Senator MITCHELL, S. 2357. Again, the graph is the same. Every box in red is a new agency, board, commission, or function and there are 170 new boards, agencies, councils, commissions, programs, and bureaucratic responsibilities. In green, there are the existing agencies which have new responsibilities.

Again, Mr. President, I believe that this program is much too costly and much too bureaucratic. It really throws out the baby with the bath water in not retaining the valuable points of the present system and working on targeting the specific problems.

Senator PACKWOOD has already made the point, and I shall not repeat it, about the changes in what Senator MITCHELL has already done. I compliment Senator MITCHELL on his effort. It is a massive job to try to bring forward a health care plan. The first draft I saw was in looseleaf form which was last Thursday, and John McCann, the intern from the Fells Institute at the University of Pennsylvania, went to work to put together the chart. Then we had a bill which was put out on Friday which may have been the same or may have been different. It was renumbered. Then we have a separate bill which has just been put out. And Senator PACKWOOD comments there is talk about putting out another bill.

The Washington Post reported yesterday, "Since Senator MITCHELL unveiled his plan last week, the legislation has been rewritten hundreds of times."

And there has been an evaluation by the Congressional Budget Office, which is the agency which tells us how much the plan is going to cost and how effective it is. On August 9, the day before yesterday, the Congressional Budget Office published what they call "a preliminary analysis of Senator MITCHELL's health care proposals". My suggestion to my colleagues and to the American people is that what we do on health care is much too important to handle by a preliminary analysis on legislation which is still being rewritten.

I ask unanimous consent that the full text of this Congressional Budget Office report appear at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 3.)

Mr. SPECTER. Again, this would be a very lengthy speech all by itself. But I would make reference to just a couple of comments here. I think the Congressional Budget Office is trying to be as kindly disposed and gently disposed to the bill by Senator MITCHELL as they can, but there are a lot of very serious questions and critiques raised in this report. For example, at page 11 the comment is made about the system of multiple subsidies:

> Integrating these three subsidies in a sensible and administrable fashion would be extremely difficult, especially if some families receive subsidies from more than one program.

At page 14 the report comments:

> Because of the disruptions, complications and inequities that would result, CBO does not believe it would be feasible to implement the mandated system in some States but not in others. The system would have to include all States or none.

And, on the mandate provision, that is a very, very key factor.

Then they come to the question of work incentives—and this is a subject which is being considered by Congress in trying to reform the welfare system, which is a priority item on the President's agenda and on mine, too, to try to find ways to take people off welfare and into good jobs. This is what the Congressional Budget Office report says on page 16.

Senator MITCHELL's proposal would discourage certain low-income people from working more hours, and in some cases from working at all, because subsidies would be phased out as family income increased.

As you take a look at this proposal, there are just an enormous number of questions which are raised and unanswered. When I went back to Pennsylvania last weekend, after reviewing the preliminarily draft of Senator MITCHELL's proposal, I heard a great many questions on the street. I ride Amtrak, and no sooner am I on Amtrak than people are saying, "Hey, what's going on with health care? What is Senator MITCHELL doing?"

That is the same question I am asked at the shopping mall in King of Prussia; the same question I get going out to the Phillies' baseball game. When I came back to Washington on Monday of this week and took the floor to manage, with Senator HARKIN, the final phases of our appropriations subcommittee report for appropriations for Labor, Health and Human Services, I made a statement that, although I had said many times in the past weeks and months that I would oppose any effort at a filibuster, I said I was not quite so sure, and I was rethinking it.

And I made a comment in my floor statement on Friday about a telephone call which I had made to my Aunt Rose over the weekend. My aunt Rose was an 18-year-old Secretary in Wichita, KS, when I was born, and has been sort of a surrogate mother to me for many years. I made a brief comment on the floor, which is worth just a moment. When the 1986 tax bill was considered, the creation of Senator PACKWOOD and Senator BRADLEY—Senator PACKWOOD is on the floor—I came to the floor and debated Senator BRADLEY about the flat tax, 28 percent. I asked Senator BRADLEY a question which my Aunt Rose had asked me, which is why should she pay 28 percent, the same rate as millionaires?

Senator BRADLEY did not give me a very good answer. Maybe Senator PACKWOOD has a better answer. Senator PACKWOOD is on the floor.

I think we made some mistakes—I say this respectfully—on that tax bill. We should have listened to Aunt Rose. But I made a comment on the Thursday night before we started the questioning of Professor Hill. My aunt called me and said, "I heard on television you are going to question Professor Hill." And she gave me some advice I did not take. So this time I called her and said, "What do you think about health care, Aunt Rose?"

She said, "I am very worried about it." She said, "I now have good coverage." She told me about a series of tests she had. I will not tell how old she is. She was 18 when I was born, but I will not say how old I am, either. She said, "I pay $91 a month and I like the care I am getting. I would like to see poor people covered, but I am worried about what is going on."

So after talking with a lot of people, including my Aunt Rose, I decided I was going to rethink this idea of a filibuster.

That thought was short-lived because—I do not want to get too personal with my family, but I have a good network that tells me what is going on with America. My aunt Ann called me from Chicago, IL—some press will probably call Aunt Ann Rosenberg—and said, "Don't get involved in a filibuster." Actually I got this message through my secretary. "We need health care legislation."

I will agree we do need health care legislation, and I have decided not to join in any filibuster attempt, but take up Senator MITCHELL's bill and see what we can do with it, and hopefully to craft a proposal which is a step at a time, and which does not undertake the enormous changes which Senator MITCHELL's bill would have.

On the timetable, I hear the talk about the necessity to get this legislation finished during this session of Congress so that it is a done deal before the November elections. I do not believe that we ought to have a timetable to serve either political party. I do not believe we ought to have a timetable for a filibuster which would stop the consideration of this bill. Although if at some point we come to the judgment that we have a monstrosity, something which is really awful for America, and something which can be controlled by the Democrats because they control the White House and both Houses of Congress, then we might have to reconsider whether we would prolong the debate and stop legislation which would be an anathema and really terrible for the American people.

I do not think we ought to do that at this point. But I do think we have to take our time. And it has to include consideration and input from the American people.

It would be very useful to have hearings on Senator MITCHELL's bill, but I do not think that is indispensable. But I do think it is necessary that there be talk in the country about what this legislation means; that there would be a time for analysis by the newspapers and a digestion by the American people; and the chance for editorial comment. Already the op-ed pages are containing comments about, "Let's not rush to do it this year. Let's wait until next year."

I am not saying they are right about waiting until next year. I think the Congress ought to take up the bill to see if we can do it in a nonpartisan way with Democrats reaching across the aisle to Republicans, Republicans reaching across the aisle to Democrats, to do it. But we ought not to be on any timetable.

If we have to sit through all of the August recess, so be it. And if we have to move beyond October 7, when we are scheduled to adjourn, so be it. We ought to take our time. If we cannot do it right, we should not do it at all. We ought to do what is good for America.

Mr. President, the cost of administration of these health care proposals is totally unpredictable. Senator HARKIN and I, in our capacities as chairman and ranking member of the Subcommittee on Health and Human Services, asked for the General Accounting Office to give us an estimate of what it would cost to set up the Clinton health care proposal.

At this time, I ask unanimous consent that the letter from Senator HARKIN and myself to the GAO dated November 30, 1993, and the reply from the General Accounting Office dated June 15, 1994, be printed in the RECORD.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
Washington, DC, November 30, 1993.

Mr. CHARLES A. BOWSHER,
Comptroller General, General Accounting Office, General Accounting Office Building, Washington, DC.

DEAR MR. BOWSHER: We are writing concerning the recent introduction of the Health Security Act, the President's comprehensive legislative proposal to extend affordable health care coverage to all Americans and to implement reforms to improve the quality and efficiency of the health care system. While we concur in the broad objectives outlined in the plan and look forward to working with the President and the relevant legislative committees, we believe that a careful analysis of all aspects of the proposal is essential.

As the Chairman and Ranking Member of the Senate Appropriations Subcommittee which has jurisdiction over funding for discretionary health programs, we are particularly interested in an analysis of the federal costs required to set up, administer and support the programs authorized in the legislation. This analysis is especially important given the action by the Congress to freeze discretionary appropriations over the next 4 years. We, therefore, request that the General Accounting Office conduct an in depth analysis by agency of the federal costs of administering the new health care system, and of fully funding the new and expanded authorizations of discretionary programs outlined in the legislation. The study should also examine the impact to these expenditures on overall health care spending.

Your prompt attention to this request is appreciated.

Sincerely,
TOM HARKIN,
Chairman,
Labor, HHS and Education Subcommittee.
ARLEN SPECTER,
Ranking Member.

U.S. GENERAL ACCOUNTING OFFICE,
HEALTH, EDUCATION AND HUMAN SERVICES DIVISION
Washington, DC, June 15, 1994.

Hon. ARLEN SPECTER,
Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations U.S. Senate.

DEAR SENATOR SPECTER: In November 1993, the President released his detailed legislative proposal for national health care reform. The proposed Health Security Act (HSA) is a comprehensive plan to provide universal health insurance for a broad range of services. The President's 1995 budget request to the Congress includes a $5.4 billion estimate of the federal expense to start up and administer the proposed new health care system over 6 years.

Concerned about how the administrative costs of implementing the proposed new health care system would be funded, given the limit Congress placed on discretionary appropriations,[1] you asked that we determine what justifications the administration used to support the federal administrative cost estimates that appear in the President's 1995 budget. Specifically, you asked that we identify the federal administrative functions that were considered and determine the underlying assumptions used to derive the estimated costs. On April 29, 1994, we briefed your staff on the results of our work.

In summary, the Office of Management and Budget (OMB) identified the federal functions required to implement the proposed HSA and estimated the federal administrative costs of starting up and supporting these functions over 6 years. OMB staff said that pricing out the proposed HSA was difficult. The staff attributed the difficulty in estimating the federal administrative costs to primarily two factors: (1) decisions had not been made about what entity would carry out some of the functions and (2) the staff was given a very short time frame to develop the estimates. The staff said that they did not document the assumptions they used and, in our discussions with them, they would not fully discuss the details of their estimating strategy. As a result, we could not reconstruct the information for you.

FEDERAL ADMINISTRATIVE COSTS TO IMPLEMENT HSA

OMB was responsible for identifying the federal administrative functions to implement the proposed HSA and for developing the administrative cost estimates that appear in the President's fiscal year 1995 budget. Normally, OMB does not independently prepare cost estimates for proposed legislation.[2] In this instance, however, OMB's budget examiners, not the executive branch departments or agencies, estimated the federal administrative costs for the administration. Moreover, while these estimates of federal costs appeared in the President's fiscal year 1995 budget, preparing them was conducted outside OMB's normal budget estimating processes.[3] OMB staff stated that they were asked to estimate the cost of the proposed bill in a very short time frame. Also, there was some uncertainty about whether some of the functions under the proposed new health care system would be carried out by the federal government, the states, or the proposed alliances. OMB staff stressed that these factors made estimating the federal administrative costs very difficult.

FUNCTIONS IDENTIFIED AND ANNUAL COSTS ESTIMATED FOR 6 YEARS

OMB staff identified the specific detailed federal administrative functions required under HSA and estimated the implementation cost of these functions rather than by a department or other entity such as the National Health Board (NHB) that would be responsible for the function. OMB did not provide cost estimates for each detailed federal administrative function. Instead, OMB grouped the detailed administrative functions and provided us annual federal cost estimates by four functional categories: (1) Information Systems and Quality Assurance, (2) Monitoring of States and Alliances, (3) Program Oversight and Financial Management, and (4) Transition to the New System. The estimates are of new or add-on costs. Table 1 shows, by these four functional categories, OMB's estimates of the federal administrative costs for implementing HSA over 6 years. Estimates of federal administrative costs for 1995 through the year 2000 totaled $5.4 billion. OMB staff did not determine federal full-time-equivalent employee requirements for HSA implementation.

TABLE 1.—PROPOSED HEALTH SECURITY ACT—OMB'S ADMINISTRATIVE COST ESTIMATES FOR FEDERAL FUNCTIONS

[In millions of dollars]

Functional Categories	Fiscal Years—						1995–2000
	1995	1996	1997	1998	1999	2000	
Information systems and quality assurance [1]	915	95	94	81	81	81	1,347
Monitoring of States and alliances [2]	40	92	174	241	272	279	1,098
Program oversight and financial management [3]	77	178	194	226	226	230	1,131
Transition to the new system [4]	247	527	726	353	7	8	1,868

Footnotes at end of article.

TABLE 1.—PROPOSED HEALTH SECURITY ACT—OMB'S ADMINISTRATIVE COST ESTIMATES FOR FEDERAL FUNCTIONS—Continued

[In millions of dollars]

Functional Categories	Fiscal Years— 1995	1996	1997	1998	1999	2000	1995–2000
Total, HSA start-up and administration	1,279	892	1,188	901	586	598	5,444

[1] HSA specifies that the federal government would help develop and maintain a health information network; establish a National Quality Management Program; provide technical assistance to alliances, states, and health plans; and set standards to implement privacy protections, malpractice reforms, and administrative simplification measures.

[2] Under HSA, the federal government would oversee key state and alliance functions. The federal government would monitor alliance financial operations (including audits of alliances); ensure that plans and alliances conform to applicable regulatory requirements; make certain that employers make premium contributions and provide insurance through qualified plans; oversee the administration of premium targets; monitor and audit employer subsidies; and back up state guarantee funds.

[3] Federal responsibilities under HSA would include development of rules and standards for and overall financial oversight of the new system. The pricing reflects several oversight functions, including update of the comprehensive benefits package, examination of new drug prices, development of rules for health plans, monitoring of alliance grievance procedures, development of a risk adjustment system, monitoring health care prices and expenditures, and supporting antitrust reform and fraud and abuse prevention activities.

[4] The federal government would help states make the transition to the new system. The federal government would administer planning and start-up grants, issue standards for health plans during the transition, process state waivers, and administer a national risk pool for the uninsured during the period prior to phase-in of universal coverage.

Sources.—Analytic Perspectives, Budget of the United States Government, fiscal year 1995; and OMB staff.

In discussions with us, OMB staff added the following qualifiers to the federal cost estimates they developed for HSA start-up and administration:

Administrative costs associated with providing health security cards are not included in the estimates because OMB staff assumed this would be an alliance function rather than a federal function.

Start-up costs are reflected in the first 2 years (1995 and 1996).

The $1.279 billion estimate for 1995 costs was designated PAYGO.[4] OMB staff told us that this was done because the estimated costs would exceed the discretionary spending cap for that year. The administration suggested that revenue from a tobacco tax would be used to fund these costs.

NO RECORD OF ESTIMATING ASSUMPTIONS

OMB staff told us that they did not document the assumptions they used to estimate federal costs for HSA start-up and administration, and they would not reconstruct the information for us. In discussions with us, OMB staff provided sketchy information about the assumptions used to cost-out the detailed federal administrative functions they identified in the proposed HSA. In some cases, they extrapolated from existing functions. Where they extrapolated or used proxy measures, however, they did not disclose any dollar values associated with their analyses. Furthermore, they did not provide any information on analyses they conducted that showed the difference in magnitude, if any, between the proxies they used and the proposed federal administrative functions. OMB staff provided some information about their estimating assumptions and the rationale they used in costing out the federal administrative functions for implementing the proposed HSA (see enclosure).

In conclusion, OMB staff did not provide us complete information about the underlying assumptions they used to estimate the federal costs for HSA start-up and administration. The staff stated that they did not follow their normal budget estimating process. They made the budget estimates in a short time frame and based them on proposed legislation that did not have responsibilities for some of the functions clearly defined. OMB staff said they did not document their estimating assumptions and were reluctant to discuss the details of their work.

To identify the federal functions and determine the estimating assumptions the administration used, we met with staff from OMB and the Department of Health and Human Services (HHS).[5] HHS officials told us they had no involvement in estimating the federal costs and did not know what estimating assumptions OMB used. As agreed with your staff, we did not attempt independently to estimate the federal costs of administering the proposed new system or measure the impact of the expenditures on overall health care spending. Also, we did not evaluate the appropriateness of the estimating assumptions used. We conducted our work from February to May 1994, in accordance with generally accepted government auditing standards.

OMB officials reviewed a draft of this correspondence and offered some technical changes. We made the technical changes as appropriate.

We are sending copies of this correspondence to the Chairman of the Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Senate Committee on Appropriations, and the Director of the Office of Management and Budget. We will also make copies available to others on request.

Please contact James O. McClyde, Assistant Director, at (202) 512-7119, if you have any questions about this letter.

Sincerely yours,

SARAH F. JAGGAR

(For Mark V. Nadel).

Enclosure.

PROPOSED HEALTH SECURITY ACT—INFORMATION OMB PROVIDED ABOUT ESTIMATING ASSUMPTIONS THEY USED TO COST OUT FEDERAL ADMINISTRATIVE FUNCTIONS

(By functional category)

Information Systems and Quality Assurance:

About 60 percent of 1995 costs is for start-up of this function.

Standard-setting would be a major part of this function.

The federal government would not build new data systems because existing systems can be expanded.

Private sector data systems that could be used include Blue Cross and Blue Shield's electronic claims system.

Analogues considered in pricing this function were resources of the Health Care Financing Administration (information systems) and the Social Security Administration (system resources), and data from the Agency for Health Care Policy and Research (quality management data) and the Aid to Families With Dependent Children program (quality control data).

NHB will probably contract out any additional work it is responsible for under this function.

DOL's responsibilities would be very small.

Monitoring of States and Alliances:

About 50 to 75 percent of 1995 costs would be for standard-setting.

Most of the total cost would be for federal staff to monitor alliances and employers.

It is not very likely that DOL would have to take over corporate alliances, so a very small cost was included for readiness.

Program Oversight and Financial Management:

About 10 percent or less of 1995 costs would be for start-up.

Many main NHB functions would be included.[6]

Some standard-setting would be included along with ongoing activities such as updating the benefits package.

Most of the costs would be for federal staff, including a small HHS staff to monitor health care prices and expenditures[7] and the HHS Inspector General's office to conduct fraud and abuse reviews.

It is not very likely that HHS would have to take over alliances, so a small cost was included for readiness.

Transition to the New System:

About 90 percent of the costs would be associated with setting up and administering a national risk pool and for grant administration.

FOOTNOTES

[1] The Budget Enforcement Act of 1990 (BEA) contains procedures designed to enforce the deficit reduction agreement. The act divides the budget into two mutually exclusive categories: (1) discretionary programs and (2) direct spending. The act also provides pay-as-you-go (PAYGO) procedures for legislation affecting direct spending or receipts. For 1991 through 1995, among other provisions, the act limits discretionary spending. The Omnibus Budget Reconciliation Act of 1993 extended the discretionary spending limits through 1998.

[2] OMB is responsible for cost estimates used in the President's budget and for enacted legislation to meet the requirements of BEA. OMB is also responsible for pricing legislative proposals on behalf of the administration. However, in fulfilling these responsibilities, OMB generally relies on executive branch agencies to prepare initial cost estimates. OMB budget examiners then review and modify these estimates as needed.

[3] Under the normal executive budget formulation process, beginning in the fall, OMB works closely with agencies to prepare cost estimates of agency activities to be incorporated in the President's budget. As agencies prepare their budgets for submission to OMB, they maintain continuing contact with OMB budget examiners. OMB also provides agencies detailed instructions for preparing submissions through Circular A–11. This process is more fully described in appendix I of A Glossary of Terms Used in the Federal Budget Process (GAO/AFMD-2.1.1).

[4] Under BEA, PAYGO requirements stipulate that any new legislation that increases direct (mandatory) spending or decreases receipts be deficit neutral (that is, not increase the deficit). For discretionary programs, the act establishes discretionary spending caps or limits. These measures are designed to reduce or limit the growth in the federal budget deficit. BEA rules require that new accounts or activities be categorized in consultation with the House and Senate Committees on Appropriations and the Budget.

[5] We interviewed officials from HHS' Offices of the Assistant Secretary for Program Evaluation and Assistant Secretary for Management and Budget.

[6] OMB did not use analogues/proxies for estimating NHB costs. They assumed a staff of about 30 people and one auditor per alliance for financial monitoring. OMB officials talked about the Federal Reserve Board and the Securities Exchange Commission as possible models for costing-out the NHB financial management responsibilities.

[7] The Health Care Financing Administration already publishes some health care price data.

(Mr. KERREY assumed the chair.)

Mr. SPECTER. Mr. President, again, this would be the topic of a long speech all by itself. I think it is important and I want to make a brief comment about it.

The General Accounting Office said they went to the OMB staff and they could not tell us what the overhead administrative costs would be of President Clinton's health care program. Quoting from page 5 of the report by the General Accounting Office:

> OMB staff told us they could not document the assumptions they used to estimate Federal costs for the Health Security Act's —

President Clinton's act.

> startup and administration, and they would not reconstruct the information for us. The staff stated that they did not follow their normal budget estimate process. OMB staff said they did not document their estimating assumptions and were reluctant to discuss the details of their work.

I think these are questions which need to be answered. The cost of President Clinton's bill is no longer relevant, but the cost of Senator MITCHELL's bill is relevant.

Mr. President, when we talk about estimates, and we have the comments by the Congressional Budget Office, I think it is very important to focus on the undisputed facts that these estimates often go awry, are invariably wrong, and invariably understate what the cost would be.

Information provided to me—and one of the difficulties, as I said before, is knowing what is exactly accurate, but I believe these figures to be accurate—show the enormous increase in costs of Medicare and Medicaid over what was originally projected.

Medicare was projected in 1965 to total $9 billion in spending in 1990. Instead, the cost of Medicare was $106 billion. That is more than 11 times the estimated cost. Or on a percent basis, 1,177 percent.

When Medicaid was started, it was projected in 1965 to cost less than $1 billion in spending in 1990. Instead, Medicaid costs $76 billion a year, or 76 times the cost, or as a percentage, 7,600 percent.

One of the things we have to do in our consideration of health care legislation is accommodate the interests of senior citizens—and I think we need long-term health care and prescription drugs. And we have to consider the next generation and what we are doing to the deficit. The one subject which has been discussed more than any other in the 14 years that I have been here has been the deficit.

No matter what we try to do, we cannot seem to get the annual deficit under $250 billion. The national debt is now $4.5 trillion. None of us would think of taking our children's credit cards or our grandchildren's credit cards and going out on a spending spree. I am not saying this is necessarily a spending spree, but it is money which we do not have.

The entitlement program which is present under Senator MITCHELL's legislation is an enormous entitlement program which will involve, under current projections, enormous deficits and, by the experience with Medicare and Medicaid, are totally out of sight.

It is curious that 1 day earlier than the Congressional Budget Office's preliminary analysis, we have the Bipartisan Commission on Entitlements and Tax Reform issuing a statement about the danger to America. This can be capsulated in one sentence, and this again is a matter for very extensive analysis and consideration:

> The Bipartisan Commission on Entitlement and Tax Reform today adopted an interim report to the President starkly depicting the need for the President and a bipartisan coalition in Congress to enact entitlement reforms to preserve the standard of living of future generations of Americans.

I note the change of the hour, which reminds me that I have been going on a little long. I am about to conclude. "In conclusion" are the two most popular words of any speech.

I note there has been a change in the Presiding Officer to the distinguished Senator from Nebraska, Senator KERREY, who is a cochairman of this Commission. We are struggling to limit entitlements and expenditures, and if we are to preserve financial stability in America, so says this bipartisan Commission report, we have to get entitlements under control.

The legislative proposals put forward by Senator NUNN and Senator DOMENICI were drawing more votes from Senators. Several years ago, they got about 28 votes; last year, about 45 votes. We have to know what we are doing when we move ahead with health care reform.

So my view is that the massive bureaucracies which the President suggests and which Senator MITCHELL suggests are not the answer for Americans. The answer is to retain the current system, which provides the best health care in the world to 86.1 percent of the American people, and to target specific reforms such as contained in S. 18.

I am sorry to have taken so long. There is a great deal more I would like to say, but there are others on the floor who are awaiting recognition. I think this will be a historic debate, Mr. President. I am hopeful that we can come to agreement in a bipartisan way, and reach the goal many were talking about: A health care bill that 70 or more Senators can agree to which would not bankrupt America but which would reform the health care system and take care of the problems of coverage, portability, preexisting conditions, and spiraling health care costs.

I yield the floor.

EXHIBIT 1

TITLE I—HEALTH CARE INSURANCE REFORM PROVISIONS

Subtitle A—Model Health Care Insurance Benefits Plan

Sec. 101. Model health care insurance benefits plan.
Sec. 102. Definitions

Subtitle B—Managed Care

Sec. 111. Development of standards for managed care plans.
Sec. 112. Preemption of provisions relating to managed care.

Subtitle C—Small Employer Purchasing Groups

Sec. 121. Qualified small employer purchasing groups.
Sec. 122. Preemption from insurance mandates for small employer purchasing groups.

Subtitle D—Insurance Market Reform

Sec. 131. Failure to satisfy certain standards for health care insurance provided to small employers.

Subtitle E—Deduction for Health Insurance Costs of Self-Employed Individuals

Sec. 141. Increase in deductible health insurance costs for self-employed individuals.

TITLE II—PRIMARY AND PREVENTIVE CARE SERVICES

Sec. 201. Maternal and infant care coordination.
Sec. 202. Reauthorization of certain programs providing primary and preventive care.
Sec. 203. Comprehensive school health education program.
Sec. 204. Comprehensive early childhood health education program.

TITLE III—DISCLOSURE OF CERTAIN INFORMATION TO BENEFICIARIES UNDER THE MEDICARE AND MEDICAID PROGRAMS

Sec. 301. Regulations requiring disclosure of certain information to beneficiaries under the medicare and medicaid programs.
Sec. 302. Outreach activities.

TITLE IV—PATIENT'S RIGHT TO DECLINE MEDICAL TREATMENT

Sec. 401. Right to decline medical treatment.
Sec. 402. Federal right enforceable in Federal courts.
Sec. 403. Suicide and homicide.
Sec. 404. Rights granted by States.
Sec. 405. Effect on other laws.
Sec. 406. Information provided to certain individuals.
Sec. 407. Recommendations to the Congress on issues relating to a patient's right of self-determination.
Sec. 408. Effective date.

TITLE V—PRIMARY AND PREVENTIVE CARE PROVIDERS

Sec. 501. Increasing payments to certain nonphysician providers under the medicare program.
Sec. 502. Requiring coverage of certain nonphysician providers under the medicaid program.
Sec. 503. Medical student tutorial program grants.
Sec. 504. General medical practice grants.
Sec. 505. Payments for direct and indirect graduate medical education costs.

TITLE VI—MEDICARE PREFERRED PROVIDER DEMONSTRATION PROJECTS

Sec. 601. Establishment of medicare primary and specialty preferred provider organization demonstration projects.

TITLE VII—COST CONTAINMENT

Sec. 701. New drug clinical trials program.
Sec. 702. Medical treatment effectiveness.
Sec. 703. Health care cost control—expenditure targets.

TITLE VIII—LONG-TERM CARE

Subtitle A—Tax Treatment of Qualified Long-Term Care Insurance Policies

Sec. 801. Amendment of 1986 Code.
Sec. 802. Definitions of qualified long-term care insurance and premiums.
Sec. 803. Treatment of qualified long-term care insurance as accident and health insurance for purposes of taxation of insurance companies.
Sec. 804. Treatment of accelerated death benefits under life insurance contracts.

Subtitle B—Tax Incentives for Purchase of Qualified Long-Term Care Insurance

Sec. 811. Credit for qualified long-term care premiums.
Sec. 812. Deduction for expenses relating to qualified long-term care.
Sec. 813. Exclusion from gross income of benefits received under qualified long-term care insurance.
Sec. 814. Employer deduction for contributions made for long-term care insurance.
Sec. 815. Inclusion of qualified long-term care insurance in cafeteria plans.
Sec. 816. Exclusion from gross income for amounts withdrawn from individual retirement plans and section 401(k) plans for qualified long-term care premiums and expenses.
Sec. 817. Exclusion from gross income for amounts received on cancellation of life insurance policies and used for qualified long-term care insurance.
Sec. 818. Use of gain from sale of principal residence for purchase of qualified long-term health care insurance.

Subtitle C—Medicaid Amendments

Sec. 821. Expansion of medicaid eligibility for long-term care benefits
Sec. 822. Effective date.

EXHIBIT 2

U.S. SENATE,
Washington, DC, October 31, 1990.

Hon. LOUIS W. SULLIVAN,
Secretary, Department of Health and Human Services, Washington, DC.

DEAR LOU: Today, I visited Mr. Leonard Abramson, President of U.S. Healthcare, Inc., at their operations in Bluebell, Pennsylvania.

After touring U.S. Healthcare's highly automated and computerized facility, I then discussed with Mr. Abramson in some detail their methods of containing costs. I then asked Mr. Abramson if his success could be applied to federal health care expenditures and he replied that they could be in Medicare.

Mr. Abramson suggested a pilot program by asking 100,000 volunteer Medicare patients, perhaps based in the Philadelphia area, to be subject to the test procedures contrasted with another 100,000, again in the Philadelphia area, who were a control group but not subject to the test procedures.

Mr. Abramson felt that it would be realistic to save as much as 20% by using the methods for his company employees.

He said that he would be willing to administer the test program without any fixed charges with the fee of 5% of the savings actually realized.

I strongly believe that this is an idea worth pursuing.

Obviously, the U.S. government would have nothing to lose if there were no savings and much to gain if the procedures of Mr. Abramson's company could set a pattern with significant cost reduction which could be applicable nationwide.

I am asking Mr. Pat Meehan, the Executive Director of my Philadelphia office, to contact your Administrative Assistant early next week to pursue this proposal.

My best.

Sincerely,

ARLEN SPECTER.

U.S. SENATE,
Washington, DC, April 8, 1991.

Hon. LOUIS W. SULLIVAN,
Secretary, Department of Health and Human Services, Washington, DC.

DEAR LOU: Last October 31 I wrote to you (copy enclosed) concerning a suggestion by Mr. Leonard Abramson, President of U.S. Healthcare, Inc. on reducing Medicare costs.

There have been a number of meetings between Mr. Abramson and his representatives with personnel from your Department; but Mr. Abramson's suggestions have not been carried out because of bureaucratic red tape.

Your Department wants to give Mr. Abramson's company a grant which he does not want and the forms and protocol seem to be defeating his extraordinary suggestion.

Based on his tremendous success in this field, Mr. Abramson is convinced that he could save Medicare 20 percent which would constitute a savings approaching $20,000,000,000.

I called Mr. Abramson again today and he would be willing to reduce the sample from 100,000 to 25,000 and would be willing to forego the fee of five percent of the savings actually realized which had been originally suggested.

Mr. Abramson would like to participate in any follow-up programming with a reasonable fee for his services; but, as I understand it, he would be willing to await the outcome of this project to discuss that arrangement with your Department.

If your personnel and Mr. Abramson with his personnel cannot work this out, then I would like to have the three of us, you, Mr. Abramson and me, sit down to try to work out this important proposal on the issue of medical costs which is at the forefront of our nation's problems.

Sincerely,

ARLEN SPECTER.

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, April 19, 1991.

Hon. ARLEN SPECTER,
U.S. Senate, Washington, DC.

DEAR ARLEN: Thank you for your recent letter of April 8, 1991, on behalf of Mr. Leonard Abramson, regarding medicare.

We will be responding to the issues you raised as quickly as possible.

Thank you for bringing your concerns to my attention.

Sincerely,

LOUIS W. SULLIVAN, M.D.

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, June 4, 1991.

Hon. ARLEN SPECTER,
U.S. Senate, Washington, DC.

DEAR ARLEN: I am responding to your letter concerning the Department's response to a suggestion offered by Mr. Leonard Abramson, President of U.S. Healthcare, Inc., to reduce Medicare cost.

I have been advised that staff from the Office of Research and Demonstrations (ORD) within the Health Care Financing Administration (HCFA) met with Mr. Abramson on December 14, 1990. At this meeting Mr. Abramson and his staff presented a broad concept for providing specialized medical care through a preferred provider network. HCFA staff expressed considerable interest in the concept and offered to provide assistance as he worked out details of the formal proposal necessary for approval and implementation of a demonstration project.

HCFA staff subsequently met with Dr. Steven Zatz of U.S. Healthcare on January 24, 1991, to further discuss the Medicare applicability of the concept and to describe the process for carrying out a Medicare demonstration. Dr. Zatz indicated that he would initiate ongoing dialogue with HCFA if U.S. Healthcare decided to pursue a demonstration proposal. HCFA staff have not been contacted since the January 24 meeting.

Because this type of demonstration would apparently affect Medicare beneficiaries' choice of providers and could require new payment provisions, a formal process for awarding Medicare research and demonstration waivers and development of a contractual arrangement with U.S. Healthcare is required. HCFA advises it will try to make the required process expedient and informational.

Another avenue for U.S. Healthcare, Inc., might be the President's proposal in the Fiscal Year 1992 Budget for a new Medicare coordinated care option called "Point of Service." We are still developing the details of the proposal. You should hear more about this in the near future.

HCFA would welcome renewed discussions with U.S. Healthcare of our mutual interests in innovative coordinated care delivery systems for the Medicare program and will contact Mr. Abramson to reaffirm the offer of assistance.

I appreciate your interest in the Department's research and demonstration initiatives in the Medicare program.

Sincerely,

LOUIS W. SULLIVAN, M.D.

EXHIBIT 3

A PRELIMINARY ANALYSIS OF SENATOR MITCHELL'S HEALTH PROPOSAL, AUGUST 9, 1994

(By the Congressional Budget Office)

INTRODUCTION

The Congress Budget Office (CBO) and the Joint Committee on Taxation (JCT) have prepared this preliminary analysis of Senate Majority Leader George Mitchell's health proposal, as introduced on August 9, 1994. The analysis is based on the text of S. 2357 as printed on August 3 and subsequent revisions specified by the Majority Leader's staff. Because the estimate does not reflect detailed specifications for all provisions or final legislative language, it must be regarded as preliminary.

The first part of the analysis is a review of the financial impact of the proposal. The financial analysis includes estimates of the proposal's effects on the federal budget, the budgets of state and local governments, health insurance coverage, and national health expenditures. It also includes a description of the aspects of the proposal that differ from S. 2357, as well as other major assumptions that affect the estimate.

The second part of the analysis comprises a brief assessment of considerations arising from the proposal's design that could affect its implementation. The issues examined in this discussion are similar to those considered in Chapters 4 and 5 of CBO's analyses of the Administration's health proposal and the Managed Competition Act.

FINANCIAL IMPACT OF THE PROPOSAL

Senator Mitchell's proposal aims to increase health insurance coverage by reforming the market for health insurance and by subsidizing its purchase. If these changes failed to increase health insurance coverage to 95 percent of the population by January 1, 2000, coverage would become mandatory in 2002 in states that fell short of the goal. Individuals in those states would be required to purchase insurance, and employers with 25 or more workers would be required to pay half of the cost of insurance for them and their families.

In CBO's estimation, the proposal would just meet its target of 95 percent coverage without imposing a mandate. Because the actual outcome could easily fall short of the estimate, however, this analysis shows the effects of the proposal both without the mandate and with the mandate in effect nationwide. In both cases, the proposal would slightly reduce the federal budget deficit, and it would ultimately reduce the pressure on state and local budgets as well. But the expansion of coverage would add to national health expenditures.

The estimated effects of the proposal are displayed in the six tables at the end of this document. Tables 1 and 2 show the effects on federal outlays, revenues, and the deficit. Tables 3 and 4 show the effects on the budgets of state and local governments. Tables 5 and 6 provide projections of health insurance coverage and national health expenditures, respectively.

Like the estimates of other proposals for comprehensive reform—such as the single-payer plan, the Administration's proposal, the Managed Competition Act, and the bills reported by the Committee on Finance and Ways and Means—CBO's estimates of the effects of this proposal are unavoidably uncertain. Nonetheless, the estimates provide useful comparative information on the relative costs and savings of the different proposals. In estimating Senator Mitchell's proposal, CBO and JCT have made the following major assumptions about its provisions.[1]

Health Insurance Benefits and Premiums

Senator Mitchell's proposal would establish a standard package of health insurance benefits, whose actuarial value would be based on that of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program. The Congressional Research Service and CBO estimate that such a benefit package would initially be 3 percent less costly than the average benefit of privately insured people today and 8 percent less costly than the benefit package in the Administration's proposal.

The proposal adopts the four basic types of health insurance units included in the Administration's proposal—single adult, married couple, one-parent family, and two-parent family. In addition, separate policies would be available for children eligible for subsidies, as explained below.

In general, workers in firms with fewer than 500 full-time-equivalent employees (and their dependents) and people in families with no connection to the labor force would purchase health insurance in a community-rated market. Firms employing 500 or more workers would be experience-rated. States would operate a risk-adjustment mechanism covering both community-rated and experience-rated plans, thereby narrowing the differences between the average premiums in the two insurance pools. The estimated average premiums in 1994 for the standard benefit package for the four types of policies in both pools are as follows:

Single Adult—$2,220.
Married Couple—$4,440.
One-Parent Family—$4,329.
Two-Parent Family—$5,883.

Supplementary insurance would be available to cover cost-sharing amounts and services not included in the standard benefit package.

Subsidies

Starting in 1997, the proposal would provide subsidies for low-income people and certain firms to facilitate the purchase of health insurance. The system of subsidies would change somewhat if a mandate to purchase insurance went into effect. States would determine eligibility for subsidies and distribute subsidy payments to health plans.

Without a Mandate in Effect. The proposal would make low-income families eligible for premium subsidies. Recipients of Aid to Families with Dependent Children (AFDC) and families with income below 100 percent of the poverty level would be eligible for full subsidies, and those with income between 100 percent and 200 percent of poverty would be eligible for partial subsidies. For children and pregnant women, full subsidies would extend to 185 percent of the poverty level and partial subsidies to 300 percent of poverty. In addition, workers who become temporarily unemployed would be eligible for special subsidies for up to six months. Families could become eligible for more than one type of subsidy at the same time. Families could use the special subsidies for children and pregnant women to help purchase coverage for the entire family, or they could purchase coverage only for the eligible individuals.

States would be required to establish and administer a program of enrollment outreach that would allow people eligible for full subsidies of their premium to sign up for health insurance with health care providers whenever they sought health care services. People eligible for health insurance under this provision would be counted as insured in determining whether the target of 95 percent coverage is met.

In determining eligibility for premium subsidies, a family's income would be compared with the federal poverty level for that family's size. The maximum amount of the subsidy would be based on family income relative to the poverty level and on the weighted average premium for community-rated health plans in the area. The estimate assumes that a family's subsidy could not exceed the amount it paid for coverage in a qualified health plan. Therefore, if an employer paid a portion of the premium, the subsidy could at most equal the family's portion of the premium.

People with income up to 150 percent of the poverty level, as well as AFDC recipients, would be eligible for reduction cost sharing if they were unable to enroll in a plan proving a low or combination cost-sharing schedule. AFDC recipients in low or combination cost-sharing plans would also be eligible for cost-sharing assistance. The amount of assistance would vary slightly for the two groups. In both cases, health insurance plans would be required to absorb the cost of the reduced cost sharing.

Employers who voluntarily expanded health insurance coverage to classes of workers whom they previously did not cover could also receive temporary subsidies. Employers would become eligible for a subsidy if they began paying at least 50 percent of the cost of coverage for an additional class of worker. In the first year, the amount of the subsidy for each worker would equal the difference between half of the average insurance premium in the area (or in the worker's plan, if lower) and 8 percent of the worker's wage. Over the following years, the subsidy would be gradually phased out.

With Mandate in Effect

If a mandate to purchase insurance went into effect in a state, the system of subsidy would change. Subsidies for families with income up to 200 percent of the poverty level would remain, as would subsidies for people who were temporarily unemployed. The special subsidies for children and pregnant women would be eliminated, however, as would the subsidies for employers who voluntarily expanded coverage.

Medicaid and Medicare

Medicaid beneficiaries not receiving Supplemental Security Income or Medicare would be integrated into the general program of health care reform and would be eligible for federal subsidies in the same way as other low-income people. For these people, Medicaid would continue to cover services not included in the standard benefit package. For children, Medicaid would also continue to cover services whose scope or duration exceeded that in the standard package. States would be required to make maintenance-of-effort payments to the federal government based on the amount by which their Medicaid spending was reduced in the first year. The proposal would phase out federal Medicaid payments to disproportionate share hospitals and replace them with a program to make payments to financially vulnerable hospitals.

The proposal would expand Medicare by adding a prescription drug benefit for outpatients starting in 1999. The Secretary of Health and Human Services would set the deductible so that the net incurred cost of the benefit would total $13.4 billion in the first year. In CBO's estimation, the initial deductible would be about $700. The deductible would be indexed in later years so as to hold constant the proportion of Medicare beneficiaries receiving some drug benefit.

Reductions in Medicare spending would provide a major part of the funding for the proposal. The growth in reimbursement rates for hospitals covered by Medicare's prospective payment system would be reduced by 1 percentage point in 1997 and by 2 percentage points each year from 1998 through 2004. Payments to disproprtionate share hospitals would be cut in half. Reimbursements to physicians and other providers of health care services would also be restrained. Beneficiaries would be required to pay higher premiums for Supplementary Medical Insurance (SMI) and part of the cost of laboratory services and home health care.

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[1] For descriptions of CBO's estimating methodology, see Congressional Budget Office, An Analysis of the Administration's Health Proposal (February 1994), and An Analysis of the Managed Competition Act (April 1994).

Other Spending

The proposal would restructure the system of subsidies for medical education and academic health centers. Current payments from Medicare for direct and indirect medical education would be terminated. New programs would provide assistance for academic health centers, graduate medical education, graduate training for nurses, medical schools, schools of public health, and dental schools.

The proposal would create several additional mandatory spending programs. A capped entitlement program would help states finance home- and community-based care for the severely disabled; spending for this program would be limited to $48 billion over the 1998–2004 period. A biomedical and behavioral research trust fund would be financed by a portion of the assessment on private health insurance premiums starting in 1997. The proposal would also provide direct spending authority for a variety of public health initiatives totaling almost $10 billion in the 1996–1999 period and almost $15 billion in the 1996–2004 period.

The assurance of access to health insurance and the provision of subsidies to low-income families would encourage some older workers to retire earlier and would raise outlays for Social Security retirement benefits. Over the long term, Social Security would incur no additional costs, because benefits are actuarially reduced for early retirement.

Revenues

The Joint Committee on Taxation has estimated the impact of the provsions of the proposal that would affect federal revenues. The bulk of the additional revenues would stem from an increase in the tax on tobacco, a 1.75 percent excise tax on private health insurance premiums, and a tax on health plans whose premiums grew by more than a specified rate. The proposal would also increase SMI premiums for single individuals with income over $80,000 and couples with income over $100,000.

Fail-Safe Mechanism

The proposal would scale back eligibility for premium subsidies, increase the deductible for the Medicare drug benefit, and reduce every other new direct spending program as necessary to offset an increase of more than $10 billion in the cost of the bill and the Medicare and Medicaid compared with the initial estimate. Because the reductions would be applied proportionately, to the extent possible, to all the direct spending programs in the proposal, the bulk of any savings would have to come from limiting eligibility for subsidies. As a result, application of the fail-safe mechanism could make previously eligible people ineligible for subsidies and would, in the absence of a mandate, reduce the extent of health insurance coverage.

Budgetary Treatment of the Mandate

A mandate requiring that individuals purchase health insurance would be an unprecedented form of federal action. The government has never required individuals to purchase any good or service as a condition of lawful residence in the United States. Therefore, neither existing budgetary precedents nor concepts provide conclusive guidance about the appropriate budgetary treatment of a mandate. Good arguments can be made both for and against including in the federal budget the costs to individuals and firms of complying with the mandate. It is only appropriate, therefore, for policymakers to resolve the issue through legislation.

Some budget analysis argue that the costs of the mandate should be included in the Federal budget because these transactions would be predominantly public in nature. A second argument for inclusion, closely related to the first, is that the premiums that people would have to pay to comply with the mandate would be compulsory payments and should therefore be recorded as governmental receipts. A third argument is that including these costs in the budget would preserve the federal budget as a comprehensive measure of the amount of resources allocated through collective political choice at the national level.

There are also cogent arguments against including the costs of complying with the mandate in the budget. First, the costs would not flow through federal agencies or other entities established by federal law. Unlike the Administration's proposal, this proposal would not require participation in federally mandated health alliances. Second, this approach would be consistent with the current practice of excluding from the budget the costs to private firms of federal regulatory mandates. Third, the costs of compliance could not be directly observed and would not flow through the federal Treasury.

OTHER CONSIDERATIONS

Like other fundamental reform proposals, Senator Mitchell's would require many changes in the current system of health insurance. For the proposed system to function effectively, new data would have to be collected, new procedures and administrative mechanisms developed, and new institutions and administrative capabilities created. In preparing the quantitative estimates presented in this assessment, the Congressional Budget Office has assumed not only that all those things could be done but also that they could be accomplished in the time frame laid out in the proposal.

There is a significant chance that the substantial changes required by this proposal—and by other systemic reform proposals—could not be achieved as assumed. The following discussion summarizes the major areas of potential difficulty as well as some other possible consequences of the proposal.

Risk Adjustment

Most health care proposals that would create community-rated markets for health insurance also incorporates provisions to adjust health plans' premiums for the actuarial risk of their enrollees. These provisions are intended to redistribute premium payments among health plans, compensating them for differences in risk. Although effective risk-adjustment mechanisms would be essential for the functioning of community-rated markets, the feasibility of developing and implementing such mechanisms successfully in the near future is highly uncertain.

The risk-adjustment mechanism in this proposal is more complex than those in other proposals analyzed by CBO. Most other proposals would restrict risk adjustment to the community-rated market; in Senator Mitchell's proposal, risk adjustment would operate in both the community-rated and the experienced-rated markets in each community-rating area. The risk-adjustment mechanism would attempt to recompense plans for the higher costs associated with certain groups of enrollees. It would also adjust payments to health plans to reflect the cost-sharing subsidies for low-income participants that health plans would have to absorb. Such transfers would ensure that plans enrolling large numbers of low-income people were not placed at a cost disadvantage. As discussed below, implementing the risk-adjustment process would be a major undertaking for the states.

States' Responsibilities

Most proposals to restructure the health care system incorporate major additional administrative and regulatory functions that new or existing agencies or organizations would have to undertake. Like several other proposals, this one would place significant responsibility on the states for developing and implementing the new system. It is doubtful that all states would be ready to assume their new responsibilities in the time frame envisioned in the proposal.

Under the voluntary system, the states' primary responsibilities would fall into four major areas:

determining eligibility for the new subsidies and the continuing Medicaid program;

administering the subsidy and Medicaid programs;

establishing the infrastructure for the effective functioning of health care markets; and

regulating and monitoring the health insurance industry.

States would also have to prepare for the possibility that mandates requiring firms with 25 or more employees to provide insurance and all individuals to obtain coverage might be invoked in 2002. If that occurred, those states with coverage rates below 95 percent would need to have the necessary infrastructure already in place. In addition, they would have to be prepared to expand their regulatory and monitoring functions considerably.

Determining Eligibility for Subsidies and Medicaid. As with other proposals, determining eligibility for subsidies would be an enormous task for the state, made more complicated by the three different subsidy programs for premiums that would be in effect: regular subsidies for low-income individuals and families; special subsidies for children and pregnant women; and special subsidies for people who were temporarily unemployed. The eligibility criteria would be different for each of these programs and would also differ from those of the Medicaid program. (The role of the Medicaid program in paying for acute care services would be significantly reduced. The program would, however, cover wraparound benefits for those subsidized families who would be eligible for Medicaid under current law. It would also pay for emergency services for illegal aliens and would continue to cover beneficiaries of the Supplemental Security Income program and Medicare beneficiaries who qualified for Medicaid.) Some families would be eligible to participate in more than one subsidy program concurrently, and this proposal would allow them to do so in certain circumstances. They might also be entitled to receive Medicaid wraparound benefits.

States would bear the responsibility for the required end-of-year reconciliation process in which the income of a subsidized family was checked to ensure that the family received the appropriate premium subsidy. Reconciliation would be a major undertaking since, even if federal income tax information could be used, many of the families receiving subsidies would not be tax filers. Tracking people who moved from one state to another during the year would also be difficult and would require extensive cooperation among the states.

Administering the Subsidy and Medicaid Programs. The states would have other major administrative responsibilities for the subsidy and Medicaid programs. In particular, they would make payments for premium subsidies to health plans and would be required to develop and implement a complex outreach initiative to expand enrollment.

The outreach program would be designed to ensure that people eligible for full subsidies would be able to enroll in health plans on a year-round basis and would not be denied coverage for preexisting conditions. They would also be able to have their eligibility for subsidies established presumptively by certain health care providers at the point of service, enabling them to enroll in health plans and receive full premium subsidies for a period of 60 days during which they could apply for continuing assistance. States would not be held responsible for premium assistance provided to low-income families on a presumptive basis, if those families subsequently proved to be ineligible for full subsidies. Instead, the federal government would bear the costs.

The program would guarantee that poor families, as well as children and pregnant women with income up to 185 percent of the poverty level, had financial access to the health care system when they needed care. It would, however, be difficult to administer, and its success in enrolling low-income families in health plans on a permanent basis would depend on extensive outreach efforts by the states to ensure that people declared presumptively eligible completed the full process for determining eligibility. The program would be considerably more complex than the current presumptive eligibility programs for pregnant women that are operated by Medicaid programs in about 30 states. Those programs are dealing with a clearly defined target population of individuals and only one health plan—the Medicaid program. By contrast, the system envisioned under the proposal would be dealing with the enrollment of individuals plus their families in their choice of health plan.

Establishing the Infrastructure for the Effective Functioning of Health Care Markets. States would designate the geographic boundaries for the community-rating areas as well as the service areas for carrying out the provisions regarding essential community providers. They would also have ongoing responsibilities for ensuring that health care markets functioned effectively. Those responsibilities would include developing and implementing the complex risk-adjustment and reinsurance system and providing information and assistance to consumers.

Each state would be required to establish a risk-adjustment organization. That agency would determine the adjustments to be made to premiums for all community-rated and experience-rated plans in each community-rating area in the state. The agency would collect assessments from health plans and redistribute the payments to community-rated and experience-rated plans whose expected expenditures exceeded the average for enrollees in standard health plans.

State risk-adjustment organizations would also have to address the special issues raised by multistate plans. When such plans owed risk-adjustment assessments, they would make payments on behalf of all their enrollees in different states to a single state risk-adjustment organization. The designated organization would determine the applicable assessments for the plan's enrollees in each community-rating area across the country and would make payments to other state risk-adjustment organizations as required.

Another responsibility of the states would be to provide consumers with the necessary information to make informed choices among health plans. States would be required to produce annual standardized reports comparing the performance of all health plans in the state, using data from surveys designed and carried out by the federal government. To do so effectively would require states to establish systems for analyzing data and qualitative information. In each state, a private nonprofit organization under contract to the federal government would distribute the reports, educate and provide outreach to consumers, and help them to enroll in health plans. States would also be required to establish an office in each community-rating area to provide a forum for resolving disputes over claims or benefits.

Regulating and Monitoring the Health Insurance Industry. Like most other health care proposals, this one would place major new responsibilities on state health insurance departments. They would have to certify standard health plans and health insurance purchasing cooperatives (HIPCs), establish separate guaranty funds for community-rated and self-insured health plans, monitor variation in the marketing fees of HIPCs and other systems for purchasing insurance, and ensure that carries met minimum capital requirements. Moreover, the standards that health plans would have to meet would be largely federally determined and would include areas, such as data collection and reporting, that are outside the traditional purview of insurance regulators. It is doubtful that all states could develop the capabilities to perform these functions effectively in the near future.

Preparing for and Implementing Individual and Employer Mandates. If insurance coverage nationwide was below 95 percent in 2000, those states in which the coverage rate was below 95 percent would have to be prepared to implement individual and employer mandates in 2002—the year that those mandates would go into effect. The affected states would have to establish mechanisms—possible through designated HIPCs—to collect and redistribute premium payments from employers with workers enrolled in other employers' health plans. They would have to set up systems to ensure that employers and families complied with the mandates, and they would have to prepare low-income families for the possibility that their subsidies could change significantly.

The System of Multiple Subsidies

In order to maximize voluntary enrollment in health plans, Senator Mitchell's proposal would establish multiple schedules of subsidies for premiums, targeting special populations as well as low-income families in general. The basic system of subsidies would cover individuals and families with income up to 200 percent of the poverty level. Added to this would be subsidies for children and pregnant women with family income up to 300 percent of the poverty level. In addition, a special initiative would provide subsidies for workers and their families when the workers were temporarily unemployed; the subsidies would be available for a period of unemployment not to exceed six months. Integrating these three subsidies in a sensible and administrable fashion would be extremely difficult, especially as some families could receive subsidies from more than one program.

The subsidies for people who were temporarily unemployed would be particularly hard to administer and monitor. It would be difficult, for example, to determine whether people had left their jobs voluntarily or involuntarily, or whether they could receive employer contributions for health insurance through an employed spouse. Moreover, because of the way these subsidies would be structured, significant horizontal inequities could result. That is, families with similar income could receive quite different subsidy amounts. In determining their eligibility for subsidies, people who were temporarily unemployed could subtract from their family income the lesser of their gross wages or a flat amount equal to 75 percent of the poverty-level income for an individual for each month the worker was employed. In addition, they could subtract any unemployment compensation they received while unemployed. Consequently, people who were unemployed for several months could receive larger subsidies than year-round workers with similar annual income. Workers in seasonal businesses—construction workers and resort employees, for example—would be particularly favored. The incentives inherent in this subsidy could increase unemployment slightly.

The Tax on High-Cost Health Plans

Like the tax contained in the bill reported by the Committee on Finance, the tax on the premiums of "high-cost" health plans in Senator Mitchell's proposal would be difficult to implement. In addition, its contribution to containing health care costs would be limited, and it might be considered inequitable and an impediment to expanding coverage.

The tax would be a 25 percent levy on the amount by which health insurance premiums for a standard health plan exceeded a "reference" premium. Separate reference premiums would be established annually by the Secretary of the Treasury for each class of coverage in each community-rating area and for each experience-rated plan. These determinations would be extremely complex and difficult to make, requiring adjustments for demographic characteristics (age, sex, and socioeconomic status), health status, current levels of health care expenditures, uninsurance and underinsurance, the presence of academic health centers, and other factors. Little reliable information of this sort is available, and the Secretary would have to collect a mass of new information. With the reference premiums affecting not only tax liability but also premium levels, the process could prove to be quite controversial.

Although the tax would not be imposed on community-rated plans operating in areas where the average premium did not exceed the national average reference premium, few if any areas would meet that test for more than the first year or two because the reference premiums would be constrained to grow far more slowly than the expected growth of health insurance premiums. In community-rating areas, the growth would be 3 percentage points over the consumer price index in 1997, declining to 2 percentage points over the CPI by 1999.

Unlike the taxes contained in the Managed Competition Act and the bill reported by the Committee on Finance, which would not affect the lowest-cost plans, virtually all plans would be subject to the assessment called for in Senator Mitchell's proposal. Such an assessment would increase premiums, and higher premiums would discourage participation during the voluntary period. The tax would be imposed in 1997 on plans in the community-rated market, in which small firms and most of the uninsured would obtain coverage. In contrast, the experienced-rated market would not be subject to the tax until 2000, and that differential treatment might be viewed as inequitable.

Although the proposal would provide sponsors of health plans with the right to recover half of the tax from health care providers,

providers would incorporate their portion of the expected tax into their charges, so the right of recovery would be unlikely to have any real effect on the cost of health insurance. Moreover, because the mechanics of enforcing the right of recovery are unclear, the provision might lead to costly and unproductive litigation.

The proposal would be, in effect, a tax cap, but one imposed on the providers of health insurance rather than its consumers. A tax cap is an important element in the managed competition approach to controlling health care costs, and a tax on providers could serve this purpose effectively. However, this tax, by exempting cost-sharing and other supplemental policies, would provide much less incentive for containing costs.

Research by the RAND Corporation and others indicates that a tax cap might constrain costs in either of two primary ways: by encouraging consumers to choose health insurance plans with greater cost sharing (that is, higher copayments and deductibles) or by encouaging the use of managed care providers like health maintenance organizations (HMOs) that can control costs more effectively than fee-for-service plans. This tax, however, would not apply to supplemental insurance policies that cover cost sharing. Workers whose employers provided cost-sharing supplements would pay less tax than workers whose employers did not and instead paid higher wages, and the average employee probably would pay lower copayments and deductibles under the proposal than under a tax cap that applied to supplements as well as to basic insurance. Furthermore, HMOs and similar types of managed care arrangements, which build the cost of the low copayments and ddeductibles into their premiums, would be placed at a tax disadvantage compared with less cost-effective fee-for-service plans in which the cost-sharing supplements would be tax-fee.

A final reason that the tax's promise of cost containment would remain far below its potential relates to the method for calculating reference premiums for experience-rated plans. These premiums would be calculated based on actual expenditures during the 1997–1999 period, which could undermine the incentive for experience-rated plans to economize before the tax took effect in 2000.

The Effects of Invoking Mandates

If less than 95 percent of the population had insurance coverage on January 1, 2000, and if the Congress did not enact alternative legislation before the end of that year, mandates on employees and consumers would automatically come into effect in 2002. The proposed mandatory system would be problematic for several reasons.

The mandates would be imposed only in states that had failed to meet the 95 percent threshold for coverage. In those states, all firms with 25 or more workers would be required to contribute to the costs of health insurance for their employees, and all individuals and families would be required to obtain coverage. These requirements would produce inefficient reallocations of business activity. Some firms that did not wish to provide insurance would migrate to states that were not included in the mandate. Furthermore, because the transitional subsidies for employers that voluntarily expanded coverage to additional workers would terminate in mandated states, some firms might be attracted to nonmandated states where these temporary subsidies would still be available.

Moreover, the practical problems of implementing mandates in some states and not in others could be overwhelming, especially in border markets. What, for example, would happen to individuals who lived in mandated states but worked for employers that did not contribute to the cost of insurance in neighboring, nonmandated states?

The system of subsidies for families would also change significantly in the mandated states, raising concerns about affordability and equity. The special subsidies for low-income children and pregnant women would be dropped, making health insurance more expensive for some low-income families without an employer contribution, even though they would now be required to purchase coverage. (for example, a family with income at 150 percent of the poverty level and no employer contribution in a mandated state would have to pay 50 percent of a family premium. A similar family in a nonmandated state might be able to combine regular subsidies and special subsidies and pay far less than 50 percent of the premium for a family policy.) Concerns about the affordability of health insurance under a mandate would be heightened because the incentives to contain costs in their proposal are limited.

Because of the disruptions, complications, and inequities that would result, CBO does not believe that it would be feasible to implement the mandated system in some states but not in others; the system would have to include either all states or none. Accordingly, CBO's cost estimates of the mandated system assume that a nationwide mandate would be in effect.

Reallocation of Workers Among Firms

Senator Mitchell's proposal, like many other reform bills, would encourage a reallocation of workers among firms in ways that would increase its budgetary cost. That process would occur gradually as employment expanded in some firms and contracted in others and as workers sought the jobs that would provide them with the largest combined amount of wages and premium subsidies.

In the voluntary system, this sorting would occur because the family subsidies would be reduced by up to the amount that employers contributed for insurance; therefore, a worker employed by a firm that did not pay for health insurance would receive a larger subsidy than a worker earning the same wage at a firm that did pay. (In addition to this reallocation, some companies might stop paying for insurance, but the number of firms that would do so would be limited because high-wage workers in those firms would lose the benefit of excluding health insurance from their taxable income.) Some sorting would also occur because firms that expanded insurance coverage to classes of workers not previously covered would be eligible for temporary subsidies; workers employed by those firms could receive higher take-home pay for a few years than could workers at firms that currently provide them with insurance coverage.

In the mandated system, reallocation of workers would occur because some workers would pay less for health insurance if they were employed by small firms excluded from the mandate than they would if they were employed by firms covered by the mandate. For example, many low-wage workers could receive a larger subsidy for their insurance costs in uncovered firms than in covered firms. In addition, married couples with both spouses working would have an incentive under the proposal to have one spouse employed by an uncovered firm, because if both spouses worked in covered firms, they would each have to pay something for insurance. A similar incentive exists in the current system, but by requiring more firms to provide insurance coverage than they do now, the proposal would affect more people.

Under both the voluntary and mandated systems, some workers could gain several thousand dollars in higher wages by moving between firms, and over time a significant number of them would probably do so. This reallocation of workers among firms accounts for about $14 billion of the cost of the subsidies in 2004 under the voluntary system and for about $8 billion in 2004 under the mandated system. In addition to raising the government's costs, the reallocation of workers could reduce the efficiency of the labor market.

Finally, the subsidy system would not treat people with similar incomes and family circumstances alike. Under the voluntary system, for example, workers eligible for subsidies who worked at firms that paid for insurance would face larger costs for their insurance when the reduction in their cash wages is taken into account than similar workers at firms that did not pay.

Work Disincentives

Senator Mitchell's proposal would discourage certain low-income people from working more hours or, in some cases, from working at all, because subsidies would be phased out as family income increased. It is important to note that work disincentives are an inherent element of all health proposals that target subsidies toward the poor and near-poor, and that these subsidies would significantly improve the well-being of many low-income people by assisting their purchase of health insurance.

In both the voluntary and mandated systems, many workers who earned more money within the phaseout range would have to pay more for health insurance, which would cut into the increase in their take-home wage. In essence, these workers would face an implicit tax on their economic advancement. Changing the design of the subsidy systems in this proposal could reduce the marginal levy on some people's income, but it might raise the marginal levy faced by other people or make insurance unaffordable for some people.

The Voluntary System. Estimating the precise magnitude of the implicit tax rates in the voluntary system requires information that is not readily available, but rough calculations suggest that the rates could be extremely high for some families. For workers whose employers did not pay for insurance, the implicit marginal rates from the phaseout of subsidies for low-income families would apply to income between 100 percent and 200 percent of the poverty level, and the phaseout of subsidies for children and pregnant women would apply to income between 185 percent and 300 percent of poverty.

In 2000, the effective marginal tax on labor compensation (wages and benefits) could increase by as much as 30 to 55 percentage points for workers with family income in the phaseout range. Moreover, those levies would be added to the explicit and implicit marginal taxes that such workers already pay through the income tax, the payroll tax, and the phaseout of the earned income tax credit. In the end, some low-wage workers would keep as little as 15 cents of every additional dollar they earned.

For workers whose employers paid some of the costs for insurance, these marginal levies would apply to income in a much smaller range. However, such treatment of employer payments would also create the previously described incentive for workers to move to firms that did not pay for insurance.

The Mandated System. Rough calculations suggest that the implicit marginal rates from the phaseout of subsidies under the mandated system could also be extremely high for some families. These rates would apply to income between 100 percent and 200 percent of the poverty level for workers in uncovered firms. For workers in covered firms, these marginal levies would apply to workers in a smaller income range. In 2002, the effective marginal tax on labor compensation could increase by as much as 35 to 55 percentage points for workers who received subsidies. As in the voluntary system, this new levy would be added to the explicit and implicit marginal taxes that these workers already face, producing total marginal tax rates of more than 95 percent for some workers.

The mandated system would also discourage some people who have spouses working at covered firms from participating in the labor force or at least from taking a job at a firm with more than 25 employees. If those people took a job at a covered firm, their wages would be reduced by the additional cost for insurance but they would receive no additional benefits. The current system also discourages some of these people from working at firms that pay for insurance, but by requiring more firms to provide insurance coverage, the proposal would increase the number of people who were affected.

In the mandated system, the combination of the subsidies and the requirement to purchase insurance would increase the effective income of people who wanted insurance at the net-of-subsidy price, but would reduce the economic well-being of people who would have preferred not to buy insurance. Because the net-of-subsidy price (including employer payments) would be high for many families, the number of people who valued insurance at less than its cost could be large. For example, for a family of two adults (one working in a covered firm) and two children, with income just below the poverty threshold in 2002, the firm contributing 50 percent of the premium would pay more than $5,000 on the worker's behalf for insurance; that would represent roughly one-quarter of the family's income.

Effect on Employment

If the voluntary system in Senator Mitchell's proposal did not result in insurance coverage for 95 percent of the population, mandates would be triggered unless the Congress adopted an alternative approach. Under the mandated system, firms with more than 25 employees would be required to contribute to each worker's health insurance. The imposition of the mandate would raise the cost of employing workers at firms that do not currently provide insurance. Economic theory and empirical research both imply that most of this increased cost would be passed back to workers over time in the form of lower take-home wages. Such shifting would not be possible, however, for workers whose wages were close to the federally regulated minimum wage. Therefore, the net cost of employing those workers would be raised by the mandate, and some of them would lose their jobs.

Nevertheless, the quantitative effect of the mandate in this proposal would probably be quite small because the mandate would not be implemented until 2002. Market wages for low-income workers will rise over time, reflecting general inflation, and, probably, some share of the nation's real economic growth. As a result, few workers will be earning the current minimum wage by 2002. If the Congress did not raise the minimum wage, loss of jobs from this mandate would likely be very limited.

Employment would also be affected by the implicit taxes on work described above. In both the voluntary and mandated systems, some workers would voluntarily withdraw from the labor force in response to the new incentives they faced.

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-23.8	-35.6	-39.7	-44.4	-49.6	-55.2	-61.2	-67.6
2 State Maintenance-of-Effort Payments	0	0	-18.5	-26.5	-28.7	-31.1	-33.6	-36.3	-39.3	-42.4
3 Disproportionate Share Hospital Payments	0	0	-8.8	-13.4	-14.8	-15.6	-18.8	-20.7	-22.9	-25.2
4 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	0.1	0.1	0.1
5 Offset to Medicare Prescription Drug Program	0	0	0	0	-0.7	-1.5	-1.6	-1.9	-2.1	-2.3
6 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total - Medicaid	a	a	-51.4	-76.0	-84.4	-93.2	-104.3	-114.8	-126.2	-138.3
Medicare										
7 Part A Reductions										
Inpatient PPS Updates	0	0	-0.3	-1.6	-3.4	-5.6	-8.0	-10.7	-13.8	-17.4
Capital Reductions	0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9
Disproportionate Share Hospital Reductions	0	0	-1.7	-2.1	-2.3	-2.5	-2.8	-3.1	-3.4	-3.7
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0	0	0	0
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a
Part A Interactions	0	0	0.1	0.2	0.4	0.6	0.7	0.9	1.1	1.3
8 Essential Access Community Hospitals										
Medical Assistance Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
9 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Competitive Bid for Part B	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
Competitive Bid for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Elimination of Balance Billing	0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Correct MVPS Upward Bias	0	0	0	0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Nurse Pract/Phys Asst Direct Payment	0	0	0.1	0.2	0.3	0.3	0.4	0.5	0.6	0.7
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Durable Medical Equipment Price Reduction	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
10 Parts A and B Reductions										
Home Health Copayments (20%)	-0.7	-3.4	-4.2	-4.6	-5.0	-5.5	-5.9	-6.4	-7.0	-7.6
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0	0
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
11 Medicare Outpatient Prescription Drug Benefit	0	0	0	0	6.2	14.4	15.7	17.5	19.7	21.5
Total - Medicare	-2.4	-6.6	-10.2	-14.1	-14.7	-14.3	-21.1	-28.9	-38.1	-48.4
Subsidies										
12 Persons between 0-200% of Poverty	0	0	66.7	95.4	105.3	116.8	129.3	142.7	157.3	172.3
13 Pregnant Women and Kids 0-300% of Poverty				---------- Included in Line 12 ----------						
14 Temporarily Unemployed	0	0	0.0	5.0	7.1	7.7	8.3	9.0	9.8	10.6
15 Enrollment Outreach	0	0	1.3	3.3	5.2	6.9	8.4	9.9	10.8	11.3
Total - Subsidies	0	0	68.0	103.7	117.6	131.3	146.1	161.6	177.9	194.3
Other Health Programs										
16 Vulnerable Hospital Payments	0	0	0	2.5	2.5	2.5	2.5	2.5	2.5	2.5
17 Veterans' Programs	0	0	-1.4	-1.4	-1.7	-1.8	-1.9	-2.0	-2.0	-2.1
18 Home and Community Based Care ($48 bil. cap)	0	0	0	1.8	2.9	3.6	5.0	7.9	11.4	15.4
19 Life Care	0	0	-0.6	-1.1	-1.1	-0.3	-0.3	-0.3	-0.3	-0.3
20 Academic Health Centers	0	0	4.7	7.0	8.0	9.1	10.3	11.0	11.5	12.1
21 Graduate Medical and Nursing Education	0	0	2.6	3.9	5.8	6.4	6.6	6.8	7.2	7.5
22 Medicare Transfer - Direct Medical Education	0	0	-1.6	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
23 Medicare Transfer - Indirect Medical Education	0	0	-3.4	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
24 Public Health Schools; Dental Schools	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
25 Women, Infants and Children	0	0.3	0.5	0.5	0.5	0.5	a	0	0	0
26 Administration of Enrollment Outreach	0	0	0.4	0.7	0.9	1.0	1.1	1.3	1.4	1.4
Total - Other Health Programs	0	0.3	1.3	6.7	10.0	12.6	14.1	17.2	20.6	24.6
Public Health Initiative										
27 Biomedical and Behavioral Research Trust Fund	0	0	0.9	1.4	1.5	1.6	1.7	1.9	2.1	2.2
28 Health Professions	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
29 Core Public Health	0	0.1	0.3	0.3	0.4	0.4	0.3	0.2	0.1	0.1
30 Prevention	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
31 Capacity Building and Capital	0	0.3	0.5	0.5	0.4	0.2	0.1	0.1	0.0	0.0

Continued

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
32 OSHA and Workforce	0	0.3	0.4	0.3	0.3	0.2	0.2	0.1	0.1	0.1
33 Supplemental Services	0	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.0
34 Enabling Services	0	0.1	0.2	0.3	0.3	0.3	0.2	0.2	0.1	0.1
35 National Health Service Corps (NHSC)	0	0.1	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.0
36 Mental Health & Substance Abuse (CMMH&SA)	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
37 School Clinics	0	0.1	0.2	0.3	0.4	0.4	0.3	0.2	0.1	0.1
38 Indian Health Service	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Public Health Initiatives	0	1.4	3.2	3.9	4.0	3.9	3.5	3.0	2.8	2.9
39 Social Security Benefits	0	0	0.2	0.5	0.9	0.9	0.9	0.9	0.8	0.8
MANDATORY OUTLAY CHANGES	**-2.4**	**-4.9**	**11.1**	**24.7**	**33.4**	**41.3**	**39.2**	**39.0**	**37.9**	**35.9**
DISCRETIONARY OUTLAYS										
Health Programs										
40 Veterans' Programs	1.2	0.6	-2.9	-4.8	-4.9	-5.1	-5.2	-5.4	-5.6	-5.8
41 Indian Health Supplementary Services	0.7	1.2	1.5	1.6	1.6	1.6	1.6	1.6	1.7	1.7
42 Misc. Public Health Service Grants	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total Health Programs	1.9	1.8	-1.4	-3.1	-3.3	-3.4	-3.6	-3.7	-3.9	-4.1
Administrative Expenses										
43 Administrative Costs	0.5	0.9	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.2
44 Costs to Administer the Mandate	0	0	0	0	0	2.0	2.0	0	0	0
45 Planning and Start-Up Grants	0.1	0.4	0.6	0.3	0	0	0	0	0	0
Total Studies, Administrative Expenses	0.6	1.3	1.6	1.3	1.0	3.0	3.1	1.1	1.1	1.2
Studies, Research, & Demonstrations										
46 EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research, & Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
DISCRETIONARY OUTLAY CHANGES	**2.5**	**3.2**	**0.3**	**-1.7**	**-2.3**	**-0.4**	**-0.6**	**-2.6**	**-2.8**	**-2.9**
TOTAL OUTLAY CHANGES	**0.1**	**-1.6**	**11.4**	**22.9**	**31.1**	**40.9**	**38.7**	**36.3**	**35.1**	**33.0**

Continued

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
RECEIPTS										
47 Increase in Tobacco Tax	0.7	2.7	4.5	6.1	7.6	7.4	7.1	6.9	6.8	6.7
48 1.75% Excise Tax on Private Health Ins Premiums	0	3.5	6.1	7.1	7.7	8.4	9.1	9.9	10.8	11.7
49 Addl Medicare Part B Premiums for High-Income Individuals ($80,000/$100,000)	0	0	2.0	2.0	2.8	3.5	4.4	5.5	6.9	8.7
50 Increase Excise Tax on Hollow-Point Bullets			---------- Negligible Revenue Loss ----------							
51 Include Certain Service-Related Income in SECA/Excl Certain Inven-Related Income from SECA										
a) General Fund Effect	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
b) OASDI Effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
52 Extend Medicare Coverage & HI Tax to All State and Local Government Employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
53 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rules	0	a	a	a	a	a	a	a	a	a
54 Provide that Health Benefits Cannot be Provided thru a Cafeteria Plan/Flex Spend Arrangements	0	0.5	2.5	3.9	4.8	5.6	6.3	7.0	7.7	8.5
55 Extend/Increase 25% Deduction for Health Insurance Costs of Self-Employed Individuals	-0.5	-0.6	-1.2	-1.3	-1.4	-1.5	-1.6	-1.8	-2.0	-2.1
56 Limit on Prepayment of Medical Premiums			---------- Negligible Revenue Gain ----------							
57 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Svcs			---------- Negligible Revenue Effect ----------							
58 Trmt of Certain Ins Companies Under Sect 833	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
59 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
60 Remove $150 Million Bond Cap on Non-Hospital 501(c)(3) Bonds	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
61 Qualified Long-Term Care Benefits Treated as Medical Care; Clarify Tax Treatment of Long-Term Care Insurance and Services	0	a	-0.2	-0.3	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4
62 Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
63 Increase in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

Continued

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
64 Post-Retirement Medical/Life Insurance Reserves			---------- Negligible Revenue Effect ----------							
65 Tax Credit for Practitioners in Underserved Areas	a	-0.1	-0.2	-0.2	-0.2	-0.2	-0.1	a	a	a
66 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
67 Tax Credit for Cost of Personal Assistance Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
68 Disclosure of Return Information to State Agencies				---------- No Revenue Effect ----------						
69 Impose Premium Tax with Respect to Certain High Cost Plans	0	a	0.9	2.2	3.3	6.1	9.5	12.5	16.0	19.9
70 Limit Exclusion for Employer-Paid Health Benefits	0	0	0	0	0	0	0	0	0	0.9
71 Indirect Tax Effects of Changes in Tax Treatment of Employer & Household Health Ins Spending	0	-0.5	-0.3	-0.7	-1.3	-2.0	-2.4	-3.0	-3.3	-3.7
TOTAL RECEIPT CHANGES	**0.1**	**7.1**	**15.7**	**20.2**	**24.5**	**28.3**	**33.4**	**37.8**	**43.5**	**51.2**
DEFICIT										
MANDATORY CHANGES	**-2.5**	**-12.0**	**-4.6**	**4.5**	**8.9**	**13.0**	**5.8**	**1.2**	**-5.6**	**-15.3**
CUMULATIVE MANDATORY TOTAL	**-2.5**	**-14.5**	**-19.2**	**-14.7**	**-5.8**	**7.2**	**13.0**	**14.1**	**8.6**	**-6.7**
TOTAL CHANGES	**-0**	**-8.7**	**-4.3**	**2.7**	**6.6**	**12.6**	**5.3**	**-1.5**	**-8.4**	**-18.2**
CUMULATIVE DEFICIT EFFECT	**-0**	**-8.8**	**-13.1**	**-10.3**	**-3.7**	**8.9**	**14.2**	**12.7**	**4.4**	**-13.8**

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-23.8	-35.6	-39.7	-44.4	-49.6	-55.2	-61.2	-67.6
2 State Maintenance-of-Effort Payments	0	0	-18.5	-26.5	-28.7	-31.1	-33.6	-36.3	-39.3	-42.4
3 Disproportionate Share Hospital Payments	0	0	-8.8	-13.4	-14.8	-15.6	-18.8	-20.7	-22.9	-25.2
4 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	0.1	0.1	0.1
5 Offset to Medicare Prescription Drug Program	0	0	0.0	0.0	-0.7	-1.5	-1.6	-1.9	-2.1	-2.3
6 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total - Medicaid	a	a	-51.4	-76.0	-84.4	-93.2	-104.3	-114.8	-126.2	-138.3
Medicare										
7 Part A Reductions										
Inpatient PPS Updates	0	0	-0.3	-1.6	-3.4	-5.6	-8.0	-10.7	-13.8	-17.4
Capital Reductions	0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9
Disproportionate Share Hospital Reductions	0	0	-1.7	-2.1	-2.3	-2.5	-2.8	-3.1	-3.4	-3.7
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0	0	0	0
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a
Part A Interactions	a	a	0.1	0.2	0.4	0.6	0.7	0.9	1.1	1.3
8 Essential Access Community Hospitals										
Medical Assistance Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
9 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0.0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Competitive Bid for Part B	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
Competitive Bid for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Elimination of Balance Billing	0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Correct MVPS Upward Bias	0	0	0	0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Nurse Pract/Phys Asst Direct Payment	0	0	0.1	0.2	0.3	0.3	0.4	0.5	0.6	0.7
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Durable Medical Equipment Price Reduction	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8

Continued

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
10 Parts A and B Reductions										
Home Health Copayments (20%)	-0.7	-3.4	-4.2	-4.6	-5.0	-5.5	-5.9	-6.4	-7.0	-7.6
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0	0
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
11 Medicare Outpatient Prescription Drug Benefit	0	0	0	0	6.2	14.4	15.7	17.5	19.7	21.5
Total - Medicare	-2.4	-6.6	-10.2	-14.1	-14.7	-14.3	-21.1	-28.9	-38.1	-48.4
Subsidies										
12 Persons between 0-200% of Poverty before Mandate	0	0	66.7	95.4	105.3	116.8	129.3	33.1	0	0
13 Persons between 0-200% of Poverty after Mandate	0	0	0	0	0	0	0	96.1	137.2	149.6
14 Pregnant Women and Kids 0-300% of Poverty				---------- Included in Line 12 ----------						
15 Temporarily Unemployed	0	0	0.0	5.0	7.1	7.7	8.3	12.5	14.7	15.9
16 Enrollment Outreach	0	0	1.3	3.3	5.2	6.9	8.4	2.5	0	0
Total - Subsidies	0	0	68.0	103.7	117.6	131.3	146.1	144.2	151.9	165.5
Other Health Programs										
17 Vulnerable Hospital Payments	0	0	0	2.5	2.5	2.5	2.5	2.5	2.5	2.5
18 Veterans' Programs	0	0	-1.4	-1.4	-1.7	-1.8	-1.9	-2.0	-2.0	-2.1
19 Home and Community Based Care	0	0	0	1.8	2.9	3.6	5.0	7.9	11.4	15.4
20 Life Care	0	0	-0.6	-1.1	-1.1	-0.3	-0.3	-0.3	-0.3	-0.3
21 Academic Health Centers	0	0	4.7	7.0	8.0	9.1	10.3	11.0	11.5	12.1
22 Graduate Medical and Nursing Education	0	0	2.6	3.9	5.8	6.4	6.6	6.8	7.2	7.5
23 Medicare Transfer - Direct Medical Education	0	0	-1.6	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
24 Medicare Transfer - Indirect Medical Education	0	0	-3.4	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
25 Public Health Schools; Dental Schools	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
26 Women, Infants and Children	0	0.3	0.5	0.5	0.5	0.5	a	0	0	0
27 Administration of Enrollment Outreach	0	0	0.4	0.7	0.9	1.0	1.1	1.3	1.4	1.4
Total - Other Health Programs	0	0.3	1.3	6.7	10.0	12.6	14.1	17.2	20.6	24.6
Public Health Initiative										
28 Biomedical and Behavioral Research Trust Fund	0	0	0.9	1.3	1.5	1.6	1.7	2.0	2.2	2.4
29 Health Professions	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
30 Core Public Health	0	0.1	0.3	0.3	0.4	0.4	0.3	0.2	0.1	0.1
31 Prevention	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
32 Capacity Building and Capital	0	0.3	0.5	0.5	0.4	0.2	0.1	0.1	0.0	0.0
33 OSHA and Workforce	0	0.3	0.4	0.3	0.3	0.2	0.2	0.1	0.1	0.1
34 Supplemental Services	a	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.0
35 Enabling Services	0	0.1	0.2	0.3	0.3	0.3	0.2	0.2	0.1	0.1
36 National Health Service Corps (NHSC)	0	0.1	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.0
37 Mental Health & Substance Abuse (CMMH&SA)	a	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
38 School Clinics	a	0.1	0.2	0.3	0.4	0.4	0.3	0.2	0.1	0.1
39 Indian Health Service	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Public Health Initiatives	a	1.4	3.2	3.9	4.0	3.9	3.5	3.1	3.0	3.0
40 Social Security Benefits	0	0	0.2	0.5	0.9	0.9	0.9	0.9	0.8	0.8
MANDATORY OUTLAY CHANGES	**-2.4**	**-4.9**	**11.0**	**24.7**	**33.4**	**41.3**	**39.2**	**21.7**	**12.1**	**7.2**
DISCRETIONARY OUTLAYS										
Health Programs										
41 Veterans' Programs	1.2	0.6	-2.9	-4.8	-4.9	-5.1	-5.2	-5.4	-5.6	-5.8
42 Indian Health Supplementary Services	0.7	1.2	1.5	1.6	1.6	1.6	1.6	1.6	1.7	1.7
43 Misc. Public Health Service Grants	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total Health Programs	1.9	1.8	-1.4	-3.1	-3.3	-3.4	-3.6	-3.7	-3.9	-4.1
Administrative Expenses										
44 Administrative Costs	0.5	0.9	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.2
45 Costs to Administer the Mandate	0	0	0	0	0	2.0	2.0	2.0	2.0	2.0
46 Planning and Start-Up Grants	0.1	0.4	0.6	0.3	0	0	0	0	0	0
Total Studies, Administrative Expenses	0.6	1.3	1.6	1.3	1.0	3.0	3.1	3.1	3.1	3.2
Studies, Research, Demonstrations, Other										
47 EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research, Demonstrations, Other	a	0.1	0.1	0.1	a	a	a	a	a	a
DISCRETIONARY OUTLAY CHANGES	**2.6**	**3.2**	**0.3**	**-1.7**	**-2.3**	**-0.4**	**-0.5**	**-0.6**	**-0.8**	**-0.9**
TOTAL OUTLAY CHANGES	**0.1**	**-1.6**	**11.4**	**22.9**	**31.1**	**40.9**	**38.7**	**21.1**	**11.3**	**6.3**

Continued

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
RECEIPTS										
48 Increase in Tobacco Tax	0.7	2.7	4.5	6.1	7.6	7.4	7.1	6.9	6.8	6.7
49 1.75% Excise Tax on Private Health Ins Premiums	0	3.5	6.1	7.1	7.7	8.4	9.1	10.4	11.5	12.4
50 Addl Medicare Part B Premiums for High-Income Individuals ($80,000/$100,000)	0	0	2.0	2.0	2.8	3.5	4.4	5.5	6.9	8.7
51 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
52 Include Certain Service-Related Income in SECA/ Excl Certain Inven-Related Income from SECA										
a) General Fund Effect	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
b) OASDI Effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
53 Extend Medicare Coverage & HI Tax to All State and Local Government Employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
54 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rules	0	a	a	a	a	a	a	a	a	a
55 Provide that Health Benefits Cannot be Provided thru a Cafeteria Plan/Flex Spend Arrangements	0	0.5	2.5	3.9	4.8	5.6	6.3	8.2	9.5	10.5
56 Extend/Increase 25% Deduction for Health Insurance Costs of Self-Employed Individuals	-0.5	-0.6	-1.2	-1.3	-1.4	-1.5	-1.6	-1.8	-2.0	-2.0
57 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
58 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Svcs	---------- Negligible Revenue Effect ----------									
59 Trmt of Certain Ins Companies Under Sect 833	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
60 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
61 Remove $150 Million Bond Cap on Non-Hospital 501(c)(3) Bonds	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
62 Qualified Long-Term Care Benefits Treated as Medical Care; Clarify Tax Treatment of Long-Term Care Insurance and Services	0	a	-0.2	-0.3	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4
63 Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
64 Increase in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

Continued

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
65 Post-Retirement Medical/Life Insurance Reserves	---------- Negligible Revenue Effect ----------									
66 Tax Credit for Practitioners in Underserved Areas	a	-0.1	-0.2	-0.2	-0.2	-0.2	-0.1	a	a	a
67 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
68 Tax Credit for Cost of Personal Assistance Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
69 Disclosure of Return Information to State Agencies	---------- No Revenue Effect ----------									
70 Impose Premium Tax with Respect to Certain High Cost Plans	0	a	0.9	2.2	3.3	6.1	9.5	10.2	11.2	14.7
71 Limit Exclusion for Employer-Paid Health Benefits	0	0	0	0	0	0	0	0	0	0.9
72 Indirect Tax Effects of Changes in Tax Treatment of Employer & Household Health Ins Spending	0	-0.3	-0.3	-0.7	-1.4	-2.1	-2.6	-11.1	-15.9	-19.0
TOTAL RECEIPT CHANGES	**0.2**	**7.3**	**15.7**	**20.2**	**24.4**	**28.3**	**33.2**	**29.1**	**28.6**	**33.5**
DEFICIT										
MANDATORY CHANGES	**-2.6**	**-12.2**	**-4.7**	**4.5**	**9.0**	**13.0**	**6.0**	**-7.4**	**-16.5**	**-26.3**
CUMULATIVE MANDATORY TOTAL	**-2.6**	**-14.8**	**-19.5**	**-15.0**	**-6.0**	**7.0**	**13.0**	**5.6**	**-10.9**	**-37.3**
TOTAL CHANGES	**-0.1**	**-8.9**	**-4.3**	**2.7**	**6.7**	**12.6**	**5.5**	**-8.0**	**-17.3**	**-27.2**
CUMULATIVE DEFICIT EFFECT	**-0.1**	**-9.1**	**-13.4**	**-10.6**	**-3.9**	**8.7**	**14.2**	**6.2**	**-11.1**	**-38.3**

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The budgetary treatment of mandatory premium payments is under review.

The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

TABLE 3. PRELIMINARY ESTIMATES OF THE STATE & LOCAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-17.9	-26.7	-29.8	-33.3	-37.2	-41.4	-45.9	-50.7
2 State Maintenance-of-Effort Payments	0	0	18.5	26.5	28.7	31.1	33.6	36.3	39.3	42.4
3 Disproportionate Share and Vulnerable Hospital Payments a/	0	0	1.1	-0.8	-0.6	-0.5	-0.1	0.2	0.5	0.8
4 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	a	a	a
5 Offset to Medicare Prescription Drug Program	0	0	0	0	-0.5	-1.1	-1.2	-1.4	-1.6	-1.7
6 Administrative Savings	0	0	-0.2	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7
Total - Medicaid	a	a	1.6	-1.4	-2.6	-4.3	-5.4	-6.9	-8.3	-9.9
Administrative Expenses										
7 Expenses Associated with Subsidies	0	0	3.6	5.1	5.5	6.0	6.5	7.1	7.7	8.3
8 General Administrative and Start Up Costs	0	0	1.0	1.1	1.1	1.2	1.3	1.4	1.5	1.6
9 Automobile Insurance Coordination	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Administrative Expenses	0	0.3	4.7	6.3	6.7	7.3	7.9	8.6	9.3	10.0
Public Health Initiatives										
10 School Health Clinics	0	0.1	0.1	0.2	0.3	0.5	0.5	0.5	0.3	0.2
TOTAL OUTLAY CHANGES	a	0.3	6.4	5.1	4.4	3.5	3.1	2.2	1.3	0.3
RECEIPTS										
11 Revenue Collected for Subsidy Administration	0	0	3.6	5.1	5.5	6.0	6.5	7.1	7.7	8.3
Total State Changes	a	0.3	2.8	-0.0	-1.1	-2.5	-3.4	-4.9	-6.4	-8.0

SOURCE: Congressional Budget Office.

a. The estimate assumes that states will continue to provide some assistance to hospitals serving disproportionately large numbers of uninsured or underinsured people.

TABLE 3. PRELIMINARY ESTIMATES OF THE STATE & LOCAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-17.9	-26.7	-29.8	-33.3	-37.2	-41.4	-45.9	-50.7
2 State Maintenance-of-Effort Payments	0	0	18.5	26.5	28.7	31.1	33.6	36.3	39.3	42.4
3 Disproportionate Share and Vulnerable Hospital Payments a/	0	0	1.1	-0.8	-0.6	-0.5	-0.1	0.2	0.5	0.8
4 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	a	a	a
5 Offset to Medicare Prescription Drug Program	0	0	0	0	-0.5	-1.1	-1.2	-1.4	-1.6	-1.7
6 Administrative Savings	0	0	-0.2	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7
Total - Medicaid	a	a	1.6	-1.4	-2.6	-4.3	-5.4	-6.9	-8.3	-9.9
Administrative Expenses										
7 Expenses Associated with Subsidies	0	0	3.6	5.1	5.5	6.0	6.5	7.1	7.7	8.3
8 General Administrative and Start Up Costs	0	0	1.0	1.1	1.1	1.2	1.3	1.4	1.5	1.6
9 Automobile Insurance Coordination	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Administrative Expenses	0	0.3	4.7	6.3	6.7	7.3	7.9	8.6	9.3	10.0
Public Health Initiatives										
10 School Health Clinics	0	0.1	0.1	0.2	0.3	0.5	0.5	0.5	0.3	0.2
TOTAL OUTLAY CHANGES	a	0.3	6.4	5.1	4.4	3.5	3.1	2.2	1.3	0.3
RECEIPTS										
11 Revenue Collected for Subsidy Administration	0	0	3.6	5.1	5.5	6.0	6.5	7.1	7.7	8.3
Total State Changes	a	0.3	2.8	-0.0	-1.1	-2.5	-3.4	-4.9	-6.4	-8.0

SOURCE: Congressional Budget Office.

a. The estimate assumes that states will continue to provide some assistance to hospitals serving disproportionately large numbers of uninsured or underinsured people.

Table 5. Health Insurance Coverage (By calendar year, in millions of people)

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline								
Insured	224	226	228	229	230	232	233	234
Uninsured	40	40	40	41	42	43	43	44
Total	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	15	15	15	15	15	16	16	16
Senator Mitchell's Proposal--Without Mandate in Effect								
Insured[a]	250	253	255	257	259	261	262	264
Uninsured	13	13	13	14	14	14	14	14
Total	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	5	5	5	5	5	5	5	5
Senator Mitchell's Proposal--With Mandate in Effect								
Insured	250	253	255	257	259	274	276	278
Uninsured	13	13	13	14	14	0	0	0
Total	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	5	5	5	5	5	0	0	0

SOURCE: Congressional Budget Office.

a. Includes people eligible for coverage under the enrollment outreach provisions of the proposal.

Table 6. Projections of National Health Expenditures
(By calendar year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Senator Mitchell's Proposal—Without Mandate in Effect								
Proposal	1,301	1,401	1,519	1,647	1,779	1,923	2,079	2,246
Change from Baseline	38	29	31	33	31	29	27	25
Senator Mitchell's Proposal—With Mandate in Effect								
Proposal	1,301	1,401	1,519	1,647	1,779	1,943	2,093	2,254
Change from Baseline	38	29	31	33	31	48	41	34

SOURCE: Congressional Budget Office.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. PACKWOOD. Mr. President, let me thank my good friend from Pennsylvania. "A picture is better than a thousand words" is true. You look at that chart and say, how on Earth can we do this to the American medical system? I do not mean doctors and hospitals, I mean the American medical system.

I know the Senator indicated he ran out of time now—that is true—and he has much more to say. I encourage him to come back, because after today, we have no unanimous consent agreement on time, and I would appreciate it if he would come back and continue.

Mr. SPECTER. I thank my colleague for those kind remarks.

Mr. PACKWOOD. I yield the floor.

Mr. MOYNIHAN. Mr. President, I am happy to yield 10 minutes to the distinguished Senator from South Dakota, who is the chairman of the Democratic Policy Committee.

The PRESIDING OFFICER. The Senator from South Dakota is recognized.

Mr. DASCHLE. I thank the Senator.

I commend the Senator from Pennsylvania for much of what he has said this morning.

I must say, however, that I am surprised, given the Senator's admission yesterday that he had not had time to read the bill offered by the majority leader, that he has had time to diagram the bill as it is now portrayed in one of his charts.

I have had a chance to look at some of the charts, and I am surprised that many of the existing programs that we have in our current health system are listed on his chart as new programs. Standard health plan sponsors are listed as a new entity on this chart, even though the private health insurance companies of today will certainly exist as they are, tomorrow. I certainly do not think he is proposing that we eliminate these "bureaucracies."

Guaranteed funds are listed as a new function even though every State in the country already has such funds to protect consumers.

ERISA enforcement mechanisms are listed as some new bureaucratic scheme. That sounds large and bureaucratic until you realize the chart is referring to existing law that allows the Federal Government to investigate and enforce civil and criminal activities such as embezzlement and health insurance scams.

There are many ways to chart the current systems; I wish we could have a chart to compare the current system with what our colleague from Pennsylvania has depicted in the Chamber.

What is not depicted, of course, are the 38 million Americans who have no insurance, including more than a million people in Pennsylvania today without insurance; 58 million Americans who have preexisting conditions are not listed anywhere on the charts.

I wonder how we would chart electricity today. Americans go into a bedroom, or a kitchen, or a living room and flick on a switch and they have electricity. I doubt many know how they got the electricity into their house, but they sure know it works. And they depend on it. It is there when they need it. But certainly people recognize that electricity is complicated, and that electricity would take a lot of boxes and charts and graphs and grids. The fact is, it is there.

Time after time, you can put charts together to reflect the complexity of whatever it is we use. Take for another example the automobile. I guarantee you the Senator from Pennsylvania, the Senator from South Dakota, the Senator in the chair, and the distinguished Presiding Officer from Nebraska, could not today write down how an automobile works. We could not depict the engine and all of its parts. But when I turn the key on, I expect it to work.

That I think is what we are attempting to do with health care. Let us make it work better. Let us make sure the parts work. Let us not make it any more complicated than it has to be, but let us recognize that it is complex.

Mr. KENNEDY. Will the Senator yield?

Mr. DASCHLE. I would be happy to yield.

Mr. KENNEDY. Does the Senator not agree with me that, first of all, if we just accept the argument that we see, we cannot predict projected costs of medical needs, that could just lead us to paralysis?

On the other hand, does the Senator not agree with me that we can project what it is going to cost if we do not take any action, that we are going to be approximately $1 trillion this year and $2 trillion by the year 2000? We know that. We know it is going to be $100 billion more this year over what it was last year. We can predict those escalations of cost, can we not?

When we are talking about where it was a number of years ago and how Medicare started off, we understand that, No. 1, we have much better ways of predicting and projecting costs certainly today than we had at that time, and second, we do know what is going to happen if we do not take any action at all. Those numbers are virtually certain in terms of the escalation of costs without taking any action.

Does the Senator think that is something we ought to take note of as well?

Mr. DASCHLE. The Senator is absolutely correct. We do need to take note of the cost of doing nothing. Let us try to find a chart depicting the incredible obstacles people have today in trying to achieve meaningful health care. These are the people whose faces we see on the steps of the Capitol and the people who write and call our offices. These people are extraordinarily frustrated with the current system because of its complexity, because of their inability to access the system, and because they do not have the resources that some of the wealthy in this country have to get health care. There are a lot of people in this country who simply cannot get through the maze that we have in our current system, and that is in itself a tragedy and something that we have to address.

Mr. KENNEDY. Just one final question. We knew we were to spend a good deal of time here on the issue of cost. But how do we cost out the anxiety of those mothers or fathers of the close to 10 million children that are not either being covered by Medicaid or covered by good health insurance? How do you measure out the anxiety that they have every night when they go to bed and wonder about whether their child is going to get sick? How do we measure the costs of those parents that say I am not going to let my child ride a bicycle today—all the other children are going—because that child might break his or her arm and we have not the money to do it. I am not going to let them go skating in the wintertime; I am not going to let them go sledding because we cannot afford it.

Around here, we begin to look very quickly at the cost of everything, and we begin to loose the value of some other parts.

I am just wondering if the Senator does not agree with me that there is a lot we have to deal with on the issue of cost, but we also ought to think about what the costs are in terms of families, working families, that suddenly lose their job and lose the coverage when they have children that have special needs, that cannot afford a pair of glasses when their children go to school—and we provide glass care and some dental care in this program—and those children are reading the charts and are slow in learning. What is the cost of that? For all those who say, "Oh, well, we can't."

We have a big chart here. We have a big chart. Let us put up the chart for the Federal employees insurance—I daresay it would be as big as any one of those—and find out how many of these members do not want to get covered. Let us get real in terms of some of these matters. I see other colleagues here.

Mr. REID. Will the Senator from South Dakota yield?

Mr. DASCHLE. The Senator from Massachusetts made a very important point. The Senator from Massachusetts drew the distinction between cost and value. We know what it costs; we can even project how much this system is going to cost our country and the average American family in the future. But what is the value today to a family that would like to have the opportunity to have access to good medical care? How much do we value having health security that can never be taken away? It is incalculable.

And so the distinguished Senator from Massachusetts makes a very important point. We can calculate the cost. It is difficult for us to calculate the value.

I yield to the Senator from Nevada.

Mr. REID. Our colleague from Massachusetts reminded me of something that is so important, I believe. Twenty-four years ago, I was elected Lieutenant Governor of the State of Nevada. One of the first meetings I had, having been elected, was a woman working for the State welfare department. She came over to see me to talk about dental care. She explained to me how important dental care was to children especially, that a child who has crooked teeth, rotting teeth, may talk during their whole childhood like this. They are afraid to talk. They develop speech impairment.

Now, that was 24 years ago, and we as a nation still do not have decent dental care for children. In the Mitchell plan, there is dental care up through the 21st year. Do you realize how important this is to somebody who grows up with teeth that are crooked?

When I grew up in a small rural community, I was very fortunate; my teeth turned out OK. I did not go to a dentist until I was 16 years old. My teeth are fairly straight. But I am only lucky.

Today, in America, the public should be advised if we pass the Mitchell bill, up through age 21, no matter how rich you are, no matter how poor you are, you can go to a dentist and have your teeth taken care of. That is not the case with the bill across the aisle. Dental care is null.

Mr. WELLSTONE. Will the Senator yield?

Mr. DASCHLE. I think the Senator from Nevada makes a very important point.

I wanted to talk a little bit more about the comparison we have between the Mitchell and Dole bills. I would be happy to yield to the Senator from Minnesota.

Mr. WELLSTONE. I appreciate it. It is more a comment about what the Senator from Massachusetts just said with a tremendous amount of power and passion.

The PRESIDING OFFICER. The Chair would notify the distinguished Senator from South Dakota that the 10 minutes allocated to him has expired.

Mr. MOYNIHAN. Mr. President, I yield another 5 minutes to the Senator from South Dakota.

Mr. WELLSTONE. I do not want to take up 5 minutes. The Senator from South Dakota can go ahead.

Mr. KENNEDY. Mr. President, how much time remains? This is a rather interesting debate.

Mr. MOYNIHAN. We are not short of time, Mr. President.

The PRESIDING OFFICER. The remaining time allocated to the distinguished Senator from New York is 70 minutes.

Mr. WELLSTONE. Mr. President, I wonder if I could ask the Senator. I have one comment that will take about a minute, and then I would be pleased to yield, but only if the Senator from South Dakota will have more time.

Mr. DASCHLE. I think the chairman has indicated we would have plenty of time.

Mr. WELLSTONE. This is said more in the spirit of reflection.

I would say to the Senator from Massachusetts that I remember when we had before the committee a group of citizens from Kentucky, and none of them had health insurance. They worked for Kentucky Fried Chicken, and Pizza Hut. It was very moving to me because that is where my wife is from. I had been just looking at all the statistics about all the big campaign contributions. But these people get hurt. I mean, in some sort of an awful way they are getting left out of the picture. I think the Senator from Massachusetts was really speaking for them. Their testimony was so compelling.

So when I debated Senator MCCONNELL this morning on a show—this is not a criticism of him at all. We had very little time. At one point I said, "What is the alternative?"

When I looked at the distinguished Republican leader's plan, those people, I say to my colleague from Massachusetts, that came all the way to Washington to lay bare their personal lives, they are out of luck. I mean 30 million people still are without any insurance, and some 6 million children are still without any insurance. Older people still have to live with the terror of either not being covered because of a sickness or having to pay four times what others pay. They are just out of luck.

So I think we should be clear about what is at stake here. For those who are saying no, no, no, this is awful, awful, awful, bureaucracy, bureaucracy, bureaucracy, et cetera, et cetera that we have heard over the years, what is the alternative to make sure that we can provide dignified health care for citizens in our country? The vast majority of people in the United States of America with their goodness of heart have said we believe everybody should be covered, and we believe employers should pay their fair share, and we believe it should be as good a plan as Senators and representatives have.

I think that is what the Senator just said.

I thank my friend from South Dakota.

Mr. DASCHLE. I thank the Senator from Minnesota. I certainly agree with his comments. Obviously, that is really what this debate ought to be about, to flush out the differences. That is why I asked to take the floor this morning.

I have had the good fortune to serve on the Finance Committee since I came to the Senate. I certainly have developed a profound respect for the Republican leader, and have noted with great interest his extraordinary attendance in the committee as we have attempted to address the issue of health reform. He has been an extraordinary participant in the health care debate now for many, many months. I know he is as troubled as we are about trying to arrive at a consensus on meaningful health reform this year.

Two nights ago, the Republican leader introduced his version of health reform. We are just beginning to understand what is in it, what it does, and what its impact would be on the American people. Obviously, we are going to have a lot more to say about that in the coming days. We have just had the opportunity over the last 24 hours to examine it in any detail. I must say, after a preliminary look, I think it is fair to state that this bill falls far short of the goals enumerated even by the Republican leader himself.

Unlike the Mitchell bill, which provides a road to universal coverage, the Dole bill provides no one with guaranteed coverage. No one has the assurance that they are going to be protected in the future. Lewin VHI, one of the most respected private analytical firms, estimates that more than 30 million people, 75 percent of those uncovered now, will still be uncovered if the Dole bill were to pass. Six point two million children are left uncovered under the Dole bill. It does nothing to reverse the trend among employers to drop back family coverage to covering only one worker, a trend that is happening all across the country today.

In order to cut costs, businesses are saying we will insure you but we simply cannot afford to insure your families anymore. There is nothing in the Dole bill that addresses that problem. We are leaving millions of children at risk of losing the coverage that they have now as a result of that trend.

Mr. President, 30 million people with no coverage means we are going from about 80 percent coverage to 88 percent; not 100 percent as the President proposed, not even 95 percent as our majority leader proposed by the year 2000; in fact, not even 92 percent as the Finance Committee bill would propose; 12 percent of the American people would be left without coverage if this bill were to pass.

The Dole bill is not health security. No one should be misled. If every other industrialized country in the world can reach 100 percent, Mr. President, why can't we? Why do we have to tell millions of Americans in 1994 that they are out of luck? It is not just a matter of health security. It is also a matter of responsibility.

The message is loud and clear. If we were to pass the Dole bill, the message is simple. If you want someone else to pick up your health care costs, go right ahead. Just quit paying premiums. Do not worry about it. Somebody else will take care of it. We can shift those costs on to those who do pay. So do not worry. You do not have to pay your health care premiums. That is how things are now. And we will continue that practice as far into the future as we can see under the Dole bill.

Let those conscientious businesses who now pay pick up your costs take heed. Conscientious businessmen paid $35 billion more in additional costs just this year as a result of the cost shifting currently in place.

We all talk about ending cost shifting. It's easy to talk about. But this bill is an open-ended invitation to accelerated cost shifting, Mr. President. So if you are a business paying premiums, hoping that everyone will pay their fair share, you, too, are out of luck. Luck just runs out, especially if you are a small or a medium-sized business.

The Dole bill would continue to permit insurers to charge different rates to small employers because of their size. The smaller you are, the more you might pay. It discriminates against small employers who already pay more. Unlike the Mitchell bill, there is no discount to small business.

You have a situation where small businesses may actually be required to pay more because they are small and because there may be an additional risk associated in some cases with smaller business. But then in many cases the Dole bill says insurance companies do not have to sell to small businesses at all. Insurance companies can sell whenever and wherever they want.

So the bottom line is there is little new coverage, and, most probably, much higher premiums.

Mr. KENNEDY. Mr. President, will the Senator yield?

Mr. DASCHLE. I would be happy to yield to the Senator from Massachusetts.

Mr. KENNEDY. Just on this issue about the cost, on this chart I have, the comparison between what would be the amounts under the Mitchell and under the Dole program, it is here in the bill itself. There are provisions in the bill that outline the subsidy provisions.

It talks about, on page 28, in "general purposes of this part," the term "premium subsidy." "Eligible family" means a family income determined under the various provisions, and then it outlines it later on. I hope we will have a chance to go through this because I hope those who are supporters of the Dole bill will find someplace in its 600 pages where the opportunity for choice is available. There is no opportunity for choice of a doctor.

Let us just talk about, as the Senator was talking about, the availability. Once you reach the 150 percent, you are on your own. So these are for the income of $22,000. You are talking about the premiums here. This is percent of income, 27 percent; 23 percent; 20 percent. So we are talking here about hardworking men and women. Under the Dole proposal, they will have access to health care if they get that kind of funds, if they have that amount. If they want to pay 23 or 27 percent of their income, they will be able to buy that, as compared to the shared responsibility program.

Mr. DASCHLE. What you are saying is that somebody who is making $22,000 a year would pay $6,075, about 27 percent of their income; it is 27 percent of the income under the Dole plan, is that what the table says?

Mr. KENNEDY. Exactly. Based on CBO estimates from the Mitchell bill and the Finance bill. We have been listening to the debate and discussion about how we are not going to permit the Federal Government to sort of take over. Well, you do not have to worry with the Dole bill, because how many of the families are going to be able to afford that outcome? At least in the Mitchell bill we are talking about the shared responsibility. Under the Dole bill, we see even when you are down to $14,000, you will pay $1,000 for your program, at 6.8 percent. I think what this shows is you can have all the words that you want, but it just does not begin to show.

The other part of the program here is on page 54. Under the State program, it says a State program shall require each health plan sponsor to make available to each community-rated individual the opportunity to enroll, directly or indirectly through a purchasing cooperative, in a certified health plan which provides Fed-med benefits. There is nothing in here about choice or individual choice.

Mr. REID. Will the Senator yield?

Mr. DASCHLE. Yes.

Mr. REID. I say to my two friends who are here on this colloquy now that it seems to me that the Dole proposal keeps things the way they are, because now we have universal access. If somebody gets hurt or sick, they can go to the emergency room. But that is different than universal coverage, is that not true?

Mr. DASCHLE. It is different. Universal access is the opportunity to walk into the show room, but you may be unable to buy the car.

Mr. REID. We have that now.

Mr. KENNEDY. Certainly. As you see under the Dole program, for working families with $25,000 to $29,000 in income, that is pretty good, but it is right in there for hardworking men and women, factory workers, school teachers, construction workers. You will be able to pay $6,000—20 percent or 23 percent or 27 percent—at an income of $22,000. That is a wonderful program. To think that that is going to reach universality, I think, defies logic and understanding of the real purchasing ability of families. Most families in these areas are hardworking, having a difficult time paying a mortgage, putting their kids in school, putting food on the table, and providing heating oil for themselves up in my part of the country. I thank the Senator for yielding for that purpose.

Mr. DASCHLE. I appreciate the Senator's contribution.

There are two other stories to tell from this chart. First of all, these are 1994 figures. That does not tell the story of a 15- or 20-percent increase, the inflationary costs, in premiums every year. What will it be in the year 2000? Nor does it say what a sick family will pay or what an old family will pay. This chart assumes a healthy family. The Dole bill has a modified community rate. Insurance premiums under the Dole bill actually get more expensive the older you are or the sicker you are.

A Newsweek magazine article on the 25th of July, on page 19, said the Dole plan "will increase premiums for middle-class people and could increase the number of uninsured." It could increase premiums for the middle class. I think that is really what this chart is all about. It is really remarkable. There is less coverage and more cost. So if you are in the middle class, Mr. President, you, too, are out of luck.

You are especially out of luck if you are one who is seeking worker protection. If you are unemployed or if you lose your job, you are in particularly difficult circumstances. If you lose your job, you cannot take your insurance plan with you. If you are unemployed you have to pay the entire premium yourself if you want to have the protection you had on your job. So you are out of luck as well if you lose your job or are unemployed.

Not only are working people out of luck with this proposal but, frankly, so are retired people. We talked earlier about the chart's implications for those who are older. Well, the Dole bill relies heavily on savings from Medicare. Unlike the Mitchell bill, it gives nothing back to older Americans. Medicare cuts provide the savings, but, unlike the Mitchell bill, there is no help with prescription drug costs. Or with long-term care costs. The Dole bill ignores the fact that drug costs are the highest out-of-pocket expense for three out of four seniors in the country today; that 31 million Americans under the age of 65 would have no protection for prescriptive drugs under the Dole bill; and that 18 million people over the age of 65 would be denied drug coverage.

AARP said it probably as succinctly as you can: "The Dole bill is a harmful prescription for older Americans. Unlike the Mitchell proposal, which invests $50 billion in new home- and community-based long-term care, the Dole bill does virtually nothing for long-term care."

Small firms with more than 50 employees will remain at the mercy of insurance companies who charge even higher rates for sick and older workers, and even raise rates when one employee gets sick. That means older workers will have jobs at risk when their employers look closely at the insurance premiums.

So, if you are a sick or older person, you are in particular jeopardy under the Dole bill. There is nothing, in my view, to rein in the bureaucracy that the Senator from Pennsylvania talked about earlier. More workers today are the victims of administrative costs and bureaucracy than in any other system anywhere else in the world. We have a 20-percent administrative cost today associated with the current system, and we have not yet found anything in the Dole bill that deals with the extraordinary administrative costs.

So bureaucracy is likely to grow under the Dole bill. The bill does nothing to stop the flow of tax dollars into the health system. We are told we can see a proliferation of costs over the next 10 years which would double the cost of health care. I am, frankly, very concerned about the cost implications of the Dole bill. It is very simple. If the Dole bill passes, millions of Americans are just out of luck—if you are uninsured; if you lose your job; if you are a senior citizen; if you are a business-paid insurance; if you are a small business; or if you are a taxpayer. During the last 24 hours we have had a chance to examine what will happen if the Dole bill were to pass; we are beginning to come to some very concrete conclusions.

We can do better than this. If this had been our attitude 30 years ago at NASA, JOHN GLENN would still be waiting to make his first orbit. If other countries had not addressed this issue more effectively, then they too would be suffering the consequences of failure that we in the United States do in 1994.

We can do better than this. We can solve this problem. We all agree we must go slowly, step by step as the Mitchell bill has laid out, but we need a plan; we need a blueprint; we need to know exactly how it is we are going to get from here to there.

Will we change it along the way? Of course we will. Do we need to modify as we understand implications of this growth in coverage? Absolutely. But there is a big difference between doing it slowly and not doing it at all.

I know I have used more than my share of the time. I appreciate the time.

Mr. MOYNIHAN. Mr. President, the Senator did very well indeed.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, how much time does the Senator from Nevada desire?

Mr. REID. Fifteen minutes.

Mr. MOYNIHAN. Could he make that 12½ minutes?

Mr. REID. I am happy to.

Mr. MOYNIHAN. That is because we have a fixed amount of time, and we have many of our friends and colleagues waiting.

Mr. President, I yield 12½ minutes.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, this morning on a telephone call I was asked why I am supporting the Mitchell bill. It was an opportune question asked this morning because I had just been through a relatively traumatic experience dealing with a woman from the State of Nevada. Her name is Erin Dowell. I met Erin in Washington less than a year ago. She was here to testify about the high cost of health care. Her bills were, at that time, about a half million dollars. She is 27 years old, a vivacious young woman.

A week later I saw her in Reno, bedridden, a blanket wrapped around her, trying to stay warm even though it was warm in the house. You see, Mr. President, she is one of the people, one of the faces, a real human being, that the Mitchell plan will take care of and the Dole plan will not.

The reason this was an opportune time for me to be asked that question was because yesterday we were told by Erin that she is now in a hospice. Erin is going to die in a matter of a few days, maybe a couple weeks.

She has given up medical treatment. She is, as I indicated, one of those people who fell through the cracks. She had an industrial accident. From the time that she was treated for the industrial accident until the time she got another job, with no insurance, she got leukemia, cancer of the blood. During this period of time she had time to be cured but could not get the programs worked out. She was not able to take the insurance that she had with her, to take care of her medical condition.

You see, Mr. President, what we are talking about here in this historic debate—one of the most important debates in the history of this country—are the Erin Dowells of the world, people who have fallen through the cracks and are not being taken care of. We have the opportunity, after 50 years of debate and six or seven Presidents, to provide health security for the Erin Dowells of the world, my world, the State of Nevada, and our country.

I enter this debate encouraged and committed to passing a bill that the majority leader has put forth. A perfect bill? No. There are things in the bill that I do not like, but I am going to support the Mitchell legislation because it does so much good, because it is the best that we can do. And if there are amendments that improve the bill, I will support those as well.

I am charged for action because the people of Nevada cannot afford any more delay. Almost 300,000 people in Nevada make between $20,000 and $75,000 a year. It does not sound a lot by the standards of New York. It is a lot of money by the standards of South Dakota, and not a lot by the standards of California. But it is 300,000 people who, if we do not do something, their insurance premiums will escalate. Next year they will go up about $700, and after that even more.

Since 1986, health insurance premiums in this country have gone up almost 120 percent, and they will continue to go up if we do not do something. The average for people who have no insurance and are working is about 60 percent. In the State of Nevada it is 83 percent. In the State of Nevada, 83 percent of the people that have no insurance are workers. They work. This legislation will help. The Dole legislation will not.

Erin Dowell, if the Mitchell plan were in effect, would be OK. Under the Dole plan she would not be OK.

As Newsweek magazine predicted on July 25, the Dole plan will increase premiums for the middle class and could increase the number of insured.

Mr. DASCHLE. Mr. President, will the Senator yield?

Mr. REID. I yield.

Mr. DASCHLE. What does the Senator think happens in Nevada when the costs continue to escalate? Is he finding the same thing in Nevada that we find in South Dakota?

Mr. REID. The uninsureds skyrocket.

Mr. DASCHLE. I understand that every minute 48 people lose health insurance.

Mr. REID. That is right, permanently. There are more who lose their insurance. Two million people a month lose their insurance in this country; 100,000 of the 2 million each month, permanently. When we put those to numbers, it is thousands and thousands of people a day.

Mr. DASCHLE. Is that not the big concern? If we do not contain costs, if we do not find a way to get down into the single digits, we are going to ultimately have a higher percentage of people in Nevada uninsured than there are insured simply because they cannot afford it.

Mr. REID. I say to my friend from South Dakota, there will be no Erin Dowells in the world. We have here, if you lose your job, you are out of luck, and that is what they are saying about the Dole plan. The Dole plan does nothing to change the law as it now exists.

Now, as we have talked before with the Senator from Massachusetts, there is universal access. Sure, if you have money you can go to any doctor or hospital in the country. But the Mitchell plan does more. It allows portability so Erin Dowell, when she lost her industrial job that she got hurt on, would have been able to carry the insurance with her automatically, because she is out of work. And this will allow someone out of work to make the premiums on their private insurance. This is not a Government-run program.

That is another thing that kind of irritates me, and I am trying to educate the people of Nevada. This is not a Government-run program. The program we are developing, we are going to privatize Medicaid. Does that not sound good?

Mr. DASCHLE. If the Senator will yield, I appreciate his raising that issue because we hear so often that we are adding to the bureaucracy and we are somehow adding to governmental controls when, in fact, we are doing just the opposite. We are moving away from Government controls and more to the privatized system, providing the incentives in the system itself to work. We are privatizing Medicaid. We are giving opportunities to senior citizens that they do not have today, to buy adequate prescription drugs. We are using the competitive method to achieve effective cost containment.

So I appreciate the Senator raising the issue, and I hope over the course of this debate, at least on that point, we can clarify what it is that the American people can expect when it comes to passage of the Mitchell bill.

Mr. REID. Let me say to my friend from South Dakota, while talking about myths, could I discuss another myth that just irritates me because it is not true?

We have heard a number of statements. In fact, one of our colleagues on the other side of the aisle read a letter from a doctor constituent saying "My boy nearly drowned." That if the Mitchell plan had been in effect, the doctor would have been put in jail—or words to that effect—for treating my son because he was not part of an approved plan. That you cannot give doctors money unless they are part of this little program.

That is simply not true. If you look on page 23 of Senator MITCHELL's bill, you can pay a doctor anything you want. You can pay him in South Dakota a bale of hay, or in Nevada maybe they could go to one of the gaming tables for a while. You can pay. Or you can pay him in cash or check or credit card. There is no limitation what you can do doctor/patient.

So I think that is a myth we need to get rid of here. The fact is it is not going to take away the choice factor.

Mr. DASCHLE. If the Senator will yield, there is a point that oftentimes is raised about fines that are generated as a result of misusing the system. I think there is a significant degree of confusion about what it is we are talking about with regard to these fines.

There are fines directly written into the bills. Those fines are very easily understood if you read the bill as you should. Those fines simply go to the concern raised on countless occasions before the Finance Committee about the tremendous amount of fraud that currently exists in the system; $70 billion of fraud today.

So clearly if we are going to rid ourselves of that fraud, there has to be a penalty associated with those who are perpetrating fraud.

This is what this bill does. It addresses, in ways that we do not do in the current system, effective methods of fraud prevention. I hope that too is something we can address in the debate in the future?

Mr. REID. I appreciate my friend from South Dakota.

I would also like to say two other things I think are important. In Nevada—a small State populationwise, large in area—right now there are 400,000 Nevadans who have insurance that have lifetime limits; that is, they reach a certain amount they lose their insurance. So if they get a dreaded disease, they have to live in fear of losing their insurance.

And I am sure the numbers are significantly high in South Dakota and in California and in New York. The Mitchell plan would do away with lifetime limits. That is important.

I mentioned earlier, and I wanted to touch on it again, dental coverage. Do we realize how important it is, especially for young people, to be able to have their rotting teeth, their crooked teeth, taken care of? It changes people's personalities; it changes their ability to learn; it changes their whole outlook on life.

Under the Mitchell plan, if you are 22 years of age or younger, everybody can see a dentist. Is that not important? With the bill that is sponsored by the minority leader, my friend, it does not do that. There is no dental coverage. I think that is a significant difference between these two pieces of legislation.

I also suggest that one reason, in addition to Erin Dowell, that I feel we have to do something, is that in Nevada we have almost 80,000 children that will no longer go without health insurance. And preexisting conditions, in the State of Nevada, we have over 350,000 Nevadans who will no longer be denied coverage based on a preexisting condition. If you get insurance under the present system and you get sick, you do not want to leave that job, because if you go get another job they can deny you coverage because you have a bad back, because you had a heart attack, because you developed diabetes.

So, Mr. President, this legislation is important legislation. It is important because it will change not only how it deals with the Erin Dowells of the world, but it is also important how it deals with small businesses.

Why should a small business that wants to insure its employees pay 35 percent more for the same coverage that big business gives its employees? There is no reason. Why should small business have to pay 50 percent higher insurance premium rates every year than big business? There is no good reason. And that is why small businesses are, right and left, dropping their insurance.

So I hope that, as this debate develops, Mr. President, we will understand that it is individuals that we are dealing with. We want to make sure that human beings in America are taken care of when they get sick or are injured, and are not denied treatment where and when they want to be treated.

We all receive letters and we receive telephone communications about people who are sick.

Mr. President, I want to tell you about a woman who wrote me a letter saying that her husband is one of the uninsured in the State of Nevada. He is retired; too young to qualify for Medicare. As a result of his symptoms for diabetes, he tried to go to a doctor. "Nobody will take a patient who is uninsured," she writes, "especially when hundreds of dollars' worth of tests need to be taken before that doctor can arrive at a decision."

This woman writes to me saying that she could not receive treatment for her husband. Time and time again, she tried. She closes her letter by saying, "Hopefully, this letter will encourage you to see that somebody else's loved one does not have to suffer needlessly just because he does not have the money or insurance."

That is why the Mitchell bill needs to pass and the Dole bill needs to be defeated.

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. I thank the Senator from Nevada for his very fine statement.

Mr. PACKWOOD. Mr. President, I yield 5 minutes to the Senator from Arizona.

The PRESIDING OFFICER. The Senator from Arizona is recognized

Mr. McCAIN. Mr. President, we learned yesterday that the American Association of Retired Persons has endorsed the Clinton-Mitchell health reform bill. This announcement should sound a trumpet of alarm to the American people, particularly to our seniors.

Mr. President, in the words of Yogi Berra, it is deja vu all over again.

History—the great predictor of the future—tells us that when it comes to determining whether a piece of legislation is best for older Americans, the position of the AARP in Washington in no way illuminates the answer.

We might remember the Medicare Catastrophic Coverage Act of 1988. That bill was conceived, written, and pushed by AARP's Washington lobbyists. As we all know, when seniors were finally privy to the practical impacts of the catastrophic bill a veritable revolt among the beneficiaries forced Congress to repeal the act.

Notwithstanding the ground-swell of opposition by seniors to the catastrophic bill when they learned what it was really all about; and notwithstanding the repudiation of the national AARP by its local chapters, including every chapter in Arizona, the organization's Washington leadership fought repeal of the mistake every step of the way in an enlightening demonstration of just how painfully out of step they are with their members. Mr. President, that is a fact.

The same indifference to the interests of their members characterizes the AARP hierarchy's lack of vision and leadership on the Social Security earnings test, which overwhelmingly the seniors of this country want to repeal and they continue to oppose.

Mr. President, the fact is, my phones are ringing off the hook from members of the AARP in Arizona. AARP's phones are ringing off the hook from outraged citizens who want to know what they purport to represent, because they are not representing the views of senior Americans, as they did not on catastrophic health care, as they do not on the repeal of the Social Security earnings test, nor do they on this issue.

Great stock is placed in where this group or that group comes down on a piece of legislation. But let us not make the mistake of confusing an association's leadership for its membership. The AARP's famous pattern of being grossly out of touch with seniors should be sobering, as should their endorsement of the Mitchell-Clinton health bill.

Mr. President, I fear that with the Clinton-Mitchell bill we are headed down the same garden path as the catastrophic bill—legislation where motives were good and intentions honorable but the views of the public were grossly miscalculated and real world outcomes were woefully ignored.

It is time for groups like AARP to put the prerogatives of the people they represent ahead of their politics.

The AARP's endorsement of the Clinton-Mitchell plan is another eerie reminder of the catastrophic experience. Let us hope we learned from the experience, and that our vision will be clearer and the outcome more enlightened.

Mr. President, I reserve the remainder of the time for the Senator from Oregon.

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. Mr. President, I yield myself some time. I will be very brief.

Mr. President, I rise to correct any possible misunderstanding that my colleagues may have about the provisions in the majority leader's proposal dealing with medical residency training.

In my opening statement, I made clear my concern about attempts to control either the number of training positions available for medical residents in this country or the distribution of those positions as between general practitioners and specialists. In my judgment, it would be an act of hubris for the U.S. Senate to presume to know what the future course of medical science will be, let alone to try to dictate that course through regulatory controls.

My concern is that while the majority leader has now deleted the specific numerical limits of his first version, there is still a clear mandate to reduce residencies by an unspecified number. On page 495 of the most recent version, it states that the "total of the respective annual numbers" of residencies "shall be reduced by a percentage determined by" the new National Council on Graduate Medical Education—for each year between 1998 and 2001; reduced over the same period in which they were stipulated to go from 134 to 110 in the earlier version.

Hence, a distinction without a difference. With or without a target of 110 percent or any other number, the purpose is clear, the statute would be straightforward: cut the number of residency training positions, and do so soon. Any such mandate to reduce medical residency positions would be an unprecedented intrusion into the science of medicine.

Morever, the newest proposal still includes specific requirements that would reduce the number of residencies in specialties other than primary care to no more than 45 percent of the total. Here, surely, we encounter social engineering at its most audacious and problematic.

I am much impressed by the analysis of this subject by Dr. Richard Cooper, who is dean of the Medical College of Wisconsin. In an article entitled "Regulation Won't Solve Our Workforce Problems," published in the medical journal The Internist in March of this year, Dr. Cooper observes that the considerations that go into determining how many primary care doctors a society needs are altogether different from those that determine how many physicians are needed in other specialties.

He states that "Primary care needs are based on demographic considerations" and that 80 to 85 primary care physicians per 100,000 population should be adequate and could be "assured if approximately 35 percent of medical graduates entered the primary care disciplines."

The need for specialists in other fields, however, is not so easily predictable "because it is so diverse"—again, I quote Dr. Cooper from a recent speech, "and because the development of the technology that underlies much of specialty medicine is so unpredictable—the appropriate size of the specialty work force is difficult to relate to any standard or proportional characteristic, such as population."

There you have it plain and simple. Primary care needs are based on demography, and specialty needs are based on science. Even if our projections with respect to population are correct—and in the near term they are very dependable now—we simply cannot predict developments in science. Who will tell you when the first breakthrough in Alzheimer's disease will come? Or AIDS? Or Parkinson's disease and such like, as others have come in the past?

Science does not proceed in predictable ways. It proceeds by insight and innovation that cannot be scripted.

We are now in the great age of medical science and it is centered here in the United States. The innovations come tumbling.

Dr. Cooper notes that artificial hip replacements became widely available in 1970, knee replacements in 1975, autologous bone marrow, liver and heart transplants in 1980. Oncology was scarcely a science until the advent of combination chemotherapy in the 1960's. You can reach out and touch those moments that changed the history of science and medicine—and they were not regulated.

Regulatory controls on specialists pose a threat of cutting off widespread access to such breakthroughs in the future. For that reason alone they are seriously ill-advised in my opinion. Moreover, in New York as elsewhere, academic health centers are located in urban areas that often have no other source of medical care. Reductions in the number of residents trained threatens access to basic as well as advanced medical care in those areas.

I reiterate my objections to these provisions. We should do everything we can to sustain the miracle of modern medicine that is found in our academic health centers and teaching hospitals. We should not tinker with matters so profound as the future of science or the academic freedom of our medical schools and teaching hospitals.

I thank the Chair.

Mr. BOREN. Will the Senator yield for a question? A comment?

Mr. MOYNIHAN. I am happy to yield.

The PRESIDING OFFICER (Ms. MOSELEY-BRAUN). The Senator from Oklahoma.

Mr. BOREN. Madam President, I compliment my colleague, the distinguished chairman, for the comments which he just made. I associate myself with those comments.

It would indeed be a tragedy for us to take legislative action that would curtail the progress in the field of science, progress which none of us can predict at this point. And it would be a very serious mistake.

The Senator has spoken with great wisdom. I compliment him on his remarks and I associate myself with him.

Mr. MOYNIHAN. I thank my friend from Oklahoma.

Madam President, I yield 12½ minutes to the distinguished and able junior Senator from California.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. I thank the chairman of the Finance Committee for yielding.

Madam President, before I give a few remarks on health care in general, I want to address the issue the Republican Senator from Arizona raised, which to me is another way of trying to scare senior citizens, much like Republicans did in the years when Medicare was brought into being.

I quoted just the other day a Senator from Nebraska, a Republican Senator in the 1960's, who said in his opposition to Medicare, "This is something the Senate is doing to the elderly, not for the elderly." Of course that was a discussion about Medicare, which is one of the most popular programs in this Nation.

I have to say it is not surprising the American Association of Retired Persons would endorse this. Look what is happening to seniors under the Mitchell bill. They get to keep Medicare exactly as they have it, exactly as they like it, and they get two new things. One thing they get is a prescription drug benefit which they desperately want and need. And second, for the first time we will have a long-term care benefit.

On a very personal note, when my mother passed away it was in a nursing home. She lost her last ounce of dignity because her last dollar that she had saved for her grandchildren went to pay that nursing home. It was very ironic that on the day my mother died, that was the day that she had given her last penny. And my mother was too prideful—too prideful—to take support from her family and she just checked out. I am convinced of that.

I said when I ran for the Senate that this had happened to me, I had seen this happen to my mother, and I did not want to ever see it happen to any other grandma or grandpa.

Frankly, I am so happy that the Senator from Massachusetts in his work, worked so hard on that issue and we do have the start of a long-term care benefit in the Mitchell plan.

So I hope when the Senator from Arizona, my friend Senator MCCAIN, gets up again that he will recognize that the fact that the AARP supports this is not such a surprise.

Mr. KENNEDY. Will the Senator yield for a brief comment?

Mrs. BOXER. I will be very happy to yield.

Mr. KENNEDY. Madam President, the Senator is describing an enormously touching, sad and all-too familiar tale of life for many of our senior citizens, because appropriate long-term care is not available. As someone who is blessed with a mother who is 104, we are doubly blessed in being able to care for her at home.

As a society, we are trying to find a way to provide more options for the elderly. Where an individual would like to stay at home and can do so with appropriate help, we should make that help available by providing home care. A second option is community-based care, which can enable people to live at home and obtain needed services in local centers. Many others will need nursing home care, and that ought to be available too. The Mitchell proposal offers many of these protections. It ensures that appropriate care will be available, without requiring senior citizens to pauperize themselves.

People wonder about these debates and whether the country is really watching. We have been talking about long-term care, and I received a wonderful communication just an hour ago from a person who has been watching the debate. It is a sheet called "Health Care Tips During Floor Debate on S. 2351." It has a picture of a little hot water bottle up here in the right front corner of the page. It is from Lou Swan of Elder Home Care, 1241 Main Street in Worcester, MA. He says:

> Don't allow your colleagues to swallow the line that the Mitchell bill is a big government take-over. Families in Massachusetts are being taken-over by the high cost of health care insurance.

He says:

> Filibuster is just another word for gridlock. To those who say we cannot afford health reform—gridlock is more expensive. That's a pretty good comment.

He says:

> Back in 1964, some of the same anti-reform forces tried to block Medicare by saying it was socialized Medicine. Fortunately, they lost—and millions of Americans today have Medicare.

The Senator from California was commenting about her mother and talking about her dignity. Here is what Lou Swan says: "We have been waiting for 30 years for Congress to take the third step to dignity—Social Security, Medicare, long-term care. Don't let the spin-doctors extract long-term care from S. 2351," he says.

And then Lou Swan goes on to say:

> Support language in the Mitchell bill which prevents providers of long-term care, like hospitals and home health agencies, from self-dealing and self-referring. Keep independent assessment and care planning for long-term care in the Mitchell bill.

That is excellent advice, and Congress ought to heed it.

Finally, Lou Swan concludes by saying, "The elderly of Massachusetts want a health care reform bill with long-term care and prescription drugs. A filibuster won't pay anyone's home care bills." He is absolutely right.

People like Lou Swan are listening to this debate. People are watching around the country, in Massachusetts and every other State. They know how important these hours of debate these votes in the Senate are going to be.

I thank the Senator for permitting me to make these comments. The Senator was sharing a very touching and very human story with the Senate and with the American people about what is really happening in rural America.

Mr. MOYNIHAN. Madam President, may I yield an additional 5 minutes to the junior Senator because we have had a very important exchange here and wanted to have that.

Mrs. BOXER. Madam President, I thank the chairman. I want to thank the Senator from Massachusetts, chairman of the Labor Committee, and say that I so well remember that in keeping my mother home, she needed 24-hour attention. It was $240 a day, and we did it as long as we could. And so our seniors out there who are listening to this debate—and not only our seniors, but the children and the grandchildren of those—should be calling our offices in droves and saying we need to support long-term care, we need to support the Mitchell bill because it is in the Mitchell bill.

In my State of California, 6 million people live without the security of health insurance—6 million people. One in four Californians under the age of 65 is uninsured; 59 percent of those without health insurance are in families headed by someone who works. So these are working families; 1.3 million are children.

My State's uninsured rate is 5 points above the national average, making my State the eighth worst among the 50 States and DC. These statistics are chilling. In 4 years, the number of uninsured in my State exploded by more than 1 million people.

So when I hear the Republican pundits, Bill Kristol to name one, say there is no health care crisis, well, Madam President, maybe there is not one for him and his friends who may well be wealthy, but for ordinary citizens in our country—and that is most of the citizens in our country—they have trouble, they have problems, they are worried that their own health insurance could be canceled at a moment's notice when they need it the most. They are worried that their young children, when they move outside of school age, will not be able to get their insurance. They are worried that if their benefits are capped and someone gets a catastrophic illness, they are out of the ball park, they are finished, they will go broke. And we have seen it again and again.

So let us put to bed this notion that we do not have a problem in America. You have to be, frankly, completely insensitive and, frankly, out of touch to say that this is not a problem.

It goes well beyond the uninsured, as I have pointed out, because those of us with insurance are walking on a tightrope. It is like Russian roulette. What is going to happen? Who is going to pull the trigger? Will my body get a disease that takes me out of the insurance pool? We have to stop this. It is un-American.

I am so proud, as Senator MOYNIHAN predicted in the last colloquy we had—I think it was last night or the night before, these days are blending—he predicted that we would vote not to delay; that we would defeat the Helms amendment, and he was right on target. We defeated the Helms amendment. I think that vote was important, although I do not know how much the press discussed it.

But I think the crunch time is coming, and I think to delay would be cowardly, to filibuster would be cowardly, and it is time to stand up and be counted on an issue we should be proud to be involved in.

Does that mean that the Mitchell bill is perfect? I do not think it is perfect. I think we can fix it. I have talked to Chairman MOYNIHAN and Chairman KENNEDY about things I think we can do to make it better. And frankly, I think we are going to make it better. I am one of those optimistic people who thinks we will make it better, but we have to begin soon to start offering those amendments and getting down to those tough votes.

I want to tell you that after listening to Harry and Louise for several months now, I decided to find out about Harry and Louise in real life. Who are these people? They are actors. They do a great job. Terrific. They get on television and they act like they are just ordinary folk and they are afraid of any change, and they scare people.

Harry and Louise in real life are very highly paid actors, and they are good. They have terrific insurance. Do you know they belong to a union, Madam President, and have terrific insurance? So what do they care if we do nothing? They are fine.

I like to think America is about more than just speaking out for things when you need it. I hope we would be more of a community. I have already shown you by telling you the problems that we face—those of us with insurance—that it really is our problem anyway. Why do you think we pay $5 or $10 for aspirin in the hospital? It does not make any sense on its face. But the reason we pay $5 or $10 in a hospital when we are insured is because there are so many uninsured Americans who are using the emergency room, it is so expensive, they do not carry their weight and we, those of us who are insured, have to carry their weight. So we need to insure as many Americans as possible. That is what the Mitchell bill tries to do.

People who quibble 95 percent, 98 percent, 96, let us face it, we are in the eighties now. If we can get to 95 percent with the Mitchell bill without any mandates, which is what that bill does, that is a huge step forward.

Would I like to get to 99? Yes. Theoretically, I would like to get to 100 percent. As I understand it, no program gets to 100 percent. With Social Security, there is an argument about whether it is 96, 97 or 98. Somebody told me it might be 99. I doubt that. But the fact is if we are getting high up into the nineties, we are doing an enormous amount for an enormous number of people.

The fact is we who have insurance are paying 30 percent more than our actual health care costs because we are carrying the burden of those uninsured.

Madam President, I want to tell you a story about when I was in the House. I was chairperson of a committee on health for the Budget Committee working under now chief of staff Leon Panetta. It was a privilege to work with him. He said, "Barbara, you go out there to the country and you find out about our health care system." This was some years ago.

What I found out is what we now all know to be true: That in America, we practice emergency-room medicine. I found a particular case in San Diego, and I will never forget it. A little child who did not get a measles vaccine, a little baby, 2 years old, no measles vaccine, gets the measles and gets very sick. The county and the city of San Diego, through their health care system, pumped $800,000 into that little child who did not get a $14 vaccine. And $800,000 later we lost the baby.

So what are we doing? We should be embracing the notion that if we invest in our children, not only is it morally right but it saves money, not condemning the notion that preventive care does not make any sense and it is too expensive. I will tell you it is the cheapest thing we can do to vaccinate those babies, and the Mitchell bill goes further. It says that children in our country will be covered.

There are a lot of people around here who talk about our children are our future, they are our best asset; without our children, where are we? We have a chance to prove it, Madam President, because the Mitchell bill covers every child and the Dole bill does not. So maybe we can stop the rhetoric.

I already talked about the fact that prescription drugs is a very important benefit for our elderly, but it is important for everyone. And in the Mitchell bill we will have a prescription drug benefit. It reminds me of another story.

In a small town in California, an elderly woman was a nurse who got very sick. She had a very complicated operation and needed $10,000 a month for her medicine. That was the difference between life and death.

The last time I saw her, she was selling off furniture in the house, and her children, whom she loved and to whom she wanted to leave her money, were having bake sales to get money for her medicine.

This is the kind of situation we have in our country—real stories about real people. So I hope, Madam President, that as we move forward, we are going to keep those people in mind. It makes so much sense for us to take people out of the shadows and bring them into the light of day and say we have a problem; it is a problem for all of us; it is a problem for our grandmas and grandpas, our moms and dads, and it is about us.

I truly think that some of the choices that families face today are barbaric. I went to a hearing with disabled children. The Senator from Massachusetts was there. The First Lady was there. There was not a dry eye in the place. We saw babies who could barely control their muscles, and we heard stories from parents who said they had to give up children because if they did not give up their children, they would go bankrupt, they would have nothing.

This is barbaric, and anyone who says we have to study more, we do not know what the problems are, simply is not alive and paying attention to life. I think the Mitchell bill is a fantastically intelligent step forward. I think we can improve it. I think we can improve it for California and for the other States. I look forward to working on it.

I close with this. Any American who is watching today, please listen for certain things. Listen for the scare tactics. Listen to the facts. Make up your own mind and let your voice be heard because we are still threatened by a filibuster, a filibuster that would mean we could not move forward on this issue, and this whole issue of health reform will languish into the next century and, who knows, the century after.

So I wish to thank the leaders on the Democratic side who have played such a positive role in this: Senator KENNEDY, Senator MOYNIHAN, the majority leader, Senator MITCHELL, Senator DASCHLE. I say to them I will be here as long as it takes, as late as it takes to be in attendance, to do what I can to help bring this to fruition. I think we will be proud when that moment comes that we send a bill to the President of the United States and we can say, when we are old and very gray, to our children and our grandchildren and our great grandchildren we did something to help the people of America.

I yield the floor, and I thank the chairman.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. May I thank the Senator from California. May I note the advantages of having on our side of the aisle someone who represents Hollywood and knows about the actors' union.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. PACKWOOD. The Senator from California is giving California a left and right body blow. First, she is going to levy a 1.75 percent tax on every local government that spends money on health premiums in California, which is all of them, the State and local governments.

Second, everyone with under 500 employees is going to be thrown into a different system. And CalPERS, as it is known, has perhaps one of the best health insurance purchasing organizations in the United States. All of the California municipalities with under 500 employees will no longer be allowed to belong. They go into a different system. And that is going to be a body blow to the California retirement system.

I thank the Chair.

Mr. MOYNIHAN addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. I have two requests. First, I ask unanimous consent that when this morning's debate expires at 1:35, approximately, it be extended to 2 o'clock, the additional time to be equally divided.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MOYNIHAN. Madam President, I yield 10 minutes to the able Senator from Wisconsin [Mr. KOHL], followed by 10 minutes to my good friend and fellow committee member, the Senator from Oklahoma [Mr. BOREN].

Mr. KOHL. I thank the Senator.

The PRESIDING OFFICER. The Senator from Wisconsin.

Mr. KOHL. Madam President, today our government is on trial. There is a widespread belief in America that Congress can not act when it needs to. We run the risk of confirming yet again this belief if we fail to enact health reform, that will be broadly accepted across our country.

The nation is watching, because we are addressing a problem that affects every American. They will hold us accountable for the outcome of this debate. They know that this is the most important piece of legislation we have considered in 30 years. And they know that our health system has needed reform for even longer.

On this we all agree. Whether we call it a crisis, a problem, or a catastrophe, we all agree the current health care system is too expensive, and not inclusive enough.

So why is so much of the debate about political parties and not about principles? How can we seriously discuss delay? And why does it appear that special interests and big money control this debate?

I believe the answer is that we are letting partisanship and politics get in the way of doing our job. And this only confirms people's views that we are not able to work together, in a mature and civilized way, to address the real problems of health care.

We must have bipartisanship, because without broad acceptance, reform will not be successful. Health reform touches every one of the people we are here to represent. If 100 of us can not put aside our differences, how can we develop a plan for 250 million?

We have to address Health Reform in a constructive, not a destructive, way. If we fail, the people's judgement will be severe.

This debate then is about more than health care. This is about whether we can govern.

Senator MITCHELL's bill is a good place to begin a constructive debate on health reform, because it addresses the basic problems the American people are concerned about—(1) knowing that their health insurance can never be taken away; (2) controlling costs; and (3) moving toward universal coverage.

The Mitchell bill reforms some of the worst abuses of the current health insurance system. 37,000 Wisconsinites lose their health insurance every month. While progress has been made, over 450,000 Wisconsinites still lack health insurance. Under the Mitchell bill, those who have insurance now will not lose it if they have a preexisting condition or change their job. This is what Americans want, need, and deserve.

The Mitchell bill moves toward universal coverage in a responsible way. Instead of forcing business to provide coverage, the Mitchell bill lets insurance reforms, State reforms, and market reforms work. Only if these reforms do not achieve universal coverage does this plan ask some businesses to contribute. And even then, only businesses in States that have not reached the goal of 95 percent coverage. That is an immense improvement over the President's original plan.

I believe we can make the Mitchell bill a strong, bipartisan bill—if we pay attention to what people do not want in the health reform bill.

People do not want government making their health care choices for them. Washington has an obligation to set the boundaries for a system that will produce decent, affordable, and accessible health care. But Washington should not run that system. People are frightened—I think rightly—about how a government that cannot balance its books can be expected to balance the myriad of health care choices that each individual faces.

For example, the Mitchell bill requires that all businesses with fewer than 500 employees contract with State-regulated purchasing cooperatives. I believe voluntary cooperatives—where businesses pool their purchasing power to get the best health care deals—have proven their worth. I am concerned that the Mitchell bill is moving away from these sort of voluntary choices and toward government solutions.

Second, people do not want to continue to pay ever-increasing amounts for health care. Until health care is affordable, universal coverage is only a slogan—and deficit reduction a dream. We must contain health care costs.

The Mitchell bill hampers efforts to constrain spiraling health care costs by tampering with the decisionmaking process of managed care networks. As the New York Times put it in an editorial 2 days ago, the bill would require.

> * * * health plans to do business with a long list of community providers—even if they give poor treatment, or if the health plan offered better ways to treat the population. The Mitchell bill would also force health plans to hire every type of specialist [on its list] even if such services were unneeded and costly.

Do we need to hobble our chance to contain health care costs with such government intrusion, in effect picking winners and loser before the competition starts? I do not think so.

I am also concerned about the Mitchell tax on high-cost plans that might not actually tax high-cost plans. It could easily penalize plans that have kept their costs low in the past, we certainly want to avoid this.

And third, people do not want new bureaucracies, unnecessary programs, and entitlements targeted toward special interests. We fool ourselves if we believe the American people want us to create scores of new and expensive programs. This legislation is an historic opportunity to bring affordable and stable health insurance to all Americans. It should not become a Trojan Horse, hiding pet programs, bits of legislative pork, or unnecessary new entitlements.

The bill creates over 20 new entitlements in addition to the low-income subsidies. This bill ignores an important fact: until we get the deficit under control we have no business creating new entitlements.

And some of the entitlements in this bill are not essential to achieving universal coverage or containing costs. Why do we need an entitlement for schools of public health? Why do we need an entitlement for dental schools? Why do we need an entitlement for OSHA to conduct education and training? These may be remotely connected to health reform, but health reform is too important to treat that way. I think the American people expect more of us.

I think they will be even more upset about these entitlements when they find out they are partially funded with an estimated $100 tax on every family's health insurance premium. This should not be acceptable. I will fight to get this deal out of the bill.

Our country needs health reform now. I will work with the majority leader, the committee chairmen, and my colleagues in the bipartisan mainstream coalition to improve the Mitchell bill.

The way we can do it is to remember where we agree, argue about where we differ, and move together toward a health care system that provides every American with affordable and fair health care coverage. Those of us responsible for drafting this bill will all have to give up something of significance to get a bill we can all agree on.

America is watching. We can fight each other, or we can fight for our country. I think the choice is clear.

I thank the Chair.

Mr. BOREN addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma [Mr. BOREN] is recognized.

Mr. BOREN. Madam President, I am very glad that I was in the Chamber to hear the remarks of my friend and colleague from Wisconsin. He has struck some themes that resonate with each and every Member of this Chamber on both sides of the aisle. I want to commend him for his appeal for bipartisanship.

When I go home and talk with my constituents, they say to me very bluntly:

> We don't want a Democratic health care bill and we don't want a Republican health care bill. We want an American health care bill, one that is the product of cooperation from both sides of the aisle, one that represents a consensus on both sides of the aisle. We know if we have that consensus there will be a blueprint that will not be changed, a blueprint upon which we can rely and make future decisions.

Those hospitals, those who are the health care providers, those in the insurance business, and average citizens seeking to obtain health insurance coverage, all need some certainty about the rules of the game.

We are embarking upon major changes in health care for this country that will take at least a decade to carry through. The only way to stay on the right path, on the same path, so there can be certainty for the American people, is to come to a bipartisan consensus. The American people must know that the decisions we have reached will not be reversed and changed with every succeeding election.

If we have a Democratic plan, and the next election tilts toward the Republicans, there will be major changes in it. If we have a Republican plan, and the next election tilts towards the Democrats, there will be major changes in the other direction. The people in America will be left with uncertainty about where we are going.

So I want to commend the Senator from Wisconsin for his appeal to bipartisanship.

I came to this Chamber today, I must confess, with something of a heavy heart because I believe we are on the wrong path. Senator MCCAIN quoted Yogi Berra a few moments ago when he said, "deja vu all over again."

A little over a year ago, I think we made a tragic mistake in this country by passing the budget of the U.S. Government for the first time in modern memory totally along a party line vote with 51 votes in the Senate, a tie-breaking vote all from one party with all of the other party in opposition. The same happened in the House of Representatives.

What a tragedy that is for the country because, like the changes that will come in health care, the need to bring down the deficit of this country will take a long, sustained joint partnership on the part of all of the American people. While we have made some progress toward getting the deficit down, the job is far from over. The administration's own figures indicate that with the additions to the deficit that are anticipated under the budgets that we have passed, shortly into the next century we will reach the point in which all of the private savings, 100 percent of the private savings in this country, will be used just to pay the interest on the national debt.

That, Madam President, will mean that our economic growth in this country is imperiled, and our future will be subject to the decisions of investors in other countries, not in this country.

The only way we are ever going to get the deficit under control and to sustain a long-range approach is to have a bipartisan plan, one that will have the support of the vast majority of the American people in both of our political parties. And the only way, Madam President, that we are going to have health care carried through in an efficient and in an effective way is to reach a bipartisan consensus so that plan can be sustained for many years.

When I had the opportunity to study in Great Britain, I saw what happened in that country. They nationalized some of the basic industries when one of the parties got in power. When the other party got into power the next election, they denationalized the industries. When the other party won, they renationalized the industries. Then they denationalized it again. By the time it was all over, there was precious little left of the basic industries like the steel industry of that country.

If we ram a bill through this Congress—and I hope my colleagues will hear me, I pray that they will hear me, I plead with them to hear me. We have to stop this train right now and get off, go back to the drawing boards, and start on the basis of trying to get something done together.

Let us not destroy the quality of health care in this country by passing a bill along party lines, by having 51 votes and ramming it through, and then waiting until the next election and have it reversed as the political fortunes of one party or another change.

Nothing discourages me more, Madam President, than to read that the First Lady, in a press conference 2 days ago said, "I have a lot of confidence in the outcome, and, if it is a 51-vote outcome, fine." And she went on to say, "That is what we had on the budget," and it was fine then.

Madam President, it was not fine. And it will not be fine either if we have a 51-vote outcome in this situation.

Recent polling data indicates that only one out of five Americans has confidence in the Congress of the United States; one out of five. The data indicates reasons for it, and there are several reasons. They do not like the way we finance campaigns. They do not like the fact that more and more money is being poured by special interest groups into political campaigns. They do not like the fact that Congress has not reformed itself institutionally. But above all—above all—the American people say they do not have confidence in Congress because they think too many Members of Congress put party ahead of country. They say they are sick and tired of seeing Democrats and Republicans bicker with each other like children on the school ground instead of getting together to work together as Americans. And at the very moment that more Americans now consider themselves to be independent, not firmly aligned with one party or another, the U.S. Congress becomes more and more and more polarized on a party line basis.

Madam President, I will not be part of that process. I wish I could stand here in the middle, in the center of this aisle to make this speech and to share these thoughts with my colleagues because I plead; let us move across this aisle and work with each other to do something.

I can feel what is happening here. I feel it. I felt it on the budget and I feel it now. People are saying, "They are dividing now on party lines." We are saying, "We have to get together to make sure our team wins." Our majority leader has presented a bill; our President has asked that it be passed, and therefore those of us on our side of the aisle must get together on our team and make sure that our team wins.

Madam President, I do not say what I have just said out of any disrespect to any Senator, particularly the majority leader. He has a very difficult task. If you were to ask me to name five Members of this body for whom I have the greatest personal admiration and respect, the majority leader of the U.S. Senate would be on that list. I have enormous respect for him and his personal integrity.

But, with all due respect, my duty is not to help the majority leader pass a bill or to help the administration pass a bill. It is to make sure that this is the right product for the American people.

I talked to one of my constituents last night, and he said, "Do you know what it sounds like to me when I tune in to the radio or watch the television? You people are working yourselves into a mindset that we have to have a bill, saying we have to pass something, and if we do not pass something, we will have failed." He said, "I hope you will stop and think what the people back home want you to do is not pass something; they want you to take an intelligent step toward health care reform for the American people."

Let me say, with all due respect to some of my colleagues on the other side of the aisle, who feel this is a chance to hand the President another defeat if they can stop anything from happening in the health care field, that is not what the American people want, either. It is not about embracing the President, and it is not about embarrassing the President. It is about getting together—getting together to write a health care bill that will work.

Madam President, with all due respect, I do not believe that the proposal now before us will work. I cannot support it, nor will I be the 51st vote on any bill or the 50th vote on any bill because, as a matter of principle, I believe it is a serious mistake.

Madam President, I do not think this approach is going to work. This bill sets up employer mandates in the year 2002. We do not know where we will be in 2002. Let us be honest. We have so little experience in the health care field in terms of the impact and unintended consequences that can flow from any piece of major legislation we pass that we have no idea where this country will stand in the year 2002, or what it would be wise for us to do at that time.

Why tie our hands in the future? Why pass a bill that sets up 13 new Federal boards and commissions and puts more regulatory burdens on the States, as well? Why pass a bill that will increase the amount of litigation by dramatically increasing the rights of people to press their claims in legal forums? Why pass a bill that does not have an efficient and effective standby mechanism to make sure costs are brought under control if, in fact, the costs exceed our estimates?

Madam President, the American people are way ahead of us. They know that the Government is notoriously bad when it comes to estimating what things are going to cost. They know that the Government of the United States does not have a good track record in running huge Government programs. Therefore, Madam President, what I think the American people want us to do is, first, get together. I wish the President would suspend this debate and call the leadership of both the Republican and Democratic parties together and say: Let us find those areas in which there is agreement. I think we can get broad agreement on insurance reform to make sure people who have preexisting medical conditions can get health insurance; make sure those people will still have coverage when they change jobs or lose jobs; provide subsidies for low-income people to help them purchase insurance; provide pooling for small businesses to get their costs down; provide tax credits for the self-employed to make sure more of them get coverage. These are significant first steps. I believe we can get 70 or 80 votes for that package of reforms.

Let us stop this train. Let us stop this mistake. Let us stop choosing up sides and asking "Are you a Democrat or Republican?" Let us be Americans, and let us find out what we can agree about. And then let us take a reasonable, important major step; and then 2 or 3 years later, let us see where we are and see how much it costs. Let us see what we ought to do next and take the second step together—as Americans.

Let us not try to ram something through on a party-line basis, with provisions to take effect in the year 2002, when we do not know what is going to be happening in this country or how much this program will have cost. Let us not do it. Let us go back to the boards. Let us prove once and for all that we can surprise the American people by having as much common sense in the Senate of the United States as they have back at the grassroots. We know we should work together, we know we should start on those things upon which we can agree. Instead of trying to revolutionize something all at once that we do not know much about, we can take a major and important step toward reform, cover more people, and take care of the glaring abuses. Then, let us evaluate where we are.

I plead with my colleagues, let us go back to the boards before we try to ram this through.

Mr. MOYNIHAN. Madam President, I would like to say to the Senator from Oklahoma, on a bipartisan note, and inform the Chamber, that even as he was speaking about bipartisanship, the House of Representatives, on a rollcall vote, was unanimously adopting the proposal for an independent Social Security Administration, which Senator PACKWOOD and I proposed on this floor about 3 weeks ago. After 15 years of debate, that is done, and well done. Did the Senator from Oregon wish to say something?

Mr. PACKWOOD. Madam President, I would like to add that the Senator is very kind to say "Senator PACKWOOD" and him, but no one deserves greater credit for that, and no one has worked longer for this time, than the chairman of the Finance Committee—even before he was chairman. I take my hat off to him and congratulate him.

Mr. MOYNIHAN. I thank the Senator.

I yield 10 minutes to the Senator from Nebraska, Mr. KERREY.

The PRESIDING OFFICER. The Chair advises the Senator that there are 18 seconds remaining.

Mr. PACKWOOD. I have no objection to extending the time, if we can extend it equally on each side.

Mr. MOYNIHAN. Madam President, I ask unanimous consent that the time be extended until 2:15.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. PACKWOOD. Where does that leave us? How much time do we have left now?

The PRESIDING OFFICER. The Senator from Oregon controls approximately 13 minutes.

Mr. PACKWOOD. I will get half of the time after 2 o'clock, then?

The PRESIDING OFFICER. Yes.

The Senator from Nebraska is recognized.

Mr. KERREY. I thank my friend, the chairman of the Finance Committee.

Madam President, following on the remarks made by the distinguished Senator from Oklahoma in an appeal for a bipartisan bill, I would like to describe what I think are ways for us to close the differences between the Republicans and the Democrats on this very important piece of legislation.

I will begin with an observation that two people who are apparently a long way apart—at least, I think observers would say that we are a long way apart on this issue of health care—are much closer than what meets the eye.

In this case, it is the Republican leader, Senator DOLE, and I who share a very similar experience. His is a bit more visible than mine. Fully dressed, you can hardly tell that I have been the recipient of health care that saved my life, and without which I would not be here today—which might trouble some in this country. Nonetheless, it is important to note that similarity.

I have read Senator DOLE's bill. It has the name of the Senator from Oregon on it. It is S. 2374. Unlike some who have urged me to say it is a sham, I do not believe it is a sham. I see principles in this bill that are similar to principles that I have, as well. Indeed, I think it is quite fair to say that the mainstream group has worked very closely with Majority Leader MITCHELL, the distinguished Senator from New York, and the distinguished Senator from Massachusetts, in trying to fashion an amendment that would strike many of the Government provisions that have been identified so eloquently—and sometimes, I might say, a bit preposterously by those who would like to describe the Mitchell bill as a "Government takeover" of health care.

I note with some pride that yesterday's speech by the distinguished Senator from Rhode Island, Senator

CHAFEE, identified 10 areas where he is prepared to make changes where he wants changes made to my bill. And I noted with some considerable excitement the distinguished Senator from Massachusetts immediately went and spoke for a considerable period of time.

My understanding is there is a possibility of agreement between those two distinguished Senators, apparently of opposite parties and apparently of opposite views.

Apparently as well, they are preparing to resolve the conflicts that they have about the Mitchell bill. If we can resolve those conflicts, we will have taken a very big step forward. We would have taken a lot of the Government intrusion out of this thing, and perhaps we can come to the floor and talk about some other things, some other differences that we have with one another.

I suspect that the distinguished Senator from Kansas, the Republican leader, and representing the good State of Kansas, looks in Kansas and sees the same sort of things or similar sorts of problems that I see in Nebraska. There is a serious problem with preexisting conditions. The distinguished Senator from Kansas, the Republican leader, and the Republicans—I believe there are 40 Republicans, are there not, on this bill S. 2374? Could the distinguished Senator verify that?

Mr. PACKWOOD. There are 39.

Mr. KERREY. There are 39 Republicans.

I would point out to my colleagues that the last time I got on a Republican bill, Senator CHAFEE's bill, there were 20-some Members on that bill. And I hope the same fate does not occur on this occasion. The last time I got on a Republican bill, Senator DOLE got off it the next day. I hope that does not happen in this case. Indeed, I do not think it will.

We are in the end game here. We know there is a problem. Senator DOLE does not come to the Senator and say there is no problem. He sees a problem with preexisting conditions. He sees a serious problem with cost. He sees a serious problem with regulation, a serious problem with insecurity that exists today in Kansas, as it does in Nebraska, with working families not able to pay the bills.

This bill, S. 2374, begins with the premise that we are prepared to subsidize people. Senator DOLE and I do not disagree on that. We do not disagree that there are times when we have to pass the collective hatch through our tax system or whatever system we want to use, when there are people who cannot afford to pay the bills.

There is a difference between how far we go between Senator MITCHELL and Senator DOLE, but we have to sit down and agree how we are going to settle that.

By the way, the problem here is not ideological so that citizens of the United States understand. This is not an ideological problem. This is a money problem. When a man or woman tells you very often that the issue is a principle, it typically is money. That is what is going on here. It is a money problem, Madam President.

From last year to this year, the Federal Government spent $38 billion more on Federal spending on health care, $38 billion more. We spent $318 billion this year, and we spent about $280 billion last year. That is a substantial increase, I would say, indeed. It leaves us with a great deal of difficulty. It leaves us with a big problem.

That is when Senator DOLE and I have agreed and the distinguished Senator from Oregon and I have agreed that we are prepared to subsidize people. We do not have much money to provide that subsidy. We are a little short of cash, and the problem here, it seems to me, is a lot smaller than meets the eye.

I have the bill marked up with many other problems that I have with this legislation—legitimate differences. I do not come and say that the distinguished Senator from Oregon has introduced a sham bill. I am not going to stack up a chart back here showing the complexity of this thing, the difficulty of understanding. This bill is 614 pages long.

I would suggest the Senator get a table of contents, by the way. It is not easy to read. The table of contents will add a few pages, I know, and we are all trying to keep it as small as possible. For those of us trying to understand, legitimately trying to bridge the differences, we need the table of contents.

I do not want to get the Senator in trouble having to introduce a new bill, and that sort of thing. It would help to try to figure it out.

This piece of legislation is not a sham proposal. It is, in my judgment, up to us as representatives of the people to say we know there is a problem in the United States with health care. We see it. We all see that there are people that right now cannot afford to pay the bills and live a radically different life than all of us do in this Senate.

Senator DOLE and I understand what it is like to have high quality health care there when you need it. We know it. Our deductible is somewhat higher than most people's deductibles for health care. But we know how important it is to have it there. We agree on that as a foundation.

The principles I believe that have guided the writing of S. 2374 are principles that I myself hold dear. My hope is that this debate now will not be a debate where people come down with charts and show how terrible the other person's proposal is and make a list of things that are terrible about what is in the other person's proposal.

Now is the time, Madam President, on behalf of all those American people who want us to pass legislation to fix those things that are broken in an otherwise excellent health care system, on behalf of all those Americans who want us to come together and act, now is the time not to come and exaggerate the proposal of someone else but to come and say—as I believe the distinguished Senator from Kansas is first and foremost a patriot. He is a patriot before he is a Republican. I have seen him lay aside his party concerns for his concerns for this Nation on many occasions. And I believe sincerely and genuinely that he is prepared to do it again now.

I intend to participate not only with the distinguished Senator from Kansas but with other Members from this body who see a problem in this country and are urgently prepared to work to try to solve it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Madam President, may I just express my gratitude for those noble words from the Senator from Nebraska in the U.S. Senate. They have the capacity to change the course of this debate, and I hope they will do so.

Mr. PACKWOOD. Madam President, I add that based upon that speech, I will personally handwrite a table of contents.

Mr. MOYNIHAN. A table of contents.

The PRESIDING OFFICER. The time of the Senator from New York has expired.

Mr. PACKWOOD. I ask for another 20 minutes.

Mr. MOYNIHAN. Madam President, I ask unanimous consent for an additional 20 minutes, equally divided.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MOYNIHAN. Madam President, I yield 10 of those minutes to the Senator from Rhode Island, the distinguished chairman.

Mr. PELL. I thank the Senator.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

Mr. PELL. Madam President, never in my years in the Senate has a moment arrived so full of promise and opportunity. In the next few weeks, we will collectively make history. But whether the history we make will show that we took on the special interests and made our Nation's health care system work for all our people, or whether it will show that we failed to rise to the challenge of leadership that we were elected to assume—is yet to be decided. And though our thoughts and views during this debate may be reported by the media largely through 30-second sound bites, the history books will record what we really do, and will—without the editing of modern technology—reveal the truth of whether we were consistent or hypocritical, helpful or obstructionist, altruistic or mired in the greed of the status quo.

Madam President, as I have said before, health care reform is an issue whose time has finally come. Honest debate is welcome, but delay and obstruction for political or grandstanding purposes is an obstruction to the American people and should not be tolerated. Because Madam President, while others have a political agenda for delay, I—and I hope many of my colleagues—have an agenda for action for the millions of good people who have waited too long for us to act.

Some of these people are people whom we know. Judging by statistics alone, every American surely knows someone who does not have health insurance. With 37 million uninsured people in a country of 250 million people, this means that one out of every six people has no health insurance. So the next time you go to the supermarket, or stop at the gas station, or walk in the park, or go to a shopping mall, remember that one of every six people you see may not be able to go to a doctor when they are sick. They do not have an insurance card to present to the desk when they need to go to a hospital or buy a prescription drug. They often cannot get early preventive care, and many of them wait so long for care that—when they do seek care—they need emergency care. These are people who worry every day that they might get sick, or injured, or that their children might get sick or injured. Most of these people are employed, or are the children or spouses of people who work, yet they are often a paycheck away from financial disaster should an illness or injury occur.

Madam President, when we begin to think about who has no health insurance coverage, we realize that this is a topic that simply does not come up outside of two very specific and limited settings—a doctor's office or hospital when the discussion turns to billing, and during the debate on national health care reform. Who goes to a summer cookout, or a family gathering, or out to dinner or a movie, and mentions that they do not have health insurance? It is something that people do not discuss; it is a private—and for many people—a painful matter.

So it did not come entirely as a surprise to me to learn from a member of my own staff—a bright and capable member of my staff—that he just discovered that his own mother does not have health insurance. His parents are upstanding citizens who have played by the rules. His father worked for many years and then retired. He has health insurance. But the family cannot afford coverage for the mother, a woman in her fifties who knows she should be getting regular medical care but who lives on a limited income and has difficult choices to make. This woman is a Rhode Islander who has raised healthy, successful children and contributed to her community in many ways. Why should she have to fear what will happen to her and her family if she gets sick? Why should she have to fear that she will lose her home if she cannot pay her medical bills? Why should she fear that she could lose her home—as another member of her family already has—in order to pay for an operation that she needed? How can this happen in a society as rich and generous and compassionate as ours? Something is wrong with a system that fails to protect these Rhode Islanders, and the millions of people like her all across the Nation.

During this debate, we will hear much about the health and vitality of American business. I am second to no one in wanting to create an economic climate in which our industries can thrive. But I urge my colleagues—and the millions of Americans who are watching or tuning in to this debate—to remember that there is a difference between advocacy and fact—that there is a wide gap between profits and bankruptcy—and that the business community is very much divided on the issue of national health reform. A very wise Rhode Islander named Larry LaTour—whom I have come to know and respect in the last 9 months and who has become an eloquent spokesman for many business-people—illustrated this point very well in a letter he wrote to me last September, and from which I quote:

> DEAR SENATOR PELL: Being a member of the NFIB [National Federation of Independent Business], I am periodically urged to write and express my opinion on the various issues that affect small business. This month is no different as I have been requested to write and take an adverse position on President Clinton's proposed health care reform program. I certainly cannot speak for the majority of NFIB members. However, I am sure that there are many small business owners who favor mandatory employer-backed health coverage as does L&G Engineering. It is moral, ethical, humane, and practical. By passing the mandate, you will help level the playing field.

So, Madam President, as we debate health care reform, let us forget about Harry and Louise, who are actors hired by the Health Insurance Association of America to advertise their viewpoint, and let us think about those two Rhode Island mothers without health insurance, and Larry LaTour, the Rhode Island businessman who does provide health insurance. Let us focus this debate on real people who have real problems and real lives. I pledge that I will do my utmost to ensure that we address the real problems and real fears of American families. And I urge every American to listen carefully to this debate, to look beyond the flowery words of their Senators and see if their votes match the positions they espouse. If they do, we may soon see sensible, quality health care reform legislation come to be.

I yield back the remainder of my time.

Mr. MOYNIHAN. Mr. President, I thank the distinguished and learned chairman of the Committee on Foreign Relations, my friend from Rhode Island.

Mr. President, I believe our time has expired.

The PRESIDING OFFICER (Mr. MATHEWS). The Senator has 2 minutes and 44 seconds.

Mr. MOYNIHAN. I yield those 2 minutes to the distinguished gracious Senator from Illinois, whose time was cut short because she had to preside over the Senate on an occasion when she was about to address the Senate.

I want to congratulate her on the birthday of her son. I believe she would like to speak to him in her remarks.

Ms. MOSELEY-BRAUN. I thank the Senator from New York very much, and the Senator from Oregon, as well.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

HAPPY BIRTHDAY MATT

Ms. MOSELEY-BRAUN. Mr. President, I had prepared to deliver a speech this afternoon. I know that we will have ample opportunity, given the length and the importance of the health care debate, and so I will file my statement for today and deliver a speech on this issue at a later time.

But I did want to take this special opportunity.

Unfortunately, I am here doing my job in Washington, but my son is 17 years old today. He is in Chicago and it is his birthday. I just wanted say happy birthday, Matt.

I thank the chairman again.

Mr. MOYNIHAN. And we will all say happy birthday. Let it be so ordered.

Mr. President, I yield the floor.

Ms. MOSELEY-BRAUN. Mr. President, we are in the midst of a historic debate in Congress this summer.

Many believed that this time would never come. The naysayers and those who believe in the status quo have made the road to reform a difficult one.

Many continue to say that we need to go slow, take our time and not rush congressional consideration.

I disagree—the Finance and Labor Committees have held over 100 hearings on health care reform and as Senator MITCHELL said the other day:

> President Truman proposed reform in the 1940's; President Nixon proposed it in the 1970's and I don't think 50 years is rushing anything.

I do agree that reforming our Nation's health care system is an enormous and complex task. But we were elected to tackle complex tasks and we have a job to do.

One of the reasons so many new faces were elected to Congress in 1992, was because the American people were tired of the status quo and wanted change.

We continually hear that Americans are happy with their health care and do not want reform.

And this morning we have heard so many horror stories of the Mitchell plan there is no wonder. What I would say, however, is that the Republicans have diverted back to a past-failed policy and are now engaged in the 1,000 points of fright.

Let me start with some facts.

I have always said that America has the best health care system in the world if you can afford it.

For far too many, there is a deepening anxiety about the cost and availability of health care among the middle class.

With good reason, each year fewer and fewer Americans can afford health care coverage. Since 1988 the number of uninsured has increased steadily each year from 33.9 to 37.5 million in 1992.

I recently received a letter from a constituent that described her family's experience in obtaining insurance. The Pascals are self-employed with three healthy children. Over the past 8 years they have been forced to change insurance carriers six times. The first company increased the rates on their individual family policy 600 percent in a 5-year period. Finding the cost of that plan prohibitive, the Pascals joined a group plan to lower their costs. Unfortunately, the group was dropped because one member became sick. The family then moved back to an individual policy, but due to a 65-percent rate increase after the first year, could no longer afford it. In desperation the family settled on a catastrophic coverage plan—no preventive care; a $5,000 deductible; and limits on providers. The Pascals can no longer take their children to their pediatrician of 12 years.

This family has done everything right. They've even managed not to get sick, but affordable comprehensive coverage is still beyond their reach. Clearly, our system should not work this way. Not for the self-employed and not for the employed with employer-provided coverage.

Statistics indicate, however, that over half of employed Americans who receive coverage through their employer, have had their health benefits cut back or have had their employee contribution increased during the last 2 years.

No wonder a poll taken by the Los Angeles Times last week showed that 60 percent of the respondents were worried about losing their current coverage.

Some say, "if it ain't broke don't fix it." Those are the folks who benefit from the status quo.

There are problems in the system and cosmetic surgery won't do the trick. Our current health care system is simply unaffordable.

Millions of Americans like the Pascal family cannot afford it, our Government cannot afford it and our Nation cannot afford it.

Last year we spent $1 out of every $7 on health care. That amounts to 14.3 percent of GDP and a total of $898 billion.

Health care costs are rising at twice the rate of inflation.

Medicare and Medicaid, the two Federal programs financed in part by the Federal Government eat up nearly one-fourth of the entire Federal budget.

Since 1980 Medicare has increased from $32 to $131 billion in 1993, an average annual growth rate of 11.5 percent.

Not only has Medicaid become one of the fastest growing components of the Federal Government, many State budgets, including my home State of Illinois are being crippled by rising Medicaid costs.

These exploding governmental health care system costs not only add to government deficits and debt, they make government less able to meet other important social needs. Take education for example. Last year, for the very first time, State governments spent more on Medicaid than they spent on education.

If you want U.S. businesses to be able to compete against their foreign competitors, health care reform is essential. If you want to see real deficit reduction, health care reform is essential.

And finally, if you want to find the money to deal with the problems plaguing our cities—education, welfare, job training, and crime—health care reform is essential.

What this means is that every American has an interest in fundamental comprehensive reform of our health care system.

Curing our sick health care system is the biggest challenge of this decade, maybe even this century. It is time to act.

Now it is time to take a look at the entire system and take a comprehensive approach.

The Congress has a window of opportunity to move forward in an area that has a profound impact on each and every American and the economy of this Nation.

This morning the Republicans have spent the majority of their time bashing the Mitchell bill, but very few have even mentioned the plan that they advocate.

As I see it we have two options. One is to use the Mitchell bill as a base for building health care security for the American people, the other is to use the Dole plan signed onto by the majority of the Republicans in this body.

I have believed from the beginning that in order to be successful health care reform must include four essential elements: universal coverage; choice; high quality care; and, cost containment.

Let us take a moment to contrast the two plans:

The Mitchell bill puts us on the road toward universal coverage. According to the CBO, the Mitchell bill will reach 95 percent coverage by 1997 and the employer-mandate provision will result in universal coverage by 2002.

The Dole bill does not seek to achieve universal coverage and will leave 30 million Americans uninsured.

The Mitchell plan significantly improves and expands coverage for millions of Americans: All children and pregnant women up to 300 percent—$44,000—of the poverty level would be covered; preexisting conditions exclusions will be eliminated; coverage would be portable; insurance discrimination based on age and geographic location will be eliminated.

Under the Dole bill children will not be guaranteed coverage, insurance discrimination will continue, including preexisting condition exclusions, and coverage will only be portable if you can pay 100 percent of the premium. The Mitchell bill also guarantees choice.

Every American will have a choice of at least three private insurance plans—fee for service, HMO, point of service plan.

The Federal Employees Health Benefits Program [FEHBP], available now to the Congress and Federal employees, will be available to many more Americans.

High quality care will be maintained. Funds will be made available through an assessment on premiums for graduate medical education and for biomedical research—NIH Trust Fund—and health care services research.

A National Quality Council will be established to set national quality goals/standards and performance standards for health plans.

Consumer information and advocacy centers will be created to disseminate information, hear grievances, and provide consumer education.

Health plans must ensure that enrollees have access to specialty care.

The Dole plan does not even address the quality issue.

The Mitchell plan has included cost containment measures.

The Dole plan relies on capping Medicaid, and reducing Medicare reimbursement to doctors and hospitals.

Medicare already pays providers less than the cost of care. If these cuts were to go into effect, Illinois would see a reduction of $1.28 billion in reimbursement to Illinois providers in the first 5 years of the Dole plan.

There is no question that the Mitchell bill is a better alternative.

Many wonder what this plan means for real people. Some on the other side of the aisle would have you believe that the bill would create a bureaucratic maze that bankrupts the American people.

Let me, for a moment, add a real life example to the mix—the Pascal family I mentioned earlier. The Mitchell bill would vastly improve their coverage.

The Pascal family could join a health insurance purchasing cooperative or HIPC. They would be a part of a large pool, pay much less in premiums than they do now, and could not be dropped because some members of the pool became sick.

They could choose from at least three types of health plans. They could even choose to enter the FEHBP program, available to Congress. All of their choices would offer comprehensive care.

They could choose a plan that allows them to pick their favorite providers.

The Mitchell plan will also afford them what so many Americans lack right now—peace of mind. No longer would they worry about their ability to afford care if one of their children becomes sick.

An analysis of the Dole plan reported in Newsweek last week found that premiums would probably increase for the middle class under the Dole plan. For the Pascal family that would mean higher premiums, no more choice than they have now, and no health care security.

The Mitchell plan takes care of middle-class Americans like the Pascal family. They, and millions of other Americans, cannot wait for reform. We must act now.

The choice is clear—if you want the status quo, to pay more for health care, leave millions of uninsured, and continue the upward spiral of our health care costs, choose the Dole plan.

For an alternative that increases coverage, improves the quality of health care, and affords Americans choice, then you start with the Mitchell bill.

There will be changes to the Mitchell bill and there are several areas that I believe can be strengthened.

For the next few weeks I will be working with my colleagues to ensure that the bill passed by the Senate is the best bill possible.

The time to act is now. Let's not squander the chance.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

The Senator from Oregon has 29½ minutes remaining.

Mr. PACKWOOD. I thank the Chair.

Mr. President, one of the joys of dealing with this bill is the perpetual surprises that you get, not just day to day, but from hour to hour.

I noticed when the distinguished Senator from South Dakota was speaking earlier, he had a chart, or maybe it was the Senator from Massachusetts, as to how much you would pay under the Dole bill and how much you would pay under the Mitchell bill.

And I noted that they subsidized individuals, the Mitchell bill, up to 300 percent of poverty. Now that was news to me; it was the first time I knew that. That figure at one time was 240 percent, but only for certain categories of children; 200 percent for others.

That is one of the difficulties of trying to keep track of what is going on.

I mentioned earlier the shifting of the bills. If they were smaller, I would say shifting them around under the shells.

But this does not fit under any normal shell. This is the bill I referred to earlier as Lethal Weapon 1, which was introduced last week for the first time. We have had this in our possession now—1,400 pages—we have had it about a week, give or take a few hours. It contained lots of things we had never seen before. In theory, we are still on the Finance Committee bill. As a matter of fact, we seem to be on the majority leader's bill.

But the night before last, we received this. It has no number on it yet. It has been printed. It has not been introduced. It is what I call Lethal Weapon 2. And there are things in this different from Lethal Weapon 1.

And I am now told that there is going to be another bill. I do not know if it will be as big as that, with numerous changes, things I have discovered today are going to be dropped out of the bill, or maybe added to the bill.

I understand now that Congressman GEPHARDT has added back into the Gephardt bill the retiree health insurance provision, where the Federal Government is going to pick up 75 or 80 percent of all the retirement health costs of people age 55 and up who have retired. That was out of the bill. Now it is back in. Maybe it is back in the Clinton-Mitchell bill. I do not know.

So as I address myself to a particular subject at the moment, I apologize to the Chair if it is not in the bill we are finally going to consider. All I can do is go on what we do have and, at the moment, I am going to have to go on the first bill, Lethal Weapon 1.

I want to talk about a subject that is called essential community providers. I also call it a shirttail relative to any willing provider. Any willing provider really applies to doctors or individuals who provide health services. Essential community providers essentially relates to things—clinics, Indian health service, something like that.

Now here is the situation. This country is moving fast toward what we call managed care. We have had it for years in the West. It is much more prevalent in the West than it is in the East.

Managed care is a simple concept. It is most easily illustrated by the Kaiser Health Plan in the West.

Under the Kaiser Health Plan and managed care, they make a deal with you. They make a contract with you.

They say, "Mr. Jones, Ms. Smith, for a fixed dollar amount, we will provide you all of your health care. And it is up to us to live up to"—us, Kaiser health clinic—"up to us to live within the amount of money we said we'll charge you."

Let us say they are going to charge you $250 a month. And if you do not go this month, do not go to them at all, you still pay them $250. If you do not go next month, you still pay them $250.

If you do not go for a year, you pay them $3,000. Now, the second year you have a bad auto accident. You are in the Kaiser hospital for 6 or 7 days and you run up $10,000 or $12,000 in bills and you are still paying them $3,000 a year.

In exchange, you have to use Kaiser facilities, the Kaiser doctors, the Kaiser hospital, because that is the way they can attempt to get a long medical history of you. You are using them all the time. They have your records. Their doctors have treated you. They know if you have any adverse reactions to prescriptions. They have an entire medical history, and they are very good at working at preventive health.

I remember years ago, this was 35 years ago, when I first became familiar with Kaiser, even then they were very good about trying to get all the people enrolled to do annual physicals and everything they could to prevent hospitalization. They once admitted in a hearing in the Oregon legislature when I was in the legislature 30 years ago that they really were not any better than anybody else at actual hospital costs when you were finally hospitalized. What they were better at is keeping you from being hospitalized. And we all know it is infinitely cheaper to treat somebody out of a hospital than in a hospital.

We all know the existing practice, good preventive care, annual physicals and catch things early—it is cheaper catching things like that. They were good. They are good. They were the forerunner. But now managed care is running rampant throughout this country, and I use that as a good term. I will use Blue Cross/Blue Shield in Oregon as an example. We have 2.9 million people in Oregon. Blue Cross/Blue Shield insures 1.1 million. That is a large carrier in a State of 2.9 million.

Ten years ago Blue Cross/Blue Shield had no managed care. Everything was what we called indemnity insurance. You bought a policy from Blue Cross. There were some deductibles, maybe you paid the first $200, there were some copayments—if the doctors visit was $25 you paid $2 or $3 or $5 of it and they paid a certain amount over a certain amount—but they reimbursed the doctors and the hospitals on basically a cost basis. What did it cost you to do the operation? $20,000. All right, here is your $20,000. There were no efforts to control costs. You were just reimbursed on cost.

It is not unlike what the Federal Government did during World War II when we were in an urgent situation. We needed to build ships. We needed to build tanks. We just told industry, "Go ahead, do not worry about the cost; we will reimburse you on a cost-plus basis. Get it done."

It is no wonder that health costs went absolutely through the roof. If there was no restraint on what you charged and if the insurance company paid what you charged and the individual was not paying it—who cared? Until finally medical costs and insurance premiums got so high that people began to care. Insurance companies began to care and we started through this managed care process.

I said 10 years ago Blue Cross/Blue Shield in Oregon had zero managed care. It was all indemnity, it was all cost reimbursement. Today Blue Cross/Blue Shield in Oregon has 62 percent of its enrollees in managed care. They expect that to be 90 percent by 1998.

Remember what I said the tradeoff is, though, for managed care. In exchange for a guarantee that all of your expenses, all of your medical costs will be covered barring very minor exceptions, you agree to use the facilities of Kaiser, in the case of Kaiser. They actually have hospitals and they actually have doctors they employ. In the case of insurance companies, they normally contract with a certain group of doctors or they will contract with a certain hospital. They do not actually run the hospital themselves, the insurance company, but they contract for it and say, "We have 100,000 enrollees on average, Mr. or Ms. Hospital Administration. Out of 100,000 we figure that is 5,000 patient days a year. Your hospital has been charging $600 a day. We will guarantee you 5,000 patient days a year but we are not going to pay you $600, we will pay you $400, and we will pay it whether we send you 4,000 people or 6,000 people, but we will pay you up front, quarterly, and you will be guaranteed that amount of money."

The hospital administrator thinks to itself, "We are running 30 percent uncollectibles and a third of our beds are empty. Why not? $400 is better than nothing and it is payment 100 percent guaranteed."

So the hospital and the doctors bargain with the insurance company. That is a form of managed care. But the key to making it work is that the Kaisers of the world, or the insurance companies of the world, have control over the delivery of the care so they can manage it. That is where the name comes from.

Now we come down to this issue of any willing provider, or essential community providers. Any willing providers being doctors and nurses and what not. Essential community providers being the hospitals or the clinics.

Managed care has become so successful and so prevalent in this country that many doctors and many hospitals now object if they are left out of the reimbursement system from some particular insurance company. They want to be inside. They want to be able to say, "I am a willing provider. If you are only reimbursing $800 for an appendectomy instead of $1,000, I will do it for $800 and I demand—because I am willing to do it for $800, you have to let me in your system.

The insurance company says, "We do not need any more doctors in the system, we have all we need to do appendectomies. We know who they are, we have a long history on them, and we think they are qualified and we do not need any more people."

So the doctors ask the legislatures and ask the Congresses to pass any willing provider laws that say they have to be let in.

Think to yourself, in a situation which would be more common to all of us, what would you do in this situation? You go out and buy a new dishwasher and with the dishwasher comes a little piece of paper that says, "If you would like us to service this dishwasher for the next 3 years or 5 years, it will cost you $30 a year. If you want to sign this contract send it back with your purchase, we will take care of all your repairs for nothing." So you sign it and send it back to General Electric dishwasher.

The only people who will repair it for nothing are the people that GE has contracted with. There may be 1,000 repair shops in the area that would be willing to repair your dishwasher, but GE has said we are going to use this 30 and, Mr. or Ms. Jones, if you bought our dishwasher and bought our service contract, here are the 30 you can use. The other 970 say, "We would like to be in on the deal also," and GE says, "We do not need 1,000 people to repair it, we need 30 good ones we can keep track of."

Under the equivalent of an any willing provider statute, all the other 970 repair shops could be let in. Now GE has to keep track of 1,000 of them and decide which ones they want to use. That is in essence the concept of any willing provider.

Picture the same thing again with car repairs. You buy your car, get a service contract on it, but you have to get it repaired where the person you contract with, the company you contract with, says to get it repaired. You do not have to sign up with them, but if you do, that is the trade-off.

Now we come to this bill, at least the one that is before us—this is not even before us yet, this one that was given to us last week. It is not before us technically, but we are discussing it as if it were. We take this bill and we come to a particular section—this is one of the reasons it is so hard to figure out what the bill means—section 1462: Categories of Providers Automatically Certified.

> (a) IN GENERAL.—The categories of providers and organizations, including subrecipients, specified in this subsection are as follows:
>
> (1) CATEGORY 1 ENTITIES.—The following entities shall be considered category 1 entities:
>
> (A) Covered entities as defined in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)), except that subsections (a)(4)(L)(iii) and (a)(7) of such section shall not apply.

That tells you a lot. It does not tell you anything. That is why it is hard to go through this bill. So let me tell you what that section means.

Every single health plan in the country—every Blue Cross plan, every Blue Shield plan, every Metropolitan Life, every Kaiser plan, every self-insured company that insures themselves, will have to contract for the provision of services with an absolute litany of organizations. They must contract with them. They can no longer say, "If you sign up with us, as Kaiser, and you pay us $250 a month and we take care of all of your needs, but you must come to us." You can no longer say that.

Now, if you contract to provide coverage, here are the additional organizations that you have to allow, in essence, to be willing providers:

One, federally qualified health centers;
Two, public housing clinics;
Three, Indian Health Service clinics;
Four, urban Indian health clinics;
Five, Ryan White Act HIV disease clinics;
Six, maternal and child health clinics;
Seven, school health service centers;
Eight, black lung clinics;
Nine, comprehensive hemophilia diagnostic treatment centers;
Ten, native Hawaiian health centers;
Eleven, sexually-transmitted disease clinics;
Twelve, tuberculosis clinics;
Thirteen, Medicare disproportionate share hospitals,
Fourteen, hospitals that serve a high proportion of the poor. That is the definition, hospitals that serve a high proportion of the poor.
Fifteen, mental health and substance abuse clinics;
Sixteen, runaway homeless youth centers or transitional living programs for homeless youth;
Seventeen, rural health clinics; and
Eighteen, children's hospitals.

Every health plan has to contract with every one of those organizations. Anybody they cover that goes to one of these organizations, they have to pay them the same amount as if they went to the organization that the organization runs.

Kaiser would have to say—let us say they have 100,000 people. Kaiser has actually 400,000 in Oregon. At the moment, they all must go to the Kaiser clinics. Kaiser has two hospitals, almost 600 doctors and close to 6,000 employees.

But now for your $250 a month, you can go to any one of these and Kaiser must reimburse them. How on Earth is Kaiser or Blue Cross or Metropolitan Life or Aetna supposed to manage this care when you have all of these organizations over whom they have no management control, free to come and pick off your patients and say, "Kaiser, pay us." That is one of the little hidden subsections in this bill.

Why is it in the bill? You think to yourself, "That doesn't make any sense. Why is it in the bill?" It is in the bill for a simple reason: Many of these organizations do serve the poor, and they fear that as we move toward managed care, they will not have a method of collecting money sufficient to keep their organizations going.

A good example would be New York. The State of New York allows Medicaid recipients—this is the poorest of the poor—if the Medicaid recipient wants to take the Medicaid money that they are entitled to and purchase a managed care contract rather than going to the local public hospital, free hospital, almost 90 percent of the last 300,000 Medicaid recipients who have made a choice have chosen managed care.

There is a wonderful story in the New York Times about the public hospitals—they pay no taxes; they are supported by the taxpayers—saying that the very poor that they treated, that no one else used to want, are now going elsewhere under managed care contracts to private hospitals.

They do this as a matter of choice. No one compels them to do this. And the poor are not dumb. They are just poor. They know where they get better service. They know where they get better quality, faster treatment. So they are leaving the Government system, the New York municipal hospital system, in droves and going to the equivalent of the Blue Cross/Blue Shield managed care programs or the Kaisers of New York City.

So many of these organizations have said to Senator MITCHELL, the majority leader, "Please put us in your bill so that we are guaranteed if we can drain off some of the patients of Kaiser or Blue Cross/Blue Shield that they will have to pay us."

Mr. President, that is going to be the breakdown of the managed care system.

Mr. GREGG. Will the Senator yield for a question?

Mr. PACKWOOD. I will be happy to.

Mr. GREGG. I am not sure I completely understand this. Basically what you are saying is that instead of this bill generating an incentive for cost control through allowing managed competition and HMO-type of facilities within managed competition to determine who can best provide and most efficiently deliver the health care, what this bill does is basically punch large holes in the opportunity for cost control by creating really nonmarketplace expenditures being put on the backs of those who might want to contract with an HMO.

So it puts a stake through the idea of cost control, does it not?

Mr. PACKWOOD. It is bigger than a stake; it is bigger than a hole. This absolutely rips apart the concept that you are going to manage the care of these 100,000 people you have.

If any organization in this list wants a contract with the HMO, they get one—and I cannot think of any other organizations that would not fit in this list. I have not gotten to the doctors yet, these are just the organizations —if any one of them can come to you, do you know what they are going to try to do? They are going to try to pick off your best patients, your healthiest patients, the ones that are not going to cost them $250 a month and you have to pay. You no longer have any control over them. You have it exactly right.

Mr. GREGG. If the Senator will yield, will this not sort of generate like a cottage industry of these types of entities growing up, that basically will be able to come in and demand payment as, basically, a way of tapping into this revenue stream rather than trying to contract the revenue stream? It is going to explode the demand on the system.

Mr. PACKWOOD. I think you are right. I am not sure how long we have had some of these clinics. Runaway homeless youth centers or transitional living programs for homeless youth I do not think would have been a normal medical provider 10 years ago. Sexually transmitted disease clinics, comprehensive hemophilia diagnostic treatment centers—Kaiser can do all these things. It is not a question of a need that has never been filled before.

The mind of men and women, given an incentive, is amazing, and as long as you have this definition of what an essential community provider is, my hunch is a lot of people will figure out a way to become an essential community provider.

Mr. GREGG. If the Senator will yield further, it is sort of as if you put this huge trough out there and then you arbitrarily allowed anybody to be issued a bucket.

Mr. PACKWOOD. Yes.

Mr. GREGG. You wanted to run for the trough.

Mr. PACKWOOD. You have it.

Mr. GREGG. I was looking at the CBO estimate of the Mitchell bill, and I noticed it estimates the baseline goes from $1.2 trillion in health care spending—I am sorry. The Mitchell bill goes from $1.3 trillion to $2.24 trillion in spending. Is that rather dramatic increase in spending over a 7-year period probably in part due to this sort of lack of cost control within the bill?

Mr. PACKWOOD. That is a bigger projected increase in spending than if we do nothing. The bill actually causes us to spend more than we would spend if we do nothing.

Mr. GREGG. Because the marketplace today is actually functioning with some cost controls which are generated by managed care which comes through HMO's, which will basically no longer function under this bill.

Mr. PACKWOOD. Just as we are starting to see this deluge—and again I use that word happily—of movement toward managed care, we really have only had competition in health delivery in the last 10 years. Even Medicare, up until 10 years ago, we reimbursed on cost. "Tell us your cost, hospital, here's the money."

Mr. GREGG. Cost plus care.

Mr. PACKWOOD. Cost plus care. You got it. "Your cost went up 20 percent last year? Here is your extra 20 percent."

Just as it is working—you are right—we want to drive the stake into the heart of the system that is holding down costs.

I will give you another example. In the metropolitan Portland area—and again this is a voluntary basis—56 percent of those eligible for Medicare have voluntarily signed up with managed care organizations. We have eight major—we are only a small State; we only have 2.9 million people—we have eight major HMOs in Oregon. Five of them have managed care Medicare programs. Of those five, three have had no premium increase for 4 years, and they are still surviving. It is working, and no one has to join. And yet 56 percent of the Medicare recipients in the Portland metropolitan area—it is about a million people—have voluntarily signed up, which proves they are satisfied with the service, they are hearing about it from their neighbors, and they are signing up.

Mr. GREGG. If the Senator will yield further. But this bill essentially creates a mandate, it is a mandate on the local HMO. It would undermine that sort of cost control activity.

Mr. PACKWOOD. Absolutely right. They have to contract with these. And they have to contract with every one of these that exist in their areas. You may have—I said the first one is federally qualified health center. You may have a number of these in the area, in which case you contract with all of them. That is just the first definition.

Mr. GREGG. I thank the Senator.

Mr. PACKWOOD. How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 4 minutes remaining.

Mr. PACKWOOD. How many?

The PRESIDING OFFICER. Four minutes.

Mr. PACKWOOD. I thank the Chair. I believe I finished. I yield to the minority leader.

The PRESIDING OFFICER. The Chair would indicate the Republican leader has 10 minutes of leader time.

Mr. DOLE. I thank the Chair, and I thank my colleague from Oregon.

I know my colleague from Hawaii, Senator INOUYE, and Senator STEVENS want to begin very quickly on the DOD appropriations bill. So I will not take but a few moments.

I first want to personally thank my colleague from Nebraska, Senator KERREY. I was not on the floor when he spoke, but I did pick up some of his comments just at a personal level, not anything to do with any legislation pending. I appreciated very much his words because of his understanding that maybe few have of some of the problems that we have to face up to in the next few weeks.

I also wanted to just take slight issue with some of my friends, and I hope we do not get this game of "if ours is bad, why, yours is worse" and whatever. I think we have a lot of debate that is going to happen here, a lot of things need to be discussed. But I sort of felt like I was watching "Dr. Jekyll and Mr. Hyde." Senators BOREN, KERREY, and KOHL spoke about the need to be constructive rather than destructive, and the need to search for a bipartisan solution rather than a bill that splits the Senate down party lines, and I agree.

I think there is a lot of agreement in the Senate on that general theme. Now, maybe we cannot get there. Maybe we ought to try. And it is not enough to say we have tried to pass because we have never really tried. But moments before these calls for cooperation and consensus, a number of my friends on the other side led at least a rather partisan attack—and that is not without precedent in this body. I assume there may be a lot of it on both sides in the next few weeks—a bit misleading attack about the American option, the Dole-Packwood bill, and I want to take just a few moments to respond to some of the statements that were made.

I guess, first, I should admit that they now say we have a bill. So we stipulate that. There is a bill. There is a Republican bill. It is Dole-Packwood and 38 other Republicans. But we have not tried to make it a partisan bill. We think there is still opportunities there for bipartisanship, and we are not going to close that door until the final moment.

I think it also indicates that we have been trying to propose real solutions to real problems. My friend from South Dakota, Senator DASCHLE, stated there was, and I quote, "a significant degree of confusion" about Senator Mitchell's bill. And that is part of the problem. The American people are confused, Members of the Senate are confused, and even the authors of the bill are confused as new provisions are introduced almost by the hour.

That is the confusion about the majority leader's bill. Also there was a bit of confusion about the Dole-Packwood bill. Senator DASCHLE claimed ours does not do anything to reduce bureaucracy, which I thought was rather startling. But maybe he means we did not make it grow, it did not expand, which it does not do.

It is sort of ironic that anyone who may be supporting the majority leader's bill and maybe supported the original Clinton bill proclaims their concern about the size of bureaucracy. We hope that ours is fairly free of any expanding bureaucracy. That was one of the efforts.

I would point out that the largest section of the Dole-Packwood bill is the one that deals directly with administrative simplification because we believe most American people believe it is too complicated, it is too complex, and there should be an effort by all of us to make it much less complicated.

The Senator from South Dakota also quoted CBO estimates of the cost of the Dole-Packwood bill. I wish we had the same pipeline into the CBO that the Senator from South Dakota has, but we have not received any CBO estimates, and we called Mr. Reischauer, who said that nobody has been given any CBO estimates on our bill. And it seems to me that if Senator DASCHLE has CBO estimates, maybe he would be happy to share them with us. We would be happy to have those estimates because we think it is necessary before we proceed here that we do have estimates on all these bills and all the changes and all the modifications. We believe it is very important.

Senator REID said that the Dole-Packwood bill does not cover dental care. That may be true, it may not, but the Dole-Packwood bill does not have a one-size-fits-all Government-mandated basic benefits package. We leave decisions such as dental coverage up to the consumer. Why not leave it up to the consumer? Let them determine whether they want dental coverage or substance abuse coverage and the like. We let the American people decide what plan best fits their need and pocketbook. That is the way we ought to do it.

Another statement was that our bill still allows for discrimination in dealing with preexisting conditions. It seems to me this is one area we are all in agreement on. I did not know there was any disagreement until earlier today.

We talk about market reforms and things we ought to do and things we agree on. Under the Dole-Packwood bill, insurers would not be allowed to deny coverage because of preexisting conditions. It is that simple. That is it. That is it. It is what we have been saying.

And all we are doing is maintaining the status quo. I guess that is another charge. In reality, we do not want to disturb the 85 percent, the millions of Americans who are fairly well satisfied with their health care. We do not want Government intervention. We do not want to add about $500 per family for costs. There are a lot of things we do not want to do.

So if we are being charged with being for the status quo, then we will plead guilty to that. But it seems to me that we are addressing the concerns many people want to address. The Senator from Nebraska indicated many things he would like to address. We believe they are addressed in our bill.

The Senator from Nebraska went on to say he did not like everything in our bill, but he thought it had a lot of merit. We believe it does. We are not a bit defensive about our proposal. Maybe it can be modified. Maybe it can be changed. It certainly can be made better. But if better means more Government, more bureaucracy, more mandates, more price controls or more taxes, then we do not want to make it better. That is not better for most Americans. I think that is the bottom line.

We will admit when it comes to the status quo, our bill does not weigh as much as the others. It has about half the number of pages, or less. We left out taxes, and we left out mandates, and we left out price controls; we left out new agencies. But our 641-page bill does a lot more than just maintain the status quo. We think it makes health care more accessible and more affordable to millions of Americans and that is the goal we hope we can reach.

And if we reach 91, 92, or 93 percent without mandates and without new taxes and without price controls, then I think we come back and see where we are and find out what we need to do at that point. And I certainly believe if the majority leader finds somebody out here saying something has no relevance, no basis in fact to his bill, he will probably be on his feet.

I want to mention just one other thing, and then I will be happy to yield the floor.

I think there is another concern, and I am now checking with my Governor, a Democrat, from the State of Kansas, Governor Finney, because I remember when the Dole-Packwood bill was introduced, we had a letter within a few days from the Governors Association saying, "Wait a minute; we don't like your Medicaid cap." I was told that also in Boston when I went up to address the Governors what, a month ago, I guess, 3 weeks ago. And so we worked with the Governors. And we resolved our problems. We will have a letter today hopefully from all Governors, not just Republican Governors, saying they do not have a problem with those aspects of the American option, with the Dole-Packwood bill.

But I think they have a lot of problems—I do not know that to be a fact, but I believe that they may have a lot of concerns with reference to other bills that are pending. And if I read the Washington Post as any guide, the article entitled "Health Bill 'Death' to D.C.," which quotes delegate ELEANOR HOLMES NORTON as saying the Mitchell bill is death to the District, I guess the particular issue raised is how the insurance reforms will be implemented and whether the cost of insurance to the District will become prohibitive and the number of uninsured increased. That is the way she sees it.

I think we have to take a look at how this impacts on various States. I had a phone conversation, I guess night before last, with the Governor of Wisconsin, Governor Thompson, who has been very active in the Governors' Association with the Democrats and Republicans on health care. In fact, you could go back and take a look at the health care principles outlined by Democratic and Republican Governors about 8 months ago. It is pretty much like the Dole-Packwood bill. The thing that they did not like in the Dole-Packwood bill was the Medicaid cap, and other things they did not like concerning ERISA. But the principal thing is the Medicaid cap.

So they identified a number of concerns in our proposal. Their biggest concern was the potential increase in their Medicaid costs as a result of the cap on Medicaid which we considered earlier. We think we have solved that problem.

But it does appear that perhaps some of the bills, including the majority leader's, would also add burdens on the States. The Governor of Wisconsin indicates after a quick look at the majority leader's bill that there are additional costs, at least $800 million to $850 million in the State of Wisconsin over a period of years. These increased burdens come in the form of 177 new administrative responsibilities, and additional Medicaid cost as a result of the maintenance of effort provision in the bill, as a result of the new 1.75 percent tax on health care insurance costs for their State and local employees. Of course, we can estimate the cost to the States is the loss of jobs, if and when employer mandates kick in, particularly if you have different States kicking in at different times. Some States are never going to kick in. As indicated by the CBO, it is going to be very hard to implement.

So we are waiting to hear from our Governor, and I am certain that many Governors are hoping to get a State-by-State analysis from the Governors Association because the Governors are there every day. They are on the firing line every day. They are talking with their taxpayers every day, and they are going to be very concerned about what any of us do, Republicans or Democrats. I think they have been fairly objective and fairly nonpartisan in addressing concerns in the so-called Dole-Packwood bill, and I assume they will do the same with the majority leader's bill unless everything is resolved.

We sort of looked at the States. And we have former Governors in our midst right now, Senator CRAIG of New Hampshire, Senator BOND, and there are a number of former Governors on the Democratic side. And I think they watch very closely at what happens in Congress, particularly something like health care that is going to affect everyone.

I think we also have to ask about the implications of the rules for mandatory costs as envisioned in the Mitchell bill. Those States like California, Florida, Iowa, and Texas, which will put in place purchasing alliances will be permitted to ask this question. I think this is a fair question. And the preliminary CBO report projects that a State-by-State mandate would produce inefficient reallocations of business activity moving across State lines. Maybe that is true. Maybe it is not. But it is raised in the CBO report, not some Republican newsletter.

I think all of these are questions that we must ask our Governors. And, as I said, I think they may have as much or more at stake than we have. We pass the legislation. We pass mandates. The thing that the Governors hate is unfunded mandates. We say, "OK. You go ahead and do it. We don't have any money. But there is a mandate. You figure out how you can do it." And I must say that the President has indicated his opposition to any mandates. I think most every Senator knows that we have to be very careful in whatever we may pass; that we listen carefully to Governors, whether they be Democrats or Republicans.

Finally, I would say the Capitol is filled with rumors about maybe the House is not taking up health care next week, and maybe not for the next couple of weeks. The majority leader is here. He may have more information than I have.

I just ask the question. I think it is because of the question Senator HELMS raised. Some were chuckling about Senator HELMS' amendment. The reason they cannot take up the House bill, as I understand it, is because they do not have CBO numbers.

That is precisely what Senator HELMS was suggesting—that we not proceed until we had numbers. We do not have numbers on our bill yet. I am not certain we have all the numbers on the majority leader's most recent entry.

It is very important that we have at least some guideline as to what it is going to cost and who it is going to cost, and all the other things that the CBO should provide to us.

So I understand there may be a meeting at 4 o'clock. Maybe at that time we will be informed of what may be the pleasure of the House. That may not affect our schedule directly. But I think it will have a big impact indirectly.

Mr. MITCHELL. Mr. President, I listened with interest to the remarks of my friend, the distinguished Republican leader, and I, perhaps better than any other Member of the Senate, can understand his sensitivity to the criticism of his bill. Everything in life is relative. Before he becomes too defensive, and if he wants to feel better, I would suggest that he take the CONGRESSIONAL RECORD of the past few days and read what his colleagues have been saying about me and my bill.

I think it will make him feel a little bit better because the words were far more critical, and indeed in some respects inflammatory, than anything I believe that has been said about his bill.

So on the theory that misery loves company, I commend to him the CONGRESSIONAL RECORD for the last few days to read some of the words that his colleagues have said about me, and perhaps he will not feel quite as badly about any criticism of his bill.

Mr. President, I have not heard the so-called rumor about the House of Representatives, except from the minority leader. So he may have a better pipeline than I do into the House leadership. But I will be talking with the House leaders later today.

In any event, I think it clear given the different rules of the two bodies that the length of consideration of any bill will be much greater in the Senate, that it is going to take some weeks for the Senate to consider this important matter. By contrast, the House under their rules can obtain a rule which would permit consideration in a matter of a few days, if they like. Therefore, I think it appropriate, and I think the most prudent course of action is for the Senate to proceed in an effort to complete action irrespective of what the House does because the fact of the matter is whenever they begin they might well finish before we do even though we start a lot earlier.

But I will be meeting later today with the House leadership and will of course, as is my practice, discuss that with the Republican leader following that meeting.

Mr. President, is it in order now for the Department of Defense bill to be reported for further consideration by the Senate?

The PRESIDING OFFICER. That is the regular order. The majority leader also has the right to use his leader time, if he so desires.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

Mr. MITCHELL. Mr. President, I ask for the regular order.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

A bill (H.R. 4650) making appropriations for the Department of Defense for the fiscal year ending Sepember 30, 1995, and for other purposes.

The Senate resumed consideration of the bill.

Pending:

Dole Amendment No. 2479, to provide for the termination of the United States arms embargo of the Government of Bosnia and Herzegovina no later than November 15, 1994.

Mr. MITCHELL addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. MITCHELL. Mr. President, I had hoped that we could return to the Department of Defense authorization bill by 1:30. We are obviously not on that schedule. But we are back on it now, and will continue.

It is my intention that the Senate complete action on that bill today, and if possible take up other measures and then turn to the health care legislation tomorrow at a time and under circumstances which I will, of course, discuss further with the Republican leader as is my practice before making a final decision.

Mr. President, I yield the floor. I believe the managers are ready to proceed with the Department of Defense appropriations bill.

Mr. GRASSLEY addressed the Chair.

The PRESIDING OFFICER. The Senator from Iowa.

AMENDMENT NO. 2510

(Purpose: To require the strengthening of Department of Defense procedures for matching disbursements to particular obligations)

Mr. GRASSLEY. My amendment is at the desk. I would ask to call up 2510. It deals with the subject of matching disbursements. I will probably only speak about 5 minutes. I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY] proposes an amendment numbered 2510.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a)(1) The Secretary of Defense shall develop a plan for establishing and implementing a requirement for disbursing officials of the Department of Defense to match disbursements to particular obligations before making the disbursements. The Secretary shall transmit the plan to Congress not later than March 1, 1995.

(2) The Inspector General of the Department of Defense shall review the plan and submit the Inspector General's independent assessment of the plan to the congressional defense committees.

(b)(1) Not later than July 1, 1995, the Secretary of Defense shall require that each disbursement by the Department of Defense in an amount in excess of $5,000,000 be matched to a particular obligation before the disbursement is made.

(2) Not later than October 1, 1995, the Secretary of Defense shall require that each disbursement by the Department of Defense in an amount in excess of $1,000,000 be matched to a particular obligation before the disbursement is made.

(c) The Secretary shall ensure that a disbursement in excess of the threshold amount applicable under subsection (b) is not divided into multiple disbursements of less than that amount for the purpose of avoiding the applicability of such subsection to that disbursement.

(d) The Secretary of Defense may waive a requirement for advance matching of a disbursement of the Department of Defense with a particular obligation in the case of (1) a disbursement involving deployed forces, (2) a disbursement for an operation in a war declared by Congress or a national emergency declared by the President or Congress, or (3) a disbursement under any other circumstances for which the waiver is necessary in the national security interests of the United States, as determined by the Secretary and certified by the Secretary to the congressional defense committees.

(3) This section shall not be construed to limit the authority of the Secretary of Defense to require that a disbursement not in excess of the amount applicable under subsection (b) be matched to a particular obligation before the disbursement is made.

Mr. GRASSLEY. Mr. President, this amendment addresses the continuing financial mismanagement at the Department of Defense. This is something that I have spoken about on this floor many times in the last year and a half. My colleague from Hawaii has been very cooperative in the past, and he is likewise cooperative this time. I thank him for that.

This amendment is going to restore some accountability over the Department of Defense appropriations. It follows up on an initiative launched last year with the help of my good friend from Hawaii. It is the direct result of one particularly troublesome incident, but this incident is just an example of a greater problem. That was the disappearance, Mr. President, mind you, of $649.1 million. I spoke on this issue on several occasions last year.

The Defense Department inspector general discovered that the Air Force accounting records maintained by the Defense Finance and Accounting Service—I am going to refer to that as DFAS—were out of whack by $649.1 million. They were out of whack because DFAS's bookkeeping operations are in shambles. Instead of recording obligations and expenditures in a ledger as they occur—and that is commonsense bookkeeping or accounting, or whatever you want to call it—DFAS and the Air Force were using algorithms—mathematical equations—to estimate the missing accounts.

Well, Mr. President, any first year accounting student knows that is no way to do accounting.

When I brought this problem up to the attention of my colleagues, about 1 year ago now, my friend from Hawaii, the distinguished chairman of this subcommittee, agreed to ask the Department of Defense IG to review base-level records—that is, at the grassroots—to pinpoint this problem.

Well, the IG has just completed the review ordered by Senator INOUYE and, quite frankly, after 1 year of review, it is the very same story.

This IG report is entitled—I give you these titles and references because I want people to read them, as we do—"Air Force Merged Account Obligations," No. 94-139, dated June 17, 1994. The report tells us that we can expect more of the same in the future. The systemic problems that produced the $649.1 million fiasco are still working full bore. The IG auditors discovered that DFAS accountants are still using mathematical equations to generate phony bookkeeping entries.

I refer here to page 13 of the report under the heading "Contractor Billing and DFAS Paying Practices." I will summarize the information and place it into the RECORD. This particular problem arose at the DFAS Center in Columbus, OH.

When accounting clerks—get this, this is how IG lays it out, not how I as a political leader describe it—receive an invoice that does not identify the account or contract to be charged, they do not even bother to do the leg work necessary to get the right information. They simply use a formula to spread the payments across any appropriation, if that appropriation still has positive balances. There is no attempt to post payments to the correct account. In fact, they deliberately force payments onto the wrong accounts. This is a random allocation process. It is completely inconsistent with the laws governing the use of appropriations.

This is the very same kind of procedure that led to the $649.1 million mismatch—just a $649.1 million mismatch.

It is the kind of flawed procedure that gave the Department of Defense a whole great big $41 billion headache, by what they term "unmatched disbursements." So the $649.1 million is just a small part of a $41 billion big problem entitled "unmatched disbursements."

Matching disbursements with obligations is a very fundamental tool for internal financial management. If you do not match disbursements with obligations, your accounts are vulnerable to theft and abuse. I have spoken about millions being stolen by fake organizations like the one operated by Mr. McGill in Norfolk, VA.

I ask unanimous consent to have printed in the RECORD that section of the IG report.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Contractor Billing and DFAS Paying Practices. We discussed billing and paying problems with accounting officials at the DFAS-

Columbus Center. They stated that when contractors did not include the ACRN and CLIN on bills submitted to the DFAS, accounting clerks had to make a decision as to which appropriation's unliquidated obligations the disbursement should be recorded against. The accounting clerks also stated that if they could not specifically identify the ACRN and CLIN that should be paid on a particular invoice, the Mechanization of Contract Administrative Services system used a formula to charge disbursement to all appropriations with unliquidated obligations for the contract at the time of the disbursement and not to the specific appropriation that was obligated.

However, even when the ACRN and CLIN were shown on the invoice, the payment was not always charged to the correct account. For example, we found one contract for which $11.2 million was disbursed and charged to the "M" account that should have been charged to the FY 1988 3010 (Aircraft Procurement) account.

The DFAS accounting clerks were concerned with paying the invoices promptly to avoid interest penalties and lost discounts; therefore, they used whatever funds were readily available when no specific funds were specified through use of the appropriate ACRN and CLIN. Accordingly, as time passed and more and more progress payments were made, visibility over appropriation accounting decreased, and reconciliation required more time to complete.

Mr. GRASSLEY. I compliment the new Department of Defense Comptroller, John Hamre. He is struggling with the problem. He has succeeded in reducing the number of unmatched disbursements.

But there is another problem. No one really knows for sure how big the problem really is. We think it is $41 billion, but is it bigger? It is just a guess. But the best available guess says that that number now, because of Mr. Hamre's work, may be down from $41 billion to $34 billion. I suppose in this town that is progress.

But Mr. Hamre is still wrestling with a $21 billion problem in disbursements that cannot be matched at all. They may never be matched.

The Deputy DOD IG, Mr. Derek Vander Schaaf, has suggested that the problem of this $21 billion may be so bad and the documentation so poor that it may be necessary just simply to "write off" those unmatched disbursements. This kind of thing must come to a screeching halt.

If DOD asks Congress for authority to "write off" $10 billion to $20 billion in unmatched disbursements, then I think heads should roll.

As legislators, we have a responsibility to correct the problem. We were assured that DFAS would fix the problem, but it has not been fixed. It must be fixed.

Mr. President, I look to my friend from Hawaii for leadership and advice on how to proceed, and he has been very helpful in that area.

I had another amendment, other than the one before us, that would have imposed very stringent measures immediately. And I would hold DFAS Director Springett accountable for continuing financial mismanagement by cutting off his salary, effective December 31, 1994. I suppose that sounds like a bill of attainder, but something has to be done.

The chairman of the subcommittee now has developed what we have before us. We worked together on this to develop a more orderly approach for phasing in new procedures for matching disbursements with obligations. His solution is very acceptable to me, Mr. President. It is a good compromise. It will keep the pressure on. I think it sends a right signal to the Department of Defense managers.

The chairman's compromise would provide the following: By March 1, 1995, DOD would have to submit a plan to Congress requiring that disbursing officers match disbursements; the IG would provide an independent assessment of the plan; by July 1, next year, all disbursements over $5 million would have to be matched; by October 1, 1995, all disbursements over $1 million would have to be matched; DOD would be prohibited from breaking down disbursements to evade thresholds; requirements could be waived in a national emergency; and DOD would have authority to lower thresholds. In other words, as you have just heard, rather than taking a one-step, drastic approach, as I suggested in my original amendment, our distinguished chairman has helped us work out a very phased approach to getting all of these unmatched disbursements accounted for. Next year, after we have had an opportunity to assess the plan, then we should be in a better position to refine the procedures and lower the threshold, if that is necessary.

I think this is an excellent beginning, and I thank the chairman, and particularly his staff assistant, David Morrison, for his help and cooperation in this effort.

I yield the floor.

The PRESIDING OFFICER. Is there further debate?

Mr. INOUYE. Mr. President, as manager of the bill, I wish to commend my good friend, Senator GRASSLEY, for his diligent leadership in this very important area of military financing. His intent is a very simple one: to do business in a businesslike manner.

I believe that this step, this proposal will eventually lead the Department of Defense to that goal.

So if I may in behalf of the managers of the bill we are prepared to accept the amendment.

Mr. GRASSLEY. I am ready for a vote.

The PRESIDING OFFICER. Is there further debate on the amendment?

If not, the question is on agreeing to the amendment.

The amendment (No. 2510) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. GRASSLEY. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. INOUYE. Mr. President, I ask unanimous consent that the pending amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2519

Mr. INOUYE. Mr. President, I call up Amendment No. 2519, an amendment by Senator COHEN.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. COHEN proposes an amendment numbered 2519.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, insert the following section:

SEC. . SENATE ADVICE AND CONSENT TO CHANGES IN OBLIGATIONS UNDER THE CFE TREATY.

(a) FINDINGS.—

(1) On November 25, 1991, the Senate gave its advice and consent to ratification of the CFE Treaty.

(2) The President would need to seek the Senate's advice and consent to any change in obligation of the states parties under the CFE Treaty, unless such change were a minor matter of an administrative or technical nature.

(3) A change in the allowed holdings of treaty limited equipment in the area of application or any geographic sub-zone of the area of application would constitute a change in obligation for which the Senate's advice and consent would be required.

(b) REAFFIRMATION OF SENATE'S TREATY-MAKING POWERS.—The President shall submit for the Senate's advice and consent any change in the obligations of any state party under the CFE Treaty, unless such change is a minor matter of an administrative or technical nature.

(c) CFE TREATY DEFINED.—For the purpose of this section, the CFE Treaty means the Treaty on Conventional Armed Forces in Europe, signed in Paris on November 19, 1990, and associated protocols.

Mr. INOUYE. Mr. President, on behalf of Senator COHEN I withdraw the amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

So the amendment (No. 2519) was withdrawn.

AMENDMENT NO. 2523

Mr. INOUYE. Mr. President, I call up Amendment No. 2523 proposed by Senator MCCONNELL.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE] for Mr. MCCONNELL, proposes an amendment numbered 2523.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill insert the following:

SEC. .

(a.) Within 60 days of enactment of this Act, the President, in consultation with NATO, shall submit a report to the Committee on Appropriations defining specific military, economic, and political standards required to gain admission to NATO; *Provided further*, that such report shall not be limited to the principles enunciated in the Partnership for Peace; *Provided further*, such report shall include an assessment of measures which would be necessary to guarantee the armed services of Poland, Hungary, the Czech Republic, Slovakia, Lithuania, Latvia and Estonia are capable of military cooperation and interoperability with NATO and fulfilling other member responsibilities.

Mr. INOUYE. Mr. President, on behalf of Senator MCCONNELL, I withdraw the amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

So the amendment (No. 2523) was withdrawn.

AMENDMENT NO. 2529

(Purpose: To authorize assistance to promote the peaceful resolution of conflicts in Africa)

Mr. INOUYE. Mr. President, I call up Amendment No. 2529 proposed by Senator SIMON.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE] for Mr. SIMON, for himself, Mr. JEFFORDS, and Mr. HELMS, proposes an amendment numbered 2529.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the bill, add the following new title:

TITLE—AFRICAN CONFLICT RESOLUTION

SEC. 01. SHORT TITLE.

This Act may be cited as the "African Conflict Resolution Act".

SEC. 02. FINDINGS AND STATEMENT OF POLICY.

(a) FINDINGS.—The Congress makes the following findings:

(1) It is in the national interest of the United States to help build African capability in conflict resolution. A relatively small investment of assistance in promoting African conflict resolution—

(A) would reduce the enormous human suffering which is caused by wars in Africa;

(B) would help the United States avoid huge future expenditures necessitated by Somalia-like humanitarian disasters; and

(C) would reduce the need for United Nations intervention as African institutions develop the ability to resolve African conflicts.

(2) Africa, to a greater extent than any other continent, is afflicted by war. Africa has been marred by more than 20 major civil wars since 1960. Rwanda, Somalia, Angola, Sudan, Liberia, and Burundi are among those countries that have recently suffered serious armed conflict.

(3) In the last decade alone, between 2,000,000 and 4,000,000 Africans have died because of war. There were 5,200,000 refugees and 13,100,000 displaced people in Africa in 1993. In Angola, relief organizations estimated that 1,000 people were dying each day at the end of 1993. In Rwanda, more than 200,000 people died in less than 5 weeks of fighting during 1994, while 300,000 people fled to other countries to escape war.

(4) Millions more Africans are currently at risk of war-related death. Looming or ongoing conflicts in Zaire, Angola, Sudan, Rwanda, and other countries threaten Africa's future.

(5) War has caused untold economic and social damage to the countries of Africa. Food production is impossible in conflict areas, and famine often results. Widespread conflict has condemned many of Africa's children to lives of misery and, in certain cases, has threatened the existence of traditional African cultures.

(6) Conflict and instability in Africa, particularly in large, potentially rich countries such as Angola, Sudan, and Zaire, deprive the global economy of resources and opportunities for trade and investment. Peace in these countries could make a significant contribution to global economic growth, while creating new opportunities for United States businesses.

(7) Many African armies are far too large, threatening political and economic stability while diverting scarce resources from development needs. Military expenditures in Africa average over twice the level in Latin America. Demobilization and other measures to reduce military expenditures are thus a critical need for many African countries.

(8) Conflict prevention, mediation, and demobilization are prerequisites to the success of development assistance programs. Nutrition and education programs, for example, cannot succeed in a nation at war. Billions of dollars of development assistance have been virtually wasted in war-ravaged countries such as Liberia, Somalia, and Sudan.

(9) Africans have a long tradition of informal mediation. This tradition should be built upon to create effective institutions through which Africans can resolve African conflicts.

(10) The Organization of African Unity, under the leadership of Secretary General Salim Salim, has established a conflict resolution mechanism and has been active in mediation and conflict resolution in several African countries. Various subregional organizations have also become active in conflict resolution efforts. These are encouraging developments.

(b) UNITED STATES POLICY.—The Congress declares, therefore, that a key goal for United States foreign policy should be to help institutionalize conflict resolution capability in Africa.

SEC. 03. IMPROVING THE CONFLICT RESOLUTION CAPABILITIES OF THE ORGANIZATION OF AFRICAN UNITY.

(a) AUTHORIZATION OF ASSISTANCE.—The President is authorized to provide assistance to strengthen the conflict resolution capability of the Organization of African Unity, as follows:

(1) Funds may be provided to the Organization of African Unity for use in supporting its conflict resolution capability.

(2) Funds may be used for expenses of sending individuals with expertise in conflict resolution to work with the Organization of African Unity.

(b) FUNDING.—Of the foreign assistance funds that are allocated for sub-Saharan Africa, significant sums for each of the fiscal years 1995 through 1998 should be used to carry out subsection (a).

SEC. 04. IMPROVING CONFLICT RESOLUTION CAPABILITIES OF MULTILATERAL SUBREGIONAL ORGANIZATIONS IN AFRICA.

(a) AUTHORIZATION OF ASSISTANCE.—The President is authorized to provide assistance to strengthen the conflict resolution capabilities of subregional organizations established by countries in sub-Saharan Africa, as follows:

(1) Funds may be provided to such an organization for use in supporting its conflict resolution capability.

(2) Funds may be used for the expenses of sending individuals with expertise in conflict resolution to work with such an organization.

(b) FUNDING.—Of the foreign assistance funds that are allocated for sub-Saharan Africa, up to $1,500,000 for each of the fiscal years 1995 through 1998 may be used to carry out subsection (a).

SEC. 05. AFRICAN DEMOBILIZATION AND RETRAINING PROGRAM.

(a) AUTHORIZATION OF ASSISTANCE.—In order to facilitate reductions in the size of the armed forces of countries of sub-Saharan Africa, the President is authorized to provide assistance for—

(1) encampment and related activities associated with demobilization of such forces, and

(2) the retraining for civilian occupations of military personnel who have been demobilized.

(b) FUNDING.—Of the foreign assistance funds that are allocated for sub-Saharan Africa, up to $25,000,000 for each of the fiscal years 1995 and 1996 should be used for the assistance described in subsection (a), if conditions permit.

SEC. 06. TRAINING FOR AFRICANS IN CONFLICT RESOLUTION AND PEACEKEEPING.

(a) AUTHORIZATION OF ASSISTANCE.—The President is authorized to establish a program to provide education and training in conflict resolution and peacekeeping for civilian and military personnel of countries in sub-Saharan Africa.

(b) FUNDING.—Funds made available for military education and training activities under chapter 5 of part II of the Foreign Assistance Act of 1961 may be used to carry out the program provided for in subsection (a).

SEC. 07. BUILDING MEDIATION CAPABILITY IN AFRICA.

(a) AUTHORIZATION OF ASSISTANCE.—The President is authorized to provide assistance to nongovernmental organizations that are engaged in mediation and reconciliation efforts in Africa.

(b) FUNDING.—Of the foreign assistance funds that are allocated for sub-Saharan Africa, funds for each of the fiscal years 1995 and 1996 should be used to carry out subsection (a).

SEC. 08. DEFINITION.

As used in this title, the term "foreign assistance funds" means funds made available—

(1) under chapters 1 and 10 of part I of the Foreign Assistance Act of 1961 (relating to development assistance and the Development Fund for Africa),

(2) under chapter 4 of part II of the Foreign Assistance Act of 1961 (relating to the economic support fund), and

(3) under section 23 of the Arms Export Control Act (relating to foreign military financing),

and includes unobligated funds in such accounts which remain available from previous fiscal years.

Mr. INOUYE. Mr. President, on behalf of Senator SIMON, I wish to withdraw the amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

So the amendment (No. 2529) was withdrawn.

AMENDMENT NO. 2548

Mr. INOUYE. Mr. President, I call up Amendment No. 2548, an amendment proposed by Senator COHEN.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. COHEN, proposes an amendment numbered 2548.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At an appropriate place in the bill, insert the following section:

SEC. . SENATE ADVICE AND CONSENT TO CHANGES IN OBLIGATIONS UNDER THE CFE TREATY.

(a) FINDINGS.—

(1) On November 25, 1991, the Senate gave its advice and consent to ratification of the CFE Treaty.

(2) The President would need to seek the Senate's advice and consent to any change in obligation of the states parties under the CFE Treaty, unless such change were a minor matter of an administrative or technical nature.

(3) A change in the allowed holdings of treaty limited equipment in the area of application or any geographic sub-zone of the area of application would constitute a change in obligation for which the Senate's advice and consent would be required.

(b) REAFFIRMATION OF SENATE'S TREATY-MAKING POWERS.—The President shall submit for the Senate's advice and consent any change in the obligations of any state party under the CFE Treaty, unless such change is a minor matter of an administrative or technical nature.

(c) CFE TREATY DEFINED.—For the purpose of this section, the CFE Treaty means the Treaty on Conventional Armed Forces in Europe, signed in Paris on November 19, 1990, and associated protocols.

Mr. INOUYE. Mr. President, I ask that the amendment be withdrawn.

The PRESIDING OFFICER. The amendment is withdrawn.

So the amendment (No. 2548) was withdrawn.

AMENDMENT NO. 2516

Mr. INOUYE. Mr. President, I call up amendment No. 2516 on behalf of Senator COHEN.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. COHEN, proposes an amendment numbered 2516.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At an appropriate place in the bill, insert the following section:

SEC. . SENATE ADVICE AND CONSENT TO CHANGES IN OBLIGATIONS UNDER THE CFE TREATY.

(A) FINDINGS.—

(1) On November 25, 1991, the Senate gave its advice and consent to ratification of the CFE Treaty.

(2) The President would need to seek the Senate's advice and consent to any change in obligation of the states parties under the CFE Treaty, unless such change were a minor matter of an administrative or technical nature.

(3) A change in the allowed holdings of treaty limited equipment in the area of application or any geographic sub-zone of the area of application would constitute a change in obligation for which the Senate's advice and consent would be required.

(b) REAFFIRMATION OF SENATE'S TREATY-MAKING POWERS.—The President shall submit for the Senate's advice and consent any change in the obligations of any state party under the CFE Treaty, unless such change is a minor matter of an administrative or technical nature.

(c) CFE TREATY DEFINED.—For the purpose of this section, the CFE Treaty means the Treaty on Conventional Armed Forces in Europe, signed in Paris on November 19, 1990, and associated protocols.

Mr. INOUYE. Mr. President, this matter has been studied by both managers and we find the amendment acceptable.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 2516) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2525

(Purpose: To state the sense of Congress on negotiation of limitations on nuclear weapons testing)

Mr. INOUYE. Mr. President, I ask that we take up for immediate consideration Amendment No. 2525.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. HARKIN, proposes an amendment numbered 2525.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. 8121. SENSE OF CONGRESS ON NEGOTIATION OF LIMITATIONS ON NUCLEAR WEAPONS TESTING.

(a) FINDINGS.—Congress finds the following:

(1) On January 25, 1994, the United States joined with 37 other nations to begin negotiations for a comprehensive treaty to ban permanently all nuclear weapons testing.

(2) On March 14, 1994, the President decided to extend the current United States nuclear testing moratorium at least through September 1995.

(3) Germany and the Group of 21 Non-Aligned States have publicly stated their support for the completion of a comprehensive nuclear test ban treaty by 1995.

(4) On June 6, 1994, the People's Republic of China conducted its second nuclear weapons test explosion since the United States, Russia, and France initiated their current nuclear test moratoria.

(5) On September 7, 1994, the third and final test ban negotiating session of the year will end.

(6) While some progress toward a comprehensive nuclear test ban treaty has been achieved, there is little chance that an agreement will be reached before April 1995 at the current rate of negotiation.

(7) The United States is seeking to extend indefinitely the Non-Proliferation Treaty at the April 1995 Extension Conference.

(8) Conclusion of a comprehensive nuclear test ban treaty could contribute toward successful negotiations to extend the Non-Proliferation Treaty.

(9) Agreements to eliminate nuclear testing and control the spread of nuclear weapons could contribute to national security of the United States, its allies, and other nations around the world.

(b) SENSE OF CONGRESS.—The Congress—

(1) applauds the President for maintaining the United States nuclear testing moratorium and for supporting the negotiation of a comprehensive nuclear test ban treaty;

(2) encourages the People's Republic of China and all other nuclear powers to refrain from conducting nuclear explosions prior to conclusion of a comprehensive nuclear test ban treaty; and

(3) urges the President and the other nuclear powers to take measures necessary to achieve a multilateral comprehensive nuclear test ban treaty before the Non-Proliferation Treaty Extension Conference.

(c) DEFINITION.—As used in this section, the term "Non-Proliferation Treaty" means the Treaty on the Non-Proliferation of Nuclear Weapons, done at Washington, London, and Moscow on July 1, 1968 (21 U.S.T. 483).

Mr. HATFIELD. Mr. President, negotiations are currently underway to draft a Comprehensive Test Ban Treaty [CTBT] and I commend the Senator from Iowa [Mr. HARKIN] for bringing this resolution before the Senate. I ask that he include me as a cosponsor of his resolution.

Two years ago, the Congress ended underground nuclear testing. That action paved the way for the negotiations which are being held in Geneva today. Strong interest by Members of the Senate, the House, and by the President are vital to the effort to swiftly agree on a treaty. Several Senators, including myself, have tracked these negotiations closely and I hope that the message we send today will redouble the resolve of the U.S. negotiators and send a strong signal to other, participating nations that the United States wants a CTBT as soon as possible.

I would ask that included in my remarks be printed a copy of a speech delivered by the U.S. Director of the Arms Control and Disarmament Agency, John Holum. As he says in his speech before the Conference on Disarmament, which is sponsoring the negotiations, "A Comprehensive Test Ban

Treaty is an opportunity whose time has arrived." By approving this resolution today, the Senate is sending that very same message.

There being no objection, the speech was ordered to be printed in the RECORD, as follows:

STATEMENT BY THE HONORABLE JOHN D. HOLUM, DIRECTOR, U.S. ARMS CONTROL AND DISARMAMENT AGENCY

Thank you, Mr. President. I am pleased to have this opportunity to address the Conference on Disarmament again during its session this year. First, Mr. President, may I congratulate you on the skillful way in which you have conducted the business of the CD during your presidency; I know that the U.S. Delegation has provided you with its fullest cooperation. I would also like to extend once again my greetings to Mr. Petrovsky, the CD Secretary General, and to his Deputy, Mr. Bensmail. We appreciate the efforts you are making on behalf of all of us in facilitating our negotiations.

Mr. President, the Conference on Disarmament has accomplished a great deal in recent years—and much since the opening of the January session.

In one sense our progress in the CD is more than any of us had a right to expect—a testament to the abilities of this body.

But in another sense our recent efforts are not enough. The United States is more committed than ever to concluding a comprehensive test ban treaty at the earliest possible time. None of us can rest—none can be satisfied by our noteworthy progress to date—until the world's nations have agreed once and for all to stop testing nuclear weapons.

So I am here neither to criticize the CD nor praise it unconditionally—but rather to exhort it.

Last January I was privileged to report to you President Clinton's commitment to achievement of a comprehensive test ban "at the earliest possible time." Six months later, he has asked me to return here to tell you that these instructions remain fully in effect—and that "earliest possible time" means just what it says. It most assuredly is not diplomatic code for a "relaxed pace." It does not mean take all the time allowed by U.S. law. It means take only the time necessary, negotiating diligently and in good faith, to write a sound treaty.

President Clinton's commitment to the test ban is authenticated by another decision—our continued moratorium on nuclear testing. Despite China's tests, President Clinton has extended our moratorium for a third year, through September of 1995.

I ask you to consider carefully what this means.

The President's decision to extend the testing moratorium balanced the potential value of additional tests against (1) restraint by others, (2) the impact on our nonproliferation goals, and (3) progress in the test ban negotiations here.

In practical effect, this means that where the United States is concerned, the central and profound policy decision that many seek has already been made. If things here and elsewhere go as we hope, the testing moratorium the United States adopted in 1992 will last forever.

This practical reality is underscored by the President's definitive declaration to the UNGA last September, when he said, "In the face of disturbing signs, I renew my call on the nuclear states to abide by that moratorium as we negotiate to stop nuclear testing for all time."

Simply put, we are prepared for the conclusion that the United States has already conducted its last nuclear test—that we will never test again.

As we contemplate that reality, these negotiations—and other developments, including preparations for the NPT Conference next year—should be given even greater energy and purpose.

The United States seeks a CTBT that will bring an end to all nuclear explosions—period. No thresholds. No exceptions. And by that I mean not just all explosions, but all states. Success demands in particular the full support and participation of all five nuclear-weapon states. And we seek universal adherence.

Of course the United States and the other nuclear-weapon states bear a special responsibility in this negotiation, and of course we also have special experience and knowledge that can aid it considerably. So we will continue to seek closely with the other nuclear-weapon states to propel this effort toward fruition.

I wish to commend Ambassador Marin Bosch, Chairman of the NTB Ad Hoc Committee, as he accelerates the Committee's work. The United States supports his efforts to develop a complete text from contributions developed in the Working Groups on Verification and on Legal and Institutional Issues under the leadership, respectively, of Ambassadors Hoffman and Dembinski. Nevertheless, much time has passed and much work remains to be done. We need a document that will both focus and energize our work. And we look to the committee Chairman for his leadership to bring this about.

Now when I last spoke to you I said the United States would be out front pulling in these negotiations, rather than in the back dragging its heels. We plan to persist in—and indeed, to intensify—our efforts to fulfill our President's instructions.

So I urge the Conference to make use of all time possible available to it, even outside the normal term of the CD, to move these negotiations forward. The U.S. delegation is prepared to work continuously in the NTS Committee and its working groups in the period after the September 7 end of session and the opening of the 1995 session so as to make all possible progress this year and prior to the start of the NPT Extension Conference in April 1995.

A kind of linkage has grown in the minds of some between the NPT Extension Conference and progress in other areas. All parts of the international arms control, nonproliferation, and disarmament architecture are, of course, interrelated. But it is a disservice to major regimes or initiatives to posit any kind of rigid "quid-pro-quo" relationship between them.

The NPT should be extended because of its own intense merits to world peace. A comprehensive Nuclear Test Ban Treaty is an opportunity whose time has arrived. We should seize it not because it goes well with NPT extension, but because it deserves to be done.

Mr. President, President John Kennedy was fond of saying that from those to whom much has been given, much is expected.

The CD's remarkable success with the CWC and its notable progress on the CTBT prove it is a body of great ability. And so the world expects much of it—of you.

One of the encouraging trends of these times has been an ability of the international community to clear away much of the divisive ideological and political underbrush that occupied so much time, to so little effect, during the era of maximum East-West and North-South confrontation. Of course those habits have not entirely disappeared. My appeal to you is that to the extent such inclinations persist, this is the last place they should be exercised. For the CD is not a place for scoring political points, but for doing serious work—and producing tangible results.

Indeed, in a world where even bilateral arms control has become multilateral, this institution, the able statesmen and experts who labor here, and the extraordinary and intricate methods of diplomacy you have mastered here, have become the wave of the future—and the embodiment of our hopes for a safer world.

With the end of the Cold War, nuclear proliferation pressures may be more substantial than ever. Such pressures, as you know, can be vertical as well as horizontal. So this is at once the best time to buttress international security—and the most essential. Now especially—with the largest nuclear-weapon powers finally able to deemphasize nuclear weapons in their defense planning—this is no time to revert to old habits.

We have now had five decades of nuclear testing—and are in the fifth decade of calls to stop it. By any fair description, the world's pursuit of a CTBT has been a long-distance race.

But such races are not won by limping across the finish line, or even by being satisfied with moderate progress. They are won with concluding surges of energy and commitment.

We are in the final stages of our race. The finish line is within our view. We must pick up the pace. We must agree to cease nuclear explosive testing, without exceptions, without artificial linkages, without delay—to conclude a CTBT before the chance of our lifetime has passed.

Mr. President, it is an intriguing historical coincidence that the fiftieth anniversary of the first nuclear explosion and the twenty-fifth anniversary of the entry into force of the NPT fall in the same year—1995. I hope our efforts can make this coincidence into an important signpost of progress.

From the very first atomic blast at Alamagordo, mankind has been struggling to free itself from the ferocious beast unleashed there. Since then, thousands of women and men of good will and intellect have pursued—passionately, painstakingly—the compelling mission of our age. Working together, let us rededicate ourselves to that mission: to shepherd this beast back into its cage—to bring what was unleashed in a blinding blast of heat in the New Mexico desert to a fitting end in the cool atmosphere of reason in Geneva—to ensure that our first half-century of nuclear explosions is our last.

Mr. INOUYE. This amendment has been studied by both managers and we find it acceptable.

The PRESIDING OFFICER. Is there further debate?

The question is on agreeing to the amendment.

The amendment (No. 2525) was agreed to.

AMENDMENT NO. 2526

Mr. INOUYE. Mr. President, I call up Amendment No. 2526, an amendment by Senator LIEBERMAN.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. LIEBERMAN, for himself, and Mr. HATCH, proposes an amendment numbered 2526.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 39, after the words "such section" on line 2, insert: ": *Provided further*, That of the funds appropriated in this paragraph, not less than $2,000,000 shall be made available for International Cooperative projects to be funded under the Counterterror Technical Support program element.

Mr. INOUYE. Mr. President, the managers of the bill have discussed this matter and studied it. We find it acceptable.

The PRESIDING OFFICER. There being no further debate, the question is on agreeing to the amendment.

The amendment (No. 2526) was agreed to.

AMENDMENT NO. 2527

(Purpose: To set aside operation and maintenance funds of the Air Force for the Core Automated Maintenance System/Reliability and Maintainability Information System (CAMS/ REMIS)

Mr. INOUYE. Mr. President, I ask that the Senate take up Amendment No. 2527, an amendment by Senator SHELBY.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. SHELBY, for himself, Mr. COCHRAN, and Mr. LOTT, proposes an amendment numbered 2527.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 10, line 17, before the period insert the following: "*Provided*, That, of the amount appropriated under this paragraph, not less than $8,000,000 shall be available only for the upgrading of the Air Force's Core Automated Maintenance System/Reliability and Maintainability Information system (CAMS/REMIS)"

Mr. INOUYE. Mr. President, the managers have studied this amendment, and we find it acceptable.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 2527) was agreed to.

AMENDMENT NO. 2533

(Purpose: To add $1.296 million to the Air Force F-111 squadrons program element)

Mr. INOUYE. Mr. President, I ask that we take up amendment No. 2533.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. BINGAMAN, for himself and Mr. DOMENICI, proposes an amendment numbered 2533.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 37, line 21 of the committee reported bill, before the period insert the following: ": *Provided further*, That of the funds appropriated in this paragraph, $2,800,000 shall be made available only for the F-111 Squadrons program element".

Mr. INOUYE. Mr. President, the managers have studied the amendment, and we find it acceptable.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 2533) was agreed to.

AMENDMENT NO. 2543

(Purpose: To authorize that Secretaries of the military departments to contract for commercial or proprietary credit card services for use by nonappropriated fund instrumentalities of the United States that are under the jurisdiction of such Secretaries)

Mr. INOUYE. Mr. President, I ask that we consider Amendment No. 2543, an amendment by Senator JOHNSTON.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. JOHNSTON, proposes an amendment numbered 2543.

Mr. INOUYE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a) Notwithstanding any other provision of law, the Secretary of a military department may enter into a contract for use of commercial or proprietary credit card services for augmenting or replacing any in-house account receivable system in use by a nonappropriated fund instrumentality under the jurisdiction of that Secretary if the Secretary determines that such contract is in the best interest of that department.

(b) No official of the Department of Defense outside a military department may, by regulation or otherwise, limit or control the exercise of authority under this section by the Secretary of that military department.

Mr. INOUYE. Mr. President, the managers have studied this amendment, and we find it acceptable.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 2543) was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. MURKOWSKI. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. INOUYE. Mr. President, may I ask that the Senator from Alaska be recognized.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. MURKOWSKI. Mr. President, I thank the floor leader for allowing me to offer my amendment at this time, the distinguished senior Senator from Hawaii.

AMENDMENT NO. 2511

(Purpose: To prohibit the availability of any funds for North Korea unless certain conditions are met)

Mr. MURKOWSKI. Mr. President, I call up an amendment numbered 2511.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Alaska [Mr. MURKOWSKI], for himself and Mr. DOLE, proposes an amendment numbered 2511.

Mr. MURKOWSKI. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, insert the following new section:

SEC. . PROHIBITION ON ASSISTANCE FOR NORTH KOREA.

(a) PROHIBITION.—No funds appropriated under this Act or any other Act may be made available to the Democratic People's Republic of Korea until the President certifies and reports to Congress that the Democratic People's Republic of Korea—

(1) does not possess nuclear weapons;

(2) has halted its nuclear weapons program; and

(3) is not exporting weapons-grade plutonium.

(b) NATIONAL SECURITY WAIVER.—The President may waive the prohibition in this section if he determines and certifies in writing to the Congress that to do is vital to the national security interest of the United States, and notifies the appropriate Committee of Congress 15 days in advance in accordance with the regular notification procedures of such Committees. Such notification shall include the nature, purpose and amount of the proposed assistance.

AMENDMENT NO. 2511, AS MODIFIED

Mr. MURKOWSKI. Mr. President, I ask unanimous consent to send a modification to the desk at this time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Without objection, the amendment is modified.

So the amendment (No. 2511) was modified, as follows:

At the appropriate place in the bill, insert the following new section:

(a) PROHIBITION.—No funds appropriated under this Act may be made available to the Democratic People's Republic of Korea until the President certifies and reports to Congress that the Democratic People's Republic of Korea—

(1) does not possess nuclear weapons;

(2) has halted its nuclear weapons program; and

(3) is not exporting weapons-grade plutonium.

(b) NATIONAL SECURITY WAIVER.—The President may waive the prohibition in this section if he determines and certifies in writing to the Congress that to do is vital to the national security interest of the United States, and notifies the appropriate Committee of Congress 15 days in advance in accordance with the regular notification procedures of such Committees. Such notification shall include the nature, purpose and amount of the proposed assistance.

Mr. MURKOWSKI. I thank the Chair.

Mr. President. On July 15, this body unanimously approved an amendment I offered on behalf of myself and the distinguished minority leader, Senator DOLE, to the foreign operations appropriations bill. The amendment barred United States aid to North Korea until President Clinton certified to Congress that certain conditions about North Korea's nuclear weapons program were met.

The amendment was adopted 95-0 on a rollcall vote, representing, I think, the widespread feeling in this body that United States taxpayer dollars should not be used to subsidize this rogue regime until the President can certify that North Korea is no longer a nuclear threat. Not one person spoke against my amendment.

I was dismayed, therefore, to learn that the final conference report did not contain the North Korea language. I am told that the House conferees, under pressure from the Clinton administration, objected to including the North Korea amendment in the final package.

I am here today to offer this amendment again, with slight modifications, and to ask the managers to fight for this bill at conference.

The amendment, offered on behalf of Senator DOLE and myself, says that this body will not provide any aid to North Korea until the President certifies that three conditions have been met:

First, that North Korea does not possess nuclear weapons. If North Korea possesses a nuclear weapon already, the weapons must be destroyed.

Second, that North Korea has halted its nuclear weapons program. This includes full compliance with the terms of the Nuclear Proliferation Treaty and the January 30, 1992, full scope safeguards agreement between the IAEA and North Korea.

Third, that North Korea is not exporting weapons-grade plutonium to other countries on missiles or otherwise.

The amendment also contains a provision allowing the President to waive the provisions of the amendment if he finds that is vital to the national security interest of the United States, and notifies Congress accordingly.

I remind my colleagues of the history of this regime in contemplating whether such assurances are necessary before giving the North Koreans aid.

This was the regime which launched the invasion of South Korea in 1950 resulting in the deaths of 3 million of their countrymen and more than 33,000 American troops; a regime whose agents detonated a bomb in Rangoon killing 16 South Korean officials; a regime which sanctioned the bombing of a Korean Airlines flight killing 115 passengers and crew; and a regime whose military hacked American personnel to death in the DMZ.

Kim Il-song leaves a very unpredictable legacy, and he leaves it to a very unpredictable son. I have not met with anyone in the U.S. intelligence community who has first-hand information about Kim Chong-Il. There are reports that it was Kim Chong-Il who actually orchestrated the Korean Airlines bombing.

I would also like to remind my colleagues of the ominous announcement in Seoul by Kang Myong Do, a defector identified as the son-in-law of North Korea's Prime Minister. Kang indicated first, that Pyongyang has developed five nuclear warheads and second, that North Korea is purposely delaying international inspection of its nuclear sites by stalling talks with the United States and South Korea. The accuracy of the defector's claims are disputed by the State Department, but the mere fact that our intelligence cannot readily confirm nor dispute his allegations illustrate how dangerous the North Korean nuclear situation has become.

Now, more than ever, the United States must demand that North Korea come clean on past nuclear activities and follow through on past commitments to allow IAEA inspectors complete access to nuclear facilities, both suspected and declared.

As this amendment makes clear, it is up to the Administration, as the party directly negotiating with the North Koreans, to send a clear and strong message that the United States is prepared to offer incentives for North Korea, but on our terms.

Unfortunately, up to now, our strategy with North Korea has been less than consistent. Everyone who has negotiated deals in the Asia Pacific understand a key point that I think the U.S. negotiators have missed—Asians understand strength and consistency. Our policy has lacked both.

For more than 2 years Kim Il-song has dictated and our negotiators have conceded.

North Korea extracted concessions from the United States:

United Stated agreed to high-level talks; United States suspended joint military exercises team spirit; United States delayed sending Patriot missiles requested by General; The North Koreans got another year to work on their nuclear capability; and the North Koreans moved fuel rods into the cooling pond without IAEA monitoring procedures in place.

What did the United States get, nothing. The IAEA is still unable to verify whether nuclear activity is taking place. Two suspected nuclear sites remain off limits. And North Korea is a month or so away from being able to reprocess the spent fuel rods into weapons grade plutonium for perhaps four to six more bombs.

It is more than 2 years since North Korea signed the Nuclear Non-Proliferation Treaty Safeguards agreement that requires regular inspections of its nuclear facilities.

It is more than 1 year since North Korea threatened to pull out of the NPT because IAEA was demanding access to the two undeclared nuclear sites and we are no further along in halting their nuclear weapons program.

Mr. President, I have charts, but in view of the fact both sides have looked at the merits of the amendment, I will defer from going through the charts.

However, I think it is important to recognize that since North Korea threatened to pull out of the IAEA in June, five significant events have occurred:

First, the United States declared it would seek U.N. sanctions against North Korea;

Second, Jimmy Carter visited Kim Il-song,

Third, United States agreed to resume high-level negotiations with North Korea on July 8, but then postponed the talks because of the death of Kim Il-song;

Fourth North and South agreed to hold a summit scheduled for July 25 to 27, but now postponed; and

Fifth, the United States and North Korea resumed high-level negotiations in Geneva on August 8 which are ongoing.

Mr. President, Dr. Davis, the assistant secretary for political/military affairs at the State Department testified before the Foreign Relations Committee in March of this year that she was not concerned about this loss of time because North Koreans told us their program was frozen. Mr. President, I am concerned.

By allowing North Korea to continue their drive toward nuclear capability we face a more ominous enemy than we did just last year.

If the new North Korea regime is ready to put aside its drive for nuclear arms and to move toward the family of nations, then I believe the United States should rightfully welcome such a move and offer rewards. However, I strongly believe that North Korea must offer the concessions, and not the other way around.

For too long, we let Kim Il-song dictate the terms of the negotiations, while he gained valuable time to push the suspected nuclear program ahead. From the track record, it was hard to tell which country was a tiny, isolated, terrorist regime violating international agreements and which country was a superpower that was pulling the weight for the international community. This must change.

This amendment sets goalposts for the new leadership in North Korea and signals the United States Administration that this body is ready to provide carrots to North Korea only after explicit guarantees about their nuclear weapons program are met.

Why did the administration oppose the amendment? Is the United States prepared to offer North Korea economic assistance at the high-level negotiations ongoing in Geneva without ensuring that North Korea will abandon its nuclear intentions? Comments made by North Korean and American officials indicate that economic concessions are on the table.

What types of concessions might the administration be considering? It has been widely reported that North Korea is demanding light-water-based nuclear reactors [LWR's] to replace the outmoded graphite-moderated reactors that they currently possess. I do not doubt that the United States negotiators view this technology upgrade as a significant carrot to offer North Korea.

My concern is that the United States will give this carrot away without gaining tangible concessions from North Korea on its nuclear program. I am also concerned that the long-term nature of this project has not been sufficiently thought through by our negotiators. I refer my colleagues to a Washington Post op ed by Victor Gilinsky, a former member of the Nuclear Regulatory Commission, entitled "No Quick Fix on Korea", which I included in the RECORD on August 8. I believe that Mr. Gilinsky exposes some of the fallacies in believing that LWRs will solve the nuclear issue. As Mr. Gilinsky observes:

> In the end, what is wrong with the LWR proposal is that it presumes a level of goodwill on North Korea's part that, were it present, would obviate the need for the proposal. If the North Koreans are interested in electricity, there are much cheaper, better and safer ways to provide it. If they insist on a prestige nuclear project, we can be sure the deal is, in fact, too good to be true. There are no neat technological fixes to the present impasse. What is needed is change in North Korea.

The administration's written position paper on the Murkowski-Dole amendment listed six examples of possible assistance to North Korea that would be precluded by the language of the amendment. I would remind the administration that this amendment would not preclude any of these examples of assistance, if North Korea lived up to the conditions on nuclear concessions.

It is appropriate to note that on November 7, 1993, President Clinton stated: "North Korea cannot be allowed to develop a nuclear weapon."

I agree. And this is exactly what this amendment is about. The President must certify that North Korea does not possess a nuclear weapon at such time as we consider giving them any type of United States aid or assistance.

After watching the administration negotiate with the North Koreans over the last year, I continue to believe that economic concessions for anything short of nuclear concessions would be a mistake. Rewarding North Korea for empty words and promises brings us no closer to a resolution of the nuclear issue. For example, the United States agreed to resume high-level negotiations with North Korea after former leader Kim Il-song promised former President Carter that the spent fuel rods at its Yongbyon reactor would not be reprocessed.

But this promise was merely empty words. The fuel rods cannot be reprocessed for 2 months whether we negotiate or not because the rods are too "hot" with radioactive material. The promise that meant something was the promise the North Koreans did not keep, the promise to not move the fuel rods into the pond in the first place.

Allowing IAEA [International Atomic Energy Agency] inspectors full and unhindered access to the two suspected and seven declared nuclear sites would distinguish this regime from the rogue tactics of the last. This come clean approach was taken in 1991 by South Africa's former President F.W. de Klerk when his country opened up its program to reveal past nuclear activities. We should expect no less from North Korea.

And what should the American people and Congress expect from the Clinton administration during these negotiations? We should expect that the administration will use its leverage as the sole superpower to refrain from rewarding North Korea with taxpayer dollars until the President can certify that the nuclear threat on the Korean peninsula is eliminated. Economic concessions should be made only for good deeds, not just good words.

Unfortunately, the administration's opposition to my amendment leads me to believe that the administration is betting, once again, that rewards given now will lead to good behavior in the future. Every other time the administration has made such a bet, it has lost. This time, North Korean concessions should come first.

I think Congress would be irresponsible to write the President a blank check for any other approach.

Mr. President, I ask unanimous consent that an article appearing in today's issue of the Washington Times, entitled, "Don't Bribe North Korea," be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Washington Times, Aug. 11, 1994]

DON'T BRIBE NORTH KOREA

(By Frank H. Murkowski)

The United States late last week resumed high-level negotiations with North Korea, seeking to encourage the North to abandon its nuclear intentions. While I support the administration's decision to talk, I'm afraid that I may not agree with part of what the administration may be saying.

Comments by North Korean and American officials indicate that the United States may be moving to offer economic concessions to push the North to abandon its nuclear intentions. I believe that economic concessions for anything short of true nuclear concessions would be a mistake, but unfortunately, some in Congress apparently favor writing the president a blank check for this approach.

In response to administration pressure, House and Senate conferees for the Foreign Operations Appropriation bill dropped my amendment, which had been unanimously approved (95-0) by the Senate on July 15. The amendment stated that North Korea would receive no United States foreign assistance until the president certified to Congress that the following three conditions had been met:

North Korea does not possess nuclear weapons. If North Korea possesses a nuclear weapon already, then the weapon must be destroyed.

North Korea has halted its nuclear weapons program. The program must be halted, not frozen. This means full compliance with the terms of the Nuclear Non-Proliferation Treaty and the Jan. 30, 1992, full-scope safeguards agreement between the International Atomic Energy Agency and North Korea.

North Korea has not exported weapons-grade plutonium to other countries on missiles or by other methods.

The administration's opposition to my amendment can only fuel speculation by critics of the president's foreign policy that U.S. officials are prepared to reward North Korea with economic concessions for something far short of the conditions outlined by my amendment. This would be a mistake.

The United States must present North Korea with clear alternatives: Either drop its nuclear intentions and gain the economic and diplomatic benefits of membership in the community of nations, or continue down its current perceived nuclear path and face the consequences of heightened economic and diplomatic isolation.

Rewarding North Korea for empty words and promises brings us no closer to a resolution of the nuclear issue. For example, the United States agreed to resume high-level negotiations with North Korea after former leader Kim Il-sung "promised" not to reprocess the spent fuel rods at its Yongbyon reactor during these talks. But this was an empty promise—the North Koreans could not move these rods for two months in any event because they are "hot" with radioactive material.

Now, administration officials indicate that negotiators are considering North Korea's request for lightwater nuclear reactors. This project would involve a significant commitment of U.S. technology, financial assistance and time. Such a perk might be appropriate at some stage in the negotiations, but I would caution that North Korea should first make tangible concessions. Granting a technological perk to a country that is in violation of international nuclear standards tells the other rulebreakers (Iran, Iraq, Libya) that the rulemakers are prepared to reward intransigence.

The world wants the nuclear impasse created by North Korea's refusal to abide by the terms and conditions of the Nuclear Non-Proliferation Treaty to end. But it should end on our terms.

Kim Jong-il has a historic opportunity to end the impasse and to begin a new era for his people. He can start by announcing that North Korea is prepared to come clean on its past and present nuclear activities. While Kim Il-sung may have felt that he would lose face by revealing hidden activities, the new leader need not be bound by the deeds of his father.

Allowing International Atomic Energy Agency inspectors full and unhindered access to suspected and declared nuclear sites would distinguish this regime from the rogue tactics of the past. This approach was taken in 1991 by South Africa's former president, F.W. DeKlerk, when his country opened up its program to reveal past nuclear transgressions. The United States should expect no less from North Korea.

And what should the American people and the U.S. Congress expect from the Clinton administration during this new round of negotiations? We should expect the administration to use its leverage as the sole superpower to refrain from "rewarding" North Korea with taxpayer dollars until the president can certify to the American people and Congress that the nuclear threat is eliminated.

Mr. MURKOWSKI. Mr. President, I would be happy to respond to any questions by the floor leaders on the merits of my amendment.

Mr. INOUYE. Mr. President, I wish to commend my friend from Alaska for his diligence and leadership in this area. With the modification, we are able to send a strong and clear message to the dictatorial regime on the Korean peninsula.

On behalf of the managers, I am pleased to accept the amendment. And may I, with the acceptance, assure my friend from Alaska that we will do our best to see that it remains in the bill during conference.

Mr. MURKOWSKI. I am most appreciative. I thank my good friend from Hawaii. I do look forward to his assurance that he will do the very best he can in conference on this matter.

The PRESIDING OFFICER. Is there further debate on the amendment? If not, the question is on agreeing to the amendment.

The amendment (No. 2511), as modified, was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. MURKOWSKI. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2509

Mr. INOUYE. Mr. President, I ask that the pending amendment be set aside and wish to call up amendment No. 2509, an amendment by Senator CHAFEE.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the amendment.

The bill clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. CHAFEE, proposes an amendment numbered 2509.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection it is so ordered.

The amendment is as follows:

From the Defense Environmental Restoration Account, $1 million for environmental restoration of the Derecktor Shipyard, Newport, Rhode Island, owned by the U.S. Department of the Navy.

Mr. INOUYE. Mr. President, I send to the desk a modification of the amendment on behalf of Senator CHAFEE.

The PRESIDING OFFICER. Without objection, the amendment is so modified.

The amendment (No. 2509), as modified, is as follows:

On page 9, line 13, before the period, insert: ": *Provided further*, That of the funds appropriated under this heading, not less than $1,000,000 shall be made available only for environmental hazard response and remediation activities at facilities owned by the Department of the Navy at the Derecktor Shipyard, Newport, Rhode Island".

Mr. CHAFEE. Mr. President, the managers of the bill have informed me that they are both supportive of my amendment.

The amendment I offer today in the Senate would make $1 million in funding available for cleanup of environmental contamination at the Derecktor Shipyard in Newport, RI. The Derecktor site is seriously contaminated with PCB's and other hazardous substances. The Navy has indicated to me that it will not fund cleanup of the site until an administrative process to include the shipyard within an existing Superfund site is complete. Well, Mr. President, in my view, the cleanup cannot wait until the shipyard is put on the proper list. The time for cleanup is now, and I am pleased to be able to help start the process.

I thank the managers of the bill for working with me to develop this worthwhile amendment.

Mr. INOUYE. Mr. President, with the modification, the managers are pleased to accept the modified amendment.

The PRESIDING OFFICER. The question is on agreeing to the amendment, as modified.

The amendment (No. 2509), as modified, was agreed.

Mr. INOUYE. Mr. President, I move to reconsider the vote.

Mr. MURKOWSKI. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2512

(Purpose: Regarding Aviation Continuation Pay)

Mr. INOUYE. Mr. President, I ask that the pending amendment be set aside and I call up amendment No. 2512, an amendment by Senator HATCH.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. HATCH, proposes an amendment numbered 2512.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, add the following new section:

"SEC. . Notwithstanding any other provision of law, the Department of Defense shall pay the appropriate amount of Aviation Continuation Pay authorized by 37 U.S.C. Sec. 301(b) to the survivors of persons who have signed reenlistment contracts but whose service connected death predates the effective date of such reenlistment contract by less than 14 days."

Mr. INOUYE. Mr. President, I send a modification to the desk.

The PRESIDING OFFICER. Without objection, the amendment is so modified.

The amendment (No. 2512), as modified, is as follows:

SEC. . Notwithstanding any other provision of law, within the funds made available by the Act, the Department of Defense shall pay the appropriate amount of Aviation Continuation Pay authorized by 37 U.S.C. Sec. 301(b) to the survivors of persons who have signed reenlistment contracts on or after January 1, 1994, but whose service connected death predates the effective date of such reenlistment contract by less than 14 days.

Mr. HATCH. Mr. President, I am deeply moved on this day to pay tribute to Capt. John R. Kindred, a U.S. Air Force pilot, who died in the line of duty in a midair collision on May 6, 1994, over the Yellow Sea, west of South Korea. Captain Kindred, of course, is only one of our brave military men and women who have given their lives in service to our country.

However, my amendment was prompted by an unusual circumstance in the case of Captain Kindred. Captain Kindred had just reenlisted in the U.S. Air Force to serve another 7 years when his untimely death occurred. Although he had signed an agreement to serve under the Aviation Continuation Pay Program, he was not protected by this contract when he died 13 days short of the effective date of his contract. He was in an interim status of completing his old enlistment and beginning his new enlistment period when the collision occurred. Had he not chosen to reenlist, he would have been grounded and would not have been flying in preparation for possible conflict with North Korea on the tragic day of his death.

I have, therefore, offered an amendment to H.R. 4650, the Department of Defense appropriations bill, which will pay the appropriate amount of aviation continuation pay authorized by 37 United States Code section 301(b) to the surviving members of his immediate family, his wife, Lori K. Kindred, and their 2-year-old daughter, Bryndel Kindred.

I thank Senator INOUYE and Senator STEVENS for their support of this amendment.

Mr. INOUYE. With the modification, Mr. President, the managers find the modified amendment to be acceptable.

The PRESIDING OFFICER. The question is on agreeing to the amendment, as modified.

The amendment (No. 2512), as modified, was agreed to.

Mr. INOUYE. Mr. President, I move to reconsider the vote by which the amendment was agreed to, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2530

(Purpose: To include the military services more actively in defense technology reinvestment programs)

Mr. INOUYE. Mr. President, I ask the pending amendment be set aside, and I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. BINGAMAN, for himself, and Mr. PRYOR, proposes an amendment numbered 2530.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Strike section 8096 and insert in lieu thereof:

Amendment No. : None of the funds appropriated or otherwise made available by this Act may be used for a defense technology reinvestment project that is not selected pursuant to the applicable competitive selection and other procedures set forth in chapter 148 of title 10, United States Code: *Provided*, That notwithstanding any other provision of law, funds appropriated for defense reinvestment programs under the heading "Research, Development, Test and Evaluation, Defense-Wide" shall not be obligated until the Secretary of Defense has ensured that the Assistant Secretaries for Research, Development, and Acquisition of the separate Military Departments are full members of the Defense Technology Conversion Council: *Provided further*, That notwithstanding any other provision of law, of the funds appropriated for defense reinvestment programs under the heading "Research, Development, Test and Evaluation, Defense-Wide", $150,000,000 may only be obligated for projects selected as a result of a focused competition held in subject areas selected by the Assistant Secretaries for Research, Development, and Acquisition of the separate Military Departments in coordination with the Director of the Advanced Research Projects Agency: *Provided further*, That in addition to the restriction contained in the preceding provisos, the focused competitions shall be conducted in accordance with other unaffected statutory provisions of the Defense Conversion, Reinvestment, and Transition Assistance Amendments of 1993.

AMENDMENT NO. 2530, AS MODIFIED

Mr. INOUYE. Mr. President, I send to the desk a modification in behalf of Senator BINGAMAN.

The PRESIDING OFFICER. Without objection the amendment will be modified.

The amendment (No. 2530), as modified, is as follows:

In Sec. 8096, on page 113, line 4, strike ": *Provided*," and all the text that follows through "Amendments of 1993", on line 2, page 114, and insert in lieu thereof: ": *Provided*, That notwithstanding any other provision of law, funds appropriated for the Advanced Research Projects Agency defense reinvestment program element under the heading "Research, Development, Test and Evaluation, Defense-Wide" shall not be obligated until the Secretary of Defense has ensured that the Assistant Secretaries for Research, Development, and Acquisition of the separate Military Department are full members of the Defense Technology Conversion Council and are fully integrated into the process of selecting dual-use technology focus areas for such programs and evaluating proposals for such projects: Provided further, That notwithstanding any other provision of law, of the funds appropriated for defense reinvestment programs under the heading "Research, Development, Test and Evaluation, Defense-Wide", $150,000,000 may only be obligated for projects selected as a result of a competition held by the Advanced Research Projects Agency in focus areas selected exclusively by the Assistant Secretaries for Research, Development, and Acquisition of the separate Military Departments: *Provided further*, That in addition to the restriction contained in the preceding provisos, the competition in focus areas shall be conducted in accordance with other unaffected statutory provisions of the Defense Conversion, Reinvestment, and Transition Assistance Amendments of 1993."

Mr. BINGAMAN. Mr. President, on behalf of Senator PRYOR and myself, I am offering an amendment to clarify provisions in the bill with regard to involving the military departments more in the technology reinvestment program run by ARPA.

I first want to note that I agree with the thrust of the provision in the bill. It is vital that the dual-use approach to technology development be inculcated more deeply into the service acquisition systems. We will soon conclude a conference on S. 1587, the most far reaching acquisition reform bill in at least 20 years, and the heart of that bill is the commercial-military integration paradigm espoused by Secretary Perry at least since he was a member of the Packard Commission. DOD should move away from military specifications and toward greater use of commercial products wherever possible, particularly at the subtier industries such as electronics, materials, machine tools, manufacturing technology, communications, and computers. Secretary Perry has spoken eloquently about the opposition this paradigm shift is likely to face from those comfortable with the defense-unique or autarkic strategy DOD has followed too often in the past at great expense in its acquisition system.

So I commend the Senator from Hawaii for the strong support he has shown for the ARPA technology reinvestment program in this bill and for his support for better integrating the services into this program, which is really the flagship of Secretary Perry's and Deputy Secretary Deutch's new dual-use model.

Over the past few days our staffs have had very productive discussions as to how best to achieve the Senator from Hawaii's and our mutual goal in this area. The amendment before us would make the Service acquisition executives full members of the Defense Technology Conversion Council, along with the Director of ARPA and representatives of DOE, the Commerce Department, NASA and the National Science Foundation, and fully integrate them into the technology reinvestment program, including selecting focus areas for competitions and evaluating the proposals that come in as a result of those competitions. We feel that this will better achieve our goal than having an additional step at the end of the selection process involving the service acquisition executives as had been proposed.

The amendment also clarifies that while the service acquisition executives will select the focus areas for $150,000,000 of the funds in the technology reinvestment program element, ARPA will hold the competition for these focus areas and remain the leader of the overall effort.

I believe that this amendment is a step in the right direction compared to the provision currently in the bill. It will both better propagate this new way of doing business into the services and better protect the program from the sort of criticism it received in last night's debate that the program is insufficiently attentive to defense needs, criticism which I believe is wrong. If we have all three service acquisition executives fully involved as stakeholders in this program, as our amendment would do, it will be a better and stronger program.

I understand the amendment is acceptable to the Senator from Hawaii and urge its adoption.

Mr. INOUYE. Mr. President, with the modification the managers find the amendment to be acceptable.

Mr. PRYOR. Mr. President, I rise today to offer an amendment with Senator BINGAMAN that would include the military services more actively in our Federal Government's defense technology reinvestment programs.

This amendment would replace language previously included in this bill that would have required the military services to certify that each technology reinvestment program addresses a bona fide defense need. The language offered by Senator BINGAMAN and myself would remove this certification and replace it with language that places a representative from each military department on the Defense Technology Conversion Council—the guiding body of the Clinton administration's technology reinvestment project that, among other things, selects focus areas, evaluates proposals, and ensures that each program addresses a bona fide defense need.

Although I personally feel that the military departments are currently well represented in the Technology Reinvestment Program [TRP], I acknowledge that the distinguished chairman, Senator INOUYE, and others in Congress wish to see a greater participation of the military departments in this important dual use initiative, to help ensure that each project addresses a true military need.

I would like to express my extreme displeasure with one portion of this bill, relative to the technology reinvestment project. The appropriators have included language that would allow the military departments to select focus areas for $150 million of the $625 million technology reinvestment project. Mr. President, this is a direct violation of the intent and spirit of the TRP. TRP encourages partnerships in a bold effort to integrate military and commercical technology initiatives. To set an example for these partnerships, the Federal Government has assembled five agencies, each working together to foster dual-use technologies and competitiveness. This bill requires the military departments to select focus areas on 40 percent of the TRP without any input or consultation from the other agencies involved in this important initiative. I strongly oppose this shortsighted proposal.

Mr. President, aside from my opposition to this provision, I feel compelled to acknowledge that, for the first time, all four congressional defense committees have provided funds for the Clinton administration's technology reinvestment project. I applaud Senator INOUYE for his leadership in appropriating $625 million for TRP in the Senate version of the fiscal year 1995 Defense Appropriations bill. I also applaud Senator INOUYE for upholding the integrity of our technology reinvestment programs by discouraging the deplorable practice of earmarking specific projects with funds that are designed to be awarded via a merit-based process. Finally, I thank the distinguished Senator for accepting our amendment.

The PRESIDING OFFICER. If there be no further debate, the question is on agreeing to the amendment.

The amendment (No. 2530), as modified, was agreed to.

AMENDMENT NO. 2532

Mr. INOUYE. Mr. President, I ask the pending amendment be set aside. I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. WELLSTONE, proposes an amendment numbered 2532.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, insert the following:

SEC. . The Senate finds:

a. In 1953, the U.S. Army conducted chemical and biological warfare tests in Minneapolis, MN, involving the spraying of zinc cadmium sulfide particles.

b. Members of the Senate have requested the Department of Defense to provide full disclosure of all documents pertaining to this and similar tests conducted nationwide.

c. The Department of Defense has thus far failed to provide even a time certain at which such documents will be made available.

SEC. . It is the sense of the Senate that the Department of Defense shall immediately provide, in writing, a schedule of production for the requested documents.

AMENDMENT NO. 2532, AS MODIFIED

Mr. INOUYE. Mr. President, I send to the desk a modification in behalf of Senator WELLSTONE.

The PRESIDING OFFICER. Without objection the amendment is modified.

The amendment (No. 2532), as modified, is as follows:

SEC. . It is the sense of the Senate that not later than 90 days after the enactment of this Act, the Department of Defense shall submit all documents pertaining to any and all Department of Defense chemical and biological warfare tests involving the use of zinc cadmium sulfide conducted anywhere in the United States.

Mr. WELLSTONE. Mr. President, in 1953 the U.S. Army conducted chemical and biological warfare experiments in Minneapolis that involved the spraying of a potentially dangerous compound called zinc cadmium sulfide over the city. On June 10, 1994, I sent a letter to Defense Secretary Perry asking for all documents relating to these experiments, and since then, I have learned that similar tests were carried out using different materials in various locations throughout Minnesota and most of the United States.

I offer this amendment not to make any judgments about the appropriateness of the experiments. I offer this amendment to ensure that the American people get the full disclosure they deserve. When the Army conducted its testing in Minneapolis and other cities, they made up a cover story so that the citizens wouldn't know what the tests really were. That was a long time ago and most of the people who directed those tests are probably no longer with the Department, but the American people still deserve to know what happened during the cold war. That is why I have requested documents and made those documents available to the public as I have received them.

As I have said, my first request for disclosure was a letter to Defense Secretary Perry dated June 10, 1994. The letter asked for all documents relating to zinc cadmium sulfide spraying in Minneapolis and throughout the United States.

On June 14, when I received a briefing from Army officials, I made it clear that I wanted full disclosure by the DOD of all documents involving zinc cadmium sulfide spraying in the United States, as well as involving any other chemical and biological warfare testing that occurred in Minnesota, even if zinc cadmium sulfide was not involved. The officials promised full disclosure and presented me with some very general documents, previously released in 1977. They also agreed to provide a timeline for the production of the rest of the documents.

Over the next month, DOD provided my office with a number of very specific documents, detailing spraying experiments in Minneapolis, St. Louis, and Winnipeg in 1953.

At a briefing July 15, DOD officials provided a health effects assessment of the Minneapolis spraying and promised to provide all documentation relevant to experiments in Minnesota and zinc cadmium sulfide spraying in the rest of the United States by August 15.

In a July 28 telephone discussion, we were informed that DOD would not be able to provide anything but the Minnesota-related documentation by the August 15 deadline, and that the U.S.-wide documentation would not be available until some unspecified time in the future. DOD was requested to write a letter explaining their failure to meet the deadline. The letter was to be provided by August 9. No such letter has been received.

DOD apparently still plans to provide the Minnesota-related documents by August 15, but I have no idea when I will see the rest of them, including those involving tests conducted in the rest of the country.

This is an issue of public accountability. For some reason the Department seems incapable or unwilling to give me a time certain for delivery of these documents. They made a commitment, and then failed to keep it, without even providing a reason.

This amendment assumes that the Department will keep its earlier commitment to make all Minnesota-specific documents available on August 15, 1994. The amendment sets a 90-day deadline for DOD to provide the rest.

Mr. INOUYE. Mr. President, as modified the managers find the amendment to be acceptable.

The PRESIDING OFFICER. If there be no further debate, the question is on agreeing to the amendment.

The amendment (No. 2532), as modified, was agreed to.

AMENDMENT NO. 2544

(Purpose: To limit funds to ensure the operation of Fort Chaffee, AR, in accordance with the report of the 1991 Base Realignment and Closure Commission)

Mr. INOUYE. Mr. President, I ask the pending amendment be set aside to consider amendment No. 2544, an amendment by Senator BUMPERS. I send the amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The bill clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. BUMPERS, proposes an amendment numbered 2544.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, and the following:

"SEC. . None of the funds made available under this Act may be obligated or expended for the relocation or reduction of the functions specified in the 1991 Report to the President of the Defense Base Closure and Realignment Commission to be maintained at Fort Chaffee, Arkansas, including ndall civilian management, support personnel and operations associated with these functions that are in existence as of September 30, 1994."

AMENDMENT NO. 2544, AS MODIFIED

Mr. INOUYE. I send to the desk a modification to this amendment in Senator BUMPERS' behalf.

The PRESIDING OFFICER. Without objection, the amendment is modified.

The amendment No. 2544, as modified, is as follows:

At the appropriate place in the bill, and the following:

"SEC. . None of the funds made available under this Act may be obligated or expended for the relocation or reduction of the functions specified in the 1991 and 1993 Reports to the President of the Defense Base Closure and Realignment Commission to be maintained at Fort Chaffee, Arkansas, including all civilian management, support personnel and operations associated with these functions that are in existence as of September 30, 1994."

Mr. INOUYE. With such modification the managers find the amendment to be acceptable.

The PRESIDING OFFICER. If there be no further debate, the question is on agreeing to the amendment.

The amendment (No. 2544), as modified, was agreed to.

Mr. INOUYE. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. INOUYE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2506

Mr. INOUYE. Mr. President, I ask the pending amendment be set aside and we consider amendment No. 2506, an amendment submitted by Senator DOMENICI. I send the amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. DOMENICI, for himself and Mr. BINGAMAN, proposes an amendment numbered 2506.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, insert:

SEC. . No funds appropriated by this Act may be obligated or expended during fiscal year 1995 for retiring, or preparing to retire, any B-52H, B-1B, or F-111 bomber aircraft.

Mr. DOMENICI. Mr. President, this amendment would prohibit the expenditure of Department of Defense funds to retire, or prepare to retire, B-52H, B-1B, or F-111 bomber aircraft in fiscal year 1995. The language in this bill can also be found in this year's Defense authorization bill.

The F-111 fighter bomber played a critical role in the Persian Gulf war in delivering precision-guided munitions deep behind enemy lines against high value targets. The F-111s at Cannon Air Force Base continue to demonstrate their prowess in exercises. Should they be called upon again to support our forces anywhere in the world they would be ready and they would make a tremendous contribution.

The August 8 edition of Defense News contains an article dealing with F-111 force structure. It begins with the statement, "Senior uniformed U.S. Air Force officials are opposing a plan to retire the F-111 long-range strike aircraft by 1996, citing a gap in combat capability."

Mr. President, the Air Force officers referenced in the Defense News article are right. Their comments echo the Bottom-Up Review which says that the F-111 is necessary to carry out the missions of the Department of Defense through fiscal year 1999. This amendment is a step in the right direction. I thank the managers for the consideration of this amendment.

Mr. INOUYE. This amendment has been authorized and accordingly the managers have no objection to its acceptance.

The PRESIDING OFFICER. If there be no further debate, the question is on agreeing to the amendment.

The amendment (No. 2506) was agreed to.

Mr. INOUYE. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. INOUYE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. INOUYE. Mr. President, I ask the pending matter be temporarily set aside and that the Chair recognize the Senator from Ohio [Mr. METZENBAUM].

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. METZENBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

UNANIMOUS CONSENT AGREEMENT

Mr. METZENBAUM. Mr. President, I ask unanimous consent that the Senator from Ohio and the Senator from Utah be permitted to offer a bill at this time, which I send to the desk and ask that the bill be placed on the calendar.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. METZENBAUM. I thank the Chair.

(The remarks of Mr. METZENBAUM and Mr. HATCH pertaining to the introduction of S. 2380 are located in today's RECORD under "Statements on Introduced Bills and Joint Resolutions.")

MEASURE READ FOR THE FIRST TIME—S. 2380

Mr. METZENBAUM. Mr. President, I ask unanimous consent that the previous unanimous consent agreement relating to placing on the calendar S. 2380 be vitiated, and I now ask for its first reading.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will read the bill for the first time.

The assistant legislative clerk read as follows:

A bill (S. 2380) to encourage serious negotiations between major league baseball players and the owners of major league baseball in order to prevent a strike by the players or a lockout by the owners so that the fans will be able to enjoy the remainder of the baseball season, the playoffs, and the World Series.

Mr. METZENBAUM. Mr. President, I now ask for its second reading.

Mr. HATCH. Objection.

The PRESIDING OFFICER. Is there objection?

Mr. HATCH. I object.

The PRESIDING OFFICER. Objection is heard. The bill will be given its second reading the next legislative day.

Mr. PRESSLER. Mr. President, I ask unanimous consent to speak for 5 minutes as if in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. PRESSLER. Mr. President, all of us are very concerned about helping those Americans without health insurance. We want to ensure that they get insurance benefits. In my State a survey in one of our leading newspapers found that about 75 percent of our people were satisfied with the present health insurance and health care system. This does not mean that people do not want any change. Rather, it means they only want us to fix that which is broken.

I lived in England many years ago as a student, and I found that there were people unhappy with the health care system there. There are people unhappy with the health care system in Canada, in Germany. There is no perfect way to deliver those kinds of services and have everybody happy.

The point is we have the best health care system in the world, and the one that produces the most new drugs and the most new medical procedures. I think we should move very cautiously before we change the basic type of health care system we have. That does not mean we do not need to improve things in certain areas.

Now, the President and the First Lady have done a good job of raising this subject. They deserve a great deal of credit. What happens in most of their seminars and meetings is that three or four people who have suffered from great health problems are showcased. We sympathize with those people who suffered. We would like to solve their problems. Everybody leaves the room and the meeting, and the implication is that everybody's problems would be solved if we just passed the Clinton health care plan or the Mitchell health care plan.

But that is not true. There is much misunderstanding about what is in these bills, and it is part of my purpose to try to increase the understanding.

For example, the health bill, according to the Washington Post, the Mitchell bill, the 1,410 page bill—and this is as reported in the Washington Post—"would create dozens of new Federal and State agencies. They would have untested authority to centralize, reorganize, monitor and enforce the way medical care is bought, sold and, to a lesser extent, practiced in this country."

In other words, we are setting up Government health insurance, and we should remember that, because that is exactly what it is.

I cite another article from the Philadelphia Inquirer. "Health bills increase taxes of middle class." According to the Philadelphia Inquirer, this is one of the largest tax increases aimed at the middle class in American history. "The bottom line," it says, "most people who now have generous health-insurance plans would end up paying more for reduced benefits, said Joseph Walshe, a benefits specialist with the Coopers & Lybrand accounting firm.

> Families in the $50,000 annual income range may see their insurance costs rise by several hundred dollars per year, Walshe said; actual costs would vary depending on a host of individual circumstances.

Mr. President, I have long felt that my principal job here is to represent the middle class. Of course, we are concerned about the very rich and the very poor, and we want to take care of the very poor and help them. But most people that I represent are middle-class Americans. You do not get any medals, I guess, for representing the middle class or being in the middle class, but the point is this health care bill is a massive tax increase for the middle class.

The Philadelphia Inquirer article lists four major new taxes on the middle class. First of all, it would "impose a new tax on health insurance premiums—2 percent in the House bill and 1.75 percent in the Senate plan." Most middle-class Americans have their own health insurance premiums, so most middle-class Americans would be paying that new tax.

Second of all, the bill ends "current tax breaks for 'flexible spending accounts' in so-called cafeteria-style benefit option plans. This probably would affect more ordinary taxpayers than any other proposed tax change." That is another heavy tax on the middle class.

Third, there is "a 25 percent penalty tax on 'high cost' insurance plans that 'would be difficult to implement' and 'might be considered inequitable.'" That is another tax on the middle class.

Finally, there is an "extension of the Social Security tax on non-wage income to owners of 'S corporations,' a tax category of service businesses."

So the point I am trying to make here is that the middle class' taxes are going to be substantially increased in this bill, and that should be understood. The very rich will pay the same increase, but it will be incrementally much smaller. But to a family of four on an income of $40,000- to $50,000 a year, that is a heavy tax increase on a percentage basis. And we should not apologize about representing people who make $30,000- or $40,000 a year or $50,000 a year. They are American citizens. They deserve representation. They should be told what is in this bill. It is a major tax increase on middle-class Americans, those Americans who take care of themselves, those Americans who obey the laws, pay their taxes, and carry out the duties of citizenship in this country. I think that has been overlooked, where the incidence of this tax increase falls. These new taxes fall on the middle class.

I know there is very little sympathy in this Chamber from some of my friends for the middle class. To be very wealthy is very fashionable. To help the very poor is compassionate and you get awards and medals for it. But everybody forgets about the middle class, those people out here who are working, doing their jobs, who insure themselves, take care of themselves and their families, contribute to their communities. And this bill hits them hardest. It punishes the middle class. I think we should look at the new taxes that are in it and see if this is what we really want.

Also, we must take a very careful look at the dozens of new Federal and State agencies that are being created, because once these new agencies are created there will be 98,000 new Federal employees and we all know what happens when there are new Federal employees—it keeps growing and growing and growing. And again, the taxpayers of America must pay.

It has been said that our country is something like a wagon. There are only so many people pulling the wagon. Some people must ride in the wagon because they are handicapped or they are disadvantaged or they are poor. But more and more people are getting of the philosophy that they will ride in the wagon rather than pull the wagon. We are penalizing those people who pull the wagon—the backbone of our country. The way the taxes are built in this health care bill, the way the taxes will fall, they fall the hardest on the hardworking, honest, middle-class people of this country. And I make no apologies about standing up and speaking for them because I do not think they are spoken for enough.

Now, this bill is put forth that it is going to solve all the problems and that somehow it is free. There is a tendency here to promise all these things in 1998 and the year 2000 and 2002. The balanced budgets are being promised, and the President talks about the benefits and the other goodies. But we really do not have good CBO figures. How much is it going to cost? Yesterday, we had a resolution in the Senate saying we should have the CBO figures, real budget figures before we act on such a major piece of legislation.

The American middle-class taxpayer is being locked into a heavy load of taxes on a whole series of promises that are going to come into effect.

Now, none of these taxes will come into effect until after the next Presidential election. That is another phenomena of this bill. If the President and the people advocating this health care reform were sincere and they thought we needed it, they should make it effective today. People would know what the rate of taxation would be during the next Presidential election. They are not going to find out because it very carefully takes us beyond 1996. It takes us on to 1998. Indeed, the biggest taxes come into effect in 2002, the employer mandates. By that time, we will have had two Presidential elections.

So what this Congress is doing is putting a burden on future generations. It is promising people a whole bunch of things that are not going to be delivered until 2002, but meanwhile the taxes are creeping in. And it is doing it without a budget estimate, which is just absolutely amazing. So that is not a good management way to do business.

I have frequently been a critic of Congress because of the way we do our business and how we are organized. But we should have a budget estimate before we go into something like this. If we are going to increase people's taxes, we should tell them how much and when. Those are some of the things that we must do.

Mr. President, I ask unanimous consent to place the article from the Washington Post about the dozens of new Federal and State agencies into the Record, and also from the Philadelphia Inquirer titled "Health bill increase taxes of middle class." This is from a very liberal paper that is writing that. I do not usually cite liberal papers, but when they write the truth I do.

There being no objection, the articles were ordered to be printed in the Record, as follows:

[From the Washington Post, Aug. 7, 1994]

Health Bills May Have No Substitute for Bureaucracy

(By Dana Priest)

President Clinton and members of Congress last week hailed the Senate Democratic leadership's health bill as a vast improvement over the bureaucracy-laden 1,462-page plan produced by the White House.

But the 1,410-page bill proposed by Senate Majority Leader George J. Mitchell (D-Maine) also would create dozens of new federal and state agencies. They would have untested authority to centralize, reorganize, monitor and enforce the way medical care is bought, sold and, to a lesser extent, practiced in this country.

New bureaucracy is unavoidable in legislation that sets out to tackle the job of reforming the health care system, which makes up one-seventh of the economy, policy analysts say.

"While it appears as more bureaucracy, it's actually less than the current system," said David Kendall, a health policy expert with the Progressive Policy institute, a conservative Democratic think tank. "Having one purchasing group buying insurance for 1 million people is a lot more efficient than having 10,000 employers do it."

Even so, the Mitchell bill substitutes government bureaucracy for private in some instances, challenging states and federal agencies to set up new agencies with complex responsibilities never before performed on the same scale by public or private enterprise.

The Mitchell bill would require states to enforce complex new insurance industry laws designed to prevent companies from discriminating against the old and sick.

It would obligate states to verify that health plans had the ability to care for patients in the way the law requires and were financially sound.

And it would force states to monitor the transfer of billions of dollars in insurance premiums paid by employers and individuals to private insurers.

States also would set up at least three new, multibillion-dollar government subsidy programs for low-income people. One would be for people temporarily unemployed. Another would be for low-income pregnant women and children. The third would be for hard-to-reach low-income groups like the homeless.

In addition, states would have to dismantle Medicaid, the current federal-state health insurance program for the poor, and give money to those same people to buy private insurance.

Moreover, the states would be asked to collect new data in each community on patient care, health spending and on the functioning and efficiency of health plans. The data would be used to compile a report card on each health plan that consumers would use to select a plan every year. it also would be used by each insurance company to set standard prices in each community.

"It's so much at one time," said Raymond C. Scheppach, executive director for the National Governors' Association. "You're trying to build a very different delivery system at the same time there's a new low-income program. and then you have to worry about waste, fraud and abuse because you're reshuffling so much money."

Mitchell's requirement that states collect insurance and health data, for example, also would be necessary to make sure no health plan collapsed financially. This could occur if a disproportionately large number of sick people enrolled in one particular plan.

To protect against this possibility, states would be required to do something called "risk adjustment," a task no one has carried out successfully anywhere on a large scale. It involves figuring how much more one particular health plan spent because it had more sick people than the average plan in a given community and then giving it money to make up the difference attributable to the disparity.

In Mitchell's bill, large companies allowed to keep their own health plans would be required to contribute toward the overall cost of health care for people in the community beyond their employees. Senate aides believe large companies would be required to pay less than a 1 percent payroll tax.

The Congressional Budget Office recently said, "The feasibility of developing and successfully implementing such a mechanism in the forseeable future is highly uncertain."

Proponents of the Democratic leadership bills argue the new bureaucracies are a necessary part of fixing the health care system and they have designed them in the least disruptive way.

"It requires a lot of administrative work, and we don't know whether they can be done, especially by the states," Mitchell said at a news conference last week. "That states have been the laboratories of democracy in health care . . . and the alternative to the states doing it are two: the federal government doing it or doing nothing."

Opponents say the bills are another example of government run-amok lawmaking. "With 17 new taxes and 20 new bureaucracies, the Mitchell plan is enormously irresponsible and expensive," said Sen. Don Nickles (R–Okla.).

Nickles 17 "new taxes" include increases in penalties for not complying with proposed new rules and changes in how the tax code treats some health benefits. It also includes some taxes Republicans have championed, such as taxing wealthy Medicare beneficiaries for part of the Medicare benefits they receive.

Scheppach of the governors' group said states would need a three- to five-years period of phase in the new system before being judged on whether the reforms reduced health spending and provided insurance to more people.

Under the Mitchell bill, employers in a state that did not reach 95 percent coverage by 2000 might then be required to pay 50 percent of their workers' health insurance. Employees would be required to pay the rest.

In the Mitchell bill, for example, small businesses that voluntarily pay workers' insurance would no longer have to search out health companies to insure their workers. The company simply would send the money to the health plan or Health Insurance Purchasing Cooperative that it employees choose.

The cooperatives, new nonprofit agencies monitored by the states, would be responsible for enrolling individuals, collecting and distributing premium payments to health plans and providing consumer information on plans' quality and costs. In regions where no nonprofit organization took on that task, states would be required to run a cooperative for consumers.

States also would have to offer employees in every community the chance to enroll in the federal employee health program. And if no such program existed in a given region, the federal Office of Personnel Management would have to set up and run one there.

People on all sides of the health care debate criticize the massive amount of red tape in the current system. Health experts say paperwork and overhead add 30 percent to the cost of insurance for small businesses. Consumers complain frequently about the paperwork and coverage battles with insurance companies, and standardizing the system requires new regulations. The question is whether the government can, and can be trusted to, oversee a health system in an efficient and cost-effective way. As everything else in health care reform, that will be a much-debated point. "To us, it's the Clinton alliances all over again," said Mary Nell Lehnhard, senior vice president of the Blue Cross Blue Shield Association, referring to the much-maligned insurance purchasing cooperatives in the original Clinton plan that were denounced by all sides.

In addition to the expanded role for the states, the federal government also would have new responsibilities under the Mitchell plan. It calls for a new National Health Care Cost and Coverage Commission, a seven-member presidentially appointed panel empowered to monitor and recommend ways to cover more people and reduce health spending. It mandates a National Health Benefits Board, also seven members, set up to decide the scope of medical services guaranteed in the standard benefit package each health plan must sell.

There is the National Council on Graduate Medical Education, which would reorganize medical education so 55 percent of the residency students were working in primary care by 2001.

And there is the National Quality Council, which would set quality standards and performance measurements for health plans. And then, there is the House bill drafted by Majority Leader Richard A. Gephardt (D-Mo.). It contains many elements of the Mitchell plan, plus others.

Health Bills Hike Taxes of Middle Class

(By Robert A. Rankin)

Washington.—The two main health-reform bills moving through Congress contain several provisions that would raise the taxes of middle-class Americans as a tradeoff for providing universal insurance coverage.

Every income group would be affected by the most-publicized tax contained in both bills: a 45-cent-per pack increase in the cigarette tax, which would rise to 69 cents per pack by 1999.

But other less-noticed terms largely would hit the middle class. The bills would end current tax breaks for employee health insurance, add taxes on health-insurance premiums and, in the Senate version, slap a 3 percent income tax increase on many small-business owners.

The bottom line: Most people who now have generous health-insurance plans would end up paying more for reduced benefits, said Joseph Walshe, a benefits specialist with the Coopers & Lybrand accounting firm.

Families in the $50,000 annual-income range may see their insurance costs rise by several hundred dollars per year, Walshe said; actual costs would vary depending on a host of individual circumstances.

New taxes are never popular, but their proponents say these are necessary to provide universal health insurance to the 39 million Americans who lack coverage and to finance standard benefits for everyone.

The effect on individuals would vary considerably by region, by plan and by the demographic profile of clients sharing in group plans, said Bill Custer, research director for the Employee Benefit Research Institute, a nonpartisan, nonprofit study center.

In addition to raising the cigarette tax, the plans sponsored by House Democratic Leader Richard A. Gephardt of Missouri and Senate Democratic Leader George J. Mitchell of Maine would:

Impose a new tax on health-insurance premiums—2 percent in the House bill, 1.75 percent in the Senate plan. While insurers would pay the tax initially, "it's clear the effect of that tax is either going to be a reduction in benefits or simply passed along [to policyholders] as higher premiums," said Custer.

End current tax breaks for "flexible spending accounts" and so-called cafeteria-style benefit option plans.

This probably would affect more ordinary taxpayers than any other proposed tax change, said Clint Stretch of the Deloitte & Touche accounting firm. Reformers hope to make consumers more aware of the full costs of their health-care spending—in hope of encouraging more cost-efficient spending—but this change would pinch the middle class.

About 40 percent of corporate employees now take advantage of flexible accounts, through which they set aside pre-tax dollars to cover their insurance plan's annual deductible fee, and co-payments for medical services. About 8 percent use cafeteria-style option plans, which let employees use pre-tax dollars either for insurance or other expenses such as child care.

A family in the 28 percent tax bracket that sets aside $400 in a pre-tax "flex" account can cut its income tax by $112. Ending that break "is a tax increase, in effect," said Custer.

He warns that as employers lose their tax incentives to offer such health-care plans, they also may drop the rest of their "cafeteria" offerings on the ground that they are more administrative trouble than they are worth.

Gephardt's chief reform-financing tool is to impose a mandate on employers to pay 80 percent of their employees' health insurance. Economists call this an indirect tax; politicians call it dynamite because business groups oppose it so vehemently.

To avoid the political explosion from that proposal, Mitchell backed several other taxes, including:

A 25 percent penalty tax on "high-cost" insurance plans that "would be difficult to implement" and "might be considered inequitable," as determined by complex formulas. Like the small tax both bills would impose on premiums, insurers also would pass this 25 percent tax along to consumers one way or the other, analysts agree.

"A lot of plans will try to keep under the [25 percent] cap by skimping on benefits and other ways to keep costs down," said Custer. He said the pace of medical inflation was so hard to restrain that it eventually would push nearly all insurance plans into triggering Mitchell's 25 percent tax.

Extension of the Social Security tax on non-wage income to owners of "S Corporations," a tax category of service businesses.

"A lot of small-business owners are S Corps," said Pamela Pecarich, director of tax policy for Coopers & Lybrand. "For them this is going to be a big hit, because it's a 2.9 percent tax on their total income."

The biggest taxes in both bills, however, are the ones economists call "indirect." Like Gephardt's employer mandate, these are "taxes" because they involve the government confiscating private money for a public purpose.

Another indirect tax on both bills stems from their deep cuts in Medicare's projects payments to doctors and hospitals.

Medicare already pays doctors and hospitals less than their true costs for treating the elderly. Doctors and hospitals make up these losses by shifting the unpaid expenses to bills of the privately insured.

Mr. PRESSLER. Let me also indicate what I am for. Meaningful reform must include: malpractice reforms, insurance reforms—making insurance permanent and portable, preventing insurance companies from denying benefits to individuals with a pre-existing condition, antitrust reform, paperwork reduction, reduction of Federal regulation, medical savings accounts, tax fairness to the self-employed, and voluntary purchasing pools.

I yield the floor.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

The Senate continued with the consideration of the bill.

Mr. INOUYE. Mr. President, what is the pending business?

The PRESIDING OFFICER. The pending business is the first committee amendment.

AMENDMENT NO. 2534

(Purpose: To limit the use of funds for a joint program for the development of an advanced threat radar jammer with a foreign government, other than a major ally of the United States, or with an entity controlled by a foreign government, other than such an ally)

Mr. INOUYE. Mr. President, I ask that the amendment be set aside, and I ask that amendment No. 2534, an amendment by Senator FEINSTEIN, be considered.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mrs. FEINSTEIN, for herself, Mr. SASSER, Mr. BINGAMAN, and Mr. ROTH, proposes an amendment numbered 2534.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a) None of the funds available to the Department of Defense during fiscal year 1995 may be used for negotiating or entering into any agreement with, nor for accepting funds from, a foreign government or an entity controlled by a foreign government for a joint program for the development of an advanced threat radar jammer for combat helicopters until 30 days after the Secretary of Defense, in consultation with the Secretary of State, the Secretary of the Army, and the Director of the Defense Security Assistance Agency, conducts a comprehensive review of the program and submits a report on the results of that review to the congressional defense committees.

(b) This section does not apply with respect to a major ally of the United States.

(c) In this section:

(1) The term "entity controlled by a foreign government" includes—

(A) any domestic or foreign organization or corporation that is effectively owned or controlled by a foreign government; and

(B) any individual acting on behalf of a foreign government, as determined by the Secretary of Defense. Such term does not include an organization or corporation that is owned, but is not controlled, either directly or indirectly, by a foreign government if the ownership of that organization or corporation by that foreign government was effective before October 23, 1992.

(2) The term "major ally of the United States" has the meaning given such term in section 2350a(i)(2) of title 10, United States Code.

Mr. INOUYE. Mr. President, the managers find this amendment to be acceptable.

Mrs. FEINSTEIN. Mr. President, I rise today to support my amendment that would require the Secretary of Defense to report to Congress on a very important issue that involves not only congressional oversight of a defense program, but also proliferation concerns and stability in the Middle East: a Department of Defense proposal to codevelop the Advanced Threat Radar Jammer [ATRJ] with the United Arab Emirates [UAE].

I understand that the U.S. Army and Defense Security Assistance Agency [DSAA] are prepared to offer the UAE a proposal to codevelop the ATRJ—the Army's next generation radar receiver and jamming system. Under this proposal, the UAE would provide funding for research and development of the ATRJ and then be allowed to purchase the sophisticated systems for installation on recently acquired AH-64 Apache helicopters.

I and many of my colleagues are concerned about this proposal for several reasons. First, this agreement would establish an arrangement wherein a foreign nation would fund a U.S. defense program in an apparent circumvention of the normal authorization and appropriations process, and beyond the effective oversight of Congress. The Congress has repeatedly voiced its objections to executive branch efforts to solicit funds in support of U.S. foreign policy or defense initiatives that were not first made subject to the scrutiny of the legislative branch.

Second, I believe this agreement would undermine the President's own efforts to constrain weapons proliferation. It provides the UAE with a quantum improvement in its war fighting capability which could provoke other hostile nations to seek advanced systems to counter the new perceived UAE threat.

Third, this arrangement would violate a departmental policy, recently reaffirmed by the Deputy Secretary of Defense on March 15, 1994, which states that:

> The Department of Defense remains committed to the policy of no foreign military sales or commitments for foreign sales of defense systems prior to the successful completion of OT&E [operational test and evaluation], and the specific approval of the Under Secretary of Defense. This policy remains in effect today.

Finally, I am deeply concerned that if this new weapons system were introduced into a volatile region and ever fell into the hands of a U.S. adversary, its state-of-the-art jamming capability could pose a serious threat to U.S. forces. When fully operational, this system will be capable of friend or foe identification, pulsed radar jamming, extreme radio frequency sensitivity and processing capability, as well as multiband situational awareness.

I see little justification for proceeding with an arrangement that is fraught with so many questionable funding practices and policy implications. While I and many of my colleagues believe that the United States shares an interest in the security of the UAE, the ATRJ would provide a level of jamming capability significantly greater than that possessed by many of our close NATO and major non-NATO allies. The possible threats to the UAE are no greater than those faced by other nations in the region, none of which have been asked to participate in the ATRJ program.

I have already contacted the Defense Department on this issue, expressing my concern over the codevelopment of the ATRJ with the UAE. Unfortunately, I found the response to my concerns to be inadequate.

Therefore, I have offered this amendment that directs the Department of Defense not proceed to with the codevelopment of the ATRJ with any foreign entity until the Department has fully consulted with Congress, and evaluated both legal and policy implications. The amendment exempts our NATO and major non-NATO allies.

Specifically, the report to be submitted by the Secretary of Defense should include the following:

First, the legal basis for seeking for the program funds that are neither authorized to be appropriated nor appropriated.

Second, the consistency of the program with the Department of Defense policy that no foreign military sale of a defense system, and no commitment to foreign military sale of a defense system, be made before operational test and evaluation of the system is successfully completed and the Under Secretary of Defense for Acquisition and Technology has specifically approved the system for sale to a foreign government.

Third, the mission requirement for an advanced threat radar jammer for combat helicopters.

Fourth, an assessment of each threat for which an advanced threat radar jammer would be developed, particularly with regard to each threat to a foreign country with which the United States would jointly develop an advanced threat radar jammer.

Fifth, the potential for sensitive electronic warfare technology to be made available to potential adversaries of the United States as a result of U.S. participation in the program.

Sixth, the availability of other nondevelopmental items and less sophisticated technologies for countering the emerging radar detection threats to U.S. combat helicopters and combat helicopters of U.S. allies.

Seventh, a capability assessment of similar technologies available from other foreign countries and the consequences of proliferation of such technology.

I urge my colleagues to support this commonsense amendment and I urge its adoption.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from California.

The amendment (No. 2534) was agreed to.

AMENDMENT NO. 2539

(Purpose: Limitations on military assistance for the Sandinista Popular Army of Nicaragua)

Mr. INOUYE. Mr. President, I ask that the pending amendment be set aside, and I ask for the immediate consideration of amendment No. 2539, an amendment by Senator HELMS.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. HELMS, proposes an amendment numbered 2539.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the Committee amendment, insert the following:

SEC. . LIMITATION ON THE USE OF FUNDS FOR THE SANDINISTA POPULAR ARMY AND SECURITY FORCES OF NICARAGUA.

(a) IN GENERAL.—None of the funds appropriated under this Act may be obligated or expended for the armed forces or security forces of Nicaragua, and none of the funds appropriated by this Act may be obligated or expanded to pay the salaries of United States military personnel to provide assistance for the armed forces or security forces of Nicaragua, until the President determines and certifies to the Congress that—

(1) Nicaraguan military officers implicated for committing human rights violations, including those involved in the murders of Enrique Bermudez, Arges Sequeira, and Jean Paul Genie, have been removed or suspended from the military and judicial proceedings have commenced;

(2) officers of the Nicaraguan armed forces or security forces are not involved in the illicit trafficking of military equipment, including those seized by Colombian authorities on the San Andres Islands on July 24, 1994;

(3) civilian control over the military and security forces, including control over the budget and expenditures of such forces, has been clearly established; and

(4) there has been a full and independent investigation conducted relating to issues raised by the May 23, 1993 discovery of the Santa Rosa arms cache of the existence of a terrorist/kidnapping ring and any individuals identified by the investigation as being part of such ring are being prosecuted.

NO MILITARY AID TO THE SANDINISTA POPULAR ARMY

Mr. HELMS. Mr. President, one would assume that the dismal record of the Sandinista Popular Army would preclude the United States from providing them with military aid—at least until serious and genuine reform has occurred. I have learned, however, that there are some in the administration who advocate U.S. cooperation with the Sandinista Popular Army some time in the future, the theory being that the U.S. military can somehow reform the Sandinista Popular Army, which of course is the militia of the Sandinista Communist Party.

That mistake must not be allowed to happen and that's why the pending amendment is important.

This amendment prohibits assistance from Department of Defense funds to the Nicaraguan Armed Forces or security forces—unless certain conditions are met, relating to: First, human rights; second, illicit trafficking of weapons; third, civilian control over the military; and fourth, an investigation into allegations of a terrorist-kidnaping network operating in Nicaragua with the knowledge and approval of the Sandinista Popular Army.

Mr. President, the so-called Sandinista Popular Army, and those associated with it, have compiled a record of assassinations that should provoke cries of death squads. Take the case of Frank Ibarra, a former Sandinista army officer. He publicly claimed credit for the assassination of property rights advocate and leading Sandinista critic Agres Sequeira. And the Sandinista Popular Army still shelters Frank Ibarra.

Then there is the tragic case of Jean Paul Genie, a 16-year-old who was killed by Gen. Humberto Ortega's bodyguards. The Sandinista military court, beholden to General Ortega, absolved his bodyguards of guilt. So, there's still no justice for Jean Paul Genie and his family.

Last year, I reported to the Senate that nearly 300 demobilized and disarmed former resistance members had been murdered by the Sandinistas since Mrs. Chamorro's election. At the time, only two civilians were in jail. And since then, more former resistance members have been murdered. Just 2 weeks ago, I met with our Ambassador to Nicaragua, John Maisto, and he told me that the Sandinista Popular Army and the Nicaraguan police continue to resist any accountability for their crimes.

Mr. President, there are other important issues in addition to human rights that this amendment addresses. For example, there has been no thorough and impartial investigation into terrorist activities in Nicaragua, as required by section 562 of the fiscal year 1994 Foreign Operations Appropriations Act. The Sandinista-controlled National Police have been conducting the so-called investigation, so Mrs. Chamorro has put the fox in charge of the henhouse. The investigation is so blatantly a farce that even the State Department isn't fooled. U.S. officials have admitted to me that no progress had been made on the investigation.

I have serious concerns about continuing Sandinista support for the few remaining Communist guerrilla movements. As recently as July 24 in the San Andres Islands, Colombian authorities seized weapons shipped from Nicaragua that were bound for the guerrillas in Colombia. There are indications that the Sandinista Popular Army was involved in this illicit arms transfer. On July 29, I asked Secretary Christopher to look into this situation, and I look forward to hearing what he finds. But, Congress should make it clear that the U.S. Government will not aid the Sandinista military as long as it supplies weapons to terrorists.

Mr. President, there is no civilian control over the military. General Ortega—the Al Capone of Nicaragua—is still head of the Sandinista Popular Army. Nothing has been done to put the National Police—still staffed with Sandinista personnel—under effective civilian control.

The United States should not even consider establishing official relations with, or providing military aid to the Sandinista Popular Army, until it accepts genuine civilian control, adjudicates those implicated in human rights abuses, and stops supporting terrorist and Communist guerrilla movements. And that is all that the pending amendment requires. Let us not legitimize Gen. Humberto Ortega and the Sandinista Popular Army.

Mr. INOUYE. Mr. President, the managers find this amendment to be acceptable.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from North Carolina.

The amendment (No. 2539) was agreed to.

AMENDMENT NO. 2508

(Purpose: To require congressional notification prior to the expenditure of certain Department of Defense funds)

Mr. INOUYE. Mr. President, I ask that the pending amendment be set aside, and that we consider amendment 2508, introduced by Senator HELMS.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. HELMS, proposes an amendment numbered 2508.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the committee amendment, insert the following:

SEC. . None of the funds appropriated to the Department of Defense may be used to enter into any agreement or to pay any logistical or support costs, including air transportation, for foreign military participation in any multilateral military activity or in any United Nations sanctioned multilateral force unless the President provides notification 5 days in advance to the appropriate Committees of Congress.

Mr. INOUYE. The managers have considered the amendment.

May we withdraw it?

The PRESIDING OFFICER. Without objection, it is so ordered. The amendment is withdrawn.

The amendment (No. 2508) was withdrawn.

AMENDMENT NO. 2540

(Purpose: To prohibit U.S. military participation in any multilateral military force which includes Nicaraguan military or security forces)

Mr. INOUYE. Mr. President, I call up amendment No. 2540, and ask that the pending amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. HELMS, proposes an amendment numbered 2540.

Mr. INOUYE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the committee amendment, insert the following:

SEC. . PROHIBITION ON U.S. MILITARY PARTICIPATION IN ANY MULTILATERAL MILITARY FORCE WHICH INCLUDES NICARAGUA ARMED FORCES.

None of the funds appropriated or otherwise made available by this Act may be provided for any U.S. military participation in any multilateral operation which also involves elements of the military or security forces of Nicaragua unless the President certifies and reports in writing to the Congress that—

(1) Nicaraguan military officers implicated in human rights abuses by the Tripartite Commission, the Inter-American Commission on Human Rights, the Nicaraguan Association for Human Rights, the Permanent Commission for Human Rights, or the judiciary in Nicaragua, have been removed or suspended from military service, as the case may be, and judicial/legal proceedings have commenced;

(2) officers of the Nicaraguan armed forces or security forces are not involved in the illicit sale, transport, or trafficking of weapons and military equipment, including those seized by Colombian authorities on the San Andres Islands on July 24, 1994;

(3) civilian control over the military and security forces by the democratically-elected President and Congress of Nicaragua, including control over the budget and expenditures of the military and security forces, has been clearly established and evidence that such control is respected by such forces; and

(4) fair and impartial civilian judicial proceedings have been completed against those involved in the murders of Enrique Bermudez, Arges Sequeira, and Jean Paul Genie.

Mr. INOUYE. In behalf of Senator HELMS, I withdraw his amendment.

The PRESIDING OFFICER. Without objection, the amendment is withdrawn.

The amendment (No. 2540) was withdrawn.

AMENDMENT NOS. 2518 AND 2524

Mr. INOUYE. Mr. President, I believe the Senator from Connecticut wishes to be recognized. Mr. President, I believe that this is part of the unanimous-consent agreement that was reached last evening. We are now taking up amendment 2518 on Bosnia and 2524 also on Bosnia.

Mr. President, am I correct that the time on these two amendments will run concurrently for 2 hours?

The PRESIDING OFFICER. The Senator is correct.

Mr. INOUYE. Mr. President, I have been advised that the DOLE amendment on Bosnia is designated as amendment No. 2479.

The PRESIDING OFFICER. The Senator is correct.

Mr. LIEBERMAN addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Connecticut.

Mr. LIEBERMAN. I thank the Chair. I thank my distinguished colleague from Hawaii.

Mr. President, I yield myself 10 minutes from the time allocated.

The PRESIDING OFFICER. Without objection, the two amendments will be pending simultaneously under the order.

Mr. LIEBERMAN. I thank the Chair.

Mr. President, once again we gather in this Chamber to debate the question of lifting the arms embargo against the Government of Bosnia.

PRIVILEGE OF THE FLOOR

Mr. President, I ask unanimous consent that Debra Shelton of my staff be granted floor privileges for the duration of debate on this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LIEBERMAN. Mr. President, once again I am privileged to join with the Senate Republican leader in a remarkably diverse, encouragingly diverse, group of colleagues who support the ultimate unilateral lifting of the arms embargo against Bosnia. Those colleagues include Senators MCCAIN, MOYNIHAN, WELLSTONE, EXON, FEINGOLD, HATCH, DECONCINI, LUGAR, and HELMS.

Mr. President, this is not the first time we have debated this matter. It seems that in the previous debates in which we have come very close—in fact on the last occasion a tie vote—to lifting the arms embargo, a clear majority of Members of this Chamber has expressed the desire to lift what I consider to be the immoral, ineffective, insensible arms embargo against the people of Bosnia. But on each occasion there seems to be some reason, some excuse given for not doing it quite this time. I am encouraged, although I will not be confident until the vote is cast, that we are approaching that moment when the Senate of the United States will express its opposition to the arms embargo against Bosnia.

Mr. President, this embargo was imposed in 1991 by the Government of the United States against the former country of Yugoslavia as an attempt to keep arms out of that smoldering region—at that time it was smoldering, but it has since caught fire—as a way to avoid the conflict that we feared would result. The fact is, as we know, there was then aggression by Serbia against its neighbors, most viciously against the people of Bosnia, and specifically against the Moslem population of Bosnia. People were harmed not for military purposes but simply because of their identity, because of their status, because they were Moslems, pushing them out of their homes, putting them into concentration camps, subjecting them to murder, to systematic, systemic use of rape as an instrument of war. These were horrible acts of violence against a people.

The original hope and premise behind the arms embargo was not realized. War broke out. But we continued to maintain the arms embargo with its effect falling almost totally on the people of Bosnia, while the Bosnian-Serb soldiers have been supplied by the munitions factories in Serbia. They have been very well armed, and they have acted as the rest of the world has allowed them to act—without fear—because they had nothing to fear, over and over again, taking aggressive action, moving with tanks into a city only to meet opposition from light arms, light gunfire.

On each occasion when Senator DOLE and I and others have brought this amendment to the floor, there has always been some reason of statecraft, some reason of diplomacy that took us away from our moral and strategic responsibilities—which I think a majority of the Members of this Chamber feels—against the embargo to the tepid and inconclusive language of diplomacy.

Well, now in the most recent chapter, the so-called "contact group" comes up with a peace plan that, in fact, validates, acknowledges, and accepts the taking of land from the Bosnian Moslems by force, contrary to all the principles of international law and the premises of the United Nations; and the Bosnian Moslems have accepted the contact group's peace plan. But the Bosnian Serbs, as Members of this Chamber know well, consistently refuse to accept the plan and have found various excuses to put it off. They have thumbed their noses at the international community.

Mr. President, I fear that we are moving again toward a wider war in the Balkans. In this instance, as we ask the Senate once again to lift the arms embargo—unilaterally, if necessary—against the Bosnian Moslems, we are saying that it would not only not be in our strategic interest, but also in our interest in security in Europe, our interest in deterring those who would in the future seek to take land by force, and our interest in the moral principle of not standing by while genocide occurs. It is in those interests that we come, once again, to say that it is time for the United States to set down its marker—a strategic and moral marker—and say: If the nations of the world do not multilaterally lift this arms embargo, we will do so unilaterally, because as this wider war begins, which I fear will break out in the Balkans, do we really want to be following a policy that effectively denies the victims of aggression and genocide the arms to defend themselves and their families and their country? I say, in all that is good about America, the answer to that is, no, we do not want to be part of imposing that policy.

Mr. President, this amendment to unilaterally lift the arms embargo is an expression of the policy the Clinton administration outlined more than a year ago of lifting the embargo and striking from the air. It was not implemented. The European allies expressed their opposition.

There are two amendments before this Chamber: The one Senator DOLE and the bipartisan group and I have introduced, and another introduced by Senators NUNN, WARNER, and others. The other amendment expresses the language of the conference report on the DOD authorization bill. I am, frankly, disappointed with that language, resulting, as it does, from a process in which this Chamber tied, 50–50, on the question of an early lifting of the arms embargo unilaterally—and the House actually adopted a directive that this administration lift the arms embargo unilaterally by a margin of 66 votes.

As disappointed as I am, though, I must say that the language in the Nunn-Mitchell-Warner amendment, which expresses the DOD conference report language, at least moves toward lifting the embargo. It directs the President, and he acknowledges in a letter to Senator NUNN that he will go to the United Nations to seek a multilateral lifting of the embargo if the contact group's plan is not accepted by the Bosnian Serbs by the middle of October. And if that plan is not accepted, the Nunn-Mitchell-Warner amendment at least removes the hands of the United States from enforcing this embargo.

The embargo is not just a policy statement that bounces around the State Department or the United Nations. The arms embargo is an actual policy which military personnel of the United States are enforcing on ships in the Adriatic and on the access points on the ground into Bosnia. We are enforcing an ineffective, immoral policy. At least the Nunn-Mitchell-Warner amendment moves in that direction, but it does not go far enough.

This process has to end with a clear statement to the world of where America is, a clear statement of American leadership, and a clear statement to the Serbian aggressors that they are now on a limited string, and if they do not accept the peace plan of the contact group, and the arms embargo is not lifted by the United Nations, then the arms embargo will be unilaterally lifted by the United States of America on November 15 of this year.

So while I say that the Nunn-Mitchell-Warner amendment is a step forward from where we have been, it goes from a sense of the Senate in the previous Nunn-Mitchell-Warner amendment to a directive that clearly does not go far enough. I see the amendment, No. 2479, that I am privileged to cosponsor, as consistent with the other amendment. But more than consistent, it gives it the ultimate teeth, it puts in the moral content, it draws a final line in the Balkans for the Serbian aggressors.

A final point: We have been concerned about our allies—the British and French particularly—who are on the ground as part of United Nations forces in Bosnia. Secretary Boutros-Ghali has recently said he thinks the U.N. forces probably should be removed, that it is a mission to be undertaken by the forces of the contact group. We have been told by Ambassador Redman, and others, that the allied forces need 60 to 90 days to get out. What is going to happen to the Bosnian Moslems during that period? When the U.N. forces pull out, the Bosnian Serbs have full access to weapons of aggression, and the Bosnian Moslems do not have the arms with which to defend themselves. This policy has to end somewhere. I hope it ends and that the beginning of the end is today.

Again, every time we have spoken to the leaders of Bosnia, they have said to us, "We are not asking for your American soldiers on the ground." This amendment not only does not call for American soldiers on the ground, it says specifically that nothing in it shall be interpreted as authorization for deployment of U.S. forces in the territory of Bosnia and Herzegovina for any purpose, including training, support, or delivery of military equipment.

No, the Bosnians do not want our soldiers there. They know this is their fight. They are spirited and courageous, and they want to defend their families and their land. But they do not have the weapons to do so.

This amendment will give them the wherewithal to fight the fight that I fear they will have to fight, and it will do so in a way that puts America, once again, clearly on the right side.

I thank the Chair, and I yield the floor.

Mr. DOLE addressed the Chair.

The PRESIDING OFFICER (Mr. DORGAN). The Senator from Kansas is recognized.

Mr. DOLE. I thank the distinguished Senator from Connecticut. We have had this debate a number of times, and I hope this may be the last time, but it may not be.

Today the Sarajevo airlift is again suspended, after two planes delivering humanitarian aid were hit by small-arms fire. There had been no flights into Sarajevo for 18 days prior to Tuesday's resumption of the airlift, and relief officials say that the city's food stocks are dangerously low—at only 30 percent of the city's food needs for the next two weeks.

This rapid deterioration of conditions in Sarajevo and throughout Bosnia and Herzegovina is the reality and the context in which we need to consider the amendments before us today.

That is what is happening today. The airlift has been suspended. They are short of food. So that is where we are today. It is not as if we are talking about something that may happen 6 months or 1 or 2 years from now—it is today.

Almost everyone in this body would say that they support lifting the arms embargo in Bosnia and Herzegovina, not just the supporters of this amendment but the supporters of the Nunn-Mitchell amendment as well.

Those who oppose our amendment, the amendment of myself, the Senator from Connecticut, and the Senator from Minnesota, we are pleased to say, and others who joined with us that support the Nunn-Mitchell amendment will probably say, the difference is on how the embargo is lifted. The difference is more likely to be whether it is lifted, not how, but whether it is going to be lifted.

We believe our amendment is fairly simple. We listened to some critics and tried to move in that direction, and maybe the criticism was valid. I am not suggesting it was not.

So the amendment is very simple. It sets a firm and definite deadline for terminating the U.S. embargo on Bosnia. The Government of Bosnia and Herzegovina will no longer be denied its inherent right to self-defense as of November 15, 1994—no ifs, ands, or buts. That is all the amendment says. The reason we chose the mid-November date is that some of our allies with troops in Bosnia have told United States officials they need up to 90 days to redeploy or withdraw. Plus, we heard that from our colleagues on both sides of the aisle in previous debates that we were not giving enough time. Plus, this gives the administration a lot of time to try to figure out some multilateral lifting of the arms embargo. But aside from the date, there are no conditions. The objective, like the language of our amendment, is straightforward: To allow the Bosnians to defend themselves against aggression come November 15, at the latest. That is it.

It does not seem like it is too much to ask to allow someone to defend themselves, particularly in light of what is happening there today.

Mr. President, the message this amendment sends to Bosnian Serbs is that time is running out. This message is not being sent by the United States and the so-called contact group. The message being sent to Bosnian Serbs by the contact group is: Take more time to accept our July 6 proposal because we are not ready to do anything more than talk.

It seems to me that the administration claims there is a lot of pressure on the Bosnian Serbs. Maybe I am missing something, but I do not see a lot of pressure on the Bosnian Serbs. I do not see the tough action that the contact group promised in its meeting 2 weeks ago.

At the same time, I want to commend the distinguished chairman of the Armed Services Committee, Senator NUNN, for recognizing the weaknesses of the administration's approach and for his efforts to move the administration toward setting a timeline for real action.

But I do not think the amendment goes far enough, and I have had a discussion personally with Senator NUNN, and I think he pretty much agrees with us, and I think at the same time he feels a certain obligation to the administration. I do not quarrel with that. It is not an effort to embarrass the administration. But, although it urges the President to go to the U.N. Security Council to lift the arms embargo, which I support, there are no guarantees that it is going to be lifted.

Again, I refer to the letter received by the chairman from the President, dated August 10, which talks about a reasonable time. I do not know how long the U.N. action takes. It seems to me it does not set any mandatory deadline.

According to the Nunn-Mitchell-Warner amendment, if the Bosnian Serbs do not accept the contact group proposal by October 15, the President should, and the President said he will. In fairness to the President, he says in this letter he will go to the U.N. Security Council to seek termination of the arms embargo on Bosnia. So that letter has been received, and the President states that it is his intention to propose a resolution in the U.N. Security Council by the end of October if the Bosnian Serbs have not accepted the July 6 peace plan.

Mr. President, we should ask ourselves why give the Bosnian Serbs 2 more months? They have already rejected the contact group proposal four times. They have ambushed and stopped U.N. convoys. They continue violating NATO exclusion zones, and they continue the reprehensible practice of ethnic cleansing. Why does not President Clinton go to the U.N. Security Council right now? In fact, we have urged that in the last two times we had this vote. That has been one of the provisions, that the President be urged to go to the U.N. Security Council in an effort to have a multilateral lifting of the arms embargo.

Now, according to the Nunn-Mitchell-Warner amendment, if such a Security Council resolution fails, or no later than November 15, a prohibition on Department of Defense funding for enforcing the U.N. arms embargo will go into effect, not the lifting, but we just want to enforce the embargo. It is limited to the Department of Defense. It does not include Customs personnel overseas or cover intelligence that is outside the Defense Department.

The Nunn-Mitchell amendment also includes a Presidential waiver for United States personnel serving in NATO headquarters.

At present, the U.N. embargo is being enforced by NATO forces, not by the United States independently. Therefore, if the waiver is invoked, it could undermine the intended effect of this provision, which is already weakened as a result of the funding restriction being limited to the Pentagon. Let me give you an example. Theoretically, if the CIA picks up some intelligence on an arms shipment to the Bosnians, it could share it with NATO, and other NATO allies, such as the British and French who support the U.N. arms embargo on Bosnia—who could then respond by enforcing the embargo—without violating this provision. In short, this provision looks far more significant on paper than it would likely be in practice and thus is no substitute for lifting the arms embargo on the Bosnians.

The Nunn-Mitchell-Warner amendment also requires, in the event a United States resolution to lift the arms embargo fails in the U.N. Security Council, that the President submit a plan to Congress and consult with Congress on providing training to the Bosnians and lifting the embargo unilaterally.

The fact is that by the time October 15 rolls around, we are not going to be here. Congress will probably be in recess by then. There will be a lot of Members of the Senate and House running for reelection, the election in November. We do not think we are going to just stay here for that purpose, which means we will be waiting, if we do not come back until January—unless there is a special session, it means we can wait a full 2 years after President Clinton was sworn into office, and he came into office saying lift the arms embargo, have air strikes, a lot of things which I supported which are no longer probably viable, and we still would not have lifted the embargo.

It just seems to me we do not need any more plans, we do not need any more consultation. We need to do something. We are not talking about American troops; we are not talking about air strikes; we are not talking about endangering any NATO forces. We are talking about doing something, and that is lifting the arms embargo.

In January of this year—it is now mid-August—in January of this year Congress passed a nonbinding amendment urging the President to lift the arms embargo unilaterally. In May, the Senate passed S. 2042, which terminated the embargo. In June, the House passed the McCloskey-Gilman amendment to the defense authorization bill which would have immediately ended the U.S. arms embargo. And although the Dole-Lieberman amendment failed in July, it was on a tie vote.

So we have this debate time after time—January, May, June—and nobody has responded in the administration. So it seems to me that it is time to do what we should have done some time ago. I think the bottom line is the majority of Congress, Democrats and Republicans, support ending this illegal and unjust arms embargo on the Bosnians.

So it seems to me we prefer to listen to the French and British and the Russians. Certainly they are allies; we should listen to them. But in this case it seems to me that we ought to take the moral high ground, and we ought to be providing the leadership, and we still have one more opportunity to do it.

I think setting the definite date is very, very important. So, I think if we make the decision, if we stand up and provide the leadership, I think it adds a very positive impact on what might happen in NATO. Historically our leadership has been the source of NATO's strength. It is the lack of this leadership and willingness by this administration to go long with failed policies that damaged NATO's credibility.

I say there have been some improvements in the conference report. I know the Senator from Georgia and the Senator from Virginia were well-intentioned, but it seems to me that it is not going to happen. So the President's request for multilateral lifting of the arms embargo does not happen. Then the President consults with Congress, it is October, Congress is not in session, probably will not be in session until sometime around January 20, 1995. I do not know what happens in the meantime. So I guess the President could do it on his own, or he may consult with the leaders in the Congress even though we are not in session.

But I want to just make one final point. A vote in support of the pending amendment means that the U.S. arms embargo in Bosnia will end by mid-November. August, September, October, November.

It means that the President has plenty of time to go to the United Nations, but finally it means that we are committed to doing what is morally and legally right.

And there is a real chance, if our amendment is not adopted and the other amendment is adopted, we will be here next year debating this amendment. The only difference is, we will be in the third year of debate and thousands more Bosnians will have been driven from their homes and killed and our credibility and global leadership will be further eroded.

This is a bipartisan effort. It has been from the start. There is no effort—and I say this in all sincerity —to in any way embarrass the administration.

It just seems to me, notwithstanding the good efforts made by some in the Armed Services Committee, that they are not good enough and we should recognize once and for all what our obligations are.

Mr. President, I ask unanimous consent to have printed in the RECORD at this point an editorial which appeared in this morning's Washington edition of the Los Angeles Times, dated August 10, 1994, which is entitled, "Why U.S. Should Lift Bosnian Embargo." And they have been slow in coming to this position, I might add.

There being no objection, the editorial was ordered to be printed in the RECORD, as follows:

[From the Los Angeles Times, August 1994]

WHY U.S. SHOULD LIFT BOSNIAN EMBARGO

The time has come for a unilateral U.S. lifting of the arms embargo on Bosnia-Herzegovina. The Clinton Administration has preserved the Serbs' arms advantage for two years, deferring to the wishes of the British and French and ignoring the stated preference of Congress. The result has been a sorry disappointment.

When the Bosnian Serbs defied a July 20 ultimatum for the acceptance of a peace plan, the five powers that had issued the ultimatum responded with only a minor tightening of economic sanctions on Serbia proper. Several other threats the five had made turned out to be empty.

Even leaky sanctions (Russia has ignored them) hurt in the long run, however, and Serbia has sought an end to the sanctions by suddenly stopping traffic with Serbian Bosnia and denouncing its recalcitrance. But in the Stalinist manner of old, President Slobodan Milosevic controls both policy and media. Yesterday's dogma is today's heresy and may be dogma again tomorrow.

The Serbian action that matters is the action being taken in Bosnia. Momcilo Krajisnik, speaker of the Bosnian Serb assembly, has declared that the Serbs will not settle for less than 64% of Bosnian territory—as against the 49% assigned them in the five-power plan. Consistent with this view, the Bosnian Serbs are continuing their notorious ethnic cleansing. Within the past few days, according to reports confirmed by the Red Cross, the Serbs have sent 100 Muslim men to a labor camp in the Bosnian northeast and expelled more than 300 Muslim women and children from a town in the area.

In the NATO heavy-weapons exclusion zones around Sarajevo and Corazde, the Serbs, undeterred by a pinprick NATO air attack, have escalated their attacks with virtual impunity. The U.N. commander, British Lt. Gen. Sir Michael Rose, declined to call for NATO retaliation in Gorazde on Monday even after Serb forces fired anti-aircraft rounds in the exclusion zone and repeatedly attacked his forces there.

Sarajevo is the soul and the symbol of ethnically mixed Bosnia. The lifting of the arms embargo should not mean an end to the NATO exclusion zone there. That zone should be enforced by vigorous retaliation against, among other targets, the Bosnian Serb capital, Pale. But given Rose's refusal to enforce the zone, his call for a broader demilitarization of Sarajevo rings hollow.

Elsewhere in the country, in any event, only the Bosnians themselves can deter further aggression; and they can only do so if they bring their forces into parity with those of the Serbs. The lifting of the arms embargo will take months to have any effect and can be reimposed if needed, but the moment for the change is now. Given the isolation of the Bosnian Serbs, the risk to the U.N. troops will never be smaller. And even that risk cannot be overwhelming in view of the reluctance of the United Nations to avail itself even of the NATO protection already available.

Mr. DOLE. Mr. President, it says:

The time has come for a unilateral U.S. lifting of the arms embargo on Bosnia and Herzegovina. The Clinton Administration has preserved the Serbs' arms advantage for 2 years, deferring to the wishes of the British and the French and ignoring the stated preference of Congress. The result has been a sorry disappointment.

I will not read the entire editorial, but I think it makes a point that this is an opportunity for us to end this disadvantage the Serbs have had and it gives the Bosnians a chance to defend themselves. They are an independent nation. They are a member of United Nations. Under article 51 of the U.N. Charter, they have that right.

The PRESIDING OFFICER. Who yields time?

Mr. DOLE. I yield to the Senator from Minnesota as much time as he may consume.

The PRESIDING OFFICER. Senator WELLSTONE is recognized for as much time as he may consume.

Mr. WELLSTONE. I thank the Republican leader. I will be relatively brief.

Mr. President, I want to say first that I am pleased and proud to be an original cosponsor of this amendment. But I must say, I am sad that it has come to this point, Mr. President.

I also believe—and I said this to Senator NUNN a few minutes ago—that the Nunn-Warner-Mitchell amendment goes in the same policy direction as the Dole-Lieberman amendment, and I intend to support that initiative, as well. I believe that, when taken as a whole, they are complementary, not contradictory. Approving both today would provide an opportunity for the administration and our allies including U.N. forces in the region, to prepare for the unavoidable lifting of the embargo while setting a firm deadline for this action.

Mr. President, I want to talk a little bit about my own journey on this, because back on July 1, we had a very close vote on this issue—in fact a tie vote that was broken by Vice President GORE. And I want to give the Republican leader a tremendous amount of credit for his conviction and consistency on this issue.

Rarely have I agonized more over a vote than I have over this one. I had briefings from all sorts of different people in the U.S. Government who work in the region, including our Ambassador in Croatia, Peter Galbraith, for whom I have a tremendous amount of respect. I talked to the President, the Vice President, others in the State Department, I had as many briefings as I could about the situation—what kind of arms did the Muslims have now, what was the situation on the ground, what were the prospects for the contact group discussions, and the like.

Ultimately, I decided then the timing was such that the contact group's proposal should be given a chance. I believed that we ought not to make important and far-reaching policy decisions based on anything but the situation on the ground and our interests in peacefully resolving the conflict, and not simply on the fact that the defense bill happened to be on the Senate floor.

I was not optimistic, but I was hoping and praying—as I think many Americans and others were—that that proposal would be accepted by the Bosnian Serbs. But it is quite clear that that is not going to be the case.

But even in early July, Mr. President, I did not decide until the very end, when I received a letter from Strobe Talbott with a commitment from the administration that if the contact group's peace proposal was rejected, they would go to the United Nations and that if our allies balked and we could not get Security Council approval, then the administration would come and consult with the Congress on lifting the embargo unilaterally. Even back then, I felt that commitment from the administration was necessary to me in terms of securing my vote.

But now the Serbs have turned down the contact group plan, and we are seeing increased sniping in Sarajevo, and unprovoked attacks on U.N. forces in the region.

It just seems to me, Mr. President, that it is time for the U.S. Senate to convey a very strong message to the Bosnian Serbs.

For my own part, I support a clear deadline of November 15, 1994. I think it is the right thing to do. I also believe that we should step up our efforts to enforce safe havens. If necessary, we should take additional military action from the air against targets, in retaliation for any further provocations.

I do not want to see our troops directly involved on the ground. But, Mr. President, I think most of us are agreed, one way or another, the Muslims have a right to defend themselves.

I want to conclude with two points. The first is that: I hope and I pray that the Bosnian Serbs will accept the contact group's peace proposal, and if they do, lifting the embargo may not be necessary. There is nothing that I want to see happen more than Serb acceptance of this plan, followed by tough, strict enforcement of the agreement by NATO and the United Nations.

Mr. President, I think that if they do not, and if what we end up doing—and I believe we will, because I think we must—is to unilaterally or multilaterally end this arms embargo, I think may expand to an even more uncontrolled war and many more men, women, and children could die. In that case, the prospects for a peaceful short-term settlement are almost nil. I recognize that, but, Mr. President, this is what it has gotten down to for me. I am lucky to have a tremendous staff person in Colin McGinnis, with whom I work on these issues. We were talking before I came down here, discussing the options facing the parties right now. As we were talking to one another, and as I was analyzing it, I was thinking to myself, it might very well be that if the embargo is ended—and it should and it must be if there is no acceptance of the peace proposal by the Serbs—there may be more men, women and children in the long run that die that way than if it was not ended and we continue to have instead a kind of gradual slaughter, gradual genocide, because I fear that is the direction that we would be heading in. So you see, there are no good options in this situation.

But, Mr. President, I think the people in Bosnia, the Muslims themselves, have the right to decide. At this point, it seems to me that virtually all efforts have been made toward some kind of successful resolution; all efforts have been made toward getting the Serbs to accept the peace proposal. It does not look like the contact group's proposal is going to be accepted, even with the pressure from Milosevic, and the Russians. And I think if we are not going to intervene militarily—and I do not believe we should —on the ground, then the Muslims have the right to defend themselves.

So I am an original cosponsor now of the amendment similar to one that I have voted against before, because I think now the time has come for us to move in this direction. And because this Dole-Lieberman amendment gives our allies time to redeploy their forces before the embargo is unilaterally lifted.

I do believe that the Nunn-Warner-Mitchell amendment takes us in the same direction with the intermediary step of trying to get the United Nations to support us in lifting the embargo. If we can do it multilaterally, Mr. President, that is always my preference. But if we cannot—and I think November 15 gives this process plenty of time—then I think we must unilaterally end this embargo. In the interim, our allies will have time to redeploy their troops in order to protect them, and the package of consequences—tightening of sanctions, tougher enforcement of the safe havens, providing aid to regional powers to help them mitigate the effects of enforcing the sanctions—will have time to work, increasing pressure on the Serbs.

I pray that it will not be necessary, because I think it could have grave implications. But I am also clear-eyed about the abysmal Serb record on such agreements, and I am not very hopeful. I fear it will be necessary. I think we in the U.S. Senate have to be clear that we will support such a step.

I yield the floor.

Mr. McCAIN addressed the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. McCAIN. Mr. President, I yield myself 10 minutes.

The PRESIDING OFFICER. The Senator is recognized for 10 minutes.

Mr. McCAIN. Mr. President, we basically have a choice here between two amendments. The fundamental difference between the two is that the Dole amendment will force the President to assume leadership in the Security Council that he has so far avoided. He will be forced to either gain the approval of the United Nations by November 15 or lift the embargo unilaterally. And this also gives our European allies plenty of time to withdraw their forces if they are concerned for their safety.

The Mitchell amendment encourages the President to seek a multilateral lifting of the embargo. If the President fails to gain Security Council approval, the Mitchell amendment would end U.S. participation in enforcing the embargo.

Mr. President, let me just say at the outset that there has been fighting going on in this very unhappy country, with a few pauses, for well over 500 years. I greatly fear that despite what we may or may not do, there will be a certain level of fighting that will continue for a long, long time.

Can the United States beneficially affect that situation? Of course we can. There is a fundamental right at issue here and it is whether a nation has the right to defend itself. We have been over a lot of this before, and we have gone in the debate in this body from a choice between lifting the embargo and doing nothing, which was the view of many, to when we are going to lift the embargo on people who in my view have the fundamental right to defend themselves.

It is not only my view that nations have the right to defend themselves, but that of the United Nations Charter which states unequivocally in article 51 that "nothing in the present Charter shall impair the inherent right of individual or collective self-defense if an armed attack occurs against a Member of the United Nations, until the Security Council has taken measures to maintain international peace and security," and article 2 of the United Nations Charter which says, "the inherent right to self-defense is a preeminent right of international law and may not be abridged by actions of the Security Council."

As I have stated before, the United Nations is in violation of its own charter. By imposing this punishment on Bosnia—which was never a country, by the way, when the arms embargo was put into being. The embargo was placed against then-Yugoslavia. This nation has committed no aggression against its neighbors. There is no comparison between this nation and Iraq and Libya, who are now under embargoes enacted by the United Nations Security Council.

What we have done to this tragic and unhappy country is to allow—in fact, we are now implicated in causing—an unequal battlefield scenario and equation to the point where 200,000 citizens of that country have been killed and more than 2 million displaced.

It is unfair. We should have lifted this embargo a long time ago. We listened to the siren song of a peaceful settlement now for 28 months. We have listened to this siren song and many have believed it when the fact is time after time after time the hopes for a peaceful settlement have been dashed.

I hope and pray that tomorrow there will be a peaceful settlement. But history tells us that the way, sometimes, peace is achieved is when there is a balance on the battlefield that makes it in the interests of neither warring party to continue the conflict further—or victory is gained by one party or another.

I just received information from the Action Council for Peace in the Balkans, of which Marshall Harris is the executive director. Let me just give a recent rundown of what has been going on in the last few days.

Mr. President, I ask unanimous consent that this entire chronicle of Serbian attacks be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

On July 30 in Geneva, Secretary Christopher and his "contact group" counterparts agreed to tighten economic sanctions against Serbia in the face of Bosnian Serb rejection of the group's plan.

Since then, the sanctions have not been tightened. In fact, this week, Secretary Christopher spoke of actually easing sanctions if Serbian President Milosevic actually cuts off his proxies in Bosnia.

Also since the Geneva meeting, the Bosnian Serbs have rejected the contact group's plan a third and a fourth time. This week they announced that they wanted 64% of Bosnian territory—not 49% as offered by the Contact Group. So much for the take-it-or-leave-it plan.

[Meanwhile,] on the ground, the Bosnian Serbs have: launched artillery attacks on Visoko and Breza from inside the Sarajevo weapons exclusion zone; resumed constant sniping at civilians in Sarajevo; resumed the shelling of Tuzla; and fired more than 300 shells into Olovo and Vares (in central Bosnia) in one day.

In addition, beyond the weapons thefts that prompted NATO's mini-strike against a World War II-vintage gun inside the Sarajevo exclusion zone, Bosnian Serb forces have committed the following atrocities or violations. This is only a partial list of violations of which we are aware:

August 1:

Serbian forces moved tanks, artillery, anti-aircraft guns, and mortars inside the Sarajevo exclusion zone.

Serbian snipers wounded two civilians riding in a tram.

Serbian troops launched attacks in Gorazde, Olovo, and Kalesija.

They launched tank attacks on Zavidovici and Maglaj.

They wounded five civilians in rifle grenade attacks in Dobrinja on the outskirts of Sarajevo.

They expelled more than 300 refugees from Banja Luka, Sanski Most, and other regions in northwest Bosnia. The refugees, mostly women, children, and elderly men, arrived in Travnik.

August 3:

Serbian forces renewed sniper attacks on three cities (Marindvor, Nedzarici, and Stup).

They killed one civilian and wounded three others in Tesanj.

They regrouped soldiers and supplies in Maglaj in central Bosnia.

They launched grenade, mortar, and howitzer attacks on Visoko.

They launched howitzer attacks on Breza and Kladanj.

They hit Zivinice with tank and mortar fire.

They hit Kalesija with artillery fire.

They launched infantry attacks on Gorazde.

August 4:

Serbian forces fired twelve artillery shells into Tuzla.

They fired 238 shells into Dastanko in central Bosnia. The Bosnian Army responded with 132 shells, according to the U.N.

They hit Gradacac in northern Bosnia with 532 shells.

August 5:

Serbian forces lobbed two 82 mm shells into Sarajevo.

August 6:

Serbian forces forced more than 300 Muslims from their homes in Bijeljina. The refugees have been arriving in Tuzla. According to the U.N., only 7,000–8,000 of Bijeljina's prewar Muslim population remains.

August 9:

Serbian forces used howitzers and mortars inside the Sarajevo exclusion zone to attack Visoko and Breza.

Mr. McCAIN. Mr. President, while I am at it, I ask unanimous consent Senator JEFFORDS be added as a cosponsor to the Dole-Lieberman amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. McCAIN. Mr. President, the plan is unjust and it is unworkable. It is unjust because it cedes 49 percent of Bosnian territory to the aggressors, thereby validating the aggression of the Bosnian Serbs. It is unworkable because it is unjust. Not one of our allies in Europe—not one—would agree to a settlement that required handing over half of its national territory. That Serb forces have seized 70 percent of the nation is a gross injustice. That negotiators have attempted to legitimize the bulk of those gains is a travesty. And despite the unjust nature of the peace proposal, the Bosnians accepted it. And guess who rejected it? The Serb forces who have now even been deserted by some of their greatest sponsors, including apparently President Milosevic. In the meantime Serb forces, as I mentioned, have renewed the siege of Sarajevo, ambushed a U.N. convoy and other acts which I have chronicled for the record.

The Bosnians have identified an end to the arms embargo as their highest priority. Many military experts say that will cause them to suffer more losses. I would think the Bosnians are in a better position to make that judgment than some military experts. The Bosnians state in very simple terms, "We are dying. At least let us die fighting."

The Bosnians only want defensive weapons and, clearly, unless they are allowed the ability to defend themselves, there will be a continued gradual bloodletting to the point where that nation, tiny now—a much smaller nation—disappears. I believe after 28 months of diplomacy, after 200,000 dead and 2 million refugees, the time has come to embark on a new course of action, and that is lifting the arms embargo.

Let me make it clear. The Dole amendment clearly prefers—clearly prefers—a lifting on the part of the United Nations of the embargo. We strongly prefer that to be done multilaterally. What the Dole amendment says is if we do not do it multilaterally, then unilaterally we must do so. I think we should wonder, Mr. President, what would have happened if in our struggle for independence the European nations had imposed an arms embargo on the then-revolutionaries, the United States? We were not even recognized as a country yet we received important, and in the view of many historians, vital assistance in our struggle for independence.

This is an independent and recognized nation and we should cease punishing them and allow them to defend themselves.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time? The Chair recognizes the majority leader, Senator MITCHELL.

Mr. NUNN. Mr. President, I believe the time is controlled by myself and the majority leader. Of those two, the majority leader will decide how much time he requires.

Mr. MITCHELL. Mr. President, the Senate is again debating whether to terminate the arms embargo that was imposed upon Bosnia and Herzegovina at the beginning of the conflict in the former Yugoslavia.

Every member of the Senate is deeply concerned with the tragic events in Bosnia and Herzegovina. All would like to see a peaceful settlement and an end to the fighting which has left thousands dead and millions of people displaced from their homes.

There is no disagreement about the goal of a peaceful resolution of the conflict. The disagreement is over the best way to achieve that goal, consistent with the national interests of the United States.

The question again before the Senate is whether the United States should now, on its own, simply terminate the arms embargo on Bosnia, as Senator DOLE and his colleagues propose, or whether the United States should first act in concert with our allies in NATO and the United Nations to seek a decision in the Security Council to end the arms embargo on Bosnia.

I do not believe this to be the time for the United States to act unilaterally, without regard to the views of our allies or the safety of their citizens and troops.

At this time there are several multilateral actions in which the United States is a participant with other nations to impose sanctions or take other collective actions, in many parts of the world.

There is an ongoing collective action to impose sanctions on Haiti. There continues to be the likelihood of collective action to impose sanctions on North Korea. Sanctions on Iraq continue. These are actions which are important to the United States as well as to other nations.

If the United States is now to unilaterally drop out of collective action whenever it chooses, then what is to prevent every other country from doing the same thing on collective actions in which we want them to participate but they do not agree with?

We must understand we cannot have it both ways. We cannot say there must be collective action when it suits us, but when we want to drop out at any time we can, because to do that will give other governments the incentive and the legitimacy to drop out of any actions which are disadvantageous to them. And that will be true of the sanctions on Haiti; that will be true of the sanctions on Iraq; it will be true of the sanctions on Serbia.

We have been told repeatedly by the governments of those nations, which are close to those situations in Iraq and Serbia, that they are hurting economically because of the sanctions which we insist be imposed. If we now unilaterally, without regard to anything our allies think or do or say, pull out of this, then we invite others to do the same on other sanctions.

The effective end of collective action through the use of sanctions is a consequence that I think should be avoided. And I urge those who are considering the Dole amendment to ponder very carefully the implications it has for future policy all around the world.

The end of the cold war and the resurgence of ethnic conflict and nationalism has created turmoil in many parts of the world. The United States is going to be asked over and over again to send American troops to solve problems in every part of the world. The United States is the world leader, but it cannot by itself solve every problem in the world. We are going to have to ask others to join with us in dealing with problems, especially those distant from our shores.

If we now say that we want to go it alone whenever we choose, what claim do we have on the cooperation of others when we do not want to go it alone? We can lead, and as a dominant military and economic power in the world, we must lead. We all know and recognize that there are going to be occasions when we will want and need help and support from other countries. If we are not going to get much help, if we say now that in this case we do not agree with collective action and so without any regard to the views of our allies we are just going to drop out, unilaterally end this collective embargo, never mind what the British think, never mind what the French think, never mind what our other allies who also have troops in Bosnia think—we do not like it so we are going to drop out, regardless of whether such action endangers the lives of thousands of our allies' troops and humanitarian workers who are there trying to enforce peace, trying to help the thousands of people who have been displaced by the war.

Mr. President, let us remember, over the course of this conflict, the British have had several thousand of their troops in Bosnia on the ground. The French have had even more thousands. So have many of our other allies. Dozens have been killed, hundreds have been wounded, all are in danger. The United States has had virtually no one there. The British and the French and our other allies have been willing to do what we have been unwilling to do; and that is to place their young men and women in the line of fire to take risks that have resulted in dozens of deaths and hundreds of casualties.

And yet here we are in this extraordinary circumstance telling them that we do not care what they think, we do not care what risk we impose upon their troops and their humanitarian workers—sent there when we would not—we are going to go ahead and do this alone.

I think it is a very unwise course, even as I understand and sympathize with the motives of those who have offered this amendment. They are horrified and frustrated by the events in Bosnia. They want action. I also am horrified. I also am frustrated. I also want action. But let us take action which is consistent with our national interests. Let us take action which will help us deal with similar situations in the future.

We should take action to cause the Bosnian Serbs to accept the most recent proposal for peace, and we should do so in concert with our allies. That is what the amendment does that has been offered by Senator NUNN in which I join and which I support.

Senator NUNN will describe it in more detail. Let me touch just briefly on the principal points of that amendment.

It states that the Congress supports the efforts of the contact group to bring about a peaceful settlement of the conflict in Bosnia and Herzegovina based upon their proposal of July 6, 1994, which has been agreed to by the Government's of Bosnia and Herzegovina and rejected by the Bosnian Serbs. It establishes a process to end the arms embargo if the Bosnian Serbs continue to reject the July 6 proposal.

The amendment specifies simultaneous complementary action on two tracks:

First, an international track which provides that if the Bosnian Serbs have not accepted the July 6 proposal within 10 days of the enactment of this act, or by October 15, 1994, the President, or his representative, should within 14 days formally introduce a resolution in the U.N. Security Council to terminate the arms embargo on Bosnia no later than December 1, 1994.

And second, a unilateral track which specifies that if the U.N. Security Council has not voted to lift the international arms embargo within 15 days after the President, or his representative, has introduced the above resolution or not later than November 15 of this year, and if by that date the Bosnian Serbs have not accepted the contact group's July 6 proposal, then no funds may be used for the arms embargo. And the President shall submit a plan to, and consult with, the Congress regarding unilaterally lifting the arms embargo and how the United States would provide training to the Bosnian armed forces outside the territory of that country.

Additionally, the amendment would provide that if the Bosnian Serbs attack U.N. declared safe areas, the President and his representative shall promptly introduce a resolution in the U.N. Security Council that authorizes a selective lifting of the arms embargo on the Government of Bosnia to provide defensive weapons to enable the Bosnian armed forces to defend the safe areas.

This amendment reflects the recent consensus reached by the House and Senate conferees on the Department of Defense authorization bill. The House bill included language similar to the Dole amendment authorizing unilateral U.S. termination of the arms embargo. The Senate bill included language authorizing the U.S. to seek multilateral termination of the arms embargo.

These different points of view were reconciled and agreed to by the conferees, and the essential change of that agreement is contained in the amendment being offered today by Senator NUNN, which I support.

The President has expressed his support and willingness to implement the provisions of this amendment. Thus, the language of the amendment reflects an agreement of the authorizing congressional conference committee and the administration on a proper course of action to follow in seeking a peaceful resolution to the fighting in Bosnia.

I hope my colleagues will join me in supporting this carefully worked out alternative amendment. It is consistent with the best interests of the United States. It will be most helpful to an ultimate peaceful resolution of the conflict that has raged for too long in that tragic country.

Mr. President, I also want to say that this constructive alternative, this reconciliation of the divergent views previously expressed by the House and Senate, is possible only because of the leadership and determination of Senator NUNN. He has clearly understood the important issues at stake, not just in Bosnia but for the United States and the rest of the world, and has fashioned a policy which I think makes sense for the United States and provides a specific and firm deadline for action with respect to the arms embargo. I think it makes a great deal of sense. I commend Senator NUNN for his leadership and his diligence in this area, and I urge my colleagues to support the Nunn amendment.

Mr. President, I thank my colleague for his courtesy and I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. NUNN. Mr. President, how much time does our side have remaining?

The PRESIDING OFFICER. The Senator from Georgia controls 47½ minutes.

Mr. NUNN. I thank the Chair, and I thank the majority leader for his kind comments and for his support of this amendment that we will be voting on, I understand, first. This amendment is being offered, Mr. President, on behalf of myself, the majority leader, Mr.MITCHELL, the Senator from Virginia, Mr. WARNER, the Senator from Kansas, Mrs. KASSEBAUM, and the Senator from Florida, Mr. GRAHAM.

Mr. President, I yield myself such time as I may require.

The PRESIDING OFFICER. The Senator from Georgia is recognized.

Mr. NUNN. Mr. President, first, I would like to thank Senator LIEBERMAN and Senator DOLE for their positive comments about the conference report. We did the best we could. We had a very difficult job. The Senate had a multilateral position. There were a lot of people who were involved in working out this conference report, the essence of which we will be voting on as the first amendment, the Nunn-Mitchell-Warner-Kassebaum-Graham amendment.

I would also like to thank Senator LIEBERMAN, in addition to his comments, for his work on this conference report. I know that he prefers a unilateral lifting, and that is what is reflected in the Dole-Lieberman amendment. I know that the view of Senator DOLE and Senator LIEBERMAN is absolutely sincere and they are working on it because they believe in it, and I respect that very much.

I differ with them, but I have great respect for their views. I think all of us, virtually all of us, would like to lift the embargo. The difference—an important difference—is whether we do it unilaterally or multilaterally.

In addition, on the conference report, Senator GRAHAM headed up the general provisions. This appropriation came under that. Senator GRAHAM from Florida did an enormous amount of work here. It could not have been done without him and without Senators LIEBERMAN, WARNER, THURMOND, and others.

On the House side, Congressman MCCLOSKEY, Congressman DELLUMS, the chairman of the committee, Congressman HOYER, who was not on the conference committee, and Congressman HAMILTON were all very involved in the deliberations.

Mr. President, I would like to review the action recently taken by the House-Senate conference on the fiscal 1995 defense bill regarding the arms embargo on Bosnia.

For those who may be interested in this debate, we in the Senate have a dual process. First, we have to pass an authorization bill on defense. Then we have to pass an appropriations bill. The authorization bill passed several weeks ago. We have been in conference. That conference report is completed. We announced the results today. That conference report, as soon as all the technical details are drawn up, will go to the President. Hopefully, he will sign that conference report.

In that conference report, which will soon go to the President, hopefully for his signature, we have the provision that we will be voting on today. In other words, that is being agreed to by the House conferees and the Senate conferees. And of course, the conference report has to be agreed to by the Senate and then by the House and then go to the President.

The bill we are on now, managed by the Senator from Hawaii and the Senator from Alaska, is an appropriations bill on defense. This bill has not yet been conferenced. Of course when it passes—and I know my colleagues hope it will pass this evening—this will go to conference. In all likelihood—I cannot speak for them; they would know better than I—in all likelihood this conference would be completed sometime in September.

So we are going to have in law the authorization bill several weeks, in all likelihood, before this appropriations bill could possibly go into law, and that is assuming the President signs it. I think, of course, that depends on what we do on this and other areas as I view it. I am not sure what he will do if the Dole-Lieberman amendment goes to him in the appropriations bill coming out of conference.

Mr. President, the issue before the conference was not whether the United States should lift the embargo but, rather, whether it should be done unilaterally or whether it should be done multilaterally.

I think most of us on the conference agree that the embargo that was imposed upon the former Yugoslavia 3 years ago, supported both by the Bush administration and the United Nations and by the Clinton administration since then in their votes—our Government has voted for that embargo over and over again, and I think it is important for us to understand that. It is widely agreed among the conferees that the overwhelming source of aggression in Bosnia has been the Bosnian Serbs and their sponsors in Belgrade, and the principal victims of that aggression have been the Bosnian Moslems. Of course, there are acts of violence on both sides, tragedy on both sides, but that is our perception of the overwhelming source of aggression.

It is also widely agreed that the arms embargo has provided an enormous military advantage to the perpetrators of the principal aggression, that is the Bosnian Serbs, and denied the victims of aggression, the principal victims, the Bosnian Government and the Moslem group, the means of effective self-defense.

There is further general agreement that the embargo on the Government of Bosnia should be lifted, preferably on a multilateral basis.

Finally, there seems to be a consensus here in the Congress, certainly in the Senate, among the conferees of the House and Senate against the deployment of United States ground forces to Bosnia for any purpose other than monitoring a peace agreement acceptable to all parties concerned. And even this kind of deployment, which, of course, will not occur unless there is a peace agreement, does not enjoy wide support in the Congress. The President has already said many times he will come to the Congress before he seeks any such deployment. That would be a matter of considerable debate here in Congress.

The primary area of disagreement in the conference was reflected in the House desire to lift the arms embargo quickly and unilaterally, whereas the Senate wished to pursue remaining possibilities for achieving a multilateral lifting before considering unilateral action as a last resort.

The resolution of this issue must take recent developments into consideration, among them the acceptance of the contact group's proposed peace settlement by the Government of Bosnia; its effective rejection by the Bosnian Serbs; and the contact group's failure so far to take effective action in the wake of the Bosnian Serbs' continued defiance.

The track the contact group is pursuing logically involves, first, an attempt to obtain Bosnian Serb acceptance of the group's peace plan.

Failing that, second, preparing for the United Nations forces orderly withdrawal from Bosnia, and also the humanitarian forces being able to get out of harm's way.

And finally, once that withdrawal is completed, obtaining a multilateral lifting of the arms embargo against Bosnia.

That is what the contact group has said they are embarked upon. To lift the embargo multilaterally or unilaterally before the United Nations forces are withdrawn or before the humanitarian workers have been able to be secured or that there are other means to protect them, could subject these forces as well as these brave humanitarian workers to Bosnian attacks and hostage taking.

Potentially, the most profound recent development, however, has been an apparent parting of company between Belgrade and its Bosnian Serb proxies. During the past 2 weeks, Serbian President Milosevic has publicly denounced the Bosnian Serb rejection of the contact group's peace proposal. He called Bosnian Serb leaders, quoting him, "war profiteers," and he called upon Bosnian Serbs to dump them. Belgrade subsequently announced it was suspending all political and military ties with Serbs and was closing Serbia's border with Bosnia to all but the movement of food, medicine and clothes.

Mr. President, as recently as this morning, there are strong indications from our independent sources that that is indeed being done.

Now, I would have to add to that very hastily, skeptics are right, I think, based on history to be very wary of any pronouncement coming out of Mr. Milosevic's Belgrade government. On the other hand, the history of international relations is littered with the bodies of proxies abandoned by patrons. History tells us that.

We know the Russians have exerted great pressure on Milosevic to disown his Bosnian Serb proteges. It is also clear that Milosevic desperately wants a termination of the present economic embargo of Serbia, and he wishes to certainly avoid further tightening of that embargo which could well be in store.

Mr. President, this development is a potential watershed in the Bosnian crisis, and I think we have not discussed it nearly enough here in the Senate. Since the war erupted in the former Yugoslavia back in 1982, we have operated on two assumptions: First, that the war-fighting capability and capacity of the Bosnian Serb forces is critically dependent on the delivery of military supplies from Serbia and, second, that Belgrade and the Bosnian Serbs share an identity of interests in Bosnia.

The first assumption is almost certainly valid but now could work in favor of intense pressure on Belgrade to disown its clients in Bosnia. But if Belgrade does so, then the second assumption may be invalid. Is Serbia indeed, if only for tactical reasons, in the process of politically abandoning its brethren in Bosnia? Is it prepared to shut off military assistance and control the energy supplies to Bosnian Serb forces in a manner subject to verification? My suggestion is that the United Nations take the Serbian President Milosevic up on his offer in terms of cutting off arms, and say to him, "Yes. You are doing that. We want to verify it. We want U.N. forces on the border at each entrance point from Serbia to Bosnia, and we want to make sure that you are indeed doing what you say."

That is what I believe we should do.

(Mr. PRYOR assumed the chair.)

Mr. NUNN. If this indeed is happening, and if it continues to happen in a military position, those Bosnian forces are likely to deteriorate with or without a lifting of the arms embargo on Bosnia. This in turn places a premium on avoidance by the United States and our NATO allies and the United Nations of actions that would drive Belgrade and the Bosnian Serbs back into each other's arms. In a situation in which the Bosnian Serbs have provoked even Belgrade to ostensibly at least abandon them, we should reexamine the policy of punishing Belgrade for the transgressions of the Bosnian Serbs but only if—this is a big "if"—Belgrade does in fact cut off the Bosnian Serbs and if they also permit verification of that cutoff by international inspectors at border crossings. That is the course that we should be pursuing diligently now.

Mr. President, I believe we are obligated to weigh carefully the likely consequences of moving straight to unilateral lifting of the arms embargo. The process by which we lift the embargo is just as important as the act itself. In fact, with our broad position around the world and for our relationship with our allies, it is even more important.

Those who today seek to set a firm date in all sincerity—I want to credit them for that—for lifting the arms embargo unilaterally should think very carefully about the implications of imposing this change in law and its effect on the Serbian Government.

Would a precipitous unilateral termination of the embargo widen the war? Would it drive the UNPROFOR forces out of Bosnia? Would it place its security at risk? Would it place our humanitarian workers in security risk? Would it place Bosnia's fate—and especially the fate of those besieged Moslem communities which the United Nations has declared to be safe areas—in greater jeopardy than they are today? Would it draw the United States into the Bosnian and Balkan quagmire? Would our allies withdraw and say to us, "OK. United States, you insisted on moving alone. Now we are getting out of here, and it is up to you not only to train and supply arms but to defend the Bosnians while they are getting heavy arms, and while they are being trained." Do we really want to take this on unilaterally?

Could the United States, if it abruptly terminated the embargo, avoid both the moral and material responsibility for the defense of the Bosnian Government and its supporters? Would it not be the height of cynicism simply to declare the embargo lifted, force the U.N. forces out, whose presence at the very least has been enabling humanitarian aid to reach tens of thousands, hundreds of thousands of them who otherwise probably would not live—and then walk away from those seeking to defend themselves against aggression and genocide?

In other words, if we lift this embargo and there is a very strong I am sure case for that—I am in favor of doing it multilaterally. But if we do it unilaterally, there are some people who would like to say that is all we are going to do, that now we are through with it. Mr. President, that cannot happen. That is the worst course of all.

If we are going to lift the embargo, we have to follow through. Otherwise, we are inviting disaster. We have to follow through by training. We have to follow through by arming, hopefully with defensive weapons that would not spread the war. If we do not, we are going to leave a vacuum there that would not only lead to tragedy for those we are presumably trying to help, but it would also invite other forces to come into that area with weapons that could greatly broaden the conflict. I will not name those other forces. But you can leave it to your imagination. It would be a very grave development.

Mr. President, I have looked very carefully at the Dole-Lieberman amendment. Along that line, the way I read the amendment, the entire amendment is on one page. So it is not very hard to read. It says:

> The President shall terminate the United States arms embargo on the Government of Bosnia and Herzegovina no later than November 15, 1994 so that Government may exercise its right of self-defense under Article 51 of the United Nations Charter.

It goes on to say what it actually does. The operative phrase of this is it basically repeals a July 15 policy published in the Federal Register of July 19 under the heading "Suspension of munitions export licenses to Yugoslavia, and any similar policy adopted and implied by the United States as of the date of receipt of request of paragraph 1," and so forth.

That is what this does. If you look at what it does here, what it actually repeals, it repeals this Federal Register that says:

> Summary notice is hereby given that all licenses and approvals to export or otherwise transfer defense articles and defense services to Yugoslavia pursuant to Section 38 of the Arms Export Control Act are suspended.

So what we would be doing is saying arms can be exported to Bosnia. That means our defense contractors could sell, or, if the money is not available and they are charitable, they could give arms to Bosnia. It says nothing about how they are going to get them there. How are they going to get them there if the British and French decide to continue to enforce the embargo? Are we going to let Lockheed, General Dynamics, Hughes, and others fly through the French and British embargo and deliver arms to Bosnia? It says nothing whatsoever about that.

There is no provision in here to deliver arms. There is no provision for training. There is not even a provision in here that says that we no longer would enforce the embargo. There are some people who would read that as meaning that there is nothing to prohibit the President in here from continuing to enforce the embargo with our military forces. In my own view, that would not be a very sensible reading of the intent behind this because certainly the intent is clear, and we would not participate in the embargo.

But, Mr. President, I would say that the worst case we can get into from an international point of view, and from our own security point of view, is to lift an embargo, and then say nothing and provide nothing about training or about overall arms being delivered.

The Yugoslavian army has not entered in this conflict in a direct way. We know they are supplying weapons. We know probably there are some of them participating. But they have a lot that they could do that they have not yet done. So we do not certainly want to trigger that.

Mr. President, I think at a minimum we would be obliged to provide the Bosnian Government forces substantial quantities of weapons as well as the training necessary for their effective employment. Unless we want to lift the embargo and invite the Iranians into Europe, or unless we want Turkey to take over that obligation, unless we want to inflame the basic passions that already exist there, then we have an obligation to go much further than the Dole-Lieberman amendment goes. Maybe the authors of this amendment intend to do that. We have an appropriations bill that is about to pass. And it does provide $50 million. But it is in anticipation of either a unilateral or multilateral lifting; $50 million in arms. But it requires that the President—I believe this is the foreign appropriations act. It provides that the President certify before permitting this aid, No. 1, the transfer of such articles that would assist that nation in self-defense and thereby promote the security and stability of the region; two, that the U.S. allies are prepared to join in such a military effort.

So the only appropriations bill I know about that has any money in it, if we pass this unilateral lifting, requires that kind of certification. The President cannot certify that the United States allies are prepared to join in a military assistance effort; just to the contrary, they oppose the lifting of the embargo.

So, Mr. President, this amendment is symbolism, and it is important symbolism. It is psychology, and it is important. It is going to send—if we pass this—some messages around. But the problem is that there is nothing to carry out the policy, unless you assume that our private defense contractors are going to sell arms to Bosnia, and unless you assume that those arms are going to be delivered by somebody through an embargo that is continuing to be enforced by NATO and by the United Nations.

Mr. President, for the United States, the Balkans are important, but they are not vital to our national security. But what is central to our security, and to Europe's security, is preventing the spread of this conflict. Of course, we as Americans are sympathetic to the humanitarian needs of the Bosnian people and the terrible atrocities and tragedies that have occurred there, and we are seeking—and should seek, and even intensify—to meet the needs where we can. But there is a vast difference between dropping relief supplies to civilians and taking on the conflict as our own. There is a vast difference in those two.

Another issue posed by an abrupt unilateral termination of the embargo is a likely reaction of the Bosnian Serbs. It will take time, at least several weeks, if not months, to deliver significant quantities of weapons to the Bosnian Government, and to train government forces in their proper employment. The government's lack of access to the sea means that deliveries would have to be made via interdictable roads, initially through Croatia, and by air to airfields within the range of Serbian artillery.

Who is going to deliver these weapons through a continued embargo by the United Nations and by our allies? Who is going to deliver the weapons? Where are they going to get the weapons? Are we going to have our defense contractors come in and say: "Boy, I am sure glad that embargo is over. We are now going to find ways to deliver weapons in the middle of that conflict"?

I doubt it. I doubt it very seriously. I think those who are going to vote for this unilateral move have the obligation to think through these questions. They may have thought of them, and there may be answers, but they are not apparent on the face of the amendment.

Mr. President, are we going to assume that Bosnian Serb forces will remain idle while we go about arming and training Bosnian Government forces? Would a lifting of the embargo provoke a Bosnian Serb aim at preempting the Bosnian Government's military rearmament? The worst case is to have the Bosnian Serbs believe weapons are about to go in there because we voted in the U.S. Senate on lifting the embargo, and then have no weapons in there and have no training and have no way to get them in there, and not have any plan to get them in there. We would leave the people we are trying to help in worse shape than they are in now. We do that. We better think about it. This is not a sense-of-the-Senate resolution. If this comes up and we pass it, and it goes into conference and comes out, it could become law.

Would the Bosnian Serbs attack not only government forces but also the roads and airfields that are critical to the delivery of arms to government forces? Would they also attack the Moslem-safe areas which, with the departure of U.N. forces—and our allies told us if this happens, they are going to pull out—they would also pull out presumably the forward air controllers.

What are we going to do about targeting if we have to go in and bomb, if we do not have air controllers on the ground? How are we going to do that? Will our air power be effective without any forward air controls? Even with the assistance of forward air controls, the Bosnian Serb targets around those safe havens are very elusive, and we have done what I call a pin-prick attacking; we have not really done much damage in that. Those attacks are very difficult because it is so easy to put the weapons in the civilian populations, and then we have to decide whether we are going to go in there and knock out a church or a school that has mortars in it. What are we going to do about this? There is an obligation to think through these questions, a real obligation.

Mr. President, we would also have to be prepared for some of these same consequences if we multilaterally lift the arms embargo. But there is a huge difference. We and our allies will be acting in concert in taking collective steps preparing for withdrawing forces, deterring and reacting to any Bosnian Serb aggression. There is a huge difference between doing this unilaterally or multilaterally. We can do it unilaterally and we can take care of these questions, but only if we are willing to make a very large commitment of military forces and of training, and only if we are willing to follow the consequences of our action to their logical conclusion—and that means bombing. That means when you give out targets in Bosnia, you take it to Serbia. That is the logical consequence here, and people had better think through it.

In sum, Mr. President, a hasty unilateral lifting of the arms embargo on Bosnia will no doubt offer, for maybe a week or two, emotional satisfaction, produce a number of editorials that are favorable; but it could precipitate and intensify a conflict for which the Bosnian Government forces could find themselves militarily much worse off than today. It could also provoke a major crisis with at least two of our major European allies, as well as encourage other members of the United Nations to unilaterally themselves either ignore or violate current and prospective embargoes that we are in favor of and have pushed through the United Nations, and that we want to continue, like Libya, like Iraq, like Haiti, and like North Korea.

Mr. President, it is nice to be able to view through a telescope one small foreign policy question, even one that is as tragic as Bosnia. But it cannot be done with a country like America. We have to look at the whole scope and take into account other actions.

How many members of the Security Council, if we have to use an embargo on North Korea, are going to bring up what we do in terms of this embargo that we voted for over and over again? After much deliberation, the House-Senate conferees on the fiscal year 1995 defense authorization bill have determined what I believe to be a viable alternative to the original position of the two Chambers; I submit it is a viable alternative to the unilateral lift. Assuming a continued refusal of the Bosnian Serbs to accept the contact group's peace plan, I believe this alternative permits the Congress to support the contact group while at the same time pressuring our allies and the administration to lift the embargo multilaterally, rather than unilaterally.

This alternative rests on two tracks. The first, international; the second, unilateral. This is the amendment we will be voting on first. The international track calls for Congress to call on the President to seek, by the end of October, a U.N. Security Council termination of the arms embargo on the Bosnian Government. For over a year and a half, the administration has declared repeatedly it believes the arms embargo on Bosnia should be lifted multilaterally if possible. But while it has really talked to our allies individually on the matter, it has made no concerted effort within the Security Council to obtain a multilateral termination of this arms embargo on Bosnia.

President Clinton and his team have been kept informed of our deliberations on this issue, and the President indicated his willingness to take this effort to the U.N. Security Council by November 1, unless the Bosnian Serbs have come up with signature and agreement of the contact group's July 6 decision.

In a letter delivered yesterday, the President reaffirmed his commitment—he made it in writing—seeking a repeal of the embargo by the U.N. Security Council.

Mr. President, there is another track, in addition to the multilateral track, because we all know that the President, when he goes to the Security Council, around October 15 or November 1, he may get there and the Security Council may turn him down.

They may say we do not want anymore multilateral arms. What do we do then? We go much further in this resolution than we have gone before. If the U.N. Security Council refuses to lift the arms embargo on Bosnia and the Bosnian Serbs continue to reject the contact group peace proposal, funding for the participation in the United States forces in the arms embargo on Bosnia will be terminated no later than November 15.

Mr. President, the Senator from Kansas said we will be gone in October. Well, this is law. This will be law if it goes into effect, and this will be automatic on November 15 if these two conditions have not occurred.

What does that mean? It means our military forces no longer will be part of enforcing the embargo. We will no longer have Navy ships out enforcing the arms embargo. That is a very important step.

It is a unilateral step, but it is in no way in contravention of our national duties.

When we vote for an embargo at the U.N. Security Council, we do not sign up as the policemen. There are other members around the world of the Security Council and of the General Assembly who are honoring the embargo, but they are not enforcing it. As far as I know, the Russians are not enforcing the embargo. It is mainly the United States and our allies in NATO.

It is one thing to unilaterally violate an embargo and quite another thing to participate in its enforcement.

I personally, and I believe our conference agreed, find it unacceptable that American sailors and airmen are being deployed and engaged on behalf of an embargo that makes no moral or other distinction between the perpetrators and the victims of aggression and genocide.

Some believe we are legally obligated to observe the embargo as long as it remains in effect, although this view is debatable. But certainly, however, we are not obligated to provide ships and aircraft to enforce the embargo. There is a great difference between being a law-abiding citizen and joining the police force. We have joined the police force on this embargo that we have decried for the last 2 years both in Congress and from the White House.

What this amendment does it does not say we are going to unilaterally breach the embargo. There is a clear line. Here it says we are not longer going to enforce it. We do not know the effect of that. Our allies, the British and French, the NATO allies, can continue if they choose to enforce it without U.S. military forces.

I am not standing here saying it will end the embargo. It could, because it could have a very significant psychological effect. It could push the parties toward moving together before November 15 in some cohesive fashion. There is no guarantee of that, and we have to be prepared for that.

Mr. President, the Congress would also direct the President to submit to the Congress within a specified period of time a plan to train the Bosnian Government forces for the purpose of enabling them to defend themselves and the Bosnian safe areas from Serbian attack. It is important to recognize that any Bosnian political entity, including the one proposed by the contact group, would have to be able to defend itself. But if the peace agreement goes into effect, if everybody signs up, that country, if it is ever going to be secure, it also has to have the right to defend itself.

If we are really concerned about what has occurred there, and I really and truly believe everybody in this body is, if we are really concerned about the victims, then we have to start planning how they are going to be trained and how they are going to be armed with or without a peace agreement and, of course, without one it is much more urgent.

Mr. President, a defenseless Bosnian entity would be a standing invitation to further bloodshed in former Yugoslavia. Only a Bosnian Government capable of defending itself can escape the lurches of those who seek a greater Serbia. I think our allies have to start understanding this. I believe it is essential that they start grasping this essential fact.

Mr. President, if Bosnia continues to be without defenses, without adequate defenses, and if we decide to unilaterally lift the embargo because of that and if we go no further on training, if we do not get any kind of agreement on what we are going to do to train them, it is an invitation to outside forces to come into that area of the world and make the situation much worse than it is now. This is a situation, tragic enough. The spread of this Bosnian war would move on the scale from humanitarian and important concerns to the scale of vital concerns at which point there could be a point we would have no choice but to commit military forces, which no one wants to do.

Mr. President, sooner or later we and the other countries will be called upon to help train and arm the Bosnian Government forces, even if there is a peace agreement. The issue is not whether but when and in what context, unilaterally or multilaterally, before a peace agreement or after.

The international community, the same international community that is supporting the contact group effort to achieve a workable peace in Bosnia is obligated to assure Bosnia's military viability after a peace agreement is reached.

It is my view that we should keep the international community involved. If we have to go the unilateral route, we are basically and in my opinion morally volunteering to take it on ourselves, not simply a declaration that lifts the embargo, but training an army because that is what they need. Lifting the embargo will have no meaning unless they are trained and have arms and can defend themselves. It will have no meaning.

Mr. President, in fact I would amend that by saying it could have just a reverse meaning. It could alarm the Bosnian Serbs. It could cause attack, and when the attack comes the Bosnia Government will look around and say, what did this lifting of the embargo mean? We do not have training. We do not have antitank weapons. We do not have mortars. Where is it going to come from? It is not going to continue outside of the amendment we are voting on here today. Where is it going to come from?

Finally, we would require the President to submit a plan and consult with the Congress regarding a unilateral lifting of the arms embargo. If this amendment passes, it is a difference in planning and executing than it is implementing. This does not unilaterally lift the arms embargo, this amendment by myself and the Senator Maine and others.

What the House-Senate conferees are proposing that is in our defense authorization bill is one last stab at obtaining a multilateral lifting of the arms embargo, and failing that, placing complete responsibility on the international community for its continued enforcement. This amendment says, we want to try to work with you, but if we cannot work with you, then it is up to you to enforce it. The other amendment says we are basically going to unilaterally declare where we are going, and then I assume we would have the courage of our convictions and hopefully in some other measure follow through with what is essential, which will be training and which will be military weapons.

This proposal, the Nunn-Mitchell proposal, would do this in a nonprecipitous manner. It would ratchet up the pressure on both the U.N. Security Council and the Bosnian Serbs. If, in the interim, Bosnian Serb forces attack safe areas that have been declared safe areas, the administration is urged in this amendment to go to the U.N. Security Council and seek authorization immediately for a selective lifting of the arms embargo to enable the Bosnian Government to defend these safe areas.

Mr. President, I think that should have already been done. Why should we limit ourselves only to bombing? Why not multilaterally, not unilaterally, given people are under attack in Sarajevo, a chance to defend themselves with defensive weapons, carefully selected and prepared for? That is what we ought to do multilaterally. At least it would present more options than simply trying to bomb difficult targets in populated areas.

Mr. President, I fully understand the frustration of those who seek to lift the embargo now and who are prepared to act alone. But I urge each of the Senators who will vote for the Dole-Lieberman amendment to think through the consequences and to ask yourself are you ready to follow the line of and the concept that is required here, if you are going to think through this proposition properly, because simply lifting the embargo without providing arms, without providing training, you are doing virtually nothing but saying that American defense contractors can now export to Bosnia. You provide no money to pay for it, provide no training. I think we have to go much farther, if we are going to embark on this course, and I think this course is not wise. But if Congress is determined to take such an action, it should only do so after a multilateral lifting of the embargo is clearly impossible. We have not yet been to the Security Council and asked them to lift the embargo. There have been private conversations but we have not put that proposition down. The President is now saying he is willing to do it, no later than November 1.

Mr. President, I also want to stress again that we have to provide sufficient time for U.N. forces and humanitarian workers to debark and the Bosnian Government forces to arm and train, and we have to do that whether we lift the embargo unilaterally or multilaterally.

Those who favor a unilateral lifting now have an obligation to recognize the corresponding obligation to prepare both the Bosnians and our allies for the consequences of this unilateral action. They also have an obligation to carefully review the effect a unilateral lifting will have on continued and prospective allied participation in sanctions on Libya, Iraq, Haiti, and North Korea.

If we break ranks with our allies on an embargo that we voted for under two administrations, Bush and Clinton, however unwisely, then other nations will forever cite our action as a precedent should they decide in the future that it is in their narrow interest to break ranks with us. The consequences of this will flow with our foreign policy for a long time.

Mr. President, I reserve the remainder of my time.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent to take up to 10 minutes of Senator DOLE's time. It is my understanding that Senator MCCAIN wanted 2 minutes.

Mr. McCAIN. Of my own time.

The PRESIDING OFFICER. Is there objection?

Mr. DECONCINI. Reserving the right to object.

Mr. McCAIN. Never mind, Mr. President.

Mr. DECONCINI. Mr. President, I do not intend to object to the unanimous consent request, but I would like to ask that I could follow the Senator from Texas after her 10 minutes and the Senator from Arizona after his 2 minutes.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that Senator McCAIN be allowed to speak for 2 minutes, after which I would like to speak for up to 10 minutes from Senator DOLE's time.

Mr. McCAIN. Mr. President, if it is all right with the Senator from Texas, I yield that 2 minutes to the senior Senator from Texas, and I will take no more of my time. In fact, I will yield back the remainder of my time.

Mr. DECONCINI. Mr. President, may I ask for clarification, if the unanimous consent has been approved?

The PRESIDING OFFICER. The Chair believes that the Senator from Arizona is yielding 2 minutes of his time to the Senator from Texas [Mr. GRAMM]. The junior Senator from Texas is to be recognized for a period of not to exceed 10 minutes on Senator DOLE's time. And then the senior Senator from Arizona would be recognized.

Mr. DECONCINI. For 8 minutes on Senator DOLE's time.

The PRESIDING OFFICER. Senator NUNN's time remaining is 7 minutes 53 seconds.

Mr. DECONCINI. Mr. President, I am sorry. I confused this and I did not mean to.

It is from Senator DOLE's time, up to 8 minutes.

I ask unanimous consent that that be included in the unanimous consent agreement.

Mr. McCAIN. Mr. President, I would be glad to yield time to the Senator from Arizona. I believe I have 20 minutes. I would be glad to yield 8 minutes to the senior Senator from Arizona.

Mr. DECONCINI. There is no objection. I thank my colleague.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Texas is recognized for 2 minutes.

THE CRIME BILL

Mr. GRAMM. Mr. President, I will try to be brief, because I know it is a very important debate that is going on here.

I remember the first speech that President Clinton made to a joint session of Congress. He talked in that speech about getting tough on criminals. And I led the standing ovation on that speech.

Then I got back to my office and discovered the President has cut funding for prisons and the DEA and FBI. Immediately, the President and the Attorney General started working to try to overturn minimum mandatory sentencing for drug felons. While the administration was talking about grabbing criminals by the throat and getting tough, they were working to overturn minimum mandatory sentencing.

And when we debated the crime bill and passed a tough crime bill in the Senate, the administration, working with Members of the House, adopted an incredible provision that repealed minimum mandatory sentencing for drug pushing retroactively, and that would let 10,000 drug felons currently in the Federal penitentiary back out on the streets.

When our bill was adopted and the House bill was adopted, the bill went to conference. And in a game that is now quite old, the House dropped our get-tough provision and adopted the House provision with its get-out-of-jail-free card that would let 10,000 drug felons back out on the streets. Then the bill went back to the House. And today, miraculously, the House of Representatives voted down the rule on the crime bill.

Now my office received 1,700 calls yesterday, all worried about the fact that Congress was not listening to the American people.

Well, Mr. President, I thought it was important to note today that on the crime issue, the House did listen to the American people and they said very clearly: Do not try to let 10,000 drug felons out of prison and call it a get-tough provision on crime.

I know the American people got the message. I hope the President did.

The PRESIDING OFFICER. The Senator's time has expired.

Under the previous order, the junior Senator from Texas is recognized.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

The Senate continued with the consideration of the bill.

Mrs. HUTCHISON. Mr. President, I just listened to speech of the distinguished Senator from Georgia. I want to say how very much I respect the chairman of the Armed Services Committee. I think that he has great concerns about what is happening in Bosnia, as all of us do.

I find that I agree with him a lot more than I disagree with him, but on this occasion I am taking a different position.

It is because, Mr. President, it seems to me that we have been returning to this debate for the entire year that I have served in this august body. Each time the Serbs make the headlines with a new atrocity or outrage, we resume the debate. We talk about allowing those who are willing to fight for their freedom to be able to have the means to fight for their freedom. And each time we conduct a debate, we find some excuse not to approve lifting the arms embargo on the Bosnians.

Last week, the Serbs rejected a peace plan once again. They stole armored vehicles and fired on a U.N. helicopter.

The only improvement in the Senate, however, is that now we are debating how we will go about lifting the arms embargo instead of should we lift the embargo. But by passing two different resolutions, we are not leading, Mr. President. We are continuing to stall.

I am concerned that the other amendment, while having much of the same response, is still not going to allow the lawful countries in the international community to give arms to the Bosnians, because the law-abiding countries are not, in my opinion, going to give arms just because it is not being enforced when the embargo is still there.

On June 23, I met with Vice President Ganic at the Senate Armed Services Committee. He made a poignant appeal to the Armed Services Committee. Vice President Ganic of Bosnia said apologetically to us, "I realize I am emotional about this issue."

I thought to myself, this man is apologizing for being emotional, while his country is under armed assault, their families are being brutalized and murdered. He was very poignant, real, when he was speaking for his people as the elected Vice President of their country.

Mr. President, the Bosnians should have our support, not our sympathy. We have a moral obligation to follow declared U.S. doctrine as enunciated by U.S. Presidents from John F. Kennedy to George Bush. That obligation is to lend our support to oppressed people who are willing to fight for freedom. It is not always our responsibility to fight for others, but we must be willing to support them. The issue is America's leadership and resolve.

Three years ago, the United States formed and led a coalition of diverse nations to a stunning victory in Operation Desert Storm. At that time, the United States was the unquestioned leader of the world. Are we now perceived as simply a member of the community of nations rather than its leader? The danger lies in the false sense of security that leadership in some way will evolve from consensus.

Nothing could be further from the truth. Consensus follows leadership. Leadership does not, nor will it ever, evolve from consensus. The coalition which met the challenge in the gulf war did not result from consensus. It came about because of American leadership, and that is what is lacking today. It is up to us to provide that leadership because no other country can and no other country will.

The time for leadership should be—and this time it should be—time for us to lead. Not to fight, as it was in Desert Storm, but to lift the impediment for those who are fighting so they can defend themselves from the attacks of aggressors.

There is an old adage that it is preferable to die fighting on your feet than to live begging on your knees. It is clear that the Bosnians have made their choice and that is to fight on their feet, come what may.

Some argue that lifting the embargo gives us a responsibility to put American troops in the fight. I do not think that is the case. The Bosnians have not asked for our troops to fight for them on the ground. Dr. Ganic told us he hopes the U.N. troops will continue to do humanitarian missions in Bosnia. But, he said, even if they feel they must withdraw, Bosnia is willing to accept that fate. He simply pled with us to no longer combine big words with small deeds. He asked us to lift the arms embargo because they need arms to survive.

In closing, former State Department official Richard Perle, testifying before our Armed Services Committee, defined the stakes very well. He said:

> In considering, finally, whether to reverse the shameful policy of leaving Bosnia defenseless against a well-armed Serbian aggression, we face a decision in which the right and moral course is also the course least likely to lead to adverse consequences for the United States and its allies. That is because it has the prospect of leading to a peace the Bosnians themselves can defend, rather than a peace imposed on a vanquished country that cannot last and which the United States would then be obliged to defend.

I want to also read from a recent policy statement from the American Enterprise Institute for Public Policy Research, written by Albert Wohlstetter. He said:

> But it is not enough to resist forcefully all the bad arguments for continuing an embargo in U.N. Resolution 713, that never validly applied to Bosnia. Better to enforce the valid U.N. demands to stop the flood of arms, ammunitions and soldiers sent by Serbia, the genocide's source, to its proxies in Bosnia and Croatia. That flood, financed by drug deals, smuggling, and a network of pickpockets roaming Europe, flagrantly violates, among others, U.N. Resolutions 752, 757, 819, 820 and 838. The world's democracies and the U.N.'s bureaucrats turn a blind eye to these valid U.N. demands.

I do not like moving without our allies. That is not my first choice. Our distinguished chairman of the Armed Services Committee has repeatedly said that we should have our allies working together in concert, and I agree with him. But they have failed to move—time and time and time again. I believe and hope that if we take this action, which is a bold action, they would support our move. But the United States has acted unilaterally before and will do so again. That is what leadership is, sometimes.

We must lift the arms embargo. Vice President Ganic of Bosnia said it so well. "We are dying anyway," he said. "let us die fighting, fighting for our country."

Mr. President, I hope we hear their pleas. I hope we set a date certain for lifting the arms embargo. I am supporting the Dole resolution because it is the right thing to do. We have talked too long. The time to act has long since passed.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. DECONCINI. Mr. President, for more than 2 years I supported the lifting of the arms embargo in a unilateral manner if necessary. We have had debate time and time again, and I listened very attentively to the Senator from Georgia. As usual he points out in a very profound manner the responsibility of the United States as the embargo is lifted. If that be the case, I believe the United States would meet that responsibility.

I do not quite see it that way, however. The fact that you lift the arms embargo does not mean that you have to deploy troops there. The fact that you lift the arms embargo and this would cause some disruption with our allies, and some heartburn in our relationships with France and England, to me is not sufficient to keep us from doing what the Senator from Texas referred to as truly a moral obligation to do something to help these people.

There have been some efforts by our administration. President Clinton has talked to many people in the world, many people in the Congress, attempting to forge a multilateral effort to end this conflict. He has indicated that he himself would like to see the arms embargo lifted, but only if done on a multilateral basis.

The fact is we cannot lift it on a multilateral basis. The Senator from Maine and the Senator from Georgia now have proposed the best of all that we have had over the last 20-some months of efforts to lift the arms embargo, because they do set a date. Apparently the President now realizes that this train is moving and eventually it is going to come out of this Senate and House with a vote to unilaterally lift the arms embargo. He may be presented with no alternative but to veto it and I do not think he wants to do that. I think in his heart—and I do not know—in his mind he wants to see the Bosnian Muslims be able to defend themselves.

The reality is we have had a failed policy there, from the U.S. standpoint, but more so from the allies and the multilateral standpoint. We have not succeeded in bringing the Serbs, Bosnian Serbs to the table with any credibility, with any willingness to enter into a peace accord where they do not end up with 70 percent of someone else's country. And this accord that the contact group put together July 6 is no great accord. They end up with 49 percent of someone else's country. And that someone else is the Bosnia and Herzegovinans who want to defend themselves.

So we lift the embargo, and the question is asked by the distinguished Senator from Georgia, how are they going to get the arms in there? You know, people who want to fight for themselves, who want to die if they have to, to die with dignity, are going to fight, just like they are fighting right now with the embargo on. They are getting arms. And they have demonstrated on several occasions they can be pretty effective, even against the far greater armed force of the Bosnian Serbs.

So it gets back to where do we as a nation stand when a nation, an independent sovereign country, a member of the United Nations, part of the CSCE process, has now decided that they want to fight these invading forces? And we say because of an embargo that is imposed against the former Yugoslavia that no longer exists, that the people of Bosnia and Herzegovina cannot defend themselves. That does not make sense.

It does not make sense because it is not right on anybody's scale. And the fact is there is a moral obligation of the United States to do all we can to help these people fight and be able to defend themselves from the Bosnian Serbs.

Will they be able to do it? I do not know. It is interesting here, the debate that we have had on the Persian Gulf, for example. When the time came there was a big hue and cry—there are many who wanted to commit American troops there. They thought we should go after those invaders.

That is what we have here—we have invaders. There is no reason that we have to decide today or any time in the future that we have to deploy troops there.

But I do believe that we are committed under NATO to use air strikes and we should use them. It has been demonstrated time and time again when we are prepared to use those air strikes, there is a response from the Bosnian Serbs. General McPeak, the Chief of the Air Force, testified a little over a year ago before the Appropriations Committee, that airstrikes can be carried out with minimal risk, or very low risk of loss of U.S. pilots.

For us not to be willing to lift that embargo and to do what we have to do with air strikes, to me is walking away—walking away from a pending catastrophe.

I have been to Bosnia and Herzegovina four times, and Macedonia and other countries in the area. I have talked to people who have been put through the genocide and murder process that the Bosnian Serbs, armed by the Serbian former Yugoslav Army have subjected them to. To sit there and talk to a person of my own age who lost his mother, his sister, and his brother through murder and rape, and to hear of other relatives who were forced out of their villages through the ethnic cleansing process of the Bosnian Serbians to me is enough to make you cry, and it did just that.

It made me feel like, "What do you want from the United States?" And I asked him that. When the President of Bosnia and Herzegovina was here, I asked him, "What do you want?" He said to me, "Let us die in dignity if we have to die; let us have arms." He said, "We are not asking for your soldiers. You do not even have to give us the arms. We'll get the arms, but we cannot get them in because of the embargo."

If we lift that embargo unilaterally—I cannot believe the allies there are going to stop arms from coming in to help the Bosnians. If the allies feel it is too dangerous, it is their right to get their troops out. They do not have to be there. But their being there has not brought stability to Bosnia and Herzegovina and an end to this genocidal conflict.

So I hope this body will have the courage to stand on principles, to stand with people who have been so deprived and so victimized that there is just nothing more we can do today except vote a clear message that the United States understands the severity of the problem and is prepared to lift this embargo.

If we do not do that, then the Senator from Georgia and the Senator from Maine have crafted, in my judgment, the best alternative. I must say, it is much better than we have had before because it does set a time, it does indicate that if the multilateral effort to get the United Nations to lift it does not happen, funds are cut off from our enforcement contribution. I compliment the Senator from Georgia for his ability to craft that and get that through the conference committee and apparently get the President and the administration to support it.

So we have two good alternatives. I just happen to come down on the side that lifting the embargo is not as dangerous as the Senator from Georgia might say. Sure, it is nice to have a big plan, and we had a big plan when we went to the Persian Gulf. And in Bosnia if we were talking about arming them, that is one thing. We are not talking about arming, we are just talking about lifting, removing the prohibition now of selling arms or transferring arms to Bosnia and Herzegovina. I hope this body has the courage to do that.

In any event, the only good thing I can find out of all this is that we are moving closer and closer to where many of us thought we should have been a long time ago, and that is to let the Bosnians die in dignity, if they must die; let them fight for their own country as anybody else in this body would want to do if we were in their shoes.

Mr. NUNN addressed the Chair.

The PRESIDING OFFICER. The Senator from Georgia.

Mr. NUNN. Mr. President, I thank the Senator from Arizona for his kind and thoughtful remarks about our proposal, and I certainly understand his position on the overall issue.

I yield 6 minutes to the Senator from Rhode Island, the chairman of the Foreign Relations Committee.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. PELL. Mr. President, the distinguished minority leader has offered an amendment to this bill mandating the unilateral lifting of the arms embargo, an amendment that I will oppose.

This is an issue that knows no partisan boundaries, that cuts to the heart of issue related to U.S. influence and power abroad. There are serious and valid disagreements among us, and as public servants, we are called upon to exercise our best judgment on this very difficult issue. My own gut felling, my own conscience tells me that unilaterally lifting the arms embargo is the wrong thing to do.

Clearly, the situation in Bosnia is untenable, one we cannot support as we see the innocent civilian victims of the fighting, the vast majority of whom are Bosnian Moslems. Regrettably, the suffering of blameless civilians is far too common an occurrence in our world today. Untold misery is occurring in Rwanda, Kurdistan, Sudan, Haiti, and the Caucasus—to name just a few places.

As I have said previously, before we take any unilateral action in Bosnia—we need to answer the most serious question of all: Is it in our national interest? Where does our national interest lie. How deeply involved is our national interest in Bosnia? Regrettably, we still do not have clear answers.

My own view is we do not have an overriding national interest, but I realize that is not the view of many of my colleagues. As long as that remains the case, I would not support an action that could launch us headlong into a military quagmire.

On several occasions now, the Senate has conducted an honest and thorough examination of a difficult issue. I have listened to and participated in the previous debates on this matter, and I have previously acknowledged that I see merit in some of the arguments regarding a lifting of the embargo. My best judgment, though, tells me that unilateral action is the wrong course to take.

Today we are considering another approach. We have before us an amendment offered by the distinguished chairman of the Armed Services Committee, Mr. Nunn, which promotes a multilateral approach but which will likely lead to the nonenforcement of the embargo by the United States.

I commend the Senator from Georgia as well as the majority leader, Mr. MITCHELL, for their fine efforts to come up with compromise language. But this amendment goes quite far in urging the United States to go it alone, and for that reason, I am not completely comfortable with it. But I am more comfortable with it than I am with the Dole amendment. President Clinton has indicated that he will seek a multilateral lifting of the embargo. He did so with the full knowledge that if the Security Council does not agree to lift the embargo the language in the Nunn amendment, if adopted, would require the United States to halt enforcement of the embargo.

In my opinion, this takes us a bit down the road of unilateral action. However, I see this amendment as the lesser of two evils. Our President has made the judgment that he can live with the consequences of this amendment—that it fits in with what he is trying to accomplish on the diplomatic front. I, too, much prefer this approach to one which would mandate a unilateral lifting of the embargo. For that reason, I will support this amendment as a tactical matter—in the hopes that it will help prevent the adoption of a measure that directs the President to unilaterally lift the embargo.

One lesson that can be drawn from this debate, and previous ones, is that it is to our best advantage not to intervene with a unilateral action but to only do so in a multilateral way.

I yield the floor.

Mr. NUNN. Mr. President, I reserve the remainder of my time and suggest the absence of a quorum, and ask that the time be evenly divided.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. NUNN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mrs. MURRAY). Without objection, it is so ordered.

Mr. NUNN. Madam President, how much time is remaining on each side, now that we have split this quorum call?

The PRESIDING OFFICER. The Senator from Georgia controls 2 minutes and 30 seconds, the Republican leader controls 16½ minutes.

Mr. NUNN. Madam President, I have some other speakers. If my time is being dissipated by this, I do not know what to do about it. Perhaps the Senator from Alaska could let the time run against his time, and at least let me reserve—Madam President, I would ask that the remaining time on both sides be reserved. I ask unanimous consent that no further time be charged against either side on the Bosnian amendment.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. NUNN. Madam President, I would also like to inform the desk that the leader has authorized me to use his 10 minutes on the Bosnia question, if there are other Senators who want to speak on this side.

Mr. INOUYE addressed the Chair.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. INOUYE. I ask that the pending amendment be set aside.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

AMENDMENT NO. 2520

Mr. THURMOND addressed the Chair.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. THURMOND. Madam President, I have an amendment at the desk, amendment 2520. I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from South Carolina [Mr. THURMOND] proposes an amendment numbered 2520.

Mr. THURMOND. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of Title VIII, General Provisions, add the following new section:

SEC. . Of the funds appropriated by title VIII of Public Law 102-396 (106 Stat. 1899) for defense reinvestment for economic growth, the unobligated balance of the funds made available by such title for military service members occupational conversion and training shall remain available until September 30, 1995.

Mr. THURMOND. Madam President, I ask unanimous consent that Senators MURKOWSKI and SIMPSON be added as cosponsors, in addition to Senator DECONCINI.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. THURMOND. Madam President, this amendment would extend the obligation life of funds previously appropriated for the Service Members Occupational Conversion and Training Act [SMOCTA].

Madam President, the SMOCTA program was created by the fiscal year 1993 Defense Authorization Act to provide subsidies to employers who train recently separated service members for new careers in the private sector. The act authorized funds for the program, to be available for obligation for 3 years. The 1993 defense Appropriations Act identified $75 million for SMOCTA, as part of the $472 million appropriated for defense conversion programs. Unfortunately, the appropriation was made available for obligation for only 2 years. This amendment would correct the discrepancy between the authorization and the appropriation, making the funds available for the 3-year period. Over $40 million of the original appropriation has been obligated to date.

Madam President, although there were some initial bureaucratic delays in getting the program implemented, the program has been very successful. Over 4,500 employers have certified training programs, including national corporate chains. The program provides incentives to hire and train veterans. Over 35,000 veterans are certified for the program. Approximately 6,000 veterans are currently receiving job training, for a period of 12 to 18 months, at an average cost per veterans of $6,879.00.

The Departments of Defense, Labor, and Veterans Affairs have worked hard to establish this program, although there were some delays. However, it would be a mistake to let this program expire at this time. To not extend the life of the prior appropriation would send a message to our military members, caught in the downsizing, that we do not care about their futures. It would tell employers that the Federal Government cannot be trusted in partnership agreements. I do not believe this is the message the U.S. Senate wishes to send.

Madam President, without this amendment, SMOCTA funds will be abruptly cut off this coming September, at the end of the current fiscal year. My amendment will cure the conflict between the authorization and appropriation for this program, extending the period of availability for obligation of SMOCTA funds until September 30, 1995.

Mr. President, the SMOCTA program has strong support in the business community and the veterans community. My amendment is supported by the Veterans of Foreign Wars of the United States, the AMVETS, the American Legion, and the Vietnam Veterans of America. In addition it is supported by the Department of Labor, which administers the program.

I encourage my colleagues to join in supporting the amendment.

Mr. ROCKEFELLER. Mr. President, I rise in support of Senator THURMOND's amendment to make unobligated funds under SMOCTA available in fiscal year 1995.

The Service Members Occupational Conversion and Training Act [SMOCTA] was created by the fiscal year 1993 Defense Authorization Act to provide subsidies to employers who train recently separated service members for well-paying, stable jobs. The act authorized $75 million for the program, and provided that the money would be available for obligation for 3 years.

In the 1993 Defense Appropriations Act, $75 million for SMOCTA was identified as part of a $472 million defense conversion appropriation which was made available for obligation for 2 years. I have no reason to believe that the Appropriations Subcommittee intentionally rejected the authorizing committee's 3-year provision for SMOCTA funds.

The Department of Defense, Labor, and Veterans Affairs have worked very hard to get this important program up and running. To date, approximately 4,000 veterans have entered training, and many more have been certified as eligible.

The recent realization that SMOCTA funds could be abruptly cut off has caused much concern among veterans' advocates and the people who have worked to make this program a success. The prospect of having to turn away veterans and employers who have agreed to work together in this program is disconcerting to them and to me. We are concerned, not only about the veterans who will be let down, but also about the negative impact that the cutoff in funds may have on employers' willingness to participate in veterans' employment programs in the future.

While efforts are being made to obligate as much of the direct services money as possible before the end of this fiscal year, it appears now that this cannot be done. Obligation takes time because participants and training programs must be approved by VA. In addition, the 6 percent of the funds set aside for administration will be needed over the next year for continued monitoring, as required by law.

I want to make sure that veterans who have relied on SMOCTA are not let down, and that the people who serve them are not left without the support they anticipated. To this end, I urge my colleagues to support this amendment.

The PRESIDING OFFICER. Is there further debate?

Mr. INOUYE. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The absence of a quorum has been suggested. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. SPECTER. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SPECTER. Madam President, I ask unanimous consent that the pending amendment be set aside so that I may speak on the Bosnia amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SPECTER. Madam President, parliamentary inquiry. Has 10 minutes been set aside?

The PRESIDING OFFICER. Will the Senator from Pennsylvania indicate the time he wishes to speak?

Mr. SPECTER. Parliamentary inquiry: I believe I have 10 minutes set aside under my control.

I am advised by staff I am authorized to take 10 minutes of the time from leadership.

The PRESIDING OFFICER. The Senator may proceed.

AMENDMENTS NOS. 2518 AND 2524

Mr. SPECTER. Madam President, I might say parenthetically that I thought 10 minutes had been reserved under my control. But apparently the arrangement was not done. But I am advised I do have authority to take 10 minutes of leadership time.

Madam President, I have sought recognition to support the resolution to terminate the United States embargo of arms for the Government of Bosnia and Herzegovina no later than November 15, 1994, because I believe that is the appropriate foreign policy of the United States.

I have in the past supported other amendments advanced under the leadership of Senator DOLE because I think Bosnia and Herzegovina have a right to self-defense under the U.N. Charter.

The atrocities there are well-known. There have been major international efforts to stop the Bosnians and Serbs from proceeding with the slaughter. That stand has apparently been supported by Serbia. The United States, Great Britain, France, and other allies, joined by Russia, have tried to have a settlement there to stop the slaughter, and that has not worked.

This resolution has been before the Senate on several other occasions. There was a 50-50 vote. I believe that there are other Senators who are now willing to support this resolution so that we have a unilateral lifting of the arms embargo as a matter of basic fairness to Bosnia and Herzegovina.

I recognize the problem of the United States acting alone because that may weaken our position on unified action on other major matters around the world, such as, for example, North Korea. But I think this situation has gone on long enough. It is intolerable. We ought to move ahead, and the Senate ought to pass this resolution.

I have no doubt that this is not going to become the law of the land because, even if there is a narrow victory in favor of this resolution, it is subject to being vetoed by the President because the administration has stated its opposition to this resolution. There is no doubt that a two-thirds majority cannot be mustered to override the resolution.

So what we are really going to be doing here is making as forceful a statement as the Senate can that we do not accept the policy of President Clinton, that we do not accept the arms embargo, and we do wish to proceed to lift the arms embargo even though we are aware of the difficulties that presents in the international community.

What I think the effect will be of a forceful passage of this resolution is that it will put greater pressure on the administration to negotiate with the allies to have a multilateral lifting of the embargo, and will place pressure on the Bosnian Serbs. I think that ought to be accomplished.

Parenthetically, Madam President, I am concerned about the articulation of this resolution where it says "The President shall terminate the United States arms embargo," et cetera, from the point of view of the constitutional implications of the Congress ordering the President as to what the President should do.

This is not a ministerial act. This is a discretionary act. I think there is a constitutional question as to whether the Congress can issue this kind of order to the President.

Last week I took the position that the President did not have the authority to make war against Haiti without a congressional resolution in the context where there was ample time to get a congressional resolution. My view here is somewhat different with respect to the Presidential authority and congressional authority.

But I do believe that the practical impact of passing this resolution will be to impose greater pressure on President Clinton and on the allies to move ahead to get the arms embargo lifted.

My thinking is that there might be some more artful way to articulate this policy because, if you had the resolution passed and vetoed by the President and had the veto overridden, it would be a curious situation with the Congress ordering the President to do something in these terms.

But again, the practical effect is to put pressure to try to get a settlement to stop the bloodshed, and to give Bosnia and Herzegovina a chance to defend themselves.

Madam President, I yield the floor and any further time I yield.

The PRESIDING OFFICER. Who yields time?

Mr. INOUYE. Madam President, I ask unanimous consent that Senators BOXER, WOFFORD, and PELL be listed as cosponsors to the Bingaman-Pryor amendment No. 2530.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. INOUYE. Madam President, I ask that the pending amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2531

(Purpose: To increase the amount made available for the Defense Contract Management Command by $36,500,000)

Mr. INOUYE. I ask that amendment number 2531, the Levin amendment, be considered.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. LEVIN, proposes an amendment numbered 2531.

Mr. INOUYE. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 11, line 10, before the period insert the following: ": *Provided further*, That, of the total amount appropriated under this title, $1,224,309,000 shall be available for the Defense Contract Management Command".

Mr. LEVIN. Madam President, last night I proposed an amendment that would restore to the Defense Contract Management Command [DCMC] the $36.5 million cut by the Appropriations Committee.

DCMC is the agency responsible for managing nearly all contracts for the Department of Defense. It also administers contracts for NASA as well as a number of civil agencies and even some foreign governments. It manages some $840 billion of Federal contracts—a staggering sum.

Contract management is an absolutely critical responsibility. DCMC is on the front line of DOD's relationship with our defense contractors and is our trip wire for any problems that may develop with contractor performance. In overseeing DOD contracts, DCMC returns $10 for every $1 spent through cost savings and avoidances resulting from contract negotiations, contractor process enhancements, and contractor systems reviews. These savings and cost avoidances are realized by the services which are then able to make the best possible use of their contract dollars.

Over the last 3 years, DCMC efforts have resulted in financial recoveries of $551 million—over one-half billion dollars. And DCMC has played a significant role in obtaining the debarment or suspension of some 364 unresponsible contractors.

DCMC currently has a staff of 17,500. That is down by over 30 percent from 1989. According to DCMC, these reductions were achieved through attrition, special pay incentives, and selective reductions in force. By the end of fiscal year 1995, DCMC estimates an additional 1,000 positions will be eliminated. Over the same period of time, however, there was, according to DCMC, a 12 percent increase in the obligated value of contracts, a 19 percent decrease in the number of contracts, and a 9 percent decrease in the unliquidated dollar balance. DCMC's reduction in personnel has clearly outstripped the decrease in the workload.

An additional cut of $36.5 million could seriously weaken DCMC's ability to do its important job. According to the Department's own analysis, the proposed reduction will adversely impact DCMC's ability to invest in training, automation, and process improvements. It is these very investments that will enable DCMC to significantly improve its effectiveness in a future of continued downsizing.

My amendment would have restored the administration's full budget request for DCMC, but I am advised by the chairman of the Defense Appropriations Subcommittee that he will seek to restore funding in conference. I ask the Senator from Hawaii if that understanding is correct.

Mr. INOUYE. The Senator's understanding is correct. I am aware of the impact cuts to DCMC's operation may have on our ability to monitor the enormous volume of defense contracts. I assure the Senator from Michigan that I will work to restore funding for this agency in the conference with the House.

Mr. LEVIN. With those assurances, Madam President, I will then withdraw my amendment and express my appreciation to the floor manager for his support. Cutting DCMC's budget is cutting our ability to oversee the operation of $840 billion worth of defense contracts. In my view it is penny-wise and pound-foolish. It may look good today, but it will have costly consequences tomorrow and on into the future. I welcome the floor manager's support and offer my assistance in fighting for full funding for DCMC in the conference.

Mr. INOUYE. I thank the Senator from Michigan.

Mr. INOUYE. In behalf of Senator LEVIN, I withdraw the amendment.

The PRESIDING OFFICER. Without objection, the amendment is a withdrawn.

The amendment (No. 2531) was withdrawn.

AMENDMENT NO. 2537

(Purpose: To extend the terms of United States patent numbers 4,428,744 and 4,683,889 (relating to a photopheresis method))

Mr. INOUYE. Madam President, I ask unanimous consent that the pending amendment be set aside and that the Senate consider amendment No. 2537.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. DODD, proposes an amendment numbered 2537.

Mr. INOUYE. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . The Secretary of Commerce, acting through the Commissioner of Patents, shall, upon expiration of United States patent numbers 4,428,744 and 4,683,889 (relating to a photopheresis method involving collection and exposure of extracorporeally circulating leukocyte-enriched blood to long-wave ultraviolet energy in the presence of a photoactive drug 8-methoxypsoralen), or as soon thereafter as practicable extend such patents for four and one-half years, with all the rights pertaining thereto.

Mr. INOUYE. In behalf of Senator DODD, I withdraw the amendment.

The PRESIDING OFFICER. Without objection, the amendment is withdrawn.

The amendment (No. 2537) was withdrawn.

Mr. INOUYE. Madam President, I ask unanimous consent that the pending amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2546

(Purpose: To limit the obligation of funds for the HUNTER unmanned aerial vehicle (UAV) system)

Mr. INOUYE. Madam President, I ask that we call up amendment number 2546, the DeConcini amendment.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. DECONCINI, proposes an amendment numbered 2546.

The amendment is as follows:

On page 142, between lines 7 and 8, insert the following:

SEC. . (a) No funds may be obligated for a second low rate initial production of the HUNTER Unmanned Aerial Vehicle (UAV) system until the Secretary of Defense submits to the Committees on Armed Services and Appropriations of the Senate and the House of Representatives, the Select Committee on Intelligence of the Senate, and the Permanent Select Committee on Intelligence of the House of Representatives the Secretary's certification of the following:

(1) That the Logistics Support Analysis Report required by contract to be submitted to the Department of Defense has been received by the Department and is sufficient to fully support a determination to field the system.

(2) That 200 hours of flight time have been successfully logged on a Phase II UAV airframe for the system as part of "OPTEMPO" testing.

(b) The Secretary shall submit to the committees referred to in subsection (a), with the certification submitted pursuant to that subsection, a copy of the Logistics Support Analysis Report and the OPTEMPO testing reports relating to the HUNTER UAV system.

AMENDMENT NO. 2546, AS MODIFIED

Mr. INOUYE. I send to the desk a modification.

The PRESIDING OFFICER. Without objection, the amendment is so modified.

The amendment (No. 2546), as modified, is as follows:

On page 142, between lines 5 and 6, insert the following new general provision and number appropriately:

SEC. . (a) None of the funds appropriated in this Act for a second low rate initial production (LRIP) contract or contract option for the Hunter unmanned aerial vehicle (UAV) system may be obligated until the Department of Defense certifies to the Congressional Defense Committees that—

(1) two Hunter UAV systems have been accepted by the government using the currently defined Acceptance Test Procedure;

(2) the operational tempo (OPTEMPO) phase of the risk reduction program has been successfully completed; and

(3) the flight test portion of the first article test (FAT) has been successfully completed;

(b) None of the funds appropriated in this Act may be obligated to procure more than four Hunter UAV systems until the Logistics Support Analysis (LSA) report has been submitted to the relevant Committees of Congress and the Department of Defense has certified to these Committees that the LSA is sufficient to fully support fielding of the Hunter UAV.

Mr. INOUYE. Madam President, as modified, the managers have no objection.

The PRESIDING OFFICER. Is there further debate? If not, the question is on agreeing to the amendment.

Mr. DECONCINI. Madam President, I want to thank the managers of the bill.

I want to thank the Chairman of the Defense Appropriations Subcommittee and his staff for working with me on my amendment, which is designed to help the Hunter UAV program. As many of you know, the Hunter system is a set of unmanned aerial vehicles designed for short-range reconnaissance, supporting tactical military operations. This billion-dollar capability is a significant one; ultimately 50 systems are planned for a total of 400 unmanned airplanes distributed among the Army, Navy, and Marines. I support the Hunter UAV program.

The Hunter UAV system has experienced several fundamental—but hopefully not fatal—problems during its development and procurement. The GAO has issued three critical reports in 3 years regarding the progress of the Hunter UAV program. The GAO continues to monitor the program today and has reinforced to me that their past concerns have in fact not been resolved, that they still include insufficient/unrealistic testing, extremely poor logistics support, engine design problems, and questionable program management.

For example:

The engines—originally intended for motorcycles—have been unreliable, requiring several modifications, some of which are still ongoing.

The fact that testing has fallen behind procurement compounds this problem, increasing the danger that faulty systems are being tendered to the Government.

Logistics support—critical to a successful fielding—has been behind schedule. Without logistics support a single, minor problem with a part can incapacitate an entire system on the battlefield.

For example, a contractually required "Logistics Support Analysis Report" manual is 2 years behind schedule. The title does not do justice to the importance of this report—without it, soldiers in the field will not be prepared to perform routine maintenance and operational repairs because the right spare parts will not be available in the right quantities. Right now, I understand, there is not even a spare set of landing gear for the Hunter planes.

Several recent crashes have highlighted the program's growing pains. In at least one case the cause of the crash is not even known yet.

Over and above these substantive problems is a concern regarding what I perceive as DOD misleading the Congress on the health of the Hunter UAV program.

After Congressional staffs were assured this spring/early summer that the program was on track, that GAO's reported problems had been fixed, and that congressional concerns were outdated, the Hunter program, as submitted to Congress, was touched in markup.

However, in mid-July, staffs of the relevant congressional committees were briefed that the program had been sifnificantly restructured as a result of numerous ongoing problems. The DOD Joint Program Office, even after privately conceding many of the GAO's significant criticisms, continues to publicly claim that the program is in near-perfect health. In last week's issue of Defense News, DOD and contractor officials state that all problems with the programs have been corrected. We know this not to be true, based on DOD's own statements—and DOD's desire for a restructuring.

The Pentagon has not yet submitted changes to the FY 1995 Hunter UAV funding request. Our staffs have been briefed that approximately $65 million is needed to implement this restructuring and some $30 million of that is being borrowed from the Close Range UAV program, which my staff was initially told was not being affected.

DOD reported that the damage to a HUNTER UAV that crashed on June 19 while undergoing Government acceptance testing was minimum. In fact, the damage is so bad that a replacement vehicle has been ordered.

Before us is a request for a restructuring of the FY 1995 submitted HUNTER program to address its acknowledged deficiencies. As I understand it, the request is for $88 million to procure four low-rate systems.

This restructuring is generally well-advised: it provides more support for logistics and testing.

However, my amendment as modified by Senator INOUYE will ensure that the Department of Defense follows its own prescription for restructuring. Specifically, the Congress should fence the $88 million requested by the Department for procurement of the second low-rate initial production systems until three specific milestones have been met. These milestones have been defined by the Department of Defense as follows:

Milestone 1—requires that two HUNTER UAV systems be accepted by the Government using the currently defined acceptance test procedure;

Milestone 2—requires that the operational tempo [OPTEMPO] phase of the risk reduction program be successfully completed;

Milestone 3—requires that the flight test portion of the first article test [FAT] be successfully completed;

These milestones are designed to keep a watchful eye on both the system performance and the logistics support. Members may ask why we need this amendment. We need it because the Department has been reluctant to admit to any major problems with the program until a few weeks ago, and still only privately. Now that the program's problems are acknowledged, we must make sure that the Department's newfound concern does not dissipate in the next year. These milestones signal our resolve to keep the program on track—and ensure that the warfighter gets a product that works.

The Department has assured me that these milestones will be met in a timely fashion, perhaps as early as November. If that is so, the second low-rate production decision can be made in accordance with the Department's own schedule. Thus my amendment to fence $88 million should be considered to be an unobtrusive but important insurance policy for the taxpayer and the warfighter—if the system's problems haven't gone away, we won't permit business as usual until they are fixed.

The Hunter UAV system fills an important and substantial need for our Armed Forces. It is for this reason that we must make sure that what we pay for we count on to perform in combat. This amendment will ensure just that. Because it is based upon Department of Defense milestones and schedules, it should not impose any extra burden upon the DOD—unless there is something still seriously wrong with the program.

I appreciate the efforts of Chairman INOUYE in working with me to correct the problems with the HUNTER UAV program, make the program meet its goals so that it can perform its critical mission, and, at the same time, wisely steward taxpayer dollars. I thank the chairman and urge adoption of my amendment.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Arizona.

The amendment (No. 2546), as modified, was agreed to.

Mr. INOUYE. Madam President, I move to reconsider the vote by which the amendment was agreed to.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. STEVENS. If I might address the Senator from Arizona, Madam President, I asked the Senator from South Carolina to withhold action on his amendment until the Senator from Arizona could be here. I wonder if he realizes that was the pending amendment.

Mr. DECONCINI. No. I did not know that.

Mr. DOLE. Madam President, might I inquire of the Parliamentarian how much time remains under the agreement on the Bosnia amendment?

The PRESIDING OFFICER. The Republican leader controls 11 minutes 20 seconds. The Senator from Georgia controls 11 minutes 45 seconds.

Mr. DOLE. I do not think I will need all that time.

Let me indicate, as I did earlier this afternoon on this amendment, that we have had the debate several times in this Chamber. In nearly every case, every Senator stood up and indicated sympathy for the Bosnians, and for their plight in Sarajevo and everywhere else; and for all the people killed and made homeless, or driven from their homes. All we suggest in the Dole-Lieberman amendment is that if November 15 comes and nothing has been done by the United Nations, the arms embargo is lifted. That is all we ask. We are not asking about American troops, no air strikes, no American troops.

We are saying this is an independent nation, a member of the United Nations, and it has a right to self-defense under the U.N. Charter, article 51. And a group of us—Republicans and Democrats—believe they should have that right.

I listened carefully to the Senator from Arizona earlier. I think there is an understanding around here that this country has been asked to give up 49 percent of their territory, and we are supposed to sign on that—in fact, we have signed on to that as a Nation, the so-called contact group. Maybe that is the way to walk away from this. But history will not treat us very kindly or the international community very kindly.

I have given credit to the Senator from Georgia, [Mr. NUNN], and others on the Armed Services Committee. But under that arrangement, we would not know anything until about the middle of October, and we will not be here. We will not be able to consult with Congress. I do not think we will be here October 15. So it could be next January, January 1995 before this matter is debated again. I do not believe that is the intent of the Congress or this Senate. So I hope there will be broad support for our amendment and that the other amendment will be defeated. I know some of my colleagues have had different views, but I hope that maybe now they are coming in our direction.

HOUSE ACTION ON THE CRIME BILL CONFERENCE REPORT

Mr. DOLE. Madam President, I will now comment on the House action on the rule regarding the crime conference report, which was defeated by about 15 votes, as I understand it. I listened to President Clinton say what a sad day it was and how badly he felt because 225 Members of the House—Democrats and Republicans—chose some procedural route to indicate their displeasure with the crime bill.

The President indicated that it was because of the National Rifle Association. I do not think that is the case. The bill that passed the Senate by 94 to 4, for the most part, is a good bill. But a strange thing happened—as sometimes happens—it got loaded up with a lot of pork, a lot of spending. There was not a minute of hearings on some of this spending that added up to billions and billions of dollars. That is what killed this bill.

I put in the RECORD just a few days ago a statement by Mr. DiIulio, a professor at Princeton, a Democrat, someone who supported the Brady bill, supported the ban on assault weapons, who said that this bill, instead of being a crime bill would create more crime. He also says in his statement—and I will refer to parts of it—there are not going to be 100,000 cops on the street, there are going to be 20,000 cops on the street. We will be lucky to have 2,000 cops on the street.

He said:

> The bill calls for 100,000 new cops. But when you read the relevant titles, you discover that really means about 20,000 fully-funded positions.
>
> And when you further look at how this bill is to be administered, you come to recognize it is to be administered by the Office of Justice Programs, which is the alphabet soup of agencies left over from the days of the old Federal Law Enforcement Assistance Administration, which is to figure out some way of divvying up this money between 85 percent for more manpower and 15 percent for everything else having to do with policing, so much to jurisdictions under $150,000, so much under $150,000, and so on.
>
> And if you are stouthearted enough to look at this bill in light of the relevant academic literature, you know that it takes about 10 police officers to put the equivalent of one police officer on the street around the clock. This is factoring in everything from sick leave and disabilities to vacations and three shifts a day and desk work, and so on. So that 20,000 funded position becomes 2,000 around-the-clock cops. And 2,000 around-the-clock cops gets distributed over 200 jurisdictions for an average actual street enforcement strength increase of about 10 cops per city.

I really commend this four-page statement to everyone, regardless of politics. As I said, this person happens to be a Democrat. He said the Senate bill was not very kind.

He said:

> The Senate version of the crime bill that was drafted and put out back in November—November 19, 1993, to be exact, by a vote of 95 to 4—would, I think, have done something, though I'm not exactly sure how much, to stop revolving-door justice. But now, almost 9 months later, we have before us a crime bill that would actually, in my view, grease the revolving door, at the Federal level, at least, via such provisions as the so-called safety valve provision, which is essentially a provision that would permit certain categories of convicted drug defendants to be invited back to court, to be given a virtual retrial under a retroactive law.

In other words, about 5,000 prisoners are going to be released immediately, and he said it could go up to 16,000 that are back on the street. In paragraph after paragraph, he talks about all the bad points in this bill and all the money we put in this bill that has nothing to do with crime control, nothing to do with prevention, and he concludes that it is a terrible bill and ought to be defeated.

So I just suggest that if you have not read the statement I put in the RECORD a couple days ago—I am not going to do it again—but I would be happy to give copies.

I say this to the President: If we want a crime bill that fights crime, we ought to look at some of the provisions that were dumped out, some of the tough anticrime provisions. I think if that happens and we cut down a lot of the spending, then we might be able to pass this bill. Right now, it is full of pork. That is what killed this bill in the House, or killed the rule. I hope that the President will take a hard look at it. I wish the President would read this statement made by the Princeton Prof. John DiIulio, who supported the Brady bill and assault weapons ban, and says this bill might even create more crime.

Madam President, I yield back any time I may have.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

The Senate continued with the consideration of the bill.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Florida [Mr. GRAHAM], is recognized.

Mr. GRAHAM. Madam President, are we now on the amendment offered by the Senator from Georgia?

The PRESIDING OFFICER. We are on the Bosnia amendment.

Who yields time to the Senator?

Mr. NUNN. I yield the Senator from Florida 5 minutes.

Mr. GRAHAM. Madam President, it is ironic that as we have this debate today in August 1994, we are celebrating the 80th anniversary of the Guns of August, the commencement of World War I, with the assassination of Archduke Ferdinand in Sarajevo. That historical event underscores the complexity and almost the mystical character of these conflicts in the Balkans.

I believe it is important in that context for the United States, and particularly for this Congress, to have a clear idea of what it is we are trying to accomplish in that region and what we are trying to accomplish relative to the tragedy that is occurring in Bosnia and Herzegovina.

I would suggest that we have at least three major objectives. One of those objectives is to put maximum pressure on the Bosnian Serbs to accept the peace proposal which was placed before them on July 6 of this year.

It is certainly not a perfect plan, but it is the surest plan to achieve the goal of a cessation of the killing and the process of commencement of reconciliation.

Second, at least, we want to contain the war, to not allow this war to break out of Bosnia and inflame the entire Balkans.

And third, we need to preserve the solidarity of the western alliance, an alliance that for 45 years protected us against the Soviet Union and which now has the potential of assuring a stable peaceful future.

I believe the course of action which will best accomplish those objectives for the United States and a course of action which this Congress should participate in leading is that which has been outlined and detailed by Senator NUNN. It places a timeframe before the President to go to the United Nations and ask for a multilateral lifting of the arms embargo on Bosnia and the rest of the area which has been inflamed by this war.

Number two, it lifts U.S. enforcement of the arms embargo as it applies to Bosnia and Herzegovina. It recognizes that by lifting the arms embargo alone we have not accomplished the objective of assisting the Bosnian Moslems.

This provides for training of the Bosnian Moslems so that they will be able to effectively utilize equipment which they may receive. This also provides for interim steps if there are continued incursions in the safe areas. There will be those defensive weapons introduced which will allow for the Bosnians to assist in the sanctity of those safe areas. And it maintains the coalition by providing to primarily our European allies who have most of the combatants on the ground today a reasonable opportunity to exit without themselves becoming the object of hostage taking and violence directed at them.

I believe, Madam President, that those are important tactics for the United States if we are to accomplish those goals of maximum pressure on the Bosnian Serbs, containing the war, and maintaining the coalition.

It is very appealing to say let us let the Moslems defend themselves, let us lift the embargo unilaterally, and let the war go forth.

I believe, Madam President, that there are some consequences to that, that are very adverse to our interest, the most significant of which is that the likelihood is that as soon as the Bosnian Serbs feel that, in fact, there is going to be a lifting of the embargo they will launch a massive violent and effective assault against the Bosnian Moslems and will likely end up controlling all of Bosnia by military victory.

Madam President, I believe that the time has come for us to put reason ahead of passion. Senator NUNN has suggested a reasonable approach that will effectively buy us an additional 30 to 45 days to see if we can accomplish our multiple objectives in Bosnia. If we cannot, I will join with those who are urging a unilateral lifting of the arms embargo as the last step available to us. I do not believe we are at that stage of the last step, and now is the time to take a reasoned step, and the Senator from Georgia has given us that path to reason.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. NUNN. Madam President, I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. INOUYE. Madam President, I ask unanimous consent that the consideration of the Bosnia amendment be temporarily set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

The Senate continued with the consideration of the bill.

Mr. INOUYE. Madam President, I ask unanimous consent that the pending amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2495

(Purpose: To express the sense of the Senate concerning Lowry AFB)

Mr. INOUYE. Madam President, I call up Amendment No. 2495, the Brown-Campbell amendment.

The PRESIDING OFFICER. The clerk will report the amendment.

Mr. LOTT. Madam President, reserving the right to object, a parliamentary inquiry.

The PRESIDING OFFICER. The Senator will state it.

Mr. LOTT. Madam President, what is the situation here, now? The pending amendment is set aside; is that correct?

Mr. INOUYE. Temporarily set aside, yes.

Mr. LOTT. Do we know when we might get back? I am just inquiring so I know when we will get a vote.

Mr. INOUYE. In 1 minute.

Mr. LOTT. Thank you, Madam President.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. BROWN, for himself and Mr. CAMPBELL, proposes an amendment numbered 2495.

Mr. INOUYE. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, add the following new section—

SEC. . SENSE OF THE SENATE CONCERNING LOWRY AFB.

It is the sense of the Senate that—

(a) in issuing any lease, permit or deed of conveyance for use to assist the homeless under the Stewart B. McKinney Assistance Act concerning Lowry Air Force Base, Colorado, the Secretary of Health and Human Services, representatives of the city of Denver, Colorado, representatives of the City of Aurora, Colorado and representatives of homeless providers whose applications have been approved by the Secretary of Health and Human Services should jointly determine that such use is reasonable under the redevelopment plan for Lowry Air Force Base, Colorado; and

(b) the Department of Defense and the Department of Health and Human Services, in coordination with the appropriate committees of Congress and appropriate state and local authorities, should develop a reform proposal to address the many difficulties created for local communities by existing laws relating to the loan, lease or conveyance for use of government property during the base closure process.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 2495) was agreed to.

Mr. HATCH. Madam President, I move to reconsider the vote.

Mr. INOUYE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2541

(Purpose: To provide protection against sexually violent predators)

Mr. INOUYE. Madam President, I ask that we consider Amendment No. 2541.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE], for Mr. DOLE, proposes an amendment numbered 2541.

Mr. INOUYE. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Strike all after the enacting clause, and insert the following:

SECTION. 1. SHORT TITLE.

This Act may be cited as the "Megan Kanka Sexually Violent Predators Act".

SEC. 2. FINDINGS.

Congress finds that—

(1) there exists a small but extremely dangerous group of sexually violent persons who do not have a mental disease or defect;

(2) persons who are sexually violent predators generally have antisocial personality features that—

(A) are not amenable to mental illness treatment modalities in existence on the date of enactment of this Act; and

(B) render the persons likely to engage in sexually violent behavior;

(3) the likelihood that sexually violent predators will repeat acts of predatory sexual violence is high; and

(4) the prognosis for curing sexually violent predators is poor and the treatment needs of the population of the predators are very long-term.

SEC. 3. DEFINITIONS.

As used in this Act:

(1) MENTAL ABNORMALITY.—The term "mental abnormality" means a congenital or acquired condition of a person that affects the emotional or volitional capacity of the person in a manner that predisposes the person to the commission of criminal sexual acts to a degree that makes the person a menace to the health and safety of other persons.

(2) PREDATORY.—The term "predatory", with respect to an act, means an act directed towards a stranger, or a person with whom a relationship has been established or promoted, for the primary purpose of victimization.

(3) SEXUALLY VIOLENT OFFENSE.—The term "sexually violent offense" means an act that is a violation of title 18, United States Code or State criminal code that—

(A) involves the use or attempted or threatened use of physical force against the person or property of another person; and

(B) is determined beyond a reasonable doubt to be sexually motivated.

(4) SEXUALLY VIOLENT PREDATOR.—The term "sexually violent predator" means a person who has been convicted of a sexually violent offense and who suffers from a mental abnormality or personality disorder that makes the person likely to engage in predatory sexually violent offenses.

SEC. 4. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—

(1) STATE GUIDELINES.—In accordance with this section, the Attorney General shall establish guidelines for State programs to require a sexually violent predator to register a current address with a designated State law enforcement agency upon release from prison, being placed on parole, or being placed on supervised release. The Attorney General shall approve each State program that complies with the guidelines.

(2) STATE COMPLIANCE.—

(A) IMPLEMENTATION DATE.—A State that does not implement a program described in paragraph (1) by the date that is 3 years after the date of enactment of this Act, and maintain the implementation thereafter, shall be ineligible for funds in accordance with subparagraph (B).

(B) INELIGIBILITY FOR FUNDS.—

(i) IN GENERAL.—A State that does not implement the program as described in subparagraph (A) shall not receive 10 percent of the funds that would otherwise be allocated to the State under section 506 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3756).

(ii) REALLOCATION OF FUNDS.—Funds made available under clause (i) shall be reallocated, in accordance with such section, to such States as implement the program as described in subparagraph (A).

(b) REGISTRATION REQUIREMENT UPON RELEASE, PAROLE, OR SUPERVISED RELEASE.—

(1) IN GENERAL.—An approved State program established in accordance with this section shall contain the requirements described in this section.

(2) DETERMINATION.—The determination that a person is a "sexually violent predator" and the determination that a person is no longer a "sexually violent predator" shall be made by the sentencing court after receiving a report by a board of experts on sexual offenses. Each State shall establish a board composed of experts in the field of the behavior and treatment of sexual offenders.

(3) NOTIFICATION.—If a person who is required to register under this section is anticipated to be released from prison, paroled, or placed on supervised release, a State prison officer shall, not later than 90 days before the anticipated date of the release or commencement of the parole—

(A) inform the person of the duty to register;

(B) inform the person that if the person changes residence address, the person shall give the new address to a designated State law enforcement agency in writing not later than 10 days after the change of address;

(C) obtain the name of the person, identifying factors, anticipated future residence, offense history, and documentation of any treatment received for the mental abnormality or personality disorder of the person; and

(D) require the person to read and sign a form stating that the duty of the person to register under this section has been explained.

(4) TRANSFER OF INFORMATION TO STATE AND THE FBI.—Not later than 3 days after the receipt of the information described in paragraph (3)(C), the officer shall forward the information to a designated State law enforcement agency. As soon as practicable after the receipt of the information by the State law enforcement agency, the agency shall—

(A) enter the information into the appropriate State law enforcement record system and notify the appropriate law enforcement agency that has jurisdiction over the area in which the person expects to reside; and

(B) transmit the information to the Identification Division of the Federal Bureau of Investigation.

(5) QUARTERLY VERIFICATION.—

(A) MAILING TO PERSON.—Not less than every 90 days after the date of the release or commencement of parole of a person required to register under this section, the designated State law enforcement agency shall mail a nonforwardable verification form to the last reported address of the person.

(B) RETURN OF VERIFICATION FORM.—

(i) IN GENERAL.—The person shall return, by mail, the verification form to the agency not later than 10 days after the receipt of the form. The verification form shall be signed by the person, and shall state that the person continues to reside at the address last reported to the designated State law enforcement agency.

(ii) FAILURE TO RETURN.—If the person fails to mail the verification form to the designated State law enforcement agency by the date that is 10 days after the receipt of the form by the person, the person shall be in violation of this section unless the person proves that the person has not changed the residence address of the person.

(6) NOTIFICATION OF LOCAL LAW ENFORCEMENT AGENCIES OF CHANGES IN ADDRESSES.—Any change of address by a person required to register under this section that is reported to the designated State law enforcement agency shall as soon as practicable be reported to the appropriate law enforcement agency that has jurisdiction over the area in which the person is residing.

(7) PENALTY.—A person required to register under a State program established pursuant to this section who knowingly fails to register and keep the registration current shall be subject to criminal penalties in the State. It is the sense of Congress that the penalties should include imprisonment for not less than 180 days.

(8) TERMINATION OF OBLIGATION TO REGISTER.—The obligation of a person to register under this section shall terminate on a determination made in accordance with the provision of paragraph (2) of this section that the person no longer suffers from a mental abnormality or personality disorder that would make the person likely to engage in a predatory sexually violent offense.

(c) COMMUNITY NOTIFICATION.—The designated State law enforcement agency shall release relevant information that is necessary to protect the public concerning a specific sexually violent predator required to register under this section.

(d) IMMUNITY FOR GOOD FAITH CONDUCT.—Law enforcement agencies, employees of law enforcement agencies, and State officials shall be immune from liability for any good faith conduct under this section.

Mr. INOUYE. Madam President, the managers have considered this amendment. We approve it.

The PRESIDING OFFICER. Is there further debate?

If not, the question is on agreeing to the amendment.

The amendment (No. 2541) was agreed to.

Mr. INOUYE. Madam President, I move to reconsider the vote.

Mr. HATCH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2549

(Purpose: To prohibit fiscal year 1994 and fiscal year 1995 funds appropriated for the Joint Primary Aircraft Training System from being used for any other purpose)

Mr. INOUYE. Madam President, I ask that we consider amendment No. 2549.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. INOUYE] for Mr. DOLE, proposes an amendment numbered 2549.

Mr. INOUYE. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place insert the following new section:

SEC. . PROHIBITION ON THE USE OF FUNDS.

(a) REQUIREMENT.—None of the funds appropriated for Fiscal Year 1994 or Fiscal Year 1995 for the Joint Primary Aircraft Training System shall be obligated or expended for any other purpose.

AMENDMENT NO. 2549, AS MODIFIED

Mr. INOUYE. Madam President, I send to the desk a modification.

The PRESIDING OFFICER. The amendment is so modified.

So the amendment (No. 2549), as modified, is as follows:

At the appropriate place, insert the following:

SEC. . (a) Of the funds appropriated under the heading "Research, Development, Test and Evaluation, Navy" in title IV of this Act, $3,900,000 shall be made available only for the Joint Primary Aircraft Training System (JPATS) program.

(b) Of the funds appropriated under the heading "Research, Development, Test and Evaluation, Air Force" in title IV of this Act, $37,057,000 shall be made available only for the JPATS program.

(c) Of the funds appropriated under the heading "Aircraft Procurement, Air Force" in title III of this Act, $78,265,000 shall be made available only for the JPATS program.

Mr. INOUYE. Madam President, the amendment as modified meets our requirements. We have no objection to the amendment.

The PRESIDING OFFICER. If there is no further debate, the question is on agreeing to the amendment, as modified.

So the amendment (No. 2549), as modified, was agreed to.

Mr. INOUYE. Madam President, I move to reconsider the vote.

Mr. EXON. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Nebraska.

AMENDMENT NO. 2479

Mr. NUNN. Madam President, I yield to the Senator from Nebraska 4 minutes.

Mr. EXON. I thank the Chair and I thank my friend from Georgia.

Madam President, we have been over and over and over this Bosnian thing so many times that I think the Senate is getting weary of it. But I certainly agree it is a vital issue.

Last Friday, the Senator from Nebraska came down to the floor when the amendment was offered once again in a different form by Senator DOLE and Senator LIEBERMAN, and we had a long discussion on it.

I cited at that time and will not take the time to recite it again today my concern. I was delighted that Senator DOLE and Senator LIEBERMAN had changed their amendment dramatically to have the effective date of lifting the embargo unilaterally on November 15, and I asked to be a cosponsor and I am a cosponsor.

Subsequent to that time, Senator NUNN, Senator GRAHAM, myself, and others, were in a very contentious conference with the House of Representatives on the Defense authorization bill.

This was a key part of the compromise to get this worked out with the House of Representatives. I happen to feel that the matter written basically in advance by the chairman of the Armed Services Committee is a proper way to go. I had suggested and

I had hoped that the Dole-Lieberman amendment, of which I am a cosponsor, would be temporarily laid aside until we come back in September, because the effective date of the Dole-Lieberman amendment is not until November 15.

I have met on several occasions with people involved in this, including the minister of Defense of Great Britain and the Minister of Defense of France, and others.

I happen to feel that what has been worked out and what is being offered today by the chairman of the Armed Services Committee is a correct way to go, the expeditious way to go, the reasonable way to go right now.

Therefore, I hope that the Senate will support the amendment offered by the chairman of the Armed Services Committee, and because of the timing of the amendment, I would think that we would defeat the Dole-Lieberman amendment and revisit that if necessary in September.

I reserve the remainder of my time, and I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Madam President, I would like for make a couple of statements on the crime bill which was defeated in the House. I will not take long.

The PRESIDING OFFICER. Who yields time?

The Senator from Utah needs consent. The time is controlled.

Mr. HATCH. Madam President, I ask unanimous consent that I be given 5 minutes to make a statement on the crime bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

THE CRIME BILL

Mr. HATCH. Madam President, Congress' historic opportunity to pass a bipartisan, tough anticrime bill is still alive, in my opinion. The House wisely defeated the proposed rule on the Democrats' conference report to the crime bill. Notwithstanding personal lobbying by the President and arm twisting by partisans, the House realized that the American people do not want a bill which wastes billions and billions of dollars on social spending boondoggles. The House courageously listened to law-abiding citizens who know it is time to get tough on criminals. More pork mean less crime.

This is a bill which would release as many as 10,000 to 16,000 Federal inmates early. That is not a tough bill. That is not a smart bill.

It was a bill which spent precious crime-fighting resources on pork-barrel spending. It is not tough, and it sure is not smart.

It is a bill which increases the deficit by $13 billion. And that is not tough and it sure is not smart.

It is time for the administration to work with Republicans in a bipartisan effort to pass a crime bill for all Americans.

One year ago, the Congress defeated the administration's so-called economic stimulus package. The Congress saw it for what it was—a multibillion dollar social spending package just laced with pork.

Having failed with the economic stimulus label, the administration slapped an anticrime label on these programs, and they stuck them in the crime bill and hid them there.

Madam President, I ask unanimous consent that a side-by-side comparison of the economic stimulus package and the crime bill's social spending boondoggles be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CRIME BILL—GRANDSON OF STIMULUS

Crime bill conference report	Stimulus package (February 1993)
Approximately half of the spending in this Crime Bill is reserved for fiscal years 1999 and 2000 where no spending caps exist to ensure deficit neutrality.	Approximately half of the spending in this "emergency" legislation would not have been spent in the first year and was outside of spending caps established by law.
Bill is subject to a Section 306 (60 vote) point of order under the Budget Act because it deals with matters under the jurisdiction of the Budget Committee.	Bill was subject to a Section 306 (60 vote) point of order under the Budget Act because it dealt with matters under the jurisdiction of the Budget Committee.
$900 million Youth Employment and Skills Crime Prevention, on grants for job training, apprenticeships, occupational skills, and job experience targeted at youth in high crime, high unemployment areas.	$1 billion for summer youth employment.
$300 million for the National Community Economic Partnership, providing lines of credit through the Department of HHS to non-profit "community development corporations" for distressed communities.	$2.536 billion for Community Economic Development Grants.
$1.8 billion for the Local Partnership Act providing revenue sharing grants to localities for education, drug abuse treatment, and job training programs.	$500 million for summer school and pre-school program, $500 million for Head Start, $32 million for Community Service Employment for Older Americans, $200 million for AIDS: Ryan White Act, $15 million National Commission on Community Service.
$895 million for the Model Intensive Grant Program providing grants to fund up to 15 model programs in high crime areas. Funds can be spent on almost anything that can be justified as "crime related" including: drug treatment, deterioration or lack of public facilities, and public transportation.	$845 EPA revolving funds/construction grants, $736 million Mass Transit, $270 million in discretionary Dept. of Transportation grants, $423 million Supportive Housing, $6 million very low income housing repairs, $141 million SBA loans.

Note.—Senate Budget Committee Minority Staff Preliminary Analysis, August 3, 1994.

Mr. HATCH. Madam President, I commend my colleagues in the House for their leadership in sending a signal to the administration that Americans want a tough crime bill, not a soft-headed one.

I yield the floor.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

The Senate continued with the consideration of the bill.

The PRESIDING OFFICER. The Chair would note the Senator from Georgia controls 4 minutes.

Who yields time?

Mr. NUNN. Madam President, I am prepared to yield back the remainder of my time and go to a vote on the Bosnian amendments. There will be two of them, I understand.

But while we have Senators on the floor, I ask for the yeas and nays on the Nunn-Mitchell amendment, and as well, I am sure, on the Dole-Lieberman amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. KERRY. Mr. President, we once again face a difficult decision on the best way to help end the tragic loss of life and human suffering in Bosnia. This disastrous war has killed 200,000 Bosnians and driven 2 million from their homes. The world has witnessed events in Bosnia that we had assumed could not occur again, especially not in Europe. Ethnic cleansing, forced relocations, and concentration camps recall the horrors of another time. Unfortunately, this war has brought back all of the old demons and unleashed new despicable tools of terror as well.

There are no innocents in this conflict, but clearly the Bosnian Serbs, backed by their patrons in Serbia, must bear the lion's share of responsibility for the ongoing suffering. It is the Bosnian Serbs who continually have violated cease-fires, ignored "safe havens" and exhibited complete intransigence at the negotiating table. With utter defiance for the international community, the Bosnian Serbs have shelled civilians and attacked U.N. peacekeepers.

We must find a way to end this virtually unopposed reign of terror and reverse the collective failure of the international community to bring an end to a conflict that could spread to who knows where, perhaps Kosovo and Albania, Macedonia and Bulgaria, Greece and Turkey. The instability in the former Yugoslavia has disrupted regional trade, has revived mutual suspicions of territorial ambition, and threatens to overflow and engulf the entire region, including important American allies.

The world community has grappled with the breakup of Yugoslavia since the summer of 1991 and has searched for a resolution to the bloody war in Bosnia for 28 months. The United States, other nations, international organizations, and ad hoc groups have searched in vain for a diplomatic solution to stop the senseless slaughter and interminable suffering. The United Nations, the European Community, NATO, the combined UN-EC International Conference on the Former Yugoslavia, the CSCE, the Western European Union, and most recently the "contact group" of France, Russia, Britain, Germany, and the United States all have tried and failed to stop the violence and bring real peace to the Balkans.

The Senate has repeatedly endorsed the idea of lifting the arms embargo on the Bosnian Government as a way of creating a level playing field. I have supported this position with some reservations, but I have not supported taking that action unilaterally and without regard to international repercussions. We have discussed many times the problems with acting unilaterally—the need to maintain international cooperation in other embargoes; the danger to UNPROFOR troops, including some troops provided by our NATO allies; the fear of pushing the Russians into open support for the Serbs; and concerns about long-term damage to general international cooperation. The continued intransigence of the Bosnian Serbs, coupled with the ineffectiveness of international efforts to deal with the crisis, has shifted the balance away from these concerns and toward swift action.

I am hopeful that events have reached a critical stage, providing the President with the ability to exercise American leadership to achieve a multilateral lifting of the embargo. If that is still not possible, our actions to this end should serve as adequate notice to the world community of American intention to take this step unilaterally, if there is no other way to do so.

When the Bosnian Serbs rejected the contact group's proposed partition of Bosnia, they crossed the Rubicon and even their patrons in Belgrade have now turned against them. Yet they continue their defiance of the international community. Their actions in reimposing a siege on Sarajevo, attacking a U.N. convoy, and seizing impounded weapons should be enough to eliminate any doubt about their intention to continue the violence.

Now is the time for action. In addition to the positive steps taken by Milesovic to cut ties with the Bosnian Serbs, the Russian Government has shown an increasing willingness to take a tough line, and the Bosnia Moslem-Croat coalition has strengthened its military position. If the Bosnian Serbs refuse to accept the peace plan presented by the contact group, then the world community should take whatever action is necessary to lift the embargo and allow the Bosnian Government the right to self-defense. If the President cannot secure international agreement in a very short time on lifting the embargo, then the United States has no choice but to act unilaterally.

The Senate wants the embargo lifted, the President wants the embargo lifted, and, most importantly, the Bosnian Government wants it lifted. Whatever action we take today, the end result will be the same. The embargo will be removed and the Bosnians finally will have a fair chance.

AMENDMENT NO. 2524

Mr. DODD. Mr. President, I rise to say a few words about the events taking place in the former Yugoslavia and the legislation that we are considering at the present time.

I'd like to begin by commending the distinguished minority leader, Senator DOLE, as well as my colleague from Connecticut, Senator LIEBERMAN, for insisting that this matter remain the focus of attention of the Senate. Their efforts have made it certain that the issue of Bosnia and the plight of the Bosnian people are given the treatment and the consideration they deserve.

Mr. President, the amendment that has been proposed by Senator DOLE and Senator LIEBERMAN raises important and difficult questions that warrant the careful consideration of every Member of this body. In all candor, each time we have debated this issue, I have found myself closer and closer to agreeing to what their amendment seeks to do.

In fact, I would argue that the Nunn-Mitchell amendment currently pending before the Senate will in fact lead to the same goal that Dole-Lieberman seek; namely, loosening the strangle hold that has prevented the Bosnia Government from defending itself. Perhaps, the only real difference between the two amendments before us today is the timetable and modalities for accomplishing that goal. Furthermore, President Clinton has endorsed the approach set forth in the Nunn-Mitchell proposal.

Would we all feel momentarily better if we could say today that we were unilaterally lifting the arms embargo against the Bosnian Moslems, rather than having to wait while the Clinton administration takes additional steps—painfully slow and time-consuming steps, to work with the international community to gain support for the multinational lifting of the arms embargo against the Bosnian Government? Absolutely.

I, like others, have watched as the Bosnian Moslems have been forced from their homes and subjected to murder, rape, and unspeakable horrors. I, like others, have watched as the Bosnian Moslems have become the victims of a cruel and deliberate policy of aggression and ethnic genocide. I, like others, have watched the Bosnia Serbs as they have blatantly violated the U.N. mandated safe-havens, illegally removed arms from U.N. protection, and shot at U.N. peacekeeping forces. And I, like others, was deeply disappointed when the Bosnia Serbs recently rejected the international plan of the so-called contact group to restore peace to this war-torn region.

I share with the sponsors of the Dole-Lieberman amendment their growing frustration with the inability of the international community to bring an end to the war and bring an end to suffering of the Bosnian people.

And I am whole heartedly convinced that the arms embargo on the Bosnian Moslems, though well-intentioned when the U.N. Security Council imposed it nearly 3 years ago, was ill-conceived from the beginning and has only worsened and prolonged this dreadful conflict—and that the time has come for the embargo to be lifted.

To be candid, Mr. President, it is very easy to see the appeal of the amendment by the distinguished minority leader. After all, this amendment merely gives effect to a sentiment that many of us have certainly felt: Just lift the embargo; do it right now; and don't worry about what the rest of the world thinks.

However, upon reflection, I concur with President Clinton in the potential dangers of not trying one last time to attain international consensus. He stated in his letter to Senator NUNN that—

> (L)ifting the embargo unilaterally would have serious implications going well beyond the conflict in Bosnia itself. It could end the current negotiating process which is bringing new pressure to bear on the Bosnian Serbs. Our relations with our Western European allies would be seriously strained and the cohesiveness of NATO threatened. Our efforts to build a mature and cooperative relationship with Russia would be damaged.

Despite our frustrations, I believe that most of us would agree that the potential for international cooperation and coordination is far greater today than it has been in many, many years. The United States deserves a great deal of credit for that fact. We should think very long and very hard before taking any action that could undo the very meaningful international cooperation that is still at work.

Make no mistake, Mr. President, lifting the embargo unilaterally will not strengthen that international cooperation. It could, in fact, be a major setback to such efforts. And that is not in anyone's interest, least of all the people of Bosnia.

Mr. President, regardless of what anyone in this Chamber thinks about the Nunn-Mitchell amendment or the Dole-Lieberman amendment currently before us, there can be no disagreement over one fact: What is happening in Bosnia today is an unthinkable tragedy. Thousands of innocent civilians have been killed and countless more have been tortured, raped, or brutally uprooted from their homes. The aggression and the genocide in Bosnia must be stopped.

But the question before us today is not whether we approve of genocide or even whether we approve of all the actions that have been taken in Bosnia by the United Nations and by our partners in the international community. The question before us is whether we can do more to help Bosnia by working in cooperation with the international community, or by going it alone.

As much as in my heart I would like to be able to support the unilaterally lifting of the embargo, I continue to believe that the Nunn-Mitchell amendment is the right approach. It gives the Clinton administration our support as it endeavors one last time to lead the international community toward a policy that is the only morally right thing to do; namely, lifting the arms embargo against the Bosnian Moslems. If he should fail in that effort, then the time will be at hand for the United States to lift the embargo unilaterally, and I am confident that the President will take that course of action.

Mr. STEVENS. Madam President, I am prepared to yield back the remainder of time, if any remains on this side, on the Bosnian amendment.

Could we set a time for the vote on the Bosnian amendment? I think Members need notice to get back.

Is all time yielded back?

The PRESIDING OFFICER. The Chair would notify the Senator from Georgia that we did get consent to consider the yeas and nays for both amendments. The yeas and nays are pending.

The Chair now asks: Is there a sufficient second? There is a sufficient second.

The yeas and nays were ordered.

Mr. NUNN. Madam President, I yield back the remainder of my time on the Bosnian amendment.

Mr. STEVENS. Is all time yielded back?

The PRESIDING OFFICER. All time is yielded back.

Mr. STEVENS. Parliamentary inquiry. Which amendment will we vote on first?

VOTE ON AMENDMENT NO. 2524

The PRESIDING OFFICER. The question now occurs on agreeing to the Nunn-Mitchell amendment No. 2524.

The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

The VICE PRESIDENT. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 56, nays 44, as follows:

[Rollcall vote No. 279 Leg.]

YEAS—56

Akaka
Baucus
Bingaman
Bond
Boren
Boxer
Breaux
Bryan
Bumpers
Campbell
Chafee
Coats
Conrad
Coverdell
Daschle
Dodd
Dorgan
Exon
Feinstein
Ford
Glenn
Graham
Harkin
Heflin
Hollings
Hutchison
Inouye
Johnston
Kassebaum
Kennedy
Kerrey
Kerry
Levin
Lieberman
Lugar
Mathews
Metzenbaum
Mikulski
Mitchell
Moseley-Braun
Murray
Nunn
Pell
Pryor
Reid
Riegle
Robb
Rockefeller
Sarbanes
Sasser
Simon
Stevens
Thurmond
Warner
Wellstone
Wofford

NAYS—44

Bennett
Biden
Bradley
Brown
Burns
Byrd
Cochran
Cohen
Craig
D'Amato
Danforth
DeConcini
Dole
Domenici
Durenberger
Faircloth
Feingold
Gorton
Gramm
Grassley
Gregg
Hatch
Hatfield
Helms
Jeffords
Kempthorne
Kohl
Lautenberg
Leahy
Lott
Mack
McCain
McConnell
Moynihan
Murkowski
Nickles
Packwood
Pressler
Roth
Shelby
Simpson
Smith
Specter
Wallop

So the amendment (No. 2524) was agreed to.

Mr. NUNN. Mr. President, I move to reconsider the vote by which the amendment was agreed to.

Mr. MITCHELL. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

VOTE ON AMENDMENT NO. 2479

The VICE PRESIDENT. The question now occurs on agreeing to amendment No. 2479 offered by the Republican leader.

The yeas and nays have been ordered. The clerk will call the roll.

The bill clerk called the roll.

The result was announced—yeas 58, nays 42, as follows:

[Rollcall Vote No. 280 Leg.]

YEAS—58

Bennett
Biden
Bond
Boxer
Bradley
Brown
Bryan
Coats
Cochran
Cohen
Coverdell
Craig
D'Amato
DeConcini
Dole
Domenici
Durenberger
Faircloth
Feingold
Gorton
Gramm
Grassley
Hatch
Helms
Hutchison
Jeffords
Kempthorne
Kerry
Kohl
Lautenberg
Leahy
Levin
Lieberman
Lott
Lugar
Mack
McCain
McConnell
Metzenbaum
Moseley-Braun
Moynihan
Murkowski
Nickles
Packwood
Pressler
Riegle
Robb
Roth
Shelby
Simon
Simpson
Smith
Specter
Stevens
Thurmond
Wallop
Wellstone
Wofford

NAYS—42

Akaka
Baucus
Bingaman
Boren
Breaux
Bumpers
Burns
Byrd
Campbell
Chafee
Conrad
Danforth
Daschle
Dodd
Dorgan
Exon
Feinstein
Ford
Glenn
Graham
Gregg
Harkin
Hatfield
Heflin
Hollings
Inouye
Johnston
Kassebaum
Kennedy
Kerrey
Mathews
Mikulski
Mitchell
Murray
Nunn
Pell
Pryor
Reid
Rockefeller
Sarbanes
Sasser
Warner

So the amendment (No. 2479) was agreed to.

Mr. DOLE. Mr. President, I move to reconsider the vote.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. STEVENS. Madam President, is the pending amendment the Thurmond amendment, Thurmond-DeConcini amendment?

The PRESIDING OFFICER (Mrs. FEINSTEIN). The Senator is correct.

Mr. THURMOND addressed the Chair.

The PRESIDING OFFICER. The Senator from South Carolina is recognized.

Mr. THURMOND. Madam President, I yield to the distinguished Senator from Arizona.

Mr. DECONCINI. Madam President, I thank my colleague, the Senator from South Carolina.

Madam President, the Thurmond-DeConcini amendment to the Defense appropriations bill would cure a conflict in law which would deny defense conversion moneys already appropriated in prior years for the Department of Labor, Office of Veterans' Employment and Training—VETS. Unless current law is changed, an important employment program for Persian Gulf era veterans discharged as a part of the defense personnel down-sizing effort will prematurely end.

The Service Members' Occupational Conversion and Training Act—SMOCTA—authorized a veteran job training program for 3 years under subtitle G of the Defense Authorization Act of 1992, Public Law 102-484. However, the Defense appropriations bill for fiscal year 1993, Public Law 102-396, required obligation of all moneys made available under the bill for defense conversion within 2 years before September 30, 1994.

While SMOCTA was initially authorized as a 3-year program, the appropriations act only made funds available for 2 years. Unless the Congress and the President act immediately to correct this error, SMOCTA and the veterans it serves so effectively will be stripped of over $22.5 million of the $75 million already appropriated for this specific purpose.

Madam President, CBO scoring rules require the projected unexpended balance of SMOCTA to be considered as new budget authority for fiscal year 1995. Prior to the subcommittee consideration of the bill, CBO estimated that $22.5 million in budget authority, and $10.3 million in outlays, would be required to continue the program into fiscal year 1995.

Madam President, I was the sponsor of the original Senate-passed veteran job training legislation, S. 2515, the Veterans Employment and Training Act of 1992, that ultimately was enacted into law as SMOCTA. S. 2515 was cosponsored by the distinguished manager of this bill, Senator INOUYE, then-VA Committee Chairman Cranston, as well as Majority Leader MITCHELL, and Senators GRAHAM, AKAKA, FORD, and BURDICK.

SMOCTA is an improved version of the Emergency Vietnam Veterans Job Training Act of 1983, later known as the Veterans Job Training Act. This act provides immediate incentives to employers to hire and train veterans in fields leading to stable, long-term employment.

SMOCTA authorized a 3-year employment and training program. Employers who hire and train veterans under this act will be eligible for payments of up to $7,500 per year to defray the costs of training. Veterans participating in an approved job training program, including apprenticeship programs, may also receive reimbursement for some work-related expenses such as special clothing, tools, bus or car fare, and child care.

Madam President, I am extremely interested in completing the program as designed and evaluating its performance prior to its reauthorization. But, that is not my only motivation to be here today. Madam President, I am here to say to men and women who put themselves on the line in the Persian Gulf war, "America appreciates you." I want to say to these brave men and women that the Congress is not kicking you out of your careers in the military without a parachute.

Madam President, I am frankly tired of a seemingly ungrateful Defense Department dumping its responsibilities for the welfare of servicemen and servicewomen the day they are discharged. Madam President, too many of the people we are letting go out of the military do not have skills one can reasonably describe as transferable. These men and women are well-disciplined workers, and only need a small boost to get them through the door to new jobs.

The Departments of Defense, Labor, and Veterans Affairs took far too long to get an interagency agreement negotiated in order to implement the program. While SMOCTA was enacted in October 1992, no veterans saw any benefit from the bill until September 1993.

Despite this slow start, SMOCTA is well underway today and has attracted significant veteran and employer interest. Since last September, over 5,902 veterans have secured training and employment. As of July 29, 1994, the Department of Labor, Office of the Assistant Secretary for Veterans' Employment and Training, reports that $40,367,765 had been obligated at an average cost of $6,879 per veteran.

During the first 2 years of the program, bureaucratic tussles and poor marketing limited the amount of funds obligated under SMOCTA. Those problems do not exist today. In the past 2 months alone, the number of national contracts has tripled, and it is anticipated that at least 25 of the Fortune 500 will be actively participating by mid-August. This represents a potential for 50,000 new private sector jobs over the next 2 years.

The program is universally supported by the veterans' community and private business. Walgreen Co., with over 2,600 stores nationwide, is actively seeking store managers to open several hundred new stores and augment staff at current locations. Walgreen supports SMOCTA and sees it as a means to hire solid employees with the training they need. Beverly Enterprises of Fort Smith, AR, estimates it will add another 30,000 employees to its current work force of 93,000. Beverly is so interested in the program, it is printing SMOCTA program materials for distribution in all of its hiring locations.

Madam President, the following companies, whose employment as a group exceeds 2.1 million individuals, also have expressed great interest in SMOCTA or have already signed agreements for national contracts for SMOCTA employment programs: Revco, Rite Aid, Mead Group, American Stores, Manor Care, Columbia HCA, the Limited Group, Bell South, Chase Manhattan, UPS, Marriott, Ameritech, Kimberly Clark, Hyatt, Nationwide Wausau, American Home Products, Proctor & Gamble, Harris Corp., Carlson Co., Baxter, Asea Brown Boveri, and the city of Miami, FL.

Madam President, SMOCTA works to put vets to work now. Apple pie just doesn't sell and other employment programs are not getting veterans through the door. Employers want skills and SMOCTA gets the employers attention. In 1992, the Senate unanimously passed S. 2515, the Veterans Employment and Training Act. VETA became SMOCTA after conference with the House on the Defense Authorization Act of 1992. I say to my colleagues, SMOCTA needs your help again. This is an opportunity to make a real difference to those Americans who have put themselves in harms way for us. Please do not let our Persian Gulf veterans down. Support the Thurmond-DeConcini amendment.

Madam President, I want to thank the distinguished Senator from South Carolina for his staunch effort, and his staff and my staff for putting this together.

I understand we are going to make a modification here in a little bit. I truly hope that the managers of this bill will ensure us that in conference this funding of $22.5 million will be made available.

Mr. STEVENS. Madam President, will the Senator mind if I make a statement on this?

Mr. DECONCINI. Of course not.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. STEVENS. Madam President, I want to state to the Senate that I fully support the matter raised by the distinguished ranking member of the Armed Services Committee.

We considered this matter in our subcommittee markup at the urging of the senior Senator from Arizona. I commend him for his efforts in this regard.

At that time, Senator INOUYE and I pledged our support to identify sufficient funds in our conference to fulfill the authorization for the Service Members Occupational Conversion and Training Act.

I commend the Senator from South Carolina for his perseverance, and the Senator from Arizona for his support. I want to renew my pledge that we will work with them in conference to try to achieve their objectives.

Mr. THURMOND addressed the Chair.

The PRESIDING OFFICER. The Senator from South Carolina is recognized.

AMENDMENT NO. 2520, AS MODIFIED

Mr. THURMOND. Madam President, I appreciate the remarks of my colleagues regarding funding for the SMOCTA program. I understand the concerns expressed by the managers of the bill. I know they have a difficult task in funding the requirements for our national security.

Madam President, it is my understanding that although the amendment seeks to extend previously appropriated funds, it would be scored against current year budget authority. It is also my understanding that this would cause the Defense appropriation bill to exceed the committee's budget allocation, thus subjecting the amendment to a budget point of order. Therefore, I would ask unanimous consent to modify the amendment, and send a modification to the desk.

The PRESIDING OFFICER. Is there objection? Without objection, the amendment is so modified.

The amendment (No. 2520), as modified, is as follows:

At the end of Title VIII, GENERAL PROVISIONS, add the following new section:

SEC. . It is the Sense of the Senate that of the funds appropriated by title VIII of Public Law 102–396 (106 Stat. 1899) for defense reinvestment for economic growth, the unobligated balance of the funds made available by such title for military service members occupational conversion and training shall remain available until September 30, 1995.

Mr. THURMOND. Madam President, this modification expresses the sense of the Senate that previously appropriated funds for the SMOCTA program should be extended 1 year, consistent with the authorization. This will expressly provide the conference with the will of the Senate with regard to this matter.

I appreciate the assurances of the managers of the bill that they will work in conference to resolve this issue. I thank the managers for their leadership on this matter.

Mr. INOUYE. Madam President, I join my colleague from Alaska in commending the senior member of the Armed Services Committee.

We are most pleased to accept the modified amendment.

Mr. STEVENS. I concur in that. We accept the amendment.

The PRESIDING OFFICER. If there is no further debate, the question is on agreeing to the amendment of the Senator from South Carolina.

The amendment (No. 2520), as modified, was agreed to.

Mr. STEVENS. Madam President, I move to reconsider the vote by which the amendment, as modified, was agreed to.

Mr. THURMOND. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. STEVENS. Madam President, I ask unanimous consent that Senator DECONCINI be added as a cosponsor of amendment number 2500 which was adopted yesterday.

The PRESIDING OFFICER. Without objection, it is so ordered.

SALE OF USED MACHINE TOOLS

Mr. STEVENS. Madam President, if I may, I want to raise a matter that does not directly affect my State but is a growing national problem. It is one of personal significance to me because of my family background, having been raised by a tool and die maker who was part of the tool and die industry.

I want to express my concern over recent actions taken by the Department of Defense to sell its inventory of used machine tools.

Over the past several weeks, the Department has sold more than 1,000 machine tools at auction; another 1,000 will be sold before the end of August. Thousands and thousands more are scheduled to be sold in the coming months.

I am extremely troubled about these sales—primarily for two reasons. First, the United States has a domestic machine tool industry that is being undermined and severely weakened by the dumping of these tools into the market. Second, these machines could pose significant health risks because of PCB's and other harmful contaminants they may contain.

I was prepared to offer an amendment to this bill requiring the DOD to immediately halt sales of these machine tools in its inventory until these concerns are addressed. I have reconsidered that position and shall not offer that amendment today.

But, I urge the Department to slow down with its auctions. Officials at the Commerce Department are on notice to this problem and have described to the DOD the significant adverse impact its inventory sales will have on the domestic machine tool industry—yet the DOD refuses to act. Moreover, the Environmental Protection Agency has been asked to examine the potential environmental and health consequences that could result from contaminated machines. In my opinion, the DOD would be wise to heed the concerns raised by both Commerce and the EPA.

In conclusion, the Department should stop, or at least slow down, these sales until it has evaluated the damage that these continued sales could have upon a critical American industry and upon public health.

LHD–7 AMPHIBIOUS ASSAULT SHIP

Mr. COCHRAN. Madam President, last year the Director of Central Intelligence, James Woolsey, said, "We have slain a large dragon, but we now live in a jungle filled with a bewildering variety of poisonous snakes * * *." The American military is currently engaged all over the world, from Rwanda to Korea and in many other places that are not in the news every day. We have certainly learned that the conclusion of the cold war has not ended the dangers we and our allies face daily around world.

Our military has responded to the challenges of downsizing, reducing its budget, and reducing its fixed overseas presence while taking on an increasing number of missions, some of which include a "* * * bewildering variety of poisonous snakes * * *." Along with many of my colleagues, I am greatly concerned that our defense budget has been cut too much and, consequently, readiness will suffer. Despite these challenges, the military is doing the best it can with limited resources.

A prime example of making do with limited resources is the increasing use of Marine Corps amphibious ready groups, or ARG's. ARG's, which are centered on big deck amphibious assault ships, are called upon almost every time there is a crisis somewhere. Right now, for example, there are two amphibious ready groups in the vicinity of Haiti. In fact, a recent *Wall Street Journal* article, "Marines Re-Emerge in Post-Cold War Military To Put Out Several of the World's Small Fires," points out that the amphibious assault ship U.S.S. *Inchon* returned from 6 months at sea off of Bosnia and Somalia only to steam out of Norfolk 14 days later for Haiti. Marine Pfc. Daniel Gaita is quoted in the article as saying, "In 1994, I've spent 20 days in the United States."

I ask unanimous consent the article be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See Exhibit One)

Mr. COCHRAN. A Marine Corps operational tempo that requires an amphibious ready group to go to sea 14 days after returning from a 6-month deployment is too high. Given the instability around the world, it is likely that the demand for amphibious ready groups will continue. The answer to the problem of an unsustainable schedule of operations is to procure another amphibious assault ship, LHD–7.

The purchase of LHD–7 will enable the Navy to form a 12th amphibious ready group. Witnesses appearing before the Defense Appropriations Subcommittee voiced strong support for this ship. Secretary of Defense Perry discussed the increased need for sea-based forward presence as the number of our overseas bases decline; General Shalikashvilli emphasized the need for 12 carrier battle groups and 12 amphibious ready groups to execute the forward presence mission; Secretary of the Navy Dalton stressed the desirability of having this ship and the Navy's plans to request it in its 5-year plan; and General Mundy, Commandant of the Marine Corps, made clear the military requirement for this amphibious assault ship and the necessity of procuring it in order to attain the Navy's stated goal of 12 amphibious ready groups. Quite clearly, when faced with a problem, our military and civilian leadership look for the nearest amphibious ready group as their solution of choice.

An unsustainable tempo of operations, with its corrosive effect on morale, equipment, recruiting, and readiness, is not the only reason to procure LHD–7 right away. The Navy currently has a fixed-price option to purchase the ship. By taking advantage of this option, the Navy will save, by its own estimate, approximately $700 million. Purchasing LHD–7 5 years from now, as the Navy currently plans, will increase its cost by at least 50 percent. It makes little sense to follow a procurement path which unnecessarily increases the cost to the taxpayer.

I would like to thank Senators INOUYE and STEVENS for their strong support of LHD–7. They understand the capability LHD–7 represents, not only for forward presence but also when it is necessary to transition from forward presence to warfighting. I look forward to working with them in conference to fund this ship.

EXHIBIT 1

[From the Wall Street Journal, Tuesday, July 26, 1994]

MARINES RE-EMERGE IN POST-COLD WAR MILITARY TO PUT OUT SEVERAL OF THE WORLD'S SMALL FIRES

(By Thomas E. Ricks)

ABOARD THE USS INCHON.—With the passing of the Cold War, the U.S. Marines are happily finding a central role in the new world disorder.

Just listen to Sgt. Maj. James Rogers as he sips ice water in a sergeants' mess aboard this amphibious assault ship steaming near Haiti. The Marines he supervises aboard the Inchon were the last U.S. troops to leave Somalia last March. Then they sailed to the coast of Bosnia. Now they may be the first U.S. forces to go into Haiti if the Clinton administration decides to invade.

After years of being a Cold War sideshow to the other military services, the Marines are back. "We've got a lot of little fires to put out in the world," says Sgt. Rogers, a 25-year-veteran of the Corps. "If you look at the history books, it's nothing new. We sit on ships close to hot spots, and if the president deems it necessary, we go in."

Indeed, he notes, every new Marine even today learns in basic training about the exploits of Smedley Butler, Dan Daly and Herman "Hard Head" Hanneken, who all earned Medals of Honor in Haiti the last time the Marines fought there, from 1915 to 1934.

In the public mind the Marines may still be associated with World War II and "The Sands of Iwo Jima," But for most of its history, the Marine Corps has been the force that fights the nation's small wars "From the halls of Montezuma/To the shores of Tripoli," as the Corps' hymn puts it. In the 140 years preceding World War II, the Marines made 180 landings in 37 countries, including most near the waters where the Inchon is steaming today: Cuba, the Dominican Republic, Puerto Rico, Honduras, Nicaragua, Mexico and, of course, Haiti.

"Small wars represent the normal and frequent operations of the Marine Corps," concluded the Corps' "Small Wars Manual," a 1940 effort at distilling the lessons of all those interventions.

That wasn't true for much of the Cold War, when the Corps frequently found itself shunted aside. One president tried to abolish the Marines and another used them in Vietnam in a way they disliked. The Marines never had a significant role in the nuclear chess game that for four decades dominated the thinking of the Air Force and much of the Navy.

CENTER STAGE

But with the end of the Cold War, the other services lost a big chunk of their core missions, and the Marines secured center stage. "The Army is still trying to build the main battle tank of the future, while the Marines are worried about fighting in city streets," says Rand Corp. analyst Carl Builder, author of "The Masks of War," a comparative study of the U.S. armed services. "I like that. I think they're focused on the right problem."

It is a capability also appreciated by the Clinton administration. The Corps is the only service actually to increase in size from the Bush administration's "Base Force" plan, which would have cut the Marines to 159,000 troops. The Clinton "Bottom-Up Review" plan gives them 174,000 leathernecks.

Consuming about 5% of the Pentagon budget, the Marines are accustomed to living inexpensively. They also are equipped to be expeditionary in nature, while the far-heavier Army is built to be "forward deployed" in Europe and South Korea. In fact, the Corps' biggest worry is that its Marines are used so much that many may decide to leave the service. It is a real concern: Down on the hanger deck of the Inchon, Pfc. Daniel Gaita stares out to sea and comments, "In 1994, I've spent 20 days in the United States."

The Marines aboard the Inchon returned from six months at sea on June 23, only to be sent back out on July 7 as Haiti became a full-blown foreign-policy crisis. If that sort of fast deployment "becomes a habit, it could cripple the service, long-term," worries Lt. Col. Steve Tagg, commander of the helicopter wing aboard the Inchon.

But the Marines already are lobbying Congress to give them a bigger budget to ease that burden. Far more than the other services, the Marine Corps is accustomed to justifying its existence. That is a useful skill at a time when many Americans, especially the governing elites, know little and care less about the military. There are a dwindling number of veterans in Congress, and only one graduate of West Point. But as long as the Marines avoid the problems that have plagued them in the past—a scandal among the U.S. Embassy guards in Moscow and training abuses at Parris Island—their lobby on Capitol Hill is likely to remain influential.

'A VERY DEEP ANCHOR'

Essentially, the Marines have gone back to their traditional mission of being the world's premier force at fighting small, messy wars, a development that carries especial significance for the most tradition-conscious of the U.S. military services. "The Marine Corps feeds on its history," says James Webb, a former Navy secretary and a Marine veteran of Vietnam. "What other service celebrates its birthday as the biggest day of the year? That gives them a sense of continuity—and a very deep anchor."

This knowledge of the past makes the jobs the Marines now are taking on less of a shock. The Army is still rattled by its experience in Somalia, especially the loss of 18 Rangers in a Mogadishu firefight last Oct. 3. The Marines, by contrast, seem quite content with their time in Somalia, where they were first in and last out. They went in expecting a near-combat experience, and they weren't wrong. They used their light-armored vehicles effectively, surrounding warlords, compounds and negotiating the other guy's continued presence. The Army seemed to expect lighter work akin to United Nations-style traditional peacekeeping and only received armor after the October firefight—an omission that the "Small Wars Manual" warns against.

This comfort with low-intensity conflict extends down to the small-unit level, which actually does the fighting. At a time when most of the U.S. military still tends to think in Reagan-era terms of acting only when they posses overwhelming decisive force, the Marines are at ease with the idea of using "minimal force" as Staff Sgt. Vernon Clark put it.

SPECIALIST SNIPERS

"One of the things you want to accomplish is to get the locals behind you," he says, as his platoon from India Company of the 3rd Batallion of the 6th Marines crowds around him near a CH-53 Sea Stallion helicopter parked on the flight deck of the Inchon. If fired on by someone hiding in a Haitian mob, says Sgt. Clark, he will wait for specialist Marine snipers to retaliate. "You don't want to hose 20 people to get one guy," he explains.

Sgt. Clark hasn't heard of "Small Wars Manual," but there is a copy aboard ship, brought by Lt. Col. David Young, commander of the Marine infantry force on the Inchon.

Though a half-century old, the manual is practically a guide to how the U.S might intervene in Haiti: First invade and occupy principal cities. Then simultaneously extend control over the countryside and retrain or develop the local nonpartisan army and constabulary. Next, after stability is achieved, pull back from a broad occupation and turn over control to local authorities. But keep a presence in larger cities and remain available for emergency help. Finally, supervise elections and withdraw.

"It's the kind of thing we do well," the colonel says as he eats a tuna fish from a metal cup in the officers' mess. "All these guys here have a pretty good level of confidence from Mogadishu. They were shot at every day. Some of the aura has gone away. They know it's dirty, hard work with a lot of monotony, searching people, searching vehicles."

Mr. SPECTER. Will the distinguished Republican manager of the bill yield for a question.

Mr. STEVENS. The Senator yields for a question from the senior Senator from Pennsylvania.

Mr. SPECTER. I direct the Senator's attention to the item under Navy procurement for "Modification of EA-6B Aircraft" in the amount of $38.4 million. Does the Senator understand that the appropriation of this amount assumes that the Navy will exercise its options to begin production of the Band 9/10 jammer program?

Mr. STEVENS. The Senator is correct.

Mr. SPECTER. I thank the Senator.

Mr. DOMENICI. Madam President, I would like to seek the support of the distinguished subcommittee chairman and ranking member for an innovative program in the Department of Defense. The program is the Army Environmental Policy Institute [AEPI], which has focused on important environmental policy issues for the military since its founding several years ago.

Mr. INOUYE. I would be pleased to discuss the Army Environmental Policy Institute with the Senator from New Mexico.

Mr. DOMENICI. The distinguished chairman and ranking member are aware of my support for the work of the Army Environmental Policy Institute. I urged the subcommittee to consider funding to support two priority projects for the Institute. The first project would require $3 million and would address the technologies and policies relating to the demilitarization of conventional weapons and ammunition in the United States and abroad. The second study would require $750,000 to study the environmental consequences of the accident at the Tomsk nuclear reactor in the Russian Republic and involve the collection of data useful in developing an effective response to a comparable United States nuclear disaster. The University of New Mexico and the University of Alaska have talented researchers that would work on these initiatives.

Due to overall budget constraints, the subcommittee was unable to accommodate this additional funding.

Mr. INOUYE. The Senator from New Mexico is correct. The committee has supported the budget requests for the Institute in the current and prior fiscal years. For 2 years, we included special funding so that the Institute could carry out an important study on the effects of depleted uranium on the battlefield, recognizing this possible health hazard long before the Gulf War Syndrome emerged as a public concern. I hope the Army will be able to continue its support for the Institute.

Mr. STEVENS. I would also urge the Army to continue its support for the Institute. I am particularly interested in the proposed study of the Tomsk nuclear disaster since the toxic byproducts of this accident threaten the waters of the Arctic Circle, including those that border Alaska.

Mr. DOMENICI. I thank the distinguished chairman and ranking member for their attention to this important issue. I note that the Senate Armed Services Committee supported the Institute by authorizing an increase in base operating funds to a total of $4.7 million. I hope that my colleagues will give careful consideration during conference to the AEPI budget and the two priority projects that we have discussed.

AMENDMENT NO. 2521

(Purpose: To state the sense of the Senate concerning Japan fulfilling its commitments under the Host Nation Support Agreement it signed with the United States on January 14, 1991)

Mr. STEVENS. Madam President, I call up the amendment No. 2521 offered by the distinguished Senator from Delaware [Mr. ROTH].

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Alaska [Mr. STEVENS], for Mr. ROTH, proposes an amendment numbered 2521.

Mr. STEVENS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill, insert the following:

SEC. . Sense of the Senate concerning Japan fulfilling its commitments under the Host Nation Support Agreement it signed with the United States on January 14, 1991

That, the U.S.-Japan Security Treaty continues to be a strong bond between our two countries, serving as a main pillar of the bilateral relationship;

That, the bilateral relationship is of vital importance to both countries and to the stability of the Asia Pacific region and the entire world;

That, Japan's willingness to share the costs of maintaining forces in Japan is an important contribution to strengthening our security partnership;

That, it has often been asserted that Japan's host nation support for American forces provides a model defense burden-sharing arrangement for our allies;

That, Japan and the United States signed a new Host Nation Support Agreement on January 14, 1991, providing for Japan to assume—over five years beginning in Japanese Fiscal Year 1991 and ending in FY 1995—virtually all yen-based costs of maintaining U.S. forces in Japan;

That, Japan voluntarily entered into that agreement more than a year before the expiration of the previous Host Nation Support Agreement which was not as generous;

That, the Government of Japan hailed the new agreement as "a step of great significance for the overall relationship between the two countries;"

That, Japan's Defense Agency appears to have decided to decrease expenses for bearing the cost of stationing U.S. forces in Japan in its FY 1995 budget request, thereby failing to fulfill its obligations under the 1991 Host Nation Support Agreement;

That, should Japan fail to fulfill those obligations, the bilateral relationship may suffer negative consequences, particularly as current problems on the Korean peninsula may pose a critical challenge to U.S.-Japan security ties: Now, therefore, be it

Resolved, That:

(1) It is in the interest of both Japan and the United States to fully comply with all the provisions of the Host Nation Support Agreement of 1991; and

(2) Should Japan take actions that prevent it from fulfilling any of its obligations under that Agreement, the bilateral relationship may suffer harmful consequences.

Mr. STEVENS. I ask unanimous consent that this amendment be cosponsored by the Senator from New Jersey [Mr. LAUTENBERG].

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ROTH. Madam President, I rise today for myself and Mr. LAUTENBERG to offer a sense-of-the-Senate resolution regarding our burdensharing arrangements with Japan. As I believe Members of this body well understand, the United States-Japan relationship is vitally important to both our countries and to the entire world.

We have our differences over trade and economic issues—differences which are chronic, serious, and must be resolved. Yet on most other issues, particularly in the political and security realm, we share close and common interests.

Indeed, the United States-Japan Security Treaty is the bedrock upon which the bilateral relationship has been built. Our close security ties have provided the Asia-Pacific region with the stability requisite for the explosive economic growth the region has enjoyed. It has been an essential element in preventing the many territorial disputes and latent tensions in East Asia from escalating to dangerous levels. And given the problems we face on the Korean peninsula, it helps serve to bind our two countries together in confronting what is undoubtedly the world's most severe near-term security problem. Thus, I believe it essential that neither the United States nor Japan take actions that serve to undercut our close security relations.

Unfortunately, there are indications that Japan may embark on a path that could have the effect of loosening the ties that bind the critical bilateral security relationship. According to certain news reports, Japan's Defense Agency has decided to decrease its commitments to help bear the cost of stationing United States forces in Japan.

Should Japan actually follow this course, Tokyo will fail to fulfill its obligations under the Host Nation Support Agreement it signed with the United States on January 14, 1994. In that agreement Japan committed itself to assuming virtually all the yen-based costs of maintaining United States forces in Japan. Tokyo's commitment at that time was particularly commendable in that Japan had voluntarily entered into that agreement to replace a previous accord which was less generous to the United States, yet could have remained in force for well more than 1 year.

At the time, the Government of Japan issued a statement hailing the agreement because it "not only will contribute to the effective management of Japan-U.S. security arrangements, it should also be seen as a step of great significance for the overall relationship between the two countries."

It appears, however, that domestic politics in Japan may force Tokyo to renege on its pledges. The current coalition government is composed primarily of two long-time adversary parties, the Liberal Democrats and the Socialists. The greatest policy differences between the two always had to do with security matters.

In a series of stunning policy reversals to align himself with the LDP, however, Japan's Socialist Prime Minister abandoned most of his party's long-held positions on these matters. The Prime Minister stated within the last month that he would now recognize the constitutionality of Japan's Self-Defense Forces, uphold the United States-Japan Security Treaty, and abandon the party's previous call for unarmed neutrality. He also acknowledged the validity of Japan's national flag and national anthem, and recognized that official visits by Cabinet Ministers to Yasukuni Shrine, which enshrines Japanese war dead, including class-A war criminals, are constitutional.

Needless to say, not all Socialist party members have been comfortable with the Prime Minister's near wholesale abandonment of the key principles the party has held for 40 years. Perhaps more to the point, this latest coalition government could very well fall apart should the Socialists fail to back the Prime Minister's new positions during the Socialist party convention in early September. To provide the Prime Minister at least some political cover, the LDP yielded to the Socialists in one area—it agreed to hold down defense spending in Japan's fiscal year 1995 budget while boosting nonmilitary foreign aid.

The defense cuts will be severe enough that—according to one Defense agency official—United States forces in Japan will also need to share the pain. Mr. President, sharing the pain is one thing. Reneging on an agreement is quite another. If the 1991 Host Nation Support Agreement was the step of great significance for the bilateral relationship that Japan claimed it was, surely Tokyo's failure to fulfill its obligations under that agreement would do little to enhance United States-Japan relations.

I believe Japan should closely consider its position on this issue, and therefore urge my colleagues to adopt this resolution.

Mr. LAUTENBERG. Madam President, I am pleased to cosponsor Senator ROTH's amendment concerning Japan's compliance with the Host Nation Support Agreement of 1991.

This amendment states the sense of the Senate concerning Japan's apparent intent to decrease their fair share of the costs of stationing United States forces in Japan next year. I urge the managers of the bill to accept this amendment to the bill.

Madam President, this amendment is straightforward. It expresses the concern of the Senate about Japan's turnaround on its obligation for sharing the burden of its own security. Our agreement with the Japanese, signed in 1991, requires the host nation of U.S. military forces to pay for a significant portion of our overseas basing costs. As my colleagues are aware, this agreement resulted from strong congressional pressure.

Over the past 7 years, the Congress has taken decisive action in burdensharing. We have cut the cost to American taxpayers for basing U.S. forces overseas. We have ratified several new agreements with host nations. And, we have created several incentives for the administration to get tough and negotiate a better deal for the American taxpayers.

Madam President, while far from perfect, the Japanese agreement has been a good model for other host nation agreements. It offers a fair deal for the American taxpayer. Unlike our other agreements, our approach with Japan leaves the American taxpayer footing less of the Pacific defense burden. According to DOD, for example, in 1992 Japan paid 70 percent of the United States overseas basing costs and the United States paid for 30 percent of those costs. In fiscal year 1993, Japan paid for 72 percent of the overseas basing costs. Under the agreement, by 1996, Japan is supposed to pay all of those costs.

The Japanese can afford to pay for a large share of their national security. We've provided them with a protective security umbrella for several years while their economy has grown beyond all expectations. And we're still meeting our obligations—the Japanese have the strongest defense shield in the region in place, and ready. The United States has fully met its obligations to the Host Nation Support Agreement—even with the worldwide drawdown of U.S. military forces.

Madam President, the Japanese decrease in funding highlights the need for a strong, effective ambassador-at-large for burdensharing. My colleagues will recall that just 4 months ago, the administration attempted to downgrade that position within the State Department. The Congress, supported my efforts to retain the position as a full ambassador. We were right to stand firm—today our resolve will help the administration to be forceful in requiring the Japanese to meet their obligations.

Madam President, the Congress must continue to show its strong resolve in ensuring that Japan meets its obligations. If we don't take immediate action, they will interpret our inaction as disinterest. We should not send the wrong signal to Japan—we will never allow our wealthy allies to get a free ride at the expense of the American taxpayer. The United States simply cannot afford to pay a disproportionate share of Japan's national security. Our Nation has nearly a $400 billion deficit, and a $4 trillion national debt.

Without strong congressional action, the administration may not press Japan to meet their fair share of their defense burden. The Japanese model was negotiated only after years of pressure from the Congress. Still, we find ourselves having to press our longstanding ally to meet its obligations.

Even with this host nation agreement, the United States continues to pay enormous amounts of money to defend collective security interests in the Pacific. And we will still defend the nations, including Japan, in that region against threats to their security and ours as well. Given the ongoing tension with North Korea, Japan is not free of threats to its homeland. In exchange for our continued vigilance, we should expect and demand that Japan continue to meet its obligations to bear its fair share of our basing costs.

Madam President, this amendment will support the administration in negotiations with the Japanese. And it will show the American people the resolve of Congress to relieve them of a defense burden which they carried for many years. I urge my colleagues to support this amendment.

AMENDMENT NO. 2521, AS MODIFIED

Mr. STEVENS. Madam President, I send a modification to the desk and ask unanimous consent that it be adopted in lieu of the amendment that was just called up.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The amendment (No. 2521) as modified, is as follows:

At the appropriate place in the bill, insert the following:

SEC. . Sense of the Senate concerning Japan fulfilling its commitments under the Host Nation Support Agreement it signed with the United States on January 14, 1991

The Senate finds:

That, the U.S.-Japan Security Treaty continues to be a strong bond between our two countries, serving as a main pillar of the bilateral relationship;

That, the bilateral relationship is of vital importance to both countries and to the stability of the Asia Pacific region and the entire world;

That, Japan's willingness to share the costs of maintaining forces in Japan is an important contribution to strengthening our security partnership;

That, it has often been asserted that Japan's host nation support for American forces provides a model defense burden-sharing arrangement for our allies;

That, Japan and the United States signed a new Host Nation Support Agreement on January 14, 1991, providing for Japan to assume—over five years beginning in Japanese Fiscal Year 1991 and ending in FY 1995—virtually all yen-based costs of maintaining U.S. forces in Japan;

That, Japan voluntarily entered into that agreement more than a year before the expiration of the previous Host Nation Support Agreement which was not as generous;

That, the Government of Japan hailed the new agreement as "a step of great significance for the overall relationship between the two countries;"

That, Japan's Defense Agency appears to be considering a decrease in expenses for bearing the cost of stationing U.S. forces in Japan in its FY 1995 budget request, thereby failing to fulfill its obligations under the 1991 Host Nation Support Agreement;

That, should Japan fail to fulfill those obligations, the bilateral relationship may suffer negative consequences, particularly as current problems on the Korean peninsula pose a potentially critical challenge to U.S.-Japan security ties: Now, therefore, it is

The sense of the Senate that:

(1) It is in the interest of both Japan and the United States to fully comply with all the provisions of the Host Nation Support Agreement of 1991; and

(2) Should either nation wish to depart from fully complying with all the provisions of that agreement, it should engage in close consultations with its counterpart before taking any action:

The PRESIDING OFFICER. Is there further debate on the amendment? If not, the question is on agreeing to the amendment of the Senator from Delaware, as modified.

The amendment (No. 2521), as modified, was agreed to.

Mr. INOUYE. Madam President, I move to reconsider the vote by which the amendment, as modified, was agreed to.

Mr. STEVENS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 2522

(Purpose: To cap the amount to either replace or renovate the Pentagon Reservation)

Mr. STEVENS. Madam President, I call up amendment 2522, and I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Alaska [Mr. STEVENS] proposes an amendment numbered 2522.

Mr. STEVENS. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place, add the following: "None of the funds appropriated in this Act may be transferred to or obligated from the Pentagon Reservation Maintenance Revolving Fund, if the total cost over the life of the project for the replacement or renovation of the Pentagon Reservation shall exceed $1,009,000,000."

PENTAGON RENOVATION DOLLAR CAP

Mr. STEVENS. Madam President, I want to offer an amendment today to cap the total amount to either replace or renovate the Pentagon reservation.

My amendment places a dollar cap on this ongoing project at $1.218 billion. I remain concerned about this very expensive renovation project, especially since the price tag keeps rising.

In the March 1994 annual report to Congress on the status of the Pentagon renovation project, DOD reported estimated total construction costs of $1.009 billion. However, in late May, when they briefed the committee, DOD cited overall costs at $1.2 billion, price growth of almost $200 million, 19 percent in less than 3 months.

I feel we must constrain the process. There is always the temptation to improve or change the renovation plan in the midst of construction, which ends up costing the taxpayers more money. I suggest that we hold DOD accountable to bring this project in at cost.

There are many who criticize a billion dollar Pentagon renovation project in a time of shrinking defense dollars. However, the building is now 51 years old and needs work. Many of its corridors are lined with asbestos, it doesn't meet fire and safety requirements, the building leaks and the electrical system is severely overwhelmed. It must be brought into full compliance with the Americans With Disabilities Act.

We have placed a great emphasis in this bill on supporting readiness, combat effectiveness and quality of life for the military at the expense of other worthwhile military and domestic requirements. While I recognize the necessity of renovating the Pentagon, there are just too many other national priorities not to set some spending limits on this project.

I urge adoption of the amendment.

AMENDMENT NO. 2522, AS MODIFIED

Mr. STEVENS. I ask that the amendment be modified, and I send it to the desk.

The PRESIDING OFFICER. Without objection, the amendment is so modified.

The amendment (No. 2522), as modified, is as follows:

At the appropriate place, add the following:

"SEC. . None of the funds appropriated in this Act may be transferred to or obligated from the Pentagon Reservation Maintenance Revolving Fund, unless the Secretary of Defense certifies that the total cost for the planning design, construction and installation of equipment for the renovation of the Pentagon Reservation will not exceed $1,218,000,000."

The PRESIDING OFFICER. Is there further debate? If not, the question is on agreeing to the amendment, as modified, of the Senator from Alaska.

The amendment (No. 2522), as modified, was agreed to.

Mr. STEVENS. Madam President, I move to reconsider the vote by which the amendment, as modified, was agreed to.

The PRESIDING OFFICER. Without objection, the motion to lay on the table is agreed to.

Mr. STEVENS. Madam President, I ask unanimous consent that Senator HUTCHISON be listed as a cosponsor of the McCain amendment No. 2500.

The PRESIDENT OFFICER. Without objection, it is so ordered.

Are there further amendments?

Mr. DOMENICI addressed the Chair.

The PRESIDENT OFFICER. Senator from New Mexico is recognized.

AMENDMENT NO. 2507

(Purpose: To maintain the viability of the Nunn-Lugar Cooperative Threat Reduction Program is Russia and Ukraine by expanding the sources available for transfer to the program)

Mr. DOMENICI. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI] proposes an amendment numbered 2507.

Mr. DOMENICI. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 19, line 10, delete the period, and add the following new proviso: ": *Provided further*, That to the extent that Congress fails to approve the transfer of any part of $400,000,000 originally provided in section 9110(a) of the Department of Defense Appropriations Act, 1993, authority is provided for the Secretary of Defense to transfer funds made available in this Act, or for the President to transfer funds available for assistance to the Russian Federation in any other Appropriations Act, to this account for the Cooperative Threat Reduction "Nunn-Lugar" program: *Provided further*, That any transfer made by the Secretary of Defense under the foregoing proviso shall be subject to the limitations and the reporting requirements stipulated in section 8005 of this Act: *Provided further*, That the authority to make transfers pursuant to this provision is in addition to any other transfer authority of the President and the Secretary of Defense."

THE NUNN-LUGAR PROGRAM IS IN TROUBLE

Mr. DOMENICI. Madam President, I am going to withdraw this amendment, but first I want to make a point. Among the finest hours in my time in the U.S. Senate were when we voted in $1.2 billion over 1992–1994 for the Nunn-Lugar amendment cooperative threat reduction program. It was supposed to put money into projects that would dismantle Soviet nuclear and chemical weapon systems. I regret to inform the Senate that, as of right now, out of that $1.2 billion, which was first programmed about 4 years ago, $70 million has been spent to this point—not $700 million, but $70 million. Only $370 million has been obligated.

There have been all kinds of bureaucratic problems, which I understand, but also Congress has, to some extent, reneged on this program, because more than $500 million of that $1.2 billion never materialized.

This amendment would merely have given the President some additional flexibility to use other moneys that are destined for Russia and the Ukraine. It would have given him the latitude to use it, some of it, if he thought it was necessary and there were not sufficient funds, and dismantling could occur. The Senate agreed to a similar amendment on July 15 by a vote of 56 to 38.

Sooner or later, we better get serious about this program. I do not know what is wrong with it. But clearly something is going wrong up here between the authorization and the appropriation processes and across the river between the policy people and the implementing people. They are not getting the work done.

I did not want to see the President short of money because this is probably the single most important activity of the United States the former Soviet States. We are not doing very well at helping them dismantle nuclear weapons, as I will explain in a moment.

Madam President, this amendment would have given the President the flexibility he may soon need to keep alive the vital Nuclear Threat Reduction Program in Russia and Ukraine.

There is $400 million in new money in this bill for the Nunn-Lugar program. Of the $1.2 billion made available for this vital program in between 1992 and 1994 by this subcommittee, more than $500 million never materialized.

WHAT HAPPENED TO THE NUNN-LUGAR PROGRAM?

What happened to the Nunn-Lugar program? After all, Congress made available some $1.2 billion over the 1992 to 1994 period for the Nunn-Lugar threat reduction program. Only $70 million has been spent to date.

Well, this is what happened. The first $800 million of those funds were not direct, new appropriations. They were transfer authority from other defense department funds.

Today, the President and most of us realize that we need every dollar of our defense funds to pay for a deteriorating defense structure that faces deployment in Haiti, Bosnia, and Korea—A structure that will have to call up the reserves to fulfill its growing number of missions abroad.

As a result of the financial squeeze on defense, the defense appropriators have drawn the line. Last year, the transfer authority for the 1992 Nunn-Lugar $400 million was canceled. Only about $200 million had been used for Nunn-Lugar, so the program lost half of its 1992 funding. That's one of the things that happened.

Last year, the appropriators put very strict conditions on the transfer of Nunn-Lugar funds under the 1993 authority. Those conditions were retained in my amendment.

As a result, some $318 million in requests for essential Nunn-Lugar programs have been frozen since March 17, 1994, because there is no agreement among the relevant committees on where to find the money.

Madam President, it has taken over 2 years to get the Russians to the point where they are convinced that this threat reduction program is in their own interest. There was a lot of suspicion about our motives.

It has taken 2 years to negotiate the detailed agreements to begin safeguarding and destroying nuclear warheads and chemical weapons in Russia and Ukraine. Finally, the Nunn-Lugar program is ready to roll. Unfortunately it is broke until this bill is enacted.

We already have legal agreements to spend $1 billion to reduce the threat from excess nuclear and chemical stocks. Negotiations are approaching completion on the remaining $400 million in Ukraine, Russia, Kazakhistan, and Belarus. But, we don't have the resources in the defense budget to pay for all of these programs, unless we reduce readiness, pull back from the protection of Korea, or end participation in international peacekeeping. The managers made that point very eloquently in their opening statements.

PROBLEMS EXIST, BUT PROGRAM MUST GO FORWARD

The superb staff of the Appropriations Committee have worked with our Budget Committee staff to identify and correct deficiencies in implementation of the Nunn-Lugar program. The policy direction for this program in the Department of Defense suffers from some of the same problems that Senators McCONNELL and LEAHY have identified in the Department of State.

Like several other appropriators, I am uncomfortable with the use of Nunn-Lugar funds for officer housing. That effort is already funded at more than $160 million in the foreign operations bill. It was unwise to borrow funds dedicated for nuclear reactor safety in Ukraine to make an advance payment on officer housing programs.

Another questionable effort by the Nunn-Lugar program is the establishment of a defense enterprise fund that appears to lack the independence and adequate capitalization that enabled the enterprise funds in central Europe to succeed. I am not sure that the Nunn-Lugar program should be funding enterprise funds.

These secondary efforts divert funds from the central purpose of the Nunn-Lugar program: that objective is to help Russia, Ukraine and the other nuclear states begin to safeguard, dismantle, and destroy weapons of mass destruction and their delivery systems. That is why the Nunn-Lugar program is as important to American security as it is to the security of the former Soviet Union.

In another month there will be a summit meeting between President Clinton and President Yeltsin. The mutual security and proliferation issues that are covered by the Nunn-Lugar program will dominate their agenda. My amendment would have given the President flexibility to determine his own priorities in America's program of assistance to Russia and Ukraine. That has been his policy, as I understood it.

Let me summarize. If sufficient funds from the current defense budget were no longer available for the Nunn-Lugar program, the President could have transferred Russian aid funds from the control of the Agency for International Development to the Nunn-Lugar Nuclear Threat Reduction Program in the Department of Defense.

This transfer authority in this amendment and the one approved by the Senate on July 15th was discretionary; the President would not have to use it, unless he is convinced that the Nunn-Lugar program will fail without the full $400 million first approved in 1993. The amount of any transfer would have been limited to the $318 million not yet transferred under the original 1993 authority.

Madam President, I am prepared to ask the Senate to again go on record in support of the vital Nunn-Lugar Threat Reduction Program, but both managers indicate a reluctance to carry this issue to conference. They have requested me to withdraw the amendment, and the administration withholds its support.

I withdraw the amendment.

The amendment (No. 2507) was withdrawn.

AMENDMENT NO. 2514

(Purpose: To require the Administration to budget for the cost of humanitarian, peacekeeping, peacemaking operations, and operations other than war in which Armed Forces of the United States are or will be participating, and for other purposes)

Mr. STEVENS. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Alaska [Mr. STEVENS] for Mr. DOLE, proposes an amendment numbered 2514.

Mr. STEVENS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place insert the following new section:

SEC. . REQUIREMENT TO INCLUDE IN THE ADMINISTRATION'S DEFENSE BUDGET REQUEST FOR THE COMING FISCAL YEAR THE COST OF INVOLVEMENT BY ARMED FORCES OF THE UNITED STATES IN HUMANITARIAN, PEACEKEEPING, PEACEMAKING OPERATIONS, AND OPERATIONS OTHER THAN WAR.

(a) REQUIREMENT.—The President shall, when submitting to the Congress the budget for the United States Government for the coming fiscal year, include in the budget the cost of involvement and participation by the Armed Forces of the United States in ongoing or anticipated operations outside the United States as specified below—

(1) operations to provide humanitarian aid;
(2) peacekeeping operations;
(3) peacemaking operations;
(4) operations other than war;
(5) and any operation, other than normal troop movements, rotations, or exercises, in which U.S. military involvement during the fiscal year is anticipated.

(b) CLASSIFIED ANNEX.—If the President or the Secretary of Defense determine that disclosure of the information required in paragraph (a) of this section could reasonably be expected to damage the national security of the United States, the President shall provide the information in a classified annex.

Mr. STEVENS. Madam President, I ask unanimous consent to withdraw that amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2514) was withdrawn.

Mr. INOUYE. Madam President, I ask unanimous consent that the remaining committee amendments be considered, en bloc, and agreed to.

The PRESIDING OFFICER. Without objection, it is so ordered.

So the committee amendments were agreed to, en bloc.

FLIPPING THE U.N. PEACEKEEPING COIN: U.S. PARTICIPATION IN MULTILATERAL OPERATIONS

Mr. PRESSLER. Since taking office, the Clinton administration has committed—all will—our resources and our troops to U.N. peacekeeping operations without clear guidelines and objectives meriting U.S. participation. Remember Somalia? Will Haiti or Rwanda be next? This cannot continue.

The current conflicts in Haiti and Rwanda are operations where random U.S. commitments must not continue. A coin-flipping decision process seems to determine U.S. participation in peacekeeping operations. Heads we support. Tails we oppose.

I am tired of Administration lip service regarding U.S. support for peacekeeping operations. I am tired of policies that say one thing and actions which practice something else. The next few weeks will be a testing time for the Clinton administration. Will the President stand firm and adhere to policies outlined both in the recently signed Foreign Relations Authorization Act and the recently endorsed administration decision directive on reforming multilateral peace operations?

Already, President Clinton has failed the first test of resolve. With regard to Rwanda, the administration breached the integrity of the Foreign Relations Authorization Act—an act the President signed into law less than 4 months ago.

Specifically, the new law (P.L. 103-236) requires the Permanent Representative to transmit the text of any resolutions and reports prepared by the United Nations pertaining to U.S. involvement, logistics/and or troops, in peacekeeping operations to Congress 3 working days after a resolution is adopted by the Security Council. Additionally, the President—except in emergency situations—must submit cost assessments to Congress at least 15 days before any obligation of U.S. funds or before any actions are taken under articles 42 and 43 of the U.N. Charter involving U.S. troops.

Furthermore, the law requires the President to report each operation's expected duration, mandate, command and control arrangements, overall cost, and the cost to the United States. In addition, the report must include a detailed description of the functions to be performed by any U.S. Armed Forces used in support of an operation, as well as U.S. troop number and cost estimates.

This Member of Congress received only vague details from the administration concerning peace keeping in Rwanda, and this came 4 days after the United States agreed to U.N. Resolution 918 which called for an expansion of the UNAMIR operation. There was no consultation with Congress. No emergency waiver from the President. No concrete details of any kind.

In light of heavy criticism launched against President Clinton and his foreign policy team, one would think the administration would exercise extreme care in adhering to the new reporting requirements outlined in the Foreign Relations Authorization Act. How can Congress support a multilateral peacekeeping operation unless Members are able to assess an operation's costs, objectives, goals, duration, and effect on our national interests? The answer is simple. We can't.

The administration must not disregard these new rules. Congress would not have included the reporting requirements in the Foreign Relations Authorization Act if Members did not intend on using the reports to make informed decisions about multilateral operations. Certainly, one can overlook the administration's lack of systematic compliance with regard to Rwanda. But where does that leave Congress? When do we stop overlooking and start expecting action from the Executive Branch?

In a similar vein, President Clinton recently signed and endorsed Presidential Decision Directive 25 [PDD 25] which outlines his administration's policy on reforming multilateral peace operations. PDD 25 addresses six reform areas including management and funding reforms as well as reforms guiding determinations of U.S. support in regional conflicts. The guidelines set forth in PDD 25, however, are insufficient to serve as policy.

While I have reviewed an unclassified copy of the Executive summary of PDD 25, the full text of the directive remains classified. Again, it is difficult for me, as a Member of Congress, to support fully the specific components of this directive since we simply do not know the details of this policy. It is extremely important that PDD 25 provide a clear directive for determining the extent to which the United States will support multilateral peacekeeping operations.

Although, for example, the administration claimed the criteria in PDD 25 were factored into the decision to support U.N. Resolution 918, how can this be verified by Congress? How can we verify the administration's criteria in its decision to send troops into Haiti? How can Congress travel the same road as the President if the troop authorization road map remains unavailable for evaluation?

At best, PDD 25 is a first step in the reform process. However, it by no means should be heralded as policy, given the ambiguous language, inadequate detail, and loose guidelines outlined in the Executive summary. The United States needs a firm and consistent policy to guide our involvement in conflicts abroad. We simply cannot spend U.S. dollars and risk American lives any longer without clear mandates and cost estimates.

The situations in Rwanda and Haiti present President Clinton the unique opportunity either to begin an intervention policy of caution and prudence or to continue proceeding along the same random foreign policy path. Continued pressure and insistence from President Clinton and Ambassador Albright are essential to ensure that multilateral operation and management reforms are taken seriously.

If the United Nations is to be an effective international body, U.S. support, funding, and leadership are necessary. The administration's coin-flipping foreign policy mentality should no longer guide our peacekeeping involvements. We owe it to U.S. taxpayers to ensure that our support for U.N. operations is not wasted.

DESTRUCTION OF NEUTRALIZED CHEMICAL WEAPONS

Mr. BROWN. The bill before us includes a provision prohibiting the study of the transportation of unitary chemical weapons for destruction purposes. As many have pointed out, the issue of destruction has been studied extensively. Although this provision does not appear to preclude the study of neutralized chemical weapons, the lawyers at the Defense Department have expressed their concern that this language may be construed to prevent such a study.

It is an important question, especially to the men and women of Pueblo, CO. The Pueblo Depot Activity located on the outskirts of Pueblo is one of those bases slated for realignment and for the destruction of its chemical weapons. But before we proceed with building a very expensive chemical weapons incinerator in Pueblo, it makes sense to thoroughly study other alternatives—especially the possibility of first neutralizing unitary chemical weapons and then transporting them for destruction at existing disposal facilities.

Instead of offering a clarifying amendment to ensure that the neutralization and subsequent transportation of the neutralized portions can be studied despite restrictions in the bill, I would like to ask the chairman of the Defense Appropriations Subcommittee to enter into a colloquy with me that clarifies the intent of exiting bill language.

Mr. INOUYE. As noted by the Senator from Colorado, there is a provision in the bill currently before the Senate restricting the study of transporting unitary chemical weapons for destruction. This provision was never intended to restrict the study of transporting neutralized chemical weapons for destruction. In my view, this provision in no way restricts such a study.

Mr. BROWN. I thank the distinguished chairman for his insights. It is clear to me that as it stands, the provision does not restrict the study of transporting neutralized chemical weapons. I yield the floor.

NATIONAL PRESTO ENVIRONMENTAL CLEAN UP

Mr. KOHL. I would like to engage the distinguished chairman of the Defense Appropriations Subcommittee in a colloquy on an issue he has worked on over the years, the environmental clean up of a site formerly used by the Army in Eau Claire, WI, now owned by National Presto Industries.

During World War II, the facility was owned and operated by the Army as a manufacturing site for the production of small arms ammunition and radar tubes. Subsequently the facility was activated during the Vietnam conflict, and National Presto, working on contract to the Army, manufactured 105mm projectile metal parts.

As a result of this production, the Eau Claire site is heavily contaminated with suspected carcinogens and is a Superfund site. In 1988, the Army and National Presto signed an agreement in which the Army agreed to cooperate in seeking whatever funds might be required to complete the full remediation of the Eau Claire site. Unfortunately, the Army has not honored that agreement.

Mr. INOUYE. I am familiar with the problem at the Eau Claire site and with the 1988 agreement signed by the Army and National Presto. Also, I am aware that the Army has not sought funds for clean up activities.

Mr. KOHL. In acknowledging its responsibility to clean up the Eau Claire site, the Army and Congress made $12 million available between the years 1988 and 1993 for remediation efforts. Does the chairman agree that the Senate Appropriations Committee has tried to assist in meeting the requirement to restore the environmental damage at this site.

Mr. INOUYE. The Senator from Wisconsin is correct. In its fiscal year 1993 report accompanying the Defense appropriations bill, the Committee stated:

> The Committee is deeply disturbed by the failure of the Army to comply with the direction in last year's conference report to proceed with environmental restoration activities at the National Presto Industries facility at Eau Claire, WI. The Committee views the obstruction of the Army in this matter as in direct contravention of Congressional intent.

Mr. KOHL. I appreciate the chairman's willingness to take such a strong stand on this issue in the past. According to National Presto, $15 million would complete the clean up of this site and return it to productive use. The House fiscal year 1995 Defense appropriations bill includes $7 million for environmental remediation of the Presto site in its version of the bill. I am committed to seeing that the potential health and safety risks faced by my constituents are fully remedied at the earliest possible date. I urge my colleague to support this funding during the conference on the bill, and, as in the past, make it binding in bill language.

Mr. INOUYE. I commend the distinguished Senator's desire to see the cleanup of this site completed expeditiously. I will give his views every consideration during the conference with the House.

Mr. KOHL. I thank the Senator from Hawaii for his comments.

MILSTAR SATELLITE SYSTEM

Mr. LEAHY. Mr. President, yesterday I supported an amendment offered by Senator BUMPERS to terminate the MILSTAR satellite system. As an original cosponsor of this measure, I strongly feel that the Senate has an important opportunity to save billions of dollars without sacrificing national security.

Mr. President, the Bumpers amendment brings the Defense budget in line with reality. Why should the American taxpayer spend billions on a system that was designed specifically to fight a protracted nuclear war?

I know the Pentagon is having a rough time adapting to the realities of a post cold war. It is hard to put 45 years of East-West competition behind an institution as large as the Defense establishment. Slowly our defense leaders are focusing more on peacekeeping, joint operability, and the unique demands of the smaller conflicts that we are likely to face in the future.

The amendment offered by Senator BUMPERS offers a reality check for the MILSTAR program. Nobody in the Senate doubts that our military forces need secure digital communications. But the MILSTAR program the Pentagon is asking taxpayers to spend billions on over the next decade does much more than provide digital communications. The two satellites that my colleague from Arkansas proposes to cut weight too much and retain several of the costly capabilities designed for the cold war but that are no longer necessary.

Our national security no longer requires communications platforms with maneuverability to avoid hostile satellites. No longer do our communications need expensive shielding from nuclear blasts. What they do need, and what will not be lost by my colleague from Arkansas' amendment, is the ability to digitally communicate with U.S. forces around the world without being jammed.

This amendment deletes funding for two of the heavy satellites that were designed in the midst of the cold war. It takes half of the money saved and applies it toward the Pentagon's new MILSTAR satellites. The American taxpayer can save between $2.4 to $3.5 billion under this restructuring, and the military will have the capabilities that they need.

I thank my colleague and friend from Arkansas for again bringing to the attention of the Senate and the country a prudent way to save the taxpayers money without compromising the capabilities of the military. He consistently evaluates defense programs against the stark realities of national necessity. I urge the rest of the Senate to vote for this amendment.

KAISERSLAUTERN MILITARY COMMUNITY IN GERMANY

Mr. WOFFORD. Mr. President, I would respectfully ask the distinguished Chairman, Senator INOUYE, to clarify some essential points on section 8007. Before doing so, I would like to congratulate him and the Ranking Member, Senator STEVENS, for their leadership on this legislation.

Mr. President, section 8007 addresses opportunities for the United States coal industry as part of badly needed energy modernization at the Kaiserslautern Military Community in Germany, by far the largest concentration of American personnel overseas. The Senate committee adopted language identical to the House, a repeat of previous year provision language which emphasizes the cost-effective use of U.S. coal as part of such modernization projects.

I ask the Chairman of the Subcommittee, since it is not mentioned in either the House or Senate reports, if the Committee is aware that within the next several weeks it is anticipated that the Air Force will complete an agreement with the City of Kaiserslautern for a major new heating system to serve the U.S. installations.

Mr. INOUYE. The Committee is aware that this is the case.

Mr. WOFFORD. I must presume that the Chairman is likewise aware that U.S. coal will be the base load energy for an expanded municipal system which will serve U.S. facilities. It must be noted with due regard for the efforts of the Subcommittee on Defense Appropriations that is was only the legislative language adopted in the 1992 annual act which has made this possible.

Mr. INOUYE. I am aware of this fact.

Mr. WOFFORD. Section 8007 once again references energy modernization for the American facilities at Landstuhl and neighboring Ramstein Air Base, both of which are a part of the large Kaiserslautern Military Community. I must state, however, that progress on these project areas has been extremely slow.

Regarding an associated issue in section 8007, the pending completion of an agreement for modern heating service for U.S. facilities in the city of Kaiserslautern, when the cost effective data is available to the committees, would the Chairman be willing to address this data in conference as it pertains to any possible additional cost-effective agreements for the use of U.S. coal in the Kaiserslautern Military Community regarding Landstuhl and Ramstein Air Base?

Mr. INOUYE. If additional information indicates that the precedent set for new hearing services for DOD facilities in the city of Kaiserslautern and the use of U.S. coal in third-party projects on a cost-effective basis is confirmed as reasonable, then certainly a comprehensive review would be in order.

Mr. WOFFORD. I would like to bring to the further attention of the Committee that while the new report language stipulates that the intent of section 8007 concerning Landstuhl and Ramstein Air Base is for competition in energy procurement, that the Air Force, in fact, has already begun a sole source procurement for Ramstein Air Base.

I respectfully note that Air Force-Europe discussions for an energy agreement with the community of Ramstein-Meisenbach call for the installation of a natural gas base energy system throughout our most important air facility in Europe. The local municipality is simply decreeing what forms of energy will be used on the air base. What is more disturbing under the terms of the act is that the municipality has made it very clear that it expects the Air Force to subsidize the purchase of a certain amount of U.S. coal for use at a non-military location in Germany.

May I suggest that these merging developments warrant an updated evaluation prior to the completion of conference.

Mr. INOUYE. I do agree that these matters should be further evaluated in light of emerging data.

Mr. WOFFORD. I thank the Senator from Hawaii.

NAVAL AVIATION

Mr. BOND. Mr. President, one of the provisions in this bill that gives me great concern is the funding for F/A–18 aircraft for the Navy. The administration requested $1.032 billion to purchase 24 F/A–18s in fiscal year 1995. These aircraft are critical to the Navy's aviation plan. Specifically, they are night strike fighters which will replace older aircraft which are slated for retirement in the near future. These aircraft are necessary to ensure that our carrier fleet can project sufficient power in the period until the newer version of the F/A–18—the E/F—is deployed in substantial numbers.

Not only do we need these aircraft in the fleet, but it is important to note that the cut is unlikely to save any money. The cut will increase the unit cost, and significantly jeopardize several foreign military sales. If any of those are lost, that would further drive up the cost to the Navy.

It is also worth noting that these 24 F/A–18s are the only fixed wing combat aircraft in the entire fiscal year 1995 DOD budget. That strikes me as a dangerously small number. To cut it further does not, in my opinion, make sense.

Last month, I wrote to Secretary Dalton regarding this issue, and I would like to read from his response. He writes.

> A reduction in F/A–18C/D quantities not only increases the Navy's cost for the remaining aircraft, but also raises the cost for foreign military sales customers, thereby putting these transactions in jeopardy. The Senate reduction shows the Navy, Marine Corps, and Marine Corps Reserve F/A–18 modernization plan, forcing deployed airwings to prolong the use of older, less capable F/A–18 aircraft and thereby decreasing our warfighting capability.

I am fully aware that the Appropriations Committee was constrained in writing this bill by the fact that only 17 aircraft were authorized. However, I have shared this information with our colleagues on the defense authorization conference, and I remain hopeful that they will agree to authorize 24 aircraft.

I would ask the chairman and the ranking member if they would comment on this issue.

Mr. INOUYE. I would agree with the Senator from Missouri that the F/A–18C/Ds are very important to the Navy's ability to project power through our carrier fleet. It is important that we maintain capable aircraft on the carrier decks. This bill does that by fully funding the F/A–18E/F development program; and, in the near term, by funding as many F/A–18C/Ds as possible with the money provided. I share the Senator's concern about the small number of combat aircraft we are purchasing in this budget, and I assure him that I will work to see that the Navy gets all the F/A–18 aircraft it needs.

Mr. STEVENS. Mr. President, I share the view of the chairman. The Senator from Missouri has touched on an important issue. With the cancellation of the A/FX and the planned retirement of the A–6, the F/A–18 has become the centerpiece of the carrier aircraft force. We must ensure that the Navy has the modern versions of the F/A–18 in sufficient quantities to perform its mission.

Mr. BOND. I thank both of my colleagues, and I ask that the full text of the letter from Secretary Dalton be included in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

DEPARTMENT OF THE NAVY
Washington, DC, August 8, 1994.

Hon. CHRISTOPHER (KIT) BOND
United States Senate, Washington, DC.

DEAR SENATOR BOND: Thank you for your letter of July 11, 1994 concerning the Senate Authorization Bill recommendation for procurement of 17 F/A–18C/D "Night Strike" fighters instead of the 24 requested in the FY 1995 President's Budget.

We share your concern and have appealed to the Defense Authorization Conferees, urging support for the House position for 24 F/A–18C/D Night Strike fighters. Based on similar Senate Appropriations Committee recommendations of 17 aircraft, we are also sending an appeal to the Defense Appropriations Conferees urging them to support the President's Budget request.

A reduction in F/A–18C/D quantities not only increases the Navy's cost for the remaining aircraft, but also raises the cost for foreign military sales customers, thereby putting these transactions in jeopardy. The Senate reduction slows the Navy, Marine Corps, and Marine Corps Reserve F/A–18 modernization plan, forcing deployed airwings to prolong the use of older, less capable F/A–18 aircraft and thereby decreasing our warfighting capability.

The request for 24 F/A–18C/Ds is based on the requirement for the most modern Hornets to serve the front-line operational squadrons. Modernization with the newest F/A–18's is essential to provide the Fleet with capabilities of the "Night Strike" F/A–18C/D's more powerful engines, upgraded radar, AIM–120 AMRAAM missiles, a Forward-Looking Infrared (FLIR) sensor with a laser for self targeting, multi-sensor integration and growth provisions for a positive identification system. Also, continued procurements of F/A–18C/D aircraft will provide an important industrial bridge to the follow-on F/A–18E/F production.

As always, if I can be of any further assistance, please let me know.

Sincerely,

JOHN H. DALTON,
Secretary of the Navy.

DOD APPROPRIATIONS BILL AND THE B–1 BOMBER

Mr. PRESSLER. Mr. President, I rise today to speak in support of the B–1 1 Bomber. I am pleased to report that the readiness exercise involving the B–1 bomber, currently taking place at Ellsworth Air Force Base in my home State of South Dakota, is progressing impressively. For those of my colleagues who do not know, this test was mandated by last year's Defense authorization bill. Many doubters believed the test would put the final nail in the B–1 coffin. Fortunately, they were wrong. In fact, 2 months into the test the B–1 is demonstrating a mission capable rate of nearly 85 percent—approximately 10 percent above the standard established by last year's Defense authorization bill.

Because of the success of the test currently being conducted, it is now clear that if the B–1 is provided the parts and logistical support it requires to perform its mission, it can do so with flying colors. However, with the exception of the ongoing test, the B–1 has never been provided adequate funding for spare parts or logistical support.

I am concerned about the Senate version of the fiscal year 1995 Defense appropriations bill. The language in the bill fully funds the request for bomber modification and modernization programs and then fences the funding for all new upgrades pending the completion of a cost and operational effectiveness assessment [COEA]. This fencing will disrupt the Conventional Munitions Upgrade Program [CMUP], which is the overall DOD plan for converting the B–1 to a conventional bomber, for at least a year. The B–1 industrial base will be disrupted during this time frame and a team of 300 dedicated engineers would have to be disbanded.

The committee language fencing fiscal year 1995 appropriations for all new starts would halt the following modifications: first, Cluster Bomb Units; second, Secure Communications Radio; third, Global Positioning System; fourth, Joint Direct Attack Munition [JDAM]; and fifth, Electronic Countermeasures Upgrade [ECM].

These programs are fundamental to converting the B–1 to a conventional bomber. I cannot understand why anyone would want to stop the conversion of the B–1 at this point in time.

A robust bomber force is required for the defense of the United States and for the projection of American power worldwide. The adequacy of our current and projected bomber force is a matter of significant concern to many Members of Congress. I voted in favor of funding a contingency production industrial base program for the B–2. If we are going to consider contingencies to protect the B–2 industrial base, we should, in that same spirit give equal consideration to protecting the B–1. In the opinion of General Mike Loh, Commander of Air Force Air Combat Command, the funding restriction in the Senate Appropriations Committee language cripples the B-1 upgrade program. In order for the Air Force to perform wartime missions with a significantly reduced force the B-1 must be converted to conventional capability sooner rather than later.

Mr. President, I strongly object to the inclusion of section 8101 in the fiscal year 1995 DOD appropriation bill. I urge my colleagues to reconsider the inclusion of the fencing language in this bill and to level the playing field for all bombers. I urge all conferees to consider carefully action taken today by conferees to the Defense authorization bill: they approved an administration request for $154 million in procurement and $74 million in research to upgrade the B-1 for conventional missions. I urge conferees to the Defense appropriations conference to reject any restriction on conventional upgrades to the B-1 Bomber.

Mr. ROTH. Mr. President, I intend to vote against this appropriations bill. But, before I get into the details of my concerns, I think it is important to recognize and applaud the Appropriations Committee for including $380 million in the bill to give military retirees their well deserved annual cost of living adjustment next April, instead of next October. I remain hopeful that the President will rectify the cost of living inequity through 1999 in next year's budget submission.

Mr. President, I believe the treatment accorded the B-2 bomber typifies the failure of the Congress in tackling the national defense budget. Congress makes a great deal of noise about reducing the defense budget and focusing on core national security needs, but, when push comes to shove, very few Members want to make real cuts. Congress proudly announces to the public that we have cut the unneeded programs, while funding an additional $150 million to keep contractors working on the B-2 bomber, a program that is limited to 20 aircraft, all of which have already been funded. Meanwhile, the Congress is so committed to paying for military contractors to transition into the commercial marketplace that the appropriation bill shorts funds needed to defend against a very real ballistic missile threat in the Korean peninsula and elsewhere.

Mr. President, I am also concerned about a growing double standard in this body. Members of Congress give speeches demanding ever deeper cuts in the defense budget and then rush to the floor to protect weapon systems which are manufactured in their States. If Congress continues with this business as usual approach Congress will, in effect, have arrived at a bipartisan consensus not to make needed adjustments to our national defense budget. Such a position is indefensible at a time of escalating international tension.

Mr. President, 10 days ago, Senator GRASSLEY and I released a GAO report which found that the Defense Department Future Years Defense Plan is underfunded by more than $150 billion. I am concerned that the administration and the Congress continue to avoid the tough decisions that need to be made. Meanwhile, the Clinton administration has sent troops into Rwanda and the Balkans, and we are openly discussing the invasion of Haiti and a major injection of troops into Bosnia. All the while, we face a real danger of a major military conflict in the Korean peninsula. Yet, only $1 billion is included in the 5 Years Defense Plan to cover these costs. The bottom line here is that there is not enough money to pay for the administration's national security strategy. Sooner or later the bills will come in. When they do, tens of billions of dollars will have to be found or the hollow Army of the 1970's will recur.

If we are to avoid a return to the hollow Army of the 1970's, tough management decisions will have to be made. Programs will have to be terminated, not stretched out. Major management reforms will have to occur. To sum up, Mr. President, I cannot support this Defense appropriations bill because it does not incorporate the tough decisions needed to maintain our Nation's security.

IMPACT AID

Mr. EXON. Mr. President, I would like to engage the distinguished chairman of the Defense Appropriations Subcommittee in a colloquy to clarify the Senate's intention regarding the impact aid appropriation to the Department of Defense.

It is my understanding that this bill includes an appropriation of $119 million for impact aid assistance to school districts enrolling large numbers of military-connected children, and that this amount represents an increase of $61 million over the 1994 appropriation.

Mr. INOUYE. The Senator from Nebraska is correct.

Mr. EXON. I also understand that this increase was intended to compensate for a reduction in impact aid funding of the same amount in the Labor, Health and Human Services, and Education appropriations bill for fiscal year 1995.

School districts in my State have expressed the concern that the most effective way to allocate these Department of Defense funds would be to transfer them to the Department of Education, which administers the lion's share of impact aid funding. It also seems to me that it would be better to let the Department of Education distribute these funds than to ask the Department of Defense to develop a larger, duplicative impact aid bureaucracy.

So I ask the distinguished senior Senator from Hawaii if he would agree that the additional $61 million in impact aid funding included in this bill should be transferred to the Department of Education.

Mr. INOUYE. I would agree with the Senator from Nebraska that the purposes of the Impact Aid Program—including meeting the needs of military dependent students—would best be met if these funds ultimately are transferred to the Department of Education.

Mr. EXON. I thank the Senator from Hawaii for that clarification.

Mr. BYRD. Mr. President, I commend the chairman of the Defense Subcommittee, Senator INOUYE, and the ranking minority member, Senator STEVENS, for the outstanding manner in which they have handled this very important legislation. I believe this is the earliest that we have reported and passed a Defense appropriations bill since I became chairman of the Appropriations Committee in 1989.

Balancing the competing interests that vie for attention in the context of the defense bill is becoming a more and more difficult task, since not only are we continuing the down-sizing of the department but more and more activities, particularly in the foreign policy arena, that are looking for funding have come to the Defense Subcommittee for satisfaction. There may have been as many foreign policy amendments that we have addressed in the context of Floor consideration of this measure as there have been amendments dealing with the standard fare in procurement, operations, and research that is the cache of the usual legislative format.

In the context of all these competing demands, however, the Senate could not have been better represented to adjudicate and make fair judgments as to the merits of all these competing claims than by the Senator from Hawaii and the Senator from Alaska, who manage the Defense Subcommittee so effectively. I with I could say the pressures on the subcommittee will be eased, but I fear they will grow in intensity into the future. Pressures on the defense budget and discretionary spending, in general, remain intense and until this government steps up to the agonizing task of reviewing and reforming our entitlement system or, if the economy does an unexpected burst into the black, the situation will remain difficult at best.

Mr. President, I want to point out to all Members that there are some extremely time-sensitive matters, particularly involving our involvement in Rwanda that have been addressed in this measure. I hope that it will be possible to conclude a conference on this measure before the August recess but that is, at best, uncertain. In the alternative, a letter has been sent to the President, signed by me and the distinguished ranking minority member of the full committee, as well as the chairman and ranking minority member of the Defense Subcommittee, indicating our strong believe that the reporting requirements associated with the Rwanda matter that are included in the bill be addressed by the administration, even in the absence of a conference agreement. The timelines for the remainder of this session and what Congress will, I believe, accept as a duration of the Rwanda operation are very short, and I believe that the reporting requirements will be adopted by the conference committee. If we are going to disengage from Rwanda in a responsible and effective way around the time we adjourn sine die, the administration should act on the reporting requirements in the bill beginning today.

Again, I commend the leadership of the subcommittee for a job well done.

Mr. President, I ask unanimous consent that a letter to the President be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
Washington, DC, August 11, 1994.

THE PRESIDENT,
The White House,
Washington, DC.

DEAR MR. PRESIDENT: On July 29, 1994, the Senate Appropriations Committee reported to the Senate a fiscal year 1994 Supplemental Appropriations measure incorporated in H.R. 4650, the fiscal year 1995 Department of Defense Appropriations Bill. The supplemental would provide $170 million for the Defense Department's Rwanda relief efforts. The bill also establishes congressional policy on the Rwanda relief effort, and requests three time-sensitive reports from the Administration on this matter.

Earlier today, the Senate completed action on H.R. 4650 and included the above-mentioned provisions. We firmly believe that the Congress will adopt this language as it appears in the Senate-passed bill. Therefore, we respectfully urge you to take the necessary actions to ensure that these reporting requirements are met.

Sincerely,
ROBERT C. BYRD,
Chairman,
MARK O. HATFIELD,
Ranking Minority Member,
DANIEL K. INOUYE,
Chairman, Subcommittee on Defense,
TED STEVENS,
Ranking Minority Member, Subcommittee on Defense.

Mr. DOLE. Mr. President, during this debate, much has been said about the state of readiness of our military forces. And many of my colleagues have expressed their concern over the deep cuts the administration is making in defense spending. Both sides of the aisle—Republicans and Democrats—are increasingly alarmed about the effects these cuts are having on readiness, the morale and welfare of our military personnel and their families, and on our industrial base.

Let me briefly summarize what is going on here: According to the Defense Department, the number of Army divisions was cut from 18 divisions under President Reagan, to 12 divisions under President Bush, with President Clinton cutting our Army further to 10 Active divisions. Navy ships will be cut from 546 under President Reagan to just 330 under President Clinton. Air wings will be slashed by almost half—from 24 to 13. And over 620,000 active duty military personnel will be slashed from the Armed Forces this decade. All the way down the line, our ability to fight and win is being dismantled.

Even the Washington Post joined the Washington Times in noting that the President's Defense plan is both inadequate and massively under funded. The fact is, President Clinton's defense plan is simply not sufficient to maintain American security and American leadership. The fact is, the President's defense plan will not meet his declared objectives of fighting and winning two nearly simultaneous major regional conflicts. The fact is, even this inadequate force is not funded.

According to the GAO, the budget shortfall of the so-called bottom-up review force is $150 billion.

I would ask that the full text of these articles be placed in the RECORD accompanying my remarks.

No doubt about it, the President's defense plan is hollow. His defense budget is hollow. And no one should be surprised when our forces become hollow. In fact, the administration's own blue ribbon panel on readiness recently revealed that pockets of unreadiness are already showing up in each of the services.

What is needed is leadership. You cannot just wish threats away. You can't simply hope that other countries are going to meet the challenge for us. You cannot defer American leadership and American responsibilities to the United Nations. America must lead. And to lead, America must be strong.

The administration has failed the test. This is not a serious defense plan—and this is not a serious defense budget.

The distinguished chairman, Senator INOUYE, and the ranking Republican, Senator STEVENS have each sounded a clear warning. And I commend them for their efforts in trying to craft a responsible defense bill from an inadequate budget request. Yet in the final analysis, this is an inadequate bill.

I want to send a message that it is time for the administration to face up to the facts and get serious about our national security.

There being no objection, the articles were ordered to be printed in the RECORD, as follows:

[From the Washington Times, Aug. 8, 1994]

DEFENSE CUTBACKS HAVE MANY FEARING A LOSS OF READINESS

ALARM SOUNDED EVEN BY LIBERALS

(By Rowan Scarborough)

Rep. Ike Skelton, pro-defense Democrat from America's heartland, was doing some back-of-the-envelope calculations one day this spring and was startled by what the numbers showed.

The Defense Department's so-called Bottom Up Review (BUR), the Clinton administration's forecast of long-range spending, left the Army with 495,000 active-duty soldiers by 1997, about 306,000 of whom could be deployed to regional conflicts.

Since Operation Desert Storm used 275,000 Army troops, Mr. Skelton wondered, how could the Pentagon possibly conduct two regional conflicts nearly simultaneously—the BUR's central thesis.

"It worries me. It worries me," said the plain-speaking Missourian, who influences defense policy as chairman of the House Armed Services subcommittee on military forces and personnel.

"In the briefing I got early on from my friend [Deputy Defense Secretary] John Deutch, it appeared to me you just can't do that with the numbers he's talking about," Mr. Skelton said.

Mr. Skelton has long advocated a fleshy Pentagon budget. So it is not surprising he is yelling ouch every time the Pentagon lops off a few thousand more soldiers or cuts a weapons production line.

Others are giving similar warnings. Sen. Daniel Inouye, Hawaii Democrat, the liberal chairman of the Senate Appropriations subcommittee on defense, says the Pentagon is buying so few new weapons that private industry may not be able to produce future systems.

Commenting on his panel's defense bill for next year, he said: "This bill will buy only 17 combat aircraft. This year the Army will buy no tanks—unheard of. This year the Navy will buy four ships. * * * We are staving off the collapse of the defense industrial base."

Last month, a special task force on readiness comprising eight retired generals and admirals issued a report to Defense Secretary William Perry. Already, they wrote, "pockets of unreadiness" are erupting in the Air Force, Army, Marine Corps and Navy.

The General Accounting Office, Congress' auditing agency, concluded that the Pentagon is $150 billion short of paying for the troops and weapons the BUR envisions.

"There is a general structural problem facing the department," said Larry Seaquist, a former Navy captain who recently retired from a Pentagon policy and is now a private consultant. "They've got the right objective, but continued reductions in the amount of money is really going to continue to place stress on readiness."

Added Mr. Skelton, "Money. Money. It's all money. There's no money for all this."

Some critics say the Pentagon has no intention of meeting some of the BUR's procurement targets. For example, the plan calls for an Air Force bomber fleet of 184 B-1Bs and B-2s. But the Air Force actually plans to field no more than 120 bombers by the late 1990s, according to internal budget documents cited by the Senate Armed Services Committee.

The Clinton five-year plan projects a 346-ship Navy, down 100 from the post-Cold War fleet plan by President Bush. But the figure is not correct there, either. The Navy really plans a 300-ship fleet, deciding it can make do with fewer repair ships and amphibious assault craft.

No one at the Pentagon wants to utter that awful six-letter word. But occasionally "hollow" is creeping into discussions on how Mr. Clinton's military might look in 1997 as his first term ends.

"Hollow" refers to military units in the post-Vietnam 1970s that lacked the weapons, equipment and trained personnel to make them fully operational. The readiness task force told Mr. Perry, "We are convinced that unless the Congress focus on readiness, the armed forces could slip back into a hollow status."

The question is politically important for the president.

Mr. Clinton campaigned on a platform of cutting the Pentagon's five-year budget by $60 billion more than the Bush plan. But once in office he ended up slashing $120 billion. If the budgeting gamble leads to a damaged armed forces, Republicans may make the state of the military a campaign issue, much as Ronald Reagan did in his successful 1980 campaign.

The Cold War's aftermath has not provided a breather. First there was Desert Storm, requiring 550,000 U.S. troops—the largest overseas deployment since the Vietnam War—to eject Iraqi forces from Kuwait. Then came the 1992 deployment of 30,000 soldiers to Somalia. Now the Pentagon is deploying 3,000 troops to central Africa to care for more than 1 million Rwandan refugees.

And Mr. Perry is talking about a larger role for U.S. forces in Bosnia, seeing a U.S. peacekeeping contingent of more than 20,000 troops if a treaty is signed. His staff has drawn up an invasion plan for Haiti that will require more than 15,000 personnel. And the department plans to bolster 37,000 troops in South Korea if trouble erupts with North Korea.

Humanitarian missions such as Somalia and Rwanda are themselves a drain on readiness. While such operations hone the skills of logisticians and cargo-jet pilots, they take soldiers away from training.

A Pentagon policy-maker said the Army has committed 25 percent of its logistics people to Haiti, Bosnia and Rwanda. "You'd be surprised by the large portion of active duty that is absorbed in what appears to be fairly easy logistical support," the official said.

The task force of retired officers cited several "pockets of unreadiness" that could spread across the armed forces unless the Pentagon and Congress keep a vigilant watch. Their report said the Army, for example, is putting soldiers into jobs for which they are not trained, prompting a patchwork response to servicewide "turbulence" throughout the service.

In an interview, a Navy flier disclosed another potential "pocket." He said carrier squadrons are cutting back on pilot flying hours during the time the unit is awaiting its next sea deployment. "If you don't practice, you don't stay proficient. We're getting minimal, minimal flight hours," the flier said.

A senior Navy official who requested anonymity confirmed the cutback. He said the Navy needs the money to pay for unanticipated steaming hours for ships in the Pacific in a show of force for North Korea and in the Mediterranean to support U.N. troops in Bosnia.

He said the navy is keeping two carriers, the Kitty Hawk and the Independence, on duty in the western Pacific, where normally just one would be operating.

"Readiness will be severely reduced" for some squadrons that are weeks away from a sea deployment, the official said. But he maintained that overall Navy readiness of 85 percent of all forces was only expected to drop 2 percent because of the money shortfall.

Meanwhile, Mr. Skelton is trying to sell a plan for a 12-division Army, instead of 10.

"People should understand the military is an insurance policy," Mr. Skelton said. "You cannot shortchange it. Just because the walls came down does not mean all is well in the world."

CAN THE PENTAGON AFFORD ITS FUTURE

GOALS OF BOTTOM-UP REVIEW IN DOUBT BECAUSE OF BUDGET GAP

(By Bradley Graham and John F. Harris)

Nearly a year after the Pentagon unveiled its grand plan for a slimmer, more versatile military to take the nation into the next century, the strategy is questioned by skeptics who see a growing mismatch between the Clinton administration's national security aims and its ability to pay for them.

The cornerstone of the plan, known as "the bottom-up review," is the assumption that the United States should retain the ability to win two virtually simultaneous regional conflicts the scale of the Persian Gulf War. But doubters within the Pentagon and outside ask whether such a blueprint is workable.

When the plan was released last fall by then Defense Secretary Les Aspin, many skeptics of military spending said it didn't go far enough in scaling back U.S. forces to reflect the more benign post-Cold War world. Increasingly, though, even those who agreed with the goals of the bottom-up review doubt it can live up to its promises.

The concerns center on two main questions: Is the reduced force structure called for in the plan sufficient to fight two major regional conflicts nearly simultaneously? And is the $1.2 trillion the administration plans to devote to defense spending between now and 1999 enough to support the level of force proposed?

The concerns came into sharp focus earlier this year at a training center in Quantico when senior U.S. commanders engaged in a war game to test the two-war scenario.

Victory, they found, depended on assuming—rather unrealistically—that the rest of the world would place no additional demands on U.S. forces during the fighting. Numerous peacekeeping and humanitarian operations in which American troops now are engaged were left out of the exercise.

"There were some soft spots" in projected U.S. capabilities, Adm. Leighton Smith, head of allied forces in southern Europe, recalled at a recent Naval War College forum. "When someone says the plan will work if everything else goes okay, I worry."

Even William J. Perry, who inherited the bottom-up review as Aspin's successor at the Pentagon, concedes that reality is falling short of the plan in some respects. Last month, he told the Navy Times that the United States now couldn't win two nearly simultaneous regional wars. But he said that weapons modernizations—known as "force enhancers"—over the next few years will increase capability.

The debate reflects the absence of consensus on how much of a military the country needs now that the Soviet Union is gone. Liberals were astonished and angry when President Clinton said that there would be no further cuts than those called for in the review. Many military leaders, meanwhile, believed they were being asked to prepare for threats in a still-dangerous world without sufficient resources.

But both sides agree that the gap between Clinton's promise of a robust force at reduced cost and the reality of expensive post-Cold War operations—such as enforcing an embargo of Haiti or helping refugees in Rwanda—is undermining credibility in the bottom-up review.

"It just doesn't work," said Rep. Ike Skelton (D-Mo.), an early critic. "It just doesn't fit the way they say it does."

Just last week, the General Accounting Office told Congress that the Pentagon's $1.2 trillion estimate of the plan's cost is $150 billion short of the real cost over the next five years. The Pentagon agrees there is a gap but says it is closer to $40 billion.

Top Pentagon officials acknowledge that fulfilling the bottom-up review will be a stretch but insist they have no plans to back off it. Defending the program as realistic and achievable, the officials say the plan's biggest virtue may be its central role in structuring how the military, the White House, Congress and others talk about defense in the post-Cold War world.

"That's an enormous achievement," Deputy Defense Secretary John M. Deutch said in an interview. "We see no reason to change the basic framework."

The Clinton administration inherited the two-war strategy from the Bush administration and decided to stick with it, out of both prudence and politics. It was prudent to let potential adversaries know that if the United States got embroiled in one major regional conflict, it could still handle a second. And politically, it was difficult to win congressional acceptance for anything less.

But the Clinton administration is trying to carry out the same strategy with about 200,000 fewer troops and $104 billion less funding over the next five years than President George bush had proposed.

Army divisions and Navy ships are being cut about one-third from 1990 levels, and the number of Air Force wings has been halved. Operating funds, down about a quarter, are not being cut as much as force structure in order to preserve readiness, but procurement has been curtailed 60 percent to keep overall defense spending within limits set by Clinton during the presidential campaign.

Military officers say that has begun to pinch, and they are worried especially about the decline in dollars for weapons modernization.

"The smaller you make the Army, the more modern you've got to make it, and that hasn't happened," said Maj. Gen. Jay Garner, who works on force planning for the Army. He said that there is little doubt the United States could defeat any enemy, but he said reductions in preparedness mean "more casualties than the nation's willing to accept."

Other experts criticize the Clinton strategy as short-sighted, saying it is too focused on planning to refight the 1991 Gulf War more effectively. The real danger a decade or so from now, these experts say, will come from aggressive regional powers that by then will have adopted substantially different strategies and force structures than those anticipated by the bottom-up review.

Andrew Krepinevich, a former Army officer who now heads the Defense Budget Project, said that the military should use the current period of relative peace to invest in new technologies and military doctrines, rather than spending money on the unlikely scenario of two regional wars.

Others say that the bottom-up review calls for spending too much developing new weapon systems, such as the $99 billion F–22 fighter jet program. Expensive weapons development, according to this argument, tends to force commanders to skimp on more important factors, such as training and readiness to use the weapons the military already owns.

"You start cutting on apples and oranges, when it's really the mangoes and avocados that are draining you," said retired Rear Adm. Eugene J. Carroll Jr., director of the Center for Defense Information, a public interest group.

Another frequent criticism of the plan is that it has failed to set priorities between preparing for major regional conflicts and preparing for unconventional operations such as peacemaking. The plan assumes that forces trained for conventional conflicts can be shifted readily to unconventional operations with little or no loss of military effectiveness.

Harlan Ullman, a defense analyst with the Center for Naval Analyses, a federally financed research group, estimates that U.S. military capability will decline by a third by the end of the century. "It's death by a thousand cuts," he said.

Senior Pentagon officials say whether the United States could fight two regional wars nearly simultaneously isn't as important as whether potential adversaries believe it could.

"We were trying to put a marker down," said Ted Warner, assistant secretary of defense for strategy. "It's a planning projection, it's not a prediction."

Besides, as Pentagon officials like to point out, there is a congressional consensus behind the two-war strategy, which makes it particularly useful in trying to protect the defense budget from additional cuts.

But whether the country ultimately can afford the strategy is indeed questionable.

The plan fell more than $31 billion short almost immediately after its unveiling when inflation projections were raised and Congress refused to go along with a military pay freeze recommended by the Pentagon.

Clinton shifted more than $11 billion to the Pentagon in his budget proposals, but a shortfall of $20 billion remains over the next five years.

Defense Department officials figure that higher-than-budgeted increases in military pay will add another $18 billion in unanticipated costs over the next few years, bringing the total shortfall to nearly $40 billion during the life of the bottom-up review plan. But other estimates of the gap have run much higher, figuring lower savings from base closings and management initiatives and higher costs in weapon systems, environmental cleanup requirements and peacekeeping operations.

The funding problem could ease considerably if inflation is lower than projected. Help also could come if substantial savings result from the Pentagon's recent efforts to streamline acquisition procedures and buy more off-the-shelf commercial products.

If not, Clinton faces some options, all unpleasant. He simply could raise the top line on defense spending, although that would mean trimming some nondefense programs.

Alternately, he could further defer military modernization or put off environmental cleanup projects. Or he could push for an even smaller military.

"These would be very painful choices," said Pentagon comptroller John Hamre, "and they would mean that we wouldn't have the same program we briefed on a year ago."

NATIONAL CENTER FOR MANUFACTURING SCIENCES

Mr. SASSER. Mr. President, I rise today in support of the National Center for Manufacturing Sciences. The NCMS helps to reengineer the way we design and build weapon systems by bringing what U.S. manufacturers have learned about commercial practices and global competitiveness to defense industrial base manufacturing.

General Motors and the people of Tennessee design and build the Saturn. It is unquestionably one of the best success stories of the automotive industry. The Saturn program has blazed new trails in manufacturing—creating jobs and spurring economic growth in the process. The NCMS provides the forum in which the Defense Department and its contractors can access and utilize the know-how of General Motors and over 180 leading U.S. corporations to help benchmark, leverage, and modernize manufacturing processes. I hope my distinguished colleagues will support this important effort.

B–1B BOMBER UPGRADES

Mr. DOLE. Mr. President, I want to express my concern over a provision which, in my view, threatens the strength of our bomber force and our Nation's ability to project power. Section 8101 of the committee bill fences the conventional weapons modifications for the B–1 bomber until the completion of a cost-effectiveness analysis.

Now I support the prudent use of our scarce defense resources. But in my view, the question of the utility of our B–1 bomber fleet has been answered. The congressionally mandated test of the B–1 now under way at Ellsworth Air Force Base has demonstrated that the critics of the B–1 are wrong. The readiness rate is running at over 81 percent, which far exceeds the requirement of 75 percent.

The Air Force bomber roadmap and the administration's so-called "Bottom Up Review" validate the requirement for 184 bombers—a logical mix of B–52's, B–1's, and B–2's. In my view, the language in this bill threatens the future capabilities of the B–1 and may result in a bomber force that can't do the job.

The reason for my concern is that the fence applied by this provision prevents the obligation of funds which would outfit the B–1 with cluster bombs, secure communications, an enhanced navigation system, state-of-the-art smart weapons, and other modifications that would make the B–1 a fully capable conventional bomber. A total of $79 million in vital modifications are put in limbo until the completion of the required study. While the committee report "anticipates" completion of this study in time for the congressional budget cycle, no date certain is established. And our experience with such studies suggests that they often take a year or more. In the meantime, the critical industrial base that would support the conversion of the B–1 would be lost.

I applaud the distinguished chairman's desire to build more B–2 bombers, and I support him in that effort. But it seems to me that this provision has the unintended effect of pitting one bomber against another. And the ultimate outcome could be a much smaller and less capable bomber force. The fact is, we need all three bombers.

I ask the chairman and the ranking Republican, Senator STEVENS, if they will seek to remedy this problem in conference. I don't challenge the intentions of this provision; however, in my view, the unintended effects could be devastating.

JPATS AMENDMENT

Mr. DOLE. Mr. President, the amendment I have offered is crafted to preserve the commitment to future security. It is my understanding that the Secretary of Defense is considering slipping the Joint Primary Aircraft Training System for 7 years—over the loud objections of the Air Force. In my view, this would break faith with our future pilots. It would break faith with our future security. And it would break faith with industry.

The J-PATS Program will select and build the next generation pilot training system that will train future Air Force and Navy pilots well into the next century. It is a good program and one that nearly everyone has agreed we desperately need. The reason for this proposed "slip" is money, a problem the administration has inflicted upon itself. And while the administration talks a good game about readiness and training, their actions don't seem to square with the rhetoric.

The President has made the verbal commitment to preserve the best trained, best equipped military in the world. But any decision to skip this program is a breach of that commitment. No one should be surprised when the GAO recently announced that the President's defense plan is underfunded by $150 billion. But the answer to that problem is not canceling more programs—there are very few left as it is. And canceling vital training equipment like J-PATS is even more wrong. It would be mortgaging the future.

During World War II, I remember having to train with a broomstick. There were not enough rifles to go around because America was not prepared. The current primary trainer, the T–37, is nearing 50 years old, and the T–34, while not quite as ancient, has limited life remaining. In my view, these aircraft represent the "broomsticks" of the 1990's. With the current generation of sophisticated aircraft and the next generation soon to come into production, it is wrong to cut corners on training and expect that we will maintain superiority in the skies. We would be breaking faith with our future pilots, and breaking faith with our security.

Slipping J-PATS also breaks faith with an industry which has invested heavily in this hard-fought competition. We can't continue stringing industry along, forcing them to spend millions to compete, and then pull the rug out from under them. I have heard a lot of talk about erosion of the industrial base, and this is a classic example of how that occurs.

There is nothing wrong with the program. No one has cited it for abuse or mismanagement. To date, J-PATS has been a model program, and I think we should get on with it. We owe it to our pilots and to our future. I urge the adoption of my amendment.

ARMY BREAST CANCER RESEARCH PROGRAM

Mr. LEAHY. Mr. President, every one of us knows someone who has battled breast cancer. Every 3 minutes, another woman is diagnosed, and every 11 minutes, another woman dies from this terrible disease.

We cannot bring back those we have lost to the disease. But we can renew our efforts to beat this enemy for those who are fighting it today and for all women who will face it tomorrow.

That is why I urge Senators to support the continuation of the Army Breast Cancer Research Program, which Senator HARKIN and I worked to fund at $210 million in 1992.

This program has been a resounding success—increasing current research efforts as well as inspiring new efforts on the part of some of the Nation's best and most experienced researchers.

The Army received over 3,000 proposals in response to a solicitation for breast cancer research projects. A successful peer review process funded over 400 of these innovative proposals with the original $210 million appropriated by Congress.

When Army officials briefed me on the program this spring, they pointed out that several hundred additional meritorious proposals were left unfunded. Clearly, there is tremendous interest in this program and many other avenues of research to pursue if we are willing to continue funding this effort.

If funding is not continued in a consistent and committed way, the incentive to plan and pursue new research will be gone, the momentum will be broken, and I fear that we will lose the ground we have gained in battling breast cancer.

As a member of the Appropriations Committee, I worked this year to include report language in the fiscal year 1995 appropriations bill that directs funding for the Army program to continue on-going efforts and encourage new breast cancer research. My language urges the Army to solicit a new round of proposals and initiate another peer review process.

I know that Chairman INOUYE was faced with many program requests and a limited number of dollars this year. I requested that the chairman include $150 million, the same level as the House, for the Army program.

I look forward to working with the chairman and other Senators in conference to increase the current funding level of $60 million so that we can build on the research efforts that are currently underway.

The eradication of breast cancer has become a national priority, but we have a long way to go in this battle. I want my voice to be heard with the many breast cancer survivors, their families and friends in Vermont and across this Nation.

I join with Senators HARKIN, MIKULSKI, FEINSTEIN, D'AMATO, MURRAY and others who have championed this effort to support and continue the valuable work of the Army Breast Cancer Research Program.

MEGAN KANKA—AMENDMENT NO. 2541

Mr. DOLE. Mr. President, last week, America was shocked by the brutal murder of 7-year-old Megan Kanka, who was raped and strangled to death near her home in Hamilton Township, NJ. The police have arrested a twice-convicted sex offender, a neighbor of the Kanka family, who had served just 6 years of a 10-year sentence.

Unfortunately, the Kanka family and the residents of Hamilton Township had no idea that the beast who committed this horrendous crime was out loose in their community. If they had known about the criminal history of Megan's killer, there's a good chance that Megan would still have a childhood—and a future.

The amendment I am offering today targets that small group of predators who terrorize our playgrounds and parks, seeking to harm the most vulnerable in our society. Even after a sexual predator has been apprehended, convicted, sentenced, and incarcerated, there's no guarantee that he will not strike again once he has been released onto our streets.

the amendment is virtually identical to a bill introduced last week by Senator SLADE GORTON and Representatives DICK ZIMMER and JENNIFER DUNN. Representative ZIMMER, in particular, has been extremely helpful to me in explaining his proposal and sharing his insights on how best to target these vicious criminals and to keep local communities informed of their whereabouts.

In a nutshell, the amendment directs the Attorney General to establish guidelines for State programs requiring a sexually violent predator to register a current address with the appropriate State law enforcement agency. Any State that fails to establish a registration program within 3 years could suffer a 10 percent reduction in Federal law enforcement funding. Any funds that are released in this way are then re-allocated to those States that do have registration programs.

Registration with the State law enforcement agency must occur at the time the convicted sex offender is released from prison, placed on parole, or placed on supervised release. The State agency must then transmit this information to the FBI and to the local police department for the community in which the sex offender resides.

The amendment also requires the sexually violent predator to verify his residence with the State agency on a quarterly basis. This should help ensure that local law enforcement officials are kept up-to-date on the whereabouts of those sex offenders who are subject to the registration program.

In addition, the amendment contains a community notification provision. This provision requires State law enforcement agencies to release any information that is necessary to protect the public from a sexually-violent predator.

I know that some of my colleagues view this public notification requirement as a violation of the criminal's privacy rights. Other have described it as a modern-day "scarlet letter." But I happen to agree with one of the Kanka family's neighbors, who recently explained to the New York Times: "An innocent child's rights outweigh a criminal's rights. Posting warnings is a way to extend control beyond the limits of the sentence." The bottom line is that communities like Hamilton Township, NJ, have a right to protect themselves. If someone is so concerned about being branded a sexually-violent predator, he shouldn't commit the crime in the first place.

Finally, Mr. President, I want to thank Senator GORTON and Representative ZIMMER for their efforts on behalf of this amendment. This amendment is really their idea, and they deserve the credit for bringing this important issue to the Nation's attention.

NATIONAL CENTER FOR MANUFACTURING SCIENCES

Mr. DECONCINI. Mr. President, I rise today to speak on the activities of the National Center for Manufacturing Sciences [NCMS]. The report accompanying the fiscal year 1995 Defense appropriations bill, which we are debating today, contains critical language questioning the appropriateness of continued Defense Department funding for the NCMS. I recognize and support the need for ever-increasing scrutiny of funding for Defense Department programs, especially those whose only rationale for receiving funds each year is that they had received funds the year before. There are many programs which fall into this category, but this Senator believes that NCMS is not one of them.

The purpose of the NCMS goes right to the heart of DOD's goal, as stated by

Dr. Anita Jones, the Director of Department of Defense Research and Engineering, when she testified before the Senate Armed Services Committee this past spring that centers such as the NCMS are what we need to assist in the transition from a defense-oriented economy. She stated that DOD's

> Vision for the 21st Century manufacturing is for an integrated civil/military industrial base that can provide a flexible response to our needs for a variety of product demands at varying rates, and can reduce the cost of defense components and subsystems from dual-use production lines.

NCMS provides this type of integration. In fact, the program is designed to give the Department access to the manufacturing and research capabilities of all members of the NCMS.

As we move toward refocusing the priorities of the military-industrial complex which has served our Nation's Armed Forces so well for so many decades, we must carefully examine new methodologies and approaches to solve new problems. I think that the NCMS can make a positive contribution toward this end and I am hopeful that the Senate can move closer to the House position during conference.

The PRESIDING OFFICER. Are there further amendments to the bill?

Mr. DOLE addressed the Chair.

The PRESIDING OFFICER. The Republican leader is recognized.

Mr. DOLE. Let me say, before I send amendment No. 2515 to the desk, that I do not intend to pursue the amendment. I am going to send it to the desk and speak on it briefly and then withdraw the amendment. I am trying to accommodate the managers of the bill.

AMENDMENT NO. 2515

(Purpose: To require the Secretary of Defense to undertake a comprehensive review of the Bottom-Up Review and the Future Years Defense Program and, upon completion of that review, report to the President and the Congress on the proper funding levels and priorities, and for other purposes)

Mr. DOLE. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Kansas [Mr. DOLE], for himself, Mr. MCCAIN, Mr. ROTH, and Mr. SMITH, proposes an amendment numbered 2515.

Mr. DOLE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place insert the following new section:

SEC. . REVIEW OF THE BOTTOM UP REVIEW AND THE FUTURE YEAR DEFENSE PROGRAM AND ESTABLISHMENT OF NEW FUNDING REQUIREMENTS AND PRIORITIES.

(a) FINDINGS.—Congress finds as follows:

(1) Whereas the Administration commissioned the Bottom Up Review to properly structure the Armed Forces of the United States for the Post-Cold War Era;

(2) Whereas the Joint Staff officer responsible for force planning testified on March 1, 1994, that the Bottom Up Review force structure exposes U.S. troops to a "high element of risk;"

(3) Whereas the Secretary of Defense has testified that the Department of Defense's Future Years Defense Program includes $20 billion more in program funding requests during fiscal years 1996 through 1999 than the defense funding levels in the Administration's budget can support;

(4) Whereas the General Accounting Office reported in July 1994 that the Administration's Future Years Defense Program may be underfunded by as much as $150 billion;

(5) Whereas, the Secretary of the Navy has testified that the Department of the Navy will only operate 330 ships rather than the 346 ships required by the Bottom Up Review;

(6) Whereas, in January 1994, in his Annual Report to the President and the Congress, the Secretary of Defense reported that the Air Force will field approximately 100 heavy bombers rather than the 184 required by the Bottom Up Review;

(7) Whereas the Department of Defense's plans for a major regional contingency in the Far East call for 5 Army divisions and the plans for a major regional contingency in Southwest Asia call for 7 Army divisions, while the Bottom Up Review plans for an Army of only 10 active divisions;

(8) Whereas the Administration's budget assumes the Department of Defense will save at least $6 billion from procurement reform;

(9) Whereas the first and second rounds of the Base Realignment and Closure Commission have not yet achieved the level of savings initially estimated, and the 1995 base closure round may cost significantly more than is assumed in the Administration's budget;

(b) REQUIREMENT.—

(1) The Secretary of Defense shall, within 30 days after enactment of this legislation, initiate a review of the assumptions and conclusions of the President's Budget, the Bottom Up Review, and the Future Years Defense Program;

(2) Not more than 60 days after the review described in (b)(1) is initiated, the Secretary of Defense shall submit to the President and to the Congress a report detailing the funding level required for the defense and national security of the United States;

(3) The President shall, when submitting to the Congress the budget for the United States Government for Fiscal Year 1996, submit a defense budget for fiscal year 1996 and a Future Years Defense Plan which represents the funding level described in (b)(2).

AMENDMENT NO 2515, AS MODIFIED

Mr. DOLE. Mr. President, I send a modification to amendment No. 2515 to the desk.

The PRESIDING OFFICER. The Senator has that right.

The amendment is so modified.

The amendment (No. 2515), as modified, is as follows:

At the appropriate place insert the following new section:

SEC. . REVIEW OF THE BOTTOM UP REVIEW AND THE FUTURE YEAR DEFENSE PROGRAM AND ESTABLISHMENT OF NEW FUNDING REQUIREMENTS AND PRIORITIES.

(a) FINDINGS—Congress finds as follows:

(1) Whereas the Administration commissioned the Bottom Up Review to properly structure the Armed Forces of the United States for the Post-Cold War Era;

(2) Whereas the Joint Staff officer responsible for force planning testified on March 1, 1994, that the Bottom Up Review force structure exposes U.S. troops to a "high element of risk;"

(3) Whereas the Secretary of Defense has testified that the Department of Defense's Future Years Defense Program includes $20 billion more in program funding requests during fiscal years 1996 through 1999 than the defense funding levels in the Administration's budget can support;

(4) Whereas, the General Accounting Office reported in July 1994 that the Administration's Future Years Defense Program may be underfunded by as much as $150 billion;

(5) Whereas, the Secretary of the Navy has testified that the Department of the Navy will only operate 330 ships rather than the 346 ships required by the Bottom Up Review;

(6) Whereas, in January 1994, in his Annual Report to the President and the Congress, the Secretary of Defense reported that the Air Force will field approximately 100 heavy bombers rather than the 184 required by the Bottom Up Review;

(7) Whereas the Department of Defense's plans for a major regional contingency in the Far East call for 5 Army divisions and the plans for a major regional contingency in Southwest Asia call for 7 Army divisions, while the Bottom Up Review plans for an Army of only 10 active divisions;

(8) Whereas the Administration's budget assumes the Department of Defense will save at least $6 billion from procurement reform;

Whereas the first and second rounds of the Base Realignment and Closure Commission have not yet achieved the level of savings initially estimated, and the 1995 base closure round may cost significantly more than is assumed in the Administration's budget;

(b) REQUIREMENT.—

(1) The Secretary of Defense shall, within 30 days after enactment of this legislation, initiate a review of the assumptions and conclusions of the President's Budget, the Bottom Up Review, and the Future Years Defense Program;

(2) Not more than 60 days after the review described in (b)(1) is initiated, the Secretary of Defense shall submit to the President and to the Congress a report detailing the funding level required for the defense and national security of the United States;

(3) The President shall, when submitting to the Congress the budget for the United States Government for Fiscal Year 1996, submit a report to Congress stating whether the national defense budget submission differs in any respect from the funding level described in (b)(2), and if so, describing in detail each such difference and the reasons for such differences.

Mr. DOLE. I ask unanimous consent to add Senator ROTH of Delaware and Senator SMITH as cosponsors.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DOLE. Mr. President, the amendment Senator MCCAIN and I have introduced is simple and straightforward. The legislation requires the Secretary of Defense to reexamine both the Bottom-up Review and President Clinton's future years defense program and report to Congress on the force structure required to provide for an adequate defense for our Nation. It further requires the President to adequately fund that force structure. Senator MCCAIN and I have raised this issue because despite all of the rhetoric, we have neither an adequate force structure nor Defense budget. According to the military experts, the force represented in the Bottom-up Review is inadequate to meet our stated national security needs. And according to the administration's own experts, even that force is massively under funded.

I have heard the President's statement about providing a strong defense, fielding the best equipped fighting force, and supporting our fighting men and women. The President has stated that he would cut Defense no further. He has endorsed the Bottom-up Review as the guiding document for our Armed Forces for the post-cold war era. And he has assured us that the Bottom-up Review force is adequate for fighting two major regional contingencies, or MRC's, nearly simultaneously.

While I have listened to the President's promises, I am concerned about the impact of his actions. In the State of the Union Address on January 25, 1994, President Clinton stated that the budget he would send to Congress would draw the line against further defense cuts. Let us be clear about what this means. It means that the President remains committed to the huge cut of over $127 billion which he sent the Congress last year. The President's 5-year defense plan calls for an additional decline in defense spending of 10 percent in real terms. Regarding these additional cuts, the distinguished chairman of the Armed Services Committee said, "if these additional hidden reductions are not reversed, I believe that they will seriously erode the future capability of our military services." I share this view and that is what this amendment is all about—to put the Senate on record about this point.

The fact is, we are entering the 10th consecutive year of defense cuts. The Defense budget before us, as reflected in this bill, represents a reduction of approximately 33 percent from the 1985 Defense budget. By the end of the administration's future years Defense program, defense spending will have fallen by over 43 percent since fiscal year 1985. We are not cutting defense—we are gutting it.

According to a recent GAO report, the President's Defense plan is under funded by about $150 billion. This is no surprise to Defense experts, but it is the first quantitative evidence of the actual magnitude of the shortfall. The fact is that President Clinton's Defense budget doesn't support his own force structure.

The Secretary of the Navy testified that the Department of the Navy will operate only 330 ships, as opposed to the 346 ships called for in the Bottom-Up Review. Additionally, the President's budget request would have funded only 100 bombers during fiscal year 1995 and only 80 bombers in the out years. This, despite the Bottom-Up Review's requirement for 184 bombers. It is a fact that the Bottom-Up Review is underfunded and it appears that this administration, while making statements about commitment to a strong defense and demonstrations of support for our troops, is willing to do little if anything to address that problem. The result is the exposure of our fighting men and women to a greater level of risk.

The facts do not support the administration's assurances that the Bottom-Up Review force structure is sufficient to fight and win two major regional contingencies nearly simultaneously. One of the most glaring deficiencies is the fact that the number of army divisions called for by the president's strategy will not meet the military's stated needs for fighting and winning a major regional contingency in the Far East and a major regional contingency in Southwest Asia. During the gulf war, the United States deployed seven divisions plus two armored cavalry regiments to Southwest Asia. Recently, General Luck testified that a major regional contingency on the Korean peninsula would require at least 400,000 military personnel to reinforce the United States forces already assigned to south Korea. If the United States had to face these two wars "Nearly simultaneously", the Army would not be able to deploy all the troops required. Remember that at the same time the United States is fighting these major regional conflicts, it also would have to maintain at least one division in Europe to meet our NATO requirements. Additionally, we cannot forget the humanitarian missions and peacekeeping operations to which this administration has committed us. The administration's Army force structure simply will not allow us to fight and win two MRCs nearly simultaneously and meet all of our other responsibilities.

In summary, the funding plan does not support the force structure, and the force structure will not do the job.

During World War II, it took this Nation and our Allies almost 2 years to amass the troops and material needed for victory. The simple fact of the matter is that we will never again have that kind of time to prepare for war. You can be sure that our enemies have learned from the mistake of Saddam Hussein. The next time we face an aggressor, that aggressor will not allow us 6 months to prepare for the fight.

Look at the war in Bosnia, Saddam Hussein in Iraq, the nuclear build up in Iran, and the situation on the Korean peninsula. It should be obvious to all of us that the world is still a dangerous place. The amendment Senator MCCAIN and I have proposed goes a long way toward ensuring that our forces remain prepared to meet any future threat. I urge my colleagues to support this amendment.

Mr. ROTH. Mr. President, ten days ago Senator GRASSLEY and I released a General Accounting Office report that reveals a huge gap between the Pentagon's resource needs and the availability of funds. That report found that the current Future Years Defense Plan, which was derived from the Bottom Up Review, is unaffordable. The Clinton administration is reluctant to either get rid of the weapons and forces that are unaffordable or transfer the necessary funds into the Defense budget. So, rather than cutting costs, the Pentagon has cut the cost estimates. With the unrealistically low cost estimates, the administration is misleading itself and the American public on how much defense capability the Defense budget will buy.

Mr. President, the Congress bears some of the blame for this problem. For example, the Congress refuses to kill one of the most expensive, outdated, poorly managed, cold war programs in the entire budget—namely, the *Seawolf* submarine program. But, the administration must bear responsibility for not funding the forces its own Bottom-up Review determined to be needed to fulfill our National Security needs. The GAO report documents that the Defense Department Future Years Defense Plan is underfunded by more than $150 billion.

Mr. President, I am concerned that the administration continues to avoid the tough decisions that need to be made, rather than correcting the problem. Less than a month ago, it was reported that the Deputy Secretary canceled his directive that $25 billion be cut from the Defense budget. Sooner or later the bills will come in. When they do, tens of billions of dollars will have to be found or the hollow Army of the 1970s will reoccur.

Meanwhile, under the Clinton administration, troops have been sent into Rwanda and the Balkans, and we are openly discussing the invasion of Haiti and a major injection of troops into Bosnia. All the while, we face a real danger of a major military conflict in the Korean peninsula. Yet, only $1 billion dollars is included in the 5-year defense plan to cover these costs. The bottom line here is that there is not enough money to pay for the administration's national security strategy.

If we are to avoid a return to the hollow Army of the 1970s, tough management decisions will have to be made. Programs will have to be terminated, not stretched out. Major management reforms will have to occur.

Mr. President, I urge my colleagues to support the amendment offered by Senator DOLE. The issue here is accountability. We trust the administration with providing a national security strategy and with costing out the forces needed to fulfill that strategy. The Bottom-up Review was a major undertaking for the administration. It determined the set of forces needed to achieve the President's national security strategy. But, it is nothing less than reckless for the administration to implement its strategy when it has not provided the requisite funding.

Mr. McCAIN. Madam President, I thank Senator DOLE for his continued efforts to stop the erosion of our Nation's defenses, our capabilities, and our readiness. Madam President, there are some lonely voices out there, but I believe that, in the viewpoint of people who are wiser than I, soon we are going to face a crisis in our national security interest, and our ability to protect our national security interest and the readiness of our Armed Forces, and the quality of the men and women that man it.

Madam President, I ask unanimous consent that Senator WARNER be added as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. McCAIN. Madam President, to repeat, the amendment would require the Secretary of Defense to review the defense budget as well as the Bottom-Up Review assumptions and force levels.

The Secretary would be required to report to the President and the Congress on the funding required to ensure the national security of the United States.

Finally, the President would be required to submit a fiscal year 1996 defense budget which provides for the funding described in the Secretary's report.

Madam President, one of the most respected organizations here is the GAO. The GAO released a study last month estimating that the future years' defense plan in order to comply with the Bottom-Up Review which was carried out by former Secretary of Defense Aspin and former Chairman of the Joint Chiefs, Colin Powell, we are $150 billion short, $150 billion less than what was required to maintain the forces that were envisioned after extensive review by some of the most respected men in America just about 2 years ago.

It cites the following shortfalls in the administration's budget: $21.6 billion in inflation and negative adjustments in R&D; $32 billion in projected savings that may be only partially realized; $112 billion in potential cost increases for base closures, weapons system costs, personnel pay, environmental remediation, and peacekeeping operations.

The GAO report calls into question the Department of Defense's claim that they are only $20 billion underfunded. That they were $20 billion underfunded would be alarming in itself.

I remind my colleagues for $243 billion in this bill, we are acquiring 17 fixed-wing combat aircraft, 4 combatant ships, total. That is what we get for $243 billion, 17 fixed-wing aircraft, 4 ships. In addition to that there are 63 Blackhawk helicopters, 6 Apache helicopters, and 6 C-17 airlift air carriers; no tanks, armored personnel vehicles, none of the other equipment you would think might come from a $243 billion defense budget.

It reminds me a little bit of a story I read recently about the Cambodian Army. They have something like 3,000 generals and 7,000 colonels, and no soldiers.

What I am saying is that we are spending money on all kinds of things, except to procure the weapons of war and the capabilities with which to defend this Nation's vital national security interests.

It is obvious that the Department of Defense's 5-year plan requires more money than is being provided. The amendment that Senator DOLE proposed would require an indepartment study of the adequacy of funding in the 5-year defense plan to pay for the Bottom-Up Review force, and it would ensure that the President allocates sufficient resources to national security.

Again, I was heartened not long ago when the President of the United States said: Tell Congress not to cut defense any more. And both sides of the aisle at the President's speech stood and applauded the President's statement.

The fact is we continue to cut defense. In fact, we not only cut it, as we did because of the Exon-Grassley amendment, which cut $500 million out of this year's defense budget, but we also shift moneys around in an incredible degree. And, of course, one of the worst and outrageous actions that I think has been taken recently is the movement of $490 million. Not only after $500 million was cut off the defense budget, there was the movement of $490 million out of other defense into military construction.

Why is that so egregious? We know that military construction is needed on our bases. It is so egregious because we are about to convene a base closing commission which is going to close more bases ever in the history of this country, more than the last two base closing commissions did, and we know full well there will be bases that will be closed in your State, Madam President, and possibly in mine, and there are military construction projects going on while the bases are being closed. It does not make any sense.

Meanwhile, the USS INCHON spent 6 months off of Somalia with 2,000 Marines on board in that task force, sitting out there doing nothing, in the most difficult conditions. They come back to North Carolina to their home port. They spend 10 days with their wives, families, children, and friends, et cetera, and they are called back after 10 days and sent to sea again where they still remain to this day.

Why do they remain there? Because we did not have any other ships. The Department of Defense said we had to turn them around and in a 10-day timeframe span at home.

Madam President, do you know how much money these people are making? An E-1, that is the lowest rank, earns $9,533 a year, little more than $1,000 in allowances. Sergeants earn less than $20,000, while a few earn more than $25,000.

The military services estimate that some 20,000 enlisted service members and their families are now eligible for food stamps. And we are putting them to sea and keeping them at sea and away from their families. Then we expect to maintain a quality All Volunteer Force. I am sorry. It does not compute. It does not match up. You cannot do it.

So, yes, I thought it was outrageous, and I say this in all due respect to my friends on the Appropriations Committee that we would take $490 million out of overall defense and put it into military construction at a time when we knew that many, many bases are going to be closed in this country. We could have at least delayed that a year until we saw the results of the base closing commission. We could have waited.

I gave the other day the percentages, I might add, of the members of the Appropriations Committee and the percent of those military construction add-ons in the House of Representatives. If my memory serves me correctly—I will get the numbers here—72 percent of the add-ons in the MilCon came from the projects in the Member's State—72 percent of all dollars added for unrequested military construction projects will be spent in the States of the 60 Representatives who serve on the House Appropriations Committee, and 29 percent of the U.S. Senate. That is 66 percent of the added dollars. That is not coincidence.

Madam President, the major weapons system is clearly underfunded. The defense bill, as I said, contains 17 fixed-wing combat aircraft, 4 combatant ships. Procurement funding according to GAO is projected to $38 million shortfall to the next 5 years.

As I mentioned already, the base closing commission in 1995 will be draconian. I do not like to see it. I do not want to see a base in my State closed. Those who oppose the base closing commission, let me point out we have reduced our forces by 40 percent and we have reduced the base structure by only 15 percent. That does not make sense either.

These priorities in the administration and here hurt our national security, as I said, but most of all it impacts the men and women in the military.

Military pay increases have lagged 8 percent behind inflation in the last 10 years and 12 percent behind the increases in pay in the private sector.

I mentioned the lowest enlisted rank get $9,533 a year, sergeants earn less than $20,000.

These servicemen are exceptionally dependent on the base exchanges and commissaries and other support facilities.

The proposed budget last year called for a 1-year freeze on military pay and benefits in 1994 and a 1 percent reduction in the annual pay raise based on the economic cost index. And 200,000 military personnel last year left the military service. Enlisted voluntary separations in the Army—most of which involved no real choice by the individual involved—rose from 66,000 in 1992 to 128,000 in 1994. Air Force separations of all kinds rose from 43,500 to 63,000. Up to 400,000 additional men and women and their families will now have to leave military service by the end of 1998. Up to 400,000 additional men and women and their families will have to leave the military service by the end of 1998. We cannot continue to ask our servicemen and women to continue in this fashion.

READINESS IS SUFFERING

The significant and continuing budget cuts have already resulted in the first signs of declining readiness.

I am seriously concerned about the deleterious impact of the rapidly declining defense budget on the readiness of our military forces, as well as on the daily lives of the men and women who serve in our Armed Forces and their families.

The report of the Defense Science Board Task Force on Readiness—which was appointed by former Secretary Aspen—dated June 1994, makes some very cautious statements concerning how to avoid a future "hollow" armed forces. The report refers to "pockets" of unreadiness that exist today, and states: "We observed enough concerns that we are convinced that unless the Department of Defense and the Congress focus on readiness, the armed forces could slip back into a 'hollow' status."

I might add, as most of my colleagues know, that organization, that board, was composed of retired military people who are some of the most respected individuals that the military has had the privilege to have serve.

In testimony before the Senate Armed Services Committee and in other public fora, our highest ranking military officers have expressed concern about the serious declines in readiness now evident:

Air Force depot maintenance backlog is currently at $868 million, and Army's depot maintenance account is only funded at 62 percent of requirements.

Marine Corps is suffering severe cutbacks in combat training and in sustainability because funds and time are being redirected to support peacekeeping operations.

Navy afloat inventories have been reduced 40 percent since 1989 as a result of a desire to save money on spare parts by centralizing storage ashore; but this means that a ship at sea requiring repairs will now have to sit idly while the necessary parts are transported to their location.

Army aviator training is funded at only 76 percent of requirements, a level insufficient to make any progress in redressing the shortfall in skilled Army aviators identified in Operation Desert Storm.

Cuts in base operations funding have reduced the standard of living of our troops, which translates quickly into lowered morale and reduced readiness.

GOING HOLLOW * * * A REAL LIFE EXAMPLE

The President recently ordered the deployment of soldiers and sailors of the U.S.S. *INCHON* Amphibious Ready Group to deploy to Haiti only days after their return from 6 months in Somalia. That decision, we are told, was necessary because we did not have another unit that was adequately prepared to take on the task.

Last week, the Secretary of Defense and the Chairman of the Joint Chiefs testified to Congress that a study had been undertaken in the Pentagon to review the possibility of decreasing normal 6-month deployments. This decrease in deployment time would be required in order to keep more assets on hand to react to the growing number of regional crisis in the world. We are already looking at changing the way the U.S. military conducts business in order to accommodate declining defense budgets and escalating commitments.

These examples illustrate the need for increased operation and maintenance funding.

NONDEFENSE SPENDING IN THE DEFENSE BUDGET

Another disturbing trend in the defense budget is the inclusion of billions of dollars of spending which is not directly related to military capabilities.

The cost of conducting peacekeeping operations consumes billions of dollars every year. The administration requested $300 million in this year's budget to pay our U.N. assessment for worldwide peacekeeping operations, traditionally funded out of the State Department budget. Fortunately, it appears that saner heads have prevailed and these funds will not be provided from the DOD.

The Congressional Research Service recently prepared a study of the costs of nondefense activities funded in the Defense budget during the 6-year period fiscal year 1990–95. Their results are astonishing: Environmental remediation—nearly $24 billion; defense conversion and dual use programs—nearly $12 billion. In total, the CRS reported $52 billion in spending for nondefense programs.

OTHER "MUST-PAY" BILLS ARE UNDERFUNDED

DOD is forced repeatedly to seek supplemental funding or reprogramming authority to pay for day-to-day operations in support of expanding commitments throughout the world. Additional funding is required to offset the costs of sending troops to Rwanda, maintaining a no-fly zone over Bosnia, and forming a possible Haiti invasion force.

More importantly, additional funds are necessary to reinforce our troops currently in South Korea and improve their readiness to repel any aggression from the North.

There are many pressing military requirements that lack sufficient funding. These requirements must be identified, and resources must be provided to pay for them.

I would like to commend the Appropriations Committee and the managers of the bill. There are a number of excellent provisions in the Senate bill.

MILITARY PAY RAISE

The bill before the Senate fully funds a 2.6 percent pay raise for military personnel—redressing a serious shortfall in the President's budget submission.

The full military pay increase is essential to maintaining the high-quality All-Volunteer Force we have today.

I would also like to express my appreciation to the Committee for the COLA Equity issue.

The bill before the Senate also provides funding to redress the inequity in retired pay COLAs between Federal civilian and military retirees.

The Authorization conference includes a provision to restore the military retiree COLA to April 1, the same date as that authorized for civilian retirees.

I commend the Appropriations Committee for allocating full funding to pay these costs.

TRP

Since the inception of the program, I have been concerned that it would be used as a slush fund to prop up failing businesses or to reward politically connected organizations with defense grants and contracts.

The Appropriations Committee has acted to establish controls on this giveaway program by including very strong language requiring the Department of Defense to certify that projects funded with TRP dollars must have served some military purpose.

The authorization conference contains similar language and additionally requires the General Accounting Office to review TRP awards and identify the military utility, or lack thereof, of each of the projects funded in this account.

Again, I commend the Appropriations Committee for acting to constrain the TRP program.

UNIVERSITY RESEARCH

In the past, these funds have been a source of pork barrel funding and were earmarked for specific universities.

This year, the House halved the funding for this account, and resisted the impulse to earmark the remaining funds.

While the Senate restored a significant portion of the House cut, it, too, resisted the urge to specify the universities to whom such funds were to be granted.

I would support a lower level of funding for university research, because I believe these funds should be better spent for training, or modernization, or quality of life improvements for military personnel.

I commend the Appropriations Committees of both Houses for their responsible approach to such funding. I hope that the conference agreement on this bill will reflect the same discipline.

However, the bill provides, in my view, an inadequate level of funding for the Department of Defense.

I cannot overlook the egregious examples of wasteful, unnecessary, and nonmilitary spending of scarce defense dollars that are contained in both the House and Senate versions of this bill.

I have identified more $2.1 billion in earmarked and add-ons in the House bill, and nearly $1.9 billion in the Senate bill, which represent the most egregious examples of congressional pork barrel spending.

PROLIFERATING INDUSTRIAL BASES

The Congress has developed a proclivity to set aside slush funds to preserve so-called "defense industrial bases."

This practice started with the *Seawolf* submarine, when Congress provided $540 million to preserve the submarine industrial base. Today, the American taxpayer is burdened with paying for two $5.2 billion submarines, and possibly a third boat, which have no military utility in the post cold war world.

DOD has failed to provide any leadership in this area. Nearly 4 years ago, the Congress directed DOD to prepare a report on the defense industrial base—a report which has never been completed. Congress must have the benefit of DOD's views in order to make educated judgments about the need for the proliferating number of industrial base funds that are being set up.

I say again, Madam President, the Department of Defense, 4 years ago, should have provided an industrial base report to this Congress. They have failed to do so, so they are responsible, to a large degree, for this proliferation of so-called defense industrial base funding.

The House version of the Defense Appropriations bill included $481 million for new industrial base set-asides.

For example, as if $540 million for the submarine industrial base was not enough, the House included $1 million for a submarine main steam condenser industrial base, $2 million for a ship propulsion shafting industrial base, $4.5 million for a submarine navigation radar system industrial base, and another $13.5 million for other submarine-related technologies as an industrial base set-aside.

The House also included $30 million for a radiation resistance electronics [RRE] industrial base.

Rumor has it that an MRE industrial base is being established. The House bill does include $2 million for MRE cold pasteurization/sterilization, perhaps a start on an MRE industrial base. It also earmarks $2.8 million for combat rations advanced manufacturing technology demonstration.

The Senate bill is more restrained, but includes $150 million for a bomber industrial base, $35 million for a tank engine industrial base and $2.5 million for a reentry vehicle industrial base.

We have to stop this business of calling everything an industrial base. We cannot fund everything in the world. We have a combat boot industrial base, I believe, or some version of the same in the House bill. We cannot keep this up. The Department of Defense has to tell us which defense industrial bases have to be maintained and the Congress has to respond in a responsible manner.

This is an absurd waste of money to prop up faltering industries which may or may not represent vital sectors of American industry necessary for our future defense requirements. I hope the conferees on the Defense appropriations bill will drop these unwise provisions during their deliberations.

While the House version of the bill contains only suggested uses for defense conversion funds, a thin ruse to avoid a charge of earmarking.

Examples of such House non-earmarks include: $400,000 for Georgia Tech Center for International Defense Conversion, and $4 million for Georgia Tech Plasma Arc Remediation; $100,000 for Berkshire County Regional Employment Board; $5 million for San Diego State University Conversion Center; $2.5 million for San Gabriel Valley Community Development Corporation; $500,000 for Hunters Point Civilian Job Training in Environmental Remediation; $2.5 million for Southeast Regional College Network, Florida; $364,000 for Southwest Virginia Advanced Manufacturing Technology System; $10 million for Great Lakes Environmental Manufacturing Technology Center; and $3.5 million for California Goldstrike Program.

Now we understand better, Madam President, why we are purchasing only 4 combatant ships and 17 fixed-wing aircraft.

The House included real earmarks in this account, totaling $102.65 million. For example: $1 million for the Great Lakes Composites Consortium sonar production dome project; $6 million for the joining Center; $5.4 for the Gulf Coast Region Maritime Technology Center; $1 million for the Manufacturing Producibility Center at the Louisville, Kentucky site of the Naval Surface Warfare Center, Crane Division; and $1 million for the National Center of Excellence in Ship Hull Design and Electrical Systems.

Again, the Senate bill does not contain such earmarks. I urge my colleagues to hold their position in conference.

Madam President, I want to point out three of the committee amendments which cause me concern. I do not intend to challenge them but I am concerned about them.

First, on page 23, lines 5 through 14:

Committee amendment would provide $2.5 million to sustain operations at the William Langer Plant in Rollette, North Dakota.

The plant is a government-owned facility which manufactures jewel bearings. The military requirement for jewel bearings is essentially nonexistent at this time, but Congress has been adding money to the defense budget for many years to support the continued operation of this plant.

The Committee report notes the economic depression in this area of North Dakota and states that the funding is provided to allow the plant to continue to operate until it is converted to a privately owned fiber optic producer.

The amendment takes money from the Armament Retooling and Manufacturing Initiative, effectively making it into a slush fund for failing businesses.

It is highly likely that Congress will be asked to continue propping up this failing enterprise in the future. We cannot afford to spend scarce defense dollars to prop up failing businesses in economically depressed areas of the country. The funding should be deleted.

Second, on page 135, lines 9 through 19:

The Committee amendment directs the Navy to reimburse the Muckleshoot Indian Tribe Auburn, WA, for costs incurred in preparing and submitting a base reuse plan for Puget Sound Naval Air Station.

If approved, this would set a precedent for any other Indian tribe, or homeless or community organization, to submit claims to DOD for their costs in preparing base reuse plans.

The committee amendment should be deleted.

Third, on page 137, lines 10 through 15:

The Committee amendment appropriates $11.2 million to pay the cost-of-living raises for Coast Guard uniformed personnel.

Committee staff advises that this funding is necessary because the Defense authorization bill approved a full pay raise for all uniformed personnel, which is deemed to include Coast Guard. Further, Committee staff argues that, because of their military roles, Coast Guard personnel may be paid out of DOD funds.

The last I heard except in time of war the Coast Guard was under the Department of Transportation. It seems to me that their pay should be taken care of out of the Department of Transportation budget. I think we are setting a very bad precedent if we are paying now for the salaries of members of the Coast Guard who fall under the authority of the Department of Transportation, except in time of war.

Madam President, the hour is late. I know there are others who want to speak. In deference to the two managers of the bill who have been here for a very long time, I will resist further diatribe except to say that we better understand that we cannot afford these things. We are shortchanging our military in every way. It is not really sexy to vote for a cost-of-living adjustment for a man or woman in the military. It is not real exciting to spend more money on operations and maintenance. It does not do much good back home when you allocate more money so pilots can maintain and air crews can maintain their efficiency through increased training hours.

But all of those things are what makes the difference between the U.S. military and every other in the world. I suggest that when we start this routine again next year, we be even more careful.

I would also like to say to both the managers of the bill I think that this is a better bill than last year. I think there are some significant improvements. But I believe we have a great distance to go. And I believe, also, that we have that obligation as we continue to see reductions in our defense budget and an increase in our national security challenges throughout the world and an increase in deployments of our military to far-off places, many of which we never heard of at this time last year, and an increase in requirements to use U.S. capabilities in defense of peace and freedom throughout the world.

Madam President, I ask unanimous consent to add Senator DOMENICI and Senator SMITH as cosponsors.

The PRESIDING OFFICER (Mrs. BOXER). Without objection, it is so ordered.

Mr. McCAIN. I ask unanimous consent at this time to withdraw the Dole amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2515) was withdrawn.

The PRESIDING OFFICER. The Senator from Alaska.

AMENDMENT NO. 2518

Mr. STEVENS. Madam President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Alaska [Mr. STEVENS], for Mr. DOLE, for himself, Mr. LIEBERMAN, Mr. MCCAIN, Mr. MOYNIHAN, Mr. WELLSTONE, Mr. EXON, Mr. FEINGOLD, Mr. HATCH, Mr. DECONCINI, Mr. LUGAR, and Mr. HELMS proposes an amendment numbered 2518.

Mr. STEVENS. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place, add the following:

SEC. . TERMINATION OF ARMS EMBARGO.

(1) TERMINATION.—The President shall terminate the United States arms embargo of the Government of Bosnia and Herzegovina no later than November 15, 1994 so that Government may exercise its right of self-defense under Article 51 of the United Nations Charter.

(2) DEFINITION.—As used in this section, the term 'United States arms embargo of the Government of Bosnia and Herzegovina' means the application to the Government of Bosnia and Herzegovina of—

(A) the policy adopted July 10, 1991, and published in the Federal Register of July 19, 1991 (58 F.R. 33322) under the heading 'Suspension of Munition Export Licenses to Yugoslavia'; and

(B) any similar policy being applied by the United States Government as of the date of receipt of the request described in paragraph (1) pursuant to request described in paragraph (1) pursuant to which approval is denied for transfers of defense articles and defense services to the former Yugoslavia.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be interpreted as authorization for deployment of United States forces in the territory of Bosnia and Herzegovina for any purpose, including training, support, of delivery of military equipment.

Mr. STEVENS. I ask unanimous consent amendment No. 2518 be withdrawn.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2518) was withdrawn.

Mr. STEVENS. Madam President, parliamentary inquiry, does that dispose of all the amendments the Senator from Hawaii and I submitted yesterday on behalf of our respective Members?

The PRESIDING OFFICER. All amendments have been disposed of. That is correct.

Are there further amendments?

The PRESIDING OFFICER. The question is on the engrossment of the amendments and third reading of the bill.

The amendments were ordered to be engrossed and the bill to be read a third time.

The bill was read a third time.

The PRESIDING OFFICER. Is there a request for the yeas and nays at this time?

Mr. STEVENS. Mr. President, I ask for the yeas and nays on the final passage of H.R. 4650.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

UNANIMOUS-CONSENT AGREEMENT

Mr. INOUYE. Madam President, I ask unanimous consent that H.R. 4650 be temporarily set aside and that the Senate proceed into executive session to consider the nomination of Janet Yellen, with the nomination considered under the conditions and limitations of a previous unanimous-consent agreement; provided further that upon disposition of the Yellen nomination and the Senate returning to legislative session, and without intervening action, the Senate vote on passage of H.R. 4650, the DOD appropriations bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

EXECUTIVE SESSION

The PRESIDING OFFICER. Under the previous order the Senate will go into executive session to consider the nomination of Janet L. Yellen, of California, to be a Member of the Board of Governors of the Federal Reserve System.

NOMINATION OF JANET L. YELLEN, OF CALIFORNIA, TO BE A MEMBER OF THE BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

The assistant legislative clerk read the nomination of Janet L. Yellen, of California, to be a Member of the Board of Governors of the Federal Reserve System.

The PRESIDING OFFICER. Under the previous order, 15 minutes will be under the control of the chairman of the Committee on Banking, Housing and Urban Affairs or his designee; 15 minutes under the control of the ranking member or his designee; and 15 minutes under the control of the Senator from North Dakota [Mr. DORGAN], or his designee.

The Senator from North Dakota.

Mr. DORGAN. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from Michigan.

Mr. RIEGLE. Madam President, I thank the Presiding Officer. I rise as chairman of the Senate Committee on Banking, Housing and Urban Affairs to support the nomination of Janet Yellen to serve as Member of the Board of Governors of the Federal Reserve system for a term of 14 years.

Clearly, this is a very important position, and I think the President has chosen wisely in selecting this nominee.

I want to say before yielding to my colleague from North Dakota, I am going to defer further comment about this nominee. I know my friend from North Dakota has concerns about the Federal Reserve Board and the composition of its membership, and I am very respectful of his concerns and his view. I want to hear his views. So I am going to reserve the remainder of my time and listen to what he has to say. I can elaborate on this nominee's qualifications and why I think she will be an exceptionally good member of the Board.

Having said that, I am interested in hearing the views of my colleague from North Dakota. I reserve the remainder of my time.

Mr. DORGAN addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Madam President, I will not utilize all of the time allotted to me, but I do want to speak briefly about the Federal Reserve Board. I did not want us to confirm another member of the Board of Governors for the Federal Reserve System without a vote and without a discussion.

I should say that I intend to vote for the nomination of Dr. Yellen. I think there is much to commend Dr. Yellen about her background and her views. I should also say at the same time that I hope in the future when we consider Federal Reserve Board nominees, we will have a real discussion and a real debate about monetary policy in this country.

It is interesting that you cannot have a real debate or a thoughtful discussion about monetary policy in this country today. It does not matter what the views of a Fed appointee might be. When they come to the committee, they have to say certain things so as not to upset the financial market. The market determines what we say around here these days. You have to have a certain language, and conform to a certain view. You have to say the right kind of buzz words so as not to run the market off in some wild direction. These days the market reminds me of a wild-eyed horse I used to have when I was a kid. The least little thing seems to set it off—often without substance—in some weird direction.

I was alarmed to read in today's paper that Dr. Greenspan recently testified on the Hill that the Fed is starting to pay more attention to the market because it has more of a view of what is happening with respect to inflation and the future than some of the indices that we now use.

I can give you chapter and verse of how the market has behaved over the years. You can go back to the tulip scandal in the 1600's and go to the junk bond scandal in the 1980's to figure out where the market is and what kind of signals they give you about what is right or wrong.

I'd like to show you, if I can, the Federal Reserve Board makeup as we discuss this subject. Again, I am going to be brief. I wanted to show my colleagues, as we discuss who is going to serve on the Board of Governors, who runs monetary policy in this country today. The reason I think it is important is that four times this year they have increased interest rates and they are fixing on Tuesday of this coming week to come to town and increase interest rates once again.

That is a tax on every American family, and they will do it in secret. Most Americans will not know who they are. If we were to increase a tax, we would do it with public debate, and there would be a tremendous outcry. But that is not true of monetary policy. They will extract a tax from every American family and do it with no discussion or no thoughtful debate.

Whose interest do they serve? There are five presidents of Federal Reserve regional banks who will vote next Monday. They are noted by the yellow stars. They will cast a vote on monetary policy next Tuesday. They run the regional Federal banks and they serve a board of directors. They serve regional bankers; that is who is on their board; that is who they owe their jobs to. They will come to town, unappointed, unconfirmed, unaccountable to anybody but their boards and bankers. Yet, they make decisions about interest rates that all of our constituents will pay.

Quickly, let me run through a couple charts. Let us look at what has been happening in this country. There is no evidence that a serious threat of inflation is imminent. In fact, inflation is low and has been falling for 3 straight years in a row. Again, remember, we have had four interest rate hikes in recent months to combat inflation. Here is what is happening to inflation in this country.

Mortgage interest rates, you see what has happened here. Once the Fed decided it was going to protect its big money bank interest and fight an inflation that does not exist, we see the tax on American families with the increase in mortgage interest rates.

Employer's cost of labor are the lowest in 12 years. You see this chart. Do we have inflation coming from an increase in labor costs? Not that I can tell. Unit costs of labor are low and falling.

So what is happening here? What is happening is monetary policy in this country is made in secret by the Federal Reserve Board, by the Board of Governors and by the Fed Open Market Committee. Probably all good people. I do not know most of them, but the fact is they have a constituency and they represent them well.

I have said before that I would really prefer my Uncle Harold have a shot at serving on the Federal Reserve Board but, of course, Uncle Harold does not qualify. He does not have a Ph.D. in economics, does not have a background of having worked for the Fed at some point in his life. He has made some house payments, and knows about interest rates, but they would never put him on the Fed.

I would like just once, and I hope in the future when we take a look at new candidates for the Federal Reserve Board, to have a real debate about interest rates or monetary policy in this country. In the 1800's, from barber shops to bars, they debated monetary policy in America, and it was healthy. In fact, there would not be any likelihood of a vote on the floor tonight on this subject unless some of us who cared—the Senator from Maryland, and others, the Senator from Nevada, Senator REID—decided we probably ought to vote on this.

We have a confirmation vote on Supreme Court nominees. It is very important. Federal Reserve Board members affect the lives of every single constituent in my State and every single constituent in every State in this country. And yet not a handful of Americans know their names or what they stand for or whose interest they serve.

Dr. Yellen, as I have indicated, is a person with an excellent background. I visited with Dr. Yellen by phone today. I exchanged letters with Dr. Yellen. I raised some questions about the impact of global market activities on interest rate policy decisions.

You know, it is interesting. When we talk about trade agreements, it is a global economy—NAFTA, GATT, "It is all global," they say. So when we talk about interest rates, they say, "Gee, you know what's happening? Too many Americans are being employed. As a result, we are starting to see upward inflationary pressure."

I say, "Aren't the corporations hiring from the world's hiring halls? Gee, that's what I thought the global economy was about. Aren't consumers buying refrigerators from the world's factories?"

"Oh, that's different."

It is a global environment when you talk about trade, but it is a different measurement when you talk about interest rates and monetary policy. I raised these questions with Dr. Yellen, and she indicated to me they were interesting questions and questions not really very well addressed these days by mainstream economists.

Mr. SARBANES. Will the Senator yield for a question?

Mr. DORGAN. I will be happy to yield.

Mr. SARBANES. The Senator's charts on unit labor cost and inflation rate actually support the very argument he has been making. We have some good growth. The Fed says we have inflation, we need to slow the growth down. We need the growth and we need the jobs.

Where is the inflation? The Senator put up the chart and showed inflation is low and falling. He put up another chart to show the unit of labor cost, the best they have been in 30 years.

So exactly the point the Senator is making is substantiated by what the statistics show us.

Mr. DORGAN. I appreciate the Senator's comment. Let me make one additional point. We went through wrenching debate and agonizing debate in this country last year trying to put together a deficit reduction plan—taxes and spending cuts and a whole range of things that were very difficult—a plan to put this country back on a track toward economic growth.

So we got the economy started again. We started to gear up toward cruising speeds to get the American economic engine working to employ people and give us an opportunity. And guess what? The Fed members meet behind closed doors in secret and decide to raise interest rates. I might add that the Fed is the only dinosaur left that meets in secret that I know of, and they made a decision to put the brakes on the American economy. Too many Americans are employed. This economy is growing too fast for our tastes. We worry about the "over the horizon." We have a view that no one else can quite see and a danger that is not picked up on the charts.

Well, what is happening I think is unfortunate for the American families who are looking for work amd the families who are going to have to pay a higher mortgage because of the action of the Fed.

The Senator from Nevada and I, the Senator from Maryland and others have talked about reform of the Federal Reserve Board, and I am going to push that. I have cosponsored and sponsored that legislation in the House and the Senate. We need to do something to make the Fed more accountable to the American people.

No, I am not saying we ought to take monetary policy over in the political halls of this country or in the Chambers of the House and Senate. That is not what I am saying at all. But no longer should we have decisions that are important, that affect all of our families in this country, made in secret by people who I think represent a constituency that is different than the constituency I see.

Madam President, I am going to vote for Dr. Yellen. I am anxious to have her come to town and look forward to meeting with her. I do say again you are going to hear a lot more from me, and I hope others, on the floor about the Fed.

I would say one more thing. When these folks come trotting down next week, the ones with the yellow stars, and they sit down in the closed room of the Board of Governors and decide they want to tax every American once again in a higher interest rate because they see something that does not exist, I am going to be here on the floor of the Senate showing their picture to the American people so that we all know who is doing it and get a chance to evaluate why they are doing it. This sort of thing in my judgment needs to change, and I hope this discussion tonight may be the first step on the road to that change.

Madam President, I yield the floor.

Mr. RIEGLE. Madam President, if I may, I appreciate what the Senator has said.

The PRESIDING OFFICER. The Senator from Michigan.

Mr. RIEGLE. I think and say that I share some of the same concerns that he has expressed here both in terms of the way policy is made, what the result of some of that policy has been, and the whole process by which we reach out and look at possible candidates for the Federal Reserve Board now and in the future.

I do want to say with respect to Ms. Yellen that her job qualifications are excellent. She has been a highly regarded economics professor at the University of California, Berkeley now for 14 years. She serves on the panel of economic advisers for the Congressional Budget Office and on the Brookings panel on economic activity. Much of her professional work has focused on improving our understanding of unemployment problems in this country and business cycles and how they work.

She has also been very active in looking at a number of important international financial trade issues. She has taught a course at Harvard and the London School of Economics.

But I would say, in a sense even more importantly, 3 weeks ago we held a hearing on her nomination. We questioned her for more than 2 hours, so this was not a routine discussion. We attach the same importance to these nominees as the Senator from North Dakota properly does. And we pressed her very hard on these questions because they are matters of grave concern to us as well.

I thought she gave us very good answers. She made it clear that she feels strongly that we ought to be driving toward maximum employment in our economy with moderate long-term interest rates, without kicking off an inflationary spiral. Clearly, her work in that area has been very strong, and her sensitivity was there and it was obvious to me.

I must tell Senators I was listening very carefully on that point because we suffer from high interest rates in my State, in Michigan, probably as much as any State. I quite agree with the Senator that interest rates, high interest rates, themselves are inflationary. You can refer to them as, in a sense, a form of taxation, if you will, if they are higher than they need to be.

High interest rates are by their very nature inflationary because they add to the cost of things as the cost of credit gets factored into prices of things, whether it is a home mortgage or a car loan or whatever it might be.

You have a hard time squeezing that admission out of members of the Federal Reserve Board, that high interest rates themselves, even if offered as an anti-inflationary strategy, can in fact themselves add to the inflationary pressure. And the Fed does not do a perfect job.

During the last recession, as Senator SARBANES pointed out as skillfully as anyone else along with Senator SASSER, you had a situation where the Fed during that recession adjusted interest rates 23 times and, frankly, never got it right in terms of sort of getting us out of that condition, not that they could do it all by themselves. Monetary policy obviously had a lot to do with it, in terms of the degree to which you might help foster a turnaround in the business cycle, an upswing in better employment prospects. So the record is far from perfect.

If you a had a car that was not running right and you took it down to the service station to get it fixed, and they worked on it, charged you, and you paid the bill, and you brought it home and it still did not work right, and you took it back 23 times, after a while you would start to wonder if they knew what they were doing.

I think it is fair to say that that was part of the history of this long recession that we finally have come out of since the Clinton administration has come to town and we have put a budget package in place, and we have started to make some progress. We have seen employment go up, unemployment numbers come down, and we have not seen a re-igniting of inflation, as the Senator points out.

But without prolonging that debate, I can attest to the Senator in my own view I think this is a solid candidate. The Senator has indicated he plans to vote for her. But I thought the Senator's points were well taken and they are not lost on me as chairman of the committee.

Mr. DORGAN. If the Senator will yield, I was not chagrined at the effort by the committee.

Mr. RIEGLE. I understand.

Mr. DORGAN. I think you folks on the committee care as much as I do about this.

With respect to whether the Fed is right or wrong, you expect them to be right occasionally. As the old saying goes, even a stopped clock is right twice a day. You would expect them to stumble into the right answer on occasion, if nothing else. But the Fed using the indices it uses would measure a hurricane as a source of national economic growth. Hurricane Andrew was one-half of 1 percent of economic growth in this country because you do not measure the damage; you measure the construction. A car accident outside the Capitol would be viewed as a source of economic strength, in indices the Fed would use. Somebody is going to be employed to fix a fender. Of course, they would not count the damage to the fender.

My only point is I want this to change.

The Senator from Maryland I know wants to speak.

Mr. RIEGLE. Let me yield him the balance of my time, if I may.

Madam President, I yield the remainder of the time I have to the Senator from Maryland, who, of course, not just serves on our committee accordingly but has served previously as chairman of the Joint Economic Committee.

The PRESIDING OFFICER. The Senator from Maryland.

Mr. SARBANES. Madam President, what is the time situation?

The PRESIDING OFFICER. There are 8 minutes remaining.

Mr. SARBANES. Madam President, first of all, I wish to commend the very able Senator from North Dakota for the statement he has just made. The American people need to understand how important to their daily lives the members of the Board of Governors of the Federal Reserve are, and the various presence of presidents of Federal Reserve banks who sit on the Open Market Committee. The 7 members of the Board of Governors are on the Open Market Committee and 5 of the 12 presidents of the Reserve banks are on that committee, and they rotate. So one year one will be on, another year another will be on.

As the Senator from North Dakota pointed out, the presidents of the Reserve banks, the regional banks, are picked by private interests. They make public policy, but they are picked by private interests to make public policy.

Now, the Board of Governors is different. The Board of Governors is nominated by the President and confirmed by the Senate, so they get a legitimacy in a democratic system to make public policy by their nomination by the President and their confirmation by the Senate.

That is not true of these presidents of the Federal Reserve banks, and I think that is a very important disconnect in our system, very frankly. If it was up to me, I would think they should not be on the Open Market Committee and just the Board of Governors ought to make these decisions.

Of course, if you get on the Federal Reserve, you get a 14 year term—14 years. I think the Senator is right to say these are important positions and we ought to have a vote on them, much like we do on people who go on the Supreme Court of the United States.

Now, I agree with his economic analysis. We put a fiscally restrained policy into place last August to bring down the budget deficit. That in effect constrains the economy, so you say, well, where will you get the impetus for the economy to grow and to get economic growth and jobs?

Well, we assumed it would come from low interest rates, from an accommodating monetary policy. For years, the Fed and others have been telling the Congress you have to get the budget deficit under control. Well, that is exactly what we did a year ago, with some very tough decisions in this body.

Interestingly enough, a lot of the people who complained the most about the deficit, when it came to voting the tough decision to do something about it, were not there to do it. They will be out here for a balanced budget amendment to the Constitution, but when you come along and say, well, now here is a package, we are going to do serious spending cuts, we are going to raise some additional revenues in order to reduce the deficit, they are not to be seen or heard from.

In any event, we did that. We had an accommodating monetary policy. Interest rates were low. The economy began to grow. Beginning in February, the Fed started taking up the interest rates. And they have now gone on long-term rates, 30-year mortgage rates, from under 7 percent to almost 9 percent. So if you are a young couple wanting to buy a home, you may not be able to afford it at the current interest rates.

They sort of shrug their shoulders and, say, "Too bad." I sort of say, why are these young people who want to buy a home being denied the opportunity? What is it in the economic circumstance that calls for the higher interest rates when, as the able Senator's chart shows, there is no inflation problem? In fact, it is the best performance in 30 years. Unit labor costs are the best in 30 years. And, yet, they are dampening down the economy when we need the economic growth and when we need the jobs. The unemployment rate is still above 6 percent.

So I commend the Senator from North Dakota for his statement. I agree with him. These matters ought to be debated. The Federal Reserve ought not simply to make pronouncements sort of in a cloud of smoke. Actually Volcker did that more than Greenspan because he smoked that cigar. So he comes in and makes his statement, and with the sort of cloud of smoke that accompanied it.

But there are in some circles in this country the assumption that, if you question the judgments or the policies of the Federal Reserve, somehow you are outside of the proper bounds of political discourse. "Oh, they are trying to politicize the Fed." We are not trying to politicize the Fed. But we think the Fed ought to lay out a rationale and a justification for the policies it is taking and that it ought to be a reasonable matter for debate.

The economic journals are full of articles criticizing the Fed's policies and supporting the Fed's policies. So it is obviously a subject of reasonable debate. The newsletters from the investment houses, although biased toward the Fed, some are critical of the Fed's interest rate policies. Others support it. If it can be debated on Wall Street, why should it not be debated here in the Congress with more of a concern for Main Street? The last time the Fed took the rates up, the Chamber of Commerce, mind you, said that they were worried that Main Street was being sacrificed to Wall Street. And I worry about that as well.

Let me just very briefly turn to the nominee that is before us. I appreciate the fact that the able Senator from North Dakota has separated the broader and very important point I think he is making about monetary policy, and about debating it, about the secrecy with which the Fed operates, about the undemocratic nature of the presidents of these regional banks being on the open market committee. He has separated those very important issues from the question of this nominee because I do think that Janet Yellen is qualified. I do think she ought to go on the Board of Governors. She was approved by the Banking Committee by a vote of 18 to 1.

I think a brief review of her background makes clear that she is highly qualified to serve on the Board of Governors. She received her BA from Brown University, as a summa cum laude. She graduated with the highest honors in economics with a Phi Beta Kappa. She received the National Science Foundation Graduate Fellowship and went on to Yale where she got her Ph.D. 4 years later.

So she holds a Ph.D. in economics from Yale. She has been an assistant professor of economics at Harvard; a lecturer at the London School of Economics; and she has been now for some number of years professor of international business and trade at the School of Business of the University of California at Berkeley, since 1980. She has taught international and macroeconomics in the MBA and the executive education programs of that school. She has received the Distinguished Teaching Award at the University of California at Berkeley.

She is recognized in the profession as one of the highest quality. She is published widely in the fields of macroeconomics and international economics.

Actually, much of her work is focused on understanding the causes of unemployment and how they may be alleviated. I think the analytical talent she brings to the Federal Reserve is second to none. I think she has an understanding of the impact of economic policy decisions on the lives of everyday people.

I commend the President for nominating a person of this caliber to go on the Board of Governors. This is a very distinguished, very able, very serious-thinking person. And I for one look forward to her service on the Federal Reserve Board.

STATEMENT ON THE NOMINATION OF JANET L. YELLEN

Mr. D'AMATO. Madam President, I rise today to support the nomination of Janet L. Yellen to serve on the Board of Governors of the Federal Reserve System. Madam President, Ms. Yellen is well qualified for the position.

Educated at the distinguished Brown University, and later earning a Ph.D. from Yale University, Ms. Yellen has demonstrated a mastery of economics and monetary policy. Through her extensive published research and her prior service at the Federal Reserve as an economist in the Division of International Finance, she has demonstrated her analytical skills to assist the Fed in its complex mission as the central bank and its control over monetary policy.

More importantly, Madam President, Ms. Yellen has openly expressed the importance of securing the independence of the Federal Reserve Board. Congress has devised a system where the Federal Reserve is accountable to the Congress and can best serve the American people by focusing on long-term growth. Ms. Yellen has pledged her support to this cause.

Madam President, I recommend that this body support the nomination of Ms. Janet Yellen to the Board of Governors of the Federal Reserve.

STATEMENT ON THE NOMINATION OF JANET YELLEN

Mr. RIEGLE. Madam President, I rise in support of the nomination of Janet Yellen to serve as a member of the Board of Governors of the Federal Reserve System for a term of 14 years. This is a very important position, and I think the President has made an outstanding choice.

Federal Reserve Board members have the principle responsibility within the government for economic stability. Their goal is to maintain a healthy rate of growth in jobs while permitting only a low rate of growth of prices. It is a difficult job and a vitally important one. Mistakes, when they occur in policy formulation and adjustments, can be extremely costly. The recession we have just essentially recovered from cost us more than $700 billion in lost production over a 4-year period. It took the Fed 23 policy changes to finally get interest rates low enough for that recovery to proceed. We cannot expect the Fed to avoid recessions entirely, but I think it is fair to say that the Fed's decisions can have a powerful effect on how costly recessions are and how frequently they occur.

The Federal Reserve also has other significant tasks. It is the principal Federal regulator for a large share of our state-chartered banks. It supervises, and partly operates, our financial payments system. And the Fed has perhaps the primary role in avoiding any systemic financial market failures.

Federal Reserve Board members have a number of noteworthy issues to resolve, together with the other financial regulators. These include finding a way to significantly consolidate our bank regulatory agencies and ensuring that public risks posed by the private use of derivatives are limited and under a reasonable degree of supervision and control. In my view, the Fed must also do a far better job of enforcing and applying our community reinvestment and fair lending laws. There has been progress in that area but it has been slow in coming.

This nominee's qualifications for the job are excellent. She has been a very highly regarded economics professor at the University of California at Berkeley for 14 years. She serves on the panel of economic advisors for the Congressional Budget Office and on the Brookings Panel on Economic Activity. Her work has focused on improving our understanding of unemployment and business cycles. And she has also examined German reunification, trade responses to exchange rate changes, income distribution, and a variety of other issues. She has also taught at Harvard and the London School of Economics.

Three weeks ago, the banking committee held a hearing on this nomination and questioned Ms. Yellen for more than 2 hours. She gave us very good answers. When asked whether monetary policy should focus exclusively on fighting inflation, she said that she believed the Fed needs to be focused on maximum employment, and moderate long-term interest rates, as well as inflation. With respect to the Fed's next policy move, she said she had no predisposition to act in either direction: to lower interest rates to forestall a recession or to raise them if signs of emerging inflation appear.

I think this is a nominee who understands what the consequences of a weak economy are to real people. She has spent a large portion of her career studying unemployment. As she told our committee:

> The toll of unemployment, like that of a regressive tax, falls most heavily on groups in the workforce that are least able to bear the burden. Young workers deprived of gainful employment may have careers which are permanently stunted because they cannot develop the skills which are critical to their long-term job prospects.

She also pointed out that because a weak economy reduced the incentive and ability of firms to make investments, "high unemployment harms long-term living standards."

But she also understands the dangers of inflation. She told us:

> The recession of 1982–83 illustrates the enormous price that workers and businesses paid to bring inflation under control after it built up in the 1970's. Having incurred such a high price to lower inflation then, it would be foolhardy now to squander the fruits of this effort.

I think she is someone with balanced views and a superb background. The banking committee voted 18–1 to report her nomination favorably and I urge my colleagues to confirm this nomination speedily.

Mr. DORGAN. Madam President, I yield the remainder of my time.

Mr. STEVENS. Madam President, I yield back the time of the Senator from New York.

The PRESIDING OFFICER. The question is, Shall the Senate advise and consent to the confirmation of the nomination of Janet L. Yellen, of California, to be a Member of the Board of Governors of the Federal Reserve System? On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 94, nays 6, as follows:

[Rollcall Vote No. 281 Leg.]

YEAS—94

Akaka
Baucus
Bennett
Biden
Bingaman
Bond
Boren
Boxer
Bradley
Breaux
Bryan
Bumpers
Burns
Byrd
Campbell
Chafee
Coats
Cochran
Cohen
Conrad
Coverdell
Craig
D'Amato
Danforth
Daschle
DeConcini
Dodd
Dole
Domenici
Dorgan
Durenberger
Exon
Feingold
Feinstein
Ford
Glenn
Gorton
Graham
Gramm
Gregg
Harkin
Hatch
Hatfield
Heflin
Hollings
Hutchison
Inouye
Jeffords
Johnston
Kassebaum
Kempthorne
Kennedy
Kerrey
Kerry
Kohl
Lautenberg
Leahy
Levin
Lieberman
Lott
Lugar
Mack
Mathews
McCain
McConnell
Metzenbaum
Mikulski
Mitchell
Moseley-Braun
Moynihan
Murkowski
Murray
Nickles
Nunn
Packwood
Pell
Pryor
Reid
Riegle
Robb
Rockefeller
Roth
Sarbanes
Sasser
Shelby
Simon
Simpson
Smith
Specter
Stevens
Thurmond
Warner
Wellstone
Wofford

NAYS—6

Brown
Faircloth
Grassley
Helms
Pressler
Wallop

So, the nomination was confirmed.

The PRESIDING OFFICER. Under the previous order, the motion to reconsider the vote is laid upon the table, and the President will be notified of the Senate's action.

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will now return to legislative session.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT

The PRESIDING OFFICER. The clerk will report the pending business.

The legislative clerk read as follows:

A bill (H.R. 4650) making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

The Senate continued with the consideration of the bill.

The PRESIDING OFFICER. The question occurs on the passage of H.R. 4650, as amended. The bill having been read the third time, the question is, Shall it pass?

On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The legislative clerk called the roll.

The PRESIDING OFFICER (Mr. WOFFORD). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 86, nays 14, as follows:

[Rollcall Vote No. 282 Leg.]

YEAS—86

Akaka
Baucus
Bennett
Biden
Bingaman
Bond
Boren
Boxer
Bradley
Breaux
Bryan
Bumpers
Burns
Byrd
Campbell
Chafee
Coats
Cochran
Cohen
Conrad
Coverdell
D'Amato
Danforth
Daschle
DeConcini
Dodd
Domenici
Dorgan
Durenberger
Exon
Faircloth
Feinstein
Ford
Glenn
Gorton
Graham
Gramm
Grassley
Harkin
Heflin
Helms
Hollings
Hutchison
Inouye
Jeffords
Johnston
Kassebaum
Kennedy
Kerrey
Kerry
Kohl
Lautenberg
Leahy
Levin
Lieberman
Lott
Lugar
Mack
Mathews
McConnell
Metzenbaum
Mikulski
Mitchell
Moseley-Braun
Moynihan
Murkowski
Murray
Nickles
Nunn
Packwood
Pell
Pryor
Reid
Riegle
Robb
Rockefeller
Sarbanes
Sasser
Shelby
Simon
Simpson
Specter
Stevens
Thurmond
Warner
Wofford

NAYS—14

Brown
Craig
Dole
Feingold
Gregg
Hatch
Hatfield
Kempthorne
McCain
Pressler
Roth
Smith
Wallop
Wellstone

So the bill (H.R. 4650), as amended, was passed.

The PRESIDING OFFICER. Under the previous order, the Senate insists on its amendments, requests a conference with the House and the Chair appoints the following conferees.

The Presiding Officer (Mr. WOFFORD) appointed Mr. INOUYE, Mr. HOLLINGS, Mr. JOHNSTON, Mr. BYRD, Mr. LEAHY, Mr. SASSER, Mr. DECONCINI, Mr. BUMPERS, Mr. LAUTENBERG, Mr. HARKIN, Mr. STEVENS, Mr. D'AMATO, Mr. COCHRAN, Mr. SPECTER, Mr. DOMENICI, Mr. NICKLES, Mr. GRAMM of Texas, Mr. BOND, and Mr. HATFIELD conferees on the part of the Senate.

MORNING BUSINESS

Mr. FORD. Mr. President, I now ask unanimous consent there be a period for morning business, with Senators permitted to speak therein for up to 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

SEQUENTIAL REFERRAL—S. 2344

Mr. FORD. Mr. President, I understand that on August 9, 1994, the Committee on Labor and Human Resources reported S. 2344, Calendar No. 549, a bill to authorize appropriations for the National Science Foundation. I ask the bill be sequentially referred to the Committee on Commerce, Science, and Transportation pursuant to the order of March 3, 1988.

The PRESIDING OFFICER. The bill will be so referred.

APPOINTMENT BY THE PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The Chair, on behalf of the President pro tempore, pursuant to Public Law 99-498, reappoints William C. Hiss, of Maine, to the Advisory Committee on Student Financial Assistance for a 3-year term effective October 1, 1994.

UNANIMOUS-CONSENT AGREEMENT—S. 2082

Mr. FORD. Mr. President, I ask unanimous consent that at 9:30 a.m. Friday, August 12, the Senate proceed to the consideration of Calendar No. 501, S. 2082, the intelligence authorization, and that it be considered under the following limitations:

That the committee amendments be agreed to, en bloc, without debate; that there be a 60 minute time limitation for debate on the bill; with up to 20 minutes of that time for opening statements of the managers, that the following be the only floor amendments in order to the bill and that they be considered under the time limits specified; that no other amendments be in order except where specified; provided further that they be relevant to the subject matter of the amendment to which offered; with all time for debate equally divided and controlled in the usual form; and that any second degree amendments be allotted the same time limits as the first degree amendment to which offered:

A managers' amendment (text of S. 2056)—1 hour; with second-degree amendments in order thereto;

Warner amendment relating to a Commission—40 minutes with the time divided as follows: 25 minutes equally divided and controlled and 15 minutes allotted to Senator SPECTER;

Two amendments to be offered by Senator NUNN which are relevant with a time limitation of 1 hour on each; DeConcini amendment which is relevant—30 minutes that upon disposition of the listed amendments, the bill be read a third time, and the Senate then proceed to Calendar No. 529, H.R. 4299, the House companion; that all after the enacting clause be stricken and the text of S. 2082, as amended, be inserted in lieu thereof, that the bill be advanced to third reading and passed; that upon disposition of H.R. 4299, the Senate insist on its amendment, request a conference with the House on the disagreeing votes of the two Houses and that the Chair be authorized to appoint conferees; that upon disposition of H.R. 4299, both S. 2082 and S. 2056 be indefinitely postponed, with the above occurring without intervening action.

The PRESIDING OFFICER. Without objection, it is so ordered.

ENERGY AND WATER DEVELOPMENT APPROPRIATIONS ACT, 1995—CONFERENCE REPORT

Mr. FORD. Mr. President, I ask the Chair to lay before the Senate the conference report accompanying H.R. 4506, the Energy, Water appropriations bill; and that the Senate then proceed to its immediate consideration; that the conference report be adopted and the motion to reconsider be laid upon the table, with the above occurring without intervening action; provided further that upon adoption of the conference report, the Senate concur, en bloc, in the House amendments to the Senate amendments numbered 2, 4, 8, 28, 48 and 49.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FORD. Mr. President, I submit a report of the committee on conference on H.R. 4506 and ask for its immediate consideration.

The PRESIDING OFFICER. The report will be stated.

The Legislative clerk read as follows:

The Committee on conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 4506) a bill making appropriations for energy and water development for the fiscal year ending September 30, 1995, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses this report, signed by all of the conferees.

The PRESIDING OFFICER. Without objection, the Senate will proceed to the consideration of the conference report.

(The conference report is printed in the House proceedings of the RECORD of August 4, 1994.)

Mr. JOHNSTON. Mr. President, I am pleased to present the conference report on the fiscal year 1995 Energy and Water Development appropriation bill. This conference report on the bill, H.R. 4506 passed the House of Representatives by a vote of 393 yeas to 34 nays, on August 10, 1994.

The conference on this bill held on August 4, 1994, and the conference report was printed in the CONGRESSIONAL RECORD of August 4, 1994. Of course, the printed conference report has been available since that time also. Therefore, I will not undertake to elaborate on the disposition of all the items that were in conference.

The conference agreement provides $20,662,402,000 in new budget obligational authority. This amount is $20,236,000 less than the President's budget request. It is $136,892,000 over the House passed bill, and $19,894,000 less than the Senate passed bill. The principal reason for this difference is that the 602(b) allocation was $140 million higher for the Senate bill. The conference bill is within the 602(b) allocation for both budget and outlays.

Title I of the bill provides appropriations for the U.S. Army Corps of Engineers' Civil Works Program. The conference agreement provides $3,408,919,000 which is $43,515,000 less than the House bill and $17,354,000 more than the Senate bill.

For title II, the Bureau of Reclamation in the Department of the Interior, the conference agreement includes a total of $881,399,000. This is $2,221,000 less than the House passed bill and $11,985,000 more than the Senate passed bill.

A total of $15,901,676,000 is provided in title III for the Department of Energy programs, projects, and activities. Of this amount, $10.3 billion is for atomic energy defense activities which is $367,000 below the House passed bill and $29,452,000 below the Senate passed bill.

Mr. President, one of the major differences between the House and Senate bills was the integral fast reactor [IFR], also known as the advanced liquid metal reactor [ALMR]. The Senate position was to continue the research on actinide recycling while terminating the reactor program. The House position was to immediately terminate the program and shutdown EBR II without completing the research phase of the program. As Members will recall, we had an excellent debate in the Senate and our position to complete the research prevailed. However, the House voted three times to terminate the program as proposed by the President and the Department of Energy. In the face of the House's repeated votes against the program, the conferees have agreed to terminate the program. A total of $83,800,000 is provided for shutdown of EBR II and termination beginning this fall, as proposed by the House. In the termination process, the Department is to maximize the research on actinide recycle, and as proposed by the administration, should retain such facilities as necessary, especially the pyroprocessing facilities, to provide for alternative missions at Argonne National Laboratory in Idaho and Illinois. The Department is encouraged to identify alternate funding sources for the unfunded alternative missions at Argonne's facilities in Idaho and Illinois.

Another of the major differences, concerns the magnetic fusion energy program and what we call the TPX construction line item. TPX is the Tohamak physics experiment at Princeton University, a new machine estimated to cost about $800 million to construct and about $1 billion to operate over its life. It is a part of the larger International Tohamak experimental reactor or ITER which will cost about $10 billion to construct and about $10 billion to operate. So in this program, we would be faced with a $22 to $25 billion program to further develop magnetic fusion. I am determined that the Congress, the administration, and the White House, have an eyes-wide-open debate and decision in going forward with this program. I support it, and believe we should go forward. I am also determined to avoid another SSC debacle by doing what I can to see that we have a commitment to the program, especially because of the enormous sums involved, and to have an international process and agreements on the ITER project.

The conferees have agreed that TPX will proceed with design activity only including industrial participation in the engineering design and research and development and includes $42,000,000 for this activity. The conferees recognize the very significant scientific accomplishments of the deuterium-tritium [D-T] experiments on the Tokamak fusion test reactor [TFTR] in support of the ITER design, and it is the intent of the conferees that these important experiments continue until construction of TPX is approved. Therefore, in fiscal year 1995, $65,000,000 is provided for continuation of TFTR experiments. $8,000,000 is included for the PBX-M program. With regard to TPX design, the Department of Energy is directed to use standard, phased industrial contracts for these design activities, with options for construction that would permit continuity and would allow the project to be completed in the most efficient and cost efficient and cost-effective manner. $2,000,000 may be used for the purchase of long lead-time superconducting material critical to maintaining the schedule of the project.

The conferees also provide $52,000,000 for the DIII-D Tokamak facility and $8,700,000 for the Inertial Confinement Fusion program including an increase of $2,000,000 for the induction linac systems experiment [ILSE] to enable this program to proceed on a timely and cost-effective schedule.

I recommend to the Senate that this conference report be approved promptly so as to complete action on this appropriation bill and clear it for the President's consideration and approval.

Mr. President, I wish to express our appreciation and thanks to our House colleagues lead by the chairman of the House Subcommittee, the distinguished gentleman from Alabama [Mr. BEVILL] and the Ranking Minority Member, the distinguished gentleman from Indiana [Mr. MEYERS]. I also want to thank again my friend and able colleague, the gentleman from Oregon [Mr. HATFIELD]. It is always a happy experience to work with him. Also, I want to express my appreciation to all of the Senate conferees who are members of our subcommittee also.

DECLASSIFICATION PRODUCTIVITY INITIATIVE

Mr. SMITH. Mr. President, I would like to inquire of the Chairman of the Energy and Water Appropriations Subcommittee, Senator JOHNSTON, as to the ultimate disposition of the Declassification Productivity Initiative [DPI] provision that was originally included as report language in the Senate appropriations bill. As you recall, during consideration of the fiscal year 1995 Defense authorization bill, the Senate, and subsequently the defense conference, agreed to my amendment authorizing $3,000,000 from the account titled "Materials Support and Other Defense Programs" to fund the DPI effort.

Mr. JOHNSTON. I thank my colleague from New Hampshire for his interest in this program. I am aware of his previous actions in the Armed Services Committee and greatly appreciate his ensuring that throughout the defense conference this program received the necessary attention.

As to the outcome of the Declassification Productivity Initiative, I am pleased to inform my colleague that the original report language of the Senate was agreed to by the House conferees. The language states in part:

> * * * the Committee encourages the Department to proceed quickly with its new declassification productivity initiative to provide computer-based, expert systems to enhance the productivity of the document declassification review process.

The report language further states that up to $3,000,000 be allocated for this initiative. Though the conferees were unable to specifically earmark the $3,000,000 needed in fiscal year 1995, I want to assure the Senator from New Hampshire that I am committed to getting the Department of Energy to allocate the funds for this much-needed program. It should be fully understood by the Department of Energy that the report language submitted by the Senate in this appropriations conference report and the language Senator SMITH secured in the defense authorization conference are still enforceable and should be adhered to.

The Senate Energy and Water appropriations report also mentions that the Department of Energy is behind in processing both its Freedom of Information Act requests and the mandatory requests for information under Executive Order 12356. It is my understanding that these problems stem from the Department's inability to provide adequate financial, technical and personnel resources in the declassification review process because a significant portion of the information requested must be screened and sanitized.

Mr. SMITH. Mr. President, I am in full agreement with the Senator's comments. In fact, declassification efforts, and the need to improve upon the productivity of these programs are an issue in numerous departments and agencies—not just the Department of Energy. I believe the DPI effort, with the strong commitment of the Chairman and with the direction the Congress has already provided the Department, will take the first critical step toward improving those deficiencies just mentioned by the Senator. Furthermore, as I mentioned in my speech to the Senate during my amendment's consideration on the defense bill, the DPI is a significant first step at redefining the boundaries of technology in high-speed optional scanning, imaging and computing. This type of technology will not only enhance government efficiency, but the information-intensive segments of private industry as well such as the banking, health care and petrochemical.

Lastly, Mr. President, I believe the Department must step up its efforts not only to ensure the $3,000,000 in funding is available for the Declassification Productivity Initiative in fiscal year 1995, but also that adequate resources for this effort are included in the Department's future budget requests. I sincerely hope that the Chairman will encourage the Department along these lines, and I want to assure him that he will have my support.

Mr. JOHNSTON. I thank the Senator for his help in this matter. I will certainly do my best to help the funding along. I yield the floor.

TERMINATION OF THE ADVANCED LIQUID METAL REACTOR

Mr. KERRY. Mr. President, the Senate today is acting to accomplish the near-impossible: it will eliminate a Federal program.

When we approve the Energy Appropriations bill conference report today, we will be approving the termination of the Advanced Liquid Metal Reactor [ALMR], a program that is a complete waste of taxpayer dollars and dangerous as well. This is a program that I have fought to kill over the past year and it is with great satisfaction that I mark its demise.

Mr. President we have to-date spent close to $9 billion on this program. And we have nothing to show for it.

If we had not terminated it, we would have spent an additional $3.2 billion over the next 15 years just on ALMR research, design, development and prototyping. Termination will save $2.9 billion, according to Secretary of Energy Hazel O'Leary.

But many of my colleagues felt that even though the program is expensive, we should have funded it because scientific research is a good long-term investment. However, in this case research is a very bad idea. It is a bad idea because the technology—even if successful—is not needed and because continuing the research is extremely dangerous from a nonproliferation perspective.

I wish to make it clear that I do not feel that it is a bad idea simply because it is a nuclear program. I am a supporter of Light Water Reactors and of the Advanced Light Water Reactor Program at the Department of Energy. This is the technology supported by industry. I am opposed to the ALMR—which is not supported by industry and is not necessary to the continuation of the nuclear industry.

NON-PROLIFERATION

The prime reason I am opposed to the ALMR is the same reason that prompted Secretary O'Leary to take her very brave stand against this technology and President Clinton to decide to oppose this project. It directly violates our nonproliferation policy and hurts our credibility in discouraging proliferation. As Secretary O'Leary said, "We cannot credibly urge that others not use technologies for separating and using plutonium if we are pursuing those same technologies ourselves."

Let me make it clear to my colleagues: the Secretary of Energy and the President oppose this technology because it make it harder for the President to discourage rogue nations from acquiring the ability to build nuclear bombs. the New York Times said "Financing the Integral Fast Reactor would send the wrong signal to Japan and others who are planning to produce more plutonium to fuel nuclear power plants."

Besides sabotaging U.S. nonproliferation policy, further research into the ALMR would have put information on plutonium separation into the public domain. Proponents argued that the U.S. would be discriminating in sharing this technology. Unfortunately, in the past, technology has spread to rogue nations. North Korea reportedly has acquired advanced European reprocessing technology used in a facility in Belgium and its operating reactor is well known to be a clone of a British production reactor. Much of the ALMR's reprocessing technology would have been described in the open scientific literature. At least one of the contracts on pyroprocessing establishes the right of the contractors to publish detailed results of the R&D work.

Further, ALMR facilities themselves would have made plutonium more easily available to those wishing to acquire it for bombs. Proponents say that it is more proliferation-resistant than alternative reprocessing technology. But the meaningful comparison is with the once-through fuel cycle, which the U.S. currently uses to produce electricity from light-water reactors. Under this comparison, the ALMR clearly increases proliferation risks. The National Academy of Sciences [NAS] said in a recent study: "Possession of such a facility, however, would still offer a state the technology needed to produce separated plutonium for weapons, should it choose to do so openly."

NEW STUDIES

The proponents justified the technology by saying that it will "recycle" the spent fuel from nuclear reactors and the plutonium from weapons. However, several objective, independent studies have come out in the past year which firmly refute these claims.

The National Academy of Sciences has published a study saying that the ALMR is a bad idea for weapons plutonium disposition. The GAO has published a study saying that the ALMR is a bad idea for commercial spent fuel disposition. And the OTA has published a study agreeing with both of these studies and claiming that the ALMR could easily become a breeder reactor—producing more plutonium than it consumes. These were the only objective studies conducted in the last year and they all came out against the technology.

DISPOSAL OF WEAPONS PLUTONIUM

On the question of weapons plutonium, the NAS study concludes unequivocally that the ALMR was far less desirable than two other technologies for disposal: the vitrification technology and the MOX technology—where plutonium is run through light-water reactors and forms a mixed oxide fuel. NAS said "Advanced reactors should not be specifically developed or deployed for transforming weapons plutonium into spent fuel, because that aim can be achieved more rapidly, less expensively, and more surely using existing or evolutionary reactor types."

The NAS said that there is clear and present danger from the presence of weapons plutonium and so the most important quality in a solution is the speed with which it makes the plutonium unusable. ALMR would take far longer than either vitrification or MOX. In fact, a vitrification campaign to dispose of plutonium could be finished before an ALMR campaign was even ready to begin. The head of the NAS panel said in testimony before the Energy Committee "Considering the urgency of bringing the plutonium from nuclear weapons to the 'spent fuel standard,' the development and construction of a new generation of nuclear reactors cannot be justified for the plutonium disposition mission."

RECYCLING COMMERCIAL SPENT FUEL WASTE

The GAO study says that "DOE's radioactive waste managers are not pursuing the transmutation of waste because they believe that it is too costly and unnecessary." GAO pointed out that there is no way ALMR's, even if they do everything their advocates say they can do, could reduce waste volume enough to substitute for a repository. Further, whether or not a second repository will be needed is impossible to predict at this point, because it depends on variables such as how much waste the first repository will hold, will more nuclear plants be built, how long will the current one run, et cetera.

More important, using ALMR's even under the rosiest scenario would be less efficient, more costly, and involve more movement and above-ground storage of radioactive material than repository burial alone. Using the ALMR would take hundreds of years longer to get spent waste underground than just using the repository alone. Lawrence Livermore in a study wrote "There remain no costs or safety incentives to introduce—partitioning and transmutation—into the high-level waste management system."

Using the ALMR would add cost to the spent waste disposal method. This is why the Electric Power Research Institute said "The policy would likely incur a large cost penalty, encounter major institutional difficulties, multiply licensing difficulties, and amplify political and public opposition to the nuclear power program as a whole."

Further, it would not reduce the danger. It might eat up some of the actinides—if it does what it claims—but it would leave other longer-living fission products which are more water soluble and so more susceptible to leaks. But the DOE waste managers say that we should not even focus on the technology because our policy is to use a repository and we should focus on making that work well—not on an add-on technology.

BREEDER TECHNOLOGY

The OTA study states that "Even if the system were designed to be a plutonium consumer, it would not be mechanically difficult for an owner with technical expertise to convert it to a "breeder" * * * it would be difficult or impossible to design a reactor that could be guaranteed to not work as a plutonium breeder." Far from removing dangerous plutonium from the planet, the ALMR has the potential to increase the amount of plutonium. The OTA makes clear that this has always been the principal purpose of the technology.

The only explanation I can find for why this project persisted for as long as it did in the face of all the objective evidence is the fact that its mission changed so many times to suit the current political winds. First, it was a plutonium breeder. Then the developers began to promote the project as a method to reprocess and transform spent nuclear fuel from commercial LWRs to solve the Yucca mountain problems. After 1991, when arms reduction agreements between the United States and the former Soviet Union appeared likely to produce significant quantities of surplus plutonium, developers emphasized its potential to eliminate this plutonium by consuming it as a nuclear fuel to make electricity. Most recently proponents claimed it would prevent spent fuel from becoming a proliferation risk.

Mr. President, the ALMR was a project in search of a mission. Now it need no longer search.

The President of the United States opposes this project. The Secretary of Energy opposes this project. The House of Representatives opposes this project. The Nuclear Control Institute opposes this project. The National Taxpayers Union opposes it. Citizens Against Government Waste opposes it. Public Citizen. U.S. PIRG. Safe Energy Communications Coalition. Sierra Club. National Resources Defense Council. GreenPeace. Physicians for Social Responsibility. Union of Concerned Scientists.

And finally, today, the Senate will go on record as opposing this project as well.

Two of my colleagues have dedicated a great deal of time and energy to the termination of the ALMR on behalf of the American taxpayer. They are the Senator from New Hampshire, Mr. GREGG, and the Senator from Arkansas, Mr. BUMPERS.

The Secretary of Energy was also enormously helpful in calling on members of Congress to express the Administration's position that the ALMR violates our nonproliferation policy.

Those who fought to terminate the project in the House, Representative COPPERSMITH, Representative SHARP and others, deserve a great share of the credit for their work over the past year to eliminate this dangerous program.

I commend my colleagues for saving the taxpayers billions of dollars and for eliminating a danger to our nonproliferation efforts. I look forward to sending this bill to the President for his signature.

Mr. HATFIELD. Mr. President, I join chairman JOHNSTON in recommending final approval of the Energy and Water Development Appropriations Conference Report to the full Senate. This conference report provides funds for important projects and activities in every State, and concerns every Member of this body. I am pleased to be associated with this effort, and I especially want to thank Senator BYRD, chairman of the full Appropriations Committee, for his assistance throughout our process.

I also want to thank Senator JOHNSTON for the outstanding leadership he has provided in developing this package. Considering the many difficulties the Energy and Water Development Subcommittee encountered this year, especially with regard to a 602(b) allocation that is approximately $1.2 billion below the fiscal year 1994 enacted level, Senator JOHNSTON's efforts have been over and beyond the call of duty.

The conference report is especially important to our efforts in the Pacific Northwest to rebuild the threatened and endangered salmon runs in the Columbia River Basin. We have provided funding for the Corps of Engineers and the Bureau of Reclamation to continue their important efforts to protect and enhance the salmon stocks at risk. These activities will complement the regional efforts implemented according to the Northwest Power Planning Council's "Strategy for Salmon" which are funded by the region's electrical ratepayers through the Bonneville Power Administration.

I want to mention a specific provision included by the conferees in the joint explanatory statement concerning the administration's agreement to assume costs of the additional measures to protect endangered and threatened stocks of salmon in 1994 which go beyond the current biological opinion governing the operation of the Federal Columbia River Power System. The conferees have no objection to the administration's decision to provide this financial assistance, but believe that the proposal to fund these costs by crediting the Bonneville Power Administration's repayment to the Treasury may have broader financial and policy implications. Accordingly, the conferees expect the Bonneville Power Administration to work with the Office of Management and Budget and the House and Senate Appropriations Committees to outline the budgetary principles and financing mechanisms to be applied if it appears there will be a continuing need for this assistance beyond 1994. The administration has been most helpful to the region, and I look forward to any further discussions which may be necessary.

Once again, I thank the distinguished subcommittee chairman, Senator JOHNSTON, for his efforts and hard work in developing and shepherding this important conference report through the Congress.

I yield the floor.

Mr. CRAIG. Mr. President, I will not object to the unanimous consent request to take up the Energy and Water Development appropriations bill for fiscal year 1995. However, I want to make clear there is one item in this bill to which I strongly object.

My objection is to the conferees decision to terminate the advanced reactor research on the Integral Fast Reactor/Advanced Liquid Metal Reactor [IFR/ALMR]. This is not a cost-saving measure nor is it a good science decision. Termination will lead to more not less plutonium proliferation in the world. The technology that was being developed actually consumed plutonium.

This was the only technology being developed that could actually burn up plutonium. I strongly believe history will show this termination decision to be a wrong and short-sighted one.

However, the conferees have decided to provide only $83.8 million for the shutdown of the experimental reactor EBR II and the termination of the IFR program. I am very concerned that this is not sufficient money to even allow for a safe and orderly shutdown.

The two Senators from Illinois, my colleague from Idaho and I are all currently working with the Secretary of Energy to salvage a program that will retain a portion of this important science and to retain the brain trust that has developed around the IFR research. This is consistent with the direction of the conferees to maximize the research on actinide recycle and retain such facilities as necessary, especially the pyroprocessing facilities, to provide for alternative missions at the Argonne National Laboratory in Idaho and Illinois and for the Department of Energy to identify alternative funding sources for alternative missions at these facilities. It is my hope and intention that we will be successful in this undertaking.

Mr. HATFIELD. I want to bring to the attention of the chairman of the Energy and Water Development Appropriations subcommittee, Senator JOHNSTON, an important project in the State of Texas which, unfortunately, was not included in the conference agreement. The project is of concern to both Senator GRAMM and Senator HUTCHISON, and I believe merits special attention by the Bureau of Reclamation over the course of fiscal year 1995.

Mr. JOHNSTON. I would be pleased to hear the Senator's concerns.

Mr. HATFIELD. The project I want to highlight is the Lake Meredith Salinity Control Project. The project currently is being conducted by the Bureau of Reclamation under its construction program. Knowing of the importance of the project to our colleagues from Texas, I would ask the distinguished chairman if he would be willing to join me in asking the Commissioner of the Bureau of Reclamation to ensure that adequate funds will be provided for the Lake Meredith project over the course of fiscal year 1995.

Mr. JOHNSTON. I am aware of the interest in this project by Senator GRAMM and Senator HUTCHISON, and agree with the Senator from Oregon that this is an important project which should not be slowed or stopped due to a lack of available funds. The Bureau of Reclamation has informed the subcommittee that funds appropriated for the current fiscal year will be carried over into fiscal year 1995, and work on the project will proceed. I also want to note that the Senate conferees had tentatively agreed to provide $500,000 for Lake Meredith. Unfortunately, one of the House conferees offered an amendment which transferred the funds to another Texas project.

Mr. HATFIELD. I thank the distinguished chairman for his assurance. I also would ask whether the chairman would urge the Bureau of Reclamation to reprogram funds in fiscal year 1995 for the Lake Meredith project should additional funds be required to keep the project on schedule.

Mr. JOHNSTON. I share the distinguished ranking member's concern and agree that the subcommittee expects the Bureau of Reclamation to use carry-over funds and initiate any reprogrammings that are necessary to ensure that the Lake Meredith project is kept on track during the next fiscal year.

Mr. HATFIELD. I thank the distinguished chairman for his assistance in this matter.

Mr. KEMPTHORNE. Mr. President, I will not ask for a roll call vote but I want the RECORD to show that I would have voted "no" on the conference report now before the Senate.

The fiscal year 1995 Energy and Water Development Conference Report directs the termination of the Integral Fast Reactor [IFR] Program. I believe that this decision is a mistake and I truly believe that our Nation will one day regret the Congress' decision to turn its back on this promising technology.

I supported the IFR Program as a important technology to help this Nation deal with the problem of surplus weapons grade plutonium and spent reactor fuel. Now that the IFR Program will be terminated, I look forward to seeing how the critics of the IFR propose to deal these problems.

In my 2 years in the Senate, I have worked long and hard to complete the research on the IFR Program. Despite strong opposition, last year and this year the Senate supported the continuation of the IFR Program. Last year, the House agreed to support the Senate position but this year the House conferees refused to accept the Senate position.

I want to thank all of my colleagues in the Senate who supported my fight for the IFR. I know this was a tough vote but I will not forget your help on this very important issue.

I also want to pay a special thanks to my colleague, the senior Senator from Idaho, Senator LARRY CRAIG, and the two Senators from Illinois, Senator SIMON and Senator MOSELEY-BRAUN. Together, we formed the Idaho and Illinois coalition and I do not think there is a more effective bi-partisan team in the U.S. Senate.

In addition, I want to thank the senior Senator from Louisiana, Chairman JOHNSTON, for his generous support and strong commitment to the IFR Program. Senator JOHNSTON is the recognized expert on energy matters in the Senate and his support in committee, on the Senate floor and in conference was invaluable.

The Idaho-Illinois coalition will once again be tested as we work with the Secretary of Energy, Hazel O'Leary, to put together a program to preserve the scientific and technical expertise at Argonne East and West. The limited funding for the termination of the IFR Program that was provided by the conference report would result in an inefficient shut down of the IFR Program and the loss of hundreds of skilled scientists and engineers. While certain aspects of the IFR Program were controversial in some quarters, no one disputes the fact that the scientists, engineers, and facilities at Argonne East and West are a national asset that must be preserved. In the days ahead, the Idaho and Illinois Senators are committed to working with Secretary O'Leary to develop a plan to preserve, to the maximum extent possible, the human and physical assets at Argonne East and West.

When President Clinton signs this bill, he will signal the end of the Integral Fast Reactor Program. At the same time, Secretary O'Leary has committed to work with the Idaho and Illinois Senators to develop alternative missions for Argonne East and West. While I strongly support the effort to develop the alternative missions, and I ask my colleagues in the Senate to support me in this effort, I want the RECORD to show that I be recorded as voting "no" on the passage of the energy and water conference report.

So the conference report was agreed to.

The Senate concurred in the amendments of the House; as follows:

In the House of Representatives, *Resolved*, That the House agree to the report of the committee on conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 4506) entitled "An Act making appropriations for energy and water development for the fiscal year ending September 30, 1995, and for other purposes.".

Resolved, That the House recede from its disagreement to the amendments of the Senate numbered 6, 9, 15, 16, 21, 35, and 39 to the aforesaid bill, and concur therein.

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 2 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

Red River Navigation Study, Arkansas, $300,000;

Los Angeles County Water Conservation and Supply, California, $500,000;

Norco Bluffs, California, $200,000;

Indianapolis, White River, Central Waterfront, Indiana, $4,000,000;

Lake George, Hobart, Indiana, $200,000;

Little Calumet River Basin (Cady Marsh Ditch), Indiana, $150,000;

Ohio River Greenway, Indiana, $500,000;

Hazard, Kentucky, $500,000;

Kentucky Lock and Dam, Kentucky, $2,000,000;

Mussers Dam, Pennsylvania, $100,000;

Hartsville, Trousdale County, Tennessee, $95,000;

West Virginia Comprehensive, West Virginia, $350,000; and

West Virginia Port Development, West Virginia, $800,000.

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 4 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

Red River Emergency Bank Protection, Arkansas and Louisiana, $6,000,000;

Red River below Denison Dam Levee and Bank Stabilization, Arkansas, Louisiana and Texas, $2,100,000;

West Sacramento, California, $500,000;

Sacramento River Flood Control Project (Glenn-Colusa Irrigation District), California, $400,000;

Sacramento River Flood Control Project (Deficiency Correction), California, $3,700,000;

San Timoteo Creek (Santa Ana River Mainstem), California, $5,000,000;

Central and Southern Florida, Florida, $8,624,000;

Kissimmee River, Florida, $4,000,000;

Savannah Harbor Deepening, Georgia (Reimbursement), $11,585,000, of which $2,083,000 is for a cost-shared Savannah River recreation enhancement and public access project along 900 linear feet of shoreline in the City of Savannah;

Casino Beach, Illinois, $1,000,000;

Des Moines Recreational River and Greenbelt, Iowa, $4,000,000;

Harlan (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $20,000,000;

Middlesborough (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $1,200,000;

Williamsburg (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $3,000,000;

Pike County (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), Kentucky, $5,000,000;

Lake Pontchartrain and Vicinity (Jefferson Parish), Louisiana, $800,000;

Lake Pontchartrain and Vicinity (Hurricane Protection), Louisiana, $12,500,000;

Ouachita River Levees, Louisiana, $4,500,000;

Ste. Genevieve, Missouri, $3,000,000;

Hackensack Meadowlands Area, New Jersey, $2,500,000;

Ramapo River at Oakland, New Jersey, $600,000;

Salem River, New Jersey, $1,000,000;

Carolina Beach and Vicinity, North Carolina, $2,800,000;

Fort Fisher and Vicinity, North Carolina, $900,000;

Broad Top Region, Pennsylvania, $1,000,000;

Lackawanna River, Olyphant, Pennsylvania, $1,100,000;

Lackawanna River, Scranton, Pennsylvania, $1,000,000;

South Central Pennsylvania Environmental Restoration Infrastructure and Resource Protection Development Pilot Program, Pennsylvania, $7,000,000;

Allendale Dam, Rhode Island, $67,500;

Wallisville Lake, Texas, $1,000,000;

Richmond Filtration Plant, Virginia, $2,000,000;

Southern West Virginia Environmental Restoration Infrastructure and Resource Protection Development Pilot Program, West Virginia, $1,500,000;

Hatfield Bottom (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), West Virginia, $500,000; and

Upper Mingo County (Levisa and Tug Forks of the Big Sandy River and Upper Cumberland River), West Virginia, $250,000.

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 8 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

Tucson Diversion Channel, Arizona, $2,500,000;

Jeffersonville-Clarksville, Indiana, $750,000;

McAlpine Lock and Dam (Ohio River Locks and Dams), Kentucky, $1,000,000;

Raystown Lake, Pennsylvania, $5,330,000; and

John H. Kerr Reservoir (Mosquito Control), Virginia and North Carolina, $40,000.

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 28 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the matter inserted by said amendment, insert: *: Provided, That the Secretary of Energy may transfer available amounts appropriated for use by the Department of Energy under title III of previously enacted Energy and Water Development Appropriations Acts into the Isotope Production and Distribution Program Fund, in order to continue isotope production and distribution activities: Provided further, That the authority to use these amounts appropriated is effective from the date of enactment of this Act: Provided further, That fees set by the Secretary for the sale of isotopes and related services shall hereafter be determined without regard to the provisions of Energy and Water Development Appropriations Act (P.L. 101–101): Provided further, That amounts provided for isotope production and distribution in previous Energy and Water Development Appropriations Act shall be treated as direct appropriations and shall be merged with funds appropriated under this head*

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 48 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: *$520,501,000*

Resolved, That the House recede from its disagreement to the amendment of the Senate numbered 49 to the aforesaid bill, and concur therein with an amendment as follows:

In lieu of the sum stricken and inserted by said amendment, insert: *$498,501,000*

FEDERAL TRADE COMMISSION ACT AMENDMENTS OF 1993—CONFERENCE REPORT

Mr. FORD. Mr. President, I submit a report of the committee of conference on H.R. 2243 and ask for its immediate consideration.

The PRESIDING OFFICER. The report will be stated.

The legislative clerk read as follows:

The committee on conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2243) to amend the Federal Trade Commission Act to extend the authorization of appropriations in such Act, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses this report, signed by all of the conferees.

The PRESIDING OFFICER. Without objection, the Senate will proceed to the consideration of the conference report.

(The conference report is printed in the House proceedings of the RECORD of July 21, 1994.)

Mr. BRYAN. Mr. President, I am pleased to present for consideration the House and Senate Conference Report on legislation to reauthorize the Federal Trade Commission.

As you know, Mr. President, the FTC has proceeded without a formal authorization for over a decade. Although bills have been introduced, and passed by both bodies in the last several Congresses, final passage of the legislation has been unsuccessful as a result of differences between House and Senate Members over the application of the Commission's unfairness rulemaking authority to commercial advertisements. Several Senate Commerce Committee members had expressed concern about the potential promulgation of overly-broad rules that could intrude on or prevent legitimate constitutionally protected commercial speech. Several House Members, on the other hand, had stringently opposed any limitations on the Agency's authority.

I believe, however, Mr. President, that the House and Senate conferees have fashioned a reasonable and balanced resolution regarding this issue. This means, Mr. President, that we have been successful in removing what I consider to be the last remaining obstacle to the FTC's reauthorization. Through the passage of this legislation, the Congress will be re-asserting its full commitment to, and support for, one of the Nation's premier consumer protection agencies.

In addition to re-authorizing the Commission, the proposed legislation provides the FTC with enhanced enforcement powers and increased funding. The bill also requires the FTC to examine how its resources are allocated, and to identify areas that are most appropriately enforced by the FTC and those that are most effectively enforced by the States. These reviews are designed to ensure that the Commission's resources are being used effectively and efficiently.

When I assumed the chairmanship of the Consumer Subcommittee two Congresses ago, the reauthorization of the FTC became one of my top priorities. I cannot express how elated I am that we are now at the point of realistically achieving this goal. As I stated at the introduction of the Senate bill, I was optimistic that we were going to be successful this year. As I indicated, it has taken us many years to reach this point, and I hope that we can now proceed with the final passage of this legislation. I, therefore, urge my colleagues to support the adoption of the proposed conference report.

Mr. HOLLINGS. Mr. President, I rise in support of the conference report on H.R. 2243, the Federal Trade Commission Act Amendments of 1994.

As you know, Mr. President, appropriations for the Federal Trade Commission [FTC] have not been formally reauthorized by the Congress since September 1982. Although the Senate Commerce Committee has reported FTC authorization legislation in each Congress since the 97th Congress, we have been unsuccessful in securing enactment of a reauthorization bill for the FTC because of disagreements over the application of the FTC's regulatory authority.

The issue that has been most in dispute is the expansiveness of the FTC's unfairness authority regarding commercial advertisements. I, along with several other committee members, have had serious concerns about the promulgation of overly-broad rules that had the potential of intruding upon constitutionally protected commercial speech. I especially was concerned about the vagueness of the FTC's authority in this area, and the threat it posed to legitimate advertisements. I believe, however, that there has been a fair resolution of this issue by House and Senate conferees.

As you know, Mr. President, the FTC is a vital agency, and one that is of great importance to consumers. Its primary duties are to ensure the operation of competitive markets and to protect consumers from unfair and deceptive acts and practices. Passage of the conference report on H.R. 2243 is necessary to reaffirm the Congress' commitment to the FTC and consumer protection. I commend Senators BRYAN, GORTON, DANFORTH, and FORD for their work on the legislation, and ask for the support of all Members for the passage of this conference report.

Mr. GORTON. Mr. President, as the Ranking Republican of the Consumer Subcommittee, I am pleased to join the distinguished Chairman, Senator BRYAN, in bringing to the Senate the conference report to accompany H.R. 2243, the Federal Trade Commission Act Amendments of 1994. It has been 14 long years since the Congress last authorized this important agency.

The conferees have successfully resolved a seemingly irreconcilable disagreement regarding the central issue of rulemakings on commercial advertising pursuant to the Commission's "unfairness" authority. During the 1970's, the Commission initiated several controversial rulemakings in this area. A considerable amount of time and resources were spent on these undertakings, with poor results. The Senate's approach was to create an absolute ban on all such rulemakings; the House disagreed with these restrictions.

Fortunately, the conferees were able to reach a compromise by removing the absolute ban while retaining the definition of unfairness that the FTC has been using since it promulgated a policy statement on unfairness in 1980. We were also able to reach an acceptable middle ground on the role which public policy should play in determining unfairness. I believe that codification of the definition will provide greater stability and predictability in this area—a result that should be good to businesses and consumers alike.

Further clarification of the FTC's mission can be found in this reauthorization's restriction on FTC regulation of agricultural cooperatives and marketing orders. This will avoid duplicative regulation, as the Department of Agriculture is already responsible for monitoring these activities.

This legislation also expands the FTC's enforcement arsenal. The FTC will now have the power to issue civil investigative demands in antitrust cases. These demands will extend beyond documents alone to cover tangible evidence, as well. This provision substantially expands the Commission's ability to address consumer fraud. Similarly, we have included a crucial expanded venue provision. This provision is based in part on 28 U.S.C. §1391, the general venue provision in the U.S. Code. It will permit the FTC to bring defendants scattered throughout the country to justice in a single forum. This promotes judicial economy and will help the FTC to save precious resources for law enforcement.

The bill also addresses a long-standing problem involving the Commission's cease-and-desist orders. Currently, such orders become final only after all appeals are exhausted. Because this can take many years, the appeals process has often been abused to manufacture lengthy delays. Under this bill, however, most cease-and-desist orders become final 60 days after they are issued unless a court or the Commission issues a stay. Of course, this solution continue to protect the right of defendants to challenge these orders.

Finally, Mr. President, I would like to point out one other enforcement issue which is of particular interest to me as a former attorney general. I am pleased that this reauthorization calls for the FTC to report and make specific recommendations within six months on the subject of increasing cooperation between the FTC and the states in enforcing laws under FTC jurisdiction. I am aware that such cooperation has improved dramatically in recent years and believe that such efforts deserve our support.

Mr. President, despite a period of considerable controversy during the 1980s, the FTC continues to implement its vital role of protecting consumers in the marketplace. Under Chairman Janet Steiger's fine leadership, the Agency has regained its strength, enhanced its reputation and gained the respect of many. I believe that it will carry out its responsibilities even more effectively after this legislation is enacted. I commend Senator BRYAN for his leadership on this issue, and I urge my colleagues to support this conference report.

The PRESIDING OFFICER. The question is on the adoption of the conference report.

Without objection, the conference report is adopted.

Mr. FORD. Mr. President, I move to reconsider the vote.

Mr. GORTON. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

MORNING BUSINESS

NATION'S MONETARY POLICY

Mr. FAIRCLOTH. Mr. President, this is a crucial time for our Nation's monetary policy.

If you look on the front page of this morning's Wall Street Journal, Money and Investing section, you will see a chart that shows that our dollar has been falling all year. It has been falling not just against the yen, but against a whole index of currencies. You will also see that commodities prices are up, short term interest rates are up, and bond prices are down.

Mr. President, the Federal Government has taken on obligations which it cannot possibly hope to meet. The long-term outlook for the Federal deficit and the Federal debt are bleak. Every unbiased observer believes that if nothing is done, deficits will begin to rise again in only a couple of years, and then continue as far as the eye can see or the mind can conceive.

President Clinton's own budget indicates that a child born today will face a combined lifetime tax rate of over 80 percent simply to meet the obligations that Government has already made. That does not include new entitlements like new Government health care programs. Clearly this cannot be sustained.

The pressure will be on the Federal Reserve for easy money to try to cure the problems caused by runaway spending and runaway debt. But easy money will only make matters worse for working men and women.

What America needs is a Federal Reserve that not only will say "no" to easy money, but will also say loud and clear that its first, second, and third priorities are no inflation, no inflation, and no inflation.

Janet Yellen and I met in my office, where we had a wide ranging discussion about the economy. Mr. President, unlike most Members of this body, this is my first elected office. I spent the last 45 years in the private sector as a businessman and a farmer, meeting a payroll and creating jobs. So I was disappointed to learn that the President had nominated a person with little or no private sector experience to the Fed.

But Janet Yellen certainly has the academic credentials to be a Governor of the Federal Reserve Board. I also want to stress that I know of no deep dark secrets which would disqualify her from the job.

But, Mr. President, I simply do not believe that Janet Yellen understands how grave our country's underlying problems are. She believes that the Federal Reserve should have multiple policy goals—like targeting interest rates, promoting certain rates of economic growth, providing liquidity to the financial system, as well as promoting price stability. Many of these goals can only be achieved by easing up on the fight against inflation.

I do not believe that Janet Yellen understands what will happen if the Federal Reserve abandons a tough anti-inflation stance in order to pursue her multiple policy goals. The Federal Reserve's anti-inflation stance is one of the few things that is keeping capital from leaving this country.

Mr. President, if that anti-inflation stance is compromised, then the world's capital markets will judge this Nation's credit worthiness based upon the policies of Congress and the President, instead of the Fed. And if relying on Congress to do the right thing is what will determine whether we will continue to attract the capital we need, then I fear for the Republic.

Mr. President, it is time for this Congress to cut spending, balance the budget, and stop penalizing people who work, and save, and invest. Until it does, the Federal Reserve's inflation fight is more important than ever.

Ending barriers to economic growth is the job of Congress. Protecting the value of working people's dollars is the job of the Federal Reserve.

The Federal Reserve cannot bail out the politicians in Congress and the White House—past and present—by inflating away the Federal debt. This country is going to have to face economic reality before the world capital markets shove it down our throat.

The time to start facing that reality is right here, and right now, and with this nomination.

Mr. President, I yield the floor.

HEALTH CARE REFORM

Mr. SPECTER. Mr. President, earlier today, my distinguished colleague from South Dakota, Senator DASCHLE, made remarks on the Senate floor in which he asserted that my chart of the Mitchell health care reform bill incorrectly characterized three provisions.

As you can imagine, Mr. President, the task of summarizing and categorizing a 1,410-page bill is both arduous and complex. I have taken every precaution to ensure the validity of this chart and its predecessors and welcome constructive suggestions.

In the debate over health care reform legislation, it is vitally important that the public have all the facts. That is the inspiration behind the charts my office has prepared. To ensure that the public has all the facts, I want to address the three boxes on the chart called into question today by Senator DASCHLE.

First, Senator DASCHLE stated that guaranty funds exist currently and implied that the Mitchell bill does not create new functions or requirements regarding such funds. I disagree. My chart lists the guaranty funds provision in section 1505 as new because under the Mitchell bill, the Secretaries of Health and Human Services (section 1442) and Labor (section 1482) must establish new standards for such guaranty funds. Further, the bill requires States to establish two separate guaranty funds, one for community-rated plans and one for self-insured plans. Each of the 50 States does not currently have a guaranty fund. Therefore, the chart correctly reflects a new State function and new standards mandated at the Federal level.

Second, Senator DASCHLE also stated that the box labeled "Standard Health Plan Sponsor" reflects existing law, not new requirements. Once again, I believe that the chart accurately portrays the new requirements contained in the Mitchell bill. The term "standard health plan" is a new concept established and defined (section 1011(2)(B)) in the Mitchell bill. The bill requires the Secretary of Health and Human Services to establish rules for States to follow in establishing procedures and methods to assure that standard health plan sponsors offer equal opportunity for enrollment (Sec. 1111(b)(3)(C)). I believe that section 1111 should be characterized as new because there are no standard health plan sponsors under existing law; the term has not become law yet. And, the provisions requires the Secretary and States to promulgate new regulations requiring oversight of standard health plan sponsors.

I do agree, however, with Senator DASCHLE'S statement that the box describing the ERIS Enforcement Mechanism contained in section 1485 should not be labeled as completely new. The Secretary of Labor currently has authority to enforce certain provisions of ERISA. I understand that this provision expands his existing authority, and does not create a new entity or function. My chart is being corrected accordingly.

In conclusion, Mr. President, this one small change does not detract from the chart's stated purpose. I believe it continues to demonstrate clearly to the American public the overwhelming expansion of Government that the Mitchell bill proposes.

WE NEED THE INTERIM TRADE PROGRAM

Mr. HATCH. Mr. President, I would like to bring an important matter to the Senate's attention. I believe that the Senate should seriously consider including the Interim Trade Program, referred to as the ITP, in the GATT implementing legislation. This is a program that has the support of the administration and has already been included in the House version of the GATT implementing legislation.

The program will provide the Caribbean Basin Initiative [CBI] countries with apparel and textile regulations that are more in line with those given to Mexico under NAFTA. Inclusion of the ITP would be beneficial to the United States for several reasons.

First and foremost, the ITP will help to increase U.S. presence in the markets of the Caribbean Basin Countries. The United States already has a trade surplus of more than $2 billion with the region. The ITP will allow U.S. companies to more easily provide products that the Caribbean region has already shown a strong interest in obtaining.

Second, it will help further the ability of the U.S. apparel and textile industries to work in cooperation with the CBI countries. This will allow these industries to better compete with imports from foreign companies working out of areas with lower production costs.

Finally, the ITP contains regulations focused on improving the market situation in the CBI countries, including requirements for internal reform.

The need to enact the ITP is especially time sensitive due to the current situation in the CBI countries. Because these countries do not currently enjoy many of the cost advantages afforded under NAFTA, they are already experiencing a loss in production and are seeing investments move out of their region.

It is in the best interest of the United States to include the ITP in the GATT implementing legislation. This agreement is not designed to trade existing American jobs for foreign production. Instead, through continued cooperation with the CBI region, it allows American apparel and textile producers to better compete in the world market and maintain production in the United States. It also allows the United States to better compete against the influx of imports resulting from the phase-out of the MFA.

Mr. President, failure to include the ITP in the GATT implementing legislation will be a misstep in the administration's foreign trade policy. The ITP will help the nations of the Caribbean, it will also help the United States. The administration supports the ITP, the House supported the ITP, it is now our turn to lend our support as well.

THE ELECTIONS IN THE DOMINICAN REPUBLIC

Mr. HARKIN. Mr. President, as many of my colleagues are aware I have long advocated according a high priority to human rights in our foreign policy. And I am convinced that the institutionalization of the human rights priority over the past 20 years has given a much better overall foreign policy. It is with that background that I wish to invite the attention of my fellow Members to some recent news from the Caribbean.

On May 16 the Dominican Republic held national elections. The voting was observed by delegations from the Organization of American States and other international groups. The reports of these observers have indicated that there were serious irregularities in at least some of the voting procedures. Since then there have been allegations and rumors that the United States would ignore the observer reports and, look the other way, thereby taking the easy way out in the troubled Caribbean area.

Well, I am very happy to say that these rumors have no basis in fact. The State Department and our Embassy have taken a clear stand in support of fair elections in the Dominican Republic. Our position is entirely neutral, of course. We are not taking sides. But we are actively defending the right of the Dominican people to choose their own government.

In that connection I call your attention to the following forthright statement made by the State Department on August 5, and ask unanimous consent that it be printed in the RECORD. I congratulate the Clinton administration on its commitment to human rights and democracy in the Dominican Republic.

> The United States has consistently expressed its support for a peaceful resolution to the questions raised by irregularities in the May 16 elections. It was disappointed that the central electoral board effectively ignored the irregularities when it named president Joaquin Balaguer president. One suggestion for a peaceful resolution of the problem is to hold early elections. The United States believes that new elections are the right idea, and urges Dominican authorities to take immediate steps in that direction.

IS CONGRESS IRRESPONSIBLE? YOU BE THE JUDGE ABOUT THAT

Mr. HELMS. Mr. President, as of the close of business on Wednesday, August 10, the federal debt stood at $4,644,509,290,127.79, meaning that on a per capita basis, every man, woman, and child in America owes $17,814.78 as his or her share of that debt.

THE 10TH ANNIVERSARY SEASON OF THE SURRY OPERA COMPANY

Mr. MITCHELL. Mr. President, I rise today to congratulate the Surry Opera Co. of Maine on its 10th anniversary season. Founded in 1984 by Walter Nowick, the Surry Opera Co. has brought together amateur opera singers first from Maine and across our Nation, and then from around the world.

This week, free concerts are being performed by scores of French, German, Japanese, Russian, and American amateur singers at Mr. Nowick's invitation and under his direction. These 10th anniversary events are part of the fulfillment of Mr. Nowick's dream of cultivating international understanding and good will through the performance of great music by ordinary citizens.

The world is much different today than it was when the Surry Opera Co. was founded. Then, the cold war shaped people's attitudes toward one another to such a degree that there were few people to people exchanges between Americans, Russians and other citizens of the former Soviet Union. Walter Nowick and the Surry Opera Co. singers saw an opportunity, through music, to establish associations that would help dissolve this hostility between nations.

The Surry Opera Co. first travelled to the Soviet Union in November, 1986. Three years later, 80 members of the Leningrad Amateur Opera Co. arrived in Maine. Since those groundbreaking trips, there have been many joint performances around the world. Each time, members and supporters of the respective Opera Companies have provided food and lodging in their homes for their foreign guests. These arrangements have both fostered deep personal friendships and made the trips financially feasible.

Mr. Nowick and all associated with the Surry Opera Co. have helped to build bridges among people of different cultures. Just as Mr. Nowick envisioned, joint international performances have led to increased understanding between performers and their audiences throughout the world.

We all share the hope that the universal appeal of opera will continue to be a building block for international friendships and peace. I commend Walter Nowick for his vision, and I congratulate all members of the Surry Opera Co. on their 10th anniversary season.

TRIBUTE TO STAR KILSTEIN BLOOM

Mr. SHELBY. Mr. President, I rise today to honor Star Kilstein Bloom for her dedication and loyalty to the University of Alabama. Tomorrow, Friday August 12, 1994, she is being awarded the University of Alabama's Henry and Julia Tutwiler Award for her distinguished and exceptional service to the University. I want to take a few minutes to highlight some of her contributions and accomplishments.

Star earned a bachelor of arts degree, cum laude, from Bryn Mawr College in 1960, with honors in anthropology. She further specialized in information technologies, by continuing her education through IBM's executive training course and the University of Alabama's College of Commerce and Business Administration.

After graduating, Star served as Co-owner and Vice President for Design and Manufacturing of Coed Collar Company, Inc., of Tuscaloosa, Alabama. In 1982, she then became the Director of the Computer Program at Tuscaloosa Academy. She served at this post for two years where among her many accomplishments, she developed a computer-enhanced curriculum for grades 3–12 involving all subject areas.

In 1989, she was asked and graciously agreed to serve as Co-director of the Center for Communications and Educational Technology at the University of Alabama. To this position she has dedicated her talents and creativity, an invaluable contribution to the University. Her commitment to the promotion of distance learning, developing all education—kindergarten through graduate—into one cohesive unit, has brought the University of Alabama national recognition and significant financial support. Integrated Science, which began as Science Alabama, is the national example of what can be done through distance learning, and we have Star Kilstein Bloom to thank. Mr. President, the beneficiaries of her tireless efforts are not only the students and teachers of Alabama, but those of the entire Nation.

Mr. President, Star Bloom has spent her life in service to others. She has dedicated her time and her talents to the students of the State of Alabama, to her faith and to political causes. Her energy and commitment is an inspiration to me and is an example for us all. She is more than worthy of this award, our thanks and our respect.

COMMENDING CHARLES JONES

Mr. LEVIN. Mr. President, I take great pleasure in congratulating Mr. Charles Jones for his appointment as the Implementation Director of the Social Security Administration's Reengineering Project. An exceptional leader and motivator, Mr. Jones' accomplishments have earned him the respect and praise of his peers nationwide. He has extensive experience with the workings of the Social Security Administration from both the Federal and State perspectives. That knowledge has led to expanded and improved communication and cooperation between the public and federal agencies. I am confident that he will play an important role in the creation of a new Social Security Administration. I want to extend my thanks and appreciation to Mr. Jones for all of the help and cooperation he has provided to my staff over many years, and I wish him continued success in his public service career.

RESPONSE TO THE HOUSE VOTE ON THE CRIME CONFERENCE REPORT

Mr. SIMPSON. Mr. President, our fine Republican leader spoke earlier, as did our able ranking member of the Judiciary Committee, in response to President Clinton's unwarranted attack on the NRA and Republicans.

It is curious that our own President continues to be the leader of the "Gunsmoke" rhetoric about the conference report on the crime bill.

Wasteful and frivolous spending programs permeate every single page of what must be over 700 pages of stealth spending.

Unlike the tough Senate bill, what came out of the conference committee was not a real crime bill. It was the son of the economic stimulus package.

I commend our House colleagues, Republicans and Democrats, who had the strength to stand on principle, rather than be bought with pie-in-the-sky promises of Federal dollars being funneled into their congressional districts.

That took a great deal of courage—especially in an election year. The bipartisan majority that rejected the procedure to consider this conference report deserves our respect.

It is grossly misleading—we have an easier way of saying that in Wyoming—to suggest the embarrassing vote against the President was somehow orchestrated by the NRA.

The NRA was certainly active—they have been throughout all the many years of debate on gun control.

But they have not been very successful lately.

The Brady bill passed, the assault weapons ban, which the NRA opposed, was included in the Senate version of this legislation. It passed with only 4 dissenting votes—on a tally of 95–4.

So I find it very curious that now, the President of the United States of America believes that suddenly, in a single-party Government, the NRA has increased its awesome powers of persuasion to atmospheric levels—and killed this legislation.

He must blame someone, and the NRA is a convenient target, because I have a hunch that this administration finds it hard to justify the glut of social spending in this legislation.

The crime bill conference report is nothing more than an attempt to resurrect the urban spending programs in the failed economic stimulus package of 1993.

This legislation is flawed. It should fail. It did.

It should be returned to the Manufacturer and replaced.

We should replace it with a real crime bill. That is what the majority of House Members said today.

OLD U.S. MINT IN SAN FRANCISCO, CALIFORNIA ACT OF 1994

Mr. FORD. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of calendar No. 548, H.R. 4812, relating to the U.S. Mint in San Francisco.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

A bill (H.R. 4812) to direct the Administrator of General Services to acquire by transfer the Old U.S. Mint in San Francisco, CA, and for other purposes.

The Senate proceeded to consider the bill.

AMENDMENT NO. 2551

Mr. GORTON. Mr. President, on behalf of Senator McCAIN, I send to the desk an amendment and I ask unanimous consent that the Senate proceed to its immediate consideration; that the amendment be agreed to and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2551) was agreed to, as follows:

Add at the end of the bill the following new section:

SEC. 2. REPAIRS OF OLD U.S. MINT, SAN FRANCISCO.

(a) IN GENERAL.—Nothing in this Act shall be construed to force the General Services Administration to repair the Old U.S. Mint building prior to repairs to other Federal buildings in greater need of repair.

The PRESIDING OFFICER. The question is on the engrossment of the amendment and third reading of the bill.

The amendment was ordered to be engrossed and the bill to be read a third time.

The bill was read a third time.

The PRESIDING OFFICER. The bill having been read the third time, the question is, Shall the bill pass?

So the bill (H.R. 4812), as amended, was passed.

Mr. FORD. Mr. President, I move to reconsider the vote by which the bill was passed.

Mr. GORTON. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

MAINTENANCE OF DAMS ON INDIAN LANDS

Mr. FORD. Mr. President, I ask unanimous consent that the Indian Affairs Committee be discharged from further consideration of H.R. 1426, a bill relating to the maintenance of dams on Indian lands; that the Senate then proceed to the immediate consideration of the bill; that the bill be read three times, passed, and the motion to reconsider be laid upon the table; further, that any statements thereon appear in the RECORD at the appropriate place as though read.

The PRESIDING OFFICER. Without objection, it is so ordered.

So the bill (H.R. 1426) was deemed read the third time and passed.

HAZARDOUS MATERIALS TRANSPORTATION AUTHORIZATION ACT OF 1993

Mr. FORD. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of calendar No. 347, S. 1640, the Hazardous Materials Transportation Authorization Act.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

A bill (S. 1640) to amend the Hazardous Materials Transportation Act to authorize appropriations to carry out that act, and for other purposes.

The Senate proceeded to consider the bill which had been reported from the Committee on Commerce, Science, and Transportation, with amendments, as follows:

(The parts of the bill intended to be stricken are shown in boldface brackets and the parts of the bill intended to be inserted are shown in italics.)

S. 1640

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Hazardous Materials Transportation Authorization Act of 1993".

SEC. 2. AUTHORIZATION OF APPROPRIATIONS.

Section 115(a) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1812(a)) is amended by striking all after "not to exceed" and inserting in lieu thereof "$12,600,000 for fiscal year 1994, $13,100,000 for fiscal year 1995, and $13,600,000 for fiscal year 1996.".

SEC. 3. EXEMPTIONS FROM REQUIREMENT TO FILE REGISTRATION STATEMENT.

Section 106(c) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1805(c)) is amended by adding at the end the following new paragraph:

"(16) FOREIGN OFFERORS.—A person who is domiciled outside the United States and who offers, solely from a location outside the United States, hazardous materials for transportation in commerce does not have to file a registration statement under this subsection.".

SEC. 4. PLANNING GRANTS FOR INDIAN TRIBES.

(a) AUTHORITY TO MAKE GRANTS.—Section 117A(a)(1) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1815(a)(1)) is amended—

(1) in the introductory matter, by inserting "and Indian tribes" immediately after "States"; and

(2) in subparagraph (A), by striking "within a State and between a State and another State" and inserting in lieu thereof "within the lands under the jurisdiction of a State or Indian tribe, and between the lands under the jurisdiction of a State or Indian tribe and the lands of another State or Indian tribe".

(b) MAINTENANCE OF EFFORT.—Section 117A(a)(2) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1815(a)(2)) is amended by inserting "or Indian tribe" immediately after "State" each place it appears.

(c) COORDINATION OF PLANNING.—Section 117A(a) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1815(a)) is amended by adding at the end the following new paragraph:

"(4) COORDINATION OF PLANNING.—A State or Indian tribe receiving a grant under this subsection shall ensure that planning under the grant is coordinated with emergency planning conducted by adjacent States and Indian tribes.".

SEC. 5. TRAINING CRITERIA FOR SAFE HANDLING AND TRANSPORTATION.

Section 106(b)(3) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1805(b)(3)) is amended—

(1) in the paragraph heading, by striking "EMERGENCY RESPONSE" and [insert] *inserting* in lieu thereof "EMPLOYEE";

(2) by inserting "or duplicate" immediately after "conflict with"; and

(3) by striking all after "Labor relating to" through "(and amendments thereto) and" and inserting in lieu thereof "hazard communication, and hazardous waste operations and emergency response, contained in part 1910 of title 29 of the Code of Federal Regulations (and amendments thereto) or".

SEC. 6. DISCLOSURE OF FEES LEVIED BY STATES, POLITICAL SUBDIVISIONS, AND INDIAN TRIBES.

Section 112(b) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1811(b)) is amended—

(1) by inserting immediately after "(b) FEES.—" the following heading: "(1) RESTRICTION.—"; and

(2) by adding at the end the following new paragraph:

"(2) DISCLOSURE.—A State or political subdivision thereof or Indian tribe that levies a fee in connection with the transportation of hazardous materials shall, upon the Secretary's request, report to the Secretary on—

"(A) the basis on which the fee is levied upon persons involved in such transportation;

"(B) the purposes for which the revenues from the fee are used;

"(C) the annual total amount of the revenues collected from the fee; and

"(D) such other matters as the Secretary requests.".

SEC. 7. ANNUAL REPORT.

Section 109 of the Hazardous Materials Transportation Act (49 App. U.S.C. 1808(e)) is amended by striking the first sentence and inserting in lieu thereof the following: "The Secretary shall, once every 2 years, prepare and submit to the President for transmittal to the Congress a comprehensive report on the transportation of hazardous materials during the preceding 2 calendar years.".

SEC. 8. INTELLIGENT VEHICLE-HIGHWAY SYSTEMS.

In implementing the Intelligent Vehicle-Highway Systems Act of 1991 (23 U.S.C. 307 note), the Secretary of Transportation shall ensure that the National Intelligent Vehicle-Highway Systems Program addresses, in a comprehensive and coordinated manner, the use of intelligent vehicle-highway system technologies to promote hazardous materials transportation safety. The Secretary of Transportation shall ensure that one or more operational tests funded under such Act shall promote such safety and advance technology for providing information to persons who provide emergency response to hazardous materials transportation incidents.

SEC. 9. RAIL TANK CAR SAFETY.

Not later than 1 year after the date of enactment of this Act, the Secretary of Transportation shall issue final regulations under the following:

(1) The rulemaking proceeding under Docket HM-175A entitled "Crashworthiness Protection Requirements for Tank Cars".

(2) The rulemaking proceeding under Docket HM-201 entitled "Detection and Repair of Cracks, Pits, Corrosion, Lining Flaws, Thermal Protection Flaws and Other Defects of Tank Car Tanks".

SEC. 10. SAFE PLACEMENT OF TRAIN CARS.

The Secretary of Transportation shall conduct a study of existing practices regarding the placement of cars on trains, with particular attention to the placement of cars that carry hazardous materials. In conducting the study, the Secretary shall consider whether such placement practices increase the risk of derailment, hazardous materials spills, or tank ruptures or have any other adverse effect on safety. The results of the study shall be submitted to Congress within 1 year after the date of enactment of this Act.

SEC. 11. GRADE CROSSING SAFETY.

The Secretary of Transportation shall, within 6 months after the date of enactment of this Act, amend regulations—

(1) under the Hazardous Materials Transportation Act (49 App. U.S.C. 1801 et seq.) to prohibit the driver of a motor vehicle transporting hazardous materials in commerce, and

(2) under the Motor Carrier Safety Act of 1984 (49 App. U.S.C. 2501 et seq.) to prohibit the driver of any commercial motor vehicle, from driving the motor vehicle onto a highway-rail grade crossing without having sufficient space to drive completely through the crossing without stopping.

SEC. 12. DRIVER'S RECORD OF DUTY STATUS.

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Transportation shall promulgate regulations amending section 395.8(k) of title 49, Code of Federal Regulations, to require that any supporting document bearing on the record of duty status of a driver who operates a commercial motor vehicle—

(1) be [retrained,] *retained,* by the motor carrier using such driver, for at least 6 months following its receipt of such document; and

(2) include information identifying the driver and vehicle related to the document.

(b) DEFINITION.—In this section, the term "supporting document" means any electronic or paper document or record generated in the normal course of business, in the provision of transportation by commercial motor vehicle, that could be used by a safety inspector or motor carrier to verify the accuracy of entries in a driver's record of duty status, including trip reports, pay slips, bills of lading or shipping papers, and receipts for fuel, lodging, and tolls.

SEC. 13. SAFETY PERFORMANCE HISTORY OF NEW DRIVERS.

(a) AMENDMENT OF REGULATIONS.—Within 18 months after the date of enactment of this Act, the Secretary of Transportation shall amend section 391.23 of title 49, Code of Federal Regulations, to—

(1) specify the safety information that must be sought under that section by a motor carrier with respect to a driver;

(2) require that such information be requested from former employers and that former employers furnish the requested information within 30 days after receiving the request; and

(3) ensure that the driver to whom such information applies has a reasonable opportunity to review and comment on the information.

(b) SAFETY INFORMATION.—The safety information required to be specified under subsection (a)(1) shall include information on—

(1) any motor vehicle accidents in which the driver was involved during the preceding 3 years;

(2) any failure of the driver, during the preceding 3 years, to undertake or complete a rehabilitation program under section 12020 of the Commercial Motor Vehicle Safety Act of 1986 (49 App. U.S.C. 2701) after being found to have used, in violation of law or Federal regulation, alcohol or a controlled substance;

(3) any use by the driver, during the preceding 3 years, in violation of law or Federal regulation, of alcohol or a controlled substance subsequent to completing such a rehabilitation program; and

(4) any other matters determined by the Secretary of Transportation to be appropriate and useful for determining the driver's safety performance.

(c) FORMER EMPLOYER.—For purposes of this section, a former employer is any person who employed the driver in the preceding 3 years.

SEC. 14. RETENTION OF SHIPPING PAPERS.

(a) AMENDMENT.—Section 105(g) of the Hazardous Materials Transportation Act (49 U.S.C. 1804(g)) is amended by adding at the end the following new paragraph:

"(5) RETENTION OF PAPERS.—After the hazardous material to which a shipping paper provided to a carrier under paragraph (1) applies is no longer in transportation, the person who provided the shipping paper and the carrier required to maintain it under paragraph (1) shall retain the paper at their respective principal places of business. Such person and carrier shall, upon request, make the shipping paper available to a Federal, State, or local government agency at reasonable times and locations.".

(b) REGULATIONS.—Not later than 6 months after the date of enactment of this Act, the Secretary of Transportation shall issue regulations implementing the requirements of paragraph (5) of section 105(g) of the Hazardous Materials Transportation Act, as added by subsection (a) of this section.

SEC. 15. TOLL FREE NUMBER FOR REPORTING.

The Secretary of Transportation shall establish a toll free "800" telephone number for transporters of hazardous materials and other individuals to report to the Secretary possible violations of the Hazardous Materials Transportation Act (49 App. U.S.C. 1801 et seq.) or any order or regulation issued under this Act.

SEC. 16. TECHNICAL CORRECTIONS.

(a) AMENDMENTS RELATING TO PACKAGING.—(1) Sections 103(5)(B), 103(6)(A)(iii), and 109(c) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1802(5)(B), 1802(6)(A)(iii), 1808(c)) are each amended by striking "packages" and inserting in lieu thereof "packaging".

(2) Sections 105(a)(3), 105(a)(4)(B)(v), 110(a)(1), and 120 of the Hazardous Materials Transportation Act (49 App. U.S.C. 1804(a)(3), 1804(a)(4)(B)(v), 1809(a)(1), 1818) are each amended by striking "a package" and inserting in lieu thereof ["packaging".] *"a packaging"*.

(3) Sections 106(c)(1)(B) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1805(c)(1)(B)) is amended—

(A) by striking "a bulk package" and inserting in lieu thereof ["bulk] *"a bulk* packaging"; and

(B) by striking "the package" and inserting in lieu thereof "the bulk packaging".

(b) OTHER.—(1) Section 105(a)(3) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1804(a)(3)) is amended by inserting "hazardous materials" immediately after "shipped".

(2) Section 105(e)(1) of the Hazardous Materials Transportation Act (49 App. U.S.C. 1804(e)(1)) is amended by striking "or package" and inserting in lieu thereof ", package, or packaging (or a component of a container, package, or packaging)".

SEC. 17. EXEMPTION FROM HOURS OF SERVICE REQUIREMENTS.

The Secretary of Transportation shall exempt farmers and retail farm supplies from the hours of service requirements contained in section 395.3 of title 49, Code of Federal Regulations, when such farmers and retail farm supplies are transporting farm supplies for agricultural purposes within a 50-mile radius of their distribution point during the crop-planting season.

The PRESIDING OFFICER. The question is on agreeing to the committee amendments.

The committee amendments were agreed to.

Mr. EXON. Mr. President, the Hazardous Materials Transportation Authorization Act includes commonsense changes in the basic hazmat law and several related truck safety initiatives which will significantly advance safety on all modes. I know of no opposition to this measure.

The bill reauthorizes the hazmat program and incorporates several provisions to improve the use of hazmat resources by the Department of Transportation, as well as state and local authorities.

To improve emergency response training and planning, the 1994 bill would allow Indian tribes to qualify for hazmat planning grants, and clarifies the training criteria for emergency response.

The bill also requires the retention of shipping papers for improved hazmat enforcement.

To prevent retaliation from our international trading partners, a registration and fee exemption for hazmat shippers domiciled outside of the United States is included.

The hazmat bill requires that the promotion of safe hazardous materials transportation become a top priority in intelligent vehicle highway system program (IVHS). This provision which was expanded and incorporates language from a related provision in the House bill. As the author of the Senate provision, I make clear that the new provision does not create a preference for any specific system, technology, invention or provider. Any and all projects funded under this section should be subject to competitive selection.

This legislation also requires that the Department of Transportation issue final rules with regard to two pending rail tank car safety rulemakings. These rulemakings have taken on a life of their own. The previous administration let these important decisions linger for years. I have the assurance from Federal Rail Administrator Jolene Molitoris that she will bring this proceeding to a timely conclusion.

One provision of which I am very proud attempts to motivate safe behavior at rail/highway grade crossings. Under the bill before the Senate, a new Federal fine could be imposed on any driver of a motor vehicle carrying hazardous materials or a driver of any commercial motor vehicle, who enters a highway-railroad grade crossing without having sufficient space to drive completely through the crossing without stopping. This provision is in response to the terrible tank car train accident in 1993 where a truck gridlocked on a crossing and was hit by the train. The resulting fireball killed the driver and several innocent drivers in nearby cars.

In the area of general safety enforcement, the bill improves the ability to enforce current hours of service rules for all professional drivers and recognizes that there are seasonal needs in rural America which must be recognized by the hours of service rules. The current hours of service rules recognize that small package delivery companies need accommodation during the Christmas season. The seasonal needs of farmers and farm suppliers, also deserve accommodation. Rural Americans want to obey the law. A policy of regulatory forbearance is not enough. Such a policy tells drivers to break the law because you may not be caught. However, if you are transporting farm chemicals in violation of the hours of service rules, and you are caught, the consequences could be economically catastrophic. A clear set of rules which take into account seasonal circumstances which are obeyed is not only fair to rural Americans, it is safer for all Americans. This bill requires that the Secretary review through a rulemaking the seasonal application of the hours of service rules as they apply to farmers and retail farm suppliers.

The legislation before the Senate also requires the Secretary to issue rules which will make it easier for employers to verify the safety record of new truck drivers. A trucker fired for unsafe driving, drug use or alcohol abuse should not be able to simply walk across the street to a new employer with an unsafe record hidden in the shadows of legal ambiguity.

The bill also instructs the Secretary of Transportation to create a toll free number for drivers, shippers and the public to call to report potential hazardous materials transportation act violations. Crime stopper numbers which exist in law enforcement and have led to the arrest of dangerous criminals provide a model for the Department of Transportation.

In addition, the pending legislation embraces and slightly modifies the major provisions of the House passed Hazardous Materials Transportation Act. Members and staff of the House Public Works, Senate Commerce and House Energy and Commerce Committees worked together to craft a compromise bill which significantly advances the public safety. I am especially pleased to support the House provisions which enhance hazmat worker training.

I urge my colleagues to join me in supporting the swift enactment of the Hazardous Materials Transportation Authorization Act of 1994.

Thank you, Mr. President.

AMENDMENT NO. 2552

(Purpose: An amendment in the nature of a substitute to amend the Hazardous Materials Transportation Act, to authorize appropriations for that act, to provide for trucking industry reform, and for other purposes)

Mr. FORD. Mr. President, on behalf of Senator EXON, I send to the desk a substitute amendment and I ask unanimous consent that the Senate proceed to its immediate consideration; that the amendment be agreed to; and that the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2552) was agreed to.

(The text of the amendment is printed in today's RECORD under "Amendments Submitted.")

Mr. EXON. Mr. President, I am pleased to offer the Trucking Regulatory Reform Act of 1994 as an amendment to S. 1640, the Hazardous Materials Transportation Authorization Act of 1994. This legislation pursues a comprehensive trucking regulatory reform agenda which is designed to meet the legitimate concerns about the expense of trucking regulation expressed by both Houses of Congress.

This legislation was crafted after close consultations with the bipartisan membership of the Interstate Commerce Commission, Members of both parties and Houses of Congress, shippers, truckers, brokers and the administration.

This landmark legislation will improve surface transportation efficiency, save taxpayer dollars, protect the public interest and preserve transportation safety.

The legislation before the Senate is a compromise proposal designed to draw the Congress back from the brink of rash and unreasonable action with regard to the future of the Interstate Commerce Commission. It is an effort to pursue needed reform in Federal trucking regulation and at the Interstate Commerce Commission while at the same time preserving the much needed safety, dispute resolution and independent functions of the commission.

The Exon-Packwood amendment represents fundamental reform in trucking regulation. It also offers the Congress an opportunity to save real money, rather than just shuffle expense from one agency to another.

There are five basic elements of this reform package. Under this proposal: (1) the obligation to file rates would be eliminated for individual truck companies; (2) entry review would be streamlined and limited to insurance and safety matters; (3) the ICC would be given exemption authority over trucking matters under its jurisdiction; (4) the Secretary of Transportation would be required to report to the Congress on future organizational options for the ICC and whether further operational and regulatory efficiencies can be achieved; (5) following the philosophy of section 211 of the Airport Improvement Act of 1994 which preempts state regulation of motor carrier rate, route and services, the intra-state rate regulation of interstate bus services would preempted.

The Exon-Packwood trucking regulatory reform amendment builds on the success of the Negotiated Rates Act which this Congress enacted last year ending the nightmare of the undercharge claims form Bankrupt trucking companies. The amendment does nothing to weaken the protections of the Negotiated Rates Act and contains specific language to prevent a future undercharge crisis.

I ask the appropriations conference committee to consider this reform agenda in when it takes up the transportation appropriations bill. This reform agenda will save at least $50 million over years and likely much more.

The harsh, rash and possibly expensive action of the House of Representatives to defund the ICC without dealing with any commission functions should be balanced against this responsible, prudent approach.

Mr. President, the Negotiated Rates Act, section 212 of the 1994 Airport Improvement Program Act and this legislation form a trilogy of historic trucking economic reform legislation adopted by the 103d Congress and fully supported by the Clinton administration.

Years of gridlock, turf protection, and mistrust have been replaced by an agenda of change, productivity and efficiency. The Nation has a secretary of transportation committed to safety and efficiency and a interstate. commerce commission committed to its mission of protecting the public interest and advancing interstate commerce. These two facts make this reform agenda not only possible but responsible.

This trilogy of legislation will not only save tens of millions of dollars for Federal and State taxpayers, they will save hundreds of millions of dollars for the private sector and add to the efficiency of the greatest transportation network in the world.

Let no one interpret this agenda of reform as a license for the irresponsible. In the past, economic regulation often served as a proxy for safety regulation. The theory was that regulation and protection from competition would assure safe operations and equipment. However, we have learned that regulation for regulation's sake can divert resources away from safety and toward red tape.

This reform agenda will require the Congress and the States to rededicate and redeploy their resources to tough, modern and thorough safety enforcement. By and large, the private sector has at long last learned the link between safe operations and competent drivers and the bottom line. The slipshod, the careless and the reckless in the trucking industry should take no comfort in today's action. As long as I have a role in transportation policy, I will insist on the highest levels of safety possible.

I encourage my colleagues to support the Trucking Regulatory Reform Act and congratulate my colleagues of the 103d Congress and the administration for enacting a body of legislation which at least in the motor carrier segment of the economy reinvents government, enhances productivity, and preserves public safety.

Mr. HOLLINGS. Mr. President, I rise in support of S. 1640, the Hazardous Materials Transportation Authorization Act of 1994, as amended by Senator EXON'S amendment in the nature of a substitute. The bill as amended authorizes funding for the Department of Transportation's hazardous materials transportation program and provides for regulatory reform of the trucking industry. I urge my colleagues to support this legislation.

A safe and efficient transportation system is an important requirement for our country. In fact, the American transportation system is the envy of the world. But there is always the opportunity to improve the transportation system, both immediately and in the future. Such improvements are the goals of this bill.

Title I of this bill amends the Hazardous Materials Transportation Act. The bill mandates that the Secretary of Transportation explore the use of the intelligent vehicle—highway system technologies to promote the safe transportation of hazardous materials. In addition, there is a provision that could help to stem the appalling loss of life in grade crossing accidents. Over 600 people are killed each year due to grade crossing accidents. Further, the bill mandates tighter enforcement of truck drivers' records and their record of duty status. These provisions will allow authorities to remove fatigued and overworked drivers from the Nation's highways.

Title II of this amended bill is entitled the Trucking Industry Regulatory Reform Act of 1994. The text of title II is very similar to S. 2275, which was introduced by Senator EXON and cosponsored by Senator PACKWOOD. This title is the product of a bipartisan effort to provide meaningful reform in the surface transportation industry. The provisions address the concerns raised by some that the Interstate Commerce Commission [ICC] is no longer needed and should be abolished immediately, without further discussion as to what should be done with the ICC's functions or the effect on the public interest of eliminating the ICC.

This legislative language was developed after a Commerce Committee hearing on the ICC and its role in both the motor carrier and rail industries. The witnesses at that hearing were almost unanimous on three important issues. First, they supported further trucking reform legislation along the lines of S. 2275. Second, they agreed that there is a need for an independent ICC to attend to the important rail industry regulatory duties Congress entrusted to the ICC to protect the public interest. Third, they testified that any move to restructure or eliminate the ICC must be preceded by careful study of the advantages and disadvantages of such a move.

Title II of this bill accomplishes all of those goals. It broadens the entry provisions for carriers seeking to enter the industry. Allowing more carriers to enter the industry will create more competition within the industry and lower prices for the public. In addition, this title requires the ICC to devote more of its resources to its administration of the Nation's rail industry. The recent announcements by rail carriers of two contemplated mergers underscore the need for an ICC with the authority and expertise to pass on these very complicated and very important transactions in the public interest. Finally, this title provides for a study of the ICC's role in the future. The study is to determine which of the ICC's functions are necessary to the future of the Nation, and whether those functions should remain with the ICC or be transferred to another agency. In the case of function recommended for transfer, the study is to indicate when such a transfer could be accomplished without disruption to the public interest.

This legislation takes a constructive approach to improving the Nation's surface transportation system. Through this bill we will improve the present and future transportation of hazardous materials, increase our ability to ensure that only safe drivers use the roads, and ensure that the economic regulation of the motor carrier and rail industries is no more than is necessary to protect the public and contribute to industry's ability to move goods and provide service.

I urge my colleagues to support passage of S. 1640, as amended.

Mr. EXON. Mr. President, my substitute amendment to the Hazardous Materials Transportation Authorization Act includes a provision to improve compliance with the hours of service rules governing the number of hours which a driver can operate. These revisions will help ensure that the hours of service regulations are enforceable in a manner which does not impose an unreasonable cost to drivers or motor carriers.

The retention of documents for 6 months should not place any significant burden on carriers. In most cases, these documents are retained for tax and expense purposes. This provision will give enforcement personnel easier access to documents which can support or disprove an allegation of hours of service violation. Reports that auditors have been forced to retrieve documents from garbage dumpsters or play hide-and-seek with firms that have a policy of habitual hours of service violation give rise to the need for this provision.

Most professional drivers and trucking firms obey the law. Those that do not endanger the driving public and compete unfairly with those who follow the rules. Most truckers I know, work hard and play by the rules. This provision will eventually help make our highways safer.

The Surface Transportation Subcommittee is very concerned about reports that a small number of drivers engage in gross and repeated abuse of the rules.

The purpose of this reform is to encourage compliance, discourage gross abuses, and give auditors and enforcement personal the means to ensure, for example, that drivers are not backing their logbooks or driving "off the books."

The documents retained under this provision can help verify logbook entries, corroborate the time, date and location of a driver or serve as evidence which disproves the accuracy of log book entries. Of course, the time, date and location on a receipt, phone bill or toll stub is only as accurate as the accuracy of the issuer.

The regulations under this provision would be subject to public comment and should encourage the use of self-compliance systems by motor carriers, such as computer programs which verify driver location. The regulations should also encourage a "systems" approach by carriers to help prevent as well as penalize violations. The documents covered by this provision could be written or electronic and could be generated by the carrier, driver or a third party.

The object of this provision is to help make the roads safer by giving enforcement personnel the ability to catch those flagrant abusers. It is not designed to create a trap for drivers who receive, for example, a pre-stamped toll receipt or to unfairly punish drivers for a de minimis deviation from the current rules.

To the extent technically feasible the regulations should also look to the future and the possibility of actually reducing the burdens of record keeping while at the same time enhancing the effectiveness of enforcement through the use of Intelligent Vehicle Highway Systems [IVHS] which in the near future could provide data directly to enforcement personnel.

Mr. President, this provision is an important safety advancement and merits the support of the U.S. Senate.

On a separate matter Mr. President, section 107 of the bill before the Senate amends section 5125(g) of the Hazardous Material Transportation Act to give the Department of Transportation authority to obtain information from States on hazmat fees. Section 5125(g) as amended contains an administrative mechanism so that the Department of Transportation can determine whether hazmat fees are excessive or are used for purposes unrelated to transportation and therefore subject to preemption. While the recodification of title 49 (PL 103-272) intends no substantive chances in meaning there is a change in crucial language relating to 5125(g).

Mr. HOLLINGS. Mr. President, I rise today to advise my colleagues of the basis for my support of a provision in the amendment of the Senator from Nebraska to the Hazardous Materials Transportation Authorization Act of 1994. The provision pertains to the use of fibre drum packaging.

Congress has authorized the Department of Transportation [DOT] to grant exemptions to its requirements for packagings that are known to be safe. However, DOT has been reluctant to grant a domestic exemption for open-head fibre drums, despite DOT and industry records that show that these packagings have a 099.99 percent safety record. In fact, the open-head fibre drum—which is based upon American technology—has been used to ship hazardous materials in a safe manner in the United States for over 30 years.

DOT's reason for denying the fibre drum industry's exemption request was that open-head fibre drums for liquids fail to meet certain U.N. requirements. IT is important that Congress recognize that the U.N. standards with which these drums must conform have not been scientifically validated and there has been minimal experience in using these standards in the real transportation environment. Open-head fibre drums, on the other hand, conform to stringent industry standards and have a demonstrated 99.99 percent safety record in the real transportation environment. Despite DOT's authority under both the U.N. standards and the Hazardous Materials Transportation Act [HMTA] to make exceptions and exemptions to the standards adopted under docket HM-181, and the fact that DOT has granted other exceptions and exemptions to the HM-181 standards based on safety reasons, DOT has refused to authorize the continued use of American Fibre drums in domestic commerce beyond October 1, 1996, when the HM-181 standards become totally effective. The bill approved by the Commerce, Science, and Transportation Committee did not address DOT's failure to continue the authorization of open-head fibre drums because an appropriate provision for addressing this issue had not, at the time of the Committee's mark-up, been agreed upon.

The House of Representatives passed an HMTA reauthorization bill (H.R. 2178) on November 21, 1993. That bill included an HMTA amendment requiring DOT to conduct a rulemaking proceeding to determine whether open-head fibre drums can be safely regulated in accordance with standards other than the HM-181 standards by October 1, 1995. If the Department determines that alternative standards are appropriate, then they must issue these standards by October 1, 1996. The provision in the Senator from Nebraska's amendment to S. 1640 is the same as the one in H.R. 2178.

The provision does not specify the factors that DOT should consider in conducting the initial rulemaking. As a point of clarification, I ask the Senator from Nebraska whether my understanding is correct that it is the sponsor's intention that, in conducting this rulemaking to determine whether standards other than those of HM-181 may be used to safely regulate open-head fibre drums, DOT must consider DOT's hazardous incident reporting system and industry records and the 30 years of shipping experience associated with the use of these drums. I further understand that DOT must consider the existing industry standards for these drums since these standards have led to the industry's excellent shipping record.

Mr. EXON. Mr. President, I agree with the Chairman's understanding of DOT's consideration of the existing safety record and shipping experience of open-head fibre drums that have been used domestically in conducting its rulemaking under this provision. Additionally, DOT should consider the existing industry standards that have been developed by the fibre drum industry, since these standards are responsible for the current safety record of open-head fibre drums. The use of this data will help the Secretary of Transportation determine whether open-head fibre drums can be regulated safely in accordance with standards other than those of HM-181.

Mr. HOLLINGS. I thank the Senator from Nebraska for his comments. Based on this understanding, I support this legislation to amend the Hazardous Materials Transportation Act to authorize appropriations through fiscal year 1997 and to require DOT to conduct a rulemaking to determine if open-head fibre drums can be safely regulated. As provided in the House bill, DOT must make a determination by October 1, 1995, as to whether standards other than the HM-181 standards are appropriate and must issue these alternative standards by October 1, 1996. This amendment represents a viable approach to ensuring that a proven American technology is not unnecessarily eliminated while ensuring public safety concerns are met.

Mr. THURMOND. Mr. President, I rise today to ask Senator EXON, my colleague from Nebraska, a question regarding S. 1640, the Hazardous Materials Transportation Authorization Act of 1994. It is my understanding that S. 2275, the Trucking Industry Regulatory Reform Act of 1994, has been incorporated into this measure. My question is whether it is the intention of this legislation to include "mileage guide" within the definition of a "rate, classification, rule, or practice"?

Mr. EXON. Yes.

CONSIDERATION OF RECOMMENDATIONS

Mrs. HUTCHISON. Mr. President, I know that this Congress cannot bind a future Congress, however, as the current ranking Republican member of the Senate Surface Transportation Subcommittee, I believe that we can provide assurances of our intentions to proceed expeditiously to consider the recommendations for future reform by the Secretary of Transportation and the Interstate Commerce Commission. Does the current chairman of the Surface Transportation Subcommittee share my belief that our subcommittee should move ahead in a timely manner to consider reform recommendations in the next Congress?

Mr. EXON. I appreciate the Senator's question, and help in moving this important legislation. I share the Senator's intention. The reports required by this legislation will be taken most seriously and will be critical for future reform. I have every intention of giving the recommendations of the Secretary of Transportation and the Interstate Commerce Commission full, fair and swift consideration.

Mr. PACKWOOD. Mr. President, I am pleased to join Senator EXON in support of the Trucking Industry Regulatory Reform Act of 1994 and to thank him for his leadership.

Recently the House of Representatives voted to strike funding for the Interstate Commerce Commission from the Transportation appropriations bill for fiscal year 1995.

I strongly disagree with this approach. Anyone who knows my record knows that I would totally deregulate the trucking industry, other than safety and insurance. And I would totally deregulate the railroads except for modest exceptions. But I would keep the ICC. I do not quarrel with the job the ICC does. I quarrel with the job we give it to do.

I have learned over the years that merger for the sake of merger does not result in efficiency or reduced expenditures. I have also learned that small is better than big.

The ICC has expertise and independence that I value. It has been an asset in our efforts to deregulate transportation industries, and it is an efficient agency. Thirty years ago the ICC had 2,500 employees. Now it has 625.

We can reduce ICC's budget by eliminating some costly and obsolete motor carrier regulatory functions. Our bill will do this. Our bill will virtually eliminate the ICC's remaining motor carrier functions. However, ICC performs other functions that would have to be performed by someone else. Transferring these functions to another agency would be extremely disruptive. And the General Accounting Office has concluded that the cost savings would be small.

Our bill is intended to address perceived problems in a deliberate and systematic fashion, and avoid the uncertainty, confusion and potential chaos that could ensue if we simply eliminate the ICC without a larger strategy.

Our bill offers the potential for further efficiencies down the road. It would direct the ICC and the Secretary of Transportation to study additional opportunities to streamline or eliminate remaining functions as well as any other means of achieving further efficiencies. I look forward to full and prompt consideration of the Secretary's findings and recommendations. I pledge to continue my efforts to reduce regulation and unnecessary government spending.

The PRESIDING OFFICER. The bill is open to further amendment. If there be no further amendment to be proposed, the question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for the third reading and was read the third time.

Mr. FORD. Mr. President, I ask unanimous consent that the Commerce Committee be discharged from further consideration of H.R. 2178, the House companion bill, and that the Senate then proceed to its immediate consideration; that all after the enacting clause be stricken and the text of S. 1640, as amended, be inserted in lieu thereof; that the bill be advanced to third reading and passed, the motion to reconsider be laid upon the table; and that upon disposition of H.R. 2178, the Senate measure be indefinitely postponed.

The PRESIDING OFFICER. Without objection, it is so ordered.

So the bill (H.R. 2178) was deemed read the third time and passed.

The bill was not available for printing. It will appear in a future issue of the RECORD.

THE 100TH ANNIVERSARY OF JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

Mr. FORD. Mr. President, I ask unanimous consent that the Governmental Affairs Committee be discharged from further consideration of Senate Concurrent Resolution 60, expressing the sense of the Congress that a postage stamp should be issued to honor the 100th anniversary of the Jewish War Veterans of the United States; that the Senate then proceed to its immediate consideration; that the concurrent resolution be agreed to and the motion to reconsider be laid upon the table; that the preamble be agreed to; and that any statement appear in the RECORD as if read.

The PRESIDING OFFICER. Without objection, it is so ordered.

So the concurrent resolution (S. Con. Res. 60) was agreed to.

The preamble was agreed to.

The concurrent resolution, with its preamble, is as follows:

S. CON. RES. 60

Whereas the Jewish War veterans of the United States of America, an organization of patriotic Americans dedicated to highlighting the role of Jews in the United States Armed Forces, will celebrate 100 years of patriotic service to the Nation on March 15, 1996;

Whereas thousands of Jews have proudly served the Nation in times of war;

Whereas thousands of Jews have died in combat while serving in the United States Armed Forces;

Whereas, in World War II alone, Jews received more than 52,000 awards for outstanding service in the United States Armed Forces, including the Medal of Honor, the Air Medal, the Silver Star, and the Purple Heart;

Whereas, in World War II alone, over 11,000 Jews died in combat while serving in the United States Armed Forces;

Whereas members of the Jewish War Veterans of the United States of America have volunteered over 10,000,000 hours at veterans' hospitals; and

Whereas honoring the sacrifices of Jewish veterans is an important component of recognizing the strong and patriotic role Jews have played in the United States Armed Forces: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of the Congress that—

(1) a postage stamp should be issued to honor the 100th anniversary of the Jewish War veterans of the United States of America; and

(2) the Citizens' Stamp Advisory Committee of the United States Postal Service should recommend to the Postmaster General that such a postage stamp be issued.

Mr. GRAMM. Mr. President, I am very pleased that today the Senate will adopt Senate Concurrent Resolution 60, a concurrent resolution I submitted earlier this year expressing the sense of Congress that the Post Office should issue a stamp commemorating the 100th anniversary of the Jewish War Veterans of the United States of America. It is a testament to its broad, bipartisan appeal that 62 of my colleagues have cosponsored the proposal.

The Jewish War Veterans is the oldest active veterans organization in America. The Jewish people have a long and illustrious history of military service to this country in defense of our freedoms, including duty during the Revolutionary War. Jewish soldiers have won 15 Congressional Medals of Honor, and in World War II alone were presented over 52,000 awards for gallantry on the field of battle.

The service of Jewish veterans did not stop when they hung up their uniforms. Jewish War Veterans have sponsored a broad range of community and philanthropic activities, including summer camp opportunities for underprivileged children, college scholarships, senior citizen housing, and many veterans rehabilitation and service programs. Members of the Jewish War Veterans have volunteered over ten million hours at veterans hospitals.

The Senate now looks to the House, where they have yet to pass the companion resolution, House Concurrent Resolution 199. I urge our House colleagues to join us and adopt a resolution so that we might send a clear message to the Citizens' Stamp Advisory Committee of the Congress' strong interest in issuing a commemorative stamp in honor of this notable veterans organization.

MEASURE PLACED ON CALENDAR—S. 2374

Mr. FORD. Mr. President, S. 2374, that bill is at the desk?

The PRESIDING OFFICER. It is.

Mr. FORD. I ask for its first reading.

The PRESIDING OFFICER. The clerk will read the bill for the first time.

The legislative clerk read as follows:

A bill (S. 2374) to improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for all Americans, and for other purposes.

Mr. FORD. Mr. President, I ask for its second reading.

Mr. GORTON. I object.

The PRESIDING OFFICER. Objection having been heard, the bill will be placed on the calendar.

MEASURE PLACED ON CALENDAR—S. 2381

Mr. FORD. Mr. President, I understand that S. 2381, a bill to require the Secretary of HHS to provide health care fraud and abuse guidance, introduced earlier today by Senator COHEN, is at the desk.

The PRESIDING OFFICER. The Senator is correct. The clerk will read the bill for the first time.

The legislative clerk read as follows:

A bill (S. 2381) to require the Secretary of Health and Human services to provide health care fraud and abuse guidance, and for other purposes.

Mr. FORD. Mr. President, I now ask for its second reading.

Mr. GORTON. I object.

The PRESIDING OFFICER. There is objection. The bill will be read for the second time the next legislative day.

Mr. FORD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FORD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR FRIDAY, AUGUST 12, 1994

Mr. FORD. Mr. President, on behalf of the majority leader, I ask unanimous consent that when the Senate completes its business today, it stand in recess until 9:30 a.m. Friday, August 12; that following the prayer, the Journal of proceedings be deemed approved to date, and that the time for the two leaders be reserved for their use later in the day; that immediately thereafter, the Senate proceed to S. 2082, under the conditions and limitations of a previous unanimous consent agreement.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER FOR RECESS UNTIL 9:30 A.M. TOMORROW

Mr. FORD. Now, Mr. President, I ask unanimous consent that upon the conclusion of the remarks of the distinguished Senator from Washington, Mr. GORTON, the Senate stand in recess as previously order.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FORD. I yield the floor.

The PRESIDING OFFICER. The Senator from Washington.

TIMBER JOBS VERSUS GOVERNMENT ASSISTANCE

Mr. GORTON. Mr. President, last month the Daily Olympian, a newspaper in Olympia, WA, published a stunning 4-day set of stories as a result of a 3-month investigation by three journalists led by veteran Washington State political reporter Bob Partlow. Their stories focus on what has happened in Northwest timber communities since the Federal Government decided to stop timber harvesting and replace timber jobs with Government assistance.

For 5 years I have spoken about the Northwest timber-Spotted Owl crisis. Everyone knows where I stand. I have argued that Federal Spotted Owl protection has gone too far and that the administration has not sought a proper balance between the jobs of working families and rural communities and saving old forests.

You have heard me often, but now hear the results of the work of these reporters.

First, here is their map of Federal land that once was primarily timberland that is now set aside for owl habitat. How has this set aside affected lives?

Listen to their story. It is a story of deliberate destruction of a vital American industry and destruction of a treasured way of life for honest working families. The U.S. Government, driven by sophisticated, well financed national environmental organizations and supported by the media and urban opinion leaders, has betrayed rural communities and destroyed—yes—destroyed—the lives and careers of tens of thousands of honest working families in the Pacific Northwest.

What was that betrayal? It started when the President and Vice President at the Portland timber summit promised that people would not suffer greatly. They said that the timber harvest allocation would be reduced, causing the loss of a few thousand jobs, but that the people losing their jobs would not suffer greatly because of the Federal aid and job retraining dollars that would eliminate the pain. Just a little pain that the Government would fix.

Listen to what has happened since this promise was made. Federal timber harvesting has been stopped—not slowed or reduced—but essentially stopped. The administration has chosen not to ask Congress for relief from Federal court injunctions, thus—choosing—choosing to continue the devastation of the Northwest Federal timber harvest. Not a few, but tens of thousands of jobs have been lost.

So how successful has that retraining been?

Listen, not to my words but to the words of Jim Coates of Hoquiam as I read from the Olympian article:

> Perhaps the best measure of the government's timber relief effort is provided by people such as Jim Coates of Hoquiam, a burly former sawmill worker. Coates regularly tosses 40-pound boxes of government surplus cheese, tuna fish and juice from a truck trailer to workers at 28 food banks in the economically depressed logging country of Grays Harbor and Pacific counties. "When I started this job 5 years ago, we served 3,000 people a month," he said. "Now we're up to 18,123 in 28 food banks and two soup kitchens. Does that sound like retraining in working to you?"

Dan Goldy, former director of Oregon's Economic Development Department is quoted as follows:

> They're sticking a lollipop in the mouths of rural communities so they won't scream as loudly about shutting down their forests.

There is only one answer to this crisis that will matter to these families that are suffering and that is for the

President to propose and Congress to pass legislation allowing a reasonable and immediate timber harvest from Northwest forests.

But let nobody be fooled. This Congress has shown no willingness to help, really help, these families, nor has this administration.

Time magazine, which 3 years ago featured on owl on its cover, will never revisit these devastated timber towns to see the consequences of its advocacy journalism in support of stopping logging. The major Northwest metropolitan papers, which advocated so long and so forcefully for more habitat protection, have not followed the Olympian journalists to see what their agenda has caused. They have won their battle, accomplished their goal of stopping logging, but the messy details of the ruined lives left in the wake have not yet darkened the pages of these journals.

The lives of the urban opinion leaders who were so anxious to stop logging 2 or 3 years ago do not intersect with the lives of any of the 18,123 families who are now waiting in Jim Coates food lines. Those 18,000 families are out of sight and out of mind. These urban opinion leaders do not wish to be confronted with the consequences of their choice. It is awkward and uncomfortable. Their response is not to concern themselves with the cold human reality of those food bank families, but instead to rail against me or anyone who would dare suggest that their choice has crushed those real lives. I believe, I want to believe, that the lack of concern on the part of the opinion leaders who pushed so hard to stop timber harvesting is due to an ignorance of the rural plight rather than a lack of compassion.

This issue, in the minds of the people who dominate Washington, DC, today, has been settled. They will not be troubled by the uncomfortable truth. That uncomfortable truth is that the Clinton administration's 30-second sound bites, delivered 2 years ago when they promised both a reduced timber harvest and relief for the workers—was a fraud. What the workers got was unemployment and no real help. What those communities have is jobless families, desperation and no hope.

They have been betrayed. They will listen to no more slick promises from politicians.

One of the bitter ironies of this real drama is that these are families who did not begin despising their Government. These were the working families who, at least since FDR, believed that the Federal Government was generally on their side. These were families who paid their taxes and sent their sons to fight and sometimes die in America's wars. And they sent those sons proudly. But do not trouble yourself to ask them today whether they have faith in their Government still.

I have searched my heart deeply asking whether my own anger stems from the fact that my point of view has not prevailed on this issue. I truly believe that it is not the root of my anger. I have been in public life for more than three decades and I have won and lost more public policy battles than I can remember, but those losses do not stick with me and leave me angry. But this one sticks with me because so much has been taken from so many people—their families and communities, taken needlessly and under such false and glib pretenses.

And the glib answers do not reach the truth. The glib answer is that many people lose their jobs every day and life goes on. The truth is that timber communities exist because the Federal Government made a promise decades ago that if these workers would move there they could harvest a sustainable amount of Federal timber forever. These are towns with practically no other economic options. Timber workers laid off in a timber town whose houses have lost virtually all of their values, are not like most laid-off workers. They have no other realistic options, and the Federal promise of job retraining is a national scandal that does not work.

The glib answer says what Tom Tuchman, White House timber czar, is quoted in the Olympian as saying: "You can't repeal the laws of change," as if the deliberate federal decision to stop timber harvesting was inevitable—like a law of nature. The truth is that Tom Tuchman, like so many who dominate Washington, DC, is an advocate for stopping logging. He supports the position espoused by the national environmental organizations who demonize timber workers and seek the cessation of virtually all logging in the Northwest and it is that choice—not the inevitable fact of change—and their power to enforce that choice is the reason that these families are suffering.

The glib answer says that the Northwest is just about to run out of timber, or at least old growth timber, so that the end of the harvest was inevitable. The truth is that more than 70 percent of Northwest old growth forests were already set aside forever in parks, wilderness areas and designated reserves and that even in the 1980's we were not harvesting our Federal forests faster than the rate of regeneration.

The glib answer says that we should stop log exports to invent more mill jobs. The truth is that not a stick—not one stick of public timber is exported raw from the Northwest. We have ended all State and Federal log exports. All that remains is private property. And no honest person can, with a straight face, argue that banning private log exports will help any displaced workers in the rural communities that depend on Federal timber harvests. Nobody on this planet could survive in business by harvesting timber on the lowland private timberlands and then shipping those logs up to the more remote communities hurting today—it will not happen and the glib answer of banning private log exports is another fraud, as well as confiscation of private property values.

The truth is that we do not have to destroy these communities. 18,000 people do not have to wait in the Grays Harbor food lines in order to save old growth forests. The truth is that a fair balance can be found.

Someday, the truth will come out. But that someday has not come. The Olympian reporters have my respect. I fervently hope that their reporting prompts a reexamination of this issue that sheds light on the cold truth, the truth that the Grays Harbor food banks today serve 18,123 people in a county with a population of less than 60,000.

Can we imagine, possibly imagine, the response—properly—of decision makers in Washington, DC, the metropolitan Northwest media and opinion leaders in Washington State, if a deliberate federal policy put one-third of Portland or King County residents in food bank lines? None of us would tolerate such a result. So why do so many tolerate such a result in rural Northwest communities?

I fear that the truth affecting these rural communities is not likely soon to permeate past the tens of millions of dollars and sophisticated mass communications techniques of the national environmental organizations.

The truth is not likely to be heard or acted upon by the majority of members of this Congress who have cast their safe green vote, assuring the reelection support of the national environmental organizations and their troops.

But, still, someday the truth will out. God will not long ignore this preventable human suffering in our midst. Honest people will continue to seek the truth and question a public policy that causes so much pain.

But what do we do in the meantime? I pray to God that somebody else will listen now. I pray that wisdom, compassion and understanding will come to those who dominate Washington, D.C. now. I pray that, soon, those who have chosen this course understand that they must change to prevent even more pain from being visited on honest families who have lost so much in the Northwest.

My opponents on this question will hasten to say "we can't return to the old timber harvest levels of 5 billion board feet a year." I say "fine, but let us split the difference and immediately let these communities harvest half of what they had grown to expect. That will leave plenty of owl habitat, but it will also restore hopes and mend the broken lives of many Northwest families."

I am frustrated with this administration; I do not believe for a minute that the President wishes so much pain for so many families. I know that he does not. But the suffering is happening now because of decisions made by his administration. Through his action or inaction his administration will be judged. Thus far it has responded with indifference.

After the November elections I will make a formal request of the Senate Subcommittee on Interior Appropriations hold a field hearing in Washington State to answer some of the disturbing questions raised by the series in the Olympian. I will ask that the hearing be held before the start of the next session of Congress, so that it will be divorced from partisan politics, as this issue deserves more than partisan politics. I want these hearings to ensure that the money the Federal Government is spending is spent well and effectively. The people of these communities deserve, at the very least, to be assured that the little money that we are spending actually helps them.

So I close with a request that the President immediately propose legislation that will get timber flowing into our starving Northwest communities. If this legislation only provides for a short-term timber harvest, fine; that is not my preference, but I will be its advocate, and I will praise the President, because we need whatever we can get now.

I cannot assure that Congress will pass such legislation, though I believe that if the President pushes and the Northwest delegation supports him, we can succeed. But I can promise the only thing that an individual legislator can promise in the end. My promise is, Mr. President, that if the administration sends to Congress legislation that will cut through all of the roadblocks immediately and get timber flowing to help these desperate families and communities now, this Senator will vote, and speak and fight for it with all that is within me.

Mr. President, I ask unanimous consent to place the entire series of articles in the RECORD.

There being no objection, the articles were ordered to be printed in the RECORD as follows:

LOGGERS LEFT WITH CRUMBS

TAXPAYER MONEY: GOVERNMENT AGENCIES CANNOT PRODUCE AN ACCOUNTING OF WHERE TIMBER DOLLARS HAVE BEEN SPENT

(By Bob Partlow and Trask Tapperson)

Five years and more than $100 million later, government programs to help Northwest loggers and their communities have failed.

Massive logging cutbacks on federal forests have stripped the region of thousands of jobs.

State and federal agencies have poured money into studies, plans, consultants, unemployment benefits, seed money and retraining programs to rescue the people and their towns.

But a three-month investigation by The Olympian and The Bellingham Herald reveals:

Government agencies haven't tracked overall spending or handling of programs to train timber workers for other jobs.

They can't give an accounting of how much money they spent, where it went and whether it did any good.

Many loggers and their communities aren't finding new lives after the devastation caused by government- and court-ordered shutdowns of forests primarily to protect the northern spotted owl.

Though some retraining ideas have met success; they don't offset the widespread problems in many of the government timber programs.

"As a long-term effort, it's been a complete failure," said Roger Reidel, a former millworker who oversees forest-related issues for the Washington State Labor Council.

His assessment is shared throughout logging communities in Washington, Oregon and Northern California.

Perhaps the best measure of the government's timber relief effort is provided by people such as Jim Coates of Hoquiam, a burly former sawmill worker.

Coates regularly tosses 40-pound boxes of government surplus cheese, tuna fish and juice from a truck trailer to workers at 28 food banks in the economically depressed logging country of Grays Harbor and Pacific counties.

"When I started this job five years ago, we served 3,000 people a month," he said.

"Now we're up to 18,123 in 28 food banks and two soup kitchens.

"Does that sound like retraining is working to you?"

On the other hand, government officials point to the Clinton administration's plans to spend $1.2 billion to help loggers during the next five years.

"It's a good plan," said Tom Tuchmann, the White House czar in the Northwest.

"I believe in it. It recognizes people are hurting.

"You can't repeal that laws of change. You can only manage them. We're trying to manage," he said. "Some things are going to work. Some things aren't going to work."

But U.S. Rep. Peter DeFazio, D-Ore., said most of that $1.2 billion isn't a new infusion of cash.

Instead, it's money from other government programs repackaged as timber aid, he said.

"They're sticking a lollipop in the mouths of rural communities so they won't scream as loudly about shutting down their forests," said Dan Goldy, former director of Oregon's Economic Development Department.

Where is the money? The government can't say—it doesn't keep track.

White House response: Clinton officials say the administration's timber recovery plan takes time.

The Brewers: The Darrington logging family has tried to get government aid, but they face roadblocks.

Monday: A web of government bureaucracy captures people in its net.

Tuesday: Much of the timber money has paid for consultants, studies and administrative costs.

Wednesday: Some people have found solutions through retraining programs or community efforts.

NOBODY CAN EXPLAIN WHERE THE MONEY HAS GONE

TIMBER RETRAINING: GOVERNMENT AGENCIES CANNOT ACCOUNT FOR THE MILLIONS OF DOLLARS EARMARKED FOR COMMUNITY AND WORKER RECOVERY PROGRAMS

(By Trask Tapperson and Bob Partlow)

"Where has the money gone?"

Patti Hicklin, a part-time instructor at a job retraining center in the timber town of Forks, isn't alone in asking that question.

From union offices to university halls, people want to know how much the government has spent to help workers and communities rebound from sweeping logging cutbacks ordered mostly to protect the threatened northern spotted owl.

And they want to know if the money has done any good.

They aren't getting many answers because government officials at every level cannot or will not release bottom-line figures.

After a three-month investigation, The Olympian and The Bellingham Herald estimate that governments have channeled more than $100 million since 1989 to the recovery programs.

But that's only a guess because no clearinghouse exists to track the spending or results of training programs—either in the federal government or in Washington, Oregon and Northern California.

The newspapers filed 53 Freedom of Information requests with state and federal agencies in the three states to pursue the money trail.

"It's going to be tough for them to get the information you want because some of them don't know where their records are," said Lauri Hennessey, spokeswoman for President Clinton's forest plan. "They were never tracking it or keeping it in one place."

The newspapers followed up with repeated calls to officials at the top agencies to renew the request for numbers.

A sample of the newspapers' questions:

How much money did the agency receive, and how much did it spend?

How much did the agency use for administrative costs and how much for timber worker retraining programs?

How many people got jobs after retraining, and how long did they last?

The newspapers also tried to trace the money through dozens of people in and out of government, including officials at private industry councils and economic development associations.

In all, 42 of the agencies eventually responded to the written requests—from the giant U.S. Department of Labor to the tiny town of Naches north of Yakima.

They sent information in a variety of governmnt forms or no forms at all, producing a three-inch stack of reports on taxpayer dollars spent.

The information included actual contracts with consultants to spreadsheets (one handwritten), newsletters and newspaper clippings. They often trickled in weeks after the initial request—and even more than two months in some cases.

Some agencies put a price tag on their response.

"We estimate that gathering this information will take two full-time people five full days," wrote Jennifer Kang, spokeswoman for the Oregon Economic Development Department. "I'm guessing, but this could run you up to $1,000."

Ray Daffner, executive director of the Oregon—based WPPC, and association of businesses that make finished wood products, said Oregon officials want to keep the door closed. "They don't want any scrutiny,' he said. "If they wanted to they could tell you."

Other agencies replied, only to flatly refuse to provide any information short of a court fight.

"We must decline because your request is not focused on a specific issue or problem," wrote the Resources Agency of California, a leader for regionwide effort to help displaced timber workers.

Many agencies said they simply didn't keep track of the numbers.

"In response to your request for a head count of all persons who obtained new employment as a result of money spent, a head count of all types of new employment obtained and the length the jobs were held, please be advised that we do not have any records responsive to that request," wrote the Economic Development Administration of the U.S. Department of Commerce.

Even Robert Rheiner couldn't supply numbers. He is co-chairman of the Regional Economic Revitalization Team in Portland, Ore., created by the Clinton administration to route federal money to timber workers looking for help.

In the end, only fragmentary figures emerged, but they show a startling lack of accountability.

In many cases, government agencies didn't follow up to see if their programs helped timber workers find jobs in new professions, ranging from nurses to small-business owners.

In other cases, they knew people found jobs, but didn't know if the workers received a living wage or how long they were employed.

That's true even for programs cited by the government as models in the retraining effort, such as Lane County Community College in Eugene, Ore.

Program Director Patty Lake cited statistics to show how well former timber and millworkers are doing after attending her school's programs:

Since 1989, about three-fourths of the 2,200 laid-off wood products workers who took classes have new jobs; three-fourths of them are in their retraining field and most make at least 90 percent of their previous wage—averaging $9 to $9.50 per hour. But the program surveys students in the first three months of leaving school. After that, nobody knows.

The federal government won't begin until this fall to track the results of worker retraining and community renewal programs, said Laura McFarland, a Rheiner aide.

A long-term look at how workers are faring isn't expected for almost five years, she said.

U.S. Sen. Mark Hatfield, R-Ore., questioned how wisely the Clinton administration can spend a planned $1.2 billion on timber relief during the next five years when the current spending records are so incomplete.

"That's a whole other story," Hatfield said. "If you find out the answer, let me know."

Family Willing To Try Anything To Survive

LEARNING TO COPE: "IF YOU WANT HELP, YOU'VE GOT TO LOOK AT THE END OF YOUR SLEEVES," RON BREWER SAYS

(By Trask Tapperson)

DARRINGTON.—After more than two decades immersed in Washington's timber culture, Ron and Shari Brewer consider logging as much a lifestyle as a livelihood.

The Brewers enjoyed both from the woods as they logged in the Mount Baker-Snoqualmie National Forest under contracts with the U.S. Forest Service.

They didn't get rich working in the 1.7-million-acre stretch along the western slopes of the Cascade Mountains.

But they could afford ballet lessons for daughter Rhonda, now 14; flights on rented light planes with Ron at the controls; a family vacation to the Southwest desert so Shari could see wildflowers in bloom.

No more.

The Brewers may join tens of thousands of people in the Northwest's coastal woodbelt who must find another line of work.

That's because the Mount Baker-Snoqualmie Forest is now reserved mostly for recreation, said U.S. Rep. Al Swift, D-Bellingham. Logging has all but ended as legal protection of forestland increases.

The protections range from scenic river corridors and wilderness areas to habitat preserves for northern spotted owls—goals of predominantly urban residents and groups, Swift said.

"You live on Queen Anne Hill (in Seattle) and it's really great to save all the trees around the people in Darrington," Swift said sarcastically.

TIGHT TIMES

The Brewers, Whatcom County natives, just sold some land they have owned for years near Acme. The money may help pay for a small farm they are looking at east of the mountains.

Shari, 43, envisions running the farmhouse as a bed-and-breakfast for tourists while her husband works the farm.

Ballet lessons, recreational flying and desert vacations got squeezed out of the family's tight budget more than a year ago.

Those luxuries flowed in the mid-1980s when their R.L. Logging and Land Clearing business had 12 full-time employees and six log-truck drivers under contract, grossed an average $500,000 and netted about $50,000 a year. Like virtually all small-time operators reliant on timber-harvest contracts, the Brewers experienced tough times even before the logging bans.

A bankrupt logging company owed them $180,000. They were involved in an unrelated lawsuit that temporarily tied up collateral to refinance their house, which they then lost.

By the start of the '90s, they lived in a rented home and worked for others. Their savings dwindled.

By February, Ron's unemployment benefits ran out. By spring, Shari's part-time job at an Arlington nursing home dropped to a few days a month, barely making it worth the 28-mile round-trip drive.

Today, they put food on the table with pickup work.

Last month, Shari did occasional jobs for the U.S. Navy, conducting guided nature tours at a naval reservation in the forest. Ron does odd jobs with his bulldozer—clearing land, building ponds, fixing roads and excavating building sites. "What it boils down to is, if you want help, you've got to look at the end of your sleeves," he said.

RON'S JOB HUNTING

The two have hit dead ends in more than a half-dozen attempts in the past several years to get government aid—despite millions of dollars poured into the Northwest for timber worker retraining and community renewal.

Ron's job hunting as well as his self-employment efforts have been rebuffed, the Brewers believe, in some cases because Ron is 46. Examples include.

Helicopter logging pilot: Ron has a private pilot's license and said he needs about $4,000 to $6,000 to get rated for choppers. The role of helicopters in logging may grow with the new emphasis on selective harvests in roadless areas.

Ron said he asked for help form the Snohomish County Private Industry Council, which has received several hundred thousand dollars in grants to help timber workers.

Council Executive Director Emily Duncan said she didn't recall Brewer or his request.

Applications of that sort go to the state Employment Security Department, but Duncan said she doubted the training would receive approval because of its "higher-than-average training costs."

Another deterrent is that the helicopter job would leave Brewer in the same precarious job field, said Kathy Kerkvliet, an Employment Security Department official in Mount Vernon.

Environmental engineer: Every Sunday, Ron sees several openings for environmental engineers listed in Seattle newspaper ads. He asked the Employment Security Department for retraining help to qualify for such work but was told it would take too long and cost too much.

"The intent of the program is more vocational in nature," Kerkvliet said. "There isn't the funding to fund a person for a four-year degree. There's thousands more people than there are funds."

A Look At Your Tax Dollars At Work

The incomplete numbers tell only part of the timber story.

They don't disclose questionable spending practices or the human cost of the decision to ban logging on at least 7 million of acres in Washington, Oregon and Northern California.

The three-month investigation by The Olympian and The Bellingham Herald found these examples of how governments spent tax dollars to help dislocated timber workers and their communities:

Three loggers learned how to become scuba divers in 1992 through a state of Washington program. Price tag: $30,000, including a week of warm-water diving in the Mexican resort town of Cozumel and another week in Houston to attend a scuba equipment convention. "It was a waste of money, but I had a good time," said Carl Gockerell, one of the loggers.

Gockerell now has a job marking trees for sale in forests. Of the other two loggers, one is unemployed and the other works as a crab fisher.

Thousands of dollars went to economic development seminars. In addition to the usual speakers, a three-day Timber Communities Conference in Ellensburg last April included a series of games with plastic mice, paper airplanes and water pistols.

Price tag: $12,114.76.

Economic development activists in Grays Harbor bought self-esteem tapes to boost the confidence of unemployed timber workers and others. Price tag: $43,200 in public and private money.

A six-week government-sponsored "career assessment" program offered by Grays Harbor College included a one-day physical obstacle course on the Wynochee River. During the Outward Bound-type exercises, loggers go scurrying up ropes in a class to build their self-confidence. Price tag: $500 for each student. The college also uses state money to defray costs.

CLINTON ADMINISTRATION ON TIMBER CRISIS: JUST WAIT FOR RESULTS

GOVERNMENT RESPONSE: WHITE HOUSE OFFICIALS SAY THEY ARE REBUILDING THE TIMBER PROGRAM, BUT IT TAKES TIME

(By Trask Tapperson and Bob Partlow)

The White House is trying to reinvent the government's response to the timber crisis to avoid past failures, Clinton administration officials say.

But with more than one-third of the president's term already over, they can't provide numbers that show improvements since Clinton took office.

Yet they insist their project to retrain timber workers is turning around and blame the Bush administration for leaving them with a program in disarray.

"The alternative is to do nothing. That's unacceptable," said Tom Tuchmann, the Poland, Ore.-based White House official in charge of Clinton's forest plan.

"If we started doing this five or six years ago, we wouldn't have a crisis. We inherited a train wreck," Tuchmann said. "You can't change that overnight. It took us a year to put this plan together. In forest planning, that's fast."

U.S. Labor Secretary Robert Reich said the administration is "rebuilding the track, lining up the trains and putting on a new locomotive."

But for those already hit by the train, it's too late. "A lot of people are hurting," Reich said.

Tuchmann and other federal forestry officials said they should be judged only on what the federal government has done since November 1993, when their Economic Adjustment Initiative began.

That's the name of the people side of Clinton's two-sided approach to solving the Northwest's forest crisis. It deals with worker retraining and community renewal.

The program's other half deals primarily with the environment and other forest management concerns.

The initiative grew out of the administration's so-called Option 9 plan for Northwest forests that put more than 7 million acres of public land into reserves.

"Give us until the end of the year, when we've been at this a year, and we will be a lot more accountable," Tuchmann said.

Yet a top administration official already has touted the success of the initiative. White House Deputy Chief of Staff Roy Neel trumpeted it to 13 other top Clinton appointees in a Nov. 29, 1993, memo.

He called for a "full-court press' strategy to ensure the effective implementation of the plan. The administration has already made some significant progress on this front."

He also noted that "the plan is complex and there is little margin for error."

Away from government offices in Portland's glass skyscrapers, the common view is that the Clinton administration's revamping isn't an improvement over what came before.

"Tuchmann doesn't see it," said Portland forest economist Dan Goldy, former director of the Oregon Economic Development Department. "He's got Option 9 blinders on. Over 50 percent of Oregon lands are publicly owned. We're looking at an economic catastrophe in this state."

Said U.S. Sen. Mark Hatfield, R-Ore., "There is no accountability, I haven't seen it (in the government programs)."

Chris Chandler, state coordinator of the Salem, Ore.-based Oregon Lands Coalition, said she has no evidence that the Clinton forest plan is any better.

The coalition's 65 member groups include union locals and timber, ranching and mining interests that are promoting a larger timber harvest than allowed under the Clinton plan.

"Retraining is the hardest thing in the world to get information about," Chandler said.

But Shari said her husband got another reason, unofficially.

"A gentleman at Employment Security told him that even if he did take classes and finished at the top, he would more than likely be passed over for a younger person with the same qualifications," she said.

Equipment operator: Ron has spent 25 years running everything from giant bulldozers to yarders that pull downed trees to collection points.

"I have experience in climbing trees and operating chain saws. I have worked in all kinds of inclement weather. I am a nondrinker/nonsmoker," said his letter two years ago to the Snohomish County Public Utility District.

He didn't get the equipment operator job.

The same utility soon offered job-training classes for workers at an Everett pulp mill that Weyerhaeuser Co. was about to close. Ron would have welcomed a chance to attend those sessions, but he wasn't eligible.

Road worker: The state Department of Natural Resources is tearing up 72 miles of old logging roads in northwest Washington and leasing new equipment to do the job. "Why don't they give a logger that job so they can make payments on their own equipment?" Ron asked.

The agency has no prohibition against that, said Northwest-area spokesman Mark Morrow. "But we can't think of anyone who's met the criteria of being a displaced timber worker and had their own equipment."

SHARI'S JOB HUNTING

Shari's efforts to get the family on its feet have hit other government snags.

Like Ron, she looked at returning to school. She applied in 1990 to Skagit Valley Community College and the county Private Industry Council for assistance to get a two-year degree in parks and recreation administration.

"There was only $400 in support money for the entire two years," she said. "Round-trip mileage to the college was 120 miles a day. I didn't even begin.

She cited a string of roadblocks to a three-year effort get her "Off the Beaten Track" forest guide service up and running.

The Private Industry Council promised to help her with marketing for one year if she completed a 100-hour business course, she said.

She did, but "six weeks after the classes ended, I got a letter that said, 'We're sorry, we're out of funding, and the marketing help is not available,' "she said.

She spent $500 of the family's savings for brochures. They're gathering dust as permits and other requirements to start operations remain enmeshed in a thicket of government restrictions.

One she cites is a state constitutional ban on investing public money in private businesses such as her fledgling enterprise.

"I could be up and running for about $15,000" she said. That includes $12,000 for a used tour van, $3,000 for marketing, $600 for liability insurance and $85 for Forest Service permits. Without the insurance, the Forest Service balks at giving her permission to take people into the woods.

"All the timber dollars that have come in here have paid people to tell us how to do it," Shari said. "There's nothing for individual persons in start-up loans.

"I think it would be better spent than hiring people to come up here and tell me how to do it," she said. "They've sunk maybe $50,000 into counselors, who don't know the needs of the community. That would have started up three businesses."

Shari said she earned about $1,500 for her family last year picking wild berries. In April, she said the Natural Resources Department denied her a permit to enter Ash and Squire Creek roads to her prime berry area because they are managing it more restrictively for wildlife.

"The bottom line is you're on your own," she said.

WHERE DID $100 MILLION COME FROM?

ACCOUNTABILITY: THE OVERALL ESTIMATE OF TIMBER AID IS AN EDUCATED GUESS BASED ON FIGURES SUPPLIED BY A STATE AGENCY

(By Bob Partlow and Trask Tapperson)

The Olympian and Bellingham Herald have estimated that government agencies in Washington, Oregon and Northern California spent more than $100 million from mid-1989 to mid-1994 to aid workers and towns.

But that's only an educated guess because no state or federal agency in the region has any precise, reliable figures.

The Washington Department of Community Trade and Economic Development supplied the best numbers, saying about $34 million had been spent on the timber problem in the state during the past five years.

Estimates for Oregon and California are a guess because agencies there would not respond to requests for information or would do so only at a high cost.

Government officials and industry leaders say Washington loggers and communities feel about one-quarter of the impact of logging cutbacks. About 60 percent of the impact falls on Oregon and the rest on California, they say.

If Washington's numbers are correct, a figure of more than $100 million is a conservative estimate for the three-state region. A congressional source who asked not to be named said that estimate is probably accurate, although he indicated no overall figures exist.

The newspapers received a wide variety of responses to requests made under the Freedom of Information Act and state public records laws.

Some agencies gave clear, concise information about their small corners of the multimillion-dollar effort:

The Eastern Washington Partnership, for example, provided information about its $107,405 grant to retrain workers: length of the grant, actual expenditures, administrative costs, number of people who participated, what happened to them after they received training and the cost per participant.

They spent only $102,773 of the money allocated.

The U.S. Department of Labor also provided data that mapped how much money was spent in Washington and Oregon the past half decade under the Worker Adjustment Program. Its charts detailed the number of participants, how many weeks the average participant was trained, average hourly wage before the program and hourly wage at the program's end, total program costs and a follow-up employment rate, among other things.

"People have a right to know how their dollars are being spent," said Tom Tuchmann, President Clinton's forest plan czar.

But even the Department of Labor didn't keep track of workers after 13 weeks—and department money is only part of the government pie divided up in the states.

The lack of detailed numbers comes despite Gov. Booth Gardner's creation of a "timber team" in Washington in 1989 to bring together public agencies and private groups to coordinate a response to help timber communities.

The team produced one detailed report in December 1992 but didn't follow up after that.

State Timber Workers Last to Get Federal Aid

SLICES OF THE PIE: AT LEAST 156 AGENCIES VIE FOR FEDERAL TIMBER DOLLARS

(By Bob Partlow and Trask Tapperson)

Veteran U.S. Sen. Mark Hatfield of Oregon doesn't know how much money is being gobbled up by bureaucrats that is supposed to help timber workers and their towns.

Because he can't get answers, he just says it's quite a bit.

Laurence Larsen, the owner of a Darrington hardware store, also doesn't know but said money thrown at the problem gets whittled down like a "silver dollar to a dime."

With at least 156 agencies with a finger or two in the governmental pie cooked to help loggers and their towns, every bureaucraft and consultant seems to get a piece before the last few crumbs are sent to help timber workers.

Kristi Reece, a U.S. Forest Service employee in Darrington, said her agency is typical.

"Money comes from Congress," she said. "The Washington office takes its share. Then the regional office gets its share. Then the supervisor's office gets a percentage. Then the district office gets a percentage. By the time it gets to the workers, it's not the full amount Congress allocated. People may not like it, but that's the way it is. That's the way it's always been."

Congressional reports studying retraining programs such as those for timber workers have called them wasteful, duplicative, overlapping, late in providing help, mismanaged and inefficient.

The Clinton administration says it is trying to sort out the competing bureaucratic interests and get everybody pulling together.

Whether it can or will work remains an open question.

"This may look like a piecemeal approach to you," Reece said. "You should have seen the way it was before."

Bob Partlow, 47 has been the state government reporter for The Olympian for the past 10½ years.

He covers the Legislature, state government and politics, and has done extensive investigative reporting.

Before moving to Olympia, he held a similar job for six years with the Herald. He also was a radio reporter in Blaine and Anacortes for four years and attended Western Washington University from 1965–69.

Trask Tapperson, 55, began his newspaper career 33 years ago as a reporter for the St. Louis Post-Dispatch. Among his jobs: political, legislative and government correspondent. He also was a member of the newspapers' Editorial Board. Tapperson joined The Bellingham Herald in 1982 as environment and energy reporter and was city editor for five years before becoming business editor and special projects reporter.

Dick Milligan, 56, has been a photographer at The Olympian for the past 18 years and is now the chief photographer. Before being hired by The Olympian, Milligan spent 20 years in the Marine Corps as a photographer. In his career, he has photographed everything from politicians to posies, and he shows a strong preference for the posies.

Clinton Administration Adds to Bureaucratic Jungle

MORE GOVERNMENT: THE PRESIDENT'S SOLUTION FOR THE TIMBER CRISIS HAS ADDED LAYERS OF GOVERNMENT

(By Bob Partlow and Trask Tapperson)

No less than 156 bureaucracies help carry out President Clinton's Northwest forest plan, 98 alone to help timber workers and towns.

Some agencies are public, such as government departments; others are private, such as industry councils; still others are a blend of both, such as economic development councils.

The public players are at all levels of government—federal, state and local. Some are in separate governments, such as Indian tribes.

Together they have spent more than $100 million during the past five years on dozens of programs in a mostly unsuccessful effort to steer loggers, millworkers and their communities to new lives.

Their old lives are falling prey to logging cutbacks in Northwest forests that stem mostly from a move to protect the northern spotted owl.

BUREAUCRATIC MAZE

The maze of agencies is one of the top reasons why government officials can't say where the money has gone and whether it has done any good.

"You put a silver dollar in the end of the pipe and somehow a dime comes out the other end," said Laurence L. Larsen. He owns Darrington's only hardware store and has served on state economic development committees.

Streamlining the bureaucracy was one of the Clinton administration's early claims of success. From the president down, federal officials talked about how they were reinventing government systems.

What the administration invented for the timber crisis was at least five more layers of bureaucracy on top of the 156 departments, bureaus, administrations, boards, councils, consortia and tribes.

At the behest of the White House, the federal government and three Northwest states created "economic revitalization teams" to coordinate about 1,200 applications for money and other help for distressed communities and worker groups.

The state teams feed the applications to the regional team based in a Portland, Ore., skyscraper. The regional team, in turn, feeds them to various components of the federal bureaucracy.

"We feel we're not creating bureaucracy, we feel we're making bureaucracy run much more efficiently," said Robert Rheiner, cochairman of the regional team.

Yet a few blocks away in another Portland skyscraper is another White House creation: the Inter-Agency Office of Forestry and Economic Development. Its director, former U.S. Senate staffer Tom Tuchmann, oversees the president's timber plan to manage Northwest forests and renew timber economies.

The Clinton administration has identified 47 barriers to effective retraining and community development. They range from muddled chains of command to different criteria for approval of the same kinds of requests.

NOT THE ANSWER

Adding more bureaucratic tentacles isn't the answer, said Linda Morra, director of education and employment issues for the General Accounting Office, the investigative arm of Congress.

"Coordinators frequently carry costs," Morra said. "It's not quite clear that the most efficient way out of this maze is to have people coordinated. You're dealing with a system that's fragmented and inefficient."

Then why perpetuate it? Larsen is among those who thing they know.

"They spread all this money around, a mile wide and in inch deep," he said. "It doesn't do any good, but it does have political benefit."

That's borne out by the types of officials chosen to serve on the various revitalization teams, said David Ford, president of the Western Forest Industries Association. The group represents 100 small mill owners in 12 Western states.

"Look at their makeup," Ford said. "They're all government people looking for ribbon-cutting projects—a new sewer, lighting, paving, infrastructure things—without looking at maintaining the tax base that they have."

A big reason for that, Ford said, is that Clinton's forest plan "was cobbled together. They threw money at a problem, hoping it would go away. They start from the premise the industry will die."

In fact, Ford said, by its approach to relief "the administration is saying the industry already is dead."

Meanwhile, no one is monitoring the bottom line for cash flowing through the government programs and what the money is buying. For example:

When the U.S. Department of Labor puts federal tax dollars into state programs, the states are left to track how those dollars are spent and what they buy, said Armando Quiroz, the department's top employment and training official for Washington and Oregon.

Of 135 timber-related studies and plans performed in Washington since 1989, the state tracked the results of only 12. Local officials were left to figure out what taxpayers got for their money in the other 123.

Tuchmann said the Labor Department is a "money distributor, not a money monitor."

Government waste may be a great deal more costly than the $100 million-plus spent on the timber crisis. Several reports from the General Accounting Office criticize government job retraining programs in general.

They cite:

Complexity.

Failure to tailor programs to match worker needs.

Administrative inefficiencies.

Lack of accountability.

Particularly worrisome is the high administrative costs that agencies spend solving the same problem, according to the General Accounting Office.

Washington state numbers show costs of administering assistance programs for timber workers and towns range from little or nothing to about 12 percent. Neither Tuchmann nor officials in the three Northwest states could or would say what they are.

General Accounting Office officials said administrative costs of some other federal retraining programs are in the same range, while others are in the range of 15 percent to 20 percent.

The problem isn't just costs. There are serious problems with the way the governments set up some programs.

For example, governments typically require displaced workers to go through retraining to receive extended unemployment benefits. So they enroll in school, often community colleges. But the benefits frequently run out before their retraining programs are completed.

"Then we have to choose between survival and education," said Kevin Browning, a former logger from Roseburg, Ore. He wanted to get a business degree but now is caught in such a bind.

Many involved in the retraining programs—from timber workers to those in local businesses that depend on them—feel the bureaucrats who administer them ignore the human element.

When workers do get training for new jobs, it's often for positions that don't exist. Examples include the glutted fields of truck driver and diesel mechanic. To rectify that, Washington state was supposed to do a market study of jobs available. It hasn't been done, state officials said.

Scott Haugen, a former logger in Forks, said the only reason he successfully trained to become a diesel mechanic is because "I had every break in the world."

He overcame several bureaucratic obstacles—including having to pay for most of his tools after the government said it would provide them.

Not all the problems arise with the bureaucrats.

Another obstacle to successful retraining is the ingrained reluctance to change or relocate among those working in rural timber towns.

Often their roots sink deeper than an old-growth Douglas fir's. Already hostile toward a government they say has denied them a living, many are in no mood to leave—no matter what the cost.

"I have four or five generations of my relatives buried here," said Coin King of Forks, a onetime firebrand timber activist.

He still carries the torch but is busy nowadays trying to scrape together a living in the woods. "Why should I have to go move to become a VCR repairman in Seattle?" he asked.

George Bernard Shaw Jr. spent a quarter century falling timber in Oregon and Washington. He lost his last job in December and now is struggling to get a two-year degree at Peninsula Community College in Port Angeles.

It's part of his effort to find a new way to make a living—and a desperate attempt to avert a move to more populous places with more job opportunities.

"I don't want to live in the city," he said. "I just can't do it. I'd live out here and starve first."

RETRAINING PROGRAM TURNED OUT USELESS

SURVIVING: THE LYNCHES OF HOQUIAM HAVE FOUND A WAY TO SURVIVE—WITHOUT THE GOVERNMENTS'S HELP

(By Bob Partlow)

HOQUIAM.—If ever a man looked like a logger, it was Larry Lynch.

A 1989 photo shows him with a bushy beard, suspenders, plaid shirt, standing in a forest.

"He was the American logger," said his wife, Renee Lynch. But he lost his job in February 1990. The couple and their three children almost went bankrupt and had to cash in their insurance policies. The winter of 1980-90 was "an absolute nightmare," Renee said.

An advocate for devastated timber families, she recalls sorting out rotten potatoes from good ones at the local food bank. Her family also was getting help from the food bank. "People lived on cleaned-up pig food—that's how most of us made it," she said.

Lary, 40, decided to retrain as a nurse, thinking it was a job with stability.

He started at Grays Harbor College in spring 1991. But a year later just as he was making progress, the rules changed for awarding school grants and his money ran out. He finally gave up.

On his own, he found a job building and maintaining guardrails on state highways in 1992. It paid the mortgage, but kept him away from home for long periods. That job ended this year, and he finally found a similar job in Alaska.

The state lists him as successfully retrained, said Renee, 31.

But the Lynches are selling their home and moving near Anchorage, Alaska, to start over.

Renee has little use for retraining programs or the government that sponsored them.

"It's an absolute joke," she said, "Try retraining a Sioux Indian not to be a Sioux Indian. It can't be done."

SMALL-TIME LOGGING OUTFITS WILL BE SHUT OUT OF SALES

LOGGING SALES: OPERATORS SAY GOVERNMENT TIES THEIR HANDS WITH BOND REQUIREMENTS

(By Trask Tapperson)

A federal judge last month lifted a three-year court ban on U.S. Forest Service timber sales along the Northwest coast, but that won't set chain saws screeching anytime soon.

That's because legal challenges and sale preparations must come first.

When the trees do go on the block, perhaps next year, few of the small, often family-run logging businesses are likely to benefit much, their operators say.

The reason: The federal government thwarts its goal of helping timber businesses by the scale of its timber contracts and bond requirements.

The federal government puts no ceiling on the size of its timber sales but is trying to structure smaller contracts, said Robert Rheiner, a Clinton administration forest official.

The government also is advertising logging sales of more than $25,000 in local areas so smaller logging companies have a chance at them, Rheiner said.

But loggers claim that won't help them because they can't come up with the 10 percent performance bond required by the government to protect against improper job performance.

"When it's a big contract—$250,000 to $500,000—that's a $25,000 to $50,000 bond," said Shari Brewer, a former contract logger in Darrington. "Small operators just don't have it."

The government could do some simple things to open more doors, loggers said.

For example, they said, the government could:

Set aside a percentage of contracts for small logging operators, just as it does for businesses selling to the government and for women- and minority-owned businesses.

Put into escrow some of the money it plans to pay a contractor (say, 15 percent of the contract's value), then pay it out only as the work is approved.

Raise the minimum amount of a contract at which operators must pay prevailing union-level wages in the area in cases involving a dislocated logger.

Some of those changes would require action by Congress, Rheiner said.

Other steps within the power of the administration must await its "learning process," he said.

Meanwhile, Rheiner said, "It's just not going to be possible to save everybody."

IT SEEMED LIKE THEY PROMISED YOU EVERYTHING AT THE START

(By Bob Partlow)

FORKS—Scott Haugen, 35, successfully started a second career as a diesel mechanic after working as a logger all his life.

But he wouldn't have made it through a government retraining program without the help of family and friends.

In 1990, he signed up for a two-year diesel mechanic course at Peninsula Community College.

A state-funded training program promised him $2,000 for tools, but he got closer to $500. He borrowed the rest of the money from his dad to buy them.

His unemployment benefits ran out during his program. His family kicked in to keep him going.

He needed a space to start the business. His best friend, Dave Westerlund, provided it.

And his wife has a good job as an administrative secretary will the Quillayute Valley School District.

"It seemed like they promised you everything at the start," Haugen said. "As time went by, you because more of a case number. I quit listening to them after awhile."

The best way to help out-of-work loggers is to put them back in the woods where they belong, he said.

"How many people my age in Seattle stopped a well-paying job they enjoyed, took two years out of their life and started working another job—just to satisfy somebody else's idea of what is right and wrong?" he asked, referring to those who want to protect the northern spotted owl.

"I miss logging, I really do. There was something about it. What has happened is something like an excerpt form the 'Geraldo Rivera' show."

I HAVE NO DESIRE TO WORK AND BE POOR

A LIVING WAGE: THE COLLEGE STUDENT WILL RUN OUT OF UNEMPLOYMENT INSURANCE BEFORE HE COMPLETES HIS DEGREE

(By Trask Tapperson)

SEQUIM—George Bernard Shaw Jr. points out where the big trees used to stand as he strolls across the Peninsula Community College campus. He knows because he cut down many of them in his logging days.

Shaw, 41, now lugs a book bag instead of a chain saw as he seeks to replace his shattered, 25-year career as a timber feller. It ended when he lost his last job in December, began collecting $290 a week in unemployment benefits and enrolled in school to seek a four-year environmental policy and assessment degree offered through Peninsula by Western Washington University's Huxley College.

Shaw proved he knew how to study 19 years ago when he earned a two-year associate degree in applied sciences at Clatsop Community College. He still knows. Shaw's earned almost straight A's at Peninsula.

No matter. His re-education is becoming a tangled mess because the government-organized retraining system is out of sync.

"It's difficult to have an objective, and then they'll take you only part way," he said.

His first degree left him 30 credit hours shy of the requirements to begin working toward the Huxley degree, which he sees as a certain key to a steady living.

But limited course offerings and enrollment pressures have stretched out Shaw's preparation for the Huxley program. And come September, when he'd like to begin it, only senior-level courses will be offered, he said. That means waiting until September 1995 for the junior-year courses to roll around.

In the meantime, Shaw said, the government allows him only 18 months of unemployment benefits, which run out this summer. Without that money, Shaw said, he can't pay his bills without leaving school and building up some on-the-job hours to qualify for more unemployment benefits.

As the prospect of his environmental degree stretches out, Shaw may help his wife, Dorothy, 43, make earrings and Christmas ornaments. That $2,000-a-year enterprise "is something we can fall back on." He also can pick up about $1,500 a year trimming trees and is looking for some work with his back hoe.

"It's difficult to see what we're going to have to do to generate a living wage," Shaw said. "I have no desire to work and be poor. I'm not that noble."

Broken Promise: Family Still Waits

COPING: THE PRESIDENT VOWED TO PUT WALTER BAILEY OF HAYFORK BACK TO WORK. THAT HASN'T HAPPENED. AND A PLAN TO PUT HUNDREDS OF TOWNSPEOPLE TO WORK IS STYMIED BY A FEDERAL HOLDUP

(By Bob Partlow)

HAYFORK, CALIF.—More than a year ago on national television, President Clinton promised to put logger Walter Bailey back to work.

The family still is waiting for Clinton to make good on that pledge.

Bailey, 46, no longer has a steady job in the industry where he worked since he was 24. The timber-falling business he and his wife, Nadine, started in 1985 is gone.

It once employed 15 people with an annual payroll of $360,000.

The Baileys may lose property that has been in the family for three generations.

"This is our government, and I just can't believe our government is going to do this to us," Nadine Bailey said.

But in February 1993, the couple had hope.

Their 11-year-old daughter, Elizabeth, had written a letter to a logging magazine and was invited to an ABC show, "President Clinton Answering Children's Questions," televised live from the White House.

Elizabeth stood up and faced Clinton. Using her school yearbook, she underlined the number of kids affected by government and court actions to curb logging—140 students—about 70 percent of the school.

"She told him of all her friends' fathers who were going to lose their jobs, mothers who weren't at home for them any more, fathers who had to work miles and miles away," Nadine Bailey said. "That was how she saw it. It was pretty stark. It's not numbers. It's people."

Clinton told Elizabeth he agreed some places could be logged, but said some places also needed protection.

The promise he made then was to keep "a significant number of people working in the woods," a "stable logging industry," and "large numbers of people working and still save the owls."

The next month, Nadine Bailey was invited to take a spot on a panel at Clinton and Vice President Al Gore's timber summit in Portland, Ore.

The administration called the national meeting to discuss possible solutions to the timber industry shutdown caused by court injunctions to halt logging to protect the northern spotted owl.

Bailey, 37, returned home with a mission.

"We were ready to do anything we could to make this plan work," she said.

Hayfork, a 3,500-resident dot in the Sierra Nevada between Redding and Eureka, has been a logging community since the 1920s. It started out as an agricultural community, then slowly switched. But controversy over the spotted owl and the resulting logging slowdown in Northern California's Trinity National Forest had rocked the town.

Bailey decided to find a way to preserve both the town's livelihood and the surrounding forest land. That meant joining forces with the other side—Hayfork environmentalist Joseph Bower.

They and a handful of others in the community met daily for almost two months. Their plain; fireproof the forests and replant trees.

They would cut small trees on 40,000 acres in Tinity National Forest. The trees posed a potential fire danger if not thinned.

They plan also would put people to work maintaining the 3,500 miles of logging roads in the national forest. Dirt from the roads was washing into rivers and streams, spoiling fish habitat.

"Our plan would put 500 people to work for the next 20 years," Bower said.

It also would eliminate the need for new logger retraining programs, he and Bailey said.

But their idea remains in limbo. They tried to sell it to the Clinton administration, but U.S. Forest Service officials said they don't have the money.

The problem is that the plan requires moving money from one bureaucracy to another, and that's disallowed by federal law, said John Veevaert, assistant district ranger for the Forest Service in Hayfork.

Money intended to help fish, for example, can't go to fix logging roads. "Congress has to catch up," he said.

He believes a version of Bailey and Bower's proposal can work and urged them to keep working despite the ponderous bureaucracy.

"What they are striving for is exactly what we want," Veevaert said.

The experience has outraged Baily nonetheless.

"I think the population of Hayfork has increased 10 percent since people learned that all this federal grant money was available," she said. "We've got consultants writing grants for almost everything, mostly studies. If I read one more grant proposal for a feasibility study, I think I'll throw up.

"My personal favorite was a proposal for $20 million to build a major movie studio in Hayfork—$10 million for the property and $10 million for the studio. For $20 million, you could have the whole town of Hayfork and get me thrown in for the bargain."

Now, Bailey calls the Clinton plan a "smoke-and-mirrors-type solution that has everybody fooled."

She no longer trusts Clinton, Gore or Tom Tuchmann, the administration's timber czar who came to Ukiah in Northern California last spring and tried to convince residents that the president's plan is working.

At the meeting, Bailey disputed his contention.

Tuchmann has said the administration is doing all it can to work out solutions so people in timber communities can find work again. It's beginning to work, he said, though much remains to be done.

But Bailey wants Clinton to follow through on his promise. Her husband is doing a logging job on the ranch of a friend, but it runs out in a couple of months.

"Elizabeth said the other day, It will be a while before I trust again,'" she said.

Ex-Millworker Must Choose Between School or Survival

(By Bob Partlow)

Portland, OR.—Kevin Browning, 28, lost more than his job at the Roseburg, Ore., mill in 1992.

The upheaval that followed included a split with his wife, a plunge in self-esteem and a lost sense of direction.

He thought he was back on track, getting retrained to open a business that could hire other displaced timber workers.

He began attending Umpqua Community College, earning a 3.85 grade-point average in business administration.

But in May, he testified at a congressional hearing on retraining that his future was in jeopardy.

"Unfortunately, all my dreams and hard work may come to naught," he told U.S. Sen. Mark Hatfield, R-Ore.

"The funds that have kept a roof over my head and food on my table are running out. I have only about six weeks of unemployment insurance and still another year of my education to go.

"This places me in an extremely awkward situation—whether to keep a roof over my head and food on my table or complete my education.

"While my situation is dramatic, I do not feel it is unique.

"In recent weeks, I have seen many of my fellow students lament over having to make the same decision. Unfortunately, most are forced to pick survival over their education. And some will be forced to return to the industry which spawned their unemployment in the first place.

"This prospect truly saddens me.

"I feel that the sociological repercussions of this emotional roller coaster will be devastating, encompassing everything from a rise in domestic violence to drug abuse and education."

Loggers Say New Timber Plans Have No Magic Formula

COMMON SENSE? STUDIES AND CONSULTANTS SEEM ALL THE CRAZE, BUT MANY LOGGING FAMILIES FEEL IT'S ALL BUREAUCRATIC BLUSTER

(By Bob Partlow and Trask Tapperson)

When government officials want to help timber workers and their communities, they go to study hall.

And they usually take a consultant with them.

Consultant Eric Hovee, who did five community studies in Washington and two dozen or more in Oregon said "there's not a lot of magic" in the studies. But Washington did 135 the past half decade.

Consultants typically take the pulse of the community, hold a meeting or two, then issue a report. Much of what they recommend is "common sense," Hovee said, but the report helps focus the community.

"Yuppie bonding," Forks logger Colin King said of a community meeting he attended in Port Angeles.

He and others find little value in the studies, consultants or timber conferences done by those in government or private business who want to redirect loggers into other occupations.

"They want to make them eco-slaves," said Sarah Smyth of Olympia, whose family owns a sawmill between Olympia and Shelton. She was referring to temporary jobs in the woods the government is offering some workers.

In addition to studies and consultants, timber workers and their towns also get a healthy dose of self-esteem tapes and motivational programs such as New Chance at Grays Harbor College.

Supporters say workers need such a psychological boost. But others, such as Forks logger-turned-diesel-mechanic Scott Haugen, think the only boost timber workers need is to get back in the woods.

IS TIMBER MONEY BEING WASTED ON SILLY GAMES AT CONFERENCES

ACCOUNTABILITY QUESTION: SOME PARTICIPANTS OF A GOVERNMENT-SPONSORED MEETING WERE INSULTED BY THE CHILDREN'S GAMES; OTHERS LIKED THE SEMINAR

(By Bob Partlow)

ELLENSBURG.—Porridge in the pot! Porridge in the pot!

Jelly in the jar! Jelly in the jar!

About 60 men and women lined the walls of a conference room at Central Washington University and intoned the childhood chant—first loudly, then softly.

It was the second day of a three-day Timber Communities Conference in April. Nine state employees staffed it.

The seminar was billed as a way to help timber communities cope with financial hardship, but not a calk boot or hickory shirt was in sight.

The public employees and consultants who dominated the conference played games with plastic mice, flew paper airplanes and made luggage tags out of business cards—all in the name of revitalizing economically depressed timber towns.

They also listened to speeches from people familiar with economic development, held a mock townhall meeting in the format of the "Phil Donahue" show and tried to revitalize a fictional town called Stump Hollow.

THE PURPOSE

The conference was the brain-child of the state Department of Community, Trade and Economic Development and the U.S. Forest Service.

Apart from the games was a "core curriculum" to show people how to redirect their economies, said Maury Forman, the department's training coordinator.

That include tips on starting and expanding business and how to attract new enterprises.

"We teach all elements of economic and community development, and we try to teach through interactive learning and exercises," Forman said.

Grace Hathaway, Darrington's city planner, sat in the middle of the room while most of the others sung the porridge chant.

"I think it was an insult," Hathaway said. "This group thought they were dealing with a bunch of provincial, unsophisticated ignoramuses."

Joby Winans, a department trainer, called the chanting "an energizer" to wake people from their midafternoon doldrums, but Hathaway call the activity "ridiculous. We'd just had a break."

Hathaway got fed up with the porridge and jam and with so-called "ice breakers" the night before at the conference.

The group was divided by the different colors of plastic mice they received at the start, as well as by hair color, shoe color and shoe style, she said.

They flew planes and went on a scavenger hunt—looking for an oak leaf, foreign coin and feather, among other items.

The next day, conference leaders passed out water pistols to members of the audience to shoot at speakers if they went overtime.

Winans said her colleagues asked her to come up with ways to bring people together.

"The conference was built around sharing information from experts ... and from communities because they've tried to develop some ways and found things that worked and didn't work," she said.

The $12,114.76 spend on the conference should have gone somewhere else, Hathaway said.

"Take all the salaries these people are making to put these things on and you could pay for several timber workers for a year instead of making paper airplanes or putting porridge in the pot," she said. "I have a lot of problem seeing where the money is going. We've gone way past the realm of reality."

OUT OF CONTEXT?

Michele Brown, unit manager for local development assistance with the department, said the games should be put in context.

But measuring the success of economic development work such as the Ellensburg gathering is difficult to do.

Forman runs similar conferences in which he uses educational games based on "Wheel of Fortune," "Jeopardy!" and "The Dating Game."

"I know how this is going to look in the paper," he said of using "The Dating Game" format. "But it really works."

He has letters from people who say such conference training helped their communities keep or attract business.

Micki Colwell, executive director of the Hoquiam Development Association, attended the Ellensburg meeting to make contacts.

"It's a good way to meet people in other towns," she said, "and, of course, you get to know state people, which is important when you submit grants."

The success of economic development studies also is tough to gauge.

In the past five years, 135 such studies have been done in Washington, but the state has done little follow-up.

Although the state pays for many of the studies, "the accountability really rests with the counties," Brown said. "They are asking for them."

Neither she nor Forman could estimate how many jobs are created by economic development activities.

"It's messy, it's long-term and it doesn't get you from Point A to Point B very quickly," Brown said.

CONFERENCE COSTS

The State Department of Community, Trade and Economic Development provided this accounting of costs for the Timber Communities Conference:

WHAT MONEY CAME IN

$5,110.76 from timber funds. Department officials didn't elaborate.

$2,000 from the U.S. Forest Service.

$5,004 from registration fees. The fees ranged from $75 for community participants such as consultants and economic development officials to $150 for state and federal employees.

WHERE THE MONEY WENT

$8,461—room and board.
$800—speaker fees.
$1,200—conference handouts.
$264—conference brochures and notebooks.

TIMBER WORKERS OFFERED NEW CHANGE PROGRAM

EDUCATION: A PROGRAM OFFICIAL CITES SUCCESS STORIES BUT HAS NO NUMBERS TO BACK UP THE CLAIM

(By Bob Partlow)

ABERDEEN—What kind of chance do timber workers have to rebuild their lives?

A "New Chance," if a motivational program by that name works as touted.

During the past two years, the program at Grays Harbor College has put 504 students through a six-week course to help prepare them for further career training and education, said co-coach Cleo Norris.

"We have some really good success stories," Norris said.

But Roger Reidel calls it the "Last Chance" program.

"It makes people feel better while they're standing in the unemployment line," scoffed Reidel, a laid-off millworker who now helps other displaced timber workers for the Washington State Labor Council, the umbrella association for the state's labor unions.

The project isn't a retraining program, but a "career assessment" designed to help timber workers take their first steps into a new future.

It helps them with basic reading, writing and math skills, gives them some computer training and runs them through a rigorous one-day obstacle course on the Wynoochee River.

The course includes the "pamper pole"—a 21-foot rope that participants climb. Once they reach the top, they jump onto a net.

"It teaches teamwork and builds trust," Norris said. "We spend all day up there bonding. They become family. They meld together."

Norris said the program is a success but project officials don't have any statistics yet to back up the claim. They hope to get some during a survey of all graduates.

Norris believes a majority of their graduates are attending school. The ones she knows about—she didn't have any specific numbers—have a grade-point average of 3.23.

Some public officials point to New Chance graduation ceremonies as inspirational, a sign that retraining has its bright spots.

A good attitude is important, said Dan Wood of The Umbrella Group, a coalition of organizations focusing on land-use and property-rights issues. It also advocates opening forests to more logging.

But people need jobs, Wood said.

"Hope without income isn't going to last," he said. "You raise people's hopes, and they are going to crash down again. And it's going to be worse than the first time. They get self-esteem and positive thinking. They have a good time in class. Students tell people they are great. They got a B for the first time in their life or spoke in front of a class.

"I've attended those graduations. I'm sitting in the audience saying, 'Great, but where are the jobs?' When the excitement is gone, how will it feed your family?"

The Hoquiam Development Association, a private agency that gets some public money to develop Hoquiam's economy, also has a self-esteem program.

The association paid the final $3,200 on a $40,000 set of motivational tapes from the Seattle-based Pacific Institute. Private money paid the rest of the cost.

The tapes give people a sense of worth and help lift their spirits so they can move forward, said association Executive Director Micki Colwell.

Jim Coates, who distributes food to 28 food banks in Grays Harbor and Pacific counties, remembers when the ITT Rayonier Inc. mill closed in November 1992, putting more than 600 people out of work. The mill has partially reopened and employs about 230 people.

After the mill shutdown, "my phone was ringing off the hook with consultants and other people wanting to sell me computer programs, motivational tapes, one thing or another," Coates said.

"That kind of thing is sickening. Everybody was looking to make a fast buck. Everyone wants a piece of the pie."

"Everybody talks about bringing up esteem. (But you) put them through school and they can't find a job. Is their esteem lower than it would have been" Coates asked. "You bet it is."

RETRAINED TIMBER WORKER ONCE AGAIN WITHOUT WORK

(By Bob Partlow)

DEMING.—A state report listed only one man successfully retrained in Whatcom County under its "Dislocated Timber Worker and Employment Training Program" from mid-1991 to mid-1993.

Cost: $12,144.

The state Employment Security Department—which ran the program—took 3½ weeks to track the worker down when asked to supply his name: Philip King, 27, of Deming.

But today, King is out of work.

He first lost his job with Baker Bay Logging in Whatcom County in late 1989 because of logging cutbacks to protect spotted-owl habitat, he said. He spent a few months looking for another logging job but couldn't find one.

The state offered him a year of education, but he turned it down because he thought he needed more time to learn a new trade. So, the state offered retraining through the Department of Natural Resources, promising him some work in the woods marking trees for sale while teaching him some computer skills.

King marked trees for six months, received almost no computer training and talked his way into three more months of work fighting fires for the state.

His salary dropped from $13.75 an hour as a logger to $5.50 an hour working for the state. Then it dropped to zero when the job ran out in 1990.

He went back to the state for help but was denied further training, he said.

"'We don't have to think about you any more—we're through with you,' that's my impression of the program," King said.

He has gotten a couple of other jobs since then but injured himself on the last one and is out of work and fighting for unemployment benefits.

STATE TAKES THE CREDIT FOR CARVER

DENNIS CHASTAIN: THE WOOD CARVER SAYS THE HELP ON A LOAN WAS A FLUKE AND NOT THE ONLY REASON HE'S IN BUSINESS

(By Bob Partlow)

FORKS—After Dennis Chastain, 52, began carving out a new life for himself, the state began taking credit for it.

A 1992 issue of Timber Towns, a now-defunct newspaper put out by the state, touted Dennis and his wife, Margaret, as a success story of timber retraining.

The couple received a loan through a private revolving fund. The fund's administrators work closely with the state to help small businesses.

Chastain worked in the woods for 24 years before his last logging job on the Olympic Peninsula dried up six years ago. Margaret Chastain saw some chain-saw wood carvings she liked, and Dennis thought, "I can do that."

He was right.

He began chain-saw carving regularly and now has produced thousands of pieces, including a 12-foot-tall carving for a logger's memorial next to the visitor center in Forks."I found I had some talent and ability," he said.

Along the way, Chastain was looking for about $12,000 to help expand the business. The revolving fund provided it, but Chastain said it wasn't an essential ingredient to making a success of Den's Wood Den on state Highway 101 south of Forks.

"If it hadn't been them, it would have been somebody else," he said. "They popped up exactly when I needed them. It was a fluke."

He got a 12 percent loan, a figure that surprised him when he went to sign the papers.

"They strongly implied it would be a low-interest loan," he said.

But the state took credit for it in its newspaper article. Chastain, now making about $30,000 a year, said it's not quite what they say.

"I'm not going to come in on them, but I'm not going to brag on them, either."

CONFERENCES HELD FOR TIMBER TOWNS: IT WAS A JOKE

SMALL-BUSINESS HELP: WORKSHOPS WERE HELD IN WASHINGTON CITIES WITH FEW TIMBER CONNECTIONS

(By Trask Tapperson)

DARRINGTON—The state paid Washington newcomer M. Kathleen Duttro to arrange 10 small-business workshops, though she had no training or experience to perform the work.

Duttro said she received $2,500 "because that was the maximum they could pay for a non-bid program" awarded by the state without competition.

Her payment came out of general state training money, but Duttro viewed her work as part of the state's effort to help timber families and their communities get or stay on their feet.

Duttro acknowledged she had no background dealing with either.

She did her first workshops in Darrington about a year ago; within six months after moving from York County, Penn., to settle on a 24-acre spread near the foot of Whitehorse Mountain outside Darrington.

She called the sessions "Bootstrap Businesses and Tourism" and a "Home-based Business Workshop." She charged residents of the struggling timber-based community a "cut-rate price" of $10 to $15 for the two sessions—below the $25 admission charged others for the one-day sessions, Duttro said.

At state's behest, Duttro took her workshops on the road from September through April, but at least four of the areas and their residents had little or nothing to do with timber. They included Pullman and Walla Walla in Washington's wheat belt; Olympia; and Island County, home to a U.S. Navy air station, bedroom communities and farms.

She said she had no follow-up system to check how trainees benefited from her teaching—except for surveys at the end of the workshops that indicated people wanted more conferences.

Richard Anderson, who runs Sauk River Sporting Goods in Darrington, paid $20 last year to attend a Duttro course.

It led him to offer a fly-fishing clinic in June. It netted him $60, he said.

Grace Hathaway, Darrington's city planner, said Duttro's workshop on creating home-based businesses apparently had few results.

"I know there were none created in Darrington," said Hathaway, who prepares and helps administer the city's grant requests for timber community assistance. "It was a joke."

Maury Forman, the state official who hired Duttro, acknowledged the absence of accountability. He said it's up to the people to make connections with economic development promoters to get help after the workshops.

Duttor's arrangement with the state for workshops ended last year, but now she's applying for more grant-financed work this fall with the formation of a nonprofit organization called Threshhold.

"I decided to invent myself a job," Duttro said.

"If I get my nonprofit running, I will have invested myself a job. We've written a proposal for a program. We're looking for money to start it."

She said she wants a dependable source of cash because the financially shaky people of timber towns are an unreliable source of income.

"It's almost impossible to do it on the backs of the people who need it and make a living out of it," Duttro said.

COURSE FUNDED BY STATE ANGERS DISPLACED WORKER

COLLEGE COURSE: THE CLASS WAS DESIGNED TO GIVE DISPLACED WORKERS SELF-ESTEEM

(By Trask Tapperson)

ELVIRA, ORE.—Danele Welsh has worked in four wood mills for more the 13 years.

She graduated through the ranks from hydraulic log loader in a sawmill to plant forewoman of a specialty products plant to inventory controller at a Eugene, Ore., mill of forest products giant Weyerhaeuser Co.

That ended in 1991, when the mill closed and Welsh sought help to regain employment through a course at Lane Community College. She attended the decade-old Choices and Options program for displaced timber workers, financed with state lottery money.

Welsh, 42, wanted practical job-search guidance. But mostly, she and about 25 men got a steady dose of self-esteem promotions—daily inspirational readings from the writings of humorist Robert Fulghum, getting-to-know-you games.

Her tolerance waned on the first day of the two-week course when the instructor said, "we needed to evolve beyond the timber industry. Evolve."

"He thought we were stupid millworkers, primate material. Like we needed to evolve," she said.

Welsh rose to her feet. "I was going to scratch my sides, like an ape." Instead all she could muster were the words; "How dare you!"

College officials defended the program. "When they lose their jobs, they're angry," said staff member John Huberd. "It helps get their head back on straight . . . boost self-esteem. The members start bonding and become a support group."

Welch has had only one paying job since, and that business folded. But she said she won't become "a system sucker," her term for people who continue in government-run displaced worker programs.

"Why don't they just bundle up their assets, go out there and take their best shot?" she asked.

NONPROFIT CORPORATION'S AIM IS TO HELP CREATE JOBS

PORT ANGELES: THE DIRECTOR SAYS THE CORPORATION WILL TRANSFORM THE ECONOMY

(By Trask Tapperson)

PORT ANGELES—Dominating the walls of Gus Kostopulos's office at WoodNet headquarters are three photos and two signed letters from President Clinton.

That's in sharp contrast with the contempt that often greets the mention of Clinton's name in logging towns on the Olympic Peninsula.

The president spoke enthusiastically to Kostopulos at his timber summit in Portland, Ore., last year. The executive director of the 3-year-old nonprofit corporation had just explained to Clinton how WoodNet would help transform the peninsula's floundering timber-based economy.

WoodNet's goal: linking its 350 members to wholesalers and others who might buy their products, ranging from custom doorknobs and other specialty wood products to jewelry and other non-wood adornments.

His means: primarily a slick catalog. The first one, sent last year to 8,500 wholesale buyers, cost $62,500 in cash and another $30,000 in staff time to produce. Of that, $22,500 came from the product ads placed by craftspeople and companies.

That's almost $11 per recipient, plus postage.

Since 1991, the state has sunk $206,000 into the operations of WoodNet, a frequent object of glowing publicity for its innovative manufacturing network. Much of that money came from the two departments most responsible for helping timber workers and their towns recover.

Yet Kostopulos says he doesn't know—or care—how many of the 92 sellers in the catalog are displaced loggers.

"They weren't asked," he said. "I personally don't care how many displaced loggers work at Posey Manufacturing. WoodNet was never set up to help displaced loggers. We want to help a company that creates jobs."

TIMBER MONEY TRACED TO SEVERAL STUDIES DONE FOR WASHINGTON CITIES

ACCOUNTABILITY ISSUE: THE STATE TRACKED ONLY 12 OF 135 STUDIES DONE DURING THE PAST FIVE YEARS

(By Bob Partlow)

A close look at the government response to the region's timber woes appears to show more about consultants and studies than loggers and jobs.

Taxpayers paid for 135 timber-related studies or plans in Washington alone from 1989 to mid-1994, according to figures from the state Department of Community, Trade and Economic Development.

The Olympian and The Bellingham Herald asked state governments in Washington, Oregon and Northern California for a detailed accounting of the studies and their success.

Washington sent incomplete information, and Oregon and California didn't respond to the request.

Among the Washington studies were 12 surveys to assess the so-called "SWOT" of rural timber communities: strengths, weaknesses, opportunities and threats

Those studies cost $96,306, an average of $8,025,50 apiece. The state didn't say how much good they did or exactly how the communities spent the money.

Consultants interviewed people, held meetings in communities affected by timber cutbacks and then did reports.

Darrington had a $12,000 SWOT study done. It duplicated a separate study done by the city and was a waste of money, said Darrington hardware store owner Laurence Larsen, who is active on state boards involved in helping timber communities and workers.

"We could go out and get money for studies, but we won't finance a business or get somebody started," Larsen said.

The city of Sultan had a different experience. Its SWOT study pointed out a good direction and was widely distributed, said City Clerk Laura Koenig. "We had a lot of interest in it," she said.

Eric Hovee, principal of the Vancouver, Wash.-based E.D. Hovee & Associates, did five SWOT studies in Washington for $40,300. He estimates he has done up to 30 similar studies in Oregon.

"A lot of it is often common sense," he said. "There's not a lot of magic to it."

The surveys are only as good as the people in the communities make them, he said.

"The study doesn't produce any jobs, but the follow-up is where there is going to be job creation," he said. "That's where the value comes in. The extent to which these studies are used or sit on a shelf . . . depends on the people in the community."

Hovee said he does no follow-up.

In Washington's other 123 studies, money went to local agencies and the state doesn't monitor what happens after that, said Liz Mendizabal, spokeswoman for the Department of Community, Trade and Economic Development.

Forks had two studies done—one for $12,500 in 1991 to look at the city's future and another for $20,000 in 1992 to look at timber supply.

At the northwest tip of the Olympic Peninsular, Forks has been the self-styled "Timber Capital of the World" until the virtual shutdown of the woods in the 1990s.

In the first study, "almost all of it was stuff we already knew and many of the statistics were way out of line," said Sandra Kint, Forks economic development director. "I don't think anybody was happy with the results."

In the second study, "it gave us a lot of information in writing signed by a consultant that told us what we already knew," said Dan Lienan, Forks city clerk and treasurer.

In addition to the studies, the state had handed out 138 grants to timber communities since 1989, according to the Department of Community, Trade and Economic Development. It didn't provide a dollar figure.

One $20,000 grant went to the Hoquiam Development Association, which receives some public money to help boost the local economy.

But Executive Director Micki Colwell said the money "didn't create any jobs, except for mine." The communications graduate and former reporter moved from part time to full time.

THE FORKS STUDY AT A GLANCE

The first Forks community study, done by Gilmore Research Group of Seattle, said: "Forks is encouraged to create both short- and long-term economic strategies as part of its work program."

It recommended "short-term priorities" such as:

"The implementation of strategies which respond to the nature of the existing market, both from internal and competitive standpoints."

"The implementation of strategies which better position Forks for future growth."

"The implementation of strategies which create a series of small business successes, for example, the expansion of an existing business or the opening of a new business with five or 10 jobs."

The 107-page study also spent considerable space talking about building Forks' image and promoting tourism.

COMMUNITIES SEE HOPE AS THEY TURN AWAY FROM TIMBER

RAYS OF LIGHT; MANY IN TIMBER TOWNS ARE MOVING ON, FINDING SECURITY OUTSIDE OF THE FOREST

(By Trask Tapperson and Bob Partlow)

In the darkness of the Northwest's timber towns, some rays of light can be found:

In the persistence of Richard Anderson, who has moved into his Darrington sporting-goods store and is selling tourists everything from vibrating monkeys to fly-fishing lessons in a last-ditch effort to keep the struggling business open.

In the doggedness of people such as Jack Shipley of Grants Pass, Ore., Mike Jackson of Quincy, Calif., and Nadine Bailey of Hayfork, Calif.

They are putting aside deep differences with opponents to force agreements that will provide loggers with jobs and the forest with a chance to grow in a new and different way.

In the new chances being given to people in Prineville, Ore. They are taking advantage of an opportunity to start again in plants making wood products through a retraining program started by businesses.

They all agree the problems are daunting and the future uncertain at best, but they are trying to create a new life out of a new economy.

"We're going to get through this thing," said Shipley, a founder of The Applegate Partnership in Oregon, which hopes to create jobs and a new kind of forest. "It's going to be a major, uphill battle."

A TOWN TIED TO TIMBER INDUSTRY IS FORCED INTO A NEW WAY OF LIFE

COMMUNITY

"Darrington's got a wonderful future. It's just how soon it's going to get here," says Richard Anderson, a small-business owner.

(By Trask Tapperson and Bob Partlow)

DARRINGTON—Travelers will find the drive easier between Interstate 5 and this timber town after September when crews finish $2.5 million in improvements to Highway 530 East.

People here wonder what the traffic will bring.

Until recently, it was predictable: Scores of log trucks hauling out the bounty of the federal forest, a smattering of tourists bound for the mountains and residents with business "down below" in Everett, the lowland Snohomish County seat.

But in Darrington today almost nothing is predictable as the town undergoes wrenching change wrought by the virtual end to logging in the midsection of the Mount Baker-Snoqualmie National Forest.

In the future, many expect commuters to make up most of the new traffic; locals heading to Everett for new jobs and urbanites who find the trip to Everett and Seattle preferable to the hassles of big-city life.

SIGNS OF DECLINE

Some telling signs of Darrington's decline:

Worried timber wives sharring family crises at the "Kitchen Talk" program at the Darrington Community Support and Resource Center.

"A lot of it is fear," said center director Wyonne Perrault. "If you're born and raised here, there's a fear of losing this closeknit, family-oriented community and thinking of trying to make it somewhere else."

She cited one longtime Darrington family who lost their house to the bank by foreclosure last spring. Mom, Dad and the kids left town in the dead of night because they couldn't face their friends and neighbors, she said.

A 300 percent increase in visits at the Darrington Food Bank since 1986.

But even the threefold jump doesn't reflect the extent of hardship today, food bank managers said. "In an area like this, people won't ask for help unless they're really desperate," Geraldine Inman said as she handed out commodities behind a counter. Above it, a sign reminds volunteers: "We are serving people at this food bank, many of whom are hurting, angry or frustrated. This is often through no fault of their own."

A building that doubles as Richard Anderson's home and his Sauk River Sporting Goods store. He lives at the store now after selling his house and spending the proceeds to keep his business going.

"Darrington's got a wonderful future," Anderson said. "It's just how soon it's going to get here."

In the meantime, he has started hawking trinkets such as vibrating monkey and T-shirts for tourists.

But they aren't coming. And when they do, they don't bite.

"We had 79 (river) rafters in the store," Anderson said. "They drank free coffee, messed up the septic tank with Styrofoam popcorn and spent $6."

He's now thinking of renting out hot tubs.

Andy Thompson, who manages the Highway 530 construction from an Everett office, sums up the town's dilemma with the succinctness of a knowledgeable outsider.

"If they don't figure out a way to adapt, they're going to get pushed right out of there," he said.

DARRINGTON AT A GLANCE

Location: Eastern Snohomish County

Population: About 1,000

Rank in county: Third smallest (ahead of Woodway and Index)

Projected growth rate: 45 percent through 2020 (compared with county rate of 77 percent)

Predominant Industry: Timber

Largest employer: Summit Timber Co. (350 employees)

Median household income, 1979: $17,226 (compared with $20,760 countywide)

Median household income, 10 years later: $24,294 (compared with $29,369 countywide)

Housing construction, 1980–88: 101, including 37 mobile homes (of 46,335 homes built countywide)

Average price of house (1988): $56,422 (compared with $93,864 countywide)

Almost everyone in Darrington knows that. But the uncertainty over how to change generates sometimes intense second-guessing and bickering.

The closest thing to consensus is criticism of the government's response to their eroding lifestyle. Many residents say state and federal governments have spent too much on the wrong things, such as:

Planning sewers, industrial parks, and other expensive infrastructure without any clear hope for a return on the investment.

Touting tourism for visitors who may never come or bring enough money to even begin replacing lost timber dollars that yielded family-level wages.

Government officials push this alternative the hardest, seeing a potential in scenic forest and mountain settings of many timber towns. Few have more spectacular vistas than the Darrington area—with its views of Whitehorse, Gold Hill, Prairie, Higgins and North mountains and the stunning Glacier Peak.

Though Darrington did receive a small share of the federal government's $20 million "Jobs in the Woods" program, assessments by key local leaders are harsh.

"They spread all this money around a mile wide and an inch deep. It doesn't do any good, but it does have political benefit," said hardware store owner Laurence Larsen, Darrington's top civic leader for economic revitalization.

"It's just a great big wheel, and we're getting caught in the spokes," said Mayor Charlie White.

The state and federal timber relief program is "a support system for the state and federal agencies, not for the timber communities which it was intended to help," said city planner Grace Hathaway. "There's no accountability about who's giving money to whom."

EFFORT CRITICIZED

A frequent target of townfolks' frustrations is the three-year economic development effort led by Kathy Kerkvliet, a state Employment Security Department worker.

She became Darrington's grant-funded economic development official in 1990, several months after a Larsen-led citizens committee completed a 20-year vision for the town.

"There was a fair amount of criticism" of that nine-month effort, Larsen said. "They were concerned we were spending money on tourism and not enough on displaced workers. Unfortunately, a lot of the programs from the state were for studies, but we couldn't finance a business."

By the time Kerkvliet left a year ago, $105,400 had been spent on salaries and overhead for her effort—part of about $405,000 in government grants she said the community received.

"I went in there as a novice," Kerkvliet said. "I knew how to work with dislocated workers, but I had never done economic development."

Although the problems of the timber workers are worsening, Kerkvliet said she left because "I was an outsider. I understood my role to get resources and bring people in, but after awhile you can only have outside help for so long."

What did the taxpayers get for their money?

Already in hand: Lots of grants, studies, workshops and publications.

Yet to come: The new sewers, hopes for new industry at a possible industrial park, more tourists and possible new restrooms to accommodate them—which the government is willing to build if the community can pay to maintain them.

Kerkvliet is long on enthusiasm but short on specifics of how the town has repositioned for life after timber. She can't cite any jobs resulting from her economic development efforts.

Her prediction: "In five years, it will stay a nice, lazy, laid-back little town—more of a bedroom community. People are willing to travel to have that environment to live in."

White's vision for the resident logging families isn't so rosy.

White, 80, recalled his life in the woods that began at age 14 with a job as a signal-whistle blower and lasted through the Great Depression when "there were stump farms and no jobs."

"I got a fear that it might happen again," he said. "And you've got a different class of people today. In those days, people looked after one another."

To City Clerk and Treasurer Lyla Boyd, they may not be around to do so.

"My worse-case scenario is the timber people won't get jobs and move away," she said. "We'll become a bedroom community for Everett and the Navy base. If people can't get jobs, they'll go away. Or they'll commute."

WHAT'S AHEAD: SOME PEOPLE HAVE FOUND SOLUTIONS THROUGH RETRAINING PROGRAMS OR COMMUNITY EFFORTS

What's next: It's been 7½ years since the environmental group GreenWorld first petitioned the U.S. Fish and Wildlife Service to list the northern spotted owl as an endangered species.

Since then, loggling has virtually stopped in the owl habitat of federal forests.

The Clinton administration now plans a long term logging ban on 7 million acres in Western Washington, Western Oregon and Northern California.

But the debate over how to use public lands in the Northwest is far from over. Key actions are coming on the judicial, legislative and administrative fronts. They include:

The Clinton plan: Logging interests say it goes too far; some environmentalists say it doesn't go far enough. Both sides filed lawsuits challenging the plan. U.S. District Judge William Dwyer of Seattle is scheduled to hear their arguments Sept. 12. Both sides expect an appeal—a process that could delay a decision on the future of the forests well into next year.

East of the mountains: Dozens of government experts are drafting a land-use plan for millions of acres of federal forests east of the Cascade Mountains. Their plan, still months away, could rival the timber setasides west of the mountains—if they follow the recommendations of some environmentalists.

Logging road bans: Environmentalists continue to push hard for congressional action to ban future road construction in any 5,000-acre area of federal forest now free of roads. Such legislation hasn't fared well so far in committee but still could win approval this session, congressional sources said.

Worker relief legislation: No new initiatives to help displaced timber workers and their towns are expected in the foreseeable future in Congress, sources said.

"We start from the position that the administration's plan is the plan that will be in place," said Jim Hoff, chief of staff for U.S. Rep. Jolene Unsoeld, D-Olympia. "The challenge is to get that plan up and running."

State economic development: In the state of Washington, "our tack will continue to be to try to get businesses into the (timber) impacted areas," said Jordan Dey, deputy press secretary to Gov. Mike Lowry.

But so far, the state has no specific action plan.

I Made a Vow to Myself I Wouldn't Log

NEW BUSINESS: DEBRA AND LARRY HAGEN HOPE TO SAVE ENOUGH TO GET THE LOAN NEEDED TO BUY A PIZZA PARLOR

(By Trask Tapperson)

DARRINGTON.—As logging here dries up, Debra and Larry Hagen are watering a home-grown future for themselves.

They don't want to move away, so they turned to a new commodity: pizza.

Even by their own worst-case scenario for Darrington—a shutdown of top employer Summit Timber Co.—the Hagens are convinced their pizza parlor could survive—and perhaps even prosper.

"If the mill went down, the town would really be in a hole," said Larry, 21. "But the growth is moving up I-5, and it will hit all the crannies."

Debra has spent only one of her 22 years away from Darrington, at a Kirkland business school.

"It was an experience, but we want to spend the rest of our lives here, raise our kids here," she said, as Larry nodded in agreement.

Her family has logged in Darrington for four generations. His father, Les, leads the Glad Tidings Assembly of God flock. The couple rooted for the Darrington Loggers sports teams before graduating from high school.

Both had jobs at Pizza Plus before they got married last year. When the owners put the place on the block, the Hagens tried to buy it.

The restaurant was netting almost $30,000 a year and "making more and more every year, and we didn't plan on changing anything," Larry said. But they had no equity, so the bank turned down the $125,000 loan to buy it.

Unfazed, they got a $3,000, two-year personal loan from the bank, cut a deal with the owners last October to lease the business and will get first crack at buying it.

With the "for sale" sign still outside, the Hagens work 11-hour days, five days a week. Helping out when they can are Larry's parents, his brother and Debra's two sisters.

"It's hard, but it's worth it," Debra said.

In their first quarter of business, they made the $900-a-month payments to the owners, the $150-a-month payments to the bank for the loan and still took home $8,500.

"I think we'll be all right," Debra said.

The childless couple is trying to save as much money as they can to help cut the loan needed to buy the place, which they plan to rename "Pizza Hagen."

That beats by far the routes traditionally taken by so many of Darrington's young people.

"When you live here what you do is marry a logger," Debra said.

"I made a vow to myself I wouldn't log," Larry said. "They don't have a life. Daybreak to darkness they're working. And when your whole income is based on something you could lose over an animal, an owl, it's frightening."

Both still want to get college degrees some day—Larry in law enforcement; Debra perhaps in business.

But with only a year of college under each of their belts, the pizza parlor "is the best thing we could hope for," Debra said.

"We had confidence, it was here for the taking it's nice to work for yourself and we can stay in town," she said.

BUSINESS TRAINING PROGRAM DEEMED SUCCESSFUL

JOBS: FOUR STUDENTS PRAISE THE OREGON PROGRAM FOR ITS PRACTICAL TRAINING AND PROMISE OF EMPLOYMENT

(By Bob Partlow)

PRINEVILLE, OR.—Timber retraining programs sometimes work.

They do in the semi-arid scrub land of eastern Oregon, home to two large companies that make doors, window sills and many other products out of wood.

"We need good employees." said Gevin Brown, a board member of WPCC, an Oregon association of about 80 such businesses.

With training identified as a priority, the association began recruiting workers this year. They screened 56 applicants down to 26 students.

Eighteen people eventually completed a 54-hour, seven-week course and graduated last month. All are guaranteed jobs at a living wage at a variety of plants in central Oregon. The second class begins in September.

WPCC worked with a community college to produce the first graduating class. But the training was done on site at the American Molding Co. plant in Prineville.

Employees worked with the students and focused on jobs at the plant.

"The people that come through this program will know more than 80 percent of the employees who are working here," said plant manager John Lang.

Among those who successfully completed the program:

Lizabeth Brown, a 32-year-old single mother with three children, ages 3, 5 and 7.

"I wanted to support the family without having to rely on anybody else," she said.

She had been running a day-care center but found it was too much to handle while raising her own kids. "I wanted something for me," said Brown, who has a bachelor of arts degree in general studies.

The training program focused on survival skills needed in the plant—right down to learning the basics of how to use a tape measure, she said.

"I was impressed with how much energy they were putting into the program and how much time," Brown said.

She has been offered two wood-products jobs but wants to wait until she gets one that will put her on the day shift.

Ray Atkinson, 55, also is a single parent, raising an 8-year-old boy. The mill in Bend where he worked for nearly three decades shut down, putting him on the streets and into shock.

"I hadn't been laid off in 28½ years," he said.

He probably could have found another sawmill job, he said, but that would have meant relocating.

"I didn't want to go back to school, and I would have had to move to get back into the sawmills," he said.

He is now working for Bend Wood Products.

George Thompson, 56, "worked in the woods nearly all my life," primarily as a "gyppo" logger moving from one place to another.

The most money he ever made was about $38,000, but he loved "the individual, free-wheeling life."

Then the downturn in the industry and a desire for more stability led him to look elsewhere.

He found the WPCC retraining program and discovered "a free ride to take a new chance in life."

With a bachelor of arts degree in education, he could have gone back to the classroom to teach, but he liked working in wood products.

He was expected to begin a job in mid-July.

Dawn Helmholtz, 18, was on a fast track to nowhere in the fast-food industry, where she worked the past four years at Burger King.

With her active 1-year-old bouncing on and off her lap, she talked about her father's work at American Molding and how much she wanted to follow him.

She also liked the idea of being part of a group that is making something tangible.

And she gets benefits and steady hours, making it easier to get a baby sitter than in the past.

She is working at American Molding now.

All four of the students agreed with Helmholtz's assessment of the program: "I'm very, very impressed."

WHY DOES IT WORK

"We offer a guaranteed job in central Oregon at a choice of companies with flexible hours paying a family wage with a career path," reads a WPCC advertisement.

That means people in the program:

Have an immediate job upon successful completion of the seven-week course. The students must pass a written test. The average score was 92 percent for the first class.

Earn a living wage—about $10.50 an hour on average, or about $22,000 a year.

Got hands-on training from people working in the industry. Students and instructors said their rapport is high.

"Where it is down to our level, it makes a big difference," student George Thompson said of the teaching.

The fees are reasonable. Each student pays $100. The cost of the program is about $1,200 for each person, but WPCC absorbs most of the cost. The rest is covered by public money.

The $1,200 figure included start-up costs. That total should fall to $400 for the next group of students.

Program developers hold students accountable. Students must attend every hour of every class. But the instructors don't talk down to students. "They make you feel right at home," said student Ray Atkinson.

OPPOSITE VIEWS ON ONE ISSUE

(By Trask Tapperson and Bob Partlow)

Though adversaries over timber-cutting policies often clash, both sides can recognize the suffering spreading through towns on forest fringes.

Here are two views—from Colin King, a self-employed logger, and Elliott A. Norse, former chief ecologist of The Wilderness Society, one of the leading national environmental organizations. He is now chief scientist of the Redmond-based Center for Marine Conservation.

King's home is in Forks, the heart of the Olympic Peninsula forest. Norse's home is in Redmond, the heart of the high-tech belt east of Seattle.

THE ECOLOGIST

"We need to make sure timber communities don't become welfare havens of alcoholism and despair. These things torture me. I don't see easy answers."

His concern doesn't mean he and other key environmental leaders are ready to sacrifice their forest-protection goals to ease the economic and emotional pain woods workers and their communities feel.

"How much are they victims and how much did they create their own fate?" asked Norse, author of the book, "Ancient Forests of the Northwest."

He comes down on the side against bailing them out.

"Was it really the business of the American people to bail out Chrysler? We did it. And it worked. But I ask myself, 'Should we allow institutions and people to fail?' I think they should be allowed to fail.

"There used to be towns that made their living whaling. People went to sea."

Like their counterparts in logging, "it was dangerous. A lot didn't come back. They made good money, and they put their lives on the line. Whales disappeared, and people had to find another way," Norse said.

One answer "is to take the people who unwittingly destroyed the forest and put them to work restoring it. Don't teach them to be hamburger flippers or poets.

"It's a partial answer. If we add up all the partial answers, we're still going to have people hurt by these changes and we'll have to bite the bullet, let them sink or swim. That may sound heartless, but I can't think of anything else they can do.

"We see the anti-tax hysteria. The country's infrastructure is falling apart because people won't pay more taxes. you can't support people indefinitely."

THE LOGGER

King is bitter about what the government has done to shut down the forests and hasn't done with programs invented by bureaucrats to alleviate the suffering it has caused.

"Those programs won't do the job because those running then are so out of touch.

"They've got to talk to someone who's suicidal," he said mentioning a 22-year-old logger who hanged himself in the Forks jail. "They've got to talk to some women who's been beat up at home. You've got to talk to people who've just been evicted and they've got three kids."

He asked urban people with their jobs to consider what could happen to them "What if (the government) took your job away and it became politically incorrect to be a reporter, and for five or six years they said you were the most worthless sadistic SOB that ever lived? And they took away your living? then they said, 'Well, that's OK, we'll make a VCR repairman out of you.'"

Like many others in the industry, King believes in the words of a song sometimes heard around timber communities: "It's not just what we do, it's who we are."

That's why he thinks the only real solution is to allow loggers back into the woods to cut timber in acceptable amounts.

"You're taking those people's lives—their souls—these people are loggers."

Environmentalists, Loggers Decide To Work Together on Crisis

COPING: TWO SIDES LAY DOWN ARMS TO WORK OUT A SOLUTION TO TIMBER TROUBLES

(By Bob Partlow)

Fuel for fires has become fuel for cooperation to resolve the timber crisis in some West Coast communities.

The Applegate Partnership in southern Oregon and the Quincy Library Group in Northern California traded acrimony for accord.

Environmentalists and loggers agreed that some trees must be cut down to reduce the danger of devastating forest fires. That, in turn, will create jobs and keep the forests healthy for generations to come.

"Whining is not going to get it done," said Mike Jackson, a water-rights attorney in Quincy, Calif., who describes himself as a "flaming, left-wing environmental wacko."

Working in the same town with loggers and timber-dependent families, he decided a strategy of talking, not fighting, would lead to results.

"This is a small town," Jackson said. "You walk down the streets and see these people, and you see them at the kids' baseball games. I just decided after awhile that flipping people off three times a day gets old."

Jack Shipley, a retired public official in Grants Pass, Ore., and member of several environmental groups, came to the same conclusion as he thought about the 500,000-acre Applegate River watershed.

"The (federal) agencies had their own vision. The environmentalists had their own vision. The timber industry had its own vision," Shipley said. "Everybody had part of the truth, but nobody had the truth singly. If we were going to solve the problem, we were going to have to solve it together."

Shipley and Jackson believed that the best solution was to get people involved at the grass roots. The two also followed an initial strategy: Keep politicians and reporters away from the discussions.

The Oregon partnership's nine-member group, including three federal officials, put in 8,000 hours the first year alone.

In California, "We met until we quit arguing. We had (the plan) outlined before we let them into the meeting," Jackson said of two government officials.

A crucial element of both plans was addressing a U.S. Forest Service policy that calls for crews to immediately douse forest fires—even those caused by lightning or other natural events.

The two groups devised a response: Remove the kindling for the fires—mostly small trees—that leaves the forests tinder-dry and ripe for catastrophe.

A key to the discussions: defining what part of the forest should be logged.

Both groups advocated cutting down smaller trees and clearing out areas near streams and rivers. That provides good management and good jobs, they said.

"It's not a question of taking a person who's been a timber faller all his life, training him to be a computer operator and shipping him to Phoenix, Ariz.," Shipley said.

Neither plan has come easily.

The Oregon group has worked for months to get one sale of 500,000 board feet in the 500,000-acre Applegate River watershed. Another sale of 1.5 million board feet is pending.

Shipley said the area probably produced 500 million board feet annually at its peak.

The California group fashioned a classic compromise—the industry agreed not to log areas near sensitive watersheds or places without logging roads. In return, environmentalists agreed to support a level of cutting in other areas that would sustain the forests and hundreds of jobs for years to come. The government must buy off on it.

Shipley also said he and others in the local environmental movement had to overcome an attitude from national environmentalists who didn't trust their ideas.

"They started to get heartburn because the local people were taking control," he said.

Echoing a complaint made often by loggers in small towns. Shipley said, "Too often, folks in rural America are viewed like we fell off the turnip truck yesterday. It's a rural-urban perspective."

But he and Jackson believe the results will be worth the work and can become models for other towns.

"Every place is different," Jackson said. "So the substances of any solution might be different in Bellingham, Wash., than it is in Quincy. But what we have is an exportable commodity."

Clinton Officials Pull Out of Talks

The Clinton administration recently pulled all federal officials from community groups that are trying to fashion local solutions to timber cutbacks.

Those include the Applegate Partnership in southern Oregon and the Quincy Library Group in Northern California.

The reason: The Clinton administration has been sued by timber industry groups who argue that the government forest plan was designed in secret—against the provisions of federal law.

"Until we figure out a way to protect ourselves legally, we have to play it safe," said Lauri Hennessey, a spokeswoman for the Clinton administration's timber plan.

Jack Shipley, a founder of the Applegate Partnership, said the move was disappointing.

"The very thing we've been trying to do is keep an open public dialogue," Shipley said. "Now they're saying it's unlawful? Something is out of whack."

Several groups that are trying to work out new forest plans in their areas met earlier this month in Redding, Calif.

Shipley said he came away from the meeting with optimism.

"We're going to get through this thing," he predicted. "All it did is give us more resolve. I expect (the federal officials) will be reinvolved with us in some way within 60 days. But these things are never easy. It's an uphill battle."

Public Officials Sound Upbeat About Aid to Help Timber Workers

Some samples of news releases put out by members of Congress and others to hail their roles in directing federal money to help timber towns and worker retaining efforts:

"Unsoeld Proposes Jobs Program for Timber Communities; Swift Joins As Original Co-Sponsor"—U.S. Reps. Jolene Unsoeld and Al Swift, November 1991.

"Murray Gets Economic Development Funds for Timber Towns"—U.S. Sen. Patty Murray, September 1993.

"Economic Recovery Board Charts Course for Timber Communities"—Office of Gov. Booth Gardner, December 1991.

"Timber Retraining Benefits Expanded, Washington State Employment Security Department Says"—PR News Wire, May 1993.

"Unique Center Responds to Closures"—Grays Harbor Career Transition Center, May 1993.

"Work Force Training will Benefit Area"—Centralia College, August 1993.

"Good News for 21 Timber Distressed Counties: Jobs-In-Environment Grants Offered"—Washington Department of Natural Resources, January 1994.

"Jobs for the '90s Task Force Gathers Valuable Information on Timber and Local Economy"—Washington State House Republican Media Services, August 1991.

Timber Series Sprang From Logger Anger

(By Jack Keith)

The memo was dated Nov. 29, 1991.

Bellingham Herald writer Trask Tapperson, fresh from several conversations with timber workers, had been struck by the frustration they faced.

About fewer trees to cut? Definitely. About job layoffs or cuts? Certainly.

But what irked the workers most was that the loudly professed political "solutions" to the timber issue were failures, by and large, Tapperson's memo to editors said.

The "answers" of retraining grants and special seminars and VCR repair training were not solving the problem.

Worse, the failure was expensive; wasting taxpayer dollars left and right, the angry people said.

"Lots is getting spent with little to show for it," Tapperson wrote in his summary of the workers' comments.

We saw a story there, but we knew it was complex and difficult to get a handle on.

Today on Page A1, we begin publication of a dramatic four-day series uncovering a frightening lack of accountability in the government's effort to retrain timber workers for new jobs.

More than $100 million worth of government programs has been poured into the Pacific Northwest. But no one in government can tell us exactly who got what and how many workers have been retrained and are now working in a new field.

Tapperson and Bob Partlow, the Herald's Olympia bureau reporter, spent three months pounding on agency doors to try to find someone who was keeping track of the massive program.

Somebody thinks it's working just fine. The Clinton Administration plans to spend $1.2 billion more to help loggers over the next five years.

But when you ask—as Tapperson and Partlow did in 53 Freedom of Information requests—no one can provide the numbers.

And out in the towns of the Northwest, there is bitterness, Partlow says.

"It's very bleak out there. There's a real sense of anger with the government, a lack of trust. The same government that cost them the job was going to retrain them."

Among the contacts that prompted the series was a letter Tapperson received from a frustrated timer worker.

"One thing is very hard to understand is why 2-4 year college degree programs are not available to the displaced worker. Every week there are jobs in the paper for civil engineering/environment degrees. The only thing being offered (displaced timber workers) is less than one year schooling.

"The money being spent looks like job security for those in the (state and federal programs)."

The series continues through Wednesday.

Farewell: This is Tapperson's final series for the Herald. He turned 55 this spring and has decided to take early retirement.

He has been a key figure in Whatcom County since his arrival in Bellingham in 1982.

His early reporting included an in-depth look at the decline of the Northwest timber industry, a series that won a National Arbor Day Award. He was part of a Herald reporting team that examined the Hanford Nuclear Reservation and told Whatcom County readers of the incredible cleanup costs involved.

Tapperson served as city editor for five years, helping refocus the Herald's local coverage. In his final years with the newspaper, he returned to reporting and covered investigative and in-depth stories on a variety of topics.

Tapperson always followed the notion that a reporter's sole allegiance was to readers. He worked tirelessly to that end.

Jack Keith, managing editor of The Bellingham Herald, writes a Sunday column.

THE CRIME BILL

Mr. GORTON. Mr. President, I should like to remark informally on the responsible action of the House of Representatives today in rejecting, at least temporarily, the passage unchanged of a crime bill.

This Congress has spent the better part of 2 years in attempting to come up with a series of proposals that do something positive for the American people in restraining, and not sanctioning crime, and especially crimes of violence.

This Senator voted with considerable enthusiasm for the bill as it passed the Senate, even though there were a number of elements in that bill to which this Senator was opposed.

The House bill, and perhaps even to a greater extent the conference committee, added on, and added on, irrelevant cargo to this particular ship to the point at which it is about to sink, to the point today at least the House of Representatives caused it to sink, moving from a bill primarily concerning itself with law enforcement to one primarily concerning itself with various porkbarrel social projects, duplicative of, but independent of, others of a similar nature almost, a number of which could have passed either House of Congress alone or without being subsumed under the title of a crime bill.

Now, leaders in both Houses must go back and determine whether or not there are some things they can do to revive the good portions—and there are good portions of this bill on crime.

I would strongly suggest to the leadership in both Houses and to the conference committee that exactly that be done; that half—let us just say half of the porkbarrel social programs be stripped from the bill so it is something that can actually be enforced; that the law enforcement provisions of the bill, the aid to local law enforcement, be enhanced to a certain degree; and that some of the very important substantive provisions, like those requiring truth in sentencing on the part of State courts, like those sponsored by this Senator to track sexual predators after they have been released from jail to notify their communities that they are present, be restored to this proposal.

I think it is particularly ironic and particularly tragic that that sexual-predator-tracking provision, those notification provisions to families and communities, were removed from the conference committee report on the very day that Megan Kanka, a 7-year-old girl, was murdered by a sexual predator unknown to her and to her family, who had moved in across the street from her in a town in New Jersey.

As a consequence, an independent bill on the subject now has, I believe, the unanimous support of the New Jersey delegation in both Houses of Congress.

It can be revived, however, and made a part of this crime bill if there is enough resolution and enough leadership in the House of Representatives to do so.

That, truth in sentencing, and a slimming down of the immense pork fat in the bill will turn something which now spends far more money that we do not have than it is worth into something which can be a positive factor in the war against violent crime in the United States.

We have been given a second chance. Let us take that second chance and run with it.

MESSAGES FROM THE HOUSE

At 7:03 p.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the House agrees to the amendments of the Senate to the bill (H.R. 1933) to authorize appropriations for the Martin Luther King, Jr. Federal Holiday Commission, and to support the planning and performance of national service opportunities in conjunction with the Federal legal holiday honoring the birthday of Martin Luther King, Jr.

The message further announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4277) to establish the Social Security Administration as an independent agency and to make other improvements in the old-age survivors, and disability insurance program.

MEASURES REFERRED

The Committee on Labor and Human Resources was referred to the Committee on Commerce, Science, and Transportation pursuant to the order of March 3, 1988, for not to exceed 30 session days.

S. 2344. A bill to authorize appropriations for the National Science Foundation, and for other purposes.

MEASURES PLACED ON THE CALENDAR

The following bill was read the second time and placed on the calendar.

S. 2374. A bill to improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for all Americans, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–3204. A communication from the President and Chairman of the Export-Import Bank of the United States transmitting, pursuant to law, a report on a transaction involving U.S. exports to the Republic of Argentina; to the Committee on Banking, Housing and Urban Affairs.

EC–3205. A communication from the Director of Employee Benefits of the Farm Credit Bank of Baltimore, Maryland, transmitting, pursuant to law, the annual reports of Federal Pension Plans for calendar year 1993; to the Committee on Governmental Affairs.

EC–3206. A communication from the Director of the Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, the cumulative report on rescissions and deferrals, dated August 1, 1994; pursuant to the order of January 30, 1975, as modified by the order of April 11, 1986, referred jointly to the Committee on Appropriations, the Committee on the Budget, the Committee on Agriculture, Nutrition and Forestry, the Committee on Armed Services, the Committee on Banking, Housing and Urban Affairs, the Committee on Commerce, Science and Transportation, the Committee on Energy and Natural Resources, the Committee on Environment and

Public Works, the Committee on Finance, the Committee on Foreign Relations, the Committee on Governmental Affairs, the Committee on the Judiciary, and the Committee on Small Business.

PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM-613. A resolution adopted by the Senate of the Commonwealth of Massachusetts; to the Committee on Banking, Housing, and Urban Affairs.

"RESOLUTIONS MEMORIALIZING THE UNITED STATES CONGRESS TO DEFEAT THE ONE DOLLAR COIN ACT OF 1993.

"Whereas, the One Dollar Coin Act of 1993 under consideration in the United States Congress would, if enacted in its present form, mandate the elimination of the one dollar bill, and the replacement of the bill with a one dollar coin; and

"Whereas, the Commonwealth of Massachusetts has, for over one hundred years, produced the paper from which United States currency, including the one dollar bill, is made, and takes great pride in the product; and

"Whereas, the elimination of the one dollar bill would have a severely negative impact on the local economies of the western region of the Commonwealth and on the Commonwealth's economy at large; and

"Whereas, the economy of the western region of the Commonwealth has suffered greatly in past years due to manufacturing job reductions and attendant economic impacts; and

"Whereas, the "benefits" claimed by proponents of the dollar coin are highly suspect, and would come at the overall expense of the people of the Commonwealth; and

"Whereas, the paper from which currency is made comes from renewable resources and recycled industrial products, while the metals to produce coins come from environmentally damaging hardrock mining; and

"Whereas, the prices of coin operated machines will likely rise with the replacement of the dollar bill with a dollar coin, thereby negatively impacting those least able to afford such price rises; and

"Whereas, the overwhelming majority of Americans have consistently opposed replacing the dollar bill with a dollar coin; now therefore be it

"*Resolved*, That the Massachusetts Senate calls upon the members of its congressional delegation to withdraw any support of H.R. 1322, and to work actively to defeat such legislation or any other measure which mandates elimination of the one dollar bill; and be it further

"*Resolved*, That a copy of these resolutions be transmitted forthwith by the Clerk of the Senate to the Presiding Officer of each branch of Congress and to the members thereof from this Commonwealth."

POM-614. A resolution adopted by the City of Superior, Wisconsin relative to railroad transport; to the Committee on Commerce, Science, and Transportation.

POM-615. A joint resolution adopted by executive committees of societies of professional biologists relative to human overpopulation; to the Committee on Foreign Relations.

POM-616. A joint resolution adopted by the General Assembly of the State of Illinois; to the Committee on Labor and Human Resources.

"HOUSE JOINT RESOLUTION NO. 98

"Whereas, The U.S. Railroad Retirement Board is located in the City of Chicago, the County of Cook, employing hundreds of Illinois citizens; and

"Whereas, The railroad industry is acknowledged as the originator of private company pensions in the United States; and

"Whereas, In the 1930's, the United States Congress assumed the responsibility for developing a federally administered retirement program to place the various railroad pension plans on a solid financial basis; and

"Whereas, The railroad retirement system today covers over one million individuals who have contributed over the years in good faith and who have legitimate expectations of receiving their benefits; and

"Whereas, *The National Performance Review* in its report, 'From Red Tape to Results: Creating a Government That Works Better & Costs Less,' proposes to transfer the functions of the Railroad Retirement Board to the Social Security Administration, to other federal agencies, and to 'private section service providers'; and

"Whereas, This proposal would privatize and terminate a program that has worked well and provided retirement security to millions of people for nearly 60 years; and

"Whereas, It now costs less money per benefit dollar to administer Railroad Retirement than it costs to administer Social Security, and, consequently, the proposal is likely to increase costs to the taxpayer; and

"Whereas, The transfer would violate the federal government's stated commitment to 'serving the customer' as current and future Railroad Retirement beneficiaries vehemently oppose the transfer; and

"Whereas, This action threatens to disrupt earned and needed benefits for 1.3 million active, retired, and disabled rail workers and their families; and

"Whereas, This proposal would adversely affect all active and retired railroad employees and their families in the great State of Illinois; therefore, be it

"*Resolved, by the House of Representatives of the Eighty-eighth General Assembly of the State of Illinois, the Senate concurring herein*, That we assert that (1) a continued federal commitment to the railroad retirement system is essential to assure the integrity of the railroad retirees' benefits; and (2) the preservation of the present structure of the railroad retirement system, including the administrative framework of the Railroad Retirement Board, is necessary to fulfill the time-honored responsibility of the federal government; and be it further

"*Resolved*, That suitable copies of this resolution be presented to the President pro tempore of the U.S. Senate, the Speaker of the U.S. House of Representatives, and each member of the Illinois Congressional Delegation."

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. HOLLINGS, from the Committee on Commerce, Science, and Transportation:

Harold Jennings Creel, Jr., of Virginia, to be a Federal Maritime Commissioner for the term expiring June 30, 1999;

Delmond J.H. Won, of Hawaii, to be a Federal Maritime Commissioner for the term expiring June 30, 1997;

Dharmendra K. Sharma, of California, to be Administrator of the Research and Special Programs Administration, Department of Transportation;

Alan Sagner, of New Jersey, to be a Member of the Board of Directors of the Corporation for Public Broadcasting for the remainder of the term expiring January 31, 1998;

Ricardo Martinez, of Louisiana, to be Administrator of the National Highway Traffic Safety Administration;

Peter S. Knight, of the District of Columbia, to be a Member of the Board of Directors of the Communications Satellite Corporation until the date of the annual meeting of the Corporation in 1996; and

Rear Admiral William L. Stubblefield for appointment in the grade of rear admiral (lower half), while serving in a position of importance and responsibility as Deputy Director, Office of NOAA Corps Operations, under the provisions of title 33, United States Code, section 853u.

(The above nominations were reported with the recommendation that they be confirmed, subject to the nominees' commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.)

Mr. HOLLINGS. Mr. President, for the Committee on Commerce, Science, and Transportation, I also report favorably three nomination lists in the Coast Guard, which were printed in full in the CONGRESSIONAL RECORD of May 17 and July 27, 1994, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar, that these nominations lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The nominations ordered to lie on the Secretary's desk were printed in the RECORD of May 17 and July 27, 1994 at the end of the Senate proceedings.)

By Mr. BIDEN, from the Committee on the Judiciary:

Thomas Joseph Maroney, of New York, to be United States Attorney for the Northern District of New York for the term of four years;

Charles Redding Pitt, of Alabama, to be United States Attorney for the Middle District of Alabama for the term of four years;

H. Lee Sarokin, of New Jersey, to be United States Circuit Judge for the Third Circuit;

Alexander Williams, Jr., of Maryland, to be United States District Judge for the District of Maryland;

Larry Reed Mattox, of Virginia, to be United States Marshal for the Western District of Virginia for the term of four years; and

Walter Baker Edmisten, of North Carolina, to be United States Marshall for the Western District of North Carolina for the term of four years.

(The above nominations were reported with the recommendation that they be confirmed.)

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. BAUCUS, from the Committee on Environment and Public Works, with an amendment in the nature of a substitute:

S. 1165. A bill to provide for judicial review of Nuclear Regulatory Commission decisions on petitions for enforcement actions, and for other purposes (Rept. No. 103–331).

By Mr. BUMPERS, from the Committee on Small Business, with an amendment in the nature of a substitute and an amendment to the title:

S. 2060. A bill to amend the Small Business Act (Rept. No. 103–332).

By Mr. BIDEN, from the Committee on the Judiciary, without amendment:

S. 2222. A bill to grant the consent of Congress to the Texas Low-Level Radioactive Waste Disposal Compact.

S. 2369. A bill to grant the consent of the Congress to amendments to the Central Midwest Interstate Low-Level Radioactive Waste Compact.

By Mr. BIDEN, from the Committee on the Judiciary, without amendment and with a preamble:

S.J. Res. 185. A joint resolution to designate October 1994 as "National Breast Cancer Awareness Month."

S.J. Res. 192. A joint resolution to designate October 1994 as "Crime Prevention Month."

S.J. Res. 198. A joint resolution designating 1995 as the "Year of the Grandparent."

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. FEINGOLD (for himself and Mr. KOHL):

S. 2379. A bill to prohibit the use of certain assistance provided under the Housing and Community Development Act of 1974 for employment relocation activities; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. METZENBAUM (for himself, Mr. HATCH, and Mr. FEINGOLD):

S. 2380. A bill to encourage serious negotiations between the major league baseball players and the owners of major league baseball in order to prevent a strike by the players or a lockout by the owners so that the fans will be able to enjoy the remainder of the baseball season, the playoffs, and the World Series; read the first time.

By Mr. COHEN:

S. 2381. A bill to require the Secretary of Health and Human Services to provide health care fraud and abuse guidance, and for other purposes; read the first time.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. FEINGOLD (for himself and Mr. KOHL):

S. 2379. A bill to prohibit the use of certain assistance provided under the Housing and Community Development Act of 1974 for employment relocation activities; to the Committee on Banking, Housing, and Urban Affairs.

THE PROHIBITION OF INCENTIVES FOR RELOCATION ACT OF 1994

Mr. FEINGOLD. Mr. President, I am today introducing legislation, the Prohibition of Incentives for Relocation Act of 1994, with my colleague from Wisconsin, Senator KOHL, designed to prevent Community Development Block Grant and other HUD funds from being used to assist businesses in moving jobs from one State to another. This measure is based upon legislation authored in the House of Representatives by Wisconsin Representatives TOM BARRETT and JERRY KLECZKA which was approved in the House-passed HUD reauthorization legislation, H.R. 3838. Representatives BARRETT and KLECZKA have been deeply involved in developing this approach to curbing what is simply an unacceptable use of Federal funds, and I am very pleased to be proposing companion legislation in the Senate.

Mr. President, our concern about this issue was generated by the recent announcement that a major Wisconsin employer, Briggs and Stratton, was closing a Milwaukee plant and terminating some 2,000 workers. This devastating news was compounded by the subsequent discovery that many of these jobs were being transferred to plants which were being expanded in two other States and that Federal community development block grant [CDBG] funds were being used to facilitate the transfer of these jobs from one State to another.

This is a totally inappropriate use of Federal funds which this legislation is designed to halt. The CDBG program is designed to foster community and economic development; not to help move jobs around the country. Obviously, during this period of plant closings, downsizing of Federal programs, and defense conversion, there is tremendous competition between communities for new plants or expansions to offset other job losses. State and local communities are doing everything they can to attract and retain new businesses. But it is simply wrong to use Federal dollars to help one community raid jobs from another State. There is no way to justify to the taxpayers in my State that they are sending their money to Washington to be distributed to other States to be used to attract jobs out of our State, leaving behind communities whose economic stability has been destroyed. Thousands of people whose jobs are directly or indirectly lost as a result of the transfer of these jobs out of our State are justifiably outraged by this misuse of Federal funds.

Mr. President, this legislation is very similar to a provision in the Housing and Community Development Act of 1974 which prohibited urban development action grants from being used for projects intended to move jobs from one community to another. Section 5318(h) of title 42 of the United States Code provides that no assistance may be provided for urban development action grants "intended to facilitate the relocation of industrial or commercial plants or facilities from one area to another" unless it is determined that the relocation does not significantly and adversely affect the unemployment or economic base of the area from which the industrial or commercial plant or facility is to be relocated.

This provision, which is referred to as the "antipirating provision", should be made applicable to all federally-funded economic development grant programs. Clearly, the rationale for including such a provision when the urban development action program was established is equally applicable to other economic development programs. The legislation we are proposing would make it applicable to the CDBG program and other existing development programs such as empowerment zones, enterprise communities, and HUD special purpose grants. When the Senate takes up S. 2281, the Housing Choice and Community Investment Act of 1994, I intend to offer this language as an amendment to these programs and to the new LIFT proposed to be established in S. 2281.

Mr. President, this is an issue of fairness and sound public policy. Federal funding for economic development projects should be directed toward projects that expand employment opportunities and economic growth, not simply move jobs from one community to another. This legislation is designed to ensure that community development funds are appropriately used for that purpose. I ask unanimous consent that the text of the bill along with an editorial from the Milwaukee Journal dated July 3, 1994, discussing this issue be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2379

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SEC. 1. SHORT TITLE. This Act may be cited as the "Prohibition of Incentives for Relocation Act of 1994".

SEC. 2. PROHIBITION OF USE OF CDBG ASSISTANCE FOR EMPLOYMENT RELOCATION ACTIVITIES.

(a) AUTHORIZATIONS.—Section 103 of the Housing and Community Development Act of 1974 (42 U.S.C. 5303) is amended—

(1) by inserting "(a)" before "The Secretary"; and

(2) by adding at the end the following new subsection:

"(b) PROHIBITION OF USE OF ASSISTANCE FOR EMPLOYMENT RELOCATION ACTIVITIES.—Notwithstanding any other provision of law, no amount from a grant made under section 106 in fiscal year 1994 or any succeeding fiscal year may be used for any activity (including any infrastructure improvement) that is intended, or is likely, to facilitate the relocation or expansion of any industrial or commercial plant, facility, or operation, from one area to another area, if the relocation or expansion will result in a loss of employment in the area from which the relocation or expansion occurs.".

SEC. 3. SPECIAL PURPOSE GRANTS.—Section 107 of the Housing and Community Development Act of 1974 (42 U.S.C. 5307) is amended by adding at the end the following new subsection:

"(g) Prohibition of Use of Assistance for Employment Relocation Activities.—Notwithstanding any other provision of law, no amendment from a grant made under this section in fiscal year 1994 or in any succeeding fiscal year may be used for any activity (including any infrastructure improvement) that is intended, or is likely, to facilitate the relocation or expansion of any industrial or commercial plant, facility, or operation, from one area to another area, if the relocation or expansion will result in a loss of employment in the area from which the relocation or expansion occurs.".

Sec. 4. Guarantee of Loans for Acquisition of Property.—Section 108 of the Housing and Community Development Act of 1974 (42 U.S.C. 5308) is amended by adding at the end the following new subsection:

"(r) Prohibition of Use of Assistance for Employment Relocation Activities—Notwithstanding any other provision of law, no amount from a loan guaranteed under this section in fiscal year 1994 or in any succeeding fiscal year may be used for any activity (including any infrastructure improvement) that is intended, or is likely, to facilitate the relocation or expansion of any industrial or commercial plant, facility, or operation, from one area to another area, if the relocation or expansion will result in a loss of employment in the area from which the relocation or expansion occurs.".

Sec. 5. Economic Development Grants.—Section 108(q) of the Housing and Community Development Act of 1974 (42 U.S.C. 5308(q)) is amended by adding at the end the following new paragraph:

"(5) Prohibition of use of assistance for employment relocation activities.—Notwithstanding any other provision of law, no amount from a grant made under this subsection in fiscal year 1994 or in any succeeding fiscal year may be used for any activity (including any infrastructure improvement) that is intended, or is likely, to facilitate the relocation or expansion of any industrial or commercial plant, facility, or operation, from one area to another area, if the relocation or expansion will result in a loss of employment in the area from which the relocation or expansion occurs.".

Sec. 6. Community Investment Corporation Demonstration.—Section 853 of the Housing and Community Development Act of 1992 (42 U.S.C. 5305 note) is amended by adding at the end the following new paragraph:

"(17) Prohibition of use of assistance for employment relocation activities.—Notwithstanding any other provision of law, no amount from assistance provided under this subsection in fiscal year 1994 or in any succeeding fiscal year may be used for any activity (including any infrastructure improvement) that is intended, or is likely, to facilitate the relocation or expansion of any industrial or commercial plant, facility, or operation, from one area to another area, if the relocation or expansion will result in a loss of employment in the area from which the relocation or expansion occurs.".

[From the Milwaukee Journal, July 3, 1994]

Don't Let Taxpayers Steal Briggs Jobs

The use of American tax money to help lure jobs away from Milwaukee is nothing less than an outrage, which the Federal Government must halt. It was revealed last week that federal funds are playing a role in the loss of 2,000 jobs at the Briggs & Stratton Corp. here. For shame.

When one locality steals jobs from another, the net gain to the United States is zilch. So why should the US subsidize the move? What's more, it's blatantly unfair and absurd to have Milwaukee area taxpayers contribute money to entice jobs away from their own community.

In its bombshell in May, Briggs said it would relocate the 2,000 jobs from Wauwatosa to Poplar Bluff, MO, and Murray, KY, and to three other sites not yet disclosed. Now it turns out that Poplar Bluff is due to get $209,000 in federal community development funds to improve a sewer system to accommodate the expansion of the Briggs plant and workforce there. And in Murray, company and municipal officials have agreed to apply for up to $650,000 in community development funds to help with Briggs' expansion.

Milwaukee's mayor, John Norquist, and congressional Reps. Tom Barrett and Jerry Kleczka are rightly irate. The US Department of Housing and Urban Development must honor their call to forgo awarding the grant to the Kentucky locale and to rescind the award to the Missouri community. And Congress must bar the use of community development funds to assist in the relocation of jobs from one state to another. When used for economic development, such funds should be confined to the creation of new jobs in pockets of poverty—a purpose much more in the spirit of the Community Development Act.

By Mr. METZENBAUM (for himself, Mr. Hatch, and Mr. Feingold):

S. 2380. A bill to encourage serious negotiations between the major league baseball players and the owners of major league baseball in order to prevent a strike by the players or a lockout by the owners so that the fans will be able to enjoy the remainder of the baseball season, the playoffs, and the World Series; read the first time.

THE BASEBALL FANS PROTECTION ACT OF 1994

Mr. METZENBAUM. Mr. President, the most exciting season in a decade is about to come to a crashing halt. Fans everywhere who love baseball are about to be bitterly disappointed when the players walk off the field because the owners drove them to it. Instead of watching exciting pennant races go down to the wire, the fans will all be watching sit-com reruns. Our national pasttime deserves better; the people of this country deserve better.

I do not think we in the Congress can do anything to prevent the baseball players from going on strike tomorrow, But, we can do something to get the players back on the field and the owners back in line.

So, in hopes of preserving the pennant race, some pretty exciting playoffs and the World Series, I am introducing legislation today with Senator Hatch to encourage the players and owners to resolve their differences.

This bill is very simple. It is not complicated.

It does not eliminate the players right to strike, or the owners right to lock them out. Instead, the bill allows the antitrust laws to be invoked if the owners impose a salary cap or any other terms and conditions on the players. This should take away the owners' incentive to play hard ball and impose unilateral conditions on the players. It should also relieve the players' fear that they need to strike in order to prevent a salary cap from being shoved down their throats when the season ends. Once the owners and players resolve their differences and sign a new agreement, the bill expires. It comes to an end. It no longer is effective.

As everybody knows, I fought hard for years to lift baseball's antitrust exemption. I still believe revoking the owners' antitrust immunity is the best long-term solution to the mess the players and the owners have made of major league baseball. However, I decided to offer this compromise bill with Senator Hatch so that we can bring this strike to an end quickly.

And, no, I am not doing this just because the Cleveland Indians are within striking distance of first place. And I am not doing this because Roger Maris' home run record could finally be broken this season.

The fact is this legislation has only one purpose—to protect the season for all the fans, not just Cleveland fans. It also is not for or against: A salary cap, revenue sharing, or any other proposal the owners have made to the players, and it does not tip the balance of ongoing labor negotiations in favor of the owners or the players.

The fact is I do not have any special sympathy for the overprivileged owners or the overpaid players. I do care about the fans. A strike will ruin the season for the fans.

Right now, the big league players cannot use the antitrust laws. If they could, the owners would have to deal with them fairly or face the consequences in a court of law. In other words, what this bill does is give the players another tool they can use to avoid striking, or to bring a strike to a quick end.

The last seven times the baseball players and owners have met at the bargaining table there has been a work stoppage: A strike or lockout. This has not happened in other professional sports because those players could use the antitrust laws to settle labor disputes. Professional basketball players have avoided a strike for 24 years by using the antitrust laws. Professional football players have not struck since 1987 because they could use the antitrust laws to settle their differences. There has never been a strike in professional hockey over labor issues.

If the antitrust laws applied to baseball, the owners could not force the players to accept unreasonable terms and conditions of their labor negotiations hit impasse. The players could challenge the owners unreasonable demands by launching an antitrust suit instead of shutting down the season. Frankly, that is a much better deal for the fans.

Passing this compromise legislation is the best, maybe the only, hope we have of saving the season for the fans. But, it is up to the players and the owners to come to the bargaining table and work out their differences. We, in Congress, cannot make them do that. All we can do is level the playing field so that the owners do not have an unfair advantage over the players because they are immune from our fair competition laws. I, like every other fan in America, want the players to play ball and the owners to play fair. I believe that our bill can do that.

It should be noted that when the antitrust bill having to do with baseball was in our committee and the vote was taken to report the bill out, I voted to report it out. My colleague on the Judiciary Committee, Senator HATCH, voted against it. So we certainly were not in accord on exactly how to deal with this issue, but we are in accord that possibly this legislation may provide a way to get the players back on the field and keep the game going.

Mr. HATCH. Mr. President, I think the Senator from Ohio is introducing this bill because the Chicago White Sox fans are probably hopeful for this type of legislation as well.

I am pleased to introduce, along with Senator METZENBAUM today, the Baseball Fans Protection Act of 1994. Baseball fans throughout this country rightly dread the imminent prospect of a players' strike, especially in this season of record-threatening offensive performances. I urge baseball owners and players to engage in serious negotiations as soon as possible in order to resolve their disputes. The national pastime deserves no less; the fans deserve no less.

Unfortunately, existing law discourages the prompt settlement of this labor dispute. On the one hand, professional baseball enjoys a unique and longstanding immunity from the antitrust laws. I have opposed repeal of this immunity, and I continue to do so. On the other hand, the owners retain the right under our current labor laws to impose unilaterally new terms and conditions of employment once an impasse in the bargaining has been reached.

I am concerned that the unique combination of these two legal roles, which occurs in no other industry, has the effect of inviting delay and of discouraging prompt resolution of the pending labor dispute. The Baseball Fans Protection Act that Senator METZENBAUM and I are introducing would correct this legal anomaly. It would spur owners and players to resolve their dispute as soon as possible and without any unnecessary interruption of the baseball season.

This is an important small bill, an important step in the right direction. It does not choose one over the other. Frankly, we are not taking sides at all. We are just trying to make sure that the unique situation of baseball under the antitrust and labor laws does not encourage delay. We want the parties to get to the bargaining table, and whatever deal they decide to strike is up to them.

Frankly, as I have made it clear, baseball's unique antitrust immunity combines with labor laws to produce a situation that occurs in no other industry. This particular legislation is limited to this particular labor dispute.

So this is an important piece of legislation at this time, and we hope it will encourage both sides to get together to resolve their difficulties. I hope we can get it up as soon as possible.

By Mr. COHEN:

S. 2381. A bill to require the Secretary of Health and Human Services to provide health care fraud and abuse guidance, and for other purposes; read the first time.

HEALTH CARE FRAUD AND ABUSE GUIDANCE ACT

Mr. COHEN. Mr. President, today I am introducing legislation to provide health care providers with guidance on how to comply with health antifraud and abuse requirements.

A recent investigation by my staff on the Senate Special Committee on Aging found that fraud is rampant throughout the health care system, and that our Federal health care programs—particularly Medicare and Medicaid—and private health care plans are rife with abuse. As much as $100 billion is lost each year to fraud and abuse, driving up the cost of health care in America for millions of patients and families—as well as for the American taxpayer. Losses over the last 5 years are almost four times the total costs to date of the entire savings and loan crisis.

During the health care debate, very little attention has been paid to the pervasiveness of health care fraud and how ripping off the system has become the way to do business for some providers.

Our investigation focused on major schemes perpetrated by specific health care provider groups and industries. What we learned was that defrauding Federal and private health care programs in shockingly simple, and that Medicare, Medicaid, and private insurers are leaving their doors wide open to abuse, inviting scam artists to rip off the system. We lose as much as $275 million each day—or more than $11.5 million each hour—to health care fraud and abuse.

Major patterns of fraud that plague our system are: massive overbilling for equipment and services; billing for services never provided to patients; unbundling one item or procedure—such as wheelchair or surgery—and billing separately for individual component parts; upcoding, whereby the provider submits a bill to Medicare or an insurance company for a more expansive item or service than was actually provided; paying kickbacks to doctors for referring patients; and submitting claims for ghost patients or providing phantom therapy sessions.

The report I recently released entitled "Gaming the Health Care System: Billions of Dollars Lost to Fraud and Abuse Each Year," which I am inserting in the RECORD today, provides 50 case examples of scams that have recently invaded our health care system, resulting in higher health care costs, higher premiums, and, at times, serious risks to patients' health and safety.

For example, the physician-owners of a clinic in New York stole over $1.3 million from Medicaid by billing for more than 50,000 phantom psychotherapy sessions never given to patients. Nursing home operators charged swimming pools, jewelry, and a family nanny to Medicaid cost reports. Six million dollars' worth of pacemakers that were already beyond their expiration date or intended for animal use only were distributed for use in human patients. Doctors were given entertainment, trips, and other inducements for the heart devices in the patients. Scam artists set up a phony billing service and billed insurance companies for over $2 million in bogus claims for lab services that were never performed. The scam artists stole hundreds of claims forms, patient's medical information, and doctors' billing numbers to perpetrate their scheme and got away with payments of over $1.5 million before their scam was detected.

These types of scams are just the tip of the very large iceberg of fraud and abuse that is costing the taxpayers and patients dearly—and freezing out millions of Americans from affordable health care coverage.

Since we are losing about $275 million per day on ripoffs like this, we cannot afford to wait any longer to crack down on health care fraud and abuse. Our investigators have learned that some unscrupulous providers are already positioning themselves to take advantage of health care reform in even more creative ways.

There are steps that we can and must take now to curb this abuse, such as giving prosecutors stronger tools and tougher statutes to combat criminal health care fraud; allowing health care plans and the Government to kick the bad apples out of the system; creating tougher civil penalties and remedies for fraud and abuse; establishing a more coordinated enforcement program and beefing up investigative resources, which are now woefully inadequate. While the HHS' Office of Inspector General, the FBI and other agencies are trying their best to win the battles against fraudulent providers, their forces are sorely outnumbered; and tightening up Medicare rules for items they can purchase at any drug store for a fraction of the cost that Medicare is allowing providers to charge.

Many of these proposals are included in S. 867, which I introduced last year. I am pleased that Senator DOLE's health care reform proposal, the Mainstream Coalition's proposal, and Senator MITCHELL's legislation have incorporated these provisions.

The vast majority of health care providers are honest professionals whose highest priority is quality care for patients. Unfortunately, health care fraud has become a very lucrative business and some dishonest providers will do all they can to game the system. We have to act now to beat unscrupulous providers who are bleeding billions of dollars from taxpayers, and driving up the cost of health care for all Americans.

There is an additional element, however, that is important to complement our efforts to crack down on fraud and abuse. Specifically, adequate guidance should be given to health care providers on how to comply with antifraud statutes and regulations. I sincerely believe, Mr. President, that the broad spectrum of health care providers are honest and dedicated professionals and although I strongly believe that fraudulent and abusive activity in the health care system is a pernicious and costly problem, I also recognize that some providers have difficulty in trying to precisely comply with existing regulatory and statutory requirements. That is why today I am introducing legislation that is designed to augment current guidance procedure on compliance issues to health care providers particularly as it relates to the Medicare/Medicaid antikickback statute.

The antikickback statute makes it a criminal offense to knowingly and willfully pay or receive anything of value in exchange for the referral of Medicare or Medicaid business. The statute requires the Secretary of Health and Human Services [HHS], in consultation with the Attorney General, to issue safe harbors specifying payment practices that would not be treated as an offense under the antikickback statute.

To date, the HHS' Inspector General has issued 13 final safe harbors and solicited comments on 8 additional proposed safe harbors, for a total of 21. In addition, the HHS' Inspector General has issued three special fraud alerts describing activity which is suspect under the antikickback statute.

The bill I am introducing would provide mechanisms for further guidance to health care providers on the scope and applicability of the antifraud statutes. The further guidance would be provided by: modification of existing safe harbors and promulgation of new safe harbors; interpretive rulings providing the HHS' inspector general's interpretation of antifraud statutes; and special fraud alerts setting forth activities that the inspector general considers suspect under the antifraud statutes.

For modification of existing safe harbors and publication of new safe harbors: The bill sets forth a procedure for the modification of the existing safe harbors and for the issuance of new safe harbors. The Department of Health and Human Services would annually solicit proposals from the public for such modifications and new safe harbors. The bill sets forth the specific criteria to be considered when determining whether the submitted proposals should be adopted.

In addition to publishing proposed and final rules based on the proposals from the public, the Department would be required to report to Congress on the proposals and on the Department's response. By providing a regularized mechanism for the public to make proposals regarding safe harbors, the bill would ensure that the Department is informed of the evolving areas which should be considered for safe harbors and the reasons why they should be protected.

For interpretive rulings: The bill would provide the public with an opportunity to request interpretive rulings from the inspector general on the meaning of provisions of existing antifraud statutes. These rulings would represent the inspector general's interpretation of specific provisions of the statutes. The interpretive rulings would allow the inspector general to provide timely guidance on areas of ambiguity or potential conflict.

For special fraud alerts: The bill sets forth a procedure for the issuance of special fraud alerts describing conduct which the inspector general considers to be suspect or of particular concern under the antikickback statute. The Department would solicit proposals for special fraud alerts and be required to consider whether to issue them based on specific criteria. The special fraud alerts would provide guidance to the public by highlighting activity that the Department considers to be potentially illegal and subject to prosecution.

By creating a triad of procedures devised to assist providers, I believe that any concerns over adequate guidance will be addressed. With over $275 million being lost each day to health care fraud and abuse, we cannot afford to wait to toughen our defenses against those unscrupulous providers. Conversely, I believe that we must do all we can to try to assist those who are trying to comply with the law and I believe that this legislation does just that. I have included this bill in the Dole proposal and the mainstream coalition proposal. It is my hope that this legislation will be incorporated into the Mitchell fraud and abuse section as well.

Thank you, Mr. President. I ask unanimous consent that a copy of my legislation and a copy of the minority staff report of the Senate Special Committee on Aging be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2381

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. HEALTH CARE FRAUD AND ABUSE GUIDANCE.

(a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1995, and not less than annually thereafter, the Secretary of Health and Human Services (hereafter in this section referred to as the "Secretary") shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act (42 U.S.C. 1320a–7(b)(7));

(iii) interpretive rulings to be issued pursuant to subsection (b); and

(iv) special fraud alerts to be issued pursuant to subsection (c).

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL STATE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (hereafter in this section referred to as the "Inspector General") shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(A) An increase or decrease in access to health care services.

(B) An increase or decrease in the quality of health care services.

(C) An increase or decrease in patient freedom of choice among health care providers.

(D) An increase or decrease in competition among health care providers.

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(F) An increase or decrease in the cost to Government health care programs.

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

(i) whether to order a health care item or service; or

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Government health care programs.

(b) INTERPRETIVE RULINGS.—

(1) IN GENERAL.—

(A) REQUEST FOR INTERPRETIVE RULING.—Any person may present, at any time, a request to the Inspector General for a statement of the Inspector General's current interpretation of the meaning of a specific aspect of the application of sections 1128A and 1128B of the Social Security Act (hereafter in this section referred to as an "interpretive ruling").

(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling in response to a request described in subparagraph (A). Interpretive rulings shall not have the force of law and shall be treated as an interpretive rule within the meaning of section 553(b) of title 5, United States Code. All interpretive rulings issued pursuant to this provision shall be published in the Federal Register or otherwise made available for public inspection.

(ii) REASONS FOR DENIAL.—If the Inspector General does not issue an interpretive ruling in response to a request described in subparagraph (A), the Inspector General shall notify the requesting party of such decision and shall identify the reasons for such decision.

(2) CRITERIA FOR INTERPRETIVE RULINGS.—

(A) IN GENERAL.—In determining whether to issue an interpretive ruling under paragraph (1)(B), the Inspector General may consider—

(i) whether and to what extent the request identifies an ambiguity within the language of the statute, the existing safe harbors, or previous interpretive rulings; and

(ii) whether the subject of the requested interpretive ruling can be adequately addressed by interpretation of the language of the statute, the existing safe harbor rules, or previous interpretive rulings, or whether the request would require a substantive ruling not authorized under this subsection.

(B) NO RULINGS ON FACTUAL ISSUES.—The Inspector General shall not give an interpretive ruling on any factual issue, including the intent of the parties or the fair market value of particular leased space or equipment.

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)) (hereafter in this subsection referred to as a "special fraud alert").

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall in consultation with the Attorney General, issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

GAMING THE HEALTH CARE SYSTEM: BILLIONS OF DOLLARS LOST EACH YEAR TO FRAUD AND ABUSE

(Investigative staff report of Senator William S. Cohen)

EXECUTIVE SUMMARY

For the past year, the Minority Staff of the Senate Special Committee on Aging under my direction has investigated the explosion of fraud and abuse in the U.S. health care system. This report examines emerging trends, patterns of abuse, and types of tactics used by fraudulent providers, unscrupulous suppliers, and "professional" patients who game the system in order to reap billions of dollars in reimbursements by Medicare, Medicaid, and private insurers.

The consequences of fraud and abuse to the health care system are staggering: as much as 10 percent of U.S. health care spending, or $100 billion, is lost each year to health care fraud and abuse. Over the last five years, estimated losses from these fraudulent activities totaled about $418 billion—or almost four times as much as the cost of the entire savings and loan crisis to date.

Our investigation revealed that vulnerabilities to fraud exist throughout the entire health care system and that patterns of fraud within some provider groups have become particularly problematic. Major patterns of abuse that plague the system are overbilling, billing for services not rendered, "unbundling" (whereby one item, for example a wheelchair, is billed as many separate component parts), "upcoding" services to receive higher reimbursements, providing inferior products to patients, paying kickbacks and inducements for referrals of patients, falsifying claims and medical records to fraudulently certify an individual for government benefits, and billing for "ghost" patients or "phantom" sessions or services.

This report provides 50 case examples of scams that have recently infiltrated our health care system. While these are but a small sampling of schemes that were reviewed during this investigation, they serve to illustrate how our health care system is rife with abuse, and how Medicare, Medicaid and private insurers have left their doors wide open to fraud.

Patients—and, in the case of Medicare and Medicaid, taxpayers—pay a high price for health care fraud and abuse in the form of higher health care costs, higher premiums, and at times, serious risks to patients' health and safety. For example,

Physician-owners of a clinic in New York stole over $1.3 million from the State Medicaid program by fraudulently billing for over 50,000 "phantom" psychotherapy sessions never given to Medicaid recipients;

A speech therapist submitted false claims to Medicare for services "rendered to patients" several days after they had died;

A home health care company stole more than $4.6 million from Medicaid by billing for home care provided by unqualified home care aides. In addition to cheating Medicaid, elderly and disabled individuals were at risk from untrained and unsupervised aides;

Nursing home operators charged personal items such as swimming pools, jewelry, and the family nanny to Medicaid cost reports;

One thousand five-hundred workers lost their prescription drug coverage because a scam drove up the cost of the insurance plan for their employer. The scam involved a pharmacist who stole over $370,000 from Medicaid and private health insurance plans by billing over one thousand times for prescription drugs that he did not actually dispense;

Large quantities of sample and expired drugs were dispensed to nursing home patients and pharmacy customers without their knowledge. When complaints were received from nursing home staff and patient relatives regarding the ineffectiveness of the medications, one of the scam artists stated "those people are old, they'll never know the difference and they'll be dead soon anyway";

Durable medical equipment suppliers stole $1.45 million from the New York State Medicaid program by repeatedly billing for expensive orthotic back supports that were never prescribed by physicians;

A scheme involved the distribution of $6 million worth of reused pacemakers and mislabeled pacemakers intended for "animal use only." The scheme involved kickbacks to cardiologists and surgeons to induce them to use pacemakers that had already expired; and

A clinical psychologist was indicted for having sexual intercourse with some of his patients and then seeking reimbursement from a federal health plan for these encounters as "therapy" sessions.

Our investigation found that scams such as these are perpetrated against both public and private health plans, and that health care fraud schemes have become more complex and sophisticated, often involving regional or national corporations and other organized entities. No part of the health care system is exempt from these fraudulent practices, however, we found that major patterns of fraud and abuse have infiltrated the following health care sectors: ambulance and taxi services, clinical laboratories, durable medical equipment suppliers, home health care, nursing homes, physicians, psychiatric services, and rehabilitative services in nursing homes. Our investigation further concludes that fraud and abuse is particularly rampant in Medicaid, and that many of the fraudulent schemes that have preyed on the Medicare program in recent years are now targeting the Medicaid program for future abuse.

Greater opportunities for fraud will exist under health care reform

As our health care system moves toward a managed care model, opportunities for fraud and abuse will increase unless enforcement efforts and tools are strengthened. The structure and incentives of a managed care system will result in a concentration of particular types of schemes, such as the failure to provide services and quality of care deficiencies in order to cut costs. In addition, while efforts toward simplification and electronic filing of health care claims offer tremendous savings, they also pose particular opportunities for abuse. Thus, it is crucial that any such system be designed with safeguards built in to detect and deter fraud and abuse.

FINDINGS OF INVESTIGATION

Deficiencies in the current system expose billions of health care dollars of fraud and abuse

A. Current Criminal and Civil Statutes Are Inadequate to Effectively Sanction and Deter Health Care Fraud

Federal prosecutors now use traditional fraud statutes, such as the mail and wire fraud statutes, the False Claims Act, false statement statutes, and money laundering statute to prosecute health care fraud. Our investigation found that the lack of a specific federal health care fraud criminal statute, inadequate tools available to prosecutors, and weak sanctions have significantly hampered law enforcement's efforts to combat health care fraud. Inordinate time and resources are lost in pursuing these cases under indirect federal statutes. Often, even when law enforcement shuts down a fraudulent scheme, the same players resurface and continue their fraud in another part of the health care system.

This cumbersome federal response to health care fraud has resulted in a system whereby the mouse has outsmarted the mousetrap. Those defrauding the system are ingenious and motivated, while the government and private sector responses to these perpetrators have not kept pace with the sophistication and extent of those they must pursue.

B. The Fragmentation of Health Care Fraud Enforcement Allows Fraud to Flourish

Despite the multiplicity of Federal, State and local law enforcement agencies, and private health insurers and health plans involved in the investigation and prosecution of health care fraud, these enforcement efforts are inadequately coordinated, allowing health care fraud to permeate the system. While some strides have been made in coordinating law enforcement efforts, immediate steps must be taken to streamline and toughen our response to health care fraud.

RECOMMENDATIONS

Based on our investigation and findings, we recommend the following to reduce fraud and abuse throughout the health care system:

1. Establish an all-payer fraud and abuse program to coordinate the functions of the Attorney General, Department of Health and Human Services, and other organizations to prevent, detect, and control fraud and abuse; to coordinate investigations; and to share data and resources with Federal, State, and local law enforcement and health plans.

2. Establish an all-payer fraud and abuse trust fund to finance enforcement efforts. Fines, penalties, assessments, and forfeitures collected from health care fraud offenders would be deposited in this fund, which would in turn be used to fund additional investigations, audits, and prosecutions.

3. Toughen federal criminal laws and enforcement tools for intentional health care fraud.

4. Improve the anti-kickback statute and extend prohibitions of Medicare and Medicaid to private payers.

5. Provide a greater range of enforcement remedies to private sector health plans, such as civil penalties.

6. Establish a national health care fraud data base which includes information on final adverse actions taken against health care providers. Such a data base should contain strong safeguards in order to ensure the confidentiality and accuracy of the information data contained in the data base.

7. Design a simplified, uniform claims form for reimbursement and an electronic billing system, with tough anti-fraud controls incorporated into these designs.

8. Take several steps to better protect Medicare from fraudulent and abusive provider billing practices and excessive payments by Medicare. Specifically, Revise and strengthen national standards that suppliers and other providers must meet in order to obtain or renew a Medicare provider number;

Prohibit Medicare from issuing more than one provider billing number to an individual or entity (except in specified circumstances), in order to prevent providers from "jumping" from one billing number to another in order to double-bill or avoid detection by auditors;

Require Medicare to establish more uniform national coverage and utilization policies for what is reimbursed under Medicare, so that providers cannot "forum shop" in order to seek out the Medicare carrier who will pay a higher reimbursement rate;

Require the Health Care Financing Administration to review and revise its billing codes for supplies, equipment and services in order to guard against egregious overpayments for inferior quality items or services; and

As we revise the health care system, give guidance to health care providers on how to do business properly and how to avoid fraud.

Adoption of these recommendations will go far in shoring up our defenses against unscrupulous providers, patients, and suppliers who are bleeding billions of dollars from our health care system through fraud and abuse. Since Medicare and Medicaid lose as much as $31 billion annually to fraud and abuse, the savings from reducing fraud in these programs would go far toward paying for much needed reforms in our health care system, such as providing access to health care coverage for the uninsured, prescription drug benefits for the elderly, or long-term care for the elderly and individuals with disabilities.

We must not wait to fix these serious problems in the health care system until we see what form health care reform takes. We are losing as much as $275 million each day to health care fraud, and effective steps can be taken within the current system to curb this abuse. With billions of dollars and millions of lives at stake, we can no longer afford to wait.—William S. Cohen, United States Senator, July 7, 1994.

I. INTRODUCTION AND SCOPE OF INVESTIGATION

When the Senate Special Committee on Aging sought an expert on health care fraud in 1981, it turned to a cardiologist from Philadelphia. His credentials were impeccable; a noted physician, he was also a convicted felon who had defrauded both public and private health insurers in three states for more than $500,000 by submitting $1.5 million in claims for medical services he had never performed.

"The problem is that nobody is watching," the doctor testified. "Because of the nature of the system, I was able to do what I did. The system is extremely easy to evade. The forms I sent in were absolutely outrageous. I was astounded when some of those payments were made."

Apparently, we did not learn much from this doctor's testimony. For now, thirteen years later, he is allegedly still up to his old tricks. Last month, he was arrested by FBI agents in Philadelphia and charged once again with defrauding health insurers for millions of dollars by filing claims for procedures that were never performed. Bail was set at $2 million, and he is currently awaiting trial.

According to the U.S. Attorney in Philadelphia, since 1974, this physician has had a total of several arrests and five convictions for fraud in New York, Connecticut, and Texas. Despite his record, four years ago he was able to get his Pennsylvania physician's license reinstated. He might very well still be in business today if a former patient, who was angry about the false billings, hadn't agreed to go undercover.

How was this physician, with his long record of arrests and convictions for fraud, able to continue to perpetrate the same kinds of schemes against the health care system? Why weren't his blatantly fraudulent activities detected earlier? How could he get a previously suspended license reinstated in one state when he had been convicted for fraud in three others?

The vast majority of health care providers are honest and dedicated professionals, but the alleged activities of this physician is typical of the "bad apples" that threaten to corrupt the entire system.

Therefore, as Congress continues its work on omnibus crime legislation and crafts health care reform, the answers to these questions reveal flaws in our health care systems that we simply cannot afford to ignore.

For the past year, under my direction the Minority Staff of the Senate Special Committee on Aging has investigated the growth of fraud and abuse in the U.S. health care system and has worked to identify deficiencies in current federal, state, and private sector efforts to combat these crimes. To demonstrate the scope of the outrageous fraudulent behavior currently plaguing the health care system, this report will detail recent cases in which individuals and companies have been either indicted, convicted or fined. Those cases that have been adjudicated represent the tip of the iceberg of what has to come to light—many more go undetected or are still under investigation. For example, in the area of home health care fraud, the New York Special Prosecutor states that "We've just scratched the surface." The Minority staff is continuing its investigation of the areas of abuse identified in this report, and will issue a series of reports on particular industries engaged in abusive practices.

In addition, this report will examine emerging trends, patterns of abuse, and types of tactics used by fraudulent providers; the inadequacy of current law and enforcement resources and the need for better coordination; and how the move toward managed care presents new and different opportunities for unscrupulous providers to defraud the system. And finally, the report will offer recommendations for correcting the current deficiencies, in the system that allow fraud and abuse to flourish.

According to the General Accounting Office, each year as much as 10 percent of total health care costs are lost to fraud and abuse. With annual health care costs in the United States now exceeding $1 trillion, fraud and abuse is costing taxpayers and policyholders about $100 billion each year. Over the last five years, estimated losses from health care fraud and abuse totaled about $418 billion—or almost four times as much as the entire savings and loan crisis has cost to date. With amounts this large at stake, we simply cannot afford to wait any longer to toughen our response to health care fraud.

We would like to thank, among others, the Office of Inspector General of the Department of Health and Human Services, the Department of Justice, the Federal Bureau of Investigation, the Drug Enforcement Administration, the Postal Inspection Service, the National Association of Attorneys General, the Medicaid Fraud Control Units, and the General Accounting Office, as well as numerous health care industry representatives, for their assistance with this investigation and report.

II. BACKGROUND—CURRENT LAW: HOW THE GOVERNMENT INVESTIGATES AND PROSECUTES HEALTH CARE FRAUD AND ABUSE VIOLATIONS

A. Brief overview of health care fraud and abuse statutes

A number of Government health care programs are regular targets for fraud. Medicaid is financed jointly by the federal and state governments with states contributing up to 50 percent of the program's funding. Medicare is a federal program financed by a combination of federal payroll taxes, general revenues and beneficiary premiums. Other government-sponsored programs include benefits provided to federal employees, retired and active military and dependents, and veterans. Although government health care programs are often targeted, many unscrupulous providers are indiscriminant about who pays.

As this report illustrates, health care fraud and abuse encompasses a wide range of practices including overcharging for services, billing for services not rendered, and rendering services that are unnecessary or inappropriate. Paying kickbacks to physicians for referring patients and routinely waiving copayments or deductibles from patients are also considered fraudulent activities by the Medicare and Medicaid programs. Because kickbacks constitute payments to induce services, they increase insurers' vulnerability to claims for unnecessary services. By forgiving patient copayments and billing an insurer directly, unscrupulous providers may be able to misrepresent services rendered without the patient's knowledge.

While there currently is no specific federal health care fraud statute, Justice Department prosecutors do use traditional criminal and civil authorities, including mail and wire fraud statutes, the False Claims Act, and false statements statutes to prosecute health care fraud and abuse.

There are also criminal statutes directed specifically to prevent fraud and abuse within Federal health care programs. Such authorities include criminal penalties for false claims and statements specifically involving the Medicare and Medicaid programs, and the Medicare and Medicaid anti-kickback statute. The anti-kickback statute prohibits an individual or entity from offering, paying, soliciting, or receiving remuneration with the intent to induce Medicare or Medicaid program business.

The Department of Health and Human Services' (HHS) Inspector General (IG) is responsible for imposing the majority of health care administrative sanctions authorized under the Social Security Act. The Omnibus Budget Reconciliation Act of 1981 specifically authorized the IG, acting on behalf of the Department, to impose civil monetary penalties and assessments against health care providers who have filed false or improper claims for reimbursement under the Medicare, Medicaid, or Maternal and Child Health Block Grant programs. The law authorizes penalties of up to $2,000 for each false claim, and an assessment of up to twice the amount improperly claimed by the health care provider. The law provides a major deterrent to fraudulent and abusive activity.

The Medicare and Medicaid Patient and Program Protection Act of 1987 further increased the Department's authority to exclude both individuals and entities from participation in Medicare and State health care programs for fraudulent activities. It amended the existing mandatory and enacted new discretionary (permissive) exclusion authorities. The mandatory provisions cover program-related and patient abuse convictions and require program exclusions of no less than 5 years.

The permissive provisions cover a variety of offenses including convictions for fraud, loss of a license, and kickbacks. Once a decision has been made to impose an exclusion, the provider is given notice and advised of the right to request a hearing before an administrative law judge (ALJ). If the provider is dissatisfied with the ALJ's decision, he may request review by the Departmental Appeals Board and, if still dissatisfied, may take his case to the U.S. District Court.

Program exclusions or civil penalties are often the appropriate remedy to be utilized to address health care fraud and abuse.

The HHS Inspector General refers investigative findings directly to the Department of Justice or individual U.S. Attorneys for possible criminal or civil prosecution. Once the Department of Justice has completed or declined criminal or civil prosecution, HHS can consider imposing administrative sanctions. Successful prosecutions may take years, involve an investment of considerable staff time and resources and, in some cases, may never result in actual recovery of federal health care dollars lost to fraud.

B. "Divided We Fall"—Law enforcement agencies suffer from overlapping and unclear jurisdiction

The responsibility for investigating and prosecuting health care fraud and abuse is currently dispersed among many agencies at both the federal and state levels. The HHS IG and the FBI, the two federal law enforcement agencies with primary jurisdiction in health care anti-fraud efforts, each devote between 222 and 228 full-time equivalent (FTE) positions to health care fraud investigations.

More than 4 billion claims are processed annually. Although the IG has authority over only federal health programs, the FBI has plenary authority for all health care plans—that means less than 450 federal FTE's are devoted to investigating alleged improprieties in federal public health programs, which represent 40 percent of the nation's health care bill, and to investigate over 1,000 private payers. Thus, the two predominant health care anti-fraud enforcement agencies have only one FTE per approximately 8,890,000 claims. Agencies with some jurisdiction in anti-fraud and abuse enforcement efforts are as follows:

The Inspector General of the Department of Health and Human Services audits and investigates health care providers accused of fraud against federally-sponsored programs, primarily Medicare and Medicaid. It is authorized to conduct civil, administrative and criminal investigations of frauds associated with the federal program.

The Federal Bureau of Investigation has plenary authority to investigate all health care fraud offenses and includes all victims of the crime, whether against Federal programs or private insurance companies, business entities or individuals. Allegations of criminal conduct in the health care industry, at the onset, are presented to the U.S. Attorney's office for a prosecutive opinion. Based on the U.S. Attorney's decision, the FBI either proceeds with the investigation or closes the case.

The Drug Enforcement Administration monitors and investigates the diversion, misuse, and abuse of pharmaceutically controlled narcotic substances;

The Department of Justice combats fraud by pursuing criminal or civil proceedings when appropriate. Even if health care fraud does not constitute criminal activity, the Justice Department may try to recover damages by seeking the payment of civil penalties and restitution. Exclusions, suspensions or administrative civil penalties are still within the purview of the Department of Health and Human Services' Inspector General.

The Food and Drug Administration regulates the prescription drug market for non-controlled prescription medications as well as certain medical devices.

The Postal Inspection Service enforces a number of statutes which allow them to take action against fraudulent practices involving the use of the mails (the criminal mail fraud statute and the civil postal false representations statute). Since the majority of claims filed by providers (as well as subsequent payments) flow through the mail, the Postal Inspection Service is an active component of health care fraud investigations.

The Inspector General of the Department of Labor investigates cases involving workmen's compensation claims or fraud in health plans administered by labor unions.

The Inspector General of the Office of Personnel Management investigates when fraud is suspected in federal employee health plans, to which the federal government contributes billions of dollars annually.

The Defense Criminal Investigative Service seeks to ensure the integrity of all Department of Defense programs, including the military health care system (CHAMPUS).

The Inspector General of the Railroad Retirement Board Office handles cases regarding railroad workers fraud.

Forty-two States currently operate with Medical Fraud Control Units.

The Minority committee staff finds that agencies authorized with primary enforcement duty, such as the HHS IG, are seriously underfunded and are urgently in need of additional resources in order to keep pace with the growth in the health fraud crime problem. Many of the agencies dedicated to this effort are stretched thin and are unable to keep pace with the growing number of claims and the evolving relationships of providers and entities as our health care system moves more toward a managed care environment. The committee staff is concerned about the lack of coordination and unnecessary duplication of efforts among agencies with overlapping jurisdiction.

Historically, turf battles have existed, potentially undermining investigations and cases. A muddled chain of command and the decentralized nature of some health care fraud investigations allow many fraudulent actors to perpetrate their schemes without detection. Recently, health care fraud working groups have formed at the national, regional and local levels. Many of these groups include federal and state prosecutors and investigators from FBI, HHS IG, Medicaid Fraud Control Units, and other agencies. We have found that where a task force or working group exists to coordinate investigations of a specific fraudulent or abusive practice, the overall investigation and prosecutorial effort are positively affected.

III. "TIP OF THE ICEBERG"—SELECT CASES OF FRAUDULENT AND ABUSIVE SCHEMES

As stated above, the GAO estimates that fraud and abuse accounts for as much as 10 percent of U.S. health care spending. With health care costs approaching $1 trillion, approximately $100 billion will be lost to fraud and abuse annually. The FBI calculates that fraud accounts for between 3 percent and as much as 15 percent of total health care spending, costing the United States tens of billions of dollars each year. Despite the enormity of the problem, GAO concludes that only a small fraction of the fraud and abuse committed against the health care system is identified.

Those instances that have been detected have involved substantial sums of money, risked patients' health and lives, diverted scarce resources, and contributed significantly to national health care costs. In addition to these tangible costs, health care fraud and abuse by providers can dangerously erode the trust of patients in the quality and integrity of the health care system. The cases described in this report are cases which are based on either recent convictions, indictments or fines so as to not disrupt or prejudice ongoing investigations which may result in future convictions. The committee staff is, however, continuing its investigation of ongoing cases.

A. Durable Medical Equipment (DME)

Over the past several years, the durable medical equipment industry has been repeatedly cited as a major source of fraudulent and abusive practices in the health care system. Ongoing investigations by the Minority committee staff revealed shocking evidence of unscrupulous DME sales practices, often resulting in the sale of unnecessary, overpriced, and even dangerous equipment to Medicare beneficiaries.

While the DME industry has recently taken steps to stamp out abuse, our current investigation of health care fraud cases has concluded, unfortunately, that major abuses continue to occur within this industry. The overwhelming majority of the nation's more than 160,000 DME suppliers are dedicated and honest professionals, but the rapid growth and sheer size of the industry has greatly increased the potential for fraud and abuse. Our investigation reveals that not only do these problems continue to plague the Medicare program, but they are being replicated not only in Medicaid, but in private insurance programs as well.

DME providers are not required to be certified or licensed. In fact, until recently, they have not had to meet any kind of standards whatsoever. Medicare carrier oversight of suppliers has also been lax. Most carriers do not keep track of their suppliers, and their billing numbers are rarely canceled, even when the supplier has been excluded from the Medicare program. Insufficient carrier oversight also enables suppliers to be issued multiple billing numbers, allowing them to double bill, overbill, or avoid being caught for fraudulent activities.

Largely as a result of Congressional pressure, the Health Care Financing Administration (HCFA) has taken some action to curb fraud and abuse in the Medicare DME program. HCFA has reduced the number of Medicare carriers processing DME claims from 34 to 4, which should bring greater uniformity and consistency to coverage and payment decisions. In addition, all claims must now be submitted to the carrier serving the area where the beneficiary resides and uses the item, thus eliminating the ability of suppliers to engage in "carrier shopping" to locate the carriers paying the highest reimbursement rates in order to get the best price for their overpriced items.

These new requirements are a step in the right direction, however, Medicare and Medicaid clearly remain vulnerable to abuse, and there is more that we can and should do to strengthen the participation requirements and administrative and payment policies for durable medical equipment.

Specific areas of abuse by DME suppliers include billing Medicare and Medicaid for inferior products, billing for items never provided, paying kickbacks to physicians for referring patients to DME suppliers, forging physician signatures or falsifying prescriptions for equipment, and tainting health care products.

Inferior Products.—The problem of selling inferior products at inflated prices is an ongoing problem that this industry still has not cleaned up.

A DME supplier in Texas defrauded Medicare of over $1 million by charging Medicare for "body jackets," when what he actually provided were wheelchair pads. Legitimate custom-fit orthotic body jackets are used to treat injuries such as vertebra fractures and compressions or to aid in healing following surgery on the spine. A wheelchair pad is a cushioned seating support for the wheelchair. This supplier billed Medicare close to $1,300 for each pad, which actually cost between $50 to $100 to manufacture—representing a mark-up to Medicare of as much as 2,500 percent.

Body jacket scams have become increasing popular, prompting the HHS IG recently to conduct an inspection to determine whether Medicare was being appropriately billed for orthotic body jackets. The Medicare claims paid remained relatively steady until 1990. Then, the number of claims submitted to Medicare skyrocketed 6,400 percent by the end of FY 1992—from 275 claims in 1990 to 17,910 claims in 1992. Total allowed charges also increased significantly, from $217,000 in 1990 to $18 million in 1992—an 8,200 percent increase.

The IG found that 95 percent of the jacket claims filed in a one year period were for "jackets" which did not meet the construction and medical necessity requirements to be reimbursed by Medicare. According to the IG, an orthotic body jacket costs only approximately $100 to manufacture, while Medicare pays approximately $800 for this item. In 1991, total Medicare payments for jackets that did not meet construction and medical necessity requirements exceeded $7 million.

Medicare requires that a patient's physician complete a prescription—known as a "Certificate of Medical Necessity" (CMN) before a DME can be approved for payment. The IG found that the body jackets were marketed by salespersons before the CMN's were completed by physicians. Typically, DME salespersons marketed their devices to nursing homes for use by their residents.

The IG found that salesperson presented their products to nursing home directors and physical therapists as restraint alternatives to help patients sit upright in wheelchairs. When a patient agreed to purchase a device, salesmen either completed the CMN or gave nursing home staff the proper wording to use and they completed the CMN. The nursing home staff then sent it to a physician for signature. This practice in itself is strictly illegal because, under current law, physicians—not suppliers—are required to complete the CMN.

To market this non-legitimate device as an "orthotic body jacket," DME suppliers took advantage of nursing homes' desires for restraint alternatives. They also took advantage of the fact that these primarily Medicare and Medicaid patients did not have to pay out-of-pocket for the products and also of the fact that physicians are often far too lax in their attention to the CMN requirements.

Billing for items never provided.—Our investigation found that there are still many cases of sham companies billing for products that are never delivered. This is particularly a problem when nursing home residents are targeted for the sale of items that they never receive and, in some instances, never even ordered.

The manager of a California DME company billed Medi-Cal, in just less than seven months, for more than $500,000 for merchandise allegedly delivered to needy beneficiaries. In fact, the company was supplying nothing and the beneficiaries had no actual medical need for any of the supplies. An audit revealed that the operation was a virtual sham from its inception, and that the company had never even purchased an inventory of supplies from which deliveries could have been made. All Medi-Cal monies that were received were pocketed by the owner who used the funds to support a heavy gambling habit.

A search warrant was recently issued in New York after a number of Medicare beneficiaries complained to their local carrier that they never received durable medical equipment listed on their Explanation of Medicare Benefits form as having been delivered to them by a New York DME company. Instead the company often provided non-reimbursable substitute items, such as angora underwear, power massagers, air conditioners and microwaves, in order to induce the beneficiaries to give them their Medicare number.

Medicare beneficiaries would contact the DME company and its sales representatives to learn how they could obtain the "free" household items. After receiving telephone calls from the beneficiaries, the sales representatives would then visit them in their homes and show them household items from a catalog. More expensive reimbursable durable medical equipment, such as hospital beds, wheelchairs, and patient lifts, which were never delivered would then be billed to the carrier using the beneficiaries' Medicare numbers.

It is estimated that Medicare overpaid $1.5 million for the items, but this figure is only based on those beneficiaries who complained to their carrier. The DME company is also accused of conducting an elaborate money laundering scheme in order to obscure the proceeds of the Medicare fraud.

Kickbacks.—Under the Medicare and Medicaid anti-kickback statute, it is illegal to offer or pay a profit distribution to physicians to deliberately induce them to refer business under Medicare or any State health care program. However, the practice continues.

A cardiologist has been charged with receiving $125,000 in kickbacks from a DME company for referrals that enabled the company, which supplied oxygen and respiratory aids, to bill government programs for hundreds of thousands of dollars. The indictment claims the doctor received kickbacks in the form of cash payments, jewelry, and other gifts in exchange for referrals.

A group of Florida DME companies supplied respiratory equipment to Medicare beneficiaries without any prior physical examinations of the patients or authorization for the equipment. After the companies delivered the equipment, they paid kickbacks to physicians who agreed to write prescriptions for the equipment and medication, without ever seeing the patients. The companies then used the prescriptions as supporting documentation to obtain over $5.2 million in Medicare reimbursements.

Item not medically necessary/forging or falsifying certificates of medical necessity.—Durable medical equipment is reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers circumvent physicians into signing CMN's, persuading physicians to act in complicity with a fraudulent scheme, or forging physician signatures.

Two New York DME owners stole $1.45 million from the New York State Medicaid program by repeatedly billing for expensive orthotic back supports that were never prescribed by physicians. The DMI sales force used an aggressive personal solicitation and telemarketing campaign, offered free "angora underwear" to Russian immigrants in Brooklyn, in exchange for their Medicaid I.D. numbers. The State was then charged for costly medical supplies that were never authorized by doctors and only rarely, if ever, delivered to patients. As described in a previous case, angora underwear was again used as an inducement to obtain beneficiaries' Medicaid numbers.

The sales team recruited the Medicaid recipients in the streets with promises of the free underclothes, and then billed Medicaid for high-priced, medically unnecessary orthotic back supports—charging nearly $400 per claim. One of the owners also pleaded guilty to stealing an additional $300,000 over two years by submitting numerous false reimbursement claims from another DME company by stating that the company had provided hundreds of Medicaid patients with oxygen concentrators and nebulizers that were similarly, in fact, never ordered by physicians.

The owner of a DME company in New York was sentenced to five months in jail for Medicare fraud and ordered to pay $100,000 in restitution for falsifying blood tests to justify claims for oxygen equipment and inflating hours of oxygen use to obtain higher reimbursement.

In Florida, an investigation of physicians, middlemen and DME companies involved in selling and buying Certificates of Medical Necessity led to indictments and imprisonment. One physician was sentenced for selling the certificates for patients he neither examined nor treated, knowing full well they would be used in filing Medicare claims. Other individuals and companies are also under indictment as part of the overall investigation.

B. Other Practices of Suppliers

Unbundling and upcoding.—Unbundling is the practice through which providers submit bills piecemeal rather than for the procedure or product as a whole. These illegal practices add enormous costs to the public health care programs. Upcoding is the process of billing for a service by using a reimbursement code for a similar but more complicated service. This results in a higher reimbursement to the provider.

The case of a Pennsylvania DME company illustrates how providers have used the techniques of "unbundling" and "upcoding" to defraud Medicaid. The DME company billed Medicaid for "incontinence liners" when it was in fact providing residents of a youth home and elderly nuns in a convalescent home with disposable washcloths. The supply company misrepresented the products supplied in order to receive a higher reimbursement. During interviews at the homes, investigators also discovered considerable amounts of durable medical equipment supplied by the same DME outfit, including wheelchairs, geriatric chairs, and accessories.

A review of the Medicaid bills submitted revealed that the wheelchairs, particularly the motorized ones, had been "unbundled": the supplier was billing separately for components of a wheelchair that are generally provided as standard items. The supplier also billed for more expensive equipment than was actually provided. Company owners were convicted for this fraud.

Our investigation revealed several fraudulent billing schemes involving reimbursement for incontinence supplies. For example, a husband and wife in Michigan allegedly stole more than $25 million from Medicare in false claims for providing incontinence supplies for nursing home patients. Each time the Medicare carrier initiated proceedings to review claims before paying them, the couple allegedly incorporated a new billing company in order to avoid detection by Medicare.

Tainting of health care products.—Our investigation also revealed instances in which Medicare and private insurers have been billed for products that pose potentially serious risks to patients, such as through the sale of "tainted" products.

A former pharmaceutical salesman who was the owner of a company that distributed human heart cardiac pulse generators and human heart pulse generator leads was convicted of altering and misbranding expired pacemaker boxes to make the product appear new. By the owner's estimate, over an eight-year period, he sold about $6 million worth of pacemakers.

Former employees testified he often acquired low cost older models that were near expiration and relabeled them—a process that meant not only implanting pacemakers with older batteries but also jeopardizing the devices' sterility and putting the patient at risk of infection. In addition, accounts stated when authorities raided the owner's office, they found a number of bloody pacemakers, raising suspicions he was reselling devices that had been surgically removed from other patients or even from corpses. One former employee said he saw him wash off a pacemaker battery with tap water. Other problems discovered included implanting devices with lapsed expiration dates, improper sterilization, recycling pacemakers, mislabeling pacemakers intended for "animal use only" and mislabeling standard units as "high output" units.

The owner also provided a variety of kickbacks to attending physicians, cardiologists and surgeons to induce them to implant adulterated, misbranded, or expired pacemakers into their patients. The physicians were given entertainment tickets, vacation trips, office medical equipment, the services of prostitutes and cash for using the heart devices.

According to the Department of Health and Human Services' Inspector General, a retired electrician from Chicago had a "mystery pacemaker" implanted in his chest. The brand serial number, and even the expiration date of his pacemaker or the lead attached to his heart could not be determined. The patient did not know his pacemaker was subject to failure, which might require a pacemaker replacement operation with all the accompanying risks of further surgery. The patient's cardiologist admitted that he received the services of a prostitute, a trip to Hawaii and other types of kickbacks from the pacemaker dealer. To date, ten individuals have pleaded guilty to the scheme and the owner has been given a 6 year term of imprisonment.

C. Psychiatric Services

Our investigation has concluded that a growing area of health care fraud exists in the delivery of psychiatric and psychotherapy services, including those provided by hospitals, clinics and private practitioners. Our review of recently completed and ongoing criminal investigation indicates that psychiatric and psychological services are rife with abuse, particularly in the following areas: billing for "phantom" psychotherapy sessions; billing for excessively long hospital stays for inpatient psychiatric care; providing kickbacks to physicians; and grossly inflating the number of psychotherapy hours provided in order to reap thousands of dollars in overpayments from Medicare or private insurers.

Phantom sessions.—We have found a significant increase in cases involving the illegal practice of billing for psychiatric and psychotherapy sessions that never took place.

A New York Community Center director was indicted for stealing almost $800,000 by fraudulently billing the State for over 25,000 "phantom" psychotherapy sessions Medicaid recipients never actually participated in and for falsifying patients' medical records to cover up the theft. To perpetrate the scheme, the center director offered inducements like free food to attract thousands of Medicaid beneficiaries to the Center.

After obtaining the Medicaid recipients' names and I.D. numbers, the director allegedly used the Medicaid provider number of a psychiatrist to bill for tens of thousands of these "phantom" sessions. The billings were so excessive that the staff psychiatrist would have had to work well over 24 hours a day to handle the number of visits claimed, yet the scheme continued for over three years before being detected and stopped.

In a similar case, physician-owners of a psychiatric clinic in New York were sentenced for stealing more than $1.3 million from the State Medicaid program by fraudulently billing the State for over 50,000 "phantom" psychotherapy sessions never given to Medicaid recipients. They were also charged with conspiring to falsify patient medical records to cover up the theft.

The doctors had paid neighborhood "steerers" illegal kickbacks of $10 to $15 per session to bring in new patients. Once inside the clinic, the Medicaid beneficiaries (often drug addicts) would sit together in a big room, watch television, fill out so-called homework assignments, eat a meal, sometimes talk briefly to a doctor, and then, before leaving, receive a few dollars cabfare and prescriptions for drugs like Valium. The physicians saw patients on a twice-weekly basis, but billed Medicaid for four to seven visits per week, as well as for dates before the recipients ever even set foot in the clinic. They also billed for visits when the only licensed psychiatrist on staff was absent from the office—often on vacation in France and California.

Billing for excessive or unnecessary sessions.—A Minnesota psychiatrist was sentenced to prison for defrauding Medicare, Medicaid and the Department of Veterans Affairs by billing for extensive psychotherapy sessions with individual patients in nursing homes and board and care facilities when he either did not see them or saw them only in groups at meals. In addition, his medical license had been suspended for sexual improprieties with patients and for overprescribing medications.

A Hawaii clinical psychologist, working as a marriage and family counselor, was accused of defrauding the Civilian Medical Health Program of the Uniformed Services (CHAMPUS). He was indicted for having sexual intercourse with some of his patients and then seeking payment for these encounters as "therapy" sessions. He also claimed payment for therapy sessions which never took place; for billing individual sessions as joint sessions in order to receive higher reimbursements; and for falsely certifying to CHAMPUS that he billed and collected a required 20% copayment from his patients when he had, in fact, advised them they were not responsible for the fee. As a result, his patients had no incentive to scrutinize his billings, allowing him to continue his fraud against CHAMPUS.

A Virginia psychiatrist was recently convicted for billing different insurers for patient counseling sessions that never occurred or whose length was inflated on reimbursement claims. He is accused of defrauding seven insurers including Medicare, Medicaid and CHAMPUS. He was sentenced to home confinement for six months, ordered to perform community service, fined $10,000 and put on probation.

A record $379 million in fines, damages and penalties will be paid by a large health care corporation for kickbacks and fraud at its psychiatric and substance abuse hospitals in over 30 states. The corporation agreed to plead guilty to six counts of making unlawful payment to induce doctors to refer Medicare and Medicaid patients to the hospitals and one count of conspiracy to defraud the United States. Fraudulent practices included admitting and treating patients unnecessarily, keeping patients hospitalized longer than necessary in order to use up insurance coverage, billing insurance programs multiple times for the same service and billing when no service was actually provided, and billing Medicare for payments made to doctors that were solely intended to induce referrals of patients to the facilities.

D. Nursing homes

The investigation revealed a considerable number of cases involving direct targeting of nursing home patients in which both the industries that supply products and services to the homes and the owners and administrators of the home are involved in fraudulent and abusive practices. Nursing home owners have been convicted of charging personal luxury items like swimming pools to Medicaid cost reports. HCFA, the HHS IG, and the Minority committee staff are continuing to investigate nursing homes and the providers of rehabilitative services to nursing homes.

A Minnesota speech therapist submitted false claims to Medicare for services provided to nursing home residents. The therapist also received Medicaid payments for speech therapy he never actually performed—and the investigation revealed that he had been paid for services "rendered to patients" several days after they had died. He was also observed using flash cards with a blind resident, and then billing for reimbursement.

The owner of a Pennsylvania rehabilitation service was indicted for allegedly operating a scheme to defraud Medicare by submitting false claims for speech therapy provided to patients in nursing homes. The owner allegedly told speech therapists to recruit Medicare clients even though he knew their therapy would not be covered under Medicare.

Before submitting the paperwork for reimbursement, the speech therapists would rewrite their patient reports so that they would appear to be medically necessary rehabilitation services. The employees then allegedly falsified bills submitted to Medicare, including certifications by doctors that patients needed continued speech therapy, and also falsified patients' medical records.

A Connecticut nursing home owner allegedly overstated expenses in reports for Medicaid reimbursement over a five-year period resulting in an overpayment by the State of almost $400,000. The nursing home owner allegedly arranged a beneficial financial arrangement with a leasing corporation to procure equipment. The leasing company then sold or leased the equipment back to the owner for a far greater cost than its purchase price. The nursing home was accused of passing on these costs to the State by submitting inflated cost figures and in order to obtain a higher rate of Medicaid reimbursement.

A supply company in California billed Medicare for $5 million for post-surgery surgical dressings for nursing home patients who had never even had surgery. Medicare paid numerous nursing homes in several States for the surgical dressings, and the homes, in turn, paid a percentage to the supply company.

Nursing home operators in North Carolina and Pennsylvania have been convicted of charging personal items such as swimming pools, jewelry, and the family nanny to Medicaid cost reports.

E. Clinical Laboratories

Some of the largest health care fraud convictions and settlements to date have involved major national clinical laboratories. These providers have come under intense scrutiny by the FBI, the HHS IG, the Medicaid fraud units, and private insurers for such practices as "sink testing," by which patients' lab samples are dumped down the sink without having had the requisite tests performed, providing and billing for bogus test results; performing extra tests in order to obtain excessive reimbursements; providing kickbacks to physicians for patient referrals; and "unbundling" so that Medicare will pay individually for each test that should be billed as part of a series of tests. Our investigation reveals that clinical labs continue to be a major potential area of abuse, posing the threat of significant losses to Medicare, Medicaid, CHAMPUS, and private insurers, as well as a threat to patients' health care due to faulty or unperformed lab tests.

Three of the nation's largest clinical laboratories paid over $150 million to settle allegations that they submitted claims for unnecessary blood tests. Part of these cases arose from allegations by a whistleblower who charged that the three companies had submitted thousands of false Medicare and Medicaid claims. The labs were accused of manipulating doctors into ordering additional medically unnecessary tests when the doctors ordered basic automated blood tests. This probe is continuing and several other lab companies have acknowledged receiving subpoenas.

One of the labs, which pleaded guilty to the submission of false claims to the CHAMPUS program and to Medi-Cal, was accused of revising its order form so that doctors ordered additional tests as part of a standard test without realizing that Medicare would be charged separately for them. The unnecessary tests allegedly cost Medicare millions of dollars.

In New York, a laboratory that had billed Medicaid more than $39 million over six years was indicted for fraudulently billing for bogus ultrasound and blood tests. It was also indicted for illegally laundering over $1 million in Medicaid profits through the lab in order to generate kickback money. The sales manager of the lab was accused of submitting thousands of false reimbursement claims stating that blood tests and sonograms had been provided to Medicaid recipients, when, in fact, the tests were never medically required. Further, to the extent that services were actually provided, they were done solely to maximize the Medicaid reimbursements.

The lab sales manager then allegedly laundered the Medicaid proceeds by writing checks to fictitious employees and converting the funds to cash in order to pay kickbacks to others and also to make the fraud more difficult for Medicaid to detect.

F. Physicians/practitioners

When physicians and health care practitioners engage in fraudulent practices they not only violate their own code of ethics but also deceive their patients, add enormous costs to an already beleaguered system, possibly endanger lives and, ultimately, betray the public trust.

A physician in Hawaii who specialized in internal medicine and oncology used fake diagnoses to justify billings for treatments never provided to patients. Some examples of the physician's billing practices included: billing for treatment of appendicitis in patients who previously had their appendixes removed; billing for office visits that never took place; and billing for laboratory tests that were not performed. The physician is currently under indictment.

An Arizona physician who practiced as a radiologist is under indictment for obtaining admission into the Medicare Screening Mammography Program by falsely stating that he was certified in radiology by the American Board of Radiology, which is specifically required of interpreting physicians before admitting them to the program. This is done to ensure that a physician meets the requisite conditions for certification such as the necessary experience, continuing education, and written reports requirements.

The physician was also indicted for certain billing practices involving a mobile CT (computerized tomography) scanning service. In addition to performing CT scans of patients, the physician ordered technicians to perform reconstructions of the CT images. He is accused of directing the billing clerk to bill for reconstructions on all CT scans even when he knew that in many cases no reconstruction was done by the technicians.

Over a two-year period, a Maryland physician's billing to Medicaid quadrupled, prompting an investigation. The physician was subsequently accused of double-dipping both Medicaid and the State Department of Social Services for giving physical examinations to disability applicants. Undercover investigators witnessed an office overflowing with drug addicts, disability papers in hand, being examined in four minute intervals. "Comprehensive" exams lasted no more than two to four minutes. Records showed that the physician sometimes saw upwards of 100 patients per day, even though he only spent six hours a day at his practice.

Patients were told to drop off disability forms one day and come back the next day to pick them up, and it was obvious that the forms were being completed before the patients even met with the physician. The physician was certifying "inability to work" without verifying or treating the complaints. He had a rubber stamp with the diagnosis "lumbar spine arthropathy" created to stamp all the "bad back" disabilities. By courting addicts and other potential disability recipients, the doctor built, in a very short time, a practice which billed Medicaid and the State Department of Social Services almost $450,000 a year for services that were so superficial as to be relatively useless. In 1993, the physician filled out more than 9,900 disability forms. Another physician who at one time was in the same practice acknowledged the false certifications, stating that "these people could work."

Unfortunately, the poor care rendered by the physician as a result of his assembly line approach resulted in horror stories of poor patients care—one patient suffered a weight loss of fifty pounds in three months and received no treatment. The physician falsified the blood pressure readings of patients suffering hypertension and these patients often went untreated even though this dangerous problem existed. The physician was eventually convicted of Medicaid fraud and given a suspended sentence.

Minority staff investigators found numerous cases involving kickbacks for sonograms, ultrasound, and other diagnostic imaging tests. For example, a New York radiologist allegedly stole more than $1 million from the New York State Medicaid program during a two-year period by fraudulently billing for thousands of ultrasound tests he never reviewed. His Medicaid claims jumped from $28,000 in one year to more than $1 million two years later. The radiologist allegedly made kickbacks of 75 percent of his billings to so-called "salesmen" who regularly arrived at his office toting shopping bags full of sonograms collected at Medicaid clinics throughout the city.

The physician has been charged with billing Medicaid for reading and interpreting over 11,000 patients' sonograms and echocardiograms, that, in fact, he never reviewed.

A New York podiatrist stole more than $200,000 from Medicaid by repeatedly billing for orthotics made from high-priced custom foot molds never provided to Medicaid patients. The podiatrist filed thousands of false reimbursement claims stating that Medicaid recipients had received expensive custom orthotics—foot molds reimbursable at $46 each—fabricated from actual foot castings when, in fact, the doctor had furnished patients with cheaper devices which should have been reimbursed at only $18 each.

This case is part of an ongoing statewide investigation into Medicaid abuse involving podiatrists, orthotic labs and orthopedic shoe vendors which has resulted in criminal charges against more than 200 individuals for stealing more than $30 million from the New York Medicaid program. To date, 185 convictions have resulted in more than $25 million in court-imposed fines and restitutions.

A Georgia chiropractor, his wife and 15 former patients, were ordered to pay a total of $3.2 million in fines after being convicted of Medicare and private insurer fraud. The couple recruited patients for their clinic by promising kickbacks of up to one third the amount that Medicare or the insurance companies reimbursed. Bills were submitted for patients and their families regardless of whether they had been treated. In one instance, bills were submitted for 169 patients supposedly treated in a single day.

A Utah physician operating a clinic was charged with 34 counts of mail fraud and seven counts of false claims. He had previously been convicted of filing false Medicaid claims in the 1980's. He was to be suspended from the program for a period of ten years.

Following his conviction, however, there was no change in his billing practices. He continued to bill private insurance companies and Medicare and Medicaid (in the names of employed physicians) in the same excessive manner. When he was 'flagged' by insurance companies, he would then set up dummy billing companies to disguise his identity on claim forms. He was recently indicted on, among other things, unbounding services, identifying false diagnoses on claim forms, duplicate billings, misrepresenting the level of service, and billing for services without the knowledge or consent of patients. A jury convicted him on 32 counts.

A Maryland physician-owned corporation was convicted of Medicaid fraud and ordered to pay $190,000 in restitution for submitting false invoices to Medicaid. The corporation sought payment for several different types of medical services, including office visits and laboratory tests, which had not been done and were not medically necessary. The corporation billed Medicaid repeatedly for unnecessary laboratory tests.

In one instance, a young boy was rushed to the physician's office with a lacerated chin. The boy's chin was sutured but, in addition to this procedure, Medicaid was billed for a throat culture, a nasal culture, a non-specific culture, and three hearing tests, despite the fact that there was no reason to perform these services and that the boy's mother stated that none of the tests billed to Medicaid were performed by the physician. The investigation also revealed that the corporation had not purchased sufficient laboratory supplies to have been able to perform the laboratory tests for which Medicaid was billed.

A Pennsylvania physician was convicted of illegal prescribing controlled substances. The physician, also known as "Dr. Xanax," prescribed prescriptions for non-legitimate medical purposes to abusers and dealers. It is estimated that he diverted in excess of 20,000 dosage units of controlled substances per month. He was convicted on 59 counts of illicit distribution of Valium, Adipex, Darvocet, and Vicodin.

A scheme in New York defrauded Medicaid by conducting unnecessary medical tests on drug addicts. The addicts, who were using multiple identities and Medicaid cards, were recruited from the street and given prescriptions for drugs they abused in exchange for participating in the tests.

The insurance billings generated from these tests were made possible by an agreement between the owners of the clinics and staff physicians. For the use of their provider numbers, the physicians received a 40 to 50 percent kickback for all accrued medical charges. Loss to the Medicare and Medicaid programs in this case is estimated at $10 million. Twenty-one individuals, including seven physicians, have been charged or have entered plea agreements. This was one of the first health care fraud investigations in which Racketeer Influence Corrupt Organizations (RICO) charges were levied. Money laundering violations served as the predicate offense for the RICO charge.

A New York physician who operated a methadone treatment center stole more than $1.5 million by fraudulently charging the state for over 25,000 methadone treatments never given to Medicaid recipients. In his illicit four-year billing scheme, the physician not only used the Medicaid numbers of patients who had not yet begun the program or had died, but brazenly appropriated the names and I.D. numbers of patients at a hospital with which he was affiliated who were neither in his care nor even on methadone.

The physician systematically filed thousands of false reimbursement claims stating that he had provided methadone maintenance treatment (reimbursable at almost $60 per week) to over 1,100 Medicaid recipients at his office.

In New York, nine persons involved in a conspiracy in which Medicaid was defrauded of more than $8 million in a little over a year were given prison sentences. The owner of several medical clinics was sentenced to five years imprisonment and five other doctors were sentenced to lesser terms. The doctors were hired by the clinics for the sole purpose of using their Medicaid provider numbers.

The physicians wrote prescriptions for drugs that have a high street value and that ended up being diverted. The scam included rounding up "patients" for the clinics who had valid Medicaid cards, drawing blood and taking blood pressures, and then billing Medicaid for extensive diagnostic tests. The "patients" were also directed to specific pharmacists who filled prescriptions and billed Medicaid for drugs which were then sold on the street.

G. Non-physician providers and professional patients

Pharmacists and pharmaceuticals.—The investigation has found that the diversion of prescription drugs continues to be a major criminal problem. The buying and selling of prescription drugs on the street poses enormous problems for law enforcement, already stretched to its limits, as well as adding immense costs to society by fueling an addicted population and facilitating illegal drug trafficking.

In one of the largest fraud cases ever in New Hampshire, a pharmacist stole almost $375,000 from the State's Medicaid program and private health insurance plans. Over a two-year period, the pharmacist systematically billed over one thousand times for prescription drugs that he did not actually dispense.

The pharmacist fabricated prescriptions to justify his billings. According to State officials, he used insurance information provided by his customers to submit false billings to their insurance companies and also double-billed Medicaid and private insurance for the same services.

This case illustrates how health care fraud can have devastating effects on insurance companies far beyond the actual losses. In addition to violating the trust and confidentiality of his customers, the acts of this pharmacist resulted in the loss of prescription drug benefits to many individuals: because the pharmacist's fraudulent activity caused a local company's health plan to insure high costs, the company was forced to drop its prescription drug converge for about 1500 workers. The loss of the drug card benefit to hundreds of employees is a striking example of how health care fraud victimizes not only insurers, but also employers, employees and their families alike.

In Michigan, several pharmacists obtained large quantities of sample and expired drugs and dispensed them to nursing home patients and pharmacy customers. Pharmacy technicians were instructed to remove sample drugs from their packages, scrape or rub off the word "sample" on the tablet, and place these drugs in the general stock for dispensing prescriptions. Expired drugs generally acquired from the purchase of other pharmacy inventories were handled in a similar manner. The samples and expired drugs were dispensed to nursing home patients and the Medicaid program was fraudulently billed.

Pharmacy technicians had received complaints from nursing home staff and patient relatives regarding the ineffectiveness of the medications delivered. According to testimony at trial, when the technicians confronted the pharmacy owner with these complaints the owner stated "those people are old, they'll never know the difference and they'll be dead soon anyway."

In Florida, a pharmacist was caught purchasing and selling diverted drugs that were samples provided to representatives of drug manufacturers. The pharmacist, the owner of a Broward County pharmacy, was accused of dispensing samples of Feldens, an arthritic drug, and Naprosyn, an anti-inflammatory drug, which had been adulterated by scraping off the mark "Sample" on the capsules. The pharmacist stated that he bought them for cash from a friend who delivered them in plastic bags on a weekly basis. This was in direct violation of the Prescription Drug Marketing Act which provides penalties for selling drug samples in order to ensure that the prescription drugs purchased by consumers are safe and effective.

A black market scheme in New York has allegedly defrauded the Medicaid program by illegally buying and selling costly prescription drugs, including the AIDS medication AZT. The drug diverters are accused of warehousing an inventory of drugs pending resale for cash to pharmacies and other diverters at greatly discounted prices. The medications had originally been dispensed to Medicaid recipients in New Jersey and Connecticut.

In this illicit underground economy, Medicaid recipients—often addicts who are seeking to abuse the system—visit unscrupulous doctors and obtain prescriptions for a laundry list of costly brand name drugs. They then either sell the prescriptions to accommodating druggists or have the prescription filled and peddle their goods to street buyers who, in turn, recycle them to other pharmacies.

New York official stated that this scam was particularly insidious because the ultimate users of the recycled goods—the public—could well be taking drugs that had lost their potency or had been improperly stored and handled. One of those arrested stated that the had just made a $40,000 deal with a New Jersey pharmacy for similar prescription drugs. This case was part of a broader investigation into a vast network of physicians, pharmacists and Medicaid recipients who are engaged in dealing drugs and prescriptions for cash on the black market.

An Illinois illegal narcotics distribution ring containing three ringleaders and a group of nineteen people was charged with diverting over 60,000 Dilaudid pills. According to the Drug Enforcement Administration, Dilaudid, a synthetic, morphine-like substance, is considered the most powerful prescription pain killer sold today.

The group diverted Dilaudid from legitimate channels by using professional patients who visited doctors on a daily basis. Some of the professional patients who were recruited had cancer. One ringleader collected the Dilaudid and then sold it to individuals who took it out of the State of resale. It costs approximately $.40 a tablet at the pharmacy counter, yet demands a street price of $20 to $80 a tablet depending on availability.

Home health care.—The aging of the population, the increasing preference for home and community-based long term care, and major advances in the development of outpatient technology has resulted in the explosive growth for the home care industry in the United States. Unfortunately, commensurate with the growth of this industry has been an increase in home care fraud. Our investigation has revealed that there are two major pockets where some abusive practices have become problematic: in the home health agencies and in home infusion companies (home infusion is an industry that provides intravenous drugs and nutritional therapy for patients who are receiving care at home).

Several patterns of fraud have emerged in home health agencies, such as billing for services not rendered, use of unlicensed or untrained staff, kickbacks to referring physicians, and falsified plans of care for patients. Home health care has tremendous potential to decrease costs of both acute and long-term care and to enhance patients' quality of life. It also, however, presents a disproportionate opportunity for abusive practices, hidden from medical professionals and overseers who cannot watch delivery of care at home.

The home infusion industry has been rocked with charges of kickbacks and overcharging. Some companies have allegedly charged patients fees at much as 2,000 percent higher than hospital charges. An examination by the HHS Inspector General has revealed three types of kickback schemes used by home infusion companies to defraud the federal government: direct payment of money to a physician for the referral of patients; stock bonuses based on the amount of referrals; and companies, through the use of recruiters, soliciting beneficiaries rather than doctors.

At the end of 1994, new legislation will prohibit Medicare payment for referrals by physicians to home infusion companies in which they have a financial interest. However, this payment prohibition only applies to physicians and will not correct the potential kickback violations with the referral of patients for IDPN, and infusion used for nutrition at the same time a patient is undergoing dialysis. The HHS IG has ongoing investigations in six regions targeting home infusion companies. In addition, it has a national case pending against one of the major home infusion companies in the nation. 1993 total revenues for home infusion therapy topped $4 billion.

The owners of a large New York home health care company stole more than $4.6 million from the New York State Medicaid program by systematically billing, over a three-year period, for services rendered by untrained and unqualified home care aides. The company was accused of grossly inflating, by as much as 30,000 hours, the amount of time these employees actually worked. The company recruited untrained employees who were often immediately assigned to care for homebound Medicaid recipients, assisting them with such personal chores as bathing, dressing and feeding, and other support functions.

This scheme not only cheated Medicaid out of millions of dollars, but it also recklessly sent untrained health care workers—including a 14 year-old girl to care for a 4-year-old child with Down's syndrome—into the homes of disabled and elderly residents. According to New York officials, home care has become the fastest-growing part of the New York Medicaid program—ballooning from $400 million to over $2 billion a year since 1986.

A vivid example of kickbacks for home care patient referrals involved a family in South Florida that established four companies to distribute liquid nutritional supplements, including a milk supplement, to Medicare beneficiaries. These nutritional supplements are reimbursable by Medicare if a physician signs a Certificate of Medical Necessity indicating that the supplement is appropriate for the patient. The companies hired recruiters to go into South Florida communities with heavy concentrations of elderly residents and other "free medical milk." The senior residents then were signed on as new patients, monthly deliveries of nutritional supplements were made and Medicare was billed for these services.

The recruiters had made arrangements with Miami-area physicians to certify the medical need for the supplement. The company made kickback payments of $100 to the recruiters for the "Certificate of Medical Necessity" obtained, and the recruiters, in turn, paid kickbacks to the physicians who had signed the certifications. In less than two years, the companies had billed Medicare for over $14 million.

None of the elderly residents interviewed by the FBI during the investigation was qualified for the nutritional supplement, which is currently reimbursed by Medicare at a rate of $600 per month per beneficiary. Twelve individuals, including several physicians were indicted.

A Ohio girl who suffered from cerebral palsy was able to live at home with the help of intravenous drugs and nutritional therapy. Bills generated from her treatments ranged from $95,000 to $120,000 a month. The family filed a lawsuit against the home infusion company alleging overcharging and poor quality of care. In less than a year, the family's two private insurance policies' limit of $1 million was used up. Comparisons showed that it cost close to $1,000 a day more to treat the little girl at home than it would have cost to treat her in a hospital. When the insurance lapsed, a court order was needed to compel the supplier to keep the supply of treatment items coming to the house. The girl's mother was eventually forced to quit her job in order to qualify for Medicaid, ironically to pay for the treatment which was supposed to save money compared to the more expensive inpatient hospital fees.

Medical billing services.—The investigation found that the administrative complexity of the current health system has spawned a growth industry of billing companies to file reimbursement claims to both private insurers and federal health care programs. A consequence of this complexity is that billing firms at times falsify claims information with elaborate fraudulent schemes.

The recent case of a California medical billing service illustrates how easy it is under the current health care system to be reimbursed for services which are never actually provided.

In August 1992, state and federal agents began an investigation into a sham medical billing service that was submitting claims to insurance companies nationwide for laboratory services. The owners of the billing service first gained entry to the system when they were previously employed by another billing service. Without the knowledge of their former employer or coworkers, the con artists photocopied and smuggled home hundreds of claim forms, doctors' billing numbers, and patients' medical information.

Armed with this information, the operators set up their own phony billing service, and submitted over $2.3 million in bogus claims for lab services that were never actually performed.

By the time federal investigators arrested the owners of this company, the operators had set up several "billing' services," under at least five separate names. Each of these bogus entities had its own billing address and false business licenses.

Committee staff is concerned that the scheme only came to light after subscribers began to notify their insurance companies that they had received Explanations of Benefits (EOB) for services they had never received or for services performed by a physician they did not even know. Since many subscribers never reviewed their EOB's, some insurance companies continued to pay claims without question. As complaints from subscribers began to mount, however, insurance company investigators began to notice a pattern of fraud, and realized that the companies had each been paid hundreds of thousands of dollars in fraudulent billings.

At the time of arrest, the sham billing company's owners had stolen over $1.5 million from insurance companies across the country, and had submitted additional false bills for a total of $2.3 million in bogus bills.

Ambulance and taxi services.—Medicaid-paid transportation services is an area ripe for abuse. For example, a common practice is routinely inflating the amounts billed to the program by overstating the miles travelled. There is also fierce competition among operators in these industries to obtain Medicaid business. In one Maryland operation, for example, an unscrupulous taxicab owner violently beat a competitor who was waiting outside a clinic looking for riders.

In New York, Medicaid pays for a patient's transportation to a medical provider either when mass transit is unavailable in the recipient's area or when the patient, because of a debilitating physical or mental condition, cannot use mass transit.

The owner of a New York taxi firm allegedly stole over $100,000 from the State by fraudulently billing for thousands of taxi rides never given to Medicaid patients. The president of the taxicab company was charged with filing more than 3,000 false reimbursement claims stating that his two taxi firms had provided over 300 Medicaid recipients with taxi service on days when, in fact, no transportation at all was provided.

This case is part of ongoing investigation of New York's medical transportation industry which, to date, has resulted in convictions against 66 individuals.

The owner of a Massachusetts taxi company was recently indicted on Medicaid provider fraud and state tax violations. He is accused of charging Medicaid for separate rides when two or more recipients shared the same taxi. State Medicaid regulations require that taxi firms split the fare when two or more share the ride. Employees of the company were also indicted for failing to file tax returns over a three-year period.

A Virginia Medicaid transportation service was convicted of a criminal violation of the federal False Claims Act. The owner of the company submitted claims to Medicaid with inflated mileage for transporting indigent patients to and from health care centers. The owner was sentenced to one year probation.

Professional patients.—Our investigation found that health care providers are not the sole abusers of the health care system. Conversely, our investigation found significant abuse by so-called "professional patients" who scam the system by providing their own medical histories, blood or lab samples as the basis for fraudulent claims. In some instances these patients are provided kickbacks or inducements by health care providers to participate in schemes, while in other instances the patients themselves are the originators of the scams.

The owner of a New York medical clinic was accused of submitting bills to Medicaid for medical services, blood analysis, drug prescriptions, and laboratory tests which were medically unnecessary. Physician assistants who worked at the clinic said that little medical treatment was actually administered at the clinic. A scheme was allegedly devised in which "patients" would routinely demand certain prescribed drugs, submit to a battery of unnecessary tests, and give blood in order to receive the drugs, which the "patients" would later sell on the street. The owner allegedly paid doctors and physicians assistants five dollars per blood sample as a kickback. He then billed New York Medicaid to pay for the analysis the clinic conducted on the blood samples.

A New York woman, who had four different aliases, was arrested on mail fraud charges for making false claims seeking reimbursement for medical treatment that was never actually rendered. Over a four-year period, the woman had submitted approximately 48 claims for direct reimbursement from her private insurance carrier. The carrier contacted the treating physicians named on the claims and learned that virtually all the claims were false. In one instance, she claimed that she was treated by a dermatologist on a date when he was actually on vacation.

IV. FINDINGS OF INVESTIGATION—DEFICIENCIES IN THE CURRENT SYSTEM IMPEDE LAW ENFORCEMENT'S ABILITY TO COMBAT HEALTH CARE FRAUD

While the cases included in this report represent only a small sample of fraud and abuse perpetrated against public and private health care programs, they serve to illustrate the vulnerability of our health care system. The investigation of these and other cases and our extensive review of current federal and state enforcement efforts lead us to conclude that major deficiencies exist in our defenses against health care fraud, allowing billions of dollars to be lost each year to fraud and abuse. We further conclude that as our health care system moves toward a managed care model, even greater opportunities for fraud will occur, exposing our health care system to even greater dollar losses.

A. Major patterns of fraud exist throughout the entire health care system and patterns of fraud within some provider groups have become particularly problematic

Our investigation concluded that vulnerabilities to fraud exist throughout the entire system, affecting federal, state, and private health care plans alike. Major patterns of abuse that continue to plague the health care system are overbilling, billing for services not rendered, unbundling and upcoding services to receive higher reimbursements, providing inferior products, paying kickbacks and inducements for referrals of patients, falsifying claims and medical records to receive excessive reimbursement or to fraudulently certify a patient's eligibility for Medicaid, Social Security disability, or state welfare programs.

While these practices exist throughout the health care system and are perpetrated against both public and private health plans, our investigation found that health care schemes used to victimize payers and patients have become more complex and frequently involve regional or national corporations and other organized entities. No part of the health care system is exempt from these fraudulent practices, however, our investigation raises concerns that major patterns of fraud and abuse have existed in the following health care sectors: ambulance and taxi services, clinical laboratories, durable medical equipment suppliers, home health care, nursing homes, physicians, psychiatric services, and rehabilitative services in nursing homes. Our investigation further concludes that fraud and abuse is particularly rampant in Medicaid, and that many of the fraudulent schemes that have preyed on the Medicare program in recent years are now targeting the Medicaid program for further abuse.

We are continuing to investigate specific fraudulent schemes, particularly with regard to Medicaid and Medicare fraud.

B. Greater opportunities for fraud will exist under health care reform

As our health care system moves toward a managed care model, opportunities for fraud and abuse will increase unless enforcement efforts and tools are strengthened. Our investigation concludes that the structure and incentives of a managed care system will result in a concentration of particular types of schemes, such as failure to provide services; quality of care deficiencies; falsification or misrepresentation of professional credentials by providers; subcontractor fraud; submission of false costa data to obtain higher capitation rates; fraudulent or deceptive enrollment practices by health plans; and kickbacks, rebates, and other illegal economic arrangements to increase market share of health care services.

The experiences of several states' Medicaid programs illustrate that managed care systems often provide greater incentives and opportunities for providers to engage in health care fraud.

For example, the Arizona Health Care Cost Containment System Fraud Unit has found that Arizona's Medicaid managed care-style program has been subject to embezzlement of funds paid by the state for client services; fraudulent subcontracts; wire and mail fraud; fraudulent related party transactions; and kickbacks among physicians, osteopaths, home health care facilities, DME suppliers, and physical therapists.

The AHCCCS Fraud Unit concluded that the managed care structure of the Arizona Medicaid program offered opportunities for kickbacks and other types of health care fraud. Similarly, many other states' Medicaid Fraud Control Units have found that states which require their Medicaid beneficiaries to participate in managed care programs have experienced significant incidences of fraud, such as fraudulent marketing techniques and falsification of enrollments of new members to plans, reduced quality of care, improper disenrollment practices, deceptive marketing practices to potential enrollees, and providing substandard care to enrollees in the managed care plans.

These state experiences with HMO's and managed care plans illustrate that comprehensive health care reform incorporating the principles of managed care will exacerbate the opportunities and incentives for providers to engage in fraud and abuse.

Moreover, two other key aspects of health care reform could affect enforcement efforts. First, while uniform, standard claims forms will go far in reducing the complexity of the health care system, these revised claims forms must be designed with enforcement in mind, so that factors can be built in to detect fraud and abuse more easily. Second, electronic billing systems, while again reducing complexity, will eliminate the paper trail that enables law enforcement to track fraudulent practices. Any such system must be designed with safeguards built in to detect and deter fraud and abuse.

C. Current criminal and civil statutes are inadequate to effectively sanction and deter health care fraud

Both the Department of Justice and the Department of Health and Human Services endorse strengthening the tools available to prosecute criminal and civil cases. Currently, Federal prosecutors use traditional fraud statutes, such as the mail and wire fraud statutes, the False Claims Act, false statement statutes, and money laundering statute to prosecute health care fraud.

Additional tools, such as penalties for false claims, anti-kickback statutes, and the authority to exclude providers from participation in Medicare and Medicaid, are now available to redress fraud and abuse in the Medicare and Medicaid programs.

Despite the availability of these criminal and civil remedies, our investigation has concluded that several deficiencies exist in the tools available to law enforcement to combat fraud and abuse most effectively in the health care system. For example: Inordinate time and resources are devoted to apply traditional fraud and money laundering statutes to health care fraud.

While many egregious cases of health care fraud have been successfully prosecuted under the mail and wire fraud statutes, because there is currently no specific federal health care fraud criminal statute available to federal prosecutors, excessive time and resources must be devoted to developing a nexus to the mail and wire fraud statutes in order to pursue clear cases of fraud. Similarly, extensive resources are spent trying to track the cash flow from health care fraud schemes in order to prosecute under federal money laundering statutes. Relying on these more generic federal criminal statutes for prosecution results in an inefficient use of scarce law enforcement resources.

The case of the bogus medical billing service in California which stole over $1.5 million from insurance companies nationwide before they were arrested by federal agents provides a prime example of how extensive resources are spent on proving a nexus to traditional fraud statutes: the FBI estimates that hundreds of additional investigative staff hours were devoted to proving the trail of expenditures in order to prove money laundering, because a federal health care fraud statute does not exist.

Creation of a new, general health care fraud offense prohibiting schemes to defraud federal or private health plans or persons in connection with the delivery of or payment for health care is necessary to provide a direct response to intentional acts to defraud the health care system.

In addition to providing a more efficient response to health care fraud, the establishment of a federal health care fraud offense sends an important message that health care fraud will be pursued with the same rigor as financial institution fraud, securities fraud, computer fraud, and other areas of white collar crime in which the federal government plays a prominent enforcement role. This type of provision is included in an amendment currently pending on the omnibus crime legislation, as well as in several comprehensive health care reform proposals.

D. Improvements are necessary in the current medicare and medicaid fraud statutes

Based on our investigation, we find that additional tools are necessary to curb abuse in the Medicare and Medicaid programs. For example, the current remedies for violations of the anti-kickback statute (for kickbacks made to induce the referral of Medicare and Medicaid business) are criminal prosecution and exclusion from the Medicare and Medicaid programs.

It is important to deter kickbacks in order to deter overutilization of health care services, inappropriate "steering" of Medicare or Medicaid patients to more expensive, unqualified, or poorly equipped providers, and giving an unfair advantage to providers who offer kickbacks. When only criminal prosecution and exclusion from participation in Medicare and Medicaid are available as remedies, however, federal law enforcement may be reluctant to impose such sanctions, consequently allowing the illegal activity to go unaddressed.

Therefore, we conclude that civil monetary penalties should also be available as intermediate sanctions for anti-kickback violations in order to ensure that enforcement actions are taken against anti-kickback violations.

Similarly, it is important to provide a range of sanctions for other fraudulent or abusive activities against the Medicare or Medicaid programs, such routine waivers of copayments (except in appropriate circumstances), and the practice of knowingly submitting claims for a higher reimbursement rate than allowed under Medicare (so-called "upcoding"). Providing a full array of enforcement tools against health care fraud will better enable swift, fair responses to health care abuse.

E. Due to flaws in enforcement efforts of private payers, billions of health care dollars are vulnerable to fraud and abuse

While the federal government has many authorities available to it to combat fraud and abuse in the Medicare and Medicaid programs, private sector payers are at a greater disadvantage in fighting health care fraud, because they have a more limited set of tools available in their enforcement arsenal.

For example: Generally, insurers do not have civil monetary penalties or false claims statutes available to them to sanction claims submitted for reimbursement, false advertising, or false statements made to private health plans.

Further, despite the fact that kickbacks are a common element of many health care frauds against private insurers and health plans, many states do not have adequate anti-kickback statutes in place.

Another major obstacle facing private health plans is the lack of information available on whether a health care provider has been sanctioned for fraud in other parts of the health care system, thus leaving the plans exposed to further fraud and abuse. When a provider has been excluded from participation in Medicare or Medicaid for defrauding the programs, for example, they continue to participate—and may continue fraudulent activities—in private health plans.

Finally, private payers generally have less authority to recover overpayments than is available under the Medicare or Medicaid programs.

In addition to these statutory obstacles facing private enforcement efforts, the sheer number of different payers in the current health care system—now numbering over 1,000—results in a multiplicity of different rules, reimbursement policies, claim forms, multiple identification numbers, coding systems, and billing procedures. The complexity of the current health care system allows fraud and abuse to flourish and go undetected, resulting in billions of health care dollars lost to fraud and abuse each year.

F. The fragmentation of current health care fraud enforcement encourages exploitation of the system by fraudulent providers

A multiplicity of Federal, State, and local enforcement agencies, as well as private health insurers and health plans, are involved in various aspects of the investigation or prosecution of health care fraud. Since fraudulent providers often infiltrate many different health care plans, it is crucial that law enforcement efforts be as coordinated as possible in order to detect emerging trends in health care fraud, fully shut down fraudulent schemes, and prevent them from recurring in other parts of the health care system.

Inadequate collaboration in combating health care fraud takes a particular toll on the ability of private sector insurers to reduce fraud, and results in higher premiums for all insured. The costs for an individual insurer to investigate fraud and abuse act as a substantial disincentive to investigate—instead, it is much simpler to increase the overall premiums to cover the losses from health care fraud.

Recently, major efforts have been undertaken to better coordinate federal and state agencies involved in combating health care fraud and abuse. For example, the Department of Justice and the HHS Inspector General have established an Executive Level Health Care Fraud Policy Group to identify new methods to proceed against health care fraud, identify priority areas for fraud enforcement, and remove bureaucratic obstacles to enforcement efforts. Similarly, the Inspectors General from federal agencies have begun to better coordinate their responses to health care fraud in programs within their jurisdictions.

Our investigation concluded that substantial progress has been made toward coordinating health care fraud enforcement, but that additional steps are necessary to streamline enforcement procedures, share information among public and private health care agencies, and ensure that health care fraud is reported and referred for appropriate enforcement actions.

V. Recommendations

Based on our investigation and findings, we recommend that several reforms be adopted to reduce fraud and abuse throughout the health care system. Specifically, we recommend the following:

1. Establish an all-payer fraud and abuse program to coordinate the functions of the Attorney General, Department of Health and Human Services, and other organizations to prevent, detect, and control fraud and abuse, and to coordinate investigations, and share data and resources with federal, state, and local law enforcement and health plans.

2. Establish an all-payer fraud and abuse trust fund to finance enforcement efforts. Establishing a "revolving fund" to finance enforcement efforts would go far in addressing the current resource problems that plague federal health care fraud enforcement efforts. Fines, penalties, assessments, and forfeitures collected from health care fraud offenders would be deposited in this fund, which would in turn be used to fund additional investigations, audits, and prosecutions. Amounts in this fund would increase, not supplant, the operating budgets of federal law enforcement agencies with jurisdiction over health care fraud.

3. Toughen federal criminal laws and enforcement tools for intentional health care fraud. Specifically, create a federal health care fraud offense; provide criminal forfeiture and civil injunctive relief for health care fraud offenses; establish hear care fraud as a predicate to the Racketeer Influenced Corrupt Organizations Act (RICO); and expand the civil False Claims Act to cover claims to health plans.

4. Improve the anti-kickback statute and extend prohibitions of Medicare and Medicaid to private payers. Specifically, expand current Medicare and Medicaid anti-kickback statute to private payers and to all federal health care programs; provide civil monetary penalties for anti-kickback violations; and provide injunctive relief for anti-kickback violations.

5. Provide a greater range of enforcement remedies to private sector health plans, such as civil penalties.

6. Establish a national health care fraud data base that includes information on final adverse actions taken against health care providers. Such a data base should contain strong safeguards in order to ensure the confidentiality and accuracy of information contained in this system.

7. Design a simplified, uniform claims form for reimbursement and an electronic billing system, with tough anti-fraud controls incorporated into these designs from their inception.

8. Take several steps to better protect Medicare from fraudulent provider billing practices, such as:

Revise and strengthen national standards that suppliers and other providers must meet in order to obtain or renew a Medicare provider number;

Prohibit Medicare from issuing more than one provider billing number to an individual or entity (except in specified circumstances), in order to prevent providers from "jumping" from one billing number to another in order to double-bill or avoid detection by auditors;

Require Medicare to establish more uniform national coverage and utilization policies for what is reimbursed under Medicare, so that providers cannot "forum shop" in order to seek out the Medicare carrier who will pay a higher reimbursement rate;

Require the Health Care Financing Administration to review and revise its billing codes for supplies, equipment and services in order to update, clarify, and standardize billing codes. HCFA should be required to improve the descriptions used for reimbursement codes so that they accurately reflect the items being furnished and to make them sufficiently explicit to distinguish between items of varying quality and price. Such an updating of the billing codes used by HCFA would be a major step toward eliminating excessive reimbursements for poor quality items and Medicare reimbursement that far exceed a fair price for the item; and

Provide adequate guidance to health care providers on how to comply with anti-kickback and other health care fraud prohibitions. We recognize that due to the complexity of the health care market, many providers have difficulty interpreting reimbursement policies of public and private health plans, as well as difficulty in determining whether specific relationships with other providers or billing practices are prohibited under anti-fraud provisions. If comprehensive health care reform proposals are enacted, further confusion over what constitutes prohibited activity may result. Therefore, we recommend that the Secretary of HHS, working with the HHS Inspector General and the Department of Justice, develop a system to provide better guidance to health care providers on how to comply with anti-kickback and other health care fraud provisions.

Many of these recommendations are included in health care reform proposals now pending before Senate and House committees. Additionally, the Senate-passed version of omnibus crime legislation, now pending in conference, includes provisions to facilitate criminal prosecution of health care fraud.

While we are pleased that many of these proposals are now under consideration by the Congress, we are deeply concerned that the huge magnitude of health care fraud and the critical importance of improving enforcement efforts immediately has not received adequate attention during the course of the health care reform debate.

With over $275 million being lost each day to health care fraud and abuse, we can no longer afford to wait to toughen our defenses against unscrupulous providers and others who are bleeding our health care system. Accordingly, we recommend a two-step process;

First, action should be taken immediately to strengthen criminal laws and enforcement tools to stop abuses of our current health care system. Too many dollars and lives are at stake to delay what can and should be done now to reduce health care fraud; and

Second, tough anti-fraud and abuse provisions must be built into the foundation of any health care reform plan enacted by the Congress so that unscrupulous providers will not take advantage of health care reform to further game the system.

ADDITIONAL COSPONSORS

S. 922

At the request of Ms. MOSELEY-BRAUN, the names of the Senator from California [Mrs. FEINSTEIN] and the Senator from Colorado [Mr. BROWN] were added as cosponsors of S. 922, a bill to provide that a State court may not modify an order of another State court requiring the payment of child support unless the recipient of child support payments resides in the State in which the modification is sought or consents to the seeking of the modification in that court.

S. 1288

At the request of Mr. AKAKA, the name of the Senator from South Carolina [Mr. THURMOND] was added as a cosponsor of S. 1288, a bill to provide for the coordination and implementation of a national aquaculture policy for the private sector by the Secretary of Agriculture, to establish an aquaculture commercialization research program, and for other purposes.

S. 2060

At the request of Mr. BUMPERS, the names of the Senator from South Dakota [Mr. PRESSLER], the Senator from Georgia [Mr. NUNN], the Senator from Michigan [Mr. LEVIN], the Senator from Iowa [Mr. HARKIN], the Senator from Massachusetts [Mr. KERRY], the Senator from Connecticut [Mr. LIEBERMAN], the Senator from Minnesota [Mr. WELLSTONE], the Senator from Alabama [Mr. HEFLIN], the Senator from Illinois [Ms. MOSELEY-BRAUN], and the Senator from Rhode Island [Mr. CHAFEE] were added as cosponsors of S. 2060, a bill to amend the Small Business Act.

S. 2134

At the request of Mr. FAIRCLOTH, the name of the Senator from Florida [Mr. MACK] was added as a cosponsor of S. 2134, a bill to restore the American family, reduce illegitimacy, and reduce welfare dependence.

S. 2286

At the request of Mr. LUGAR, the names of the Senator from Wyoming [Mr. WALLOP], the Senator from Kansas [Mr. DOLE], and the Senator from Wyoming [Mr. SIMPSON] were added as cosponsors of S. 2286, a bill to amend title 23, United States Code, to provide for the use of certain highway funds for improvements to railway-highway crossings.

S. 2294

At the request of Mr. HATFIELD, the name of the Senator from Mississippi [Mr. COCHRAN] was added as a cosponsor of S. 2294, a bill to amend the Public Health Service Act to provide for the expansion and coordination of research concerning Parkinson's disease and related disorders, and to improve care and assistance for its victims and their family caregivers, and for other purposes.

S. 2305

At the request of Mr. AKAKA, the name of the Senator from Vermont [Mr. JEFFORDS] was added as a cosponsor of S. 2305, a bill to provide that members of the Board of Veterans' Appeals be referred to as veterans law judges, to provide for the pay of such members, and for other purposes.

S. 2335

At the request of Mr. BROWN, the name of the Senator from Mississippi [Mr. LOTT] was added as a cosponsor of S. 2335, a bill to amend the Balanced Budget and Emergency Deficit Control Act of 1985 to require that OMB and CBO estimates for paygo purposes to recognize the increased revenues generated by economic growth resulting from legislation implementing any trade agreement.

SENATE JOINT RESOLUTION 169

At the request of Mr. WARNER, the names of the Senator from Wyoming [Mr. SIMPSON], the Senator from Tennessee [Mr. SASSER], the Senator from Nevada [Mr. BRYAN], the Senator from New York [Mr. D'AMATO], the Senator from Montana [Mr. BURNS], the Senator from Maryland [Ms. MIKULSKI], the Senator from New Jersey [Mr. LAUTENBERG], the Senator from West Virginia [Mr. BYRD], and the Senator from Virginia [Mr. ROBB] were added as cosponsors of Senate Joint Resolution 169, a joint resolution to designate July 27 of each year as "National Korean War Veterans Armistice Day".

SENATE JOINT RESOLUTION 192

At the request of Mr. KOHL, the name of the Senator from South Dakota [Mr. DASCHLE] was added as a cosponsor of Senate Joint Resolution 192, a joint resolution to designate October 1994 as "Crime Prevention Month."

SENATE JOINT RESOLUTION 209

At the request of Mr. COCHRAN, the names of the Senator from Montana [Mr. BAUCUS], and the Senator from Minnesota [Mr. WELLSTONE] were added as cosponsors of Senate Joint Resolution 209, a joint resolution designating November 21, 1994, as "National Military Families Recognition Day."

SENATE CONCURRENT RESOLUTION 60

At the request of Mr. DOLE, the name of the Senator from Alaska [Mr. STEVENS] was added as a cosponsor of Senate Concurrent Resolution 60, a concurrent resolution expressing the sense of the Congress that a postage stamp should be issued to honor the 100th anniversary of the Jewish War Veterans of the United States of America.

SENATE CONCURRENT RESOLUTION 64

At the request of Mrs. MURRAY, the name of the Senator from Connecticut [Mr. DODD] was added as a cosponsor of Senate Concurrent Resolution 64, a concurrent resolution expressing the sense of the Congress regarding the Guatemalan peace process and the need for greater protection of human rights in Guatemala.

AMENDMENT NO. 1887

At the request of Mr. BAUCUS the names of the Senator from Ohio [Mr. METZENBAUM] and the Senator from Wisconsin [Mr. KOHL] were added as cosponsors of Amendment No. 1887 intended to be proposed to S. 687, a bill to regulate interstate commerce by providing for a uniform product liability law, and for other purposes.

AMENDMENT NO. 2380

At the request of Mr. FEINGOLD his name was added as a cosponsor of Amendment No. 2380 proposed to H.R. 4603, a bill making appropriations for the Departments of Commerce, Justice, and State, the Judiciary, and related agencies programs for the fiscal year ending September 30, 1995, and making supplemental appropriations for these departments and agencies for the fiscal year ending September 30, 1994, and for other purposes.

AMENDMENT NO. 2479

At the request of Mr. JEFFORDS his name was added as a cosponsor of Amendment No. 2479 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

AMENDMENT NO. 2500

At the request of Mr. STEVENS the names of the Senator from Texas [Mrs. HUTCHISON] and the Senator from Arizona [Mr. DECONCINI] were added as cosponsors of Amendment No. 2500 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

AMENDMENT NO. 2515

At the request of Mr. DOLE the name of the Senator from Delaware [Mr. ROTH] was added as a cosponsor of Amendment No. 2515 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

At the request of Mr. MCCAIN the name of the Senator from Virginia [Mr. WARNER] was added as a cosponsor of Amendment No. 2515 proposed to H.R. 4650, supra.

At the request of Mr. SMITH his name was added as a cosponsor of Amendment No. 2515 proposed to H.R. 4650, supra.

At the request of Mr. DOMENICI his name was added as a cosponsor of Amendment No. 2515 proposed to H.R. 4650, supra.

AMENDMENT NO. 2518

At the request of Mr. MCCAIN the names of the Senator from New Mexico [Mr. DOMENICI] and the Senator from New Hampshire [Mr. SMITH] were added as cosponsors of Amendment No. 2518 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

AMENDMENT NO. 2520

At the request of Mr. THURMOND the names of the Senator from Alaska [Mr. MURKOWSKI], and the Senator from Wyoming [Mr. SIMPSON] were added as cosponsors of Amendment No. 2520 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

AMENDMENT NO. 2521

At the request of Mr. STEVENS the name of the Senator from New Jersey [Mr. LAUTENBERG] was added as a cosponsor of Amendment No. 2521 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

AMENDMENT NO. 2524

At the request of Mr. NUNN the names of the Senator from Virginia [Mr. WARNER], the Senator from Kansas [Mrs. KASSEBAUM], and the Senator from Florida [Mr. GRAHAM] were added as cosponsors of Amendment No. 2524 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

AMENDMENT NO. 2525

At the request of Mr. HARKIN the names of the Senator from Vermont [Mr. JEFFORDS], the Senator from Arizona [Mr. DECONCINI], the Senator from South Dakota [Mr. DASCHLE], and the Senator from Wisconsin [Mr. KOHL] were added as cosponsors of Amendment No. 2525 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

AMENDMENT NO. 2530

At the request of Mr. BINGAMAN the names of the Senator from Pennsylvania [Mr. WOFFORD] and the Senator from Rhode Island [Mr. PELL] were added as cosponsors of Amendment No. 2530 proposed to H.R. 4650, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

AMENDMENTS SUBMITTED

TRANSFER OF THE OLD U.S. MINT ACT

MCCAIN (AND BOXER) AMENDMENT NO. 2551

Mr. GORTON (for Mr. MCCAIN for himself and Mrs. BOXER) proposed an amendment to the bill (H.R. 4812) to direct the Administrator of General Services to acquire by transfer the Old U.S. Mint in San Francisco, California, and for other purposes; as follows:

Add at the end of the bill the following new section:

SEC. 2. REPAIRS OF OLD U.S. MINT, SAN FRANCISCO.

(a) IN GENERAL.—Nothing in this Act shall be construed to force the General Services Administration to repair the Old U.S. Mint building prior to repairs to other Federal buildings in greater need of repair.

HAZARDOUS MATERIALS TRANSPORTATION AUTHORIZATION ACT OF 1993

EXON AMENDMENT NO. 2552

Mr. FORD (for Mr. EXON) proposed an amendment to the bill (S. 1640) to amend the Hazardous Materials Transportation Act to authorize appropriations to carry out that act, and for other purposes; as follows:

Strike all after the enacting clause and insert the following:

TITLE I—HAZARDOUS MATERIALS TRANSPORTATION ACT AMENDMENTS

SEC. 101. SHORT TITLE.

This title may be cited as the "Hazardous Materials Transportation Authorization Act of 1994".

SEC. 102. AMENDMENT OF TITLE 49, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 49, United States Code.

SEC. 103. AUTHORIZATION OF APPROPRIATIONS.

Section 5127(a) (relating to authorization of appropriations) is amended by striking out "the fiscal year ending September 30, 1993," and inserting "fiscal year 1993, $18,000,000 for fiscal year 1994, $18,540,000 for fiscal year 1995, $19,100,000 for fiscal year 1996, and $19,670,000 for fiscal year 1997".

SEC. 104. EXEMPTIONS FROM REQUIREMENT TO FILE REGISTRATION STATEMENT.

Section 5108(a) (relating to persons required to file) is amended by adding at the end the following new paragraph:

"(4) The Secretary may waive the filing of a registration statement, or the payment of a fee, required under this subsection, or both, for any person not domiciled in the United States who solely offers hazardous materials for transportation to the United States from a place outside the United States if the country of which such person is a domiciliary does not require persons domiciled in the United States who solely offer hazardous materials for transportation to the foreign country from places in the United States to file registration statements, or to pay fees, for making such an offer.".

SEC. 105. PLANNING GRANTS FOR INDIAN TRIBES.

(a) AUTHORITY TO MAKE GRANTS.—Section 5116(a)(1) (relating to planning grants) is amended—

(1) by inserting "and Indian tribes" after "States" the first place it appears; and

(2) by striking "in a State and between States" and inserting "on lands under the jurisdiction of a State or Indian tribe, and between lands under the jurisdiction of a State or Indian tribe and lands of another State or Indian tribe".

(b) MAINTENANCE OF EFFORT.—Section 5116(a)92) (relating to planning grants) is amended—

(1) by inserting "or Indian tribe" after "State" the first and third places it appears;

(2) by striking "the State" the second place it appears;

(3) by inserting "the State or Indian tribe" before "certifies"; and

(4) by inserting "the State" before "agrees".

(c) COORDINATION OF PLANNING.—Section 5116(a) (relating to planning grants in general) is amended by adding at the end the following new paragraph:

"(3) A State or Indian tribe receiving a grant under this subsection shall ensure that planning under the grant is coordinated with emergency planning conducted by adjacent States and Indian tribes.".

SEC. 106. TRAINING CRITERIA FOR SAFE HANDLING AND TRANSPORTATION.

Section 5107(d) (relating to coordination of training requirements) is amended—

(1) by inserting "or duplicate" after "conflict with"; and

(2) by striking "hazardous waste operations and" and inserting "hazard communication, and hazardous waste operations, and".

SEC. 107. DISCLOSURE OF FEES LEVIED BY STATES, POLITICAL SUBDIVISIONS, AND INDIAN TRIBES.

Section 5125(g) (relating to fees) is amended—

(1) by inserting "(1)" after "(g) FEES.—"; and

(2) by adding at the end the following:

"(2) A State or political subdivision thereof or Indian tribe that levies a fee in connection with the transportation of hazardous materials shall, upon the Secretary's request, report to the Secretary on—

"(A) the basis on which the fee is levied upon persons involved in such transportation;

"(B) the purposes for which the revenues from the fee are used;

"(C) the annual total amount of the revenues collected from the fee; and

"(D) such other matters as the Secretary requests.".

SEC. 108. ANNUAL REPORT.

Section 5121(e) (relating to annual report) is amended—

(1) by striking "Annual" in the subsection heading, and

(2) by striking the first sentence and inserting the following: "The Secretary shall, once every 2 years, prepare and submit to the President for transmittal to the Congress a comprehensive report on the transportation of hazardous materials during the preceding 2 calendar years.".

SEC. 109. INTELLIGENT VEHICLE-HIGHWAY SYSTEMS.

(A) IN GENERAL.—In implementing the Intelligent Vehicle-Highway Systems Act of 1991 (23 U.S.C. 307 note), the Secretary of Transportation shall ensure that the National Intelligent Vehicle-Highway Systems Program addresses, in a comprehensive and coordinated manner, the use of intelligent vehicle-highway systems technologies to promote hazardous materials transportation safety. The Secretary of Transportation shall ensure that 2 or more operational tests funded under such Act shall promote such safety and advance technology for providing information to persons who provide emergency response to hazardous materials transportation incidents.

(b) GRANTS FOR CERTAIN EMERGENCY RESPONSE INFORMATION TECHNOLOGIES.—

(1) In carrying out one of the operational tests under subsection (a), the Secretary of Transportation may make grants to one or more persons, including a State or local government or department, agency, or instrumentality thereof, to demonstrate the feasibility of establishing and operating computerized telecommunications emergency response information technologies that are used—

(A) to identify the contents of shipments of hazardous materials transported by motor carriers;

(B) to permit retrieval of data on shipments of hazardous materials transported by motor carriers;

(C) to link systems that identify, store, and allow the retrieval of data for emergency response to incidents and accidents involving transportation of hazardous materials by motor carrier; and

(D) to provide information to facilitate responses to accidents and incidents involving hazardous materials shipments by motor carriers either directly or through linkage with other systems.

(2) Any project carried out with a grant under this subsection must involve two or more motor carriers of property. One of the motor carriers selected to participate in the project must be a carrier that transports mostly hazardous materials. The other motor carrier selected must be a regular-route common carrier that specializes in transporting less-than-truckload shipments. The motor carriers selected may be engaged in multimodal movements of hazardous materials with other motor carriers, rail carriers, or water carriers.

(3) To the maximum extent practicable, the Secretary of Transportation shall coordinate a project under this subsection with any existing Federal, State, and local government projects and private projects which are similar to the project under this subsection. The Secretary may require that a project under this subsection be carried out in conjunction with such similar Federal, State, and local government projects and private projects.

SEC. 110. RAIL TANK CAR SAFETY.

Not later than 1 year after the date of enactment of this Act, the Secretary of Transportation shall issue final regulations under the following:

(1) The rulemaking proceeding under Docket HM-175A entitled "Crashworthiness Protection Requirements for Tank Cars".

(2) The rulemaking proceeding under Docket HM-201 entitled "Detection and Repair of Cracks, Pits, Corrosion, Lining Flaws, Thermal Protection Flaws and Other Defects of Tank Car Tanks".

SEC. 111. SAFE PLACEMENT OF TRAIN CARS.

The Secretary of Transportation shall conduct a study of existing practices regarding the placement of cars on trains, with particular attention to the placement of cars that carry hazardous materials. In conducting the study, the Secretary shall consider whether such placement practices increase the risk of derailment, hazardous materials spills, or tank ruptures or have any other adverse effect on safety. The results of the study shall be submitted to Congress within 1 year after the date of enactment of this Act.

SEC. 112. GRADE CROSSING SAFETY.

The Secretary of Transportation shall, within 6 months after the date of enactment of this Act, amend regulations—

(1) under chapter 51 of title 49, United States Code, (relating to transportation of hazardous materials) to prohibit the driver of a motor vehicle transporting hazardous materials in commerce, and

(2) under chapter 315 of such title (relating to motor carrier safety) to prohibit the driver of any commercial motor vehicle,

from driving the motor vehicle onto a highway-rail grade crossing without having sufficient space to drive completely through the crossing without stopping.

SEC. 113. DRIVER'S RECORD OF DUTY STATUS.

(a) IN GENERAL.—

(1) The Secretary of Transportation shall prescribe regulations amending part 395 of title 49, Code of Federal Regulations, to improve—

(A) compliance by commercial motor vehicle drivers and motor carriers with hours of service requirements; and

(B) the effectiveness and efficiency of Federal and State enforcement officers reviewing such compliance.

(2) Such regulations shall be proposed not later than 12 months after the date of enactment of this Act and shall be issued and become effective not later than 18 months after such date of enactment. In prescribing the regulations, the Secretary of Transportation shall ensure that compliance can be achieved at a cost that is reasonable to drivers and motor carriers.

(b) CONTENTS OF REGULATIONS.—Such regulations shall include the following:

(1) A description of identification items (which include either driver name or vehicle number) that shall be part of a written or electronic document to enable such written or electronic document to be used by a motor carrier or by an enforcement officer as a supporting document to verify the accuracy of a driver's record of duty status.

(2) A provision specifying the number, type, and frequency of supporting documents that must be retained by a motor carrier so as to allow verification of the accuracy of such documents at a reasonable cost, to the driver and the motor carrier, of record acquisition and retention.

(3) A provision specifying the period during which supporting documents shall be retained by the motor carrier. The period shall be at least 6 months from the date of a document's receipt.

(4) A provision to authorize, on a case-by-case basis, motor carrier self-compliance systems that ensure driver compliance with hours of service requirements and allow Federal and State enforcement officers the opportunity to conduct independent audits of such systems to validate compliance with section 395.8(k) of title 49, Code of Federal Regulations (or successor regulations thereto). Such authorization may also be provided by the Secretary to a group of motor carriers that meet specific conditions that may be established by regulation by the Secretary and that are subject to audit by Federal and State enforcement officers.

(5) A provision to allow a waiver, on a case-by-case basis, of certain requirements of section 395.8(k) of title 49, Code of Federal Regulations (or successor regulations thereto), when sufficient supporting documentation is provided directly and at a satisfactory frequency to enforcement personnel by an intelligent vehicle-highway system, as defined by section 6059 of the Intelligent Vehicle-Highway Systems Act of 1991 (23 U.S.C. 307 note). Such waiver may also be allowed for a group of motor carriers that meet specific conditions that may be established by regulation by the Secretary.

(c) SUPPORTING DOCUMENT DEFINED.—For purposes of this section, a supporting document is any document that is generated or received by a motor carrier or commercial motor vehicle driver in the normal course of business that could be used, as produced or with additional identifying information, to verify the accuracy of a driver's record of duty status.

SEC. 114. SAFETY PERFORMANCE HISTORY OF NEW DRIVERS.

(a) AMENDMENT OF REGULATIONS.—Within 18 months after the date of enactment of this Act, the Secretary of Transportation shall amend section 391.23 of title 49, Code of Federal Regulations (or successor regulations thereto), to—

(1) specify the safety information that must be sought under that section by a motor carrier with respect to a driver;

(2) require that such information be requested from former employers and that former employers furnish the requested information within 30 days after receiving the request; and

(3) ensure that the driver to whom such information applies has a reasonable opportunity to review and comment on the information.

(b) SAFETY INFORMATION.—The safety information required to be specified under subsection (a)(1) shall include information on—

(1) any motor vehicle accidents in which the driver was involved during the preceding 3 years;

(2) any failure of the driver, during the preceding 3 years, to undertake or complete a rehabilitation program under section 31302 of title 49, United States Code, (relating to limitation on the number of driver's licenses) after being found to have used, in violation of law or Federal regulation, alcohol or a controlled substance;

(3) any use by the driver, during the preceding 3 years, in violation of law or Federal regulation, of alcohol or a controlled substance subsequent to completing such a rehabilitation program; and

(4) any other matters determined by the Secretary of Transportation to be appropriate and useful for determining the driver's safety performance.

(c) FORMER EMPLOYER.—For purposes of this section, a former employer is any person who employed the driver in the preceding 3 years.

SEC. 115. RETENTION OF SHIPPING PAPERS.

Section 5110 (relating to shipping papers and disclosure) is amended by adding at the end the following new subsection;

"(e) RETENTION OF PAPERS.—After the hazardous material to which a shipping paper provided to a carrier under subsection (a) applies is no longer in transportation, the person who provided the shipping paper and the carrier required to maintain it under subsection (a) shall retain the paper or electronic image thereof for a period of 1 year to be accessible through their respective principal places of business. Such person and carrier shall, upon request, make the shipping paper available to a Federal, State, or local government agency at reasonable times and locations.".

SEC. 116. TOLL FREE NUMBER FOR REPORTING.

The Secretary of Transportation shall designate a toll free telephone number for transporters of hazardous materials and other individuals to report to the Secretary possible violations of chapter 51 of title 49, United States Code, or any order or regulation issued under that chapter.

SEC. 117. TECHNICAL CORRECTIONS.

(a) AMENDMENTS RELATING TO PACKAGING.—

(1) Sections 5102(3)(C)(ii) and 5102(4)(A)(iii) are each amended by striking "packages" and inserting "packagings".

(2) Sections 5103(b)(1)(A)(iii), 5121(c)(1)(A), 5125(b)(1)(E), and 5126(a) are each amended by striking "a package or" and inserting "a packaging or a".

(3) Section 5108(a)(1)(D) is amended—

(A) by striking "a bulk package" and inserting in lieu thereof "a bulk packaging"; and

(B) by striking "the package" and inserting "the bulk packaging".

(b) OTHER.—Section 5104(a)(1) is amended by striking "or package" each place it appears and inserting ", package, or packaging (or a component of a container, package, or packaging)".

SEC. 118. HOURS OF SERVICE RULEMAKING FOR FARMERS AND RETAIL FARM SUPPLIERS.

Not later than 3 months after the date of enactment of this Act the Secretary of Transportation shall initiate a rulemaking proceeding to determine whether or not the requirements of section 395.3 of title 49 Code of Federal Regulations, relating to hours of service, may be waived for farmers and retail farm suppliers when such farmers and retail farm suppliers are transporting crops or farm supplies for agricultural purposes within a 50-mile radius of their distribution point or farm.

SEC. 119. TRAINING.

(a) SUPPLEMENTAL PUBLIC SECTOR TRAINING GRANTS.—Section 5116 (relating to planning and training grants, monitoring, and review) is amended by adding at the end the following new subsections:

"(j) SUPPLEMENTAL TRAINING GRANTS.—

"(1) In order to further the purposes of subsection (b), the Secretary shall, subject to the availability of funds, make grants to national nonprofit employee organizations engaged solely in fighting fires for the purpose of training instructors to conduct hazardous materials response training programs for individuals with statutory responsibility to respond to hazardous materials accidents and incidents.

"(2) For the purposes of this subsection the Secretary, after consultation with interested organizations, shall—

"(A) identify regions or locations in which fire departments or other organizations which provide emergency response to hazardous materials transportation accidents and incidents are in need of hazardous materials training; and

"(B) prioritize such needs and develop a means for identifying additional specific training needs.

"(3) Funds granted to an organization under this subsection shall only be used—

"(A) to train instructors to conduct hazardous materials response training programs;

"(B) to purchase training equipment used exclusively to train instructors to conduct such training programs; and

"(C) to disseminate such information and materials as are necessary for the conduct of such training programs.

"(4) The Secretary may only make a grant to an organization under this subsection in a fiscal year if the organization enters into an agreement with the Secretary to train instructors to conduct hazardous materials response training programs in such fiscal year that will use—

"(A) a course or courses developed or identified under subsection)/(g); or

"(B) other courses which the Secretary determines are consistent with the objectives of this subsection;

for training individuals with statutory responsibility to respond to accidents and incidents involving hazardous materials. Such agreement also shall provide that training courses shall be open to all such individuals on a nondiscriminatory basis.

"(5) The Secretary may impose such additional terms and conditions on grants to be made under this subsection as the Secretary determines are necessary to protect the interests of the United States and to carry out the objectives of this subsection.

"(k) REPORTS.—Not later than September 30, 1997, the Secretary shall submit to Congress a report on the allocation and uses of training grants authorized under subsection (b) for fiscal year 1993 through fiscal year 1996 and grants authorized under subsection (j) and section 5107 for fiscal years 1995 and 1996. Such report shall identify the ultimate recipients of training grants and include a detailed accounting of all grant expenditures by grant recipients, the number of persons trained under the grant programs, and an evaluation of the efficacy of training programs carried out".

(b) FUNDING.—Section 5127(b) (relating to appropriations for hazmat employee training) is amended—

(1) by inserting "(1)" after "TRAINING.—", and

(2) by adding at the end the following:

"(2)(A) There shall be available to the Secretary for carrying out section 5116(j), from amounts in the account established pursuant to 5116(i), $250,000 for each of fiscal years 1995, 1996, 1997, and 1998:

"(B) In addition to amounts made available under subparagraph (A), there is authorized to be appropriated to the Secretary for carrying out section 5116(j) $1,000,000 for each of the fiscal years 1995, 1996, 1997, and 1998.".

(c) HAZMAT EMPLOYEE TRAINING PROGRAM.—

(1) The first sentence of section 5107(e) (relating to hazmat employee training requirements and grants) is amended to read as follows: "The Secretary shall, subject to the availability of funds under section 5127(c)(3),

make grants for training instructors to train hazmat employees under this section.".

(2) The second sentence of such section is amended by inserting "hazmat employee' after "nonprofit".

(3) Section 5107 (relating to hazmat employee training requirements and grants) is amended by adding at the end thereof the following new subsection:

"(g) EXISTING EFFORT.—No grant under subsection (e) shall supplant or replace existing employer-provided hazardous materials training efforts or obligations.".

(4) Section 5127(b) (relating to hazmat employee training funding is) amended to read as follows:

"(b) TRAINING OF HAZMAT EMPLOYEE INSTRUCTORS.—There is authorized to be appropriated to the Secretary $3,000,000 for each of fiscal years 1995, 1996, 1997, and 1998 to carry out section 5107(e).".

(d) CONFORMING AMENDMENTS.—

(1) Section 5108(g)(2)(A)(viii) is amended by striking "5107(e),".

(2) Section 5116(i)(1) is amended by striking "and section 5107(e)".

(3) Section 5116(i)(3) is amended by striking "and section 5107(e)".

SEC. 120. TIME FOR SECRETARIAL ACTION.

(a) EXEMPTIONS.—Section 5117 (relating to exemptions and exclusions) is amended—

(1) by redesignating subsections (c) and (d) as (d) and (e) respectively, and

(2) by inserting after subsection (b) the following:

"(c) APPLICATIONS TO BE DEALT WITH PROMPTLY.—The Secretary shall issue or renew the exemption for which an application was filed or deny such issuance or renewal within 180 days after the first day of the month following the date of the filing of such application, or the Secretary shall publish a statement in the Federal Register of the reason why the Secretary's decision on the exemption is delayed, along with an estimate of the additional time necessary before the decision is made.".

(b) DECISIONS ON PREEMPTION.—Section 5125(d) (relating to decisions on preemption) is amended by inserting immediately after the second sentence the following: "The Secretary shall issue a decision on an application for a determination within 180 days after the date of the publication of the notice of having received such application, or the Secretary shall publish a statement in the Federal Register of the reason why the Secretary's decision on the application is delayed, along with an estimate of the additional time necessary before the decision is made.".

SEC. 121. STUDY OF HAZARDOUS MATERIALS TRANSPORTATION BY MOTOR CARRIERS NEAR FEDERAL PRISONS.

(a) STUDY.—The Secretary of Transportation shall conduct a study to determine the safety considerations of transporting hazardous materials by motor carriers in close proximity to Federal prisons, particularly those housing maximum security prisoners. Such study shall include an evaluation of the ability of such facilities and the designated local planning agencies to safely evacuate such prisoners in the event of an emergency and any special training, equipment, or personnel that would be required by such facility and the designated local emergency planning agencies to carry out such evacuation. Such study shall not apply to or address issues concerning rail transportation of hazardous materials.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Transportation shall transmit to Congress a report on the results of the study conducted under this section, along with the Secretary's recommendations for any legislative or regulatory changes to enhance the safety regarding the transportation of hazardous materials by motor carriers near Federal prisons.

SEC. 122. USE OF FIBER DRUM PACKAGING.

(a) INITIATION OF RULEMAKING PROCEEDING.—Not later than the 60th day following the date of enactment of this Act, the Secretary of Transportation shall initiate a rulemaking proceeding to determine whether the requirements of section 5103(b) of title 49, United States Code, (relating to regulations for safe transportation) as they pertain to open head fiber drum packaging can be met for the domestic transportation of liquid hazardous materials (with respect to those classifications of liquid hazardous materials transported by such drums pursuant to regulations in effect on September 30, 1991) with standards other than the performance-oriented packaging standards adopted under docket number HM–181 contained in part 178 of title 49, Code of Federal Regulations.

(b) ISSUANCE OF STANDARDS.—If the Secretary of Transportation determines, as a result of the rulemaking proceeding initiated under subsection (a), that a packaging standard other than the performance-oriented packaging standards referred to in subsection (a) will provide an equal or greater level of safety for the domestic transportation of liquid hazardous materials than would be provided if such performance-oriented packaging standards were in effect, the Secretary shall issue regulations which implement such other standard and which take effect before October 1, 1996.

(c) COMPLETION OF RULEMAKING PROCEEDING.—The rulemaking proceeding initiated under subsection (a) shall be completed before October 1, 1995.

(d) LIMITATIONS.—

(1) The provisions of subsections (a), (b), and (c) shall not apply to packaging for those hazardous materials regulated by the Department of Transportation as poisonous by inhalation under chapter 51 of title 49, United States Code.

(2) Nothing in this section shall be construed to prohibit the Secretary of Transportation from issuing or enforcing regulations for the international transportation of hazardous materials.

SEC. 123. BUY AMERICA.

(a) COMPLIANCE WITH BUY AMERICAN ACT.—None of the funds made available under this title may be expended in violation of sections 2 through 4 of the Act of March 3, 1933 (41 U.S.C. 10a–10c; popularly known as the "Buy American Act"), which are applicable to those funds.

(b) SENSE OF CONGRESS; REQUIREMENT REGARDING NOTICE.—

(1) In the case of any equipment or products that may be authorized to be purchased with financial assistance provided under this title, it is the sense of Congress that entities receiving such assistance should, in expending such assistance, purchase only American-made equipment and products.

(2) In providing financial assistance under this title, the Secretary of Transportation shall provide to each recipient of the assistance a notice describing the statement made in paragraph (1) by Congress.

(c) PROHIBITION OF CONTRACTS.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a "Made in America" inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to this title, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

(d) RECIPROCITY.—

(1) Except as provided in paragraph (2), no contract or subcontract may be made with funds authorized under this title to a company organized under the laws of a foreign country unless the Secretary of Transportation finds that such country affords comparable opportunities to companies organized under laws of the United States.

(2)(A) Secretary of Transportation may waive the provisions of paragraph (1) if the products or services required are not reasonably available from companies organized under the laws of the United States. Any such waiver shall be reported to Congress.

(B) Paragraph (1) shall not apply to the extent that to do so would violate the General Agreement on Tariffs and Trade or any other international agreement to which the United States is a party.

TITLE II—TRUCKING INDUSTRY REGULATORY REFORM

SEC. 201. SHORT TITLE.

This title may by cited as the "Trucking Industry Regulatory Reform Act of 1994".

SEC. 202. AMENDMENT OF TITLE 49, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 49, United States Code.

SEC. 203. PURPOSE.

The purpose of this title is to enhance competition, safety, and efficiency in the motor carrier industry and to enhance efficiency in government.

SEC. 204. TRANSPORTATION POLICY.

Section 10101(a)(2) (relating to transportation policy) is amended—

(1) by redesignating subparagraphs (A) through (I) as subparagraphs (C) through (K), respectively, and

(2) by inserting before subparagraph (C) (as so redesignated) the following: "(A) encourage fair competition, and reasonable rates for transportation by motor carriers of property; (B) promote Federal regulatory efficiency in the motor carrier transportation system and to require fair and expeditious regulatory decisions when regulation is required;".

SEC. 205. EXEMPTIONS.

(a) IN GENERAL.—Section 10505 (relating to authority to exempt rail carrier transportation) is amended—

(1) by inserting ", or a motor carrier providing transportation of property other than household goods, or in non-contiguous domestic trade," after "rail carrier providing transportation" in subsection (a),

(2) by inserting "section 10101 or" before "section 10101a" in subsection (a)(1) and subsection (d),

(3) by inserting ", or a motor carrier providing transportation of property other than household goods, or in non-contiguous domestic trade," after "rail carrier" in subsection (f), and

(4) by striking out "or" in subsection (g), and inserting after "subtitle" the following: ", (3) to relieve a motor carrier of property or other person from the application or enforcement of the provisions of sections 10706,

10761, 10762, 10927, and 11707 of this title, or (4) to exempt a motor carrier of property from the application of, and compliance with, any law, rule, regulation, standard, or order pertaining to cargo loss and damage; insurance; antitrust immunity for joint line rates and routes, classification of commodities (including uniform packaging rules), uniform bills of lading, or standardized mileage guides; or safety fitness."

(b) DEFINITION.—Section 10102 (relating to definitions) is amended by redesignating paragraphs (18) through (31) as (19) through (32), respectively, and by inserting after paragraph (17) the following:

"(18) 'non-contiguous domestic trade' means motor-water transportation subject to the jurisdiction of the Commission under chapter 105 of this title involving traffic originating in or destined to Alaska, Hawaii, or a territory or possession of the United States.".

(c) CLERICAL AMENDMENTS.—

(1) The caption of section 10505 is amended by inserting "and motor carrier" after "rail carrier".

(2) The chapter analysis for chapter 105 is amended by inserting "and motor carrier" after "rail carrier" in the item relating to section 10505.

SEC. 206. TARIFF FILING.

(a) AUTHORITY TO ESTABLISH RATES.—Section 10702(b) (relating to authority for carriers to establish rates, classifications, rules, and practices) is amended by inserting ", except a motor contract carrier of property," after "A contract carrier".

(b) PROHIBITION OF TRANSPORTATION WITHOUT TARIFF.—Section 10761(a) (relating to transportation prohibited without tariff) is amended—

(1) by inserting "(excluding a motor common carrier providing transportation of property, other than household goods, under an individually determined rate, classification, rule, or practice, as defined in section 10102(13) or in noncontiguous domestic trade)" after "chapter 105 of this title", and

(2) by striking out "That carrier" in the second sentence and inserting "A carrier subject to this subsection",

"(3) by inserting before the period at the end of the first sentence the following: ", except that a motor carrier of property the application of whose rates is determined or governed by a tariff on file with the Commission cannot collect its rates unless the carrier is a participant in those tariffs", and

"(4) by inserting before the period at the end of the second sentence the following: ", except that a motor carrier of property the application of whose rates are determined or governed by a tariff on file with the Commission shall issue a power of attorney to the tariff publishing agent of such tariff and, upon its acceptance, the agent shall issue a notice to the participating carrier certifying its continuing participation in such tariff, which certification shall be kept open for public inspection".

(c) GENERAL TARIFF REQUIREMENT.—Section 10762(a) (relating to general tariff requirement) is amended—

(1) by inserting "(excluding a motor common carrier providing transportation of property, other than household goods, under an individually determined rate, classification, rule, or practice, as defined in section 10102(13), or in noncontiguous domestic trade)" after "A motor common carrier" in the second sentence of paragraph (1),

(2) by inserting "(excluding a motor common carrier providing transportation of property, other than household goods, under an individually determined rate, classification, rule, or practice, as defined in section 10102(13), or in noncontiguous domestic trade)" after "carriers" in the third sentence of paragraph (1),

(3) by striking the last sentence of paragraph (1) and inserting the following: "A motor contract carrier of property is not required to publish or file actual or minimum rates under this subtitle. Except as provided in the Negotiated Rates Act of 1993 and the amendments made by that Act, nothing in the Trucking Industry Regulatory Reform Act of 1994 (and the amendments made by that Act) creates any obligation for a shipper based solely on a rate that was on file with the Commission or elsewhere on the date of enactment of such Act.", and

(4) by adding at the end the following:

"(3) A motor common carrier of property (other than a motor common carrier providing transportation of household goods or in noncontiguous domestic trade) shall provide to the shipper, on request of the shipper, a written or electronic copy of the rate, classification, rules, and practices, upon which any rate agreed to between the shipper and carrier may have been based. When the applicability or reasonableness of the rates and related provisions billed by a motor common carrier is challenged by the person paying the freight charges, the Commission shall determine whether such rates and provisions are reasonable or applicable based on the record before it. In those cases where a motor common carrier (other than a motor common carrier providing transportation of household goods or in noncontiguous domestic trade) seeks to collect charges in addition to those billed and collected which are contested by the payor, the carrier may request that the Commission determine whether any additional charges over those billed and collected must be paid. A carrier must issue any bill for charges in addition to those originally billed within 180 days of the original bill in order to have the right to collect such charges.

"(4) If a shipper seeks to contest the charges originally billed, the shipper may request that the Commission determine whether the charges originally billed must be paid. A shipper must contest the original bill within 180 days in order to have the right to contest such charges.

"(5) Any tariff on file with the Commission on the date of enactment of the Trucking Industry Regulatory Reform Act of 1994 not required to be filed with the Commission after the enactment of that Act is null and void beginning on that date.".

(d) PROPOSED RATE CHANGES.—

(1) COMMON CARRIERS.—Section 10762(c)(1) (relating to proposed rate changes) is amended by inserting "(excluding a motor common carrier providing transportation of property other than household goods, under an individually determined rate, classification, rule, or practice defined in section 10102(13), or in a noncontiguous domestic trade)" after "common carrier".

(2) CONTRACT CARRIERS.—Section 10762(c)(2) (relating to proposed rate changes) is amended by inserting "(except a motor contract carrier of property)" after "contract carrier".

(e) EFFECT ON NEGOTIATED RATES ACT.—Section 10762 (relating to general tariff requirements) is amended by adding at the end thereof the following new subsection:

"(j) Nothing in this section shall affect the application of the provisions of the Negotiated Rates Act of 1993 (or the amendments made by that Act) to undercharge claims for transportation provided prior to the date of enactment of the Trucking Industry Regulatory Reform Act of 1994.".

(f) DEFINITION.—Section 10102 (relating to definitions) is amended—

(1) by redesignating paragraphs (13) through (31) as (14) through (32), and

(2) by inserting after paragraph (12) the following:

"(13) 'individually determined rate, classification, rule, or practice' means a rate, classification, rule, or practice established by—

"(A) a single motor common carrier for application to transportation that it can provide over its line; or

"(B) 2 or more interlining carriers without participation in an organization established or continued under an agreement approved under section 10706(b) for application to transportation that the interlining carriers can provide jointly over their lines.".

SEC. 207. MOTOR COMMON CARRIER LICENSING.

(a) IN GENERAL.—Section 10922 (relating to certification of motor and water carriers) is amended—

(1) by redesignating subsections (b) through (l) as (c) through (m), respectively, and by inserting after subsection (a) the following new subsection:

"(b)(1) Except as provided in this section, the Commission shall issue a certificate to a person authorizing that person to provide transportation subject to the jurisdiction of the Commission under subchapter II of chapter 105 of this title as a motor common carrier of property if the Commission finds that the person is able to comply with—

"(A) this subtitle, the regulations of the Commission, and any safety requirements imposed by the Commission,

"(B) the safety fitness requirements established by the Secretary of Transportation in consultation with the Commission under section 31144 of this title, and

"(C) the minimum financial responsibility requirements established by the Commission pursuant to section 10927 of this title.

"(2) In making a finding under paragraph (1), the Commission shall consider and, to the extent applicable, make findings on, any evidence demonstrating that the applicant is unable to comply with the requirements of subparagraph (A), (B), or (C) of that paragraph.

"(3) The Commission shall find any applicant for authority to operate as a motor carrier under this section to be unfit if the applicant does not meet the safety and safety fitness requirements under paragraph (1)(A) of (1)(B) of this subsection and shall deny the application.

"(4) A person may protest an application under this subsection to provide transportation only on the ground that the applicant fails or will fail to comply with this subtitle, the regulations of the Commission, the safety requirements of the Commission, or the safety fitness or minimum financial responsibility requirements of paragraph (1) of this subsection.".

(b) PUBLIC CONVENIENCE AND NECESSITY.—Section 10922(c) (relating to public convenience and necessity) as redesignated by subsection (a), is amended—

(1) by striking "carrier of property" in paragraph (1) and inserting "carrier of household goods",

(2) by striking paragraphs (4) and (6) and redesignating paragraphs (5), (7), (8), and (9) as (4), (5), (6), and (7), respectively,

(3) by striking "carrier holding authority under paragraph (4)(D) of this subsection" in paragraph (4) (as redesignated) and inserting "motor carrier providing transportation of

shipments weighing 100 pounds or less transported in a motor vehicle in which no one package exceeds 100 pounds'',

(4) by striking ''of property'' in paragraph (5) (as redesignated) and inserting ''of household goods'',

(5) by striking ''of property'' in paragraph (6) (as redesignated) and inserting ''of household goods'', and

(6) by striking ''Notwithstanding the provisions of paragraph (4) of this subsection, the provisions'' in paragraph (7) (as redesignated) and inserting ''The provisions''.

(c) Certificate Specifications.—Section 10922(f)(1) (relating to specifications for certificate), as redesignated by subsection (a) of this section, is amended by inserting ''of household goods or passengers'' after ''motor common carrier''.

(d) Public Convenience and Necessity.—Section 10922(h)(1) (relating to public convenience and necessity), as redesignated by subsection (a) of this section, is amended by inserting ''of household goods or passengers'' after ''motor common carrier''.

SEC. 208. MOTOR CONTRACT CARRIER LICENSING.

(a) Authority to Issue Permits.—Section 10923(a) (relating to authority to issue permits) is amended by inserting ''of household goods or passengers'' after ''motor contract carrier''.

(b) Motor Contract Carrier Permits.—Section 10923 (relating to permits of motor and water contract carriers and household goods freight forwarders) is amended by redesignating subsections (b) through (e) as (c) through (f), respectively, and by inserting after subsection (a) the following new subsection:

''(b)(1) Except as provided in this section and section 10930 of this title, the Commission shall issue a permit to a person authorizing the person to provide transportation subject to the jurisdiction of the Commission under subchapter II of chapter 105 of this title as a motor contract carrier of property other than household goods if the Commission finds that the person is able to comply with—

''(A) this subtitle, the regulations of the Commission, and any safety requirements imposed by the Commission,

''(B) the safety fitness requirements established by the Secretary of Transportation in consultation with the Commission pursuant to section 3144 of this title, and

''(C) the minimum financial responsibility requirements established by the Commission pursuant to section 10927 of this title.

''(2) In deciding whether to approve the application of a person for a permit as a motor contract carrier of property other than household goods the Commission shall consider any evidence demonstrating that the applicant is unable to comply with this subtitle, the regulations of the Commission, safety requirements of the Commission, or the safety fitness and minimum financial responsibility requirements of subsection (b)(1).

''(3) The Commission shall find any applicant for authority to operate as a motor carrier of property other than household goods under this subsection to be unfit if the applicant does not meet the safety and safety fitness requirements of paragraph (1)(A) or (1)(B) of this subsection and shall deny the application.

''(4) A person may protest an application under this subsection to provide transportation only on the ground that the applicant fails to comply with this subtitle, the regulations of the Commission, safety requirements of the Commission, or the safety fitness or minimum financial responsibility requirements of paragraph (1).''.

(c) Application Filing Requirements.—Section 10923(c) (relating to application filing requirements), as redesignated by subsection (b) of this section, is amended—

(1) by striking ''motor contract carrier of property'' in paragraphs (3) and (4) and inserting ''motor contract carrier of household goods'',

(2) by striking paragraph (5) and redesignating paragraphs (6) and (7) as (5) and (6), respectively, and

(3) by striking ''motor contract carriers of property'' in paragraph (5) (as redesignated) and inserting ''motor contract carriers of household goods''.

(d) Conditions of Transportation or Service.—Section 10923(e) (relating to conditions of transportation or service), as redesignated by subsection (b) of this section, is amended—

(1) by inserting ''of passengers or household goods'' after ''contract carrier'' in paragraph (1), and

(2) by striking ''each person or class of persons (and, in the case of a motor contract carrier of passengers, the number of persons)'' in paragraph (2) and inserting ''in the case of a motor contract carrier of passengers, the number of persons,''.

SEC. 209. REVOCATION OF MOTOR CARRIER AUTHORITY.

Section 10925(d)(1) (relating to effective period of certificates, permits, and licenses) is amended—

(1) by striking ''if a motor carrier or broker'' in subparagraph (A) and inserting ''if a motor carrier of passengers, motor common carrier of household goods, or broker'',

(2) by striking ''and'' at the end of subparagraph (A),

(3) by redesignating subparagraph (B) as (D) and inserting after subparagraph (A) the following new subparagraphs:

''(B) if a motor contract carrier of property, for failure to comply with safety requirements of the Commission or the safety fitness requirements pursuant to section 10701, 10924(e), 10927(b) or (d), or 31144, of this title;

''(C) if a motor common carrier of property other than household goods, for failure to comply with safety requirements of the Commission or the safety fitness requirements pursuant to section 10701, 10702, 10924(e), 10927(b) or (d), or 31144 of this title; and''.

SEC. 210. STUDY OF INTERSTATE COMMERCE COMMISSION FUNCTIONS.

(a) Interstate Commerce Commission Report.—The Interstate Commerce Commission shall prepare and submit to the Secretary of Transportation and to each Committee of the Congress having jurisdiction over legislation affecting the Commission a report identifying and analyzing all regulatory responsibilities of the Commission. The Commission shall make recommendations concerning specific statutory and regulatory functions of the Commission that could be eliminated or restructured. The Commission shall submit the report within 60 days after the date of enactment of this Act.

(b) Secretary of Transportation Study.—The Secretary of Transportation shall study the feasibility and efficiency of merging the Interstate Commerce Commission into the Department of Transportation as an independent agency, combining it with other federal agencies, retaining the Interstate Commerce Commission in its present form, eliminating the agency and transferring all or some of its functions to the Department of Transportation or other federal agencies, and other organizational changes that lead to government, transportation, or public interest efficiencies. The study shall consider the cost savings that might be achieved, the efficient allocation of resources, the elimination of unnecessary functions, and responsibility for regulatory functions. The Secretary shall solicit comments from the public with respect to both the Department's and the Commission's findings. The Secretary shall submit the results of such study together with any recommendations to the Congress within 4 months after the date of the submission of the Interstate Commerce Commission report required in subsection (a).

SEC. 211. LIMITATION ON STATE REGULATION OF INTRASTATE TRANSPORTATION OF PASSENGERS BY BUS.

(a) In General.—Chapter 109 (relating to licensing) is amended by adding at the end thereof the following new section:

''§ 10936. Limitation on State regulation of intrastate passengers by bus

''A State or political subdivision of a State may not enforce any law or regulation relating to intrastate fares for the transportation of passengers by bus by an interstate motor carrier of passengers over a route authorized by the Commission.''.

(b) Conforming Amendments.—

(1) Section 10521(b)(1) is amended by inserting ''10936,'' after ''10935.''

(2) Section 11501 is amended by striking subsection (e) and redesignating subsections (f) and (g) as (e) and (f), respectively.

(3) The table of sections for subchapter IV of chapter 109 is amended by adding at the end the following new item:

''10936. Limitation on State regulation of intrastate passengers by bus.''.

SEC. 212. EFFECTIVE DATE.

This title and the amendments made by this title shall take effect upon the enactment of this Act, except for sections 207 and 208, which shall take effect on January 1, 1995.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. FORD. Mr. President, I ask unanimous consent that the committee on Armed Services be authorized to meet at 2:00 p.m. on Thursday, August 11, 1994, in open session, to receive testimony on the Military Implications of the Chemical Weapons Convention [CWC].

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. FORD. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Thursday, August 11, 1994, at 10:00 a.m. for an executive session to consider pending matters before the committee.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. FORD. Mr. President, I ask unanimous consent that the Committee on

Commerce, Science, and Transportation be authorized to meet on Thursday, August 11, 1994, at 2:00 p.m. for an oversight hearing on the activities of the U.S. Olympic Committee.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. FORD. Mr. President, I ask unanimous consent that the Full Committee on Environment and Public Works be authorized to meet during the session of the Senate on Thursday, August 11, beginning at 2:00 p.m., to conduct a hearing on the reauthorization of programs under the jurisdiction of the Economic Development Administration.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. FORD. Mr. President, I ask unanimous consent that the Committee on Foreign Relations, be authorized to meet during the session of the Senate on Thursday, August 11, at 10:00 a.m. to hold a hearing on the current status of the Law of the Sea Convention.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. FORD. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to hold a business meeting during the session of the Senate on Thursday, August 11, 1994.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. FORD. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on Thursday, August 11, 1994, at 2:00 p.m., in room 226, Senate Dirksen Office Building, on the nominations of Michael Hawkins to be U.S. circuit judge for the Ninth Circuit, Napoleon Jones to the U.S. district judge for the southern district of California, John O'Meara to be U.S. district judge for the eastern district of Michigan, Barrington Parker, Jr. to be U.S. district judge for the southern district of New York and Robert Timlin to be U.S. district judge for the central district of California.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON TECHNOLOGY AND THE LAW

Mr. FORD. Mr. President, I ask unanimous consent that the Senate Subcommittee on Technology and Law of the Committee on the Judiciary and the House Subcommittee on Civil and Constitutional Rights of the Committee on the Judiciary, be authorized to meet during the session of the Senate on Thursday, August 11, 1994 at 1:00 p.m. to hold a hearing on Digital Telephony and Law Enforcement Access to Advanced Telecommunications Technologies and Services.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

PKK ATTACKS ON CIVILIANS MUST STOP

• Mr. DECONCINI. Mr. President, I wish to express my anger and frustration over recent killings of innocent civilians by members of the Kurdish Workers Party [PKK]. Yesterday, 12 innocent civilians, including women and children, were machine gunned by PKK guerrillas while riding a bus. This, and similar attacks, only propel forward the senseless cycle of violence responsible now for over 12,500 lives and widespread destruction and dislocation throughout southeast Turkey. I fail to see how the killing of innocent men, women and children serves the interests of anyone who professes to want human rights and democracy.

Mr. President, violence certainly begets violence and murder can never become an acceptable means of achieving political objectives. Mao Tse Tung believed that political power emanated from the barrel of a gun, but Mr. President, in the 21st century, political power will be built on words and the free flow of information. The force of ideas is ultimately more powerful than the force of arms. So, just as I have called upon the Government of Turkey to peacefully and democratically redress the grievances of its Kurdish citizens, so too must the PKK abandon its armed struggle. I cannot understand how PKK leaders expect their calls for political solutions to the Kurdish problem to be taken seriously as long as the PKK slaughters civilians. To the contrary, their terrorist tactics only besmirch the legitimate efforts of Kurdish leaders who are genuinely seeking a peaceful political solution.

Mr. President, the human rights situation in Turkey is not getting any better. A virtual state of civil war exists in southeast Turkey. Kurdish villages burn and tens of thousands are made refugees. Human rights and pro-Kurdish activists are regularly murdered or disappear. A relentless campaign against free speech is silencing parliamentarians, journalists and other and stifling informed public debate. Mr. President, amidst the haze of war and propaganda emanating from all sides, the truth is becoming increasingly difficult to discern.

Mr. President, for the sake of human rights and the future of democracy in Turkey, I urge Turkish and Kurdish combatants to consider an immediate ceasefire. Their military debate must end and a political debate be allowed to begin. Only after the violence and terror has ceased can the process of bringing peace and prosperity to all of Turkey's citizens commence.•

RECESS UNTIL TOMORROW AT 9:30 A.M.

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 9:30 a.m.

Thereupon, the Senate, at 9:48 p.m., recessed until Friday, August 12, 1994, at 9:30 a.m.

CONFIRMATION

Executive nomination confirmed by the Senate August 11, 1994:

FEDERAL RESERVE SYSTEM

JANET L. YELLEN, OF CALIFORNIA, TO BE A MEMBER OF THE BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM FOR A TERM OF 14 YEARS FROM FEBRUARY 1, 1994.

THE ABOVE NOMINATION WAS APPROVED SUBJECT TO THE NOMINEE'S COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

HOUSE OF REPRESENTATIVES—*Thursday, August 11, 1994*

The House met at 11 a.m.

Rev. Msgr. Roger C. Roensch, director of pilgrimage, Basilica of the National Shrine of the Immaculate Conception, Washington, DC, offered the following prayer:

The opening prayer for today is taken from one recited daily at the Basilica of the National Shrine of the Immaculate Conception:

Heavenly Father, we adore Your majesty and acknowledge Your supreme eternal dominion and authority. We put our Nation into Your hands.

Thank You for the great resources of this land and for the freedom which has been its heritage. May those who have gone before us bless this land and grant us peace.

Have mercy on our President and on all the officers of our Government. Grant us a fruitful economy born of justice and charity. Have mercy on capital and industry and labor. Protect the family life of the Nation. Guard the innocence of our children. Have mercy on the sick, the poor, and all those in need.

Keep our Nation strong and a leader sharing with all the world the principles of our Founding Fathers. We pray that we may always act according to Your will and live and die pleasing to God. Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

Mr. TRAFICANT. Mr. Speaker, pursuant to clause 1, rule I, I demand a vote on agreeing to the Speaker's approval of the Journal.

The SPEAKER. The question is on the Chair's approval of the Journal.

The question was taken; and the Speaker announced that the noes appeared to have it.

Mr. TRAFICANT. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 251, nays 160, answered "present" 1, not voting 22, as follows:

[Roll No. 391]

YEAS—251

Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Baesler
Barca
Barcia
Barlow
Barrett (WI)
Bateman
Becerra
Beilenson
Berman
Bevill
Bilbray
Bishop
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Byrne
Cantwell
Cardin
Carr
Clayton
Clement
Clinger
Clyburn
Coleman
Collins (GA)
Collins (IL)
Collins (MI)
Combest
Condit
Conyers
Cooper
Coppersmith
Costello
Coyne
Cramer
Danner
de la Garza
Deal
DeLauro
Dellums
Derrick
Deutsch
Dicks
Dooley
Durbin
Edwards (CA)
Edwards (TX)
Engel
English
Eshoo
Evans
Everett
Farr
Fazio
Fields (LA)
Filner
Fingerhut
Fish
Foglietta
Ford (MI)
Ford (TN)
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Gillmor
Gilman
Glickman
Gonzalez
Gordon
Green
Greenwood
Gutierrez
Hall (TX)
Hamburg
Hamilton
Harman
Hayes
Hefner
Hilliard
Hinchey
Hoagland
Hochbrueckner
Holden
Houghton
Hoyer
Hughes
Hutto
Inglis
Inslee
Jefferson
Johnson (GA)
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kasich
Kennedy
Kennelly
Kildee
Kleczka
Klein
Klink
Kopetski
Kreidler
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lehman
Levin
Lewis (GA)
Lipinski
Lloyd
Long
Lowey
Maloney
Mann
Manton
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCloskey
McCurdy
McHale
McKinney
McNulty
Meehan
Meek
Menendez
Mfume
Miller (CA)
Mineta
Minge
Mink
Moakley
Mollohan
Montgomery
Moran
Murtha
Myers
Nadler
Neal (MA)
Neal (NC)
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Parker
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Peterson (MN)
Pickett
Pickle
Pombo
Pomeroy
Poshard
Price (NC)
Rahall
Rangel
Reed
Reynolds
Richardson
Roemer
Rose
Rostenkowski
Rowland
Roybal-Allard
Sabo
Sanders
Sarpalius
Sawyer
Schenk
Schumer
Serrano
Sharp
Shepherd
Sisisky
Skaggs
Skelton
Slattery
Slaughter
Smith (IA)
Smith (NJ)
Spratt
Stark
Stenholm
Stokes
Strickland
Studds
Stupak
Swett
Swift
Synar
Tanner
Tauzin
Tejeda
Thompson
Thornton
Thurman
Torres
Torricelli
Towns
Traficant
Tucker
Unsoeld
Valentine
Velazquez
Vento
Visclosky
Volkmer
Waters
Watt
Waxman
Wheat
Whitten
Williams
Wilson
Wise
Woolsey
Wyden
Wynn
Yates

NAYS—160

Allard
Archer
Armey
Bachus (AL)
Baker (CA)
Baker (LA)
Ballenger
Barrett (NE)
Bartlett
Barton
Bentley
Bereuter
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bunning
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Clay
Coble
Cox
Crane
Crapo
Cunningham
DeLay
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
Ewing
Fawell
Fields (TX)
Fowler
Franks (CT)
Franks (NJ)
Gallegly
Gekas
Gilchrest
Gingrich
Goodlatte
Goodling
Goss
Grams
Gunderson
Hancock
Hastert
Hefley
Herger
Hobson
Hoekstra
Hoke
Horn
Huffington
Hunter
Hutchinson
Hyde
Inhofe
Istook
Jacobs
Johnson (CT)
Johnson, Sam
Kim
King
Klug
Knollenberg
Kolbe
Kyl
Lazio
Leach
Levy
Lewis (CA)
Lewis (FL)
Lewis (KY)
Lightfoot
Linder
Livingston
Lucas
Machtley
Manzullo
McCandless
McCollum
McCrery
McDade
McHugh
McInnis
McKeon
McMillan
Mica
Michel
Miller (FL)
Molinari
Moorhead
Morella
Murphy
Nussle
Oxley
Packard
Paxon
Petri
Porter
Portman
Pryce (OH)
Quillen
Quinn
Ramstad
Ravenel
Regula
Ridge
Roberts
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Royce
Santorum
Saxton
Schaefer
Schroeder
Scott
Sensenbrenner
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (OR)
Smith (TX)
Snowe
Solomon
Spence
Stearns
Stump
Sundquist
Talent
Taylor (MS)
Thomas (CA)
Thomas (WY)
Torkildsen
Upton
Vucanovich
Walker
Walsh
Weldon
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

ANSWERED "PRESENT"—1

Dixon

NOT VOTING—22

Abercrombie
Blackwell
Chapman
Darden
DeFazio
Diaz-Balart
Dingell
Dornan
Flake
Gallo
Grandy
Hall (OH)
Hansen
Hastings
Kingston
McDermott
Meyers
Rush
Sangmeister
Schiff
Taylor (NC)
Washington

☐ 1123

So the Journal was approved.

The result of the vote was announced as above recorded.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore (Mr. MONTGOMERY). Will the gentleman

☐ This symbol represents the time of day during the House proceedings, e.g., ☐ 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

from New York [Mr. QUINN] come forward and lead the House in the Pledge of Allegiance.

Mr. QUINN led the Pledge of Allegiance as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Hallen, one of its clerks, announced that the Senate had passed without amendment joint resolutions and a concurrent resolution of the House of the following titles:

> H.J. Res. 131. Joint resolution, designating December 7 of each year as "National Pearl Harbor Remembrance day";
>
> H.J. Res. 175. Joint resolution designating October 1993 and October 1994 as "Italian-American Heritage and Culture Month"; and
>
> H. Con. Res. 248. Concurrent resolution providing for the printing of euologies, encomiums, and funeral services for the late President of the United States, Richard M. Nixon.

The message also announced that the Senate had passed a bill of the following title, in which the concurrence of the House is requested:

> S. 2218. An act to provide authorization of appropriations for the Federal Emergency Food and Shelter Program for fiscal years 1995 and 1996.

The message also announced that the Senate agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 4426), an act making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 1995.

The message also announced that the Senate agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 4453), an act making appropriations for military construction for the Department of Defense for the fiscal year ending September 30, 1995, and for other purposes.

The message also announced that the Senate agrees to the amendments of the House to the amendments of the Senate numbered 6, 10, 13, 15, 16, 19, 20, 23, 24, 27, 31, and 32, to the above-entitled bill.

The message also announced that the Senate recedes from its amendment numbered 29, to the above-entitled bill.

The message also announced that the Senate agrees to the amendments of the House to the resolution (S. Con. Res. 38), concurrent resolution to authorize the reprinting of the book entitled "The U.S. Capitol: A Brief Architectural History."

The message also announced that the Senate agrees to the amendments of the House to the resolution (S. Con. Res. 39), concurrent resolution to authorize the printing of a new annotated edition of Glenn Brown's "History of the U.S. Capitol," originally published in two volumes in 1900 and 1903, prepared under the auspices of the Architect of the Capitol.

The message also announced that the Senate agrees to the amendments of the House to the resolution (S. Con. Res. 40), concurrent resolution to authorize the printing of the book entitled "Constantino Burmidi: Artist of the Capitol," prepared by the Office of the Architect of the Capitol.

The message also announced that the Senate agrees to the amendments of the House to the resolution (S. Con. Res. 41), concurrent resolution to authorize the printing of the book entitled "The Cornerstones of the U.S. Capitol."

ANNOUNCEMENT REGARDING AVAILABILITY OF THE NINE HEALTH CARE REFORM SUBSTITUTES

(Mr. MOAKLEY asked and was given permission to address the House for 1 minute.)

Mr. MOAKLEY. Mr. Speaker, I rise today to announce that Members have submitted health care reform substitutes to the Committee on Rules last night, including the Gephardt substitute, the Michel substitute, the McDermott substitute, and the Rowland substitute, and I expect there will be a great deal of interest in reading these.

So, the fastest and fairest way we found to get the substitute into as many hands as possible is to print them all in the CONGRESSIONAL RECORD.

Last night I submitted all the substitutes so that they will be printed in the RECORD, available today, and the nine substitutes will appear in part 2 of the RECORD in the portion entitled "Amendments." Part 2 will be available this afternoon.

WELCOMING TODAY'S GUEST CHAPLAIN, MSGR. ROGER CHARLES ROENSCH

(Mr. KILDEE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KILDEE. Mr. Speaker, it is with great pleasure that I welcome to the House today our guest chaplain, Msgr. Roger Charles Roensch.

Monsignor Roensch is the pilgrimage director at the Basilica of the National Shrine of the Immaculate Conception here in Washington, DC.

The monsignor graduated from the North American College and Gregorian University in Rome in 1958.

In the same year, he was ordained a priest and served in the Archdiocese of Milwaukee until 1970.

After serving 11 years at the North American College in Rome, Father Roensch came to the National Shrine in 1981.

Father Roensch was incardinated into the Archdiocese of Washington by James Cardinal Hickey in 1989, and he was later named a domestic prelate by Pope John Paul II in December of 1990.

Mr. Speaker, as chairman of the House Page Board, I am particularly pleased that the monsignor has joined us today.

Each year, the monsignor has graciously hosted the pages at the national shrine.

He has made them feel welcome, and encouraged them to make the national shrine their parish church while they are in Washington.

Mr. Speaker, I ask my colleagues to join me in welcoming Msgr. Roger Charles Roensch to the House of Representatives.

□ 1130

ANNOUNCEMENT OF THE DEATH OF THE HONORABLE JESSIE SUMNER, FORMER CONGRESSWOMAN FROM ILLINOIS

(Mr. EWING asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. EWING. Mr. Speaker, I regret to inform the House of the passing of a former colleague. Jessie Sumner, one of the oldest living former members, passed away yesterday at the age of 96. Originally from Milford, IL, she represented the people of east central Illinois in the U.S. Congress from 1939 until 1947.

She was a 1920 graduate of Smith College. Congresswoman Sumner studied law at the University of Chicago, Columbia University, and Oxford University. She started her political career when she was elected judge of Iroquois County in 1937. In 1938, she was elected to the U.S. Congress from the 18th District.

Congresswomen Sumner was a pioneer and served as one of only nine female Representatives in the 76th Congress. She served in the Congress with distinction during the turbulent years of World War II. She was an outspoken pacifist and fiscal conservative. As the war years continued, Representative Sumner often found herself being a lone voice of concern about the cost of the war on the lives of Americans.

Representative Sumner declined to be a candidate for reelection in 1946. She returned to Milford to resume her position as vice president and later President of the Sumner National Bank.

The citizens of east central Illinois were truly lucky to be represented by Congresswoman Sumner and to have her as a lifelong citizen of Iroquois County.

Mr. Speaker, I am pleased to have had the opportunity to have contacts with Representative Sumner. We all shall miss her, and we regret the loss of this true friend.

AARP SUPPORT FOR THE GUARANTEED HEALTH INSURANCE ACT

(Mr. DERRICK asked and was given permission to address the House for 1 minute.)

Mr. DERRICK. Mr. Speaker, Congress should be well aware of the Nation's abiding interest in health care reform. Every day more organizations representing millions of Americans voice their support for the Guaranteed Health Insurance Act.

Today you can add the 33 million members of the American Association of Retired Persons to the throngs calling for reform. Citing their long-held support for universal coverage, long-term care coverage, the protection and strengthening of Medicare, controlling health care costs and a fully funded health care system every American can afford, the AARP asked its members to support the Gephardt bill.

The AARP represents Americans over the age of 50. They know how important reform is to their members' health—and everyone's. The AARP points out that this is a historic opportunity to benefit all Americans, and that defeat will kill reform for years to come.

Give the people what they need—pass health care reform.

LESS CHOICE IN HEALTH CARE

(Mr. SAM JOHNSON of Texas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Mr. Speaker, I would say that AARP had better look at these bills.

Mr. Speaker, the Clinton-Gephardt and Clinton-Mitchell health plans claim to guarantee choice in health care. But, do they really know what choice means.

Contrary to the Democrat leadership's belief, a standard benefit package does not constitute choice. Choosing from a list of specified doctors does not constitute choice.

Maybe I should explain to Clinton, GEPHARDT, and MITCHELL what a standard benefit package is. This means that the Government tells you which doctor you can see, when you can see that doctor, and what services you can receive. Clinton-Mitchell even goes so far as to make existing health plans illegal.

These bills take away our American freedoms to make health care decisions based upon our needs, and no one is falling for this scheme of total Government control. Americans know the difference between myth and reality.

PASSAGE OF CRIME BILL THREATENED BY PARTISAN POLITICS AND SPECIAL INTERESTS

(Mr. RICHARDSON asked and was given permission to address the House for 1 minute.)

Mr. RICHARDSON. Mr. Speaker, today partisan politics and special interests could kill the crime bill. This is a crime vote, not a gun vote. Today we either pass a crime bill and do what our constituents and the American people want us to do or we once again cave in to partisanship, special interest lobbies, or gridlock.

We can sit here and talk all we want to about health care, GATT, the economy, or Haiti, but in the final analysis it is the crime issue that will determine whether we are a do-nothing Congress or a Congress that bites the bullet and does the right thing. Most importantly, this vote will determine whether many of us are here next year or not.

Mr. Speaker, let us not cave in to special interests and partisanship. Let us do what the people sent us here to do and pass the crime bill.

CLINTON HEALTH

(Mr. HEFLEY asked and was given permission to address the House for 1 minute.)

Mr. HEFLEY. Mr. Speaker, earlier this week, the First Lady lamented the overly information-loaded society, that has opposed her attempt at health care reform.

She said that when Social Security was passed, Franklin Roosevelt didn't "have to describe every jot and title of that bill."

Maybe he should have, Mr. Speaker. Here it is, 1,410 pages, and the First Lady doesn't think we need to know what is in it.

When it comes to the President's health care bill, the American people have to know what the Government is going to do to them. And the more they know about the Clinton-Gephardt health care bill, the less they like it.

According to CBO, its 47 new bureaucracies will add $9 billion to the budget deficit.

And its 175 new mandates on the States are, according to CBO, unworkable.

Mr. Speaker, the First Lady should not lament the fact the American people are actually finding out about Clinton health. She should lament the fact that Clinton health is bad for the country.

REPROGRAM RUSSIAN AID, PUT YELTSIN'S MONEY INTO HEALTH CARE FOR AMERICANS

(Mr. TRAFICANT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. TRAFICANT. Mr. Speaker, I have an idea about where we can get the money for health care. Now, check this out.

Congress gives billions of dollars a year to Russia to encourage democracy. News reports yesterday said that Boris Yeltsin used $100 million to buy a boat, two swimming pools, two tennis courts, gold and marble furnishings, and a helicopter pad with a helicopter. That was $100 million. How does that float your boat, Congress?

Here is my question. Where does Boris, big bad Boris, get $100 million to buy this "Love Boat" on a salary paid with rubles? I say it is unbelievable, folks. Sometimes you have got the bear, and sometimes the bear has got you, but in this case the bear has got us all by the throat.

Let me make a recommendation. Let us reprogram the money that goes to Russia and put it in a kitty and buy some health insurance for Americans. How does that sound?

□ 1140

RAISING TAXES

(Mr. BALLENGER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BALLENGER. Mr. Speaker, this week the Wall Street Journal ran a column by noted economist, Martin Feldstein, who explained that the Clinton-Mitchell health care bill contained a hidden $100 billion tax increase. If enacted, the Mitchell health care proposal would be the largest expansion ever of the welfare state. Enacting it, incredible as it may seem, would be equivalent to raising personal income taxes by a staggering 20 percent. No, you heard me right, 20 percent.

Last year, the Democrats claimed to solve the budget deficit problem by doing what? That is right. Raising taxes. This year both the Clinton-Mitchell and Clinton-Gephardt bills claim to be the right prescription for what ails our health care system. Their solution? Right. Government takeover of our health care system and raising taxes. And, raising taxes by the equivalent of 20 percent. That is equivalent to a tax increase of more than $5,000 for each individual person insured and a cost of $20,000 for a family of four.

The American people know what the Democrats are up to. That is why they do not support the Clinton plan, and why, if they find out what is in the Clinton-Mitchell and Clinton-Gephardt plans, they will not support them either. After all, if it is a Democrat idea, it has to involve, you guessed it, raising taxes.

THE PARTY THAT CRIED WOLF

(Ms. MCKINNEY asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. McKINNEY. Mr. Speaker, recently we celebrated the 1-year anniversary of the passing of President Clinton's deficit reduction plan.

At the time the distinguished minority whip said "it will kill 1.4 million jobs. Tragically, it will not control spending or reduce the deficit." A year later, 3 million new jobs and a lower deficit than expected, we can only assume that the Members from the other side miscalculated.

Now these same naysayers are saying that health care reform will somehow challenge the basic foundations of America. They cry socialism, the end of the best health care system in the world, it will kill jobs.

Once again the obstructionists are crying wolf. Many Americans are afraid that health care reform means that they will lose their benefits or have to pay more for less benefits. What the American people will find is that they cannot afford to listen to the party that cries wolf. Let's take a bite out of the do-nothing gang and support universal coverage today.

PRESIDENT CLINTON—HEALTH CARE TRUST

(Mr. DOOLITTLE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DOOLITTLE. Mr. Speaker, President Clinton has unveiled a new television commercial promoting his socialistic health care plans. He says his proposal will not result in the Government takeover of the health care delivery system. He asks the American people to trust him in telling the truth regarding health care.

But before the American people give the President that trust, I ask them to reflect on the President's own track record. Did you trust the President regarding his pledge to cut taxes? Did you trust him regarding his pledge to cut spending? Did you trust him regarding his draft status? Did you trust him when he said he did not inhale? Do you trust him regarding Whitewater?

Mr. Speaker, the President asks us to trust him when it comes to health care reform, but trust must be earned rather than freely given. And President Clinton's record in this regard has now become quite clear to most Americans.

SUPPORT THE CRIME BILL

(Mr. BARRETT of Wisconsin asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BARRETT of Wisconsin. Mr. Speaker, I am pleased that we are going to have the opportunity to vote today on the very important crime bill. Millions of Americans across this country are deeply concerned about crime. The crime bill that we will consider today contains many provisions that address the public's concerns.

First, the crime bill bans military-style assault weapons. It would be unconscionable for Congress to continue to condone the sale of guns that are designed specifically to kill people.

Second, it targets violence against women in their homes. The bill toughens the penalties for offenders who victimize women and authorizes help for education, prevention, and domestic abuse hot lines.

Third, it puts more cops on the streets. This is vital help in the trenches of the battle against crime and will provide 2,000 officers for the State of Wisconsin.

Opponents dismiss these measures as inadequate, but no single wave of a magic wand will restore our sense of security. These provisions in the crime bill are vital elements of a comprehensive approach.

I urge my colleagues to support the bill.

NEW TAXES NOT NEEDED BY AMERICAN PEOPLE

(Mr. BOEHNER asked and was given permission to address the House for 1 minute.)

Mr. BOEHNER. Mr. Speaker, there are three items that appear in all the major legislation that has been drafted by the Democrat leadership here in Congress. Those three things are: Taxes, taxes, and more taxes. It seems that is all they want to think about.

Both the Clinton-Mitchell bill and the Clinton-Gephardt health care bills are chock full of new taxes. And yesterday the CBO attacked the Mitchell bill, saying it would result in $1 trillion in subsidies over the next 8 years, widespread bureaucratic problems, increased unemployment, incentives for the poor not to work, more Government agencies to implement the plan, and employer mandates that are going to kill American jobs.

A group of bipartisan Members here in this House have drafted a health care bill that has no new taxes. The bipartisan supporters understand that the Government is already too big and spends too much. Passing taxes on to the American people will only result in bigger, more expensive Government bureaucracy. It is not what the American people need, nor is it what they want.

PLAY BALL

(Mr. WILLIAMS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILLIAMS. Major league baseball players, big league managers: Play ball.

INCREASED TAXES CONTRIBUTE TO WEAK RECOVERY

(Mr. RAMSTAD asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. RAMSTAD. Mr. Speaker, we know now from Bob Woodward's recent book that President Clinton called his own tax plan a turkey, and on the first anniversary of the largest tax increase in American history, this bird is coming home to roost.

With the President's high-tax, high-regulation policies, and now inflation in clear view, we face the real possibility of returning to the glory years of Jimmy Carter. Remember malaise, 20 percent misery indexes, and stagflation? The American people simply cannot afford Carter II. But the Clinton recovery looks like back-to-Carter. It is the weakest recovery in 50 years, the weakest post World War II recovery.

Mr. Speaker, the Clinton taxes have contributed to the weak recovery by taking money out of the pockets of the productive capital investing sector of our economy and giving it to the inefficient bureaucrats in Washington.

The lesson is clear: We need to reduce taxes and regulations, and realize that job creating growth comes from the private sector, not the bloated Federal Government.

Mr. Speaker, when will they ever learn?

THE CRIME BILL CONFERENCE REPORT

Mr. SANDERS. Mr. Speaker, I will be voting in favor of the crime bill today, despite some provisions in it with which I stongly disagree because, on balance, its positive initiatives to control crime outweigh the negatives. But I want to make it clear that in my view, no approach toward crime will be effective if we continue to ignore the poverty, despair and hopelessness which are the root causes of crime.

Mr. Speaker, at a time when increased property taxes in Vermont are placing a very painful burden on our citizens, it is absolutely appropriate that the Federal Government play an increased role in helping our communities address the crime problem. Under this legislation the State of Vermont will receive at least $44 million dollars to hire more than 500 new Police officers; $6.5 million for drug and crime enforcement in our most rural areas; $3 million for our cities and towns to use in ways they feel useful, and $1.2 million for a variety of children's programs.

Perhaps most important to me, however, this crime bill will provide $8 million dollars to Vermont to allow us to deal with the epidemic of violence against women. In Vermont, there were six women murdered last year, and every single one of them was killed by an abusive spouse or partner—and God only knows how many other women were beaten and assaulted. This bill, through funding for a wide variety of services, will finally allow us to give women the protection that they have long been denied.

TRIBUTE TO THE LATE RUSSELL TICKNER

Mr. BARTON of Texas. Mr. Speaker, it is my sad duty to inform the House that a dear friend of mine, Russell Tickner, passed away yesterday at the age of 71 years. Russ was the husband of my former district representative, Jan Tickner.

My heart goes out to Jan and their four children, Nancy, Suzy, Gary, and Tom, their nine grandchildren, and their hundreds of friends.

Russell Tickner's life was like Jimmy Stewart's life in the movie "It's a Wonderful Life." He honestly touched thousands of people in a very positive way, myself included. He was a World War II veteran. He was shot down on his first B-17 bombing mission over Germany, escaped by parachute, was hunted by the German soldiers, and climbed into an apple tree. The Germans came in and machine-gunned the apple orchard, but did not shoot up into the trees.

□ 1150

He escaped back to England, came back to the United States and married a young woman that he met at a USO dance before he went overseas. Russ and Jan lived their lives in Conroe, TX. He was self-employed in the restarurant business, the arts and crafts business. He was active in prison ministry. He was an avid golfer, a great coffee drinker and a great story teller.

Few people lead the kind of life that Russ Tickner lived. He had the distinction of having the street that he lived on named in honor of him, Tickner Lane. The world is a better place today because of Russell Tickner's life.

DEMOCRACY

Mr. WATT. Mr. Speaker, in the midst of all the discussion about health care and crime and issues of importance, there are some of us who are still struggling with the simple question of democracy and whether our districts will survive.

Last week in Louisiana, a three-judge panel redrew the districts there that have been worked on by the State legislature. Democracy is based on representative government, and all people in our democracy are entitled to representation in the process.

I think we should express our outrage at efforts that are on the way to undermine representative government in this body, and I call upon America to do that. I call upon the Supreme Court to stay the ruling entered by the three-judge panel in Louisiana.

WHAT'S THE HURRY?

Mr. WALSH. Mr. Speaker, to the leadership of the House, my message today is quite simple. Take a step back, hold off on your plans to bring the Clinton-Gephart bill to the floor next week, and instead provide each Member of this House with a detailed summary of your bill. Then allow us to return to our districts and discuss the legislation with our constituents. That is what the American people want, and everyone in this Chamber knows it.

If you try playing hard ball politics by jamming this down the throats of House Members without their knowing the complete content of the bill, you will do tremendous damage to those who follow your path. The public will not stand for it.

This issue is not Social Security, and for those simplistic enough to believe that line, you had better sign up to a fast economics course. The issues are deep and complex. If you have never tracked a Medicare claim or followed a constituent's case dealing with long-term care, I suggest you talk to your office caseworkers handling health care problems. The lack of factual knowledge in dealing with this issue is appalling. You cannot correct something if you do not understand it.

Instead of producing a strong foundation on which to build real health care reform, we see a Trojan Horse being readied for a sneak attack. This is no way to legislate, and shame on those who attempt such folly.

HEALTH CARE

Ms. SHEPHERD. Mr. Speaker, for near 2 years now, I have been trying to help my constituents in Utah solve their individual health care problems. This is the story of a young man in my district who has juvenile diabetes. After graduating from college he got a job with a small company as a computer programmer. His employer did offer health insurance. However, because he had a pre-existing condition, he was given two choices: He could take health coverage that excluded anything related to his diabetes, or he could accept coverage in a special group with a high deductible, high copayment, and a $700-a-month premium. His take home pay at the time was $1,000 a month. As his parents explain, "even though our son may have been counted as having health insurance by some statistics, in effect, he had no real coverage."

Without health care reform this young man will remain at the mercy of employers and insurers who decide whether he can or cannot stay healthy.

It is time we solve this problem and pass comprehensive health care reform.

THE CRIME BILL

Mr. STEARNS. Mr. Speaker, the crime bill was filed last night at 7 p.m. It is over 900 pages. Most of my colleagues in this House have not seen the bill. That is why a recent survey by the Luntz Research Group is very, very important: 36 percent of those people who were surveyed in America said they do not want to see this crime bill passed now; 55 percent felt somewhat more strongly.

If all these people knew that there were 30 new social spending programs in the bill and that it is at a cost of almost $9 billion, I think all of them would say, do not pass this crime bill.

What happened to Vice President GORE's mandate that we reduce Government programs and spending? Why are we adding 30 new social spending programs?

If we looked at the statistics from the Justice Department, since 1965, we see that the amount of money spent for welfare has increased 800 percent yet the crime rate has tripled. That is why all Americans believe our Government is too big and spends too much money. They want us to go back and develop a new crime bill.

SAVING THE ASSAULT WEAPONS BAN

(Mr. NADLER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. NADLER. Mr. Speaker, today we will be voting on the crime bill conference report. I know we are all pleased with some and disappointed with other parts of the bill. I declined to sign the conference report because of several provisions that I cannot support.

But our vote on the rule today presents every Member of this House with a straightforward, if unappealing, choice: Defeat of the rule will result in the elimination of the assault weapons ban. That will be the only change defeat of the rule can accomplish. That is what lies in the balance.

I will support the rule when it is considered later today. We have no choice. We must save the assault weapons ban. These firearms account for only one-half of 1 percent of all guns, but have been used in more than 8 percent of all gun crimes—29,058 between 1988 and 1993 according to the Bureau of Alcohol, Tobacco and Firearms.

There are valid objections to this bill, but I cannot in good conscience help defeat the rule knowing the sole result would be to kill the assault weapons ban. We owe it to our children, to our neighbors, to the voters who sent us here to get these weapons of war off the streets. I urge my colleagues to vote for the rule and to save lives by saving the assault weapons ban.

HEALTH CARE DEBATE

(Mr. HOEKSTRA asked and was given permission to address the House for 1 minute.)

Mr. HOEKSTRA. Mr. Speaker, we are about to begin on an historic process, but we have gone through it. We went through it in Education and Labor. We spent 8 weeks marking up the Education and Labor health care bill.

Now in 8 days we will measure and mark up a brand new bill. This is an outline.

What do we know is in the Clinton-Gephardt bill? We know there is mandates. We know there is subsidies for small businesses. They will be phased out by the year 2005. We know there is micromanagement of the health care education area. There is global budgeting, regional exemptions. There is new taxes, new penalties, more paperwork. And our idea of tort reform is that we are going to preempt all the tort reform that has taken place at the State level.

Trying to do health care in 8 days demonstrates Washington and this House are out of control.

CRIME BILL

(Mr. BISHOP asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BISHOP. Mr. Speaker, in order to restore sanity and security to the streets of America, I strongly support a tough but fair anti-crime package that offers a balance between punishment and prevention.

Congress must provide the people with the necessary weapons to combat drug dealers, gang leaders, robbers, rapists, and murderers.

Community-based policing, reinforced with more law officers and more resources for drug treatment, buttresses our effort to win this war.

Also, deeply rooted in any crime prevention initiative are measures that promote family values, education, and job training.

I strongly support a crime package that throws three-time convicted violent felons in jail for life and adds more Federal crimes to the death penalty list. I support more prisons.

We must protect ourselves, our families, and our neighborhoods by locking up—and when appropriate, executing—those who repeatedly demonstrate a disregard for the sanctity of human life.

We need to assure fair and impartial sentencing.

A successful crime package is one designed to displace fear with security, sanity, and confidence, through a balanced approach that provides the strength and fairness needed to win the war on crime. We must pass the crime bill today.

THE RULE FOR THE CRIME BILL CONFERENCE REPORT

(Mr. HUFFINGTON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HUFFINGTON. Mr. Speaker, I rise today to urge my colleagues to vote against the rule for the crime bill conference report. Once again, the majority leadership is trying to use parliamentary tricks and restrictive rules to ram a flawed bill through this chamber.

Mr. Speaker, I have stood here incredulous as the majority has accused the minority of forcing congressional gridlock—an amazing assertion given that the Democrat party controls both chambers and the White House. In fact, the real reason Congress is struggling to pass a crime bill is that the liberal leadership insists on stuffing legislation the country needs with social experiments the American people just do not want.

Allow me to remind my colleagues of a disturbing trend. In just 15 years we have gone from having 15 percent of the legislation on the floor considered under restrictive rules to almost three quarters of the bills considered under restrictive rules.

And the crime bill is no different. Republican attempts to improve the bill have been blocked throughout the entire process.

I may be just a freshman, but I know that clean conference reports do not need rules to come to the floor. Rules are sought when protection is needed for dubious programs. And boy does this bill need protection.

Let me make this perfectly clear for the American public: This bill needs protection because arts programs, midnight basketball programs, self-esteem programs, and most of the rest of the social welfare programs slipped into this bill have very little to do with fighting crime. And unless protected by a special rule, these pet projects would be gone.

Finally, Mr. Speaker, a simple observation. Our fellow citizens increasingly live under the specter of violent crime. And they have asked us to do something about it. They asked for a tough crime bill. And they know this is not it. I urge my colleagues to vote down the rule, send this legislation back to conference, and return a tough anticrime bill that will make our streets safer.

□ 1200

IN SUPPORT OF THE VOTING RIGHTS ACT

(Ms. BROWN of Florida asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. BROWN of Florida. Mr. Speaker, I rise today to acknowledge the importance of the Voting Rights Act signed by President Lyndon B. Johnson almost 30 years ago. Unfortunately, we are still fighting the same battles all over again—whether Congress looks like all Americans or just a few. Accomplishments in diversifying Congress have been attacked in court. History, if we are not careful, threatens to repeat itself. Districts created to remedy violations of the Voting Rights Act should not be stricken down by the courts.

As President Clinton recently stated, "Inclusion of all Americans in the political process is not a luxury; it is central to our future as the world's strongest democracy." The Department of Justice must be strong in its leadership for civil rights, and vigilant in its enforcement of the Voting Rights Act, especially in defending districts created to remedy blatant violations and abuses of voting rights for people of color in this country.

It is especially fitting today as we take up the crime bill that Congress is well-represented by diverse Members who can fully debate the root causes of crime which have been ignored in the past, such as failure in education, job training, and crime prevention. Diversity in Congress is more important now than ever.

ENCOURAGING RUSSIA'S PRESIDENT YELTSIN TO BUY HIS YACHT IN AMERICA

(Mr. CALLAHAN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CALLAHAN. Mr. Speaker, as the Members of this body know, I have been a critic of United States aid to Russia. One of my concerns has been that we have not established strong enough conditions on aid or enforced those we have imposed.

Now I discover yet another condition that we neglected to include in the Russian aid package. That is that President Yeltsin cannot use American taxpayers' dollars to purchase a luxury yacht with a swimming pool and tennis court. The Washington Times reported that Mr. Yeltsin is negotiating with a Russian shipbuilder for just such a craft.

If there is any truth to this report, I hope our administration officials will take a careful look at this ostentatious display. Even here in the United States, where we are wealthy enough to bestow $850 million on Russia, we cannot afford a yacht for our President.

At the very least, Mr. Speaker, we should demand that the Russians "buy American." There are plenty of good shipyards here looking for work, including several in my district. I would encourage Mr. Yeltsin to do his shopping here.

LIFE, LIBERTY, AND THE PURSUIT OF HAPPINESS

(Ms. FURSE asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. FURSE. Mr. Speaker, life, liberty, and the pursuit of happiness, those are the words our forefathers put in our first defining document. This week in Oregon, the life of Catalina Correa, a mother, a nurse, whose life had been dedicated to helping others, her life was snatched from her by a man with an assault weapon.

Mrs. Correa and her family have lived in my district in Oregon. I would like to ask those who think that their happiness depends on being able to buy hundreds of types of guns, guns that are designed only to kill, to kill people, people like Catalina Correa, I ask them to go to Oregon to explain to this family why their happiness is more important than Catalina's life. I certainly cannot explain it.

Mr. Speaker, it is time we protect our constituents, their lives, their liberty, their happiness. It is time we passed this rule and passed this crime bill.

LET'S CONSULT THE PEOPLE—THE NEED FOR AN ORDERLY PROCESS ON HEALTH CARE

(Mr. HORN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HORN. Mr. Speaker, the next week will bring this Congress and the Nation the historic opportunity to debate the health care reform proposals. For many of us, it may be the most important vote we cast in this House. It is quite probable that no other issue will have more impact on the lives of each and every American. It is critical, then, to take the time to do this right.

Mr. Speaker, if this were a schoolhouse and the students showed up, and the teacher was ordered by the principal to give them all the homework for the whole semester and have it done tomorrow morning, the parents of the students would revolt, go to the school board and ask that the principal be removed.

Mr. Speaker, the people of America should revolt and go to the leadership of this House and ask that they be removed. This type of a railroad train violates every common sense rule of a parliament that ought to give due deliberation to complex legislation.

One sentence in one of the many thousands of pages of four or five of the bills can mean $10 billion.

Mr. Speaker, this House should not be steamrollered and ramrodded into misconduct in the legislative arena. What is the rush? Why next week when the bills are not even printed?

Let us do this in an orderly way—read the bills, discuss them, explain them in the district to our constituents, then—after Labor Day—return to this chamber, debate the issues, and vote to meet the needs of the 37 million Americans who have no health care coverage.

GREED IN PROFESSIONAL BASEBALL CAUSES FANS AND EMPLOYEES TO LOSE OUT

(Mr. MORAN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MORAN. Mr. Speaker, tomorrow one of the most exciting baseball seasons in recent memory will come to an end. Teams like the Cleveland Indians and the Houston Astros, the Montreal Expos and the Colorado Rockies, teams that nobody thought would ever have a chance of getting to the pennant, have actually had a terrific season. Kenny Griffin, Jr., Matt Williams, even have a chance to break Roger Maris' home run record.

Yet, Mr. Speaker, none of that will happen, primarily because of greed. The Red Sox even have a chance for their August spurt, only to be crashed in September, but we have to ask ourselves why.

Mr. Speaker, major league baseball players average a $1.2 million salary a year. In fact, their salaries have increased 1,600 percent over the last 17 years. The owners say half the teams are losing money, but they will not even open their books. Attendance is way up. We should make it clear to the owners and the players that a lot more people are going to lose from this strike than can gain anything from it.

Mr. Speaker, all the people who work at minimum wage jobs are going to lose their jobs, but most importantly, the biggest price to be paid will be with the fans, whose loyalty cannot be sustained when they pull this eight times in 20 years.

THE CRIME BILL MISSES ITS MARK

(Mr. LEWIS of Kentucky asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. LEWIS of Kentucky. Mr. Speaker, I rise today in opposition to the Conference Report on H.R. 3355, the Omnibus Crime Control Act.

Mr. Speaker, this bill has missed its mark. The overall aim of a crime package should be on getting tough on criminals. Its aim should be on deterring the rate of crime in this country. Unfortunately, the crime bill does not do that.

The crime bill falls short because it punishes all American citizens by banning the possession and manufacture of certain semi automatic firearms. The conference report begins to take away the rights of law-abiding citizens which are protected by the second amendment.

This is not the aim that the crime efforts in this country should take. We cannot fight crime at the expense of our rights as American citizens. In fact, criminals will laugh at gun control—they will have their guns, no matter what gun regulations are legislated.

Now, there are a few provisions in the crime bill that are not that bad. There are programs such as funding for State and local law enforcement grant programs, a truth in sentencing provision, and money for prisons.

But as a whole, this bill does not hit the target. This bill penalizes upstanding, honest Americans.

Moreover, H.R. 3355 is a spending bill, with over $9 billion earmarked for new social programs.

Now this is completely off the mark.

Mr. Speaker, the folks in my district are like those in yours—they are deeply concerned about the safety of their homes and neighborhoods. Unfortunately, a crime package that takes away freedoms of law abiding Americans instead of getting tough on criminals, will only make the problem worse.

I urge my colleagues to vote "no" on the crime bill conference report.

CALLING FOR GUARANTEED HEALTH INSURANCE FOR EVERY AMERICAN FAMILY

(Mr. STUPAK asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. STUPAK. Mr. Speaker, on any given day 37 million Americans are without health insurance. In my district, the First Congressional District of Michigan, there are 64,000 people who are under the age of 65 who are uninsured. Of those uninsured, 14,000 are children. Over 80 percent of the uninsured in my district are working but do not receive health benefits through their job.

Constituents contact me frequently about their need for health care reform and guaranteed private health insurance.

For example, a woman from the Traverse City area called me to say that her company just cancelled her health insurance. This very woman was 8½ months pregnant, and was left with nowhere to turn.

Mr. Speaker, this woman and even those with health insurance are why we need health care reform. We need health care reform because when this woman had her child, do you know who paid? All of us, through increased insurance premiums, through increased out-of-pocket expenses, through increased State taxes, through increased Federal taxes. This bears out the fact that health care reform is for everyone. We must get this under control.

Mr. Speaker, I hope that the Congress will help every American to obtain and retain health insurance for themselves and their children.

□ 1210

SUPPORT URGED FOR TOTAL CONGRESSIONAL REFORM

(Mr. BARTLETT of Maryland asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BARTLETT of Maryland. Mr. Speaker, yesterday we took a major first step down the road toward congressional reform. Bringing Congress under the laws that we pass for the rest of Americans, reforming our travel, and having us receive the same health benefits are measures of which we should all be proud. And they are also long overdue.

We now need to rid ourselves of the perks and privileges that still separate us from our constituents. We need to reform our pensions, do away with airport parking, and stop proxying voting, among other things.

My bill, H.R. 4444, completes the job that H.R. 4822 started. We need total congressional reform, Mr. Speaker, we need H.R. 4444, the one stop shop for congressional reform.

NEW YORK TIMES SHOULD ALLOW CONTRASTING VIEWS ON CUBA

(Mr. TORRICELLI asked and was given permission to address the House for 1 minute.)

Mr. TORRICELLI. Mr. Speaker, like many Members, I have long considered the New York Times to be one of the most venerated institutions in this country, a principal dialog for opposing positions in our national debate. I therefore rise with some regret.

Today, the New York Times has published the 12th in a long series of editorials and op-eds against American policy toward Cuba. The American public may believe because those views are never answered in their op-ed page that there are no contrasting views. In fact, month after month for a second year Members of this institution and others in the country have attempted to enter into that debate. Indeed, a few months ago after repeated rejections, simple letters were offered explaining that there are other views who believe in the American embargo of Cuba. Even that letter was offered.

Today, in their editorial, the New York Times termed as a "fanatical faction" that believes in the American embargo. That fanatical faction includes the House, the Senate by a two-thirds margin, President Bush, President Clinton, and two-thirds of the American people.

Mr. Speaker, the New York Times deserves its high reputation but it better serves its history and this venerated view if it allowed contrasting views.

MAY THE CLINTON-GEPHARDT AND CLINTON-MITCHELL HEALTH CARE PLANS REST IN PEACE

(Mr. BAKER of California asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BAKER of California. Mr. Speaker, here they go again. Yes, a crime bill that does not fight crime but spends $33 billion that we do not have. Yes, it reduces the minimum mandatory sentences for drug pushers that sell poison to our children. It eliminates the minimum mandatory sentences on those who use a gun in the commission of a crime, yet makes it a crime to own a gun to protect your home or your family or your business.

Do we have the $33 billion? No. And what are we going to do later this week or next week about health care? We will turn it over to the Government. What a new concept. It has been tried in Great Britain, but if you have a business in Great Britain or you are employed there as a management employee, they give you the keys to the washroom. In other words, private health care. You do not have to stand in line with the rest of those poor people that are suffering under socialism.

How is it working in Canada? That is our model. Oh, just fine, thank you, unless you live in Ottawa and want a hip operation. It is not on the menu. Oh, they closed for 3 weeks to balance the global budget. All that is in the Clinton-Gephardt plan, all that is in the Clinton-Mitchell plan. Let them rest in peace.

MEDICAL NUTRITION THERAPY NEEDED IN THE HEALTH CARE PLAN

(Ms. SLAUGHTER asked and was given permission to address the House for 1 minute.)

Ms. SLAUGHTER. Mr. Speaker, medical nutrition therapy, when medically necessary or appropriate, is a service which saves money, improves patient outcomes and enhances the quality of life. It reduces the need for long-term drug therapies for many chronic illnesses, and reduces or prevents hospital stays and invasive medical procedures.

Medical nutrition therapy is also important in maternal and child care. For example, I recently heard from the Genesee Dietetic Association in Rochester, NY, about a 34-year-old woman with poorly controlled diabetes. With just five visits to a registered dietitian, she was able to deliver a normal, healthy baby. The cost of medical nutrition therapy was $280; the medical costs without it might well have exceed $5,000.

Mr. Speaker, as we seek to reform our health care system, we must not let medical nutrition therapy slip through the cracks.

I urge my colleagues to support legislative language which provides coverage for medically necessary or appropriate health professional services, to allow an opportunity for reimbursement for medical nutrition therapy.

AN INEFFECTIVE CRIME BILL AND THE MOVE TOWARD SOCIALIZED MEDICINE

(Mr. SMITH of Michigan asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SMITH of Michigan. Mr. Speaker, two very important issues facing this Congress but more than that facing this Nation: A dramatic crime bill which expands social programs and a bill that calls and moves us toward socialized medicine in this country.

Mr. Speaker, we are seeing the President and some of the liberal Democrats hold hostage needed changes to reduce crime in this country so that they can expand $8 billion worth of social programs in urban areas. We see individuals that are holding hostage needed changes to reduce the cost of health care in this country so that they can go to socialized medicine. I plead with the American people to look at what is happening and the consequences of having more government takeover of your individual freedoms, your life, and taking away part of our private sector economy to be managed by a government that has not done very many things very well.

SUPPORT THE CRIME BILL

(Mr. KLEIN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KLEIN. Mr. Speaker, the vote today on the omnibus crime bill is one of the most important we will ever cast. After months of efforts, we are about to pass the toughest, strongest crime bill this country has ever seen, that targets criminals and curbs violence. The time has come to stop looking at the criminal as the victim and recognize that we, the law-abiding citizens, are the victims. This bill focuses on the needs of our Nation's victims: More cops on the street, truth in sentencing, expanded prison space, and laws that keep military-style assault weapons off our streets.

There are special interest groups that would kill this bill, would hold it hostage in an effort to kill the assault weapon provisions. And they would deprive the American people of what we are demanding. We cannot afford to let that happen. Let us have the guts to pass the rule and pass the crime bill and give Americans what Americans want and need.

DELAY IS PREFERABLE TO ERROR

(Mr. LINDER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. LINDER. Mr. Speaker, in a letter to George Washington in 1772, Thomas Jefferson said, "Delay is preferable to error."

The American people know that rushing to pass the Clinton-Mitchell or Clinton-Gephardt bill would be an error of incomprehensible proportion. In fact, by a measure of 2 to 1, the American people want us to wait until next year to reform health care. I merely ask for a few days to talk to my constituents about these so-called new plans.

What would Jefferson say today if he could witness the attempt by the Democrat leadership to ram a bad health care bill by the American people without the benefit of a thorough review.

Jefferson, who advocated a "wise and frugal government" and the "suppression of unnecessary offices, of useless establishments and expenses," certainly would urge delay of a measure that would place 14 percent of the American economy under Federal control, and add at least 17 new taxes and 50 new bureaucracies.

The Democrat motto these days seems to be Anything is better than nothing. Let us reject their premise and abide by the Jeffersonian principle, Delay is preferable to error.

BARBARA BUSH SPEAKS OUT ON CHOICE

(Mrs. SCHROEDER asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. SCHROEDER. Mr. Speaker, I take the well to celebrate one of America's great treasures and finest women, Barbara Bush, and say how glad I am she has finally been freed to speak her mind on choice. We thought all along she agreed with us on choice, and she finally has been able to say she thinks the government has no business in people's personal lives and medical lives, thank you very much. And thank you, Barbara Bush. I think had she been asked about today's crime bill, she would probably say, "For crying out loud, pass it."

Let us get assault weapons off the street, get the violence against women passed, get prevention programs out there.

Mr. Speaker, punishment only has not passed and all this business about pork is a bunch of hoo-ha. The other side's bill is to spend the same amount of money but spend it all on prisons as we have been doing for the past 12 years, and we know where it has gotten us.

Mr. Speaker, thank goodness she spoke out. Let us listen to some of these reasoned voices in the heated debate today.

A CRIME BILL LOADED WITH SOCIAL SPENDING PROGRAMS

(Mr. FRANKS of Connecticut asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. FRANKS of Connecticut. Mr. Speaker, if I had a hat I would tip my hat to the congressional Black Caucus and the other liberals in Congress for having successfully orchestrated an extensive list of social spending programs in a crime bill.

□ 1220

Lyndon Johnson would be amazed that we were able to resurrect his War on Poverty in this manner.

In the past, Congress has passed make-work jobs; Congress has taken care of able-bodied people; but now Congress will start a new program, a make-busy program, complete with arts and crafts and night basketball. Is this big government cradle to grave?

Welfare reform, requiring greater parental responsibility, and other related initiatives geared to getting fathers to fulfill their obligations as fathers, would be the better way of monitoring a youngster's activities in the wee hours of the morning.

More government programs is not the answer.

I encourage my colleagues to oppose the rule on the crime bill, because we can do better, and for our Nation's sake, we must do better.

CRIME BILL CONFERENCE REPORT WORTHY TO BE PASSED

(Mr. BILBRAY asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BILBRAY. Mr. Speaker, I heard the gentleman from California from the Long Beach area say that we had not had time to study this bill. I think people forget this is the conference committee report.

For 6 years we have discussed this bill, and we had extensive debate on the floor of this House on every major issue that is in this bill including the assault ban. I voted against that ban. As the undersheriff from Clark County wrote in in support of the bill, he said he supported the bill even though the assault ban was frivolous, because we know criminals buy those guns not from authorized dealers but off the illegal market.

But, on the other hand, there is so much good in this bill, and we have certainly studied this bill and studied this bill and studied this bill. Remember, gentlemen, this is the conference committee report. This is not the initial debate. We debated and debated and debated.

Let us support the rule and move it forward.

I do not like a lot of things that are in it, but I like a lot of things that are in it. I think it is worthy to be passed.

Let us get the rule passed, and let us vote the bill in.

PASSAGE OF THE CRIME BILL WOULD BE A CRIME

(Mr. COX asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. COX. Mr. Speaker, I have just heard my colleague say that we have studied this issue and studied it and studied it.

We all know what is in it.

Well, in fact, when the conference committee was doing its work, even the conferees did not know the committee chairman was sticking in $10 million of pork for a local university in his district.

This is what totals $9 billion of pork in this bill. It is why it is not a crime bill at all. It is in fact a criminal welfare bill.

Why should we call it a criminal welfare bill? Well, first, because in it there is so much welfare for criminals.

Second, all of this pork in a bill such as this under the guise of a crime bill is, well, just criminal, and we ought not pass it.

We have got arts and crafts in this bill. We have got new social workers. We have got dance programs. I am not making this up. I suppose on Mondays and Wednesdays the murderers will lead, and on Tuesdays and Thursdays the rapists and so on.

This is a return of the discredited Clinton pork-barrel stimulus package that Congress defeated last year.

With all of this pork, is there any room for law enforcement? Well, the FBI Director, Louis Freeh, spilled the beans. He tells us the FBI and the Drug Enforcement Administration will lose over 1,000 personnel in order to pay for this bill.

Passage of this so-called crime bill would be a crime.

SUPPORT THE CONFERENCE REPORT ON THE CRIME BILL

(Ms. PELOSI asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. PELOSI. Mr. Speaker, today the House will take up the crime bill. That is good news for the American people.

Before we do, we will have to vote on the rule. I myself will vote "aye" on the rule reluctantly, because I am opposed to the death penalty, and I am opposed to the "three strikes and you are out" provisions in the legislation.

However, having made that point, I will be supporting the rule and the bill most enthusiastically, the bill because of its provisions to fight crime in our country and send a message of comfort and hope to the American people. Those provisions include initiatives to reduce the incidence of violence against women, and very importantly, it provides a civil rights cause of action for the victims of gender-motivated violence. The bill gives judges more discretion in sentencing first-time nonviolent offenders, a loosening up of the mandatory minimum sentences that are crowding our prisons.

In terms of violence against children, it strengthens Federal penalties against people convicted of assaulting children 16 years and under.

I particularly wish to commend Mr. SCHUMER and the House leadership for their commitment to a ban on assault weapons.

The list goes on and on with provisions which will help reduce crime in our country.

I urge our colleagues to support the rule in spite of reservations that you may not like the bill 100 percent. On balance, it is a great bill.

TAKE SOCIALIZED SPENDING OUT OF THE CRIME BILL

(Mr. CUNNINGHAM asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CUNNINGHAM. Mr. Speaker, the gentlewoman from California is correct. There are a lot of good items in this bill, and the little issue that most of us resent is the $9 billion in socialized spending.

Let us take ourselves back in the debate 100 years ago where we might hear:

> Marshall Dillon, do not worry about the hole-in-the-wall gang. They are not going to cause you any more problems, because we took the carbines away from Dodge residents. By the way, Marshall Dillon, the prisoners you have in jail, we are going to give them dance lessons. Miss Kitty, those folks down at the Long Branch Saloon, no problem, we have got 40,000 social workers to take care of them, and if they still get rowdy, we have got a midnight basketball program for all of those cowboys. But they have to be 2 percent HIV positive. You do not have to work past midnight.

Let us not support the rule.

> If you support this rule, Mr. Dillon, Marshall Dillon, we are going to give you a big, fat pork-barrel program in your city.

Our leadership offered the President a $9 billion way out of this bill by saying:

> Let us take the $9 billion and separate it and vote on it separately. Let us take the $9 billion and put it toward the real crime bill and take out the socialized spending.

STAY ISSUED BY SUPREME COURT IN LOUISIANA V. HAYS

(Mr. FIELDS of Louisiana asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. FIELDS of Louisiana. Mr. Speaker, I rise today to inform the House that about 30 minutes ago the U.S. Supreme Court voted to uphold the voting rights of all Americans in a decision of 8 to 1 upholding and issuing a stay in the case of Louisiana versus Hays.

I would like to at this time, Mr. Speaker, thank the President of the United States of America, who took a very firm stand for voting rights in this country, and also I would like to thank the U.S. Attorney General, Janet Reno, as well as the Assistant Attorney General for Civil Rights, Mr. Devol Patrick, who worked so hard to protect the Voting Rights Act that we passed in this Congress, and the Solicitor General, Drew Days, who worked so hard to defend the Voting Rights Act in this country, the State attorney general of the State of Louisiana, attorney general Richard Iyoube, and also the assistant attorney general, Mr. Roy Mongrue, who worked so hard day and night to defend the Voting Rights Act for the citizens across the State of Louisiana.

I would like to also thank, Mr. Speaker, the Lawyers' Committee on Civil Rights, the NAACP Legal Defense Fund, and I would like to finally thank Judge Leon Higginbotham, all who have worked hard to preserve the Voting Rights Act, an act this body passed and an act that ought to be upheld in every court all across the country.

ORDER LIST—THURSDAY, AUGUST 11, 1994

ORDER IN PENDING CASE

A-64—LOUISIANA, ET AL. V. RAY HAYS, ET AL.

A-75—UNITED STATES V. RAY HAYS, ET AL.

> The applications for stay presented to Justice Scalia and by him referred to the Court are granted and it is ordered that the judgment of the United States District Court for the Western District of Louisiana, Civil Action No. CV 92-1522S, filed July 25, 1994, is stayed pending the timely filing of statements as to jurisdiction in this Court. Should such statements be so timely filed, this order shall remain in effect pending this Court's action on the appeals. If the judgment should be affirmed, or the appeals dismissed, this stay shall expire automatically. In the event jurisdiction is noted, or postponed, this order shall remain in effect pending the sending down of the judgment of this Court.
>
> Justice Scalia would deny the applications.

JUST SAY NO TO THIS CRIME BILL

(Mr. MICA asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MICA. Mr. Speaker, I ask my colleagues to take a hard look at the final crime bill before the Congress today.

If more police were the answer to our crime problem, Washington, DC, should be one of the safest places in the Nation.

If tighter gun control laws would bring down crime, Washington, DC, with some of our Nation's toughest weapons control laws, should be a secure place to live and work.

If more social workers and government employees were the answer to our crime problem, Washington, DC, should be a model for a safe community.

Unfortunately Washington, DC—our Nation's Capital—in spite of having all the features touted as solutions in this crime bill, has one of the highest crime rates in the world.

We do not solve our crime problems with children playing federally financed basketball after midnight in cites with curfews.

We do not reduce crime by cutting drug enforcement, sending our children a mixed message about drugs, and releasing 10,000 convicted drug felons into our neighborhoods.

Send this bill back, I say to my colleagues, because we can do a better job.

TRUTH TIME ON CRIME

(Mr. KREIDLER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KREIDLER. Mr. Speaker, today we vote on the crime bill.

This bill will do more to get tough with criminals than anything we have ever done.

This bill will also do more to get smart about preventing crime than anything we have ever done.

But this bill is not tough enough for some people.

Well, how many police does it take to be tough?

This bill has 100,000 more cops.

How many prisons does it take?

This bill has $8 billion for new prisons.

And how many death penalties does it take? This bill extends the death penalty to 60 new crimes.

If you oppose this bill because it is not tough enough, tell that to the women who are beaten by their husbands, who would get help under this bill.

Tell that to the prosecutors in my district who would get help from this bill.

And tell that to Mary Glenn in my district, whose 15-year-old son, Shaun Proctor, was killed with an assault rifle when he went out for pizza.

Tell the millions of victims this bill will help that you think it is not tough enough.

Tell them that your answer to them is "tough luck."

□ 1230

CRIME BILL NOT TOUGH ENOUGH

(Mr. WALKER asked and was given permission to address the House for 1 minute.)

Mr. WALKER. Mr. Speaker, we have heard a lot today about this tough crime bill the Democrats are bringing out. I would suggest this is not a tough crime bill. They referenced the fact that there are 100,000 new police in the bill. They are going to need 100,000 new police to chase the 10,000 drug criminals that they are going to release as a result of the bill.

That is right, under this bill what they are going to do is take drug criminals who are now in jail and retroactively reduce their sentences so they are back on the streets in our communities. Most Americans understand the violence in our communities. Most Americans understand the violence in our communities is largely related to the drug crimes, and now we are going to put drug criminals back on the streets for the police to go after.

That just does not make any sense.

What else do we do in this bill? Well, we put $20 million in the bill for public policy seminars. Now is that not wonderful? I know a lot of criminals who are really concerned about public policy seminars.

What about all the social programs? Just think of this: If you are in trouble, you call 911. Instead of the police what you get is a social awareness counselor, "That is not a mugger pointing a gun at you, ma'am," they say, "that is an individual who is crying out for help."

What we need is a SWAT team of real people doing real criminal activity out there, not a lot more social workers.

CONFERENCE REPORT ON H.R. 4277, SOCIAL SECURITY ADMINISTRATIVE REFORM ACT OF 1994

Mr. JACOBS. Mr. Speaker, pursuant to the order of the House of Friday, August 5, 1994, I call up the conference report to accompany the bill (H.R. 4277) to establish the Social Security Administration as an independent agency and to make other improvements in the old-age survivors and disability insurance program.

The SPEAKER pro tempore (Mr. MONTGOMERY). Pursuant to the rule, the conference report is considered as read.

(For conference report and statement, see proceedings of Thursday, August 4, 1994, at page H6843).

The SPEAKER pro tempore. The gentleman from Indiana [Mr. JACOBS] will be recognized for 30 minutes, and the gentleman from Texas [Mr. ARCHER] will be recognized for 30 minutes.

The Chair recognizes the gentleman from Indiana [Mr. JACOBS].

Mr. JACOBS. Mr. Speaker, I yield 5 minutes to the gentleman from Texas [Mr. PICKLE].

Mr. PICKLE. Mr. Speaker, I thank the gentleman from Indiana [Mr. JACOBS] for yielding this time to me.

Mr. Speaker, I rise today in support of H.R. 4277, the Social Security Administrative Reform Act of 1994.

Title I of this bill establishes the Social Security Administration as a separate, independent agency. This is a landmark step in the continuing effort to make sure that the Social Security System is properly and impartially administered.

For too long the Social Security Administration has been caught in the middle of political and budgetary disputes. This legislation will go a long way to protecting the agency from the crossfire of partisan politics. In my judgment, granting SSA independent agency status will promote long-term stability in the Social Security Program. Such stability is essential in this program which provides basic retirement income security for almost every American worker.

I particularly want to commend Chairman JACOBS and Mr. BUNNING for their tenacity in advancing this legislation. The issue of independent agency status for the Social Security Administration has been the subject of many studies, reviews, and House votes over the years. In fact, yesterday marked the 10th anniversary of the day, August 10, 1984, that I, joined by Chairman DAN ROSTENKOWSKI, first introduced legislation to grant SSA independent status. The conference report before us today will finally make real the intent of that first bill which we introduced a decade ago. While it has been a long time coming, it has been worth the wait. And I think that Republicans and Democrats, who have consistently supported this reform over the past decade, and here I want to especially note the unwavering support of Mr. ARCHER, all should take great pride in the ultimate attainment of our goal.

Mr. Speaker, I would also like to call the Members attention two other provisions of the bill which address problems encountered in the SSI disability program.

The first provision deals with the granting of disability benefits in situations involving middlemen who are fraudulently causing millions of dollars in benefits to be paid to people who are feigning mental disorders. Section 206 of the conference report, which was proposed by myself, and Messrs. HAROLD FORD, HOUGHTON, and SANTORUM, will help to prevent this fraud by: Insuring accurate translations of interviews conducted by SSA officials; establishing streamlined procedures for terminating fraudulently obtained SSI benefits; and increasing civil and criminal sanctions available to SSA in SSI fraud cases.

The second provision deals with the continued payment of SSI disability benefits to recipients who are no longer disabled. Under current law there is no requirement for SSA to conduct continuing disability reviews for SSI recipients, even in cases where it is anticipated that the medical condition of the beneficiary will improve. The failure to conduct these disability reviews has led to the payment of hundreds of millions of dollars each year to people who are no longer disabled. Section 208 of the conference report, which is the result of a proposal advanced by Mr. HERGER and myself, requires SSA to conduct disability reviews for at least 100,000 SSI recipients per year for the next 3 years, and to report the results of such reviews to Congress no later than October 1, 1998.

Mr. Speaker, I want to conclude by complimenting the leadership of the Committee on Ways and Means for this very solid piece of legislation. Chairman GIBBONS and subcommittee Chairmen JACOBS and FORD, working closely with Mr. ARCHER, Mr. BUNNING, and Mr. SANTORUM, have crafted a bill which will significantly improve the operations of the Social Security Administration. Its immediate enactment will be a credit to us all, and I urge that all Members vote for these important reforms.

Mr. ARCHER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am extremely pleased to be here today, in support of the conference agreement on H.R. 4277, which represents the culmination of congressional action I helped initiate over a decade ago.

The Social Security System has always been extremely important to me. It's one of the very few Government agencies that most Americans have direct contact with and it's likely that many of our constituents measure the way Government performs generally by the way Social Security performs when they need it.

Bringing soundness to the Social Security System has been one of my chief legislative priorities since I was elected to Congress. We owe it not just to our senior citizens, but to our children and the obligations we leave them. That is the reason that I chose to become the ranking Republican on the Social Security Subcommittee when it was first created.

It is also the reason that I sponsored the first House bill creating an independent Social Security Administration with my colleague from Texas [Mr. PICKLE], was then the subcommittee's first chairman. I commend the work of my colleagues, JIM BUNNING and ANDY JACOBS, for carrying through that earlier work. Their efforts have been invaluable.

Mr. Speaker, making Social Security independent will not solve all of its problems, but I believe that freeing it from the layers of bureaucracy imposed on it by HHS will go a long way in making it less political, more responsive, and more accountable. It is also critical to its survival as a vital public service agency which administers the most important social program ever enacted.

The 1983 Social Security Commission, on which I served, recommended a study to make Social Security an independent agency, a recommendation that became part of the 1983 Social Security Amendments. Former Comptroller General Elmer Staats headed up the study panel, which recommended that an independent Social Security Administration be run by a single administrator, backed by a bipartisan advisory board. I am very pleased that the conference approved the form of administrative leadership specified in the bill introduced by the ranking Republican on the Social Security Subcommittee, Mr. BUNNING. His bill provided the same form of leadership as was endorsed by the experts on the Staats panel.

I believe that the seven-member bipartisan advisory board will plan a critical role making Social Security less political and in improving the public's confidence in the Social Security System.

This board will be independent of the Social Security Administration and Government in general. It will be made up of individuals who share a knowledge of the Social Security System as well as a strong desire to restore it to its former status as a premier public service agency which enjoyed the public's respect and confidence.

One of the most important jobs the Board will have is to increase the public's understanding of the Social Security System. I hope that as a result of the Board's efforts the average citizen will have more confidence in the Social Security System, and will become more aware of the need to plan and save overall.

The bipartisan, nongovernmental advisory board will play a vital role in both protecting the public's interest in Social Security and providing the public truthful information about their stake in the system.

The conference agreement contains other provisions that are important to average Americans, who strongly support Social Security, but want benefits to go to only those who are entitled to them. Thanks to the persistence of two House conferees, the gentleman from Texas [Mr. PICKLE] and the gentleman from Pennsylvania [Mr. SANTORUM], the agreement tightens up on SSI disability benefits by requiring Social Security to review cases to make sure recipients are still disabled.

It also starts to tighten up on payments to drug addicts and alcoholics by putting a 3-year limit on benefits, and by requiring that during that time recipients undergo treatment and be paid only through a responsible third party. These restrictions should provide an incentive for addicts and alcoholics to get their lives back on track. I know that average Americans and health professionals alike object to helping addicts and alcoholics fuel their addictions by giving them cash benefits, and I look forward to working with the subcommittee and committee to take further action on these issues.

Mr. Speaker, I join Chairman GIBBONS, subcommittee Chairman JACOBS, and our Republican leader on Social Security, Mr. BUNNING, in strongly supporting this conference agreement.

□ 1240

Mr. JACOBS. Mr. Speaker, I yield such time as he may consume to the gentleman from Illinois [Mr. ROSTENKOWSKI].

Mr. ROSTENKOWSKI. Mr. Speaker, for more than a decade, the Committee on Ways and Means has been seeking to give the Social Security Administration independence.

Our goal has been to restore the agency's mission of excellence, and protect SSA from short-term political pressures.

I have been a long-time proponent of this legislation. The House has passed the bill four times by overwhelming margins.

Now that the Senate has at last joined us in this effort, we are about to make our goal a reality.

Social Security is our Nation's most successful program. There is no more effective way to signify this program's importance than to give SSA independent status.

H.R. 4277 also includes a provision to restrict disability payments to drug addicts and alcoholics.

It would do this by paying through a responsible third party, requiring beneficiaries to participate in treatment, and applying time limits on benefits.

These are important reforms that would assure that Social Security and SSI benefits are used as intended—to cover the cost of basic necessities such as food, clothing, and shelter.

Mr. Speaker, this is a historic moment for Social Security and the successful end of a decade-long effort by the Committee on Ways and Means.

I commend my colleagues for their hard work, and I look forward to the improvements in service to Social Security beneficiaries that this legislation will bring.

Mr. BUNNING. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise enthusiastically in support of H.R. 4277 and urge my colleagues to join me in once again approving this monumental piece of legislation to restore independence to the Social Security Administration.

We owe a special thanks to our Social Security Subcommittee chairman, Mr. JACOBS, who has shown great leadership and dedication in the development of this bill as has our ranking member, Mr. ARCHER, who has been unwavering in his support on this issue for over a decade.

And, of course, the acting chairman of the full committee, Mr. GIBBONS, deserves recognition for shepherding this legislation through conference.

In fact, all the conferees and staff who worked at ironing out the final bill that is now before us were great to work with. The conference was very congenial, totally bipartisan and a real pleasure.

And, most importantly, we have ended up with a good bill. It does a lot of things to improve Social Security.

This bill fixes many parts of the existing law which are broke and needed fixing. It makes disability payments to substance abusers more accountable. It requires that substance abusers participate in treatment or lose their benefits. It insures that benefits will not be used to support an addiction.

It allows police and firefighters in all the States the option of participating in Social Security. Only 24 States now have this option.

It provides that any borrowing against the Social Security trust fund must be evidenced by physical documents—bonds, notes, or certificates. It's time we got the trust fund IOU's in writing and this bill does that.

This bill increases the Social Security exclusion for election workers to a reasonable level that will not discourage people from working at the polls.

It does a lot of things.

But, of course, the most important point of this bill is to accomplish something that members of this body have been trying to do for years—to restore independence to the Social Security Administration.

In 1935, when Social Security was established, it was freestanding and independent, run by a three member board. Over the years it was expanded to be the Federal Security Agency and then it was folded into the most legendary of all bureaucracies, the Department of Health, Education and Welfare.

Later, Education was spun off and H.E.W. became the Department of Health and Human Services.

Social Security got lost in the process.

This bill takes the Social Security Administration out of the basement of the Department of Health and Human Services where it has been lost in the bureaucratic shuffle.

It emancipates the Social Security Administration from the bonds of politics and insulates it against the gale winds of Presidential posturing, bureaucratic infighting, and budgetary games.

This bill insures that Social Security will no longer be a political football.

This bill provides much-needed stability at SSA by creating the positions of a Commissioner and a Deputy Commissioner to be appointed by the President and confirmed by the Senate, for 6-year terms.

In the past 17 years, 12 Commissioners or Acting Commissioners have come and gone. Social Security has suffered from revolving-door leadership. This bill changes that and provides the kind of stability and a clear-cut line of responsibility any organization the size of SSA needs to be efficiently managed.

To further strengthen oversight and accountability, this bill creates a bipartisan seven-member advisory board to provide advice on Social Security policy. Three members would be appointed by the President; four by the Congress. and, again, to provide continuity and insulate the agency from politics, the members would serve staggered 6-year terms.

I am particularly pleased that the conferees chose to go along with this form of leadership for Social Security that I specified in my bill on the subject—a single administrator backed by a seven-member board.

By granting Social Security its independence and backing it up with this well-balanced management structure, we will provide the stability and the nonpartisan credibility we need to restore the confidence of the American people that Social Security will indeed be there when they need it.

I strongly urge my colleagues to support this measure and give Social Security its independence.

□ 1250

Mr. Speaker, I reserve the balance of my time.

Mr. JACOBS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the Fourth of July has come and gone. It has been two long and eight regular-sized years now, since this effort was begun. Now on this 11th day of August, 1994, A.D., the Liberty Bill can ring for the Social Security System. The House of Representatives, by what it is about to do will take the final action in a 10-year effort. Our action realizes the perseverance and the effort of 10 years to make a declaration of independence for the Social Security System.

Many Members have made special contributions. I begin by naming my friend and my colleague, the gentleman from Kentucky [Mr. BUNNING]. Our relationship as chairman and cochairman of the Social Security Subcommittee reminds me fondly of those greats of the U.S. Congress, William McCulloch of Ohio and Emanuel Celler of New York, and the splendid fashion in which they worked and brought credit to this institution. So I pay special tribute to the gentleman from Kentucky [Mr. BUNNING] for the cooperation we have been able to find between us.

The gentleman from Texas [Mr. PICKLE] has been through the years a strong advocate, as has the gentleman from Texas [Mr. ARCHER], as has been mentioned. The gentleman from Illinois [Mr. ROSTENKOWSKI] has been also, and the gentleman from Florida [Mr. GIBBONS] has been. In fact there are very few people on the committee who have not been strong advocates for this legislation.

But I think it is especially appropriate to mention that the legislation took 10 years because the White House was opposed and in essence the other body, the Senate, was opposed. So I take this occasion to commend our colleague, Mr. MOYNIHAN of New York, for at long last reversing the refusal of the other body. Similarly, we have had three Presidents while this effort was under way, and President Clinton has endorsed the plan at long last, reversing White House opposition.

Mr. Speaker, one hears it said that the funds of the Social Security system are being purloined and used for the general government. With the exception of two occasions in the 1980's, this absolutely is not true. The Social Security System since its inception has been required to invest its surpluses in the most conservative, the safest securities available, and any financial adviser worth his or her salt will tell us that is U.S. securities. My wife and I have our life savings essentially in U.S. bonds.

If you put $1,000 in the bank and some fool comes along and borrows that $1,000 from the bank to squander on something, still as far as the bank and as far as you are concerned, the question is, Can and will that individual pay that money back and pay the interest on it? In the case of the Social Security trust fund, no doubt some of the funds borrowed, as is the case with funds borrowed from other sources by the U.S. Government, are wasted. Yet as far as the Social Security trust fund itself is concerned, it has just as legal a claim on the U.S. Treasury for the interest and repayment of the loans of the surplus as any individual who holds U.S. bonds in this country. Yet it continues to be thundered across areas of this country that the money is being taken from the Social Security System without the inconvenience of borrowing and paying interest.

I keep thinking about the story FDR told once about Uncle Jed and Ezra.

Ezra said, "Uncle Jed, aren't you getting a little hard of hearing?"

And Uncle Jed said, "Yes, I'm afeared I'm getting a mite deef." Whereupon Jed went down to Boston to see an ear doctor, and he came back and said, "That doctor asked me if I had been drinking any, and I said, 'Yes, I drink a mite.' He said, 'Jed, I might as well tell you now that either you cut out the drinking or you're going to lose your hearing altogether.' "

"Well," said Uncle Jed, "I thought it over and I said, 'Doc, I like what I've been drinking so much better than what I've been ahearin' that I reckon I'll just keep on getting deef.' "

So the assertion that you hear time and time again—that this money is being taken from the trust fund and that the Government is not keeping faith with the investors and the taxpayers of this country—is something to which I would advise you to turn a deaf ear.

Mr. Speaker, I reserve the balance of my time.

Mr. BUNNING. Mr. Speaker, I yield 1 minutes to the gentleman from New York [Mr. HOUGHTON].

Mr. HOUGHTON. Mr. Speaker, I rise in support of the conference report on H.R. 4277.

I will not repeat some of the wonderful things that have been said on a bipartisan basis. I respect the gentleman from Indiana [Mr. JACOBS] and the gentleman from Kentucky [Mr. BUNNING]. I think that what my leader, the gentleman from Texas [Mr. PICKLE], has done has been absolutely extraordinary.

I would like to focus on one particular feature that I think is important here, and that is a section called section 231. That does not mean much to a lot of people. However, it happens to involve fraud.

One of the things which the Ways and Means Committee was able to detect over the years, after a year-long investigation, was that there had been tremendous fraud perpetrated upon immigrants coming into this country. People would take advantage of them, put them on the SSI rolls, steal money from the Government and the taxpayers, and do this thing illegally. That has been stopped, to the best of my knowledge. We now have better information. We have laws to protect against this thing.

Mr. Speaker, I think this is very important. The reason I mention it is because it is one of the several features that are, I think, important in establishing Social Security as an independent agency. I thank the Members very much for accomplishing that.

Mr. BUNNING. Mr. Speaker, I yield 6 minutes to the gentleman from Pennsylvania [Mr. SANTORUM].

Mr. SANTORUM. Mr. Speaker, I thank the gentleman for yielding time to me.

I rise in strong support of the conference report, and I also want to commend the gentleman from Indiana [Mr. JACOBS], the gentleman from Kentucky [Mr. BUNNING], and also the gentleman from Texas [Mr. PICKLE], for the fine work they have done on this legislation.

I think it is important that Social Security become an independent agency, and those arguments have been made. What I want to focus on today is a subject that I was involved with in the conference, and that is the SSI reforms that are in the bill. I believe now, having looked at the SSI Program for the 2 years I have been on the

Human Resources Subcommittee, that there is no entitlement program that is more abused and more fraud-ridden than the SSI Program. What we have done today is take a first step toward entitlement reform.

We have heard a lot of talk about this and people have asked, "What are you going to do about entitlements?" Well, today we have an opportunity to do something about entitlements. We have solid reforms in this proposal that are going to make, I believe, some important gains in controlling the cost of entitlements and reducing fraud and abuse in entitlements.

But this is only a first step. There are many miles to travel before we can clean up the SSI Program from the state it is in right now or even the state it will be in after this legislation has been adopted.

Let me take the time to talk about two things that are, I think, good steps that we have taken and then focus on the problems that I think still remain. The gentleman from New York [Mr. HOUGHTON] just talked about the middleman provision about which the gentleman from Texas [Mr. PICKLE] had hearings in his Committee on Oversight and that were, I think, addressed on target. It was a very good amendment. It addresses the issue of aliens in this country who come here to this country and get on SSI fraudulently. That is a good amendment, one that is going to cut down on fraud and abuse and save the taxpayers money.

□ 1300

Another step that was a good step that the gentleman from Texas [Mr. PICKLE] and I worked on in the conference committee and were able to get installed in this legislation had to do with mandatory disability reviews. There were no mandatory disability reviews that were going to be provided for in the conference report. We were able to strike a compromise in the House position which was going to require all mandatory disability reviews for all supplemental security recipients, to 100,000 per year for disability cases and for over a 3-year period, and one-third of all children who qualify for SSI, who when they turn 18 are reevaluated under different criteria, that is as adults, and whether they would qualify for disability as adults rather than disability as children.

We think those are very important steps to determine the level of review that needs to be done. We are going to do a 3-year implementation of this, take a look at the results, and see if we save money, see if there is the need to continue these disability reviews and expand them.

I want to commend the gentleman from Texas [Mr. PICKLE], in particular, for the tremendous work he did in the conference committee to seek this provision and get it included in the conference report.

Unfortunately, we have only taken those few first steps. There are other areas that I think we need some more work to be done in. One is on the SSI DA&A Program, a supplemental security income drug addicts and alcoholics program.

These are people who qualify for SSI simply because they are so addicted to drugs and alcohol they cannot work. They have no other disability, other than the fact they are so drug addicted to illegal narcotics or addicted to alcohol that they can no longer perform work. So we give them money. We give them cash. We give them medical care. In many cases we give them food stamps.

In 1985, there were 3,500 people on this program. Today there are almost 80,000 people on this program. In 1989, we spent $55 million on this program. Today we spend $350 million on this program.

Only 8 percent of the people are in treatment. Yet every one is required to be in treatment. But only 8 percent are in treatment. The Social Security Administration testified before our subcommittee and said that we knew very little about treatment progress of SSI recipients, and could document few, if any, recoveries in the history of the program. So this is not a program that is working.

So what we have been recommending strongly is to do something dramatic to change it. What we have done in this bill, in my opinion, is piecemeal. It is a positive step, but it does not go far enough. We have capped the amount of time you can be on SSI to 36 months, 3 years, that you can be on SSI if you are in the drug addicts and alcoholics program. That is a start. But we have to be much more dramatic in trying to get people off drug addiction and alcoholism and back into the mainstream society, and not paying people money to support their addiction and their habit.

The second thing that I think we went only a very small step on has to do with SSI for children. Ever since the decision back in 1991 in the Zebley case we have seen an explosion of children going on SSI and their parents receiving large checks from the Government. In many areas of the country, they are called crazy checks. These are checks given because now under the Zebley decision, your child qualifies for SSI if your children are exhibiting age-inappropriate behavior.

Now, for age-inappropriate behavior for your children, you get a $450 check a month from the Federal Government. With the amendment of the gentleman from Wisconsin [Mr. KLECZKA] in the committee, we will do a study as to whether we can turn these cash payments to these parents, who we have evidence in some cases of coaching their children to get these checks, we have a study to look to whether we can go to a voucher program for treatment of children who are having problems, as opposed to cash to parents of these children.

Finally, we really do not address the issue of noncitizens receiving SSI. We have $7 billion a year being paid to noncitizens in this country for welfare payments, and a big chunk of that is SSI. Half a million people who are noncitizens of this country receive SSI benefits today, and it is a growing problem, growing faster every day. We must do something about that.

This is a positive first step. I hope we can come back in future Congresses to take more steps.

Mr. JACOBS. Mr. Speaker, I want the record to show that Valerie Nixon, Sandy Wise, Elaine Fultz, Cathy Noe, and Phil Mosely have all contributed mightily to putting this whole revolutionary program together. They are staffers on the committee. We could not have done it at all without the help of Janice Mays, the staff director at the Committee on Ways and Means, aka, Amazing Janice.

Mr. Speaker, I yield 2 minutes to the gentleman from Ohio [Mr. FINGERHUT].

Mr. FINGERHUT. Mr. Speaker, I thank the gentleman from Indiana for yielding. I want to compliment the gentleman and each and every member of the Committee on Ways and Means, both the majority and minority side, who have led the fight for this historic legislation for so many years. I also want to add my thanks to President Clinton and the administration for endorsing this bill, which gave it critical support when it needed it.

Mr. Speaker, I rise today in strong support of the conference report on H.R. 4277, legislation that would make the Social Security Administration an independent agency with an accountable administrator supported by a bipartisan independent advisory board.

The Social Security Administration is one of the most important agencies of our Federal Government, with 64,000 employees. It is the largest division of the Department of Health and Human Services and one of the largest Federal agencies of any kind. Maintaining the integrity of the Social Security System is vital to the well-being of our seniors. The Government must keep its promises. It must not, and it does not, as the gentleman from Indiana [Mr. JACOBS] said before, use the Social Security moneys for other programs. But an independent agency will maintain the integrity of these funds and will fight for the rights of seniors.

Most importantly, an independent Social Security Agency will protect the agency from the political whims of the moment.

I believe that the final passage of this legislation will greatly benefit my constituents. As an independent agency, the Social Security Administration will be able to focus on the goal of improving service and responding more efficiently and effectively to the people it serves. Most importantly, such a move will enhance the confidence of the American people in an agency which is a vital part of their lives.

Mr. Speaker, there are many other important provisions of this bill. The gentleman from Pennsylvania [Mr. SANTORUM] and others have referred to the provisions with respect to the Social Security disability program to tighten the requirements and make sure we are not needlessly paying out money to support drug and alcohol addiction programs. I support those reforms.

There is also a small but very important reform in this bill that allows election day workers, those people who perform their civic duty, to not have to pay Social Security benefits on their poll payments, a small but very important and significant provision of this bill.

Another important provision of the bill would increase penalties against deceptive mass mailings that cheat thousands of senior citizens by mimicking official Social Security correspondence.

Mr. Speaker, I strongly support this conference report and urge its passage.

Mr. BUNNING. Mr. Speaker, I yield 1 minute to the gentleman from Illinois [Mr. CRANE].

Mr. CRANE. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, first off, I want to congratulate the gentleman and the distinguished chairman of the Subcommittee on Social Security on which I serve, too, for the outstanding bipartisan contribution that they have made. It is long overdue, and a lot of the things that are being addressed in this bill, while perhaps there are still further improvements down the road that can be achieved, I think make a major step forward in the right direction. The most important, of course, is depoliticizing any aspect of this important new independent entity, the Social Security Administration as an independent agency.

I think in addition to that, the reforms on drug and alcohol abuse, those are critically important reforms, and the bill does indeed provide the incentives for people to get out of drug and alcohol addiction, and I think that they are two important ingredients of this that in and of themselves, aside from the other reforms that are contained therein, warrant the support on a bipartisan basis of all the Members of this Chamber. I urge every one to vote for the conference report on H.R. 4277.

Mr. Speaker, as a member of the Ways and Means Subcommittee on Social Security, I urge my colleagues to support the conference report on H.R. 4277, the Social Security Administrative Reform Act. I believe this legislation is an important step toward the efficient operation and administration of the Social Security Program.

In too many instances, political fluctuations have brought instabilities to the Social Security Administration. This legislation will remove those uncertainties and allow for continuity in the agency's operations. Starting in April of next year, Social Security will be run by a commissioner and a bipartisan board, appointed for specific terms of office and therefore somewhat more removed from the political process.

Another important provision of this legislation is the reform of disability compensation for drug and alcohol addicts. Current law allows for far too much abuse of the system, intentional or otherwise, as addicts who are not cured of their disability remain on the welfare rolls. In contrast, this legislation forces addicts to assume some measure of responsibility for their condition, not only requiring them to seek treatment but also providing an incentive for them to actively seek self-sufficiency. Requiring treatment will force addicts into beneficial programs, and cutting off benefits after 3 years will undeniably provide motivation for addicts to put their addictions behind them and return as productive members of society.

These changes are especially relevant in a year when Congress is attempting to tackle welfare reform. No longer can we afford to dole out Federal largess without any promise of improvement. Some have criticized the cutoff of benefits as arbitrary and counterproductive for those who have not yet completed treatment, but I believe that we must provide incentives for those who rely on Federal payments to find other means of support. It is a lesson that we should all bring to the debate over welfare as well.

This legislation makes important changes to the Social Security Administration. And it marks an important change in how we approach our social spending. I hope that my colleagues on both sides of the aisle will join in support of this long overdue reform.

Mr. JACOBS. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin [Mr. BARCA].

Mr. BARCA. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, today is another banner day for Congress. Yesterday we passed the Congressional Accountability Act, and today we pass the bill to make Social Security an independent agency and make other important changes within that area.

We want to protect Social Security from political pressures and, most important, guarantee the integrity of our Social Security funds. Since Franklin Delano Roosevelt first pushed Social Security, it has been one of the most important programs to provide for the security and dignity of Americans in retirement. It has always been a very important buffer for people in tough economic times.

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Senior citizens throughout Wisconsin and America can rest a little easier with the passage of this bill. Also I had heard from many poll workers in my district, such as Norm Buckholtz and Eleanor Covelli, and many others that believe that we need to exempt them from the taxes from Social Security, and I thank the gentleman from Indiana [Mr. JACOBS], for his hard work in that effort.

Finally, and equally importantly, a provision to curb benefits for alcoholics and drug addicts is part of this bill. I had visited many treatment centers in my district and have been working on legislation in this respect. I believe this is an important provision to limit payments to 36 months and ensure that the moneys are going to curb addiction rather than feed people's addiction. Hopefully this will be just one of a number of steps that we can take in this regard.

So today is a great achievement for the Social Security Program. It is a great achievement for the 103d Congress. I thank the chairman and his committee for their outstanding work. I believe that FDR is smiling with great favor upon the 103d Congress today.

Mr. BUNNING. Mr. Speaker, I yield 1 minute to the gentleman from Michigan [Mr. CAMP].

Mr. CAMP. Mr. Speaker, I thank the gentleman from Kentucky for yielding time to me.

Mr. Speaker, I rise today in support of the Social Security Administrative Reform Act Conference Report.

This bill, establishes the Social Security Administration as an independent agency. It will ensure the integrity accountability of Social Security by greatly diminishing the politics of the agency. It will remove the agency from the control of HHS and better enable the Government to keep its promise to older Americans.

As a member of the Committee on Ways and Means, I have seen evidence of Social Security disability abuse. Under the current, SSI program some drug addicts and alcoholics defraud the system, rather than get treatment for their addiction. This legislation is a first step in addressing the abuse and fraud within the SSI Program. It is our intention to continue working to reform current law and bring a balance to the disability program.

This bill will also provide Social Security tax relief to election workers which have been unfairly taxed causing added administrative burdens to local governments, charged with conducting our elections.

I urge my colleagues to restore senior citizen's trust in the Government by voting for this conference report. It is a good idea for the Social Security Administration and best of all a good idea for the American people.

Mr. JACOBS. Mr. Speaker, I yield 3 minutes to the gentleman from Wisconsin [Mr. KLECZKA], the author, I might add, of the reform on the drug addiction.

Mr. KLECZKA. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I rise in support of the conference report and ask unanimous consent to revise and extend my remarks.

Mr. Speaker, one of the focuses of the 103d Congress has been to make the Federal Government run more efficiently and to increase the general public's confidence in its Government.

We are committed to this objective and have made strides toward achieving it.

H.R. 4277 takes a step in this direction. By making SSA an independent agency, we hope to increase the quality of service it provides.

Currently, SSA is overwhelmed: there is a tremendous backlog in disability cases waiting to be processed, agency employees are sometimes difficult to reach, and responses are often slow in coming and errorprone upon arrival.

This is due to: an overburdened system plagued by shortages of staff and rising numbers of cases, as well as a high-rate of turnover among top agency officials.

By creating an independent, more stable, structure for the agency, we will hopefully correct some of the problems with the current system.

We will thereby increase confidence that the Social Security System will be able to provide the quality of service and benefits that is expected.

The bill also makes headway in reforming the current system by demanding accountability for disability payments to substance abusers.

My office has received numerous calls from constituents who are adamant that their hard-earned tax dollars not be used to finance the habits of drug addicts and alcoholics.

The issue is not that we should withhold assistance from substance abusers who are seeking rehabilitation. We should help them if they are committed to rehabilitating themselves and improving their lives.

The Department of Health and Human Services Inspector General recently tracked 196 sustance abusers on SSI for 3 years:

Only 1 of these 196 recipients left the SSI rolls due to self-sufficiency.

This led the IG to determine that current treatment efforts appear to result in few complete rehabilitations that eliminate a recipient's need for SSI.

Clearly, this is a program that's not working.

If we're not helping substance abusers successfully rehabilitate and become capable of earning income, then the program is failing both the recipient and the taxpayer.

We cannot allow this to continue.

H.R. 4277 includes a time limitation provision I offered, along with my colleague from Oklahoma, [Mr. BREWSTER].

Under this provision, substance abusers who qualify for benefits because of their addictions will only receive cash assistance for 36 months.

Mr. Speaker, at some point, we must say enough is enough. At some point, the recipient must be asked to take ultimate responsibility for his or her life.

By enacting this bill, Congress is saying 3 years is the appropriate point.

While this bill does a good job of addressing some of the problems with the SSI and SSDI Programs, this is just a first step.

Some of the changes in H.R. 4277 are modest ones, and we must ensure that payments are used for their intended purpose.

In general, the Social Security Administrative Reform Act proposes innovative solutions to problems faced in various programs under the jurisdiction of SSA.

However, more must be done.

We must continue to scrutinize this system in search of ways to improve failing programs and recoup wasted resources.

The American people expect and deserve quality service from their government, and they want to know that their tax dollars are being used wisely.

Mr. Speaker, we have the responsibility to live up to these expectations.

Mr. BUNNING. Mr. Speaker, I yield 2 minutes to the gentleman from California [Mr. HERGER].

Mr. HERGER. Mr. Speaker, I rise in strong support of this legislation, which includes a provision I offered which will begin conducting continuing disability reviews in the SSI Disability Program—a reform which will make a significant contribution to ending fraud in this program, saving up to $300 million in future years.

I would like to thank my colleagues, chairman GIBBONS and ranking member BILL ARCHER for their support. I also want to thank subcommittee chairman ANDY JACOBS and ranking member JIM BUNNING, and particularly the gentleman from Texas [Mr. PICKLE], who has been a strong advocate of this reform, and the gentleman from Pennsylvania [Mr. SANTORUM].

Mr. Speaker, compiling a profile of those collecting SSI disability benefits who are most likely to recover is crucial to getting a handle on spending in the SSI Disability Program, which is the fastest growing entitlement in the Federal budget. It is amazing that, until now, the Social Security Administration was not required to verify that persons receiving SSI disability benefits were still eligible for benefits, even after the passage of many years. While many people may well recover from their disability and be able to go back to work, until now we have not required any effort to find this out.

This has only fed the explosion of our disability rolls, thus jeopardizing benefits for those who remain truly disabled and have no other source of income.

Eliminating this oversight is an important feature of H.R. 4277. I urge my colleagues to support responsible reform of our disability programs.

Mr. BUNNING. Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky [Mr. LEWIS].

Mr. LEWIS of Kentucky. Mr. Speaker, I thank the gentleman from Kentucky for yielding time to me.

I also want to thank him for his dedicated work toward bringing this bill to the floor today.

Mr. Speaker, I rise today in strong support of this landmark legislation, H.R. 4277, that finally gives the Social Security Administration its freedom.

By making the Social Security Administration an independent agency, H.R. 4277 gives SSA a chance to operate the way it was originally intended when this program was first created. SSA will no longer be subject to the restraints and red tape that come from being part of the Department of Health and Human Services.

SSA will be able to concentrate on administering its programs, and provide better, cost effective, and more efficient service to the American people.

Social Security is one of the most important programs that our Government offers. Since just about every American pays into it during their lives, it is our responsibility to make sure that the Social Security system is strong and solvent for generations to come.

By passing this conference report and making SSA an independent agency, we can do just that.

This bill also makes many other improvements to the Social Security system that are badly needed. Specifically, H.R. 4277 cleans up the regulations on Social Security benefits for drug addicts and alcoholics. As it works now, these people can receive Federal benefits with virtually no supervision on how the money is used, or encouragement to get treatment.

But H.R. 4277 changes that. Under this bill we can be sure that American tax dollars are not being used to feed alcohol and drug habits. Instead, H.R. 4277 encourages these folks to get help, to be in therapy and to start getting their lives back on track.

These are needed changes for SSA. They have been a long time in the making and thanks to the hard work of the members on the Social Security Subcommittee and the Ways and Means Committee, we have the chance today to make them.

I urge my colleagues to support these improvements for Social Security and vote yes on this conference report.

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Mr. JACOBS. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey [Mr. HUGHES].

Mr. HUGHES. Mr. Speaker, I thank the gentleman from Indiana for yielding time to me.

Mr. Speaker, I rise in strong support of H.R. 4277, legislation to establish the Social Security Administration as an independent agency. I firmly believe that we must act now to ensure strong, stable, and independent leadership for this large Federal agency which is of crucial importance to virtually every American.

As the former chairman of the Select Committee on Aging and the current Chairman of the Older Americans Caucus, I have held a number of hearings that have detailed serious and costly problems with SSA's ability to provide appropriate assistance to older and disabled Americans. It is very clear from this testimony that we are experiencing a real crisis in service delivery in a number of different areas.

With administrative costs running around 1 percent, Social Security's staffing was put through a rapid downsizing process in the late 1980's, eliminating nearly one-fourth of its personnel. While steps were needed to streamline the agency, the evidence is overwhelmingly clear that we have gone too far. Many of these reductions were made strictly for political reasons, and they are costing the taxpayers millions of dollars in incorrect benefit payments and forcing many elderly and disabled beneficiaries to face undue hardships.

One of the most serious effects of this political jockeying can be seen in the unacceptable backlog in the Nation's disability program, which is barely treading water under a sea of unprocessed claims and paperwork. Despite completing more casework with fewer staff, the nationwide backlog of unprocessed disability cases is well over 800,000 cases, a level which is some 2½ times larger than it was just 3 years ago, and we can expect the disability caseload to be over 1 million cases by the end of the year. On the front end, the average disabled applicant must wait 5 to 6 months in many areas of the country in order to have his or her initial disability application reviewed. In many instances, people are dying before their casework is processed.

And on the back end, we are costing the taxpayers tens of millions of dollars because we do not have sufficient personnel to review the disability rolls to determine those who have improved enough medically that they should no longer be receiving disability benefits. Consequently, the taxpayers are spending tens of millions of dollars on persons who should no longer be receiving benefits.

In short, we have hundreds of thousands of people waiting inordinate amounts of time to receive the disability insurance they have paid for at the same time that taxpayers are spending estimates of up to $100 million per year on persons who should not be on disability. Is there any wonder why many of our constituents have the perception that their Government is not working?

In addition, a growing number of Social Security recipients in New Jersey and throughout the country are finding it increasingly difficult to get timely assistance. Busy signals at SSA's national 1-800 telephone service are running over 50 percent on some days, with many older persons telling me that they often just give up because of the busy signals.

Social Security recipients have a right to expect that when they call for questions or assistance, they will not be faced with inordinate delays, busy signals, or staff who are too busy to provide complete and accurate answers to their questions.

Many of these problems can be traced to the fact that Social Security's administrative operations are being driven by short-term political decisions.

There is also a real crisis in accountability and continuity within the agency. In a little over 15 years, there have been 10 Commissioners or Acting Commissioners of Social Security. We simply must have more long-term planning and accountability for this vital agency. I believe that establishing Social Security as an independent agency is the only way we can ensure some continuity within the agency and isolate it from short-term budgetary and partisan considerations.

I urge my colleagues to support this important legislation, and I commend the gentleman from Indiana [Mr. JACOBS] and the gentleman from Kentucky [Mr. BUNNING] for their leadership in bringing this bill to the floor, as well as the gentleman from Texas [Mr. PICKLE], who I saw earlier and is in the back of the Chamber, and so many others for making this day possible. It is the right decision, an important decision, I think, in the history of Social Security, and Mr. Speaker, ask my colleagues to support this particular initiative.

Mr. JACOBS. Mr. Speaker, I yield 1 minute to the gentleman from Washington [Mr. SWIFT].

Mr. SWIFT. Mr. Speaker, I want to thank the chairman of the subcommittee, the gentleman from Indiana [Mr. JACOBS], and I want to thank the Committee on Ways and Means for their perseverance.

There is a provision in this bill that is kind of a reverse unfunded mandate. We actually help local government with one of its important tasks.

Mr. Speaker, a few years ago Congress inadvertently caused local election officials some serious problems in recruiting and hiring election poll workers. Often these people are already retired, and some Social Security requirements dissuaded many from volunteering for that work on election day. This bill fixes that in a way that has bipartisan support, and will significantly help local election officials get their job done on election day.

Mr. Speaker, I want to thank the chairman of the subcommittee the gentleman from Indiana [Mr. JACOBS], I want to thank the gentleman from Kentucky [Mr. BUNNING], and I want to thank all the Members of the Committee on Ways and Means for taking care of this problem for the poll workers of America.

Mr. Speaker, as chairman of the Subcommittee on Elections of the House Administration Committee, I have a special reason for being pleased with this legislation. In July 1991, three years ago—State and local election officials noted that because of an oversight in the 1990 OBRA, Omnibus Budget Reconciliation Act, they faced an enormous administrative and financial burden. In the OBRA, Congress extended social security coverage to State and local government officials without noticing that the $100 exemption for election workers already in place would not be adequate to continue exempting those election workers that no one intended to cover. They did not need the coverage—most are already on retirement, and they did not work at the polls because they needed the money—they have been leaving in droves because of the administrative hassles they now face. And running elections has been more and more difficult to do for the state and local jurisdictions.

The solution was easy, but putting it into effect has not been. The House twice placed a provision to raise the exemption to a realistic figure—$1,000—in the budget reconciliation bills only to have the Senate object in conference.

But now, in H.R. 4277, this conference bill to make the Social Security Administration an independent agency, we find there is a small provision to raise the exemption for poll workers from $100 to $1,000. The provision did not appear by accident. Chairman JACOBS and the committee have worked hard to get this in and to keep it in, and I thank them for it.

Mr. BUNNING. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida [Mr. YOUNG].

Mr. YOUNG of Florida. Mr. Speaker, I rise in support of this all-important, long overdue legislation.

Mr. Speaker, as the representative of one of our Nation's largest populations of Social Security recipients and the chairman of the Congressional Social Security Caucus, I rise in strong support of this conference report on H.R. 4277, the Social Security Administrative Reform Act.

This legislation gives the Social Security Administration long overdue independence from the Department of Health and Human Services and, more importantly, from political pressures that can be exerted on its Commissioner. Under H.R. 4277, the agency would be headed by a single administrator, appointed by the President, but who would serve under the oversight of a seven-member bipartisan board. This board, as the voice for the almost 40 million Americans who receive Social Security benefits, would ensure that the trust funds remain sound and untouched, that payments and cost-of-living adjustment continue to be paid in full and on time, and that the agency continues to provide timely and efficient service for retirees, workers, and employers.

As a member of the House Appropriations Subcommittee on Health and Human Services, which oversees the operations of and funding for the Social Security Administration, I am well aware of the chain of command which currently requires the Commissioner of Social Security to report to the Department of Health and Human Services. Likewise, the agency's budget requests must also be reviewed and approved by the Secretary.

The legislation before us today will enable the Social Security Administration to present directly to Congress and our committee its annual budget request. This is important in that it enables us to know what the new Administrator and Social Security Board believe are the agency's true funding requirements, not those imposed upon them by the Department of Health and Human Services.

This legislation also takes a number of important steps to further enhance public confidence in the Social Security Program. It cracks down on the payment of supplemental security income [SSI] and disability insurance [DI] benefits for alcoholics and drug abusers. It also requires the Social Security Administration to direct greater resources into preventing, detecting, and terminating fraudulent claims for SSI benefits.

Finally, the conference report retains an important House provision to give the Administrator greater powers to police the mailings and fundraising appeals of various organizations who attempt to mislead and frighten older Americans, many of whom live on small fixed incomes and depend almost solely on their monthly Social Security benefits for their financial well being.

We have become all too familiar with calls, letters, and post cards from our constituents asking if they have to contribute $5 or $10 to the variety of organizations that have sprung up to purportedly protect their Social Security benefits. As I tell each of these people who contact me, they do not have to contribute a single penny to any of these organizations to protect their benefits. It is the responsibility of Congress, and my job as their Representative, to ensure that the U.S. Government continues to live up to its commitment to ensure that the Social Security trust funds remain sound and that their benefits and cost of living adjustments are protected.

Mr. Speaker, this is the fourth time the House will consider this legislation and I am pleased to know that after allowing it to die three previous times, our colleagues in the other body have finally joined us in enacting this legislation. It is a reaffirmation that the Social Security trust funds are an independent and self-supporting sector of our Federal Government and that oversight for these funds should be provided for by an independent agency and board.

Mr. BUNNING. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin [Mr. ROTH].

Mr. ROTH. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I want to join with so many of the other speakers who have had such complimentary remarks about the gentleman from Kentucky [Mr. BUNNING], the gentleman from Texas [Mr. PICKLE], and the gentleman from Indiana [Mr. JACOBS] for the fine work they have done on this legislation. I want to join in congratulating them.

Mr. Speaker, as the chairman of the House Republican Social Security Task Force, I rise in support of this conference report to reform our Social Security System.

Social Security is a trust between the American people and their Government. But as the members of the Social Security Task Force heard in a recent hearing, this trust has been eroded. Instead of being invested for the future, billions of Social Security dollars are being spent on programs other than Social Security.

Senior citizens are justifiably upset that political and budget battles have put their hard earned Social Security benefits in jeopardy. The Social Security System is also being abused. Drug addicts and alcoholics are spending their Supplemental Security Income and Social Security Disability Insurance benefits on more drugs and alcohol.

By passing this conference report today, the House will take a significant step to correct these problems. This action is long overdue. Today's bill will make Social Security an independent agency to protect Americans' retirement funds from political and budget battles. Every Social Security beneficiary, both current and future, must be assured that their benefits will be secure, and that the program will be administered fairly and soundly. By walling off Social Security as an independent agency, Congress will help to assure the American people that Social Security funds will be used for Social Security purposes only.

Today's bill also will tighten the rules for drug addicts and alcoholics who receive benefits. As I testified last February to Mr. Jacobs' subcommittee, the American people are outraged that our Social Security system has degenerated into a cash cow for addicts. Nearly 250,000 drug addicts and alcoholics received $1.4 billion in Social Security Disability Insurance payments last year, with no strings attached. Addicts are cashing their checks and buying drugs the same day. And while I would prefer to see even tougher restrictions, today's bill will impose some tighter rules on SSI and SSDI recipients who are addicts. Benefits to addicts will be cut off after 3 years. Second, benefits must be paid to a responsible party who will ensure that the recipient is participating in a treatment program.

Mr. Speaker, senior citizens deserve to have an independent and depoliticized Social Security Administration to responsibly oversee their retirement benefits. And the American people are looking to Congress to stop the scandalous waste of Social Security funds by addicts. To combat both these problems, I urge my colleagues to support this conference report and help strengthen the Social Security system on behalf of all Americans.

Mr. BUNNING. Mr. Chairman, I yield 1 minute to the gentleman from Ohio [Mr. REGULA].

Mr. REGULA. Mr. Speaker, I congratulate the sponsor and authors of this legislation. As vice chairman of the Older Americans Caucus, I know how very important it is to senior citizens to have a sense of confidence in their systems, particularly Social Security.

Mr. Speaker, as we all know, there are many groups that communicate to seniors, causing them to worry about the integrity of the Social Security System. We get letters reaffirming such worries. By making SSA an independent agency, this bill means that the integrity of the Social Security System can be maintained. Moreover, such action will prevent Social Security benefits from being further used as both political and budgeting pawns. Enactment ensures that those who pay into the system will receive their benefits.

I also commend provisions which strengthen safeguards against the use of disability and supplement income payments to support a drug or alcohol habit.

Truly, this bill restores not only the confidence of our present retirees, but the confidence of our future retirees—guaranteeing that our Social Security System can and will be preserved.

Mr. BUNNING. Mr. Speaker, may I ask how much time we have remaining?

The SPEAKER pro tempore (Mr. SERRANO). The gentleman from Kentucky [Mr. BUNNING] has 3 minutes remaining.

Mr. BUNNING. Mr. Speaker, I yield myself such time as I may consume to close debate for our side.

Mr. Speaker, there is one more important point I would like to make in closing. Ever since I have come to Congress I have received hundreds, perhaps thousands, of letters from older citizens who are frightened. They are frightened because unscrupulous lobbying organizations have been scaring them to death with unsolicited mailings saying Congress is about to cut Social Security.

These letters usually read something like this: "Congress is about to act on Social Security cuts. We need your money to stop Congress now." That is just plain cruel, and it is inexcusable.

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Older Americans are usually on fixed incomes and even $5 or $10 a month means the difference in food and medication each month. But these groups do not care. They will seize any opportunity to solicit contributions from senior citizens under the guise of lobbying Congress to stop any Social Security cuts. One of the jobs of the new bipartisan board will be to inform the public about Social Security. I am hoping the board will do such a good job of informing the public about Social Security that these unscrupulous organizations and their mailings will be put out of business.

Again, let me reiterate my strong support for this bill. It is time Social Security took its place as a nonpartisan and independent agency.

Mr. Speaker, I yield back the balance of my time.

Mr. JACOBS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, first I would be pleased to incorporate by reference every word my colleague, the gentleman from Kentucky, has just said. It is pretty reprehensible to rip anybody off, but it is particularly reprehensible to rip off people who may not be adequately informed. There is a work for it, and that is conning. That is wrong.

A moment ago, I omitted mentioning Phil Moseley, a staffer at the Committee on Ways and Means who has contributed greatly to this effort as well. While I am commending, I also commend our President who within a few days, I understand, will take the final step and sign this legislation into law. So break out the firecrackers. Let freedom reign. Independence is at hand for the Social Security System. It is a fine day for the United States.

Mr. JACOBS. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida [Mr. SHAW].

Mr. SHAW. Mr. Speaker, I thank the gentleman for yielding, and I rise in strong support of this most important legislation. I compliment both sides in working together.

Mr. Speaker, I rise today to express my strong support for the conference report on H.R. 4277, the Social Security Administrative Reform Act of 1994. This important bill makes a number of changes that will help protect the Social Security system on which millions of Americans rely.

First, it makes Social Security an independent agency, which is a position I have long supported by cosponsoring and voting for bills to this effect. Passage of H.R. 4277 this year means that Social Security will become an independent agency no later than March 31, 1995. The new agency will have independent, bipartisan leadership. This will help it function more efficiently for the seniors who depend on Social Security benefits to make ends meet. And the Social Security trust fund will remain protected from political or general budgetary pressures.

Second, the bill attempts to restrict disability insurance and SSI disability payments to substance abusers. Many hardworking Americans were outraged to learn that such a program even existed, spending Social Security funds on drug addicts and alcoholics disabled by their addictions. In my view, the restrictions in H.R. 4277 do not go far enough to get addicts into treatment and back to work. But they are an admission that a problem exists in this area, which the next Congress must continue to address.

H.R. 4277 makes positive changes in 30 other areas, including raising the Social Security exclusion for election workers from $100 to $1,000 annually starting on January 1, 1995. Prohibitions on the misuse of Social Security and other Government symbols are strengthened. That responds to mass mailings and solicitations meant to deceive those receiving them into thinking they were sent by the Federal Government. This is a problem many seniors especially have alerted me to, and I am pleased that we are continuing to strengthen penalties against this shameless practice.

Mr. Speaker, I urge Members to support this important legislation, which will help protect the Social Security system in the years to come.

Mr. STARK. Mr. Speaker, I am happy that this conference report contains three provisions that will benefit a small number of motivated, hard-working people with disabilities. I would like to describe these provisions which I offered and which were accepted by the Ways and Means Committee.

An SSI recipient who has a disability has the opportunity to have extra resources or income in order to achieve a work goal under a plan for achieving self-support [PASS]. Currently, an individual with an approved PASS may be eligible for income and resource exclusions for 18 months, followed by two possible extensions of 18 and 12 months, respectively. The maximum of 4 years to achieve a PASS is given to persons pursuing a lengthy educational program. Often it is difficult for a person with a disability to achieve their goal within the given time period and the inflexibility with regard to the length of time allowed can produce anxiety and—in cases when the goal is not achieved in the given time—produces frustration and discouragement.

H.R. 4277 requires the Social Security Administration [SSA] to take into account the needs of the individual and the difficulty of achieving the goal in determining the time necessary for the completion of a PASS.

Presently, an SSI recipient other than a child living with a parent in military service cannot remain outside the United States for more than 30 consecutive days and retain eligibility for SSI. Also, the person must be back in the United States for 30 consecutive days before being considered to be eligible for SSI and only if the individual continues to meet all other eligibility criteria.

A provision in H.R. 4277 allows the SSA to exempt SSI recipients from the 30-day time limit for a period not to exceed 1 year if the individual is fulfilling an educational requirement through a program which is not available in the United States and which will result in improved employment potential. Though this provision will help a very small number of people, it will allow these individuals to compete on a par with other students, disabled or nondisabled, if their educational requirements can only be fulfilled by study in a foreign country. The only way for many people with disabilities to become competitive in the labor force is to become highly educated. Young people, who have the intelligence and stamina to overcome the obstacles that disabilities present and acquire an advanced degree, can look forward to many years as productive members of our society.

Mr. Speaker, the third provision I would like to highlight extends the provisions in current SSI law for protection against loss of Medicaid eligibility because of subsequent cost-of-living increases in Social Security benefits, to those persons who are working and utilizing the section 1619(b) work incentives provisions.

There were a number of other provisions that I proposed and that the Ways and Means Committee accepted but were not accepted by the conferees. One of them would have deemed approved a PASS after 60 days if the SSA had not acted in that time. The Secretary could have subsequently disapproved the PASS prospectively and the individual would have had 6 months to spend down any money that had been saved to accomplish the work goal.

I am happy that in the conference report the conferees requested the General Accounting Office [GAO] to conduct a study of the PASS program and its procedures since they felt not enough information on the PASS program is available at this time. I look forward to the findings and recommendations that this study will give us.

I am pleased to support the conference report on H.R. 4277.

Ms. SNOWE. Mr. Speaker, I rise to express my support for the conference report on H.R. 4277.

I have been a cosponsor of legislation since the 99th Congress to make the Social Security Administration a separate, independent agency, and I am pleased to be able to cast my vote in favor of this legislation to make it happen. I support this effort because I believe that establishing the Social Security Administration, the ninth largest agency in the Federal Government, as a separate agency would further strengthen the program and ensure that it remains responsive to the millions of elderly and disabled Americans to whom it provides benefits and services.

The Social Security program represents a promise the Federal Government made to Americans. It is vitally important that this promise never be broken and that everyone knows that by paying into the system during their working years they will be assured of getting benefits for themselves and their family in their later years. Making the Social Security Administration an independent agency will help ensure that this promise remains unbroken.

I urge my colleagues to join me in support of this conference report.

Mr. MFUME. Mr. Speaker, I rise in support of the conference report on An Independent Social Security Administration (H.R. 4277), which makes the Social Security Administration an independent agency.

The Social Security Administration is responsible for administering the Old-Age and Survivors Insurance Program, Disability Insurance [DI] Program and the Supplemental Security Income [SSI] Program. The Social Security Administration is the ninth largest agency in the Government. The conference agreement establishes the Social Security Administration [SSA] as an independent agency, effective March 31, 1995.

Like the House bill the conference agreement includes several provisions which aim to improve the administration of Social Security DI and SSI programs. For example, the measure requires SSA to conduct continuing disability reviews for all SSI recipients in the same manner as they are now conducted for DI recipients. Further provisions in the agreement will give SSA additional authority to prevent benefit fraud and increases the penalties against deceptive mass mailings that mimic official Social Security correspondence.

In my district of Baltimore, the employees of SSA have asked that I support this measure.

However, Mr. Speaker, my support comes with some reservations. Specifically, I am concerned that Congress' desire to improve and advance the productivity and services of the Social Security Administration, while well-intentioned, may not be enough. In addition to passing this legislation, Congress must give the Social Security Administration the necessary resources to successfully make the smooth transition to independent status.

An example of the transition SSA finds itself going through was recently seen when the Social Security Administration announced that it would cut 1,000 management jobs through attrition. Shortly thereafter, SSA announced that it will need an additional 11,000 employees to handle its increased responsibility.

Another concern I have stems from the fact that the conference report brings SSA into a new realm of responsibility without giving it additional resources. An example of the new responsibilities is a provision in the agreement which restricts payment of disability insurance [DI] and supplemental security income [SSI] for persons with drug and alcohol addictions. Under current law, SSI recipients who have substance abuse problems are required to be paid through a designated second party. Unfortunately, there have been cases in which the alleged supplier of the drug to the abuser was the representative payee.

In a provision I support, this bill requires that where possible, organizations, rather than family or friends, be named as representative payees for Disability Insurance and Supplemental Security Income recipients, unless SSA determines that a family member is appropriate.

However, the agreement requires that the Social Security establish agencies in all 50 states that would find treatment programs for DI and SSI beneficiaries who are substance abusers, monitor their participation in the treatment program, and periodically conduct drug tests to determine if substance abuse problems are continuing. Under this provision, people with substance abuse problems who are receiving disability insurance would be required to participate in treatment, if available, in order to receive benefits. Regardless of participation in the treatment program, DI and SSI benefits to substance abusers would be cut off after 3 years unless the individual qualifies for benefits for reason other than the substance abuse problem.

This will require the Social Security Agency to become involved in a whole new activity; drug testing for DI recipients. I have a number of problems with this, but that discussion is better left for another time.

Mr. Speaker, it is my hope that this conference report will pass to allow the Social Security Administration to become an independent agency. It is my further hope that we recognize the need to give this new agency adequate resources to improve and provide better service.

Mr. MACHTLEY. Mr. Speaker, I rise today in support of the conference report on H.R. 4277, legislation which I believe will take important steps to restore public confidence in the Social Security system.

Throughout my tenure in Congress, many seniors have contacted me to express their fear that the Social Security Trust Fund is being mishandled.

And a recent GAO report, which reported that an estimated 250,000 drug addicts and alcoholics collected approximately $1.4 billion in Social Security disability insurance and supplemental security income funds last year, proves them right.

While the recipients of these payments are eligible for this Federal assistance, there is little or no evidence that these funds are being used for treatment. Instead, in many cases, these payments are being used to fuel the addictions.

Now my heart goes out to those families that have had to deal with a loved one who is addicted to drugs or alcohol, and I feel we should continue to offer our help in getting these people treatment.

But the purpose of the Social Security Act is straightforward—to provide for the economic security of our population as it grows older or becomes disabled. It is certainly not intended to provide drug addicts and alcoholics with the financial means to perpetuate their substance abuses.

Making the Social Security Administration an independent agency would greatly enhance public confidence in the management of these funds.

The integrity of the Social Security system is important to me and to many of my constituents, and I firmly believe that this legislation will help to protect the system now and in the future.

I urge my colleagues to support this conference report.

Mr. RIDGE. Mr. Speaker, I am pleased to rise in support of H.R. 4277, the Social Security Administrative Reform Act of 1994.

This legislation makes the Social Security Administration an independent agency within the Federal Government, removing it from its current home within the Department of Health and Human Services [HHS]. H.R. 4277 also contains provisions which place limits and restrictions on Social Security benefits paid to individuals with substance abuse problems.

Mr. Speaker, a priority of mine in Congress has always been, and continues to be, to make sure that the Social Security Administration is able to function as efficiently and timely as possible. Many older citizens in my district and across Pennsylvania live on a fixed income and rely heavily on Social Security benefits.

Giving the agency its independence will free it from the political and bureaucratic problems with which it has been forced to operate for so many years. Such political and bureaucratic problems have jeopardized its ability to perform properly. Making it an independent agency will go a long way in rectifying that problem, and, for this reason, I am pleased to support this legislation.

Also, placing some restrictions and limits on Social Security benefits paid to substance abusers is a step in the right direction. While substance abuse is no longer viewed as merely a behavioral problem and is widely regarded as a medical condition, I believe this legislation accomplishes two very worthy objectives.

First, treatment exists for substance abuse. It is compassionate therefore to encourage those suffering from substance abuse to seek help. Second, it is appropriate, and fair to other Social Security beneficiaries, to make sure that benefits being paid to substance abusers are not being used to sustain their addiction. For these two reasons, I am pleased that an effort was taken to ensure that the provisions contained in H.R. 4277 were done in both a fair and compassionate manner.

Mr. Speaker, making the Social Security program a well-working, long-lasting entity has been one of my highest priorities as a public servant. Keeping Social Security taxes down, and Social Security benefits up is paramount to that effort. H.R. 4277 goes a long way toward that end and I am pleased to rise in support of it. Passage of this legislation is long overdue.

Mrs. CLAYTON. Mr. Speaker, today the House of Representatives passed the conference report on H.R. 4277, the Social Security Administration Reform Act of 1994. I supported H.R. 4277 when it passed the House in May, and I support the conference report today.

This legislation will remove the Social Security Administration from the Department of Health and Human Services and establish it as an independent agency. Currently the Social Security Administration is the largest agency within the Department of Health and Human Services and the ninth largest agency within the Federal Government.

This agency will have direct administrative responsibility for the Social Security and Supplemental Security Income programs. The President will appoint a Commissioner to head this new agency.

Independence for the Social Security Administration is not a new idea—this issue has been addressed since back in the 1970's. However, the House and Senate could not come to an agreement. Finally during this 103d Congress both the House and the Senate have agreed to this motion, with President Clinton's endorsement.

This legislation also promotes fiscal restrictions in such areas as disability payments to alcoholics and drug addicts who refuse participation in a treatment program.

There is much dialog about Social Security during this Congress. As a member of the Entitlement Commission, I am well aware of the important part Social Security plays—we all know the system was not designed as a retirement benefit, yet millions of Americans have worked and paid into Social Security for just that reason, to be ensured benefits when they retired. Social Security is the largest entitlement program with near universal participation. It has been a successful program—yet it is imperative that some adjustments are made if the program is to continue into future generations.

I believe that this program has proven to be long-term—Social Security will be 60 years old in 1995—it is time to treat this program with the respect it so deserves. I am pleased that this legislative body has chosen to elevate the Social Security Administration to agency status.

Mr. JACOBS. Mr. Speaker, I yield back the balance of my time.

GENERAL LEAVE

Mr. JACOBS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the conference report on H.R. 4277.

The SPEAKER pro tempore (Mr. SERRANO). Is there objection to the request of the gentleman from Indiana?

There was no objection.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the conference report.

There was no objection.

The SPEAKER pro tempore. The question is on the conference report.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. JACOBS. Mr. Speaker, I object to the vote on the ground that a quroum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quroum is not present.

The sergeant at arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 431, nays 0, not voting 3, as follows:

[Roll No. 392]

YEAS—431

Abercrombie
Ackerman
Allard
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Archer
Armey
Bacchus (FL)
Bachus (AL)
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barca
Barcia
Barlow
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bateman
Becerra
Beilenson
Bentley
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Blackwell
Bliley
Blute
Boehlert
Boehner
Bonilla
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (OH)
Bryant
Bunning
Burton
Buyer
Byrne
Callahan
Calvert
Camp
Canady
Cantwell
Cardin
Carr
Castle
Chapman
Clay
Clayton
Clement
Clinger
Clyburn
Coble
Coleman
Collins (GA)
Collins (IL)
Collins (MI)
Combest
Condit
Conyers
Cooper
Coppersmith
Costello
Cox
Coyne
Cramer
Crane
Crapo
Cunningham
Danner
Darden
de la Garza
Deal
DeFazio
DeLauro
DeLay
Dellums
Derrick
Deutsch
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Dooley
Doolittle
Dornan
Dreier
Duncan
Dunn
Durbin
Edwards (CA)
Edwards (TX)
Ehlers
Emerson
Engel
English
Eshoo
Evans
Everett
Ewing
Farr
Fawell
Fazio
Fields (LA)
Fields (TX)
Filner
Fingerhut
Fish
Flake
Foglietta
Ford (MI)
Fowler
Frank (MA)
Franks (CT)
Franks (NJ)
Frost
Furse
Gallegly
Gallo
Gejdenson
Gekas
Gephardt
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Glickman
Gonzalez
Goodlatte
Goodling
Gordon
Goss
Grams
Grandy
Green
Greenwood
Gunderson
Gutierrez
Hall (OH)
Hall (TX)
Hamburg
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings
Hayes
Hefley
Hefner
Herger
Hilliard
Hinchey
Hoagland
Hobson
Hochbrueckner
Hoekstra
Hoke
Holden
Horn
Houghton
Hoyer
Huffington
Hughes
Hunter
Hutchinson
Hutto
Hyde
Inglis
Inhofe
Inslee
Istook
Jacobs
Jefferson
Johnson (CT)
Johnson (GA)
Johnson (SD)
Johnson, E. B.
Johnson, Sam
Johnston
Kanjorski
Kaptur
Kasich
Kennedy
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klein
Klink
Klug
Knollenberg
Kolbe
Kopetski
Kreidler
Kyl
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lazio
Leach
Lehman
Levin
Levy
Lewis (CA)
Lewis (FL)
Lewis (GA)
Lewis (KY)
Lightfoot
Linder
Lipinski
Livingston
Lloyd
Long
Lowey
Lucas
Machtley
Maloney
Mann
Manton
Manzullo
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCandless
McCloskey
McCollum
McCrery
McCurdy
McDade
McDermott
McHale
McHugh
McInnis
McKeon
McKinney
McMillan
McNulty
Meehan
Meek
Menendez
Meyers
Mfume
Mica
Michel
Miller (CA)
Miller (FL)
Mineta
Minge
Mink
Moakley
Molinari
Mollohan
Montgomery
Moorhead
Moran
Morella
Murphy
Murtha
Myers
Nadler
Neal (MA)
Neal (NC)
Nussle
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Oxley
Packard
Pallone
Parker
Pastor
Paxon
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pickle
Pombo
Pomeroy
Porter
Portman
Poshard
Price (NC)
Pryce (OH)
Quillen
Quinn
Rahall
Ramstad
Rangel
Ravenel
Reed
Regula
Reynolds
Richardson
Ridge
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Rostenkowski
Roth
Roukema
Rowland
Roybal-Allard
Royce
Rush
Sabo
Sanders
Sangmeister
Santorum
Sarpalius
Sawyer
Saxton
Schaefer
Schenk
Schiff
Schroeder
Schumer
Scott
Sensenbrenner
Serrano
Sharp
Shaw
Shays
Shepherd
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slattery
Slaughter
Smith (IA)
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Snowe
Solomon
Spence
Spratt
Stark
Stearns
Stenholm
Stokes
Strickland
Studds
Stump
Stupak
Sundquist
Swett
Swift
Synar
Talent
Tanner
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thomas (CA)
Thomas (WY)
Thompson
Thornton
Thurman
Torkildsen
Torres
Torricelli
Towns
Traficant
Tucker
Unsoeld
Upton
Valentine
Velazquez
Vento
Visclosky
Volkmer
Vucanovich
Walker
Walsh
Waters
Watt
Waxman
Weldon
Wheat
Whitten
Williams
Wilson
Wise
Wolf
Woolsey
Wyden
Wynn
Yates
Young (AK)
Young (FL)
Zeliff
Zimmer

NOT VOTING—3

Brown (FL)
Ford (TN)
Washington

□ 1352

So the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Ms. BROWN of Florida. Mr. Speaker, I was not present for an earlier vote, rollcall No. 392, due to unforeseen circumstances. Had I been present, I would have voted "yea".

PROVIDING FOR CONSIDERATION OF H.R. 4907, FULL BUDGET DISCLOSURE ACT OF 1994

Mr. DERRICK. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 512 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 512

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 1(b) of rule XXIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 4907) to reform the concept of baseline budgeting. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and the amendments made in order by this resolution and shall not exceed one hour, with thirty minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Rules and thirty minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Government Operations. After general debate the bill shall be considered for amendment under the five-minute rule. It shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute recommended by the Committee on Rules now printed in the bill.

The committee amendment in the nature of a substitute shall be considered as read. No other amendment shall be in order except those printed in the report of the Committee on Rules accompanying this resolution. Each amendment may be offered only in the order printed, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, and shall not be subject to amendment. All points of order against the amendments printed in the report are waived. If more than one of the amendments printed in the report is adopted, only the last to be adopted shall be considered as finally adopted and reported to the House. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendment as may have been finally adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the committee amendment in the nature of a substitute. The previous question shall be considered as ordered on the bill and any amendment thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore (Mr. SERRANO). The gentleman from South Carolina [Mr. DERRICK] is recognized for 1 hour.

Mr. DERRICK. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Florida [Mr. GOSS], pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, House Resolution 512 provides for the consideration of H.R. 4907, the Full Budget Disclosure Act of 1994. The resolution waives all points of order against consideration of the bill and provides for 1 hour of general debate, with 30 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Rules, and 30 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Government Operations.

After general debate, it will be in order under the rule to consider as an original bill for the purpose of amendment the amendment in the nature of a substitute recommended by the Committee on Rules now printed in the bill. The substitute will be considered as read.

No amendments are in order except those printed in House Report 103–689, to be considered in the following order under a king-of-the-hill procedure: First, the amendment in the nature of a substitute to be offered by Representative PENNY, or Representative STENHOLM, or Representative KASICH, or a designee; and second, the amendment in the nature of a substitute to be offered by Representative SPRATT or a designee. Should both amendments be adopted, only the second amendment adopted will be reported to the House.

Each substitute is considered as read and debatable for 30 minutes, equally divided and controlled by the proponent and an opponent. The amendments are not subject to further amendment and all points of order against the amendments are waived.

Finally, the resolution provides for one motion to recommit, with or without instructions.

Mr. Speaker, the Full Budget Disclosure Act of 1994 is designed to improve our budget process precisely as its short title suggests: By requiring full budget disclosure. The official title of H.R. 4907 is "A Bill to Reform the Concept of Baseline Budgeting." I can assure the Members the bill will do just that.

To the extent they have the time and inclination to follow it at all, most Americans find the Federal budget process difficult to comprehend at best. Part of the problem is our confusing terminology; we just don't use the same budgetary terms and concepts that ordinary people do.

We have fiscal years rather than calendar years. We have discretionary spending and mandatory spending. We have appropriations bills and we have authorization bills. We have on-budget and off-budget programs. We have the deficit and we have the national debt. We have countless other terms that we throw around here. But I dare say probably the most difficult budget concept for ordinary Americans to understand is our notion of a budget baseline.

Under the law, when the President submits his budget to the Congress, and the Congress prepares its congressional budget, they start from something called a current policy baseline. That baseline assumes for the budget year and subsequent years a continuation of the current spending level for programs and services, adjusted for inflation and certain other technical factors.

Mr. Speaker, there is absolutely nothing wrong with using a current policy baseline. After all, every American appreciates how inflation erodes the purchasing power of his dollars over time. All Americans know the same number of dollars won't buy today what they bought 10 years ago, or even last year.

This is why the law provides cost-of-living adjustments to Social Security benefits. If we did not give cost-of-living adjustments, social security benefits would over time lose much of their value, and recipients would lose much of their income, even though the number of dollars in their checks wouldn't actually drop. Those checks would buy less and less in the future as inflation eroded their purchasing power.

Well, inflation erodes the purchasing power of Federal tax revenues too. Any given number of Federal tax dollars does not buy the same quantity of goods and services today that it bought 10 years ago, or even last year. As a result, it takes more dollars to repair a mile of Federal highway, buy uniforms for soldiers and sailors, and to maintain national parks. Government must adjust to the same inflation that households do, and the current policy baseline helps policymakers to understand inflation's effect on Government.

But use of the current policy baseline has one drawback: It makes more difficult comparisons of how spending changes from year to year in actual terms. It is the problem H.R. 4907 is designed to solve.

Under the bill, the President and the Congress would have to include an additional baseline, a current funding baseline, in their budget documents. The current funding baseline would start from last year's spending level and would not be adjusted for inflation.

This additional baseline would allow people to see and understand how various budget proposals would change spending from year to year in constant dollars, without taking inflation into account.

By comparing proposed spending to the two baselines, for example, policymakers and the public could both understand that a budget proposal for a given program might very well represent an increase over last year in actual dollars, but not enough to keep pace with inflation—or effectively a cut in the program.

Or people could see that a proposal might represent an increase in actual dollars over the amount needed to keep pace with inflation, or effectively an expansion of the program.

In addition, H.R. 4907 will require the Congressional Budget Office to include its annual report to the budget committees a comparison to current spending levels, and an analysis of the causes of increased spending in mandatory programs due to cost-of-living adjustments, changes in beneficiaries, higher health-care costs, and other factors. This provision will help us better understand the reasons for growth in those programs, commonly called entitlements.

I am convinced H.R. 4907 will improve the budget process, and that it will help both policymakers and ordinary Americans to understand that process better. I urge all Members to support the bill and the rule, and I reserve the balance of my time.

□ 1400

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, one of the very real problems with our current process is that Congress can get away with accounting tricks that would actually shock most people who are responsible for family budgets or even running a small business.

That may not be exciting news, but it is important news because accountability is an awful big problem around here. So I think this is an important subject.

The confusion that stems from what we call baseline budgeting is very serious. I suspect most people do not understand what a charade it really is. No one knows when a cut is really a cut or whether it is just a slowdown in the ever-growing spending we do around here but it is still more spending than we did last year.

It is very, very easy for Congress to mask the big spending increases by claiming that we are just maintaining the baseline. When Americans hear that word, that phrase "maintaining the baseline," watch out, watch your pocketbooks, because what that means is that is code for spending more of your tax dollars.

So I am glad that the House is going to have a chance today to address this issue of what baseline really means and how we are going to be more accountable if we pass this very, very small improvement that has been suggested.

Unfortunately, as is the case for the so-called Emergency Spending Control Act, which we might actually be taking up next on the floor if we stick to the present schedule, which is presently posted in the Cloakroom if it has not already been rescheduled yet by now; if we stick with that, we will find the same thing in the Emergency Spending Control.

The rule we are proceeding under is a lot less than ideal reform. In fact, it is sort of a token. I do not like the rule, but I am not going to call for a "no" vote on the rule, but because the rule does allow for consideration of, I think, a very much improved substitute, the Penny-Kasich-Stenholm substitute. But I have got to say the same concerns that are about both this rule on budget language and on the spending language, once again we are waiving all points of order without an explanation of what possible violations the bill contains. That is a bad idea.

Then we are stacking the deck against the substitute amendment by following the dreaded king-of-the-hill procedure. Again it is one where the original bill will be considered as the final amendment in order to secure preferential treatment. Putting that in English for those who do not follow the inside-the-beltway rule lingo, we are stacking the deck to defeat an amendment which would make this bill a lot better.

Finally, I think we all recognize that this is yet another piece in the A-to-Z buy-off package.

It is a mixed blessing to have this much-needed debate under these circumstances. I think this is one of several that were designed to let some steam off the pressure for the A-to-Z package, which I understand is still a few votes short of the number necessary to bring it to the floor.

I wish I could say that even if we approve this, that we would accomplish something that A-to-Z could accomplish; there is no comparison. A-to-Z would do ever so much more in dealing with spending cuts.

Mr. Speaker, I look forward to the coming debate because I believe that we will be able to demonstrate both the need to change the current baseline standard and why the Penny-Kasich-Stenholm substitute is far stronger and a more responsible way to proceed if we are really going to get serious about addressing cutting spending around here.

OPEN VERSUS RESTRICTIVE RULES 95TH–103D CONG.

Congress (years)	Total rules granted[1]	Open rules		Restrictive rules	
		Number	Percent[2]	Number	Percent[3]
95th (1977–78)	211	179	85	32	15
96th (1979–80)	214	161	75	53	25
97th (1981–82)	120	90	75	30	25
98th (1983–84)	155	105	68	50	32
99th (1985–86)	115	65	57	50	43
100th (1987–88)	123	66	54	57	46
101st (1989–90)	104	47	45	57	55
102d (1991–92)	109	37	34	72	66
103d (1993–94)	91	25	27	66	73

[1] Total rules counted are all order of business resolutions reported from the Rules Committee which provide for the initial consideration of legislation, except rules on appropriations bills which only waive points of order. Original jurisdiction measures reported as privileged are also not counted.

[2] Open rules are those which permit any Member to offer any germane amendment to a measure so long as it is otherwise in compliance with the rules of the House. The parenthetical percentages are open rules as a percent of total rules granted.

[3] Restrictive rules are those which limit the number of amendments which can be offered, and include so-called modified open and modified closed rules, as well as completely closed rule, and rules providing for consideration in the House as opposed to the Committee of the Whole. The parenthetical percentages are restrictive rules as a percent of total rules granted.

Sources: "Rules Committee Calendars & Surveys of Activities," 95th–102d Cong.; "Notices of Action Taken," Committee on Rules, 103d Cong., through Aug. 10, 1994.

OPEN VERSUS RESTRICTIVE RULES: 103D CONG.

Rule number date reported	Rule type	Bill number and subject	Amendments submitted	Amendments allowed	Disposition of rule and date
H. Res. 58, Feb. 2, 1993	MC	H.R. 1: Family and medical leave	30 (D–5; R–25)	3 (D–0; R–3)	PQ: 246–176. A: 259–164. (Feb. 3, 1993).
H. Res. 59, Feb. 3, 1993	MC	H.R. 2: National Voter Registration Act	19 (D–1; R–18)	1 (D–0; R–1)	PQ: 248–171. A: 249–170. (Feb. 4, 1993).
H. Res. 103, Feb. 23, 1993	C	H.R. 920: Unemployment compensation	7 (D–2; R–5)	0 (D–0; R–0)	PQ: 243–172. A: 237–178. (Feb. 24, 1993).
H. Res. 106, Mar. 2, 1993	MC	H.R. 20: Hatch Act amendments	9 (D–1; R–8)	3 (D–0; R–3)	PQ: 248–166. A: 249–163. (Mar. 3, 1993).
H. Res. 119, Mar. 9, 1993	MC	H.R. 4: NIH Revitalization Act of 1993	13 (d–4; R–9)	8 (D–3; R–5)	PQ: 247–170. A: 248–170. (Mar. 10, 1993).
H. Res. 132, Mar. 17, 1993	MC	H.R. 1335: Emergency supplemental Appropriations	37 (D–8; R–29)	1 (not submitted) (D–1; R–0)	A: 240–185. (Mar. 18, 1993).
H. Res. 133, Mar. 17, 1993	MC	H. Con. Res. 64: Budget resolution	14 (D–2; R–12)	4 (1-D not submitted) (D–2; R–2)	PQ: 250–172. A: 251–172. (Mar. 18, 1993).
H. Res. 138, Mar. 23, 1993	MC	H.R. 670: Family planning amendments	20 (D–8; R–12)	9 (D–4; R–5)	PQ: 252–164. A: 247–169. (Mar. 24, 1993).
H. Res. 147, Mar. 31, 1993	C	H.R. 1430: Increase Public debt limit	6 (D–1; R–5)	0 (D–0; R–0)	PQ: 244–168. A: 242–170. (Apr. 1, 1993).
H. Res. 149 Apr. 1, 1993	MC	H.R. 1578: Expedited Rescission Act of 1993	8 (D–1; R–7)	3 (D–1; R–2)	A: 212–208. (Apr. 28, 1993).
H. Res. 164, May 4, 1993	O	H.R. 820: Nate Competitiveness Act	NA	NA	A: Voice Vote. (May 5, 1993).
H. Res. 171, May 18, 1993	O	H.R. 873: Gallatin Range Act of 1993	NA	NA	A: Voice Vote. (May 20, 1993).
H. Res. 172, May 18, 1993	O	H.R. 1159: Passenger Vessel Safety Act	NA	NA	A: 308–0 (May 24, 1993).
H. Res. 173, May 18, 1993	MC	S.J. Res. 45: United States forces in Somalia	6 (D–1; R–5)	6 (D–1; R–5)	A: Voice Vote (May 20, 1993)
H. Res. 183, May 25, 1993	O	H.R. 2244: 2d supplemental appropriations	NA	NA	A: 251–174. (May 26, 1993).
H. Res. 186, May 27, 1993	MC	H.R. 2264: Omnibus budget reconciliation	51 (D–19; R–32)	8 (D–7; R–1)	PQ: 252–178. A: 236–194 (May 27, 1993).
H. Res. 192, June 9, 1993	MC	H.R. 2348: Legislative branch appropriations	50 (D–6; R–44)	6 (D–3; R–3)	PQ: 240–177. A: 226–185. (June 10, 1993).
H. Res. 193, June 10, 1993	O	H.R. 2200: NASA authorization	NA	NA	A: Voice Vote. (June 14, 1993).
H. Res. 195, June 14, 1993	MC	H.R. 5: Striker replacement	7 (D–4; R–3)	2 (D–1; R–1)	A: 244–176. (June 15, 1993).
H. Res. 197, June 15, 1993	MO	H.R. 2333: State Department. H.R. 2404: Foreign aid	53 (D–20; R–33)	27 (D–12; R–15)	A: 294–129. (June 16, 1993).
H. Res. 199, June 16, 1993	C	H.R. 1876: Ext. of "Fast Track"	NA	NA	A: Voice Vote. (June 22, 1993).
H. Res. 200, June 16, 1993	MC	H.R. 2295: Foreign operations appropriations	33 (D–11; R–22)	5 (D–1; R–4)	A: 263–160. (June 17, 1993).
H. Res. 201, June 17, 1993	O	H.R. 2403: Treasury-postal appropriations	NA	NA	A: Voice Vote. (June 17, 1993).
H. Res. 203, June 22, 1993	MO	H.R. 2445: Energy and Water appropriations	NA	NA	A: Voice Vote. (June 23, 1993).
H. Res. 206, June 23, 1993	O	H.R. 2150: Coast Guard authorization	NA	NA	A: 401–0. (July 30, 1993).
H. Res. 217, July 14, 1993	MO	H.R. 2010: National Service Trust Act	NA	NA	A: 261–164. (July 21, 1993).
H. Res. 220, July 21, 1993	MC	H.R. 2667: Disaster assistance supplemental	14 (D–8; R–6)	2 (D–2; R–0)	PQ: 245–178. F: 205–216. (July 22, 1993).
H. Res. 226, July 23, 1993	MC	H.R. 2667: Disaster assistance supplemental	15 (D–8; R–7)	2 (D–2; R–0)	A: 224–205. (July 27, 1993).
H. Res. 229, July 28, 1993	MO	H.R. 2330: Intelligence Authority Act, fiscal year 1994	NA	NA	A: Voice Vote. (Aug. 3, 1993).
H. Res. 230, July 28, 1993	O	H.R. 1964: Maritime Administration authority	NA	NA	A: Voice Vote. (July 29, 1993).
H. Res. 246, Aug. 6, 1993	MO	H.R. 2401: National Defense authority	149 (D–109; R–40)		A: 246–172. (Sept. 8, 1993).
H. Res. 248, Sept. 9, 1993	MO	H.R. 2401: National Defense authorization			PQ: 237–169. A: 234–169. (Sept. 13, 1993).
H. Res. 250, Sept. 13, 1993	MC	H.R. 1340: RTC Completion Act	12 (D–3; R–9)	1 (D–1; R–0)	A: 213–191–1. (Sept. 14, 1993).
H. Res. 254, Sept. 22, 1993	MO	H.R. 2401: National Defense authorization		91 (D–67; R–24)	A: 241–182. (Sept. 28, 1993).
H. Res. 262, Sept. 28, 1993	O	H.R. 1845: National Biological Survey Act	NA	NA	A: 238–188 (10/06/93).
H. Res. 264, Sept. 28, 1993	MC	H.R. 2351: Arts, humanities, museums	7 (D–0; R–7)	3 (D–0; R–3)	PQ: 240–185. A: 225–195. (Oct. 14, 1993).
H. Res. 265, Sept. 29, 1993	MC	H.R. 3167: Unemployment compensation amendments	3 (D–1; R–2)	2 (D–1; R–1)	A: 239–150. (Oct. 15, 1993).
H. Res. 269, Oct. 6, 1993	MO	H.R. 2739: Aviation infrastructure investment	N/A	N/A	A: Voice Vote. (Oct. 7, 1993).
H. Res. 273, Oct. 12, 1993	MC	H.R. 3167: Unemployment compensation amendments	3 (D–1; R–2)	2 (D–1; R–1)	PQ: 235–187. F: 149–254. (Oct. 14, 1993).
H. Res. 274, Oct. 12, 1993	MC	H.R. 1804: Goals 2000 Educate America Act	15 (D–7; R–7; I–1)	10 (D–7; R–3)	A: Voice Vote. (Oct. 13, 1993).
H. Res. 282, Oct. 20, 1993	C	H.J. Res. 281: Continuing appropriations through Oct. 28, 1993	N/A	N/A	A: Voice Vote. (Oct. 21, 1993).
H. Res. 286, Oct. 27, 1993	O	H.R. 334: Lumbee Recognition Act	N/A	N/A	A: Voice Vote. (Oct. 28, 1993).
H. Res. 287, Oct. 27, 1993	C	H.J. Res. 283: Continuing appropriations resolution	1 (D–0; R–0)	0	A: 252–170. (Oct. 28, 1993).
H. Res. 289, Oct. 28, 1993	O	H.R. 2151: Maritime Security Act of 1993	N/A	N/A	A: Voice Vote. (Nov. 3, 1993).
H. Res. 293, Nov. 4, 1993	MC	H. Con. Res. 170: Troop withdrawal Somalia	N/A	N/A	A: 390–8. (Nov. 8, 1993).
H. Res. 299, Nov. 8, 1993	MO	H.R. 1036: Employee Retirement Act–1993	2 (D–1; R–1)	N/A	A: Voice Vote. (Nov. 9, 1993).
H. Res. 302, Nov. 9, 1993	MC	H.R. 1025: Brady handgun bill	17 (D–6; R–11)	4 (D–1; R–3)	A: 238–182. (Nov. 10, 1993).
H. Res. 303, Nov. 9, 1993	O	H.R. 322: Mineral exploration	N/A	N/A	A: Voice Vote. (Nov. 16, 1993).

OPEN VERSUS RESTRICTIVE RULES: 103D CONG.—Continued

Rule number date reported	Rule type	Bill number and subject	Amendments submitted	Amendments allowed	Disposition of rule and date
H. Res. 304, Nov. 9, 1993	C	H.J. Res. 288: Further CR, FY 1994	N/A	N/A	
H. Res. 312, Nov. 17, 1993	MC	H.R. 3425: EPA Cabinet Status	27 (D–8; R–19)	9 (D–1; R–8)	F: 191–227. (Feb. 2, 1994).
H. Res. 313, Nov. 17, 1993	MC	H.R. 796: Freedom Access to Clinics	15 (D–9; R–6)	4 (D–1; R–3)	A: 233–192. (Nov. 18, 1993).
H. Res. 314, Nov. 17, 1993	MC	H.R. 3351: Alt Methods Young Offenders	21 (D–7; R–14)	6 (D–3; R–3)	A: 238–179. (Nov. 19, 1993).
H. Res. 316, Nov. 19, 1993	C	H.R. 51: D.C. statehood bill	1 (D–1; R–0)	N/A	A: 252–172. (Nov. 20, 1993).
H. Res. 319, Nov. 20, 1993	MC	H.R. 3: Campaign Finance Reform	35 (D–6; R–29)	1 (D–0; R–1)	A: 220–207. (Nov. 21, 1993).
H. Res. 320, Nov. 20, 1993	MC	H.R. 3400: Reinventing Government	34 (D–15; R–19)	3 (D–3; R–0)	A: 247–183. (Nov. 22, 1993).
H. Res. 336, Feb. 2, 1994	MC	H.R. 3759: Emergency Supplemental Appropriations	14 (D–8; R–5; I–1)	5 (D–3; R–2)	PQ: 244–168. A: 342–65. (Feb. 3, 1994).
H. Res. 352, Feb. 8, 1994	MC	H.R. 811: Independent Counsel Act	27 (D–8; R–19)	10 (D–4; R–6)	PQ: 249–174. A: 242–174. (Feb. 9, 1994).
H. Res. 357, Feb. 9, 1994	MC	H.R. 3345: Federal Workforce Restructuring	3 (D–2; R–1)	2 (D–2; R–0)	A: VV (Feb. 10, 1994).
H. Res. 366, Feb. 23, 1994	MO	H.R. 6: Improving America's Schools	NA	NA	A: VV (Feb. 24, 1994).
H. Res. 384, Mar. 9, 1994	MC	H. Con. Res. 218: Budget Resolution FY 1995–99	14 (D–5; R–9)	5 (D–3; R–2)	A: 245–171 (Mar. 10, 1994).
H. Res. 401, Apr. 12, 1994	MO	H.R. 4092: Violent Crime Control	180 (D–98; R–82)	68 (D–47; R–21)	A: 244–176 (Apr. 13, 1994).
H. Res. 410, Apr. 21, 1994	MO	H.R. 3221: Iraqi Claims Act	N/A	N/A	A: Voice Vote (Apr. 28, 1994).
H. Res. 414, Apr. 28, 1994	O	H.R. 3254: NSF Auth. Act	N/A	N/A	A: Voice Vote (May 3, 1994).
H. Res. 416, May 4, 1994	C	H.R. 4296: Assault Weapons Ban Act	7 (D–5; R–2)	0 (D–0; R–0)	A: 220–209 (May 5, 1994).
H. Res. 420, May 5, 1994	O	H.R. 2442: EDA Reauthorization	N/A	N/A	A: Voice Vote (May 10, 1994).
H. Res. 422, May 11, 1994	MO	H.R. 518: California Desert Protection	N/A	N/A	PQ: 245–172 A: 248–165 (May 17, 1994).
H. Res. 423, May 11, 1994	O	H.R. 2473: Montana Wilderness Act	N/A	N/A	A: Voice Vote (May 12, 1994).
H. Res. 428, May 17, 1994	MO	H.R. 2108: Black Lung Benefits Act	4 (D–1; R–3)	N/A	A: VV (May 19, 1994).
H. Res. 429, May 17, 1994	MO	H.R. 4301: Defense Auth., FY 1995	173 (D–115; R–58)		A: 369–49 (May 18, 1994).
H. Res. 431, May 20, 1994	MO	H.R. 4301: Defense Auth., FY 1995		100 (D–80; R–20)	A: Voice Vote (May 23, 1994).
H. Res. 440, May 24, 1994	MC	H.R. 4385: Natl Hiway System Designation	16 (D–10; R–6)	5 (D–5; R–0)	A: Voice Vote (May 25, 1994).
H. Res. 443, May 25, 1994	MC	H.R. 4426: For. Ops. Approps, FY 1995	39 (D–11; R–28)	8 (D–3; R–5)	PQ: 233–191 A: 244–181 (May 25, 1994).
H. Res. 444, May 25, 1994	MC	H.R. 4454: Leg Branch Approp, FY 1995	43 (D–10; R–33)	12 (D–8; R–4)	A: 249–177 (May 26, 1994).
H. Res. 447, June 8, 1994	O	H.R. 4539: Treasury/Postal Approps 1995	N/A	N/A	A: 236–177 (June 9, 1994).
H. Res. 467, June 28, 1994	MC	H.R. 4600: Expedited Rescissions Act	N/A	N/A	PQ: 240–185 A:Voice Vote (July 14, 1994).
H. Res. 468, June 28, 1994	MO	H.R. 4299: Intelligence Auth., FY 1995	N/A	N/A	A: Voice Vote (July 19, 1994).
H. Res. 474, July 12, 1994	MO	H.R. 3937: Export Admin. Act of 1994	N/A	N/A	A: Voice Vote (July 14, 1994).
H. Res. 475, July 12, 1994	O	H.R. 1188: Anti. Redlining in Ins	N/A	N/A	A: Voice Vote (July 20, 1994).
H. Res. 482, July 20, 1994	O	H.R. 3838: Housing & Comm. Dev. Act	N/A	N/A	A: Voice Vote (July 21, 1994).
H. Res. 483, July 20, 1994	O	H.R. 3870: Environ. Tech. Act of 1994	N/A	N/A	A: Voice Vote (July 26, 1994).
H. Res. 484, July 20, 1994	MC	H.R. 4604: Budget Control Act of 1994	3 (D–2; R–1)	3 (D–2; R–1)	PQ: 245–180 A: Voice Vote (July 21, 1994).
H. Res. 491, July 27, 1994	O	H.R. 2448: Radon Disclosure Act	N/A	N/A	A: Voice Vote (July 28, 1994).
H. Res. 492, July 27, 1994	O	S. 208: NPS Concession Policy	N/A	N/A	A: Voice Vote (July 28, 1994).
H. Res. 494, July 28, 1994	MC	H.R. 4801: SBA Reauth & Amdmts. Act	10 (D–5; R–5)	6 (D–4; R–2)	PQ: 215–169 A: 221–161 (July 29, 1994).
H. Res. 500, Aug. 1, 1994	MO	H.R. 4003: Maritime Admin. Reauth.	N/A	N/A	A: 336–77 (Aug. 2, 1994).
H. Res. 501, Aug. 1, 1994	O	S. 1357: Little Traverse Bay Bands	N/A	N/A	A: Voice Vote (Aug. 3, 1994).
H. Res. 502, Aug. 1, 1994	O	H.R. 1066: Pokagon Band of Potawatomi	N/A	N/A	A: Voice Vote (Aug. 3, 1994).
H. Res. 507, Aug. 4, 1994	O	H.R. 4217: Federal Crop Insurance	N/A	N/A	A: Voice Vote (Aug. 5, 1994).
H. Res. 509, Aug. 5, 1994	MC	H.J. Res. 373/H.R. 4590: MFN China Policy	N/A	N/A	A: Voice Vote (Aug. 9, 1994).
H. Res. 513, Aug. 9, 1994	MC	H.R. 4906: Emergency Spending Control Act	N/A	N/A	
H. Res. 512, Aug. 9, 1994	MC	H.R. 4907: Full Budget Disclosure Act	N/A	N/A	
H. Res. 514, Aug. 9, 1994	MC	H.R. 4822: Cong. Accountability	33 (D–16; R–17)	16 (D–10; R–6)	PQ: 247–185 A: Voice Vote (Aug. 10, 1994).
H. Res. 515, Aug. 10, 1994	O	H.R. 4908: Hydrogen Etc. Research Act	N/A	N/A	
H. Res. 516, Aug. 10, 1994	MO	H.R. 3433: Presidio Management	12 (D–2; R–10)	N/A	

Note.—Code: C-Closed; MC-Modified closed; MO-Modified open; O-Open; D-Democrat; R-Republican; PQ: Previous question; A-Adopted; F-Failed.

Mr. Speaker, I reserve the balance of my time.

□ 1410

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Glens Falls, NY [Mr. SOLOMON], the ranking member of the Committee on Rules.

Mr. SOLOMON. Mr. Speaker, let me thank the gentleman from Sanibel, FL, for yielding me this time. And let me apologize in advance for the soft spoken gentleman from South Carolina and for the very distinguished gentleman from Sanibel, FL and for myself because we have to speak in a new language, not English. I will speak in a new language, not English, which is called Stengelese.

My colleagues all remember Casey Stengel. Well, if one is going to explain the budget process of this Congress, he has to speak in Stengelese, because nobody is going to understand it. And now my colleagues know the rest of this story, why the budget process in this House does not work.

Let me just say I have some concerns about this modified open rule. First, it contains a king-of-the-hill amendment process that says the last substitute adopted is the one reported back to the House, instead of having a normal amendment process that allows for the strongest amendment to prevail. Under the normal amendment process, Mr. Speaker, the Penny-Kasich-Stenholm substitute, which I support, would be offered to the Spratt amendment, perfecting it. If the amendment prevails, it prevails, and that is the way it should be. If the amendment loses, then Spratt wins, and that is the way that it should be.

What is wrong with that? That makes common sense.

Instead we have a Spratt bill, a Spratt amendment in the nature of a substitute, and then a Penny substitute, and then a Spratt substitute, all in that order. Does anybody out there listening understand what I just said? I do not think so. Maybe in the Democrat leadership's version of penny ante poker three Spratts beat a penny every time, but in the old fashioned version of democracy that I believe in, the amendment getting the most votes ought to win on the floor of this House.

Believe me, if the day ever comes when one of these Democrat king-of-the-hill rules results in a weaker amendment being reported to the House, there will be a bipartisan uproar like my colleagues have never heard before. The king will be seen to have no clothes, and naked power will be exposed in its rawest form. Mark my word on that; it is going to happen.

The second reason for my concern is that we are dealing with these minor budget bills individually, instead of debating a comprehensive congressional reform bill, which is what we should be spending our time on this week. Having said that, Mr. Speaker, let me say I support the Penny-Kasich-Stenholm substitute over the three identical Spratts. The Penny substitute contains more meaningful ways to deal with the problems and perceptions that stem from our current baseline budgeting than the Spratt substitutes do.

And discussion of baseline budgeting must seem very inside-baseball to most of our constituents.

But, if we told them this is really about "truth-in-budgeting" they will begin to understand the importance of this debate.

The American people know that we play a lot of games around here with our budgets, and they get thoroughly confused when we claim, on the one hand, that we are reducing spending, and yet they see spending continue to go up and up and up.

"How can this be?" they ask.

And we respond, "The baseline made me do it; it's in the law."

We measure our spending actions against what we expect something to cost in the future and not against what we are now spending out of our pocket. So, if we change a law to restrain the future growth rate of spending, we can say we are saving money, but that is not the same as reducing spending.

Mr. Speaker, when my constituents think about their household budget and this is really what this debate is all about, just listen to this when my constituents think about their household budgets, they measure their level of spending this year against how much they spent last year. That is the logical way to do it. If they were planning to spend 25 percent more this year than last, and then they trim that budget to spend just 15 percent more, that's still a 15-percent increase in spending.

When Congress cuts its spending, its anticipated spending, from a 25-percent increase down to a 15-percent increase, it claims it has reduced spending by 40 percent, when actually we have increased spending by 15 percent.

That is the whole crux of the baseline budgeting problem.

The Spratt substitutes before us today would try to deal with this problem by creating two baselines: one based on current policy levels, which is what we use now; and one based on current funding levels for discretionary spending, but with projected funding levels for mandatory spending. Boy, that sure sounds like "Stengelese." In other words, even though this new baseline is called the current funding baseline, it still uses current policy projections for mandatory spending.

So, unfortunately, this bill creates a new credibility problem for us with a baseline that is not entirely what it says it is.

Mr. Speaker, Yogi Berra, who also played for Casey Stengel, might have said, "If you try to run two baselines at the same time, you're going to split your pants."

Mr. Speaker, I fear the American people will split their sides laughing when they see us trying to run two baselines simultaneously and then claim we are clarifying rather than confusing the game further. It should be both a pants-splitting and side-splitting exercise that will not cover us in glory.

Now I prefer the Penny-Kasich-Stenholm substitute, which sticks to a single baseline but modifies it to eliminate the inflation adjuster for discretionary spending—as does the Spratt substitute in one of its baselines.

Inflating discretionary spending is not really current policy since annual appropriations are not permanent law.

At the same time, neither the Spratt nor Penny substitutes alter the definition of current services for mandatory programs in any of the baselines contained in those amendments. I think that is appropriate because those are commitments made in permanent law to our Social Security recipients, to our veterans programs, to government retirees, and others.

We will still have that current policy or current services measure for those mandatory programs under both the Spratt and Penny approaches.

Now let me just say this:

The Penny-Kasich-Spratt substitute tells our Budget Committees to begin their negotiations on the annual budget from the current levels of spending in all programs—mandatory and discretionary, so that we can better see and understand what is being increased or decreased and why it is being done. In that way, we in turn can better pinpoint where our real problems are and what we should do about them.

Mr. Speaker, the ultimate solution to our public perception and credibility problem when it comes to budgeting cannot be solved by a law. The people do not read our budget documents.

It is really a matter for the President, the Congress, and yes, the media, to level with the American people about our final budget actions, and not play games with all these baselines to claim we have reduced spending when we have only reduced its growth.

Let me say that one more time: To claim we have reduced spending when actually all we have done is reduce growth does not cut a penny out of this doggone budget.

In the final analysis, Mr. Speaker, truth-in-budgeting can only be achieved by telling the truth in our ongoing political conversation with the American people. That may be asking too much, but to do otherwise will only further erode our institutional respect and credibility.

Mr. SPRATT. Mr. Speaker, would the gentleman yield for a question?

Mr. SOLOMON. I yield to the gentleman from South Carolina [Mr. SPRATT] who I have great respect for.

Mr. SPRATT. The feeling is mutual. Just one question. The gentleman from South Carolina [Mr. DERRICK] is saying we are ready to vote, but one question: You described our baseline as providing for inflation due to COLA's implicit in the mandatory spending programs and entitlement programs——

Mr. SOLOMON. With the two baselines, right.

Mr. SPRATT. Is the gentleman aware that the Stenholm-Penny-Kasich baseline also provides a COLA for entitlement programs?

Mr. SOLOMON. Yes, as a matter of fact, I called attention to that as well, and they both do, in the gentleman's Spratt amendment and the Penny baseline, yes.

Mr. SPRATT. I ask, "Don't you think that confuses people, that there is a lack of consistency here, whereas it would back our inflation on the one hand, include it for some programs that include it for others? Is that a baseline since it has one definition for one type of program?"

Mr. SOLOMON. I really tried not to talk in Stengelese and point out that four of yours have that, two of theirs, and we really need to be consistent.

Mr. SPRATT. I thank the gentleman.

□ 1420

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Wyoming [Mr. THOMAS].

Mr. THOMAS of Wyoming. Mr. Speaker, I rise in opposition to the rule for H.R. 4907, and in support of the Stenholm-Penny-Kasich amendment. This amendment is necessary to bring about any real reform. Without the amendment, we are simply taking the next step in the Democratic leadership's effort to prevent any real reform in the institution or its processes.

We have seen this in every popular reform that has been overwhelmingly supported by the American people. The leadership has put off consideration as long as possible, when public opinion finally forces them to debate and restructure the rules and do their best to prevent the true reform.

Look back at the debate on the balanced budget amendment, the debate on line item veto, today's debate on eliminating the confusing and misleading practice of baseline budgeting.

Baseline budgeting is at the heart of what is wrong with how we do business here. The practice feeds the spending habit of an activist Congress and administration, while allowing those folks to claim to have made cuts in spending, when in fact it is an increase. The American people know that despite all the rhetoric coming from the administration that we cut spending, all we have really done is reduced the increases. Spending has not gone down. Spending has not been cut. In fact, spending continues to go up at a steady pace, and the deficit is projected to follow that route as well.

Stenholm-Penny-Kasich will bring a little common sense to the budget process. No longer will we be allowed to call spending increased cuts. Slowing down the projected increases has never been a cut in my book. With this change, the budget process will indicate that.

Mr. Speaker, the Government has not been honest with how the taxpayers' dollars are spent. We have a chance to make a small step forward, restoring some trust today. I encourage any colleagues to vote yes on Stenholm-Penny-Kasich and against the Spratt status quo amendment.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 8 minutes to the distinguished gentleman from South Carolina [Mr. SPRATT].

Mr. SPRATT. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, today the House will consider H.R. 4907, the Full Budget Disclosure Act of 1994. This act is six pages long, full of dense language, whatever you wish to call it in budget parlance. Let me just cut through the thick language, the bramble bush, the budget jargon, and get to the basics and say in a nutshell what this bill does.

Essentially this bill simply does this: It establishes two basic baselines for the budget format. First, it establishes a current funding baseline. This baseline, the current funding baseline, would be equal to the funding outlays that a function or program was receiving in that current year, the most recent year at hand. It is equivalent to what CBO would call a freeze, staying in place.

In addition, this bill would require that the budget be formatted to show in addition to the current funding baseline, a current policy baseline equal to what we now most commonly call a current services baseline.

A current services baseline, as we all know, is what it takes to keep a program serving the same eligible beneficiaries, providing them the same level of benefits adjusted for inflation in the next budget year. So we would have two baselines: a current funding baseline, and a current policy baseline.

This bill requires the President, the Congressional Budget Office, and both budget committees to give Congress, us, and the public, both the current funding baseline and the current policy baseline for budget functions and for specific programs.

The bill also requires that each of these offices compare the proposed funding for the next fiscal year with both baselines, both current funding and current policy.

As I think we have seen from the previous debate, there are a lot of similarities between this bill, H.R. 4907, and the Stenholm-Penny-Kasich substitute. In fact, I used the substitute as a basic when I drafted this bill, H.R. 4907. Both require the President, CBO, and the budget committees to provide current year funding for programs and both require comparisons between current funding and proposed funding. There is no difference there.

In the end, both have the same result. Both will make it more difficult to call a funding increase a spending cut if it is below your current services, because you will have readily available, formatted, displayed in budget presentations, what is the current funding level in the current year, and anyone who claims that he is cutting spending can be readily contradicted by referencing the budget documents that will be submitted by the committee to the Congress, and by the CBO as well.

Our bill, however, as I have said, sets up two baselines. Penny-Kasich would prevent this kind of double talk by having one baseline, which would replace the current services baseline.

I think it is important to emphasize what we are talking about is purely presentation. We are not talking about procedure. We are not talking about process. We are not talking about requiring different votes or different processes for increasing or decreasing spending. We are simply talking about how you present a proposed budgetary increase or proposed budgetary decrease, and what lines will be available, what baselines, what frames of reference will be available to determine whether or not it is an increase or a decrease.

My bill differs from the substitute in this fundamental respect: The substitute requires only information about current funding. It can even be read to say that Congress should not be given, not provided with, current policy baselines. Section 102(f) of the substitute states that OMB, in making assessments, shall not include an adjustment for inflation for programs and activities subject to discretionary appropriations. The substitute also provides that the starting points for any deliberations in the budget of each House on the concurrent resolution on the budget for the next fiscal year shall be the estimated level of outlays for the current year and each function and subfunction. Any increases or decreases in the congressional budget for the next fiscal year shall be from such estimated levels.

I am not quite sure what that means, a starting point for any deliberation. I think, frankly, that Congress and the public should be able to find out readily, as I have said, how much actual spending is going to increase in a new budget over and above current levels of spending. My bill, 4907, provides for that, clearly and distinctly.

But I also think Congress and the public should know what it will cost to keep the budget running in place, what it will cost to keep programs like Social Security, Medicare, Head Start and defense funded at current policy levels, doing next year no more or less than what it is doing this year. My bill also provides for that. The substitute does not.

So I think my bill is a distinct improvement on the current process, but it does not take away from us something that everybody finds useful. That is why we have it.

My bill provides a baseline which we in the Congress, members of the budget committees, the Committee on Appropriations, the Office of Management and Budget, the Congressional Budget Office, all have found extremely useful to have for analytical purposes. That is a current services baseline. It does not allow one to have just this baseline and to ignore current funding, because it requires that both be provided. But it does continue to provide us with this very useful reference for determining whether or not we are keeping programs apace with inflation and with the growth in beneficiary populations.

If we were to add, for example, $1 billion to Social Security in a given year, and in that given year inflation was 5 percent and beneficiary population growth was one million people, if we went back home and told our constituents that we had increased Social Security, I think they would look askance at us, because our Social Security benefits would probably be reduced if we did no more than $1 billion, given the growth in beneficiary population and given inflation.

We need the current policy baseline to tell us exactly what is required in order to keep existing programs on parity with existing levels of service. It is a very useful baseline, and I do not think regardless of what we do, if we were to pass the substitute today and send it to the other body and pass it there and have it enacted into law, the current services baseline will not go away. It will still be sought by the Committee on the Budget when we have budgets brought to the floor, whether they are resolutions or appropriations bills, these projections will still be there, and not just as to entitlements. We use current services all the time in the Committee on Armed Services because it shows what it takes to keep our defense on parity with the existing levels of readiness and force structure.

So I think it is something that we cannot uninvent, something that is not going away, because it is useful to everybody involved in this process, and given the fact that it is so useful, I think we ought to make it part of the process, but keep it honest, keep it in perspective by also requiring the current funding baseline to be provided as well.

I thank the gentleman for yielding.

□ 1430

Mr. GOSS. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from California [Mr. COX].

Mr. COX. Mr. Speaker, I thank the gentleman for yielding time to me.

I rise in support of the Penny-Kasich-Stenholm bipartisan amendment to get rid of baseline budgeting.

I extend my congratulations to the gentleman from South Carolina [Mr. SPRATT] as well with whom it is my privilege to work as the ranking member on the Subcommittee on Commerce, Consumer, and Monetary Affairs. I am glad we are all here arguing about the best way to get rid of baseline budgeting.

I happen to believe that really getting rid of it is the answer rather than tolerating it and keeping it around.

As a member of the Committee on the Budget, I introduced a resolution abolishing it successfully. It became part of the budget we adopted here in the Congress most recently. It was adopted over in the Senate. So by a nonbinding resolution we have already accomplished what our colleagues, the gentleman from Minnesota [Mr. PENNY], the gentleman from Ohio [Mr. KASICH], and the gentleman from Texas [Mr. STENHOLM], want to accomplish here today, but we have to put it into law and make sure that we can enforce it.

We all know what a scam baseline budgeting is. The real question is, Where did it come from? The answer is that the solons of the spending status quo want us to believe that we have cut spending to the bone. They want to keep talking about cutting spending when in fact it is going up.

The truth is, according to the President's own figures, that spending this year is rising dramatically. And every year for the foreseeable future, spending will rise dramatically. It will grow from more than $1.4 trillion this year to more than $1.5 trillion next year. That is an increase of $100 billion, more than $1.6 trillion in 1996 and $1.8 trillion in 1998. Collectively, altogether, that comprises the largest deficit spending increase in any 5-year period in American history.

So how is it that we say we are cutting spending and yet spending is going up and up and up?

The answer is, we are using this smoke and mirrors method called baseline budgeting by which we cut not real spending but from an inflated baseline.

Let me give an example of how baseline budgeting distorts the language. We talk about spending cuts as if they are real but they are not. Let us say that last Labor Day you had 5 hot dogs and you enjoyed the 5 hot dogs so much that this year you decide you are going to have 10 hot dogs. But your friends tell you, you would be a glutton. You need to cut back and your doctor advises you, you have to stop your intake of fat and cholesterol. So you settle for seven.

Under baseline budgeting, as you scarf down that 7th hot dog with the mustard and relish dripping from your chin, you can congratulate yourself for having cut your hot dog consumption by 30 percent because you are only having 7 instead of the 10 you wanted. Some of us here in the Congress would be quick to point out that in fact the seven hot dogs you are eating this year represent a 40-percent increase over the five you had last year.

If you work here in Congress, you are used to the status quo, you would say, "I am sorry, you just do not understand real fat and calorie reduction."

That is the way baseline budgeting works. It does not reflect reality. It is in fact like Hollywood. It is total fiction. It reminds me of a trip to Universal Studios. You might say that the phony budget numbers we get from baseline budgeting are what Arnold Schwarzenegger would call true lies.

Baseline budgeting, to carry the analogy uncomfortably further, is a clear and present danger to our current system of representative government. Like the movies, this deceptive accounting practice has blown away our constituents' confidence in representative government. We need a simple and straightforward accounting system that even Forrest Gump could understand. If we do not adopt baseline budgeting, our noses, like Pinnochio, will continue to grow and grow, along with Government spending. And Bill Clinton will keep talking about cutting Government spending while it is increasing. I guess that would make him the Lion King.

Mr. DERRICK. Mr. Speaker, I yield 6 minutes to the gentleman from Minnesota [Mr. PENNY].

Mr. PENNY. Mr. Speaker, the rule before us allows for debate on H.R. 4907, the Full Budget Disclosure Act, and for two amendments thereto, one amendment, the Penny-Kasich-Stenholm amendment which would substitute for the language of the bill a hard freeze, as the baseline for Federal budgeting.

The second amendment would be the separate amendment, which essentially would restore the language or reaffirm the language in the base bill.

Under a king-of-the-hill process, it will be possible for Members to vote for our amendment and the Spratt amendment, but we strongly urge Members not to play that game. We have stronger language in our substitute. It would be deceptive to then vote as well for the Spratt amendment because, under the king-of-the-hill procedure, even though we may pass our amendment by a larger margin, a slim majority supporting the Spratt amendment would prevail at the end of the debate.

Mr. GOSS. Mr. Speaker, will the gentleman yield?

Mr. PENNY. I yield to the gentleman from Florida.

Mr. GOSS. Mr. Speaker, I thank the distinguished gentleman for yielding to me.

I want the gentleman to know that we feel the same way. We tried to get the king of the hill changed to what we call the queen of the hill so that large a margin would prevail. Unfortunately, we were unable to succeed in the Committee on Rules.

Mr. PENNY. Mr. Speaker, I do appreciate the interest of a number of Members on the Committee on Rules in trying to protect our right to a fair fight on this issue.

As is often the case around here, if there is a real threat posed by any amendment, then substitutes are made in order or a king-of-the-hill process is put in order in order to defeat the best efforts to propose alternative policy decisions. That is clearly what we are faced with today.

Nonetheless, a yes vote and then a no vote will preserve the strongest language and we urge Members to vote in that fashion.

Mr. KASICH. Mr. Speaker, will the gentleman yield?

Mr. PENNY. I yield to the gentleman from Ohio.

Mr. KASICH. Mr. Speaker, one more time I think it is absolutely critical that we emphasize that we want to vote "yes" on the Penny amendment and an absolute vote "no" on the Spratt amendment. Because under this king of the hill, we would get rid of the baselines and have only one commonsense budgeting factor. If we adopted that and then adopted Spratt, we would be defeating ourselves.

So this king of the hill is something that Members do not understand very well, but clearly we do not want to vote for all alternatives. We want to vote for one, and that is the Penny alternative.

Mr. PENNY. Mr. Speaker, I thank the gentleman for those remarks.

The process we operate under today, this king-of-the-hill process, is another Washington-based process. It may make sense to people inside the Capitol dome, but it is nonsense to most of the American public. It is appropriate that we have this nonsensical rule with a king-of-the-hill vote, because we are dealing with a nonsensical budget process, a budget process that calls an increase a cut, a process that allows for an inflation adjustment in every part of the budget and only spending above the inflation adjustment is actually called an increase.

We try to correct that with some commonsense budget reforms. It could be best described as truth in budgeting. It could best be described as truth in budgeting, because we present to the American public with our proposal a budget process that would measure every program by last year's spending level.

In other words, a dime of increase in any program would be called an increase. A family does not plan their next year's budget based on an anticipated increase. Most families are not certain until the boss calls them in at the end of the year whether they are going to see a pay raise in their paychecks. Yet at the Federal level, we promise all of the programs and all of the beneficiaries that they will get an automatic increase from year to year.

☐ 2440

It is absurd when you do not even know that the economy will grow, or that taxpayers will get pay raises, or that more revenue will come into the government, that the government promises all of the recipients, all of the programs, an increase year to year.

We correct that by going to a hard freeze baseline on most programs in the budget, Mr. Speaker. The gentleman from South Carolina called this purely presentation. This is more than that.

By changing our budget baseline, we change the terms of the debate. We remove the spending bias. We remove the assumption that every program must automatically be increased, and we start from a hard freeze baseline, forcing us to admit that increases are increases, forcing us to justify inflation adjustments if we feel they are necessary. This will shift the burden of proof.

Current funding, current policy, current services, entitlements, mandatory discretionary, nondiscretionary, we have so many terms that govern our budget debate on Capitol Hill it is no wonder the American public cannot understand what Congress is doing. Most of the confusion is deliberate. We do not want them to understand, because it allows us to spend more and more, while pretending that we are not increasing spending levels.

Mr. Speaker, we have to end the chicanery. We have to end the charade. We have to call a freeze a freeze. We have to call a cut a cut. That is the fundamental premise of the Penny-Kasich-Stenholm amendment. When we get down to debate on the amendments, I urge a yes vote on the Penny-Kasich-Stenholm amendment, a no vote on the Spratt amendment, and then a yes vote on final passage of H.R. 4907.

Mr. DERRICK. Mr. Speaker, I yield 3 minutes to the gentleman from South Carolina [Mr. SPRATT] for the purposes of making an inquiry.

Mr. SPRATT. Mr. Speaker, may I ask the gentleman from Minnesota [Mr. PENNY] a question?

The gentleman continues to refer to his baseline as a hard freeze, and yet in the "Dear Colleague" he sent out on this particular substitute, he says:

> When the baseline must be used for 5-year projections, the automatic increase for discretionary programs is limited, but the baseline for entitlements continues to include COLAs.

So there is a baseline that is a freeze for discretionary programs, but not a freeze for entitlement programs.

Mr. PENNY. Will the gentleman yield, Mr. Speaker?

Mr. SPRATT. I am happy to yield to the gentleman from Minnesota.

Mr. PENNY. Mr. Speaker, the gentleman is correct. The gentleman would also acknowledge that on the entitlement question, the language in his bill does not differ from the language in our bill.

The point is that the cost-of-living increase in the entitlement area is mandated by law. We acknowledge that. But unlike the gentleman, we force a full acknowledgement of that fact in the budget baseline each year, so that even though there is an increase built in, we explain why that increase has occurred, and then it is open to question as to whether we want to honor that obligation.

Mr. SPRATT. Mr. Speaker, basically there is no difference between our current funding baseline and the single baseline the gentleman would require, is there?

Mr. PENNY. On the entitlement side, that would be correct, but on the discretionary or the domestic and defense side of the budget, and that deals with $500 billion, we do apply a hard freeze.

Mr. SPRATT. So do we.

Mr. Speaker, let me continue this COLA question. I think we are clarifying something that Members need to understand.

Mr. Speaker, our baseline would freeze discretionary spending. Our baseline adopts what CBO calls a hard freeze. It does accommodate COLAs for entitlement programs in the out years, but otherwise it freezes spending in place, so basically our current funding baseline is the same as the single baseline that the gentleman would enshrine in his bill?

Mr. PENNY. If the gentleman will yield further, I would concede that his current funding baseline is the same as our hard freeze baseline.He also allows for a second current services baseline, which would continue to confuse the debate.

In other words, in the gentleman's plan, he has two baselines, one that allows the inflation adjustments and the other increases to be assumed, and that would continue the obfuscation and the confusion that dominates the budget debate today. We want to get down to one simple baseline, and that would be a hard freeze.

Mr. SPRATT. If I could reclaim my time, so I have a bit left; however, our current funding baseline is the same baseline that the gentleman would provide, so we are going to provide that baseline in the budget presentations. The gentleman has no dispute with that?

Mr. PENNY. Mr. Speaker, I have no dispute with that. What I have a dispute with is the fact that the gentleman adds to the confusion by not having one simple baseline, but instead two baselines.

Mr. SPRATT. We think it adds to clarification, rather than confusion. Everybody can tell the difference between the two baselines.

I thank the gentleman from South Carolina for yielding the additional time to me.

Mr. GOSS. Mr. Speaker, I yield 1½ minutes to the distinguished champion budgeteer, the gentleman from Ohio [Mr. KASICH].

Mr. KASICH. Mr. Speaker, I want to compliment the gentleman from South Carolina for trying to develop a line of confusion in this discussion. Let us be clear about what we do.

Mr. Speaker, in the area of entitlements, we do not really have a baseline in entitlements, but it is the law, as the gentleman from Minnesota [Mr. PENNY] has said, it is the law that forces those to go up. I would remind the gentleman from South Carolina [Mr. SPRATT] that just earlier this year we offered several proposals to eliminate the automatic adjustments, which was opposed by the Majority of this House, including the gentleman from South Carolina [Mr. SPRATT].

Now, let us forget entitlements, because those increases go up by law. We have made an effort already this year to try to stop that automatically. We were defeated in that. Mr. Speaker, the only place where we really have a baseline is in the area of discretionary. What we are arguing is, we ought to base next year's budgeting based on the year before. We do not need to have more than one baseline.

I remember when Tina Turner sang the song "We Don't Need Another Hero." We do not need another baseline, we only need one. That is based on the spending of the previous year.

We should not be confused about what we are trying to do here. If we want a budget next year based on the previous year, we vote for Penny. If we want to do budgeting next year based on last year's plus another baseline, and get everything all confused, we vote for Spratt.

Mr. Speaker, I would argue to the House that if we want to do this like they do on the seat of the tractors in east Texas, as the gentleman from Texas [Mr. STENHOLM] is fond of saying, a commonsense budgeting approach, or in Westerville, or up in Minnesota, where the gentleman from Minnesota [Mr. PENNY] is from, we budget on the basis of the previous year, not the previous year plus inflation.

Vote for the Penny amendment. Let us end the confusion.

Mr. DERRICK. Mr. Speaker, I yield such time as he may consume to the gentleman from Oklahoma [Mr. MCCURDY].

Mr. MCCURDY. Mr. Speaker, I rise in support of the Penny-Kasich-Stenholm amendment, and urge a yes vote on that.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from the Commonwealth of Pennsylvania [Mr. WALKER].

Mr. WALKER. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, is it my understanding, as the gentleman has related to me, that when we finish this rule and we go to the debate on this rule, that we will in fact then be proceeding on the crime rule?

Mr. GOSS. Mr. Speaker, I am not in a position to answer that with authority.

Mr. WALKER. Mr. Speaker, may I ask if the gentleman from South Carolina [Mr. DERRICK] could answer? Is it the intention of the House, after this, to move directly to the crime rule?

Mr. DERRICK. Mr. Speaker, will the gentleman yield?

Mr. WALKER. I yield to the gentleman from South Carolina.

Mr. DERRICK. That is correct, Mr. Speaker.

Mr. WALKER. Mr. Speaker, immediately upon finishing the vote on this particular rule, we will then move to the crime rule, is that correct?

Mr. DERRICK. We were hoping maybe not to have a recorded vote on this, so we could move right on into it. That is correct.

Mr. WALKER. I think there are some of us who are concerned about the king-of-the-hill nature of this rule, and would prefer to have an opportunity to vote "no" on that, because we think that that is a bad kind of thing to have the House appear to have adopted unanimously, but I just wanted to clarify where we were in the schedule.

At the completion of that particular vote, Mr. Speaker, then we can assume that the next order of business will be to take up the crime rule?

Mr. DERRICK. If the gentleman will continue to yield, that is our intention at this time.

Mr. WALKER. I thank the gentleman.

Mr. GOSS Mr. Speaker, I yield 1 minute to the distinguished gentleman from Minnesota [Mr. RAMSTAD].

Mr. RAMSTAD. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I rise today in strong support of the Penny-Stenholm-Kasich amendment on baseline budgeting.

As sponsor of H.R. 323, a bill to eliminate the use of the so-called current services budget baseline, I have been trying to focus attention on the issue of fraudulent baseline budgeting for years.

I am gratified that my bill has 124 cosponsors from both sides of the aisle.

We are all too familiar with how the process works. Every year, Congress builds an automatic increase into all Government spending programs. Whenever a spending increase does not reach the baseline level, it is called a cut.

Congress uses such accounting deception to claim that it is cutting a specific program while actually increasing spending on it.

This process builds a bias into the Federal budget for more spending and higher deficits. Real deficit reduction requires this budget reform.

Mr. Speaker, the Penny-Stenholm-Kasich amendment will let us finally get rid of the current services budget hoax and restore credibility to the Federal budget process.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 2 minutes to the gentleman from Wisconsin [Mr. OBEY].

☐ 1450

Mr. OBEY. Mr. Speaker, I think Members do a disservice to this body when they suggest that the Spratt proposal would bring "confusion to the process."

What the gentleman from South Carolina [Mr. SPRATT] is proposing is very simple. It ought to be simple enough to understand even for a Member of Congress. What the gentleman from South Carolina [Mr. SPRATT] is suggesting is very simply this: He suggests that instead of presenting the budget from one baseline, we present it from two, so that we have two perspectives on the same issue. That is all the Spratt amendment does. This has nothing whatsoever to do with how much is spent. It has nothing whatsoever to do with how much is appropriated. It has nothing whatsoever to do with how much is made available in entitlements. It simply is a question of how we present the information.

What Penny-Stenholm-Kasich would say is that we present it only one way, in terms of nominal dollars. What Spratt says is that we present it two ways: One from the perspective of the nominal dollar base and second, from an inflationary adjusted base.

Mr. Speaker, it seems to me that when we are analyzing Social Security, for instance, that if we have an increase in the eligible population and if there is a large increase in inflation, it just might be helpful if we understand that the real effect of that is on the recipients. That is all the gentleman from South Carolina [Mr. SPRATT] does. He suggests that instead of Congress being given one piece of information, instead of the public only being given one perspective, they be given two. I ask Members what on Earth is wrong with that?

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from the greater San Dimas, CA, area [Mr. DREIER], an esteemed and important member of the Committee on Rules.

Mr. DREIER. Mr. Speaker, I thank my friend, the gentleman from Sanibel, for yielding me this time.

Mr. Speaker, I rise to strongly oppose this rule if for no other reason than the king-of-the-hill procedure.

Mr. Speaker, let me go through that process again.

I understand that my friends, the gentleman from Minnesota [Mr. PENNY] and the gentleman from Ohio [Mr. KASICH] talked about the king-of-the-hill procedure. It is absolutely nothing more than an attempt to obfuscate the issue of accountability. The way the king-of-the-hill procedure works is that we have one amendment that comes before us, and that is going to be the Penny amendment, and it could pass with 420 votes. Following that, we could have the Spratt amendment which, based on the description that the gentleman from Minnesota [Mr. PENNY] and the gentleman from Ohio [Mr. KASICH] gave is obviously a weaker position, yet with 218 votes, that vote would be the one that would actually prevail, avoiding the issue of accountability, meaning that Members could vote, in fact, for the Penny amendment and they could do it knowing that if 218 votes are gleaned on the Spratt amendment at the end that, in fact, the Spratt amendment would carry.

Mr. Speaker, this king-of-the-hill procedure is an absolutely ludicrous procedure. I offer regularly an amendment up in the Committee on Rules which simply says that if we are going to have this king-of-the-hill procedure, what we should state is that the amendment which receives the highest number of votes here on the floor is the one that prevails. That is the only responsible way to deal with this. Unfortunately this rule is one which denies that right.

Mr. Speaker, for that reason I urge a "no" vote and hope that my colleagues will join with me in opposing the rule so that we can bring back a fair and balanced approach which will give equal treatment to those who are proposing amendments.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to say, we have had a lot of discussion on the rule. I think that the goal of what we are trying to accomplish here is clarification. I think that anybody who has listened to this particular debate would understand just how confusing this particular subject is. If it is this confusing inside the Beltway, I can imagine how confusing it is out there in America for those who are trying to understand why we keep raising the annual debt and the deficit and we cannot seem to live within our means and are always having new tax proposals being presented to us by the majority.

I think that anything that comes close to clarification on this is very important. I happen to agree that the Stenholm-Penny-Kasich amendment gets closest to what we need, to what I will call full budget disclosure. What I think we have got now is full budget confusion. I hope that that amendment is going to pass.

Mr. Speaker, I feel very much the same way as my colleague, the gentleman from California [Mr. DREIER] who has just spoken, that we have stacked the deck so that it will not pass. That would be a shame, I think. One more time we will have taken a better solution, one that will actually lead to clarity in this. It does not solve the whole problem by any means but it adds some accountability, so it is a little harder to disguise what is really going on, it is a little harder to keep from the taxpayers what we are really doing here, and I think that openness and that sunshine would be very welcome. Certainly, it is the rules we use in Florida, and it is the rules I think we should use here.

Mr. Speaker, I agree that the king-of-the-hill problem is a very serious one here and the blanket waiver protecting who-knows-what points of order is a serious question. I will not call for a vote, but I understand there are others on our side of the aisle and perhaps on the majority side of the aisle who are so upset about the king-of-the-hill and the blanket waivers that they may call for a vote.

Mr. Speaker, I yield back the balance of my time.

Mr. DERRICK. Mr. Speaker, I yield back the balance of my time, and I move the previous question on this resolution.

The previous question was ordered.

The SPEAKER pro tempore (Mr. SERRANO). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. WALKER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 255, nays 178, not voting 1, as follows:

[Roll No. 393]

YEAS—255

Abercrombie
Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Baesler
Barca
Barcia
Barlow
Barrett (WI)
Becerra
Beilenson
Berman
Bevill
Bilbray
Bishop
Blackwell
Blute
Bonior
Borski
Boucher
Brewster
Brooks
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Byrne
Cantwell
Cardin
Carr
Chapman
Clay
Clayton
Clement
Clinger
Clyburn
Coleman
Collins (IL)
Collins (MI)
Condit
Conyers
Coppersmith
Costello
Coyne
Cramer
Danner
Darden
de la Garza
Deal
DeFazio
DeLauro
Dellums
Derrick
Deutsch
Dicks
Dingell
Dixon
Dooley
Durbin
Edwards (CA)
Edwards (TX)
Engel
English
Eshoo
Evans
Farr
Fazio
Fields (LA)
Filner
Fingerhut
Flake
Foglietta
Ford (MI)
Ford (TN)
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Glickman
Gonzalez
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamburg
Hamilton
Harman
Hastings
Hayes
Hefner
Hilliard
Hinchey
Hoagland
Hochbrueckner
Holden
Hoyer
Hughes
Hutto
Inslee
Jacobs
Jefferson
Johnson (GA)
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy
Kennelly
Kildee
Kleczka
Klein
Klink
Kopetski
Kreidler
LaFalce
Lambert
Lancaster
Lantos
LaRocco
Laughlin
Lehman
Levin
Lewis (GA)
Lipinski
Lloyd
Long
Lowey
Maloney
Mann
Manton
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCloskey
McCurdy
McDermott
McHale
McKinney
McNulty
Meehan
Meek
Menendez
Mfume
Miller (CA)
Mineta
Minge
Mink
Moakley
Mollohan
Montgomery
Moran
Murphy
Murtha
Nadler
Neal (MA)
Neal (NC)
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Parker
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Penny
Peterson (FL)
Peterson (MN)
Pickett
Pickle
Pomeroy
Poshard
Price (NC)
Rangel
Reed
Reynolds
Richardson
Roemer
Rose
Rostenkowski
Rowland
Roybal-Allard
Rush
Sabo
Sanders
Sangmeister
Sarpalius
Sawyer
Schenk
Schroeder
Schumer
Scott
Serrano
Sharp
Shepherd
Sisisky
Skaggs
Skelton
Slattery
Slaughter
Smith (IA)
Spratt
Stark
Stenholm
Stokes
Strickland
Studds
Stupak
Swett
Swift
Synar
Tanner
Tauzin
Taylor (MS)
Tejeda
Thompson
Thornton
Thurman
Torres
Torricelli
Towns
Traficant
Tucker
Unsoeld
Valentine
Velazquez
Vento
Visclosky
Volkmer
Waters
Watt
Waxman
Wheat
Whitten
Williams
Wilson
Wise
Woolsey
Wyden
Wynn
Yates

NAYS—178

Allard
Archer
Armey
Bachus (AL)
Baker (CA)
Baker (LA)
Ballenger
Barrett (NE)
Bartlett
Barton
Bateman
Bentley
Bereuter
Bilirakis
Bliley
Boehlert
Boehner
Bonilla
Bunning
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Coble
Collins (GA)
Combest
Cooper
Cox
Crane
Crapo
Cunningham
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Emerson
Everett
Ewing
Fawell
Fields (TX)
Fish
Fowler
Franks (CT)
Franks (NJ)
Gallegly
Gallo
Gekas
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Grams
Grandy
Greenwood
Gunderson
Hancock
Hansen
Hastert
Hefley
Herger
Hobson
Hoekstra
Hoke
Horn
Houghton
Huffington
Hunter
Hutchinson
Hyde
Inglis
Inhofe
Istook
Johnson (CT)
Johnson, Sam
Kasich
Kim
King
Kingston
Klug
Knollenberg
Kolbe
Kyl
Lazio
Leach
Levy
Lewis (CA)
Lewis (FL)
Lewis (KY)
Lightfoot
Linder
Livingston
Lucas
Machtley
Manzullo
McCandless
McCollum
McCrery
McDade
McHugh
McInnis
McKeon
McMillan
Meyers
Mica
Michel
Miller (FL)
Molinari
Moorhead
Morella
Myers
Nussle
Oxley
Packard
Paxon
Petri
Pombo
Porter
Portman
Pryce (OH)
Quillen
Quinn
Rahall
Ramstad
Ravenel
Regula
Ridge
Roberts
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Royce
Santorum
Saxton
Schaefer
Schiff
Sensenbrenner
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Snowe
Solomon
Spence
Stearns
Stump
Sundquist
Talent
Taylor (NC)
Thomas (CA)
Thomas (WY)
Torkildsen
Upton
Vucanovich
Walker
Walsh
Weldon
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NOT VOTING—1

Washington

☐ 1514

Mr. PETRI and Mr. HOUGHTON changed their vote from "yea" to "nay."

Mr. HILLIARD changed his vote from "nay" to "yea."

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON HOUSE AMENDMENTS TO SENATE AMENDMENT TO H.R. 3355, VIOLENT CRIME CONTROL AND LAW ENFORCEMENT ACT OF 1993

Mr. DERRICK. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 517 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 517

Resolved, That upon adoption of this resolution it shall be in order to consider the conference report to accompany the amendments of the House to the amendment of the Senate to the bill (H.R. 3355) to amend the Omnibus Crime Control and Safe Streets Act of 1968 to allow grants to increase police presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and otherwise to enhance public safety. All points of order against the conference report and against its consideration are waived. The conference report shall be considered as read.

The SPEAKER. The gentleman from South Carolina [Mr. DERRICK] is recognized for 1 hour.

Mr. DERRICK. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Florida [Mr. GOSS], pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, House Resolution 517 waives all points of order against the conference report on H.R. 3355, the Omnibus Crime Control Act and against its consideration. The rule further provides that the conference report shall be considered as read.

Mr. Speaker, this rule will allow the House to consider the conference report for H.R. 3355, the Omnibus Crime Control Act. Earlier this year the President urged Congress to set aside partisan differences and to pass a strong, smart, and tough crime bill. In response to this call, the House has before it today far-reaching legislation that does exactly that. The conference report establishes a Violent Crime Reduction trust fund to assure that $30.2 billion be available over the next 6 years for anticrime initiatives. Funding for the trust fund will be made available through the elimination of 250,000 Federal Government jobs.

This conference report will help our Nation to move toward a future free from crime and violence through a commitment of resources unprecedented in the history of our Nation. The legislation authorizes $8.85 billion in grants to State and local governments to place 100,000 new cops on the beat. What this represents is a 20-percent increase in the number of police officers nationwide. For South Carolina alone this could mean 1,600 additional police officers on the street. Make no mistake, the legislation before us today is tough legislation aimed at taking back our streets from the criminals.

The conference report provides $6.5 billion in grants to help States build new prisons for the incarceration of violent repeat offenders. The legislation establishes the death penalty for over 60 Federal crimes, including the murder of Federal law enforcement officers, kidnapping, terrorism, drive-by shootings, and carjackings resulting in death.

The conference report contains three-strikes-and-you're-out legislation which mandates life imprisonment for anyone convicted of a third violent felony. It also provides that juveniles 13 years or older could be tried as adults in Federal Court for crimes such as murder, assault, robbery, and rape and includes the use of bootcamps for youthful first-time offenders. Such bootcamps can provide the discipline and training necessary to deter young people from embarking on a life of crime.

The conference report makes sure that police are not outgunned by criminals and bans military assault weapons. Every year the problem of gun violence only gets worse as more assault weapons find their way into the hands of criminals. These weapons are 18 times more likely than other guns to be cop killers and 16 times more likely to be traced to crime than other firearms. The conference report contains provisions to ban 19 listed weapons, copycats, and other clearly defined semiautomatic guns.

The conference report also addresses the causes of crime. Focusing only on the symptoms of crime will never reverse the problem. The underlying causes of crime have to be addressed as well. The conference report provides funding for community programs intended to prevent crime such as summer school programs and after school programs. The legislation authorizes $125 million for programs to give young people positive alternatives to gangs and provides $300 million to stimulate business and employment opportunities for low-income, unemployed, and underemployed individuals.

The conference report also creates programs to reduce violence against women. The legislation increases Federal resources available to combat sexual and domestic violence, through education programs, law enforcement training, and a national domestic violence hotline. The legislation also provides $4.5 million in grants for shelters for battered women and their children.

Mr. Speaker, every major law enforcement organization in the country supports passage of this conference report. Organizations such as: The Federal Law Enforcement Officers Association; the Fraternal Order of Police; the International Association of Chiefs of Police; the National Sheriffs' Association; the International Brotherhood of Police Officers; the International Union of Police Associations; the National Association of Police Organizations; the National Organization of Black Law Enforcement Executives; Police Executive Research Forum; the National Trooper's Coalition; and the Police Foundation.

In addition the two largest prosecutors associations as well as groups representing cities, towns, and counties are urging the Congress to approve this legislation. These groups include: the National District Attorneys Association; the National Association of Attorneys General; the United States Conference of Mayors; the National League of Cities; the National Conference of Republican Mayors and Municipal Elected Officials; the National Conference of Domestic Mayors; and the National Association of Counties.

Mr. Speaker, far too many of us no longer feel safe in our own neighborhoods. Violent crime is on the rise across our Nation and the time has come to ensure all Americans the freedom to live and work in safety. The conference report before us today is not a panacea, but it is an important step in turning around this country's crime problem.

Mr. Speaker, House Resolution 517 is a fair rule that will allow this House to consider this wide-reaching conference report. I urge my colleagues to support the rule and the conference report.

Mr. Speaker, I reserve the balance of my time.

☐ 1520

Mr. GOSS. Mr. Speaker, I yield 4 minutes to the distinguished minority whip, the gentleman from Georgia [Mr. GINGRICH].

Mr. GINGRICH. Mr. Speaker, you know, the country should ask itself why has a vote on the rule become such a close vote? Why have the President, the Cabinet, virtually everybody available they can to find one more vote on the rule?

But I think what people need to understand is that a vote on the rule is a vote on a procedure. And this has been, for this bill, a terrible procedure.

Let me make it very clear: For Members of the Congress on the Republican side, this bill became available at 7 last night. Now, the conference ended on July 28, and on July 29 Lamar University issued a press release thanking Chairman BROOKS for $10 million.

So in the first 12 hours after the conference ended, a conference in which no Republican was involved, no Republican had access, no Republican was informed, within 12 hours the staff found the first piece of pork, made sure their district issued a press release.

But still nothing happened, and they did not have the votes. Why? Because this is not just about one item, this is a bill that has $33 billion in spending, it has 20 new social programs. This is a bill which cuts the FBI, it cuts the Drug Enforcement Administration.

I suggest every Member read the Buffalo newspapers where the FBI director is quoted inappropriately, being honest, inappropriately saying the truth, which is that his agency, the FBI, gets cut, the DEA gets cut, that mayors and police chiefs are worried.

Now, later in the day the administration got him to send a letter up because otherwise he would have had to resign. But in the newspaper he told the truth. In the so-called crime bill, we are cutting the FBI. And yet at the time he said it, no Republican Member had seen the bill. It had not been available.

Now, why was it not available? This is what Chairman BROOKS said, and every Member ought to listen to this and you ought to ask yourself how you are going to go home with any sense of self-respect and vote "yes" on a rule for a conference report you have not looked at.

This is what he said in the Rules Committee. He was asked what are you asking us to waive? When you vote for this rule, you are voting to waive points of order. He was asked what are you asking us to waive? And this is what he said: "If I had a list written, I wouldn't give it to anybody because they would use it against me. Go to the floor, say, 'Here are the items that are on the scope,' no, I do not do that."

So the chairman of the committee, on behalf of the conference report, which had never been filed, refused to tell the Rules Committee what they are going to vote "yes" on.

So if you vote "yes" and the next week the news media finds the pork, they find how bills have been weakened, and you listen to Congressman ZIMMER later and Congresswoman DUNN tell you how this bill in its current form weakens the part on sexual predators, weakens it, does not strengthen it, takes care of the ACLU. And protects sexual predators instead of protecting communities.

Finally, at some point Mr. FAZIO, in the world of fantasies he has been in, having been alarmed about the Christian Right, will warn you about the Republican National Committee and say, "We are applying pressure."

I am entering into the RECORD a letter from Chairman Haley Barbour. Republicans who want to can vote their conscience, and that is all I am asking them to do. Finally, you have not been consulted, you have not been informed, you have not seen the documents; it is weaker on crime, it is weaker on sexual predators, it cuts the FBI, it cuts the Drug enforcement Administration.

Vote "no" on the rule, send it back to conference and insist they write an honest bill out in the open where everybody can see it.

The letter referred to follows:

REPUBLICAN NATIONAL COMMITTEE,
August 11, 1994.

Re July resolution.

Memorandum for Republican Members of Congress.

From: Haley Barbour.

As usual Vic Fazio and the Democrat Congressional Campaign Committee are trying to misconstrue by 180 degrees the Republican National Committee's notice to our Members of Congress that we had caused a resolution at our July meeting, criticizing some of our Congressmen, to be withdrawn. Fazio's attempt to say this is a threat to withhold support for them is a blatant falsehood and is the exact opposite of the result of our action. We had the resolution withdrawn until January so none of our Members of Congress would have to worry about any threat of withholding support from them.

□ 1530

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 1½ minutes to the gentleman from New York [Mr. SCHUMER].

Mr. SCHUMER. Mr. Speaker, we have heard more truly inaccurate words in the last 4 minutes than we have heard in a long time on this floor.

Mr. WALKER. Mr. Speaker, I demand that the gentleman's words be taken down.

The SPEAKER. The Clerk will report the words objected to.

Mr. SCHUMER. Mr. Speaker, may I amend that to say "factually inaccurate"?

The SPEAKER. Is there objection to the request of the gentleman from New York?

There was no objection.

The SPEAKER. Without objection, the gentleman's words will be replaced with the words "truly inaccurate."

Mr. SCHUMER. Truly inaccurate.

The SPEAKER. Is that the gentleman's request?

Mr. SCHUMER. That is my request.

The SPEAKER. Without objection, so ordered.

Mr. SCHUMER. Mr. Speaker, we have heard more factually inaccurate words in the last 4 minutes than we have heard in a long time. I submit for the RECORD a statement from the FBI Director supporting the bill, put out on August 10.

I say to my colleagues, you may laugh, but you know why you're laughing, and that is because every time, every time this bill is improved, you find a new objection.

Remember the Racial Justice Act? We heard from the other side they want the bill except for the Racial Justice Act. The Racial Justice Act in my opinion regrettably is not in the bill. They are still not for it.

Then we heard from the other side they wanted $8 billion in funding for prisons. There is now $8.4 billion for funding in prisons. They are still not for it.

They wanted truth in sentencing. They got truth in sentencing, and yet they still oppose this rule.

Mr. Speaker, they still come up with one excuse after another to give the American people an up or down vote on the crime bill.

So the time has come, my colleagues, for truth in voting. I say, if you want to do what our constituents are pleading with us to do, which is make the streets safe, tough laws on punishment, smart laws on prevention, you will vote for this rule because we cannot hide behind any procedural smoke screen. If you vote down this rule, there will be no crime bill, and the American people will suffer.

Mr. GOSS. Mr. Speaker, I yield 3 minutes to the distinguished ranking member of the Committee on Rules, the gentleman from New York [Mr. SOLOMON].

Mr. SOLOMON. Mr. Speaker, when this conference report was filed on this floor last night at 7 o'clock, I was assured that plenty of copies would be available to the Committee on Rules in 2 or 3 minutes. In fact, only one copy of this 972-page crime bill, the conference report, was delivered to the Committee on Rules, and Republicans first got a copy of it only 23 minutes before the scheduled start of the Committee on Rules debate.

Mr. Speaker, the Committee on Rules then proceeded to report a rule waiving all points of order on this monstrosity. One of the rules waived was a requirement that Members of this House have 3 days in which to learn about the conference report and what is in it. There is not a Member in this House who has any idea what is in there.

Mr. Speaker, there clearly are a great many standing rules of the House that are being violated in this rule. But when we asked the chairman of the Committee on the Judiciary for a list, we were told that even if he had such a list, he would not give it to us because it might be used against him. Mr. Speaker, that is not right, and my colleagues all know it.

With regard to the conference report itself, there are a few good provisions in it. But those good provisions have been so overloaded with social program giveaways and soft-on-crime provisions that the bad news in this package far outweighs the good, and my colleagues know that if they take out the politics.

The conference report eliminates mandatory minimum sentences for certain drug traffickers. This provision is retroactive and would result in 10,000 criminals being put back on the street—10,000.

Mr. Speaker, one of the best ways to judge a piece of legislation is to see who supports it and who is opposed to it. In this case why are the liberals, who are always opposed to tough penalties for criminals like the death penalty, why are they for this? And why are conservatives like me who always vote to crack down on criminals, why am I opposed to it? The answer, Mr. Speaker, is obvious.

This is not a crime bill, as much as the liberals would want us to think, this is a welfare bill with a few good things put in there to provide political cover. For example, this bill creates a thousand new social worker positions to run all the dance lesson programs, all the arts and crafts lessons, all the midnight basketball programs. Those are all failed CETA programs from 10 years ago. There is funding in this bill sufficient to hire two new social workers for every new cop on the beat.

That is what this conference report is all about. This legislation throws a huge amount of money around in a way that is not likely to have much effect on crime, but the effect on the taxpayers may be very, very huge. The sum of $30 billion of the $33 billion in this package comes from the violent crime resolution trust fund, which is supposed to come from savings achieved by laying off 252,000 Federal employees. How many times are we going to use that money? This is the fifth time.

Mr. Speaker, this conference report lets criminals out of jail who have committed crimes with guns and takes the guns away from law-abiding citizens. That is wrong.

This is terrible legislation. We can defeat this rule, and we can come back here with a real tough crime bill that we could all support, and we would be doing what is right for the American people.

Please vote against the rule.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 1½ minutes to the gentleman from New Mexico [Mr. RICHARDSON].

Mr. RICHARDSON. Mr. Speaker, this is the vote of the year, all rhetoric aside. We either break gridlock, or we cave in once again to special interests and partisanship. Health care, Haiti, the economy; this is the vote of the year.

And what is the alternative? If this rule goes down, how many of my colleagues here actually think that we can come up with another crime bill?

Mr. SOLOMON. I do.

Mr. RICHARDSON. We have no way of ensuring that the good prevention measures that are here, that the good punishment measures that are here, and the 100,000 cops on the street will survive once again. The NRA and every group that did not get what they wanted in this bill will be back.

If this rule goes down, there will be no crime bill, and I can assure my colleagues that, if we go home, and look our constituents in the eye at town hall meetings, and one on one, and polls, and the message being to do something about crime, and we do not, I think we are going to pay.

And do not call some of these programs social welfare programs. These are programs aimed at the young men and women of our inner cities, men and woman that have lost hope. These are prevention programs designed to help these young people cope with the future. Do not call them social programs. These are investments in the future.

Mr. Speaker, if we vote to kill this rule, there will be no crime bill, or, if there is, it will be a lot worse than what we have here. Vote for the rule.

We are minutes away from breaking gridlock, putting partisan politics aside, and showing special interest groups that they do not control Congress. Mr. Speaker, we are now ready to pass a crime bill that the American people in every district and in every State have been asking for.

No Member of Congress can justify voting against this crime bill. If a Member thinks the bill is not tough enough, I say what about the three-strikes-you're-out provision that will send criminals with three serious offenses to prison for life without parole; what about the death penalty which will be added to more than 60 crimes; what about funding for more prisons which will mandate that criminals serve at least 85 percent of their sentence. Mr. Speaker, this bill is tough, and only the criminals should hope for its failure.

I also ask which Member of Congress will be the first to tell parents in their districts that Congress has chosen to do nothing to help keep their children off the streets. This crime bill provides young people with job training and opportunities so they can learn teamwork and responsibility and say no to crime.

And finally, who will want to go back to their districts to tell their local chief of police and mayor that the crime bill did not pass. Members should know that with 100,000 new cops on the beat, criminals will want to think twice before committing a crime. Our constituents will be able to work with the police to keep every neighborhood safer.

Mr. Speaker, all members should be able to go back home to tell parents, teenagers, police, and every citizen in their district that Congress has listened and has passed a crime bill. This bill fights crime and gives control of our neighborhoods back to honest citizens and keeps the criminals in jail.

Mr. Speaker, let's show America that we will no longer tolerate crime. This crime bill is our chance to give Americans what they have been asking for. I urge my colleagues to listen to the American people and to vote yes for the rule.

□ 1540

Mr. GOSS. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Illinois [Mr. HYDE], who has spoken so well on so many of these relevant subjects dealing with this bill.

Mr. HYDE. Mr. Speaker, I want to make it quite clear that I still support the legislation concerning the assault weapons, forbidding the future manufacture for 10 years and the future importation of assault weapons. I still believe in that and I still support it, but I cannot vote for this bill.

This is an awful way to legislate. There are 154 jobs programs now on the books costing $25 billion a year. AL GORE and his Commission to Reinvent Government talked about consolidating these overlapping, duplicative, redundant programs. Instead of consolidating, we are proliferating. We are throwing in 30 new social programs at a cost of $8 billion.

I did a little research, and I looked up the Omnibus Crime Control and Safe Streets Act of 1968. Shades of Lyndon Johnson. You ought to read it. It is an identical bill with what we are doing here. Has there been an improvement in street crime, in drugs, in drive-by shootings?

We spend millions for the same old thing, and our answer to the festering crime problem is more of the same. There were no hearings. We did not look at these programs and see which of them are triple funded. Social workers will be competing with each other in a tug of war to get clients to attend their self-esteem, their craft, or their dancing classes. Meanwhile, the people are ducking from stray bullets.

This is not a decent, responsible way to legislate. And then the coup de grace, $10 million for this university in Beaumont, TX. God love the chairman, I wish I had half his skill in getting things for places in my district. And this was done not in the dead of night, probably about 4 in the afternoon, after the conference was through, after the books were closed, handshakes all around, press interviews, and then, $10 million for some place in Beaumont.

That is what characterizes this whole legislation. It is a disgrace. So let us go back to the drawing boards. I do not mind social workers. I think they are great. They are underpaid. But let us look at programs that can work, that can accomplish something. Let us not just shovel with a trowel hard-earned tax dollars onto untested and unproven programs. We are not legislating responsibly.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 1 minute to the gentleman from Maryland [Mr. HOYER].

Mr. HOYER. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of the rule to the conference report on the Violent Crime Control and Law Enforcement Act. I laud Chairman BROOKS, Chairman SCHUMER, and the conferees for their hard work and dedication in crafting a comprehensive and balanced crime package.

In 1991, I stood where the Speaker stands now. It was early in the morning, as you recall, and we passed a crime bill. It was a tough crime bill. It had many of the provisions that are in this bill, and it went to the Senate. It had none of the social spending that you now talk about that so concerns you. But the point of fact is, the Republicans in the U.S. Senate filibustered the crime bill, and it did not pass. They did not send it to the then Republican President of the United States.

The fact of the matter is, in my district and in yours, there are children being killed on the streets of America. People are concerned. They want us to act. They want us to act now, not later, not tomorrow, not after a filibuster, not after another election, not after Bill Crystal tells you, hey, it is all right, it is all right to vote for something now.

Yes, the Democrats may claim credit. Yes, it may be good for America, but no, do not take Bill Crystal's advice, send them home empty-handed, which is what Bill Crystal is telling all of you to do. Because if you do, those parents on the streets of America, in the schools of America, in the communities of America, will pay the price, not those of us who sit in this Chamber.

Over the past year, I have met with mothers and fathers, law enforcement officials and ministers, community leaders and young adults. Overwhelmingly, the No. 1 concern on their minds is what does this country need to do to stop the ever growing crime epidemic? My constituents as well as yours are demanding we take action. Passage of this bill sends them a clear message that the people they elected are listening and care about their concerns.

We all recognize that this bill is not the absolute solution to the crime problem but it is an important link in the crime prevention chain. This bill is a prescription which appropriately packages prevention and punishment. It encompasses critical crime prevention measures which attack the root causes of crime allowing our State and local governments, who fight on the front lines, to have resources available to make our streets and neighborhoods safe.

It also contains vital punitive measures aimed at removing the perpetrators of violent crime from our civilized and ordered society. I am particularly pleased that the "three-time loser" provision I proposed last year is included in this bill. That provision will insure that those who continue to threaten our people and our communities will be put in jail and stay there permanently.

The time for action is now. We must not fail those who sent us here, some of whom are afraid to leave their homes at night and who are seeing the moral fibers of our society being eaten away. Enough is enough. This body must release the chains which hold the crime bill hostage.

This is a tough crime bill. Its time is now. Let us vote for this rule. Democrats, let us come together. America sent us here to act. Let us act today.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Texas [Mr. ARCHER].

Mr. ARCHER. Mr. Speaker, I rise in opposition to the rule. The big print giveth, the small print taketh away.

Mr. Speaker, while I am opposed to H.R. 3355, the Omnibus Crime Control Act Conference Report, I would like to express my strong support for the Canady-Geren amendment clarifying the Federal courts' role in selecting remedies for prison overcrowding. The provision was included in both the House and Senate crime bills.

The Canady-Geren amendment requires the Federal courts to evaluate cruel and unusual punishment claims based on how prison conditions affect the individual inmate who brings the lawsuit. In addition, it would prohibit prison population caps and limit equitable relief to the least intrusive means necessary to remedy the violation. The Canady-Geren amendment would also give State and local governments greater flexibility in seeking modifications of previous court decrees.

Like many other States, Texas' prison population is controlled by a Federal consent decree, prompting the early release of prisoners back to the streets of our communities. The consent decree in Texas provided that the Texas Department of Corrections [TDC] would limit the statewide prison population to 95 percent of TDC's maximum capacity. Among other things, the decree also forced the TDC to only use certain facilities in calculating the maximum capacity of its existing system, and only then-existing facilities which met certain standards could be counted in figuring TDC's capacity.

In September 1986, TDC petitioned the Federal district court for a modification of the consent decree to permit TDC to increase the prison system's capacity by counting certain temporary beds available in other facilities toward TDC's capacity. TDC argued that an extraordinary and unforeseen increase in inmate admissions to the prison system justified such a modification. After a hearing, the district court denied TDC's motion, on the basis that the facilities TDC wanted to count were substandard or not authorized under the consent decree. TDC appealed the decision to the Fifth Circuit Court of Appeals, but it upheld the district court's decision. As a result of the denial of the motion, the administration of the TDC was essentially performed by a single Federal judge and the State was forced to adopt the early release program in order to meet the 95 percent cap on Texas' prison population.

The States need the Canady-Geren amendment to regain control over prison policy. What the States do not need, however, is unfunded mandates and reckless social spending under the guise of crime control.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Wisconsin [Mr. SENSENBRENNER], a member of the committee.

Mr. SENSENBRENNER. Mr. Speaker, this is not an issue of Republicans and Democrats. More accurately, it is not an issue of liberals versus conservatives. The issue on this rule is whether we will legislate responsibly, both procedurally and in substance.

There is a group in town that is circulating petitions to all Members of this body pledging that they will not vote for any health care proposal that they have not read, and that is a legitimate request when we are dealing with one-seventh of the economy and something that affects all of us. But does not the same apply to this bill, which has $33 billion in spending, changes criminal procedures, and which its sponsors claim will make the streets safer and lock criminals in jail?

Should not the membership of this House have an opportunity to read this bill? Should not the media and the American public be able to analyze the provisions of this bill?

Those who vote in favor of this rule will say very clearly, no, because this rule waives points of order. There is no point of order that will lie on the fact that if this bill is brought up, the 3-day layover rule will be waived.

The conference finished its work on July 28, and it was not until 7 o'clock last night that the conference report was filed, and the printed version of the report was not available until 10 this morning, less than 6 hours ago, when the CONGRESSIONAL RECORDS were distributed.

There will also be no point of order on the conference exceeding its scope. We know that a point of order would lie if it were not for waiving the points of order on the $10 million for Lamar University.

Last night we took a great step forward in restoring the public confidence in how this House does business in passing the Congressional Accountability Act. Let us not wreck that good record. Let us not wreck that goodwill by approving this rule that does not allow Members to read the bill and waives the scope of the conference so that pure, unadulterated pork will sneak through simply because nobody has had the time to expose it to the light of day.

Please vote no.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 1½ minutes to the distinguished gentleman from North Carolina [Mr. VALENTINE].

Mr. VALENTINE. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I rise in strong support of the rule and the conference report on the crime bill.

It is clear that most Americans want the Congress, and Government at every level, to make fighting crime our No. 1 public priority. Once again, however, a debate on crime has been overshadowed by a sideshow produced and directed by the National Rifle Association.

It is time that House members recognize that the NRA leadership has no interest in combating crime. Instead, it is preoccupied with collecting dues and contributions. Any scare tactic is acceptable as long as it fills NRA coffers.

To listen to the NRA's shopworn arguments, twisted constitutional interpretations, and bullying threats, one would never know that this bill contains only a modest provision to ban a few weapons that have virtually no sporting purposes and that few law-abiding citizens own.

No one's constitutional rights are threatened by this bill. But the NRA must raise that specter in order to rouse its current members to send more cash and induce new members to join.

Make no mistake about my motives. I have been a hunter. I collect guns. I keep a loaded gun in my home for protection. I am a gunman.

But I do not need an assault rifle—and I do not believe that passage of this bill will lead to the long arm of the Federal Government confiscating all guns.

This is a reasonably good bill, and it deserves our support.

Mr. Speaker, I have found that the NRA members in the district I represent are way ahead of the NRA leadership in Washington. Rank-and-file NRA members tell me that they will fight hard to protect their right to own and use firearms for legitimate purposes but that they have no objection to reasonable efforts to keep weapons from those who would misuse them.

Contrary to NRA propaganda, this is not a gun control bill. It is an anticrime bill that includes the assault weapon ban as one part—one relatively small part—of an overall strategy.

This bill provides tougher sentences, more law enforcement, more prison cells, and more crime prevention. That is what the American people want.

Mr. Speaker, it is easy to pick apart this or any legislation. I would have written it differently. We all would have written it differently. But this bill is a step in the right direction.

This bill will not eliminate crime. It cannot. But it will prevent crimes that now occur. It will take more criminals off the street for a longer time. And most important, it will save American lives.

Let us not be diverted by a special interest group with its own narrow agenda. I urge my colleagues to reject the ravings of the radical fringe and pass this rule and this conference report.

□ 1550

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the gentleman from California [Mr. PACKARD].

Mr. PACKARD. Mr. Speaker, I rise in strong opposition to this rule.

Mr. Speaker, today we are going to vote on the Clinton stimulus package. But this time we are calling it a crime bill.

The No. 1 concern of the American people is crime. So rather than putting together a bill that cracks down on crime and puts criminals behind bars, Congress, in its wisdom, pours more money into social welfare programs.

Let us look at some of the crime programs included in this bill: $40 million to let frustrated athletes play basketball. But only frustrated athletes that are HIV-positives. $900 million for the YES Jobs Program. This is in addition to the $6.5 billion we already spend on other job-training programs. Five million to teach life skills, whatever that is; $40 million to increase the self-esteem of school dropouts; $10 million for public housing. Apparently the $309 billion we already spend is insufficient, and $630 million for things like teaching kids how to dance and make pottery.

My friends across the aisle are just sure that by throwing around a few more welfare dollars we'll be able to solve society's crime problems.

But look at the figures. We have spent $5 trillion on welfare since Lyndon Johnson declared war on poverty. Yet the national rate of crime is at the highest level it's ever been.

Let us vote this bill down and put together a bill that really addresses our crime problems.

Mr. Speaker, 1 week ago I spoke on the House floor about the false promise included in the crime bill to put 100,000 new cops on the street. At most, this bill will fund only about 20,000 new cops. And that's only for the next few years unless local cities can come up with the $33 billion they'll need to pick up the tab when Federal dollars are gone.

Even more, these cops are going to be funded by cutting other critical law enforcement. We're taking FBI and DEA agents off the street to fund, at best, 20,000 new cops that will not even be around in a few years. By the time local law enforcement are able to recruit and train their new cops, Federal funding will dry up and those new cops will be gone. In the end, not only will we have failed to put more local cops on the street, we've lost critical Federal law enforcement.

What is worse is that this bill puts more money into welfare and social programs than it puts in cops. This bill will put two new social workers on the street for every cop it funds. This is hardly fighting crime. When I call 911, I don't want to talk to a social worker, I want to talk to a cop.

This is a terrible bill and I urge my colleagues to vote it down.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the gentleman from New York [Mr. FISH] the distinguished ranking member of the Committee on the Judiciary.

Mr. FISH. Mr. Speaker, I rise in opposition to the rule. This conference report contains provisions which I oppose and, in addition, the conference committee deleted provisions which I supported. However, my opposition to this rule is based as much on procedural objections as it is on substantive policy.

As we all know, violent crime is a devastating national problem. Violent crime has increased in this country over 23 percent since 1988. A violent crime is committed once every 22 seconds and a murder is committed once every 22 minutes. A rape occurs every 5 minutes and a robbery every 47 seconds. Over 70 percent of the violent crimes committed in our country are committed by repeat offenders.

These are not just statistics. The victims of these crimes are real people—they are our constituents—and the ultimate victim is society. The crime epidemic has brought with it the pestilence of fear and Congress should address this complex problem in a comprehensive, realistic and bipartisan way. Whether we are Republicans or Democrats this is a national crisis that we share and partisan politics should not interfere with the best solutions.

Back in March, following action in the House Judiciary Committee on the Violent Crime Control and Law Enforcement Act of 1994, I went before the Rules Committee urging that certain key amendments be made in order. Those were amendments put forward by the Republican members of our Committee and reflected a number of very valid and valuable approaches to the serious problem of crime we have in this country.

Unfortunately, when this legislation was brought to the floor in April, several of my Republican colleagues were prevented from offering amendments under a highly restrictive rule. Still other Republican amendments were allowed but they were subjected to a king-of-the-hill procedure that prevented any real genuine opportunity for success.

Subsequently, after the legislation was passed by the House of Representatives, I appointed the four most senior Republican members of the House Judiciary Committee to serve on the conference committee on the Crime bill. For many weeks and months, the conference committee did not meet. Republican members were routinely excluded from closed door meetings during this time period. Then, finally, when the conference committee briefly convened, Republican Members were routinely refused key documents and several significant Republican amendments were dropped or weakened. Numerous Republican proposals were defeated in conference through the utilization of the proxy vote mechanism. Ultimately, none of the Judiciary Republican conferees signed the conference report. How could they approve a document which they had no part in formulating?

Furthermore, the conference report itself is a document that has been conspicuous by its absence. As of yesterday evening, the Members of this House did not have a complete, final copy of the conference report. The conference version, as I understand it, is almost four inches thick, it is over 1,000 pages long. How do we evaluate a major piece of legislation that no one has been permitted to read?

Mr. Speaker, I stand here as the Ranking Republican on the House Judiciary Committee. The upcoming vote on the rule is a procedural vote that must be evaluated in the light of these events. The rules process goes to the very heart of our role as legislators and our rights as Members of this House. I am angered and dismayed about the manner in which Republican Members have been denied their rightful role on this very important public policy question.

Mr. Speaker, I will vote "no" on this rule because of the tactics used by the Majority party—tactics which insult the Republican Members of this House and the American citizens we were elected to represent.

Mr. DERRICK. Mr. Speaker, I yield 1 minute to the gentleman from Massachusetts [Mr. NEAL].

Mr. NEAL of Massachusetts. Mr. Speaker, first of all, I thank the gentleman for this opportunity to address the issue that many see as the number one problem facing our Nation: violent street crime. The philosopher Rousseau described nature as a state of blissful anarchy. Well, today on the streets of our cities we have a state of unhappy chaos. Street crime is the reason people flee the city. If we reduce street crime, we greatly improve the outlook for our cities.

This crime bill is a solid mix of prevention and enforcement. Law enforcement officials will get a much-needed boost out of this bill. Additionally, this bill contains $7½ billion for community crime prevention programs. Yes, we must build bigger jails and insure that convicted criminals serve their full sentences, but we must also take steps to stop criminals before they get started. These prevention programs will do that.

Let us cut down on the violence. Let us cut street crime. Let us cut gang activity. Let us end the chaos. Let us protect the public, as we are required to do—let us pass this rule and this bill.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the gentleman from New York [Mr. LEVY].

Mr. LEVY. Mr. Speaker, I rise in total opposition to this rule.

Mr. Speaker, some weeks ago, when the crime bill originally came before this body, I reluctantly voted in favor of the bill.

It was my feeling at the time that, although there was much in the bill that I did not favor, the good in the bill outweighed the bad. I voted "aye" because I wanted the crime bill to advance to a conference committee and in the hope that the conference would strike those provisions which I opposed.

The conference committee did that in one instance, when it struck the so-called Racial Justice Act. But then it stopped.

It included in the bill a provision to retroactively eliminate mandatory minimum sentences for some drug offenders. More than 10,000 convicts in prison are hoping we pass this bill so they can apply for early release.

The conference eliminated Senate provisions which would have penalized, for the first time, those who actually use firearms illegally when those firearms have been transported across State lines.

Conferees cut, by 50 percent, the amount of money which the bill was to have spent on prison construction.

And, they left in the bill billions of dollars for programs that duplicate existing efforts and which have no proven impact on crime. You know the ones I am talking about. My constituents know the ones I am talking about and they do not want to pay the tab.

In fact, spending in the crime bill as it currently stands is 50 percent higher than that contemplated in the original Senate crime bill and $6 billion more than approved on this floor. And why?

Because conferees insist on spending public money on midnight sports leagues, arts and crafts, dance instruction and the like. The list is too long to go through here but it totals $9 billion. That is $9,000 million.

The crime bill, as currently proposed to come before us, is opposed by the Council of Citizens Against Government Waste and the National Taxpayers Union, both of which describe the crime bill as a pork-barrel waste.

I ask my colleagues to vote against this rule. It is the only way we can get the bill back to the conference committee so it can be cleaned up and the wasteful spending removed.

Finally, Mr. Speaker, and for the record: Many of my colleagues are attempting to portray the vote on this rule as a vote on gun control. For some Members, it may be that. It is not for me. And I object strenuously to those who suggest that those of us who will vote "no" on the rule will do so because of pressure which has been brought to bear by the pro-gun lobby.

The fact of the matter is that my office has not even been contacted by the pro-gun people. There has been no pressure.

I am voting "no" for one reason and one reason only: I want to vote for a crime bill but I can not vote for this one. It spends too much. It lets convicts go free. It does not punish those who use firearms illegally and it fails to live up to its billing with respect to prison construction.

Let us send the bill back to the conference so we can produce a piece of legislation we can be proud of—one that carries a smaller price tag and which is a crime bill because it fights crime and not because it, itself, is a fraud on the taxpayers.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Washington [Ms. DUNN].

Ms. DUNN. Mr. Speaker, I rise in opposition to the rule and with a deep sense of outrage.

This crime bill is not well reasoned. By now, all Members know of the ill-considered provisions that could never stand alone on this floor were they to be subjected to a vote.

My outrage, however, is reserved for another issue: What do we do when sexual predators are released back into our neighborhoods?

Let me recount the history. The Senate adopted a provision encouraging community notification when sexual predators are released from prison. The House, despite the objections of the Committee on Rules, finally made its will known when this body voted 407 to 13 to instruct House conferees to accept that Senate language.

Then what happened?

A handful of conferees snubbed their noses at the will of the U.S. Congress—both the House and Senate—and weakened the Senate language on sexual predators beyond recognition. They stacked the deck against community notification, they diminished the length of time that predators are tracked, and they did this in the face of yet another bloody tragedy.

Seven-year-old Megan Kanka of New Jersey is dead, Mr. Speaker. Sexual predators were released into her community and they lured that precious little girl to a grisly death.

Conferees who worked to protect the rights of sexual predators should understand this: The next little girl killed by a released predator will haunt them.

Mr. Speaker, it is outrageous that a few conferees have supplanted their will for the will of the House. It is outrageous that this bill effectively denies notification to the next Megan Kanka or the next Polly Klaas, or to your mother or sister or daughter. And it is outrageous that we would place the rights of criminals over the rights of victims.

I will not be a party to it. I will vote to reject this rule. I will vote to tell the conferees to reflect the will of the House and the Senate.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 1 minute to the gentleman from North Carolina [Mr. HEFNER].

Mr. HEFNER. Mr. Speaker, I speak with a little bit of credibility on, I think, this bill. I am one of those rare individuals that voted for the racial justice provision, and I also voted against the assault weapons ban. And I also supported the amendment of the gentlewoman from Washington.

This is not a perfect bill. If we wait for a perfect bill, it will never come before this House.

I would like to speak to some of those folks that say, I just cannot vote for the rule but I will vote for the bill. That does not make a lot of sense. If we cannot get a rule passed, we cannot vote for the bill.

Let me say to Members though, those folks that they say they do not understand this bill. It strikes me as a little bit odd, because every talk show host and all the pundits have been talking about the basketball and everything for two weeks on this bill. Members would think that the only thing in this bill is night basketball.

Let me say to my colleagues on night basketball, every small community in my district, when I go visit with city officials, they talk about the need to try to find something for the young people to do. Does it not make more sense to have a night league of basketball that is supervised than to have gangs on the street corners that are mugging people?

This is not a perfect bill, but this is a good bill. If it is so bad, if this bill is so bad, let us pass this rule and vote the bill down.

The Republicans do not want a vote on this bill. They want to kill this rule, and it is not about money. It is not about social programs. It is about the two issues that are predominant in this bill that have the objections: racial justice on the one hand and guns on the other. It is just as simple as that. I voted for both of them.

But give us a vote. Members that are hesitating to vote for this rule, give us a chance to vote on the bill. And then when we bring the bill up, if they do not like the bill, vote against the bill. If it is so bad, but give us an opportunity to exercise our democratic right in this body to vote for this bill and to vote for this conference.

I would hope that we would not be intimidated by the scare tactics, and I have been threatened all day that I will not be back here if I vote for this rule. I may not be back, but I can get up in the morning and look myself in the mirror and say, I gave the people an opportunity to vote for a conference report.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the gentleman from Maryland [Mr. BARTLETT].

Mr. BARTLETT of Maryland. I rise against the crime against the American people with this rule and the crime bill which I strongly oppose.

□ 1600

Mr. GOSS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from the Commonwealth of Pennsylvania [Mr. GEKAS].

Mr. GEKAS. Mr. Speaker, when the death penalty provisions in this bill reached this House, they were constitutionally flawed, purposely so, in my judgment, because those words, those provisions of the death penalty, were crafted by the long-time opponents of the death penalty. Why? So they could put together a bill that says "We are tough on crime by instituting the death penalty," but leaving it so flawed that it would not be constitutionally sound.

Mr. Speaker, the House then voted on the Gekas amendment, rejected the flawed language, reinstituted proper, constitutionally sound instructions by the court in those procedures, and lo and behold, we had a bill the death penalty portions of which we could support.

Then what happened, Mr. Speaker, was that the conferees, contrary to the will of the House, and contrary to the will of a second vote by the House on instructing these conferees, blatantly again went back to the original flawed death penalty language, and here we are today, with a death penalty bill that has no teeth in it in this particular version.

We need to go back to the conference and reconstruct a death penalty bill that will meet the constitutional muster, and which the people in our country who want to be tough, not falsely tough, who want to be strong, not apparently strong, on appearances only, but fair and tough, and to do the ultimate will of the American people, to institute a death penalty that will act as a deterrent to violent crime, and will end the endless death row appeals that make us sick and tired of the criminal justice system that now does not allow the death penalty to be applied in its proper way.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 1½ minutes to the gentleman from Pennsylvania [Mr. FOGLIETTA].

Mr. FOGLIETTA. Mr. Speaker, after much soul-searching, I rise to say that I intend to vote for the rule which will allow us to consider this crime bill. I urge my colleagues to join me in passing a bill to deal with a problem that our constituents say is most on their mind, the problem of crime.

A racial justice provision did not survive the conference committee. This is wrong. There is racism in the imposition of the death penalty in this country. We should be voting for a bill that uses basic American principles of justice if we are to send human beings to the electric chair.

But for this one provision that is not in the bill, there is much good in the bill. It is important to remind my colleagues where I come from. I founded and chaired the Congressional Urban caucus, and I represent one of the most troubled urban districts in America. It is a poor district. It is struggling, and it is at war with crime.

Mr. Speaker, in our country we are supposed to live free, but crime has robbed the people of my district from the very freedom to walk the streets outside their homes. They are now forced to keep their children prisoners in their homes. They cannot go out because other kids are playing with assault weapons.

A young girl in my district, little Michelle Cutner, was on the last day of school walking back home from school with her mother. She stopped at the corner store to by a bag of potato chips. As she ate that bag of potato chips, a 15-year-old boy, Jerome Walker, wanted a lift from his friend who would not give it to him. Jerome took out a TEC–9, started shooting. Michelle was killed.

Part of the special interest campaign to block this crime bill has been to criticize prevention programs as pork. They belittle an innovative midnight basketball program, but they ignore the facts.

Experience all around this country shows us that a little spending on recreational crime prevention stops a lot of crime. They spent 60 cents per child in Phoenix to keep basketball courts open until 2 a.m. last summer, and juvenile crime dropped by 55 percent.

What is going on here? We have to disarm the National Rifle Association in this town. They do not tell us what to do. Our constituents tell us what to do. They are telling us to pass this bill. Let us do it for them. Let us do it for little Michelle Cutner.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Nebraska [Mr. BARRETT].

Mr. BARRETT of Nebraska. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I rise in opposition to the rule, and to the conference report as well.

It includes too much spending for so-called prevention programs, and it offers too little toward keeping criminals off our streets.

And I rise in opposition, because we are again being asked to vote on comprehensive and costly legislation that we have not had time to study. The conference report was not printed in detail until yesterday, and those CONGRESSIONAL RECORDS didn't arrive in our offices until this morning.

My constituents understand when I say this is "No way to run a railroad, unless, of course, you're running it off a cliff."

And this conference report is a train wreck. It is more of an attack on our pocketbooks and constitutional rights than on the problems of crime. All that is good in the bill is cancelled out by social spending boondoggles.

Can we really consider arts, crafts, dance programs, and midnight basketball leagues crime prevention?

And what happened to "three strikes and you're out?" Now in this bill, the third strike must be a Federal crime, which constitute only 5 percent of all crimes committed. It appears criminals will get a number of foul tips before going to jail.

I also said the bill is too little. I wish we had before us needed habeas corpus reform and reforms in the exclusionary rule. We should defeat this bill and bring back legislation that we can truly call an anticrime bill.

America needs to get tough on crime. Unfortunately, this conference report, with a $33 billion price tag, is tougher on the taxpayers than it is on the criminals. Vote "no."

Mr. GOSS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from California [Mr. DREIER], my colleague on the Committee on Rules.

Mr. DREIER. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, this is a clearly unfair rule, though tragically not unprecedented. The call for blanket waivers basically means that there are many items in that thick package sitting next to Mr. SOLOMON over there which many have not been able to read.

Clearly, however, there are some appealing aspects of the crime bill. One of the most appealing is the idea of 100,000 new police officers on the street. We have all heard that figure from the President, from Members of both houses of Congress. This has been touted all across the country.

The fact of the matter is, Mr. Speaker, if we look at the funding that is ostensibly supposed to be provided by this, we would be lucky to get to one-fourth that number. Why? Because in a nationwide survey that was conducted by the Committee on the Judiciary and some other operations, they found that the average cost per officer for equipment, salary, overtime, is $65,000 per year, yet this bill only provides $14,700 per officer. So we would be lucky to get 25,000, and yet we continue to hear this 100,000 figure.

The waivers that have been granted in this thing make it a clearly unfair rule. We should reject this, bring about a rule and a crime package which can in fact deal with what the American people want us to address.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 30 seconds to the gentleman from California [Mr. TORRES].

Mr. TORRES. Mr. Speaker, I rise today in support of the rule for the conference report to the crime bill 1994.

The crime package that will soon come before us represents the largest commitment of Federal dollars, over $30 billion, to combat crime. The crime bill includes a broad range of measures to help put more police on the street, more criminals behind bars, and to help keep our children off the path to crime.

I am especially pleased that the crime bill includes a provision that I authored to combat violent criminal street gangs. The Criminal Street Gang Prevention Act sends a strong message to hardened gang members that the violence they perpetuate will not be tolerated. As violent offenders, gang members will serve their sentences consecutively to any other sentence imposed for the crimes they commit. Punishment will be enforced.

Yet passage of this crime bill will also help steer young people away from crime and drugs. The crime bill directs over $7 billion toward community crime prevention programs. These programs represent Congress' determination to help our constituents combat the social conditions that contribute to crime: delinquency rates, gang involvement, substance abuse, unemployment, teen pregnancy, school dropouts, and other factors that can lead our children toward crime.

These programs are exactly what people in the communities that I represent in Los Angeles County and people across the Nation are clamoring for—Congress must address the very real crisis of violent crime in our communities. Passage of this crime bill embodies our commitment to take back our neighborhoods, give our children a future, and provide all of us an opportunity to join together in the fight against crime. I urge all of my colleagues to vote "yes" on this rule.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida [Mr. STEARNS].

Mr. STEARNS. Mr. Speaker, I rise in opposition to the rule to accompany H.R. 3355, the Omnibus Crime Control Act Conference Report. This bill is over 900 pages of social programs masquerading as a serious attempt to control our Nation's crime—a resting place for billions of dollars for pet pork projects. A bill that even the FBI Director says will not help fight crime but, in fact, will hurt his agency.

Apparently, in a $33 billion crime bill money just could not be found for some basic law enforcement—that is incredible. However, there is plenty of money for midnight sports leagues, arts, crafts, and dance programs.

Consider for a moment a provision labeled the Local Partnership Act, a program directed toward education and abuse treatment. Sounds good? Well, there is no enforceable provision that says the funds for this provision be used to directly fight crime. In fact, the distribution of funds for this act will be based on a communities' local tax burden—this economic formula rewards high-taxing, big-spending cities and States regardless of whether these funds are being spent on crime control. If LPA was truly targeted for States and cities that are doing their best to fight crime, the funds should have been tied to the percentage of revenues used for law enforcement instead of overall tax rates.

And consider the midnight basketball programs contained in this bill. Now, it occurs to me that the Federal Government should not be encouraging children to be away from home after midnight; however, in typical Federal micro-management style the conditions for playing some ball in one of these Government leagues are: one half of the players have to live in public housing and you have to have more than 80 players to qualify and the games have to be played in communities which have high incidence of sexually transmitted diseases.

The bill's supporters maintain that this bill will hire 100,000 new police officers. Anyone making that kind of statement has not read the conference report. Many of the new officers will be replacements for those retiring or leaving the force—a net gain of zero. Supposedly, Congress was going to pay for these new cops but there is only enough money for twenty thousand fully funded positions in H.R. 3355. Pity the financially strained city that will not be able to come up with the money to buy these mythical police persons. Another unfunded mandate for our cities from the Federal Government.

The administration's touts the bill's "three strikes and you are out" Federal sentencing provisions. Sounds great. But they do not tell you that the provision covers only 1 percent of all the crimes. And probably what is the most cynical of all the provisions contained in this conference report is that this legislation will retroactively end mandatory minimum sentences for up to 10,000 drug offenders. In fact, many individuals will be released early under the bill's guidelines.

Let us not fail to mention the much debated assault weapons ban. Again, remembering the administration's promise that the bill will only cover 19 weapons, honest law abiding citizens now find that their government overnight has made them criminals if they purchase not those original 19 weapons but an additional 180 firearms.

Vote "no" on the rule and let us get to work on a bill everyone can be proud of.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Mexico [Mr. SCHIFF], a member of the Committee on Rules.

Mr. SCHIFF. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, this is supposed to be an anticrime bill, but the Congress is being blackmailed into supporting it. What do I mean? There are numerous provisions in the bill that I believe are positive accomplishments for law enforcement, but in order to get to them, we have to vote for a conference report that also contains provisions which I believe would never pass the Congress if they stood there by themselves.

Two examples: first, an elimination from mandatory minimum sentencing, totally, for certain drug traffickers. Although that provision is in the bill, the President and the Attorney General have never boasted about that provision when they go around the country and say why we need this bill. Why are they not proud enough of it to talk about it?

Second, outrageous spending that has nothing to do with law enforcement. I am not getting involved in the crime prevention versus law enforcement debate. There are spending programs in this bill which never were even intended for crime prevention by their authors. They became crime prevention programs only to get them in this bill, to have spending programs that would not pass any other way.

Mr. Speaker, we can solve this problem. We can vote against the rule. We can send this bill back to the joint committee for more revision. That is what I urge my colleagues to do.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield one minute to the gentleman from Michigan [Mr. CONYERS].

Mr. CONYERS. Mr. Speaker, I wrote the racial justice provision. The Senate took it out of this bill, but I am supporting this rule because I come from one of the cities where guns are easier to get than jobs, where gun licenses are more available and easier to obtain than drivers licenses, where we have a situation that has got to be changed by this House.

For 3 years we have tried to get a crime bill, and we have now got a smart crime bill. I do not apologize to anyone in this Nation for bringing a crime prevention package to the crime bill. We need this.

The other part of it is that the National Rifle Association is not going to get the last laugh on us. We know they are trying to get to assault weapons. That cannot come out of this bill. It will never come up in another bill.

In the name of all of those mayors and sheriffs and police chiefs and community organizations that have talked to me and begged me "Let us have a tough, sensible, smart crime bill," the time is now. Vote for the rule and support this bill.

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Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Arizona [Mr. STUMP].

Mr. STUMP. Mr. Speaker, I rise today in unwavering opposition to the crime bill, or should I say social welfare package.

Supporters of this bill seem to believe that our crime problems can be solved by increased social spending, leniency, and disarming law abiding citizens. I disagree. Whatever happened to deterrence? Whatever happened to actually carrying out severe penalties for those who commit heinous crimes? None of these elements can be found in the bill we are considering today.

Instead, we are handing the American people a plan that will do nothing but waste their hard-earned tax dollars on programs that not only fail to deter crime, but actually encourage youths to stay on the streets when they should be in their homes. Of course, I am referring to the ever-popular $40 million midnight basketball program. Although that particular provision has peaked the public's interest, it is certainly not the most egregious provision in the bill. For instance, some lawmakers feel that the answer to crime is more social workers. My guess is that most Americans will not feel safer knowing that for every police officer this bill funds, two social workers will be placed on the streets. I am confident that they will not feel safer knowing that this bill will most likely result in the release of thousands of convicts.

Mr. Speaker, let us be realistic. What Americans want is a commonsense approach to crime prevention. We cannot hand them a $30 billion election-year gimmick. They are smarter than that and deserve better. I urge my colleagues to vote against this bill.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from the Commonwealth of Virginia [Mr. GOODLATTE].

Mr. GOODLATTE. Mr. Speaker, when the President talks about fighting crime, he sounds like Dirty Harry, but his crime bill looks like Barney Fife.

Overall this crime bill includes almost $1.5 billion for cultural health classes, dance programs, cultural sensitivity instruction, counseling services, self-esteem training, and midnight basketball. With the pork-barrel spending included in this bill we could put 360,000 more criminals behind bars. How can we support this bill when the Nation's top law enforcement official, President Clinton's hand-picked crimefighter, FBI Director Louis Freeh, in a moment of candor when he was outside the Beltway told how this bill will cause drastic reductions in the number of FBI agents.

Mr. Speaker, I urge my colleagues to reject this bill, send it back to conference, and let us come back with a bill that truly does fight crime.

Mr. DERRICK. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California [Ms. ESHOO].

Ms. ESHOO. Mr. Speaker, I rise in unswerving support of the rule and the bill.

Mr. Speaker, as Members of the House, we know the cost of crime in our districts. We see the cost in broken homes, broken bodies, the emotional and physical trauma of our citizens.

We were sent here to pass laws that will fight crime effectively. This bill has more police, more prisons, more prevention, and tougher penalties.

Do not let politics, partisanship, or political action money dictate your decision on this.

Our constituents need our help. Look into your hearts. Look into the eyes of your constituents on this issue. This bill is right. It is overdue. It is necessary.

I urge my colleagues to place the public welfare above politics and pass this rule that will allow final passage of the crime bill.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 30 seconds to the gentlewoman from Utah [Ms. SHEPHERD].

Ms. SHEPHERD. Mr. Speaker, last week, a young man was shot and killed in Salt Lake County while standing in the parking lot of an apartment complex—another victim of a drive-by shooting. The perpetrator was a 16-year-old with 88 previous violations.

We need to put monsters like this away permanently and we have to stop making monsters. This crime bill does both. It is both tough and smart.

A vote against this rule is a vote against the people of Salt Lake who are waiting for us to act. I urge the House to pass the rule.

Mr. Speaker, the family of the man shot down in Salt Lake County last week is counting on us. Let us adopt the rule, pass the crime bill, and finally stem the rising tide of violence in America.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to my friend, the distinguished gentleman from the Ocean State, Rhode Island [Mr. MACHTLEY].

Mr. MACHTLEY. Mr. Speaker, I rise in opposition to the rule and conference report on the crime bill. This bill is more expensive and weaker than the House-passed bill that I voted for in April. Most Americans will agree that we need a good Crime Bill, not just any crime bill. Today, we're voting on a cop-out bill which no longer reflects many of the key crime-fighting aims of either the House or Senate-passed bills.

Mr. Speaker, after the House passed its version of the crime bill this past spring, I had hoped that the House-Senate conferees would pare down a number of noncrime social spending programs. Instead, the conferees provided more than $9 billion for social spending programs, while increasing the overall price tag of the bill from $28 billion to $33 billion. We, as a Congress, must not only make sure our law enforcement personnel have adequate resources, but we must also prevent taxpayers' dollars from being wasted. The increase of $5 billion in the conference report is a lot of money. We need more crime prevention programs, but not at the expense of putting more police on the street.

Included in this bill's social spending package are $40 million for midnight sports, $895 million for model intensive grants, and $100 million for "Ounce of Prevention." Also added was a $630 million program not included in the House bill called "child-centered activities" which funds things such as arts and crafts, dance programs, and recreational provisions and supplies. While many of these programs may have merit, the purpose of this bill is supposed to be to fight crime. We owe it to the American people to be honest about what exactly is in this bill, not to load it up with additional spending cloaked misleadingly as crime-fighting measures.

Importantly, this crime bill also significantly watered down the strong, bipartisan truth-in-sentencing provisions of the House-passed bill that were agreed to on the House floor. These provisions would have conditioned Federal prison funding to States and localities on criminals serving at least 85 percent of their sentences. The conference agreement contains a loophole in which States can avoid this incentive. We can all agree that early release of prisoners is one of the most pressing law enforcement problems that demands serious reform. I commend to all of my colleagues a recent speech by Princeton University Prof. John Dilulio, in which he clearly outlines the magnitude of this problem.

I am also troubled that this bill has reduced total prison funding from $14.1 billion in the House-passed bill down to $8.3 billion. At a time when violent prisoners in America serve an average of 37 percent of their sentences—often due to overcrowded prisons—we simply must find more space to incarcerate these criminals.

There are many other problems with the crime bill that we can and should fix before passing this measure into law. For example, the conferees rejected the House-passed so-called Gekas provisions which strengthened death penalty judicial procedures. And while they also agreed to a provision to allow prosecution of juveniles 13 and older as adults, the bill makes this provision voluntary, rather than the stronger mandatory provision of the Senate bill.

Mr. Speaker, I would like to submit for the RECORD a recent Wall Street Journal essay as well as a copy of Professor Dilulio's speech which present arguments in support of a no vote on this rule and conference report. The failure of this bill to effectively address the problem of violent crime has called into question whether we will be able to pass this crime bill at all. I don't see why we don't go back to the table, clean this bill up, and bring back something we can all be proud to vote for.

PRINCETON UNIVERSITY AND THE BROOKINGS INSTITUTION AT A FORUM—WHY THE GOP IS RIGHT TO OPPOSE THE CRIME BILL AND WHERE TO GO FROM HERE

Mr. DIIULIO. Thank you, Bill. I'm glad to be here, not only as a card-carrying Democrat but also as someone who has somewhat reluctantly and begrudgingly come to the conclusion that this crime bill ought to be scrapped.

Let me begin by saying I think there are some very good things in this crime bill, just as there were many good things in each of the major pieces of federal anti-crime legislation that were passed over the last 10 years. I'm talking here about the Comprehensive Crime Control Act of '84 which established the sentencing guidelines, the anti-drug abuse acts of '86 and '88, the Crime Control Act of 1990 and the Brady bill of 1993. And as I mentioned, the Brady bill may indicate, not among those who would oppose this crime bill because it fosters further federal restrictions on guns, in particular on certain types of assault weapons, I think that its provisions are wise.

By the same token, I wouldn't number myself among those who oppose this bill because it contains billions and billions of dollars for social programs. There is a fair amount of silly business in this bill on that side. Midnight basketball may be silly business. But prison-based drug treatment is not. And so there's a mixed bag there.

Finally, I wouldn't count myself among those who oppose the bill because of the flaws, the limitations in its more sensible or well-intentioned provisions. It's easy to deconstruct, if you will, the community policing provisions of this bill. The bill calls for 100,000 new cops. But when you read the relevant titles of the bill, what you will discover is that that really means about 20,000 fully funded positions.

And when you further look at how this bill is to be administered, you come to recognize that it's to be administered by the Office of Justice Programs, which is the alphabet soup of agencies left over from the days of the old Federal Law Enforcement Assistance Administration, which is to figure out some way of divvying up this money between 85 percent for more manpower, 15 percent for everything else having to do with policing, so much to jurisdictions under 150,000, so much to jurisdictions over 150,000, and so on.

And if you're stouthearted enough to look at this bill in light of the relevant academic literature, you know that it takes about 10 police officers to put the equivalent of one police officer on the streets around the clock. This is factoring in everything from sick leave and disabilities to vacations and three shifts a day and desk work and so on. So that 20,000 funded positions becomes 2,000 around-the-clock cops. And 2,000 around-the-clock cops gets distributed over at least 200 jurisdictions for an average actual street enforcement strength increase of about 10 cops per city.

Moreover, you learn, when you look at the relevant titles, that these positions are not really even fully funded. The money is really seed money that will run out rather quickly. And I suppose that those big-city mayors, Democrat and Republican, who are supporting the bill simply believe that in the out years the federal government will belly up to this bar again and put up more funds.

Nevertheless, I think the community policing provisions of the bill, represent tiny, perhaps faltering but tiny steps in the right direction. Why, then, should the GOP or responsible legislators of both parties or concerned citizens generally oppose this bill?

My answer is that, in the analysis, this bill, warts, beauty marks and all, simply costs far too much, is much too complicated, contains way too many untested and unwise provisions. It will do nothing, in my view, to reduce the country's crime problem. In fact, as I'll suggest in a moment, it may actually add to it. The bill is not, as the President, I think, likes to say with sincerity, smart and tough. I think rather it is, taken all in all, rather dim-witted and weak.

There are at least four specific realities about crime in this country that this bill does little or nothing to address, or addresses perversely: Revolving-door justice, the youth crime bomb, the black crime gap, and the real root causes of crime. Now, I am going to try to do the impossible—my Princeton students would not believe it—and stay within my 15 minutes. So I will say as much as I can on each of these scores before turning it over to my colleagues on the panel.

First, let me talk about revolving-door justice. Every major public opinion survey shows that the public has lost confidence in the ability of the justice system to arrest and detain and convict and punish violent and repeat criminals. From a number of recent studies published by Brookings and other institutions, it's clear that the facts and figures support the public's frustrations and fears on crime.

Let me offer just a little bit of the evidence, and I stress a little bit of the evidence, on revolving-door justice. Sixty-five percent of felony defendants are released prior to trial. That includes 63 percent of all violent felony defendants. Now, what happens to them when they're out on the streets? Well, nearly a quarter of them simply never show up in court, for starters. All 11 percent of murder arrestees and about 12 percent of all violent crime arrestees are on pretrial release for an earlier case at the time of the offense. Over 20 percent have 10 or more prior arrests. Over 35 percent have one or more prior convictions.

Case management, which is a bureaucratic euphemism for plea bargaining, means that over 90 percent of all criminal cases today do not go to court because the offender pleads guilty to a lesser charge. That's true as well for violent offenses. Only 44 percent of murder cases go to trial, 23 percent of rape cases, 15 percent of aggravated assault cases.

Now, we hear a lot about the explosion in the prison population, and it's true that the nation's prison population, federal and state, has increased dramatically over the last 15 years. But it's also true that the probation and parole population has increased even faster. Today you have about four and a half million persons under correctional supervision in this country—four and a half million. Three and a half million of them, roughly, are not incarcerated. Rather, they're under the supervision of probation and parole officers who are handling hundreds of cases and really can't provide effective supervision.

What happens in these cases? Well, a disproportionate number of the three and a half million in probationers and parolees out there circulate in and out of poor minority urban neighborhoods, repeatedly victimizing their truly disadvantaged neighbors. We have data on recidivism that could—probably books and volumes that could fill this room. But just to cite a few of the statistics, within three years of sentencing we know that nearly half of all probationers are placed behind bars for a new crime or abscond.

We know that for parole, the tale is very much the same. If you look on a state-by-state basis, you find, for example, that in Florida between 1987 and 1991 you had over 100,000 prisoners released only. At points in time when they would have been incarcerated were they not released early, these offenders committed over 26,000 new crimes, including some nearly 5,000 new crimes of violence, including 346 murders.

Now, what else do we know about probationers and parolees? Well, we know that with respect to violent crimes, violent crime arrests, 16 percent of violent crime arrestees are on probation and 7 percent are on parole. Now, if you take those two numbers and you add it to a number I gave earlier—that is, 12 percent of violent crime arrestees on pretrial release—you're left with a rather amazing number, that 35 percent of all violent crime arrestees have some criminal justice status at the time of the offense; that is, over a third of all violent crime arrestees are ostensibly in criminal custody at the time of the offense. Now, if that is not revolving-door justice, I don't know what is.

The Senate version of the crime bill that was drafted and put out back in November—November 19th, 1993, to be exact, by a vote of 95 to 4—would, I think, have done something, though I'm not sure exactly how much, to stop revolving-door justice. But now, almost nine months later, we have before us a crime bill that would actually, in my view, grease the revolving door, at the federal level, at least, via such provisions as the so-called safety valve provision, which is essentially a provision that would permit certain categories of convicted drug defendants to be invited back to court, to be given a virtual retrial under a retroactive law.

About 5,000 prisoners would be immediately eligible for this provision and they could get sentence reductions of as much as half or more in some cases of their sentences. Also, the language of the safety valve is quite elastic. I would not be surprised, if this bill passes with this provision, to see the safety valve provision applied to all of the 16,000 or so so-called low-level drug offenders in the federal prison system.

Now, interestingly, the safety valve idea has been supported by a number of Republicans as well as Democrats, including a number of conservative Republicans. And I think I know where they're coming from. I don't think anyone would believe that the federal sentencing structure is perfect. There are lots of sentences, especially, I would say, for drug offenders that are overly harsh. And I myself have taken an interest in some such cases, up to and including joining the clemency petition of one federal inmate who's serving time for a nonviolent first-time drug offense.

But what I would like to point out is that the utterly false argument behind the safety valve provision, and other provisions in this bill like it, is that many, if not most, prisoners are petty first-time offenders with few previous arrests, no previous convictions and no history of violence. The facts, which have been painstakingly put together by the U.S. Bureau of Justice Statistics and by other research organizations and widely published, speak in exactly the opposite voice.

Let me just give you a few of the facts. In 1991, fully 94 percent of state prison inmates had been convicted of a violent crime or had a previous sentence to probation or incarceration. In other words, only 6 percent of state prisoners were nonviolent offenders with no prior sentence to probation or incarceration. Nearly half were serving time for a violent crime and a third had been convicted in the past of one or more violent crimes.

If you look at the state data, you get the same picture. In New Jersey, where I spend a lot of my time, you had in 1992 a prison population in which about half of all prisoners were serving time for a violent crime. Eighty percent had criminal histories involving violence. The average prisoner had nine prior arrests, six prior convictions and so on.

Now, it is true that the federal prison system, compared to the state systems, of most state systems, has relatively fewer violent criminals and more property and drug offenders. But of the 35,000 persons newly admitted to federal prison in 1991, only 2 percent, or about 700, were convicted of mere drug possession. And even in the federal prison system, about half of all prisoners had two or more prior felony convictions and over half of all prisoners in federal penitentiaries had a history of violence.

So one has to understand as well that even these numbers, as depressing as they are, understate the actual amount and severity of crime committed by prisoners when free. For one thing, they don't take into account the effects of plea bargaining. People who may present themselves as first-time nonviolent drug offenders may, in fact, be plea-bargained or violent and repeat offenders.

Second, these numbers don't account for the wholly undetected, unpunished, unprosecuted crimes committed by prisoners when free. There have been a number of large scientific studies, prisoner self-report studies, that have tried to get a handle on this question. And the two most recent such studies indicate that in the year prior to incarceration, the typical prisoner commits a dozen serious crimes a year, violent and property crimes, excluding all drug crimes.

And finally, which brings me quickly, I hope, to my next point, these numbers do not reflect the number of crimes committed by prisoners when they were juveniles. We know that nationally juveniles account for about one-fifth of all weapons offenses. They've committed record numbers of murders in the last several years, several thousand murders a year. Today's high-rate juvenile offenders are tomorrow's adult prisoners, but today's adult criminal records don't comprehend yesteryear's slew of juvenile crimes.

America is facing a ticking youth crime bomb. We have burgeoning numbers of young people who, from all the statistical profiles, are at risk of becoming violent and repeat criminals. The rate of growth in serious youth crime among white teenagers now exceeds the rate of growth in serious youth crimes among black and Hispanic teenagers. Now, given this reality, you might think that this bill would address the problem of juvenile crime in a serious way. But I would submit to you that it does not, not even symbolically.

Let me just quickly mention the third overarching reality which I think this bill ignores, and that is what I would call the black crime gap. Most Americans, most people in this room, are safer today than they were three or four years ago. Crime rates nationally in most categories of crime have dipped down, but not so for black, Hispanic, poor minority inner-city Americans.

In 1992, which is the last year for which we have complete data, the violent crime victimization rate for blacks was the highest ever recorded. You have lots of opinion surveys and polls which show that black Americans find crime as truly the number one issue in their neighborhoods, a majority of black school children afraid to go to and from school, a majority of black school children afraid, believe that they will be shot at some point in their lives.

Now, given this reality, you might think there'd be something in this massive crime bill that would address this problem. Instead, Congress spent a lot of time debating, wasting time with the so-called Racial Justice Act. And without getting into that, at least not getting into it now, we just need to remember that the vast majority of crimes in this country are intraracial. Over 80 percent of all violent crime is intraracial. And we have a series of studies that, at a minimum, throw into serious doubt the issue of whether, in fact, there are racial disparities in sentencing even in capital cases.

Well, this bill, of course contains no racial justice provision. But the logic of that provision, I think, informs other provisions of the bill. It informs, I think, a diagnosis in the bill of the root causes of crime, which talk about things like unemployment and so on. Never mind that we now have studies which suggest that that factor is not important. Never mind the basic fact that most prisoners in the year or two prior to incarceration held a job that paid minimum wage or better. This is the diagnosis of root causes in this bill.

Well, where to go from here? To be brief, in closing, I would say that—I would hope that this bill would be scrapped, that Congress would come back in a new legislative season and take another crack at it; in other words, go back to the drawing board, but I would hope not one great big drawing board with $30 plus billion worth of talk, but rather a series of little drawing boards—a prison bill, a cops' bill, if you must, a midnight basketball bill, a prison drug treatment bill. And let's debate the merits and let's have our legislators debate the merits and vote on the merits of each provision separately.

My fonder hope, one that only an academic could bear to speak in a forum such as this, is that Congress would declare a moratorium on federal crime legislation. There is a provision in this bill for a crime commission, a bipartisan commission to study crime. I think it would be much better to have a bipartisan commission that would look at the evolution of the federal government's role in crime control, particularly since 1968, and ask the tough questions of what, in fact, has been wrought by the federal government's involvement in making, administering and funding foreign policy, and ask the tough question whether this bill or any conceivable federal crime bill could actually do much to protect the public and its purse better than they're protected by existing policies.

I'll stop there, Bill. [Applause.]

[From the Wall St. Journal, August 10, 1994]

REVIEW AND OUTLOOK—CLINTON REPUBLICANS

President Clinton and his Democrats are down in the polls, but that doesn't mean Americans are clamoring to elect Republicans. Maybe that's because they dislike the kind of political backflip that House Republicans are about to do to save what is being advertised as a "crime" bill.

This $33 billion monstrosity has been bogged down in the House by rank-in-file Members of both parties who object to one or another provision. Republicans claim to oppose needless spending and phony anticrime measures, both of which have come to dominate this bill. But instead of uniting to let the bill die of its own absurd weight, as many as 10 or 20 Republicans are rushing to give Speaker Foley and the Democratic leadership a political victory. Does anyone still wonder why House Republicans haven't won a majority since Stalin ruled the Soviet Union?

"How can you vote this down?" asks New Jersey's Marge Roukema, thus demonstrating the solid principles behind her bailout. New Yorker Sherwood Boehlert admits he wants to throw some money around to the cities. And Connecticut's Christopher Shays, who calls himself a Congressional reformer, somehow doesn't object to one of the biggest federal spending boondoggles in 20 years.

These and other me-too Republicans are falling for the line that because Americans are concerned about crime they'll swallow any bill with that label. Democratic leaders believe this, which is why they've changed what started as a crime bill into what now looks more like last year's failed fiscal "stimulus" proposal.

There's $1.8 billion for something called the Local Partnership Act, which was originally sponsored by Detroit Democrat John Conyers. Congress merely asserts that this big-city payoff for education, "jobs" and just about anything else will somehow also fight crime. There's $40 million for "midnight sports," an idea that makes some sense when it springs naturally from volunteers in a community. But this federal giveaway will now politicize each sports league—for example, by requiring that a community that wants funds for such sports have a high incidence of HIV infection. We could go on and on—to the tune of some $10 billion.

Yet even Ohio Republican John Kasich, ostensible scourge of pork, says he'll vote for this mess on the House floor. "We need to spend money in urban areas. There is some money in the bill I don't like," Mr. Kasich told us. "But people want something done" about crime.

Indeed they do, which is why John DiIulio and a growing number of principled Members of both parties now oppose this bill. Readers of this page know Mr. DiIulio, of Princeton University and the Brookings Institution, as one of the country's more hard-headed students of crime. He's also a Democrat who supported the crime bill as it emerged from the Senate last year but now says it "ought to be scrapped." The bill "will do nothing to reduce the country's crime problem," he told the Project for the Republican Future this week. "It may actually add to it."

While Mr. Clinton claims the bill would put 100,000 more cops on the street, Mr. DiIulio says, it actually pays for only 20,000. Figure in the requisite pork-barrel distribution to hundreds of cities, and each city will get about ten more cops. So much for saturation policing for high-crime areas.

The bill weakens the "three strikes and you're out" provision so that it will cover only some 300 to 400 (out of thousands of) violent federal criminals a year. It also includes a loophole that guts its juvenile justice provisions, "at a time when we have a youth crime problem that is off the charts," Mr. DiIulio says. And, maybe worst of all, the bill adds to the problem of "revolving door justice" that the public so dislikes. It does this by allowing certain drug defendants to go back to court for a virtual retrial that would let them evade mandatory sentences.

Americans are cynical about politics because they think politicians tell them one thing and do another. This crime bill will only increase that cynicism once voters understand that it has more to do with reelecting incumbents than it does with crime. As the party in power, Democrats who want something to run on in November are eager to pass it. Mr. Clinton, desperate for any "success," has climbed on for the ride.

But we can't begin to understand why Republicans would want to make this a bipartisan boondoggle. "It's clearly not a perfect bill," admits Mr. Kasich, who vows to fix it in future years when there are more Republicans in the House. But why should voters elect more Republicans if they're not willing to resist a bad bill in the first place?

Mr. GOSS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas [Mr. SMITH].

Mr. SMITH of Texas. Mr. Speaker, I thank my friend, the gentleman from Florida for yielding me the time.

Mr. Speaker, I rise to strongly oppose the rule.

The Clinton crime bill should not be enacted in its current form. Instead, it should be incarcerated for mugging the American taxpayer and for murdering the truth so many times that it qualifies as a serial killer.

This legislation is larded and laced with billions of dollars in misplaced social spending. In fact, there is more money for social programs than for prison construction.

Over $9 billion is included for vague social spending to finance such stringent anticrime measures as arts and crafts, self-esteem enhancement, dance, and midnight basketball. All this on the theory that the person who stole your car, robbed your house, and assaulted your family was no more than a disgruntled artist or would-be NBA star.

Even worse than the money this bill throws away, is the opportunity it discards to do something serious about crime.

Crime is America's primary concern. This bill makes clear it is not the administration's. I urge a defeat of the rule so we can send this bill back to conference with the message America is sending: Be tougher on criminals than they are on us.

Mr. DERRICK. Mr. Speaker, for purposes of debate only I yield 30 seconds to the gentleman from Vermont [Mr. SANDERS].

Mr. SANDERS. Mr. Speaker, last year all six women who were murdered in the State of Vermont were killed by their spouses and partners and hundreds more were battered. Domestic violence exists in epidemic proportions throughout this country. This legislation provides $8 million for my small State of Vermont to combat violence against women and $1.8 billion nationally. This is money that is long overdue.

Mr. Speaker, let us stand up for battered women, stand up for social justice, and while this is a far from perfect bill, it is a major step forward. Let us support the rule.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Ohio [Mr. OXLEY].

Mr. OXLEY. Mr. Speaker, I rise in opposition to the rule, and point out that the top law enforcement officer in this country, the Director of the FBI, has serious concerns about this legislation.

Mr. Speaker, there are a variety of reasons to oppose the conference report on the so-called Violent Crime Control Act of 1994, but allow me to enumerate just a few of the most important ones:

(1) In terms of the dollars we can realistically expect to be appropriated, there is more social spending than law enforcement spending in the bill—over $9 billion worth;

(2) The dollars that will be spent under the bill will go disproportionately to the handful of big-city mayors, at the expense of rural districts such as mine;

(3) The bill lacks exclusionary rule reform;

(4) The bill lacks mandatory victims restitution;

(5) The bill lacks real habeas corpus reform;

(6) The dollars authorized for prison construction are not fully funded;

(7) The bill's provision for training new F.B.I. and D.E.A. agents are utterly inadequate; and

(8) The bill's provisions on "three strikes and you're out" and truth-in-sentencing were weakened in conference to the point of meaninglessness.

Mr. Speaker, this bill isn't tough on criminals. It is only tough on taxpayers.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey [Mr. ZIMMER].

Mr. ZIMMER. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, in March of this year, 6-year-old Amanda Wengert of Manalapan Township, NJ, was kidnapped from her home and brutally killed by her next door neighbor who no one in the neighborhood knew had twice been convicted of sexually assaulting children in the past.

Just 2 weeks ago, 7-year-old Megan Kanka of Hamilton Square, NJ, was invited to visit her neighbors—who lived right across the street from her. One of them had a new puppy he wanted to show her, he said.

She was raped and brutally murdered. Her parents didn't know that this man had twice been convicted of similar crimes or that he was living with two other men who were also convicted sex offenders.

I believe that Amanda and Megan would be alive today if their parents knew that predators lived in their neighborhood.

We in this House and the Members of the Senate have voted overwhelmingly in favor of effective community notification legislation that would have accomplished this very simple objective. But, when the legislation came to the conference committee, a small number of conferees arrogated to themselves the right to water down and strip this legislation of its original content. Now the section that was originally captioned "Community Notification" is captioned instead "Privacy of Data."

That means that the rights of predators are being put above the rights of their potential victims. Vote to kill this rule and let's open up this legislation so we can protect young lives in the future.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 30 seconds to the gentleman from Michigan [Mr. LEVIN].

Mr. LEVIN. Mr. Speaker, Members who represent suburban districts have greater reason than ever to vote for this rule. Suburban communities like mine work together through regional task forces to target crimes that often cross municipal lines. The crime bill now contains language that I proposed so that the cops-on-the-beat provision can be used to support regional task forces in the fight against drugs, auto theft, violent criminals, and youthful offenders.

Support our suburban police in their fight against crime. Vote for the rule and the bill.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Illinois [Mr. PORTER].

(Mr. PORTER asked and was give permission to revise and extend his remarks.)

Mr. PORTER. Mr. Speaker, I rise in opposition to the rule.

Mr. Speaker, I cannot vote for this rule allowing consideration of the crime bill because the billions of dollars of new, unjustified, and unfunded social spending in this bill outweighs its benefits.

The proposed trust fund would effectively divert funds intended for deficit reduction toward new spending and would prevent increased support for existing and underfunded worthy programs such as Head Start, biomedical research, impact aid, and special education.

In order to meet the bills' goal of hiring 100,000 new police officers, State and local governments would be expected to spend as much as $33 billion in matching funds, which is, in effect, yet another unfunded mandate.

This decision is a difficult one for me because the legislation contains many provisions I favor including the ban on assault weapons which I voted for and watched for earlier this year. I have strongly supported reasonable gun control measures, but if the price of enacting this is to support a vast expansion of costly and unnecessary Government programs, then my vote must be no.

If this bill is sent back to conference, I will vigorously oppose efforts to remove the assault weapons ban. The majority party conferees will then have to decide which is more important to them—an assault weapons ban or billions for new social programs.

My first and highest priority has always been to restrain Government spending and growth and get deficits under control. It is unfortunate that this bill goes in the exact opposite direction. I am opposed to taking all the savings that were to be derived from downsizing the Government and plowing them right back into 30 new social programs, most of which have never been debated in Congress and all of which duplicate existing efforts.

The Senate's original $5.9 billion bill has snowballed into a $33.3 billion bill that is attempted to be justified by the creation of a so-called crime trust fund funded by planned reductions in the Federal work force.

But savings from Federal work force reductions will not be sufficient to fund this trust. Any savings from downsizing have already been spent, in effect, to reduce spending to accommodate the freeze Congress imposed on the appropriations this year.

This trust fund for crime programs will, however, reduce the caps on all other discretionary spending. Every category of Federal spending will have to decrease to allow for the trust fund. This means an added strain on already underfunded existing, worthy programs such as Head Start, impact aid, special education, and biomedical research.

And yet, the trust fund will not do what it claims to do—to ensure that the crime programs will be funded. Appropriators will still have to approve spending through the annual appropriations bills. The trust fund is simply an accounting device that maintains that if appropriators do not fully fund the programs authorized in this bill, they may not use the funding to supplement other priorities.

In addition, the trust fund claims to pay only for $30.2 billion of the crime bill. But the bill also authorizes about $3 billion in spending, most of which would be used for prison construction grants, that does not fall under the trust fund. There is not even an attempt to account for this $3 billion of additional Federal spending.

The bill also authorizes at least $8.7 billion in new social spending, while, according to the Government Accounting Office, there are already seven Federal departments sponsoring 266 prevention programs to serve delinquent or at-risk youth. The GAO found a "massive Federal effort on behalf of troubled youth" which already costs over $3 billion a year. The crime bill creates 30 new social programs which will duplicate at least 50 existing federally funded programs. We simply cannot tolerate nor afford this kind of irresponsible spending.

Mr. Speaker, this rule and the underlying bill is a disgrace to this Nation, and I cannot support it.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Missouri [Mr. VOLKMER].

Mr. STENHOLM. Mr. Speaker, will the gentleman yield?

Mr. VOLKMER. I yield to the gentleman from Texas.

Mr. STENHOLM. Mr. Speaker, I rise in strong opposition to the rule and the bill.

From the information I have been able to gather, I believe there are some serious flaws in this bill. First and foremost, we simply cannot afford this bill. With our budget deficit at $220 billion and national debt at $4.6 trillion we cannot afford a $33.2 billion bill which includes over $8 billion of spending on social welfare programs such as midnight basketball and afterschool arts and crafts. I am aware of a few questionable projects and would be willing to bet there are a few more tucked into this 1,000 page bill. Unfortunately, I cannot identify these for you specifically because as of this morning, I could not obtain a copy of the conference report.

This bill is to be funded through the violent crime reduction trust fund. While this might sound good, this trust fund is based on anticipated savings. We are anticipating that the Federal Government will save $30.2 billion from the Federal Workforce Reduction Act. This savings estimate is questionable given the fact that we have begun to exempt Government agencies from the Federal Workforce Reduction Act. This bill has a $33.2 billion price tag. We are going on the assumption that the trust fund will provide $30.2 billion. According to my math, at a minimum that still leaves $3 billion we need to come up with. Beyond that, however, what happens if these anticipated savings are not realized? Where will the money come from?

We need to remember that 96 percent of crimes are State offenses, only 4 percent are Federal. What I have been hearing from the law enforcement folks back in the 17th District is that they appreciate us addressing the issue of crime, but that the package before us today does not include the right mix of crime prevention programs they need at the State and local level.

Furthermore, the programs funded in the crime bill, including the 100,000 additional police officers, will only be funded for six years. After that, the financial burden will be on State and local officials. If we pass this bill, we will be creating more unfunded programs that our State and local folks don't want.

Today, there are about 4.5 million persons under correctional supervision in this county. Roughly 3.5 million of them are not incarcerated. They are under the supervision of probation and parole officers who are handling hundreds of cases and really can't provide effective supervision. Over one-third of all violent crime arrestees are ostensibly in criminal custody at the time of the offense. If that is not revolving-door justice, I don't know what is. It is no wonder that many Americans have lost confidence in the ability of the justice system to arrest and punish violent and repeat criminals.

What is truly amazing is that not only does the crime bill we are considering today not address revolving-door justice, it actually greases the revolving door.

For example, the safety valve provision would give Federal judges the discretion to waive mandatory minimum penalties for first-time nonviolent drug offenders. This provision allows a judge to apply these provisions retroactively. Essentially, this means certain categories of convicted drug defendants would be invited back to court and given a retrial under retroactive law. About 5,000 prisoners would be eligible immediately to get sentence reductions of as much as half of their sentences. In addition, the language of this provision is quite elastic and it could end up applying to all of the 16,000 so-called low-level drug offenders in the Federal prison system. This is a perfect example of how this crime bill does not address crime from the right direction.

Finally, I cannot support the assault weapon ban. There are 19 specific weapons identified in the ban, but the Bureau of Alcohol, Tobacco and Firearms has already identified over 150 weapons they will add to the list of prohibited guns if the ban is passed. Opening the door further to this sort of government by unelected bureaucrat shatters my confidence that the second constitutional amendment actually will be protected in the future.

This bill spends too much money and proposes to fund too many questionable programs. I strongly urge my colleagues to oppose the rule and H.R. 3355.

□ 1620

Mr. HALL of Texas. Mr. Speaker, will the gentleman yield?

Mr. VOLKMER. I yield to the gentleman from Texas.

Mr. HALL of Texas. Mr. Speaker, I rise in opposition to the rule and consideration of the crime bill conference report.

Mr. Speaker, I rise today to express my opposition to a provision of the crime bill conference report. In an attempt to insure that violent offenders serve longer terms, the bill allows nonviolent drug offenders to be released early so that other prisoners can be jailed.

I agree that violent offenders should be put in jail. But I also believe that drug offenders should be put in jail. By letting drug offenders go, we are sending two bad messages to the American public, and to our young people in particular.

First, by giving drug offenders special treatment we are saying that drug offenses are not as harmful to society as white collar crimes. And I ask you, who is worse, the white collar criminal or the guy who sells drugs to our schoolchildren? We must not cater to drug offenders. If we are to have early releases, what about elderly, nonviolent, non-drug-related prisoners who have served a good portion of their sentences and are not likely to be repeaters?

Second, we are saying that doing drugs in general is bad—until we need more prison space, and then it is not so bad. But it is wrong to do drugs. Drugs are harmful. Drugs are dangerous. Drugs destroy the minds of our young people. No matter how crowded our prisons are, drugs are wrong.

We need to prevent people from doing drugs. And if we can't, we need to punish drug offenders. We do not need to release drug offenders, and we do not need to give them preferential treatment. By reducing mandatory minimum penalties for non-violent drug offenders we are not only sending criminals back onto the streets, we are sending the wrong message about drug usage and the severity of it.

I know that Mr. BROOKS and the other members of the conference committee have worked long and hard to craft a good bill. But this provision, among others, needs to be deleted or refined so that we can vote on a bill that really gets tough on crime—all types of crime, illegal drug usage included.

With this in mind, I rise to oppose the rule allowing consideration of the crime bill conference report. I urge a vote against the rule so that we can send the bill back to conference.

Mr. VOLKMER. Mr. Speaker, first I want to say I commend the gentleman from Texas [Mr. BROOKS] for the work that he has done on this crime legislation. But I feel that I have to vote against the rule, and if the rule passes I am going to have to vote against the bill for various reasons.

I want to make it clear in here, in listening to both sides, it appears that maybe somebody on this side is not for fighting crime and some people on that side are really not for fighting crime. I do not know anyone in this House that is not for fighting crime. We have a disagreement as to how we should fight that crime.

I think it misleads the Members of the House also to say if this rule goes down they will never see a crime bill. Wait a minute, folks. We are going to be here to the middle of October or later. We have plenty of time to work up a crime bill that all of us could support. All of us want to support a crime bill. There is not any Member here that does not want to support a crime bill.

For that reason, I am going to vote against the rule, and hopefully, with my friend from Texas and others, we can have a crime bill that we can all support.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 1 minute to the distinguished gentleman from New Jersey [Mr. HUGHES].

Mr. HUGHES. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I disagree with my colleague who just spoke before me. There are Members in this House who do not want the President to have a crime bill, and I have never seen such arm twisting on that side of the aisle to deny him that agenda. That is what it is all about, folks.

I have listened to the description about the sexual predators. Let me say, my friends, read it, read it. It is broader than when it left the House, and it is smarter than when it left the House. The Senate version which some brag on was a very narrow definition of a sexual predator dealing with those with mental abnormalities, and it required a court adjudication. In this time bill we have registry for sexual offenders against children, and in addition to that notification by the chief law enforcement officer, and Members should read that. It is just nonsense.

What this is all about is not about a procedural vote. A vote against the rule is a vote against the crime bill. We are not going to fool the American public. It is a vote against the crime bill. They are trying to kill the crime bill.

It is about guns among colleagues on this side and that side, and an agenda on this side that does not include a crime bill.

I urge my colleagues to support the rule.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Missouri [Mr. EMERSON].

Mr. EMERSON. Mr. Speaker, I rise in opposition to the rule.

Mr. Speaker, I rise to unmask an injustice that is about to be thrust upon the American people. The so-called crime bill we are debating today picks the pockets of taxpayers, while befriending criminals who should be locked up behind bars. I truly want an anti-crime initiative—we need one desperately—but this is not the right way to go about it because many of these provisions just don't make sense.

The onerous gun ban is a perfect example. We all should know by now that guns don't kill people—people kill people. If you truly want to get at those who use guns to commit crimes—which I think we all want to do—then we should impose stiff penalties on gun-related crimes. But no, the liberals who crafted this weak legislation want to go about it in a cosmetic way by including a gun ban that disarms law-abiding citizens.

Let me make myself clear, a criminal intent on committing a crime doesn't care if Washington says you can't buy a particular type of weapon or you'll have to wait 5 days to do so. He or she will utilize their underworld sources to get their hands on those weapons, go out and commit a crime. Stiffer penalties, at least, will take these hoods and thugs off the streets and put them behind bars so they can't do it again.

I also want to register my opposition to the very questionable social spending contained in this measure. As we have already heard here today, $9 billion of the $33 billion package is earmarked for new social programs, such as community arts and crafts, midnight basketball leagues, job training, and addiction rehabilitation. These ideas in social experimentation are not without merit in theory; the question is, however, how much can the taxpayer afford to fund?

Further, these programs have little or nothing to do with fighting crime and a lot more to do with the President winning favor with big city mayors and the liberals in this Congress. Speaking for my constituents in southern Missouri, little of this money, if any, is headed for the streets of Caruthersville, Sikeston, West Plains, Rolla, Cape Girardeau, Park Hills, Poplar Bluff, or any other small, rural community—it is wired for Los Angeles, Chicago, and New York.

Finally, I'm concerned about the $8.8 billion being spent over the next 6 years to supposedly add 100,000 cops on the beat. I would support this if it were true, but even this is short of its goal. In reality, this money will only equal a little more than 20,000 new officers—one-fifth of what the President and liberals have claimed. Imagine that, another broken promise. Further disconcerting, when this funding runs out, States and local communities will be strapped with paying the salaries and pensions of these new crime fighters that the feds have given them.

Mr. Speaker, instead of wastefully spending the taxpayers hard-earned dollars, let's take off the masks and see this so-called crime bill for what it really is—a Christmas tree full of social spending ornaments and short-sighted promises. The American people deserve legislation that's tough on crime, rather than a political payoff that's friendly to felons. I urge my colleagues to vote "no" on the rule; send it back to the conference committee; and, take another shot at achieving a true anti-crime initiative.

Mr. GOSS. Mr. Speaker, I yield myself 1½ minutes.

Mr. Speaker, I would like to give Members an idea of how bad this bill is. My office received a call from a psychologist in my district whose programs stand to gain financially from the vast spending in this bill. That person called to complain about the $33 billion price tag, the lack of enforcement provisions, and the perverse priorities and incentives in this bill.

This is the true voice of the people. This bill barely mentions victims, but it lavishes billions on criminals.

Let me explain. For 30 years in this country we have been funding social programs aimed at criminal problems. We have spent $5 trillion in 30 years doing that, and the crime rate has gone up 500 percent. It does not work that way, and the American people want us to get tough. They want tough penalties, they want prisons, and they want good enforcement out there.

There is another problem with this bill. No Member has talked about the cost. It is a $25 billion budget buster. We have $22 billion in here, and that does not get us to what we are going to spend on this thing including the outyears, and I have added in $13 billion in there for the out-years so we do not create any myths.

If there is one question the American people should ask their representatives about this bill it is going to be: Have you read it? Have you read this bill? Have you read every word of it? Have you read the conference report?

I daresay there are very few Members here who could answer any of those questions in the affirmative.

Mr. Speaker, I reserve the balance of my time.

Mr. DERRICK. Mr. Speaker, I yield such time as he may consume to the gentleman from New Jersey [Mr. KLEIN].

Mr. KLEIN. Mr. Speaker, I rise today in strong support of the rule on the conference report on H.R. 3355 and on the bill.

Violent crime is the scourge of this Nation. More than anything else, Americans want us to take decisive action to fight crime. We must stop looking at criminals as victims and recognize that we, the law-abiding citizens, are the victims. Today we stand on the threshold of passing the strongest, toughest crime bill in our history.

But special interests would hold this crime bill hostage in a desperate attempt to kill a ban on military-style assault weapons that are the weapons of choice of drug dealers and criminals. We must not bow to special interests. We cannot let children die on the streets to appease the NRA.

We have an opportunity to put 100,000 more cops on the streets, to build more prisons for dangerous criminals to curb the flow of drugs into the country and, yes, to ban these assault weapons. Let us stop the rhetoric on crime. Let us do something about it.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 30 seconds to the gentlewoman from Connecticut [Ms. DELAURO].

Ms. DELAURO. Mr. Speaker, I rise today not only in support of this rule, but in support of taking a stand. After months of consideration and countless hours of debate, we have arrived at the precipice. We can take the easy way out, defeat the rule and back away from our responsibility. Or we can show some courage. Exhibit some leadership. Pass the rule and bring this crime bill to a vote.

Consider those who live in fear, and whose lives this crime bill will greatly improve. Think of this when you vote on this rule, and consider the words of Andrew Jackson: "One man or woman with courage makes a majority."

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Texas [Mr. ARMEY] our conference chairman.

Mr. ARMEY. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, earlier in this debate the gentleman from New Mexico [Mr. RICHARDSON] characterized this as the vote of the year. It may or may not be that, but it is a serious moment. This is a serious business.

I do not have to recite the crime statistics. I do not have to tell personal antidotes about youngsters harmed, maimed and killed. We know we have a crisis in America, and we know that America expects us to act.

We know that we are late in getting a crime bill to this floor, and we know that the reason we are late in doing so is that you wrote a crime bill that you cannot sell to your Members. We know that, and I am sorry for that. We should have acted before now.

The gentleman from New Mexico [Mr. RICHARDSON] says if we do not do it today it will not get done. Can it be on one hand the most important thing we have to do, and then on the other hand something we will not have time to do if we cannot do it your way?

I am told now that we Republicans are going to cast our most important vote of the year to deny the President a victory? Let me say, my friends on the Democrat side of the aisle, the President's political fortunes are just not that important to us. We will cast our vote here as a matter of conscience. We are not going to cast our vote here out of fear, and we will not be railroaded by buzzword blackmail into voting for a bill that spends $33 billion of the taxpayers' money doing too much of the wrong things and too little of the right things necessary to make our children safe in our own neighborhoods.

It is not a matter of our concern about your political future or that of the President. It is not a matter of our concern about our political future. It is a matter of our concern about whether or not we keep the trust and the faith and the commitment that the American people have given us to come to this floor, timely, which you failed to do, with good legislation, which you failed to create, in order to keep our children safe. Our children do not need midnight basketball, our children do not need more arts and crafts, our children do not need more sensitivity training. Our children need law enforcement, good jurisdiction, imprisonment for criminals and safety on their streets.

I say vote no on this and bring back a decent bill.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 30 seconds to the gentleman from Arizona [Mr. COPPERSMITH].

Mr. COPPERSMITH. Mr. Speaker, make no mistake, a vote against this rule is a vote against the crime bill.

My wife, Beth, and I share the fears of parents everywhere in this country raising our three kids in an increasingly violent world. We used to assume a loud bang on the street was a car backfire. Now we wonder if it was a gunshot. We read about school kids with guns instead of books in their backpacks.

This bill is not perfect, but if we wait for perfection we will lose our battle against crime, a fight too important to lose to partisan politics or pride of authorship or fear of the gun lobby.

□ 1630

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 30 seconds to the gentleman from Missouri [Mr. WHEAT].

Mr. WHEAT. Mr. Speaker, I rise in support of this rule and the strongest anticrime legislation in our Nation's history.

Mr. Speaker, for the last year I have traveled to Missouri communities, large and small, listening to police, prosecutors, and countless ordinary citizens who live with fear of crime every day. They all give me the same message: "Help us win the war against crime."

Mr. Speaker, let us be clear, if this rule loses, there will be no winners. If this rule loses, 100,000 cops will be lost. Crime prevention funds will be lost. Thousands of prison cells are lost. Tougher sentencing provisions are lost. The hopes of millions living in fear of crime every day are lost.

Let us pass this conference report. It is not a small step. It is a giant leap in the fight against crime and drugs. If you want to be tough on crime, prove it today. Support this rule. Support this legislation.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 30 seconds to the gentleman from Illinois [Mr. DURBIN].

Mr. DURBIN. Be honest, my colleagues. Should any Member of Congress or his family be victimized by crime, he would call the police, not a lobbyist from the National Rifle Association.

Shame on those Members of Congress who would ask our police to risk their lives to protect us and then turn their backs on these same police who beg us to pass this crime bill.

Most of my Republican colleagues are determined to gridlock Congress on this crime bill. They believe killing this bill or any crime bill will elect more Republicans. I think the American voters can see through this political charade.

The people I represent are more interested in a victory over violent crime than any political victory.

Listen to our police. Listen to America. Vote yes on the rule and on the crime bill.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 1 minute to the distinguished gentleman from California [Mr. FAZIO].

Mr. FAZIO. Mr. Speaker, on May 5 in an extraordinary effective bipartisan show of support for the banning of assault weapons, this House by a small margin did something that nobody believed we could do. We all understand, everyone in this Chamber knows, we are revoting that vote today.

There were 38 Republicans who stood courageously against the Gun Owners of America, stood up against the opposition of the NRA and told their constituents they were with them on this overwhelmingly popular position, the banning of assault weapons. But today something is different. Apparently all of those courageous Members have changed their votes.

There is intimidation, yes, pressure, yes. Where is it coming from? I can tell you that the National Committee of the Republican Party has before it a resolution which takes those 38 people to task, says they should be deprived of their funding for reelection, says they should have "real Republicans" standing up to defeat them when they go for reelection.

This is part and parcel of why this vote today is in doubt. We are not here debating the question of assault weapons honestly. What we are facing up to is intimidation and pressure from the political leadership.

I am asking those 38 Republicans who have the courage to stand up and say they are for the police in their communities and for the people who believe we should have an assault ban to stand up to the RNC, to stand up to their leadership, and ratify their real beliefs.

I am submitting the RNC resolution for the record so that the entire House will understand the kind of intimidation and strong-armed tactics the Republican leadership is employing:

REPUBLICAN NATIONAL COMMITTEE RESOLUTION

RESOLUTION OF CONDEMNATION

Whereas, The Second Amendment of the Bill of Rights of the United States Constitution supports the right of the individual American citizen to keep and bear arms; and

Whereas, Our forefathers, having just completed a war with a despotic government, provide in the U.S. Constitution for the right of individual American citizens to keep and bear arms to ensure that dictatorial governments would nevermore tyrannize American citizens, by guaranteeing such citizens the means, arms, to overthrow such a government, if necessary; and

Whereas, The Constitutions of the vast majority of the individual States also support the right of the individual American citizen to keep and bear arms; and

Whereas, The Platform of the Republican Party supports the right of the individual American citizen to keep and bear arms; and

Whereas, The Republican Party has its foundation and roots in the individual, in the rights of the individual, and in the belief that individual rights take precedence over, above, and ahead of Government; and

Whereas, A betrayal of the most basic foundation, roots, and primacy of the philosophy of the Republican Party is a negation and denial of all Republican philosophy, and therefore a denial and rejection of one's own Republicanism; and

Whereas, That basic foundation was put to a test on May 5, 1994, when the U.S. House of Representatives voted on H.R. 4296, a bill banning certain described and vaguely defined types of firearms, and that bill passed by a vote of 216 to 214, with 38 Republicans voting for that bill; and

Whereas, The Republican Party is a "big tent" that encompasses all races, ages, handicaps, and differing perspectives on many issues, but not on the fundamental issue of the rights of the individual; Now, therefore, be it

Resolved, that the Republican National Committee condemns those 38 Congressmen for voting in derogation of the individual American citizen's right to keep and bear arms; and be it further

Resolved, That the Republican National Committee shall, hereafter, deny all Republican Party funding to any and all of those 38 Congressmen should they seek reelection; and be it further

Resolved, That the Republican National Committee shall seek alternative, real Republican candidates for the seats of those Congressmen.

The 38 Congressmen are: Bateman, VA; Bereuter, NE; Blute, MA; Boehlert, NY; Castle, DE; Fawell, IL; Franks NJ; Gilchrest, MD; Greenwood, PA; Horn, CA; Houghton, NY; Huffington, CA; Hyde, IL; Johnson, CT; Kasich, OH, King, NY; Klug, WI, Lazio, NY; Leach, IA; Levy, NY; Machtley, RI; McDade, PA; Meyers, KS; Michel, IL; Miller, FL; Molinari, NY; Morella, MD; Porter, IL; Pryce, OH; Quinn, NY; Ridge, PA; Ros-Lehtinen, FL; Roukema, NJ; Saxton, NJ; Shaw, FL; Shays, CT; Smith, NJ; and Young, FL.

LANE REES,
Chairman Republican Party of Alaska.
WAYNE ANTHONY ROSS,
Republican National Committeeman, Alaska.
EDNA DEVRIES,
Republican National Committeewoman, Alaska.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 2 minutes to the gentleman from Texas [Mr. BROOKS], the distinguished chairman of the Committee on the Judiciary.

Mr. BROOKS. Mr. Speaker, I say that it is very difficult for me to believe that for the past 10 days the question that has held up the crime bill is not whether you are for or against the crime bill but whether you want the House to vote on it. Well, if your dream is becoming part of a filibuster one day, run for the Senate, but do not delude yourself into thinking that the American public is in any way impressed. No procedural vote is not about whether to gut this 2 years of work on some procedural ploy. It is about throwing away almost 4 years of work, as the American people continue to live in constant fear in their workplace, and in their neighborhoods, in their homes.

Now, I will tell you that in the last Congress there were great expectations about passing a crime bill. The House did not succumb to partisanship. We passed a crime bill October 22, 1991. The Senate did likewise a month later, on November 24, 1991.

The conference met, returned, the House approved the conference report on November 27, 1991, 4 days later. When that conference went to the Senate, a group of obstructionist Republicans, I will tell you that is right, distraught that Democrats could actually write a tough, good crime bill, they bottled the bill up for 11 months. Congress wagged its tail and adjourned.

Now the Republicans, our friends, are working day and night all in the service of a campaign to not have a crime bill for the fourth year.

We are not perfect people. I am not. I do not think you all are. And I do not think the bill is, and not many of them are. Most of you are keenly aware of my profound disappointment at inclusion of the ill-conceived ban on assault weapons so broadly cast as to insult the dignity and good name of legitimate and good, law-abiding gun owners across the Nation. I was outvoted by the House and Senate conferees in attempting to strip this punitive vendetta.

But to this day, I say plainly that the assault-ban provision should never have been included, and I will be back sooner than some think to right than wrong.

What I want to say now is I think every Member of this Congress should vote for the rule and let the Members of Congress decide whether or not to have a crime bill, whether we want to help the people in this country.

In every congressional district the No. 1 issue is, What are you going to do, if anything, about crime?

I ask you to vote for the rule and for the conference report and urge all of my colleagues to support them both.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the gentleman from Alabama [Mr. EVERETT].

Mr. EVERETT. Mr. Speaker, I oppose this rule.

Mr. Speaker, the crime bill that came back from conference reminds me of the old movie "The Good, The Bad and The Ugly." There is no question there are some good things in this bill. But for the most part—it's bad and it's ugly.

Forty million dollars for midnight basketball. There are those in this Congress who actually want to spend $40 million to keep teenagers out after midnight to play basketball. That's not going to halt crime—that's going to increase crime. What kind of logic keeps teenagers on the streets until well after midnight? Midnight basketball is bad and it's ugly, Mr. Speaker.

This bill gets worse. Rather than criminals receiving tougher punishment, this crime bill wants to teach them to dance. My constituents are tired of this kind of waltzing with criminals. They are tired of their hard-earned tax dollars supporting criminals in jail lifting weights and watching color television. Put criminals to work, Congress. That's what your constituents want—punishment not pampering.

I will repeat again—there is some good in this bill, but most of it is bad and it is ugly.

Mr. GOSS. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from New Jersey [Mr. SMITH].

Mr. SMITH of New Jersey. Mr. Speaker, I rise in opposition to this rule.

Megan Kanka, the 7-year-old who was brutally killed by a sexual predator, Mr. Speaker, lived in my district, and the language for the community right to know in this bill is very, very weak, and I would hope that we will go back to conference and parallel what my good friend from Washington tried to get passed. This is very weak language.

I rise against the rule because I believe this legislation needs to be sent back to a conference committee for significant overhaul. While this bill includes many valuable provisions for new police and prison space, it has been significantly watered-down by the House-Senate conferees in a display of arrogance toward their colleagues in both Houses of Congress.

The deleterious results of the backroom wheeling and dealing of the crime bill conferees are plainly evident. There are several examples of the conferees ignoring or defying specific instructions from the House of Representatives.

For example, on July 13, the House voted to instruct conferees to include a community notification provision, which would require local police departments to be informed about the presence of sex offenders in the community, and encourage law enforcement to disclose this information to the public. This language was watered down significantly in the conference committee report.

Mr. Speaker, Megan Kanka, a 7-year-old in my district was viciously abused and killed by a sexual predator who had been convicted twice for preying on young children.

No one in the community knew the killer's sordid past, Mr. Speaker. Had Megan's grieving parents known that their neighbor was a dangerous person, they would have taken steps to protect their precious child. Megan's parents had a right to know that information.

I'm disappointed to say that the language in the crime bill is weak—far less than the proposal offered by Senator GORDON and Congresswoman DUNN.

Mr. Speaker, the conferees also ignored the fact that on June 22, the House voted overwhelmingly to instruct conferees not to accept any agreement that reduced funding for new prisons below the House-approved level of $13.5 billion. Instead, we have a final bill that includes only $8.3 billion for prison construction.

On June 29, the House overwhelmingly approved a measure to instruct conferees to not accept any agreement that disallows evidence of similar crimes to be presented in court when hearing sex offense cases.

On July 20, the House approved a measure to instruct conferees to not accept any agreement that fails to include a Senate-approved measure that provides for mandatory prison terms for the use, possession, or carrying of a firearm during a State crime of violence.

These are but a few examples of the arrogance demonstrated by the conferees in crafting a bill that flatly contradicts the will of the House and the Senate in many important areas. There are obviously elements in this legislation that are worthwhile, but we do not have to settle for half a loaf. We do not have to deliver a less-than-adequate bill to the American public.

A vote against the rule is a vote to send this legislation back to conference where it can be fixed. I urge a "no" vote on the rule.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to my colleague and friend, the distinguished gentleman from Florida [Mr. McCOLLUM], who is a member on the committee.

Mr. McCOLLUM. Mr. Speaker, I rise in opposition to this rule.

I think it is outrageous that some have suggested on that side of the aisle we Republicans over here are somehow trying to defeat this bill. We are not. And in fact, they have got 79 more Members on that side of the aisle than we have over there. There is no way we can beat this rule or the bill, either one, without a lot of Democrats to vote to do so as well.

What we are concerned about is not playing politics like the gentleman from California [Mr. FAZIO] wanted to do here. He knows good and well that Haley Barbour, our National Republican Committee chairman, had withdrawn that resolution that might have criticized our Members for whatever they might have voted on a gun proposal.

He should know, as I do, the Republicans over here on our side of the aisle are not sending this bill back to the committee, do not want to send it over to the conference committee to get it worked on some more because of the gun issue. We want to send it back over there to be worked on, not to kill it, but to be worked on and brought back out here because we understand this is an imbalanced and imperfect bill that is not going to do the job. The fact of the matter is there are $8 to $9 billion in this $30 billion-plus bill, $8 to $9 billion in new Great Society social welfare spending, the most in 20 years, and it is imbalanced because if we look at what we have got in this bill for prisons, which is the main thing we can do to help the States solve the crime problem, we can only have $6.5 billion, not the 8 whatever that has been put out here, half the amount passed by this House of $13 billion, and not nearly enough to do the job we heard from the Bureau of Prisons is required.

They said they need at least $10.5 billion to $12 billion in grant money to the States to build new prisons if we are going to give them enough to take off the streets the 6 percent of those criminals who are committing 70 percent of the violent crimes of this country and only serving about a third of their sentences, and make them serve 85 percent of their sentences if they are repeat violent offenders.

□ 1640

That is, put truth-in-sentencing into the law. It is going to take that kind of money.

We should not be spending social welfare money out here like this. We should not be increasing programs for the midnight basketball, teaching of dance lessons and the artistic classes and all of that kind of nonsense, to get at root causes of crime.

We should be putting the money where it needs to be put, where the bureau of prisons and others have said it is required if we are going to actually solve the problems that the American public wants. We need to put certainty and swiftness and punishment back into the system again. We need to have deterrence of criminal laws in this country, deterrence of crime, which is the true prevention.

Then, if we want to get to the root causes, we need to bring out a welfare reform bill to change the rules of the game out here so that we can put incentives back in the law for families to stay together again instead of having the way it is now, and get moral values taught again.

That is the real root cause of the problem. But in the meantime let us save the patient who has been run over by the truck and has all these internal injuries, who is bleeding to death over here because his arm has been cut off. Let us at least apply the tourniquet and stop the violent crime program here that is going on in our country, by getting the resources that are necessary to the prisons.

All we have to do to do that is take away some of this nonsense, this $8 or $9 billion of this Great Society spending, take a few billion dollars of that in the conference committee when we send this bill back today, if we defeat this rule, and put it where it ought to be, on prisons, and put the right amount of money there and send a good tough, hard crime bill back here for us to vote on.

Mr. DERRICK. Mr. Speaker, for purposes of debate only, I yield 2 minutes to the gentleman from Missouri, the distinguished majority leader [Mr. GEPHARDT].

Mr. GEPHARDT. Ladies and gentlemen of the House, the decision that we make today is between one on procedure and one about people.

I know the heartfelt disagreement on so many points in this bill, on both sides of aisle. And I know those disagreements are heartfelt. But the question we have to ask is will we remain frozen in disagreement, or will we be able to act?

A lot of people say go back to conference and we will do this, we will do that and we will do the other thing. Well, it has taken us 1½ years to get to this day.

In 1991 it took over a year to get to a filibuster that stopped any crime bill from going forward.

It is overly optimistic to think that it is easy to take out the part that I do not like or the part you do not like or revise this or that to get back to something that we like.

Just for a moment before you cast this vote, take out of your mind the things in the bill that you do not like and keep in mind the four children in my town of St. Louis whose mother was shot and killed on her own porch last week in a senseless, meaningless killing. Think about the two teenagers in San Marino, CA, gunned down by gang members in a high school. Think about the young woman here in Washington who was slain in a drug-related shooting, when she was 7 months pregnant with her own child. Think of the third-grader in Chicago who was asked by her teacher to share her feelings about violence, and shared the story of her young cousin shot in the head by another boy playing with a gun. Think of the two elderly women in St. Louis, 87 and 76, who were raped at gunpoint.

That is what this bill is about. Do not think about each little provision that you may not like, think about the people who count on us today to come to their aid with something, not to be frozen out in our disagreement but to find an agreement.

And, finally, think about the young girl written about here in the Washington Post, who thinks not about her cares and concerns but because she has lived with so much death, so much pain, so much tragedy, that she dreams not of her prom dress but of her funeral dress.

Ladies and gentlemen of the House, are we going to respond to her? Or are we going to act?

Think about her, vote for this rule. Let us make this country safe again.

Mr. GOSS. Mr. Speaker, at this time it is my privilege to yield the balance of our time, 4 minutes, to the distinguished gentleman from Illinois [Mr. MICHEL].

Mr. MICHEL. Mr. Speaker and my colleagues, I rise in opposition to the rule and compliment the distinguished majority leader for the plea he has made on the other side of this issue.

Let me also take the opportunity to applaud those of you on both sides of the aisle who have so eloquently and forcefully pointed out the deficiencies in the conference report that this rule makes in order. Somewhere buried deep within the layers upon layers of big dollar items in this crime bill is a workable, useful policy of prevention, education, and punishment. But the rule does not allow us to strip away the many expensive and unnecessary parts that now deform the bill.

What we have instead is the unholy political trinity of pork, posturing, and partisanship.

At one point we did have a tough crime bill, one that focused on taking repeat offenders off the street, one that built more prisons, one that imposed tough sentences. That tough bill is not the one before us tonight.

I have put out an all-points bulletin, but I am afraid it has met its demise.

Our constituents have pleaded with us to alleviate their fear, make their schools and streets safe again. After anteing up better than $30 billion in this bill, much of it unfunded, we are not going to be answering their plea.

This bill could have been, it should have been a lean, mean, crime-fighting machine. But there are too many election year goodies, trinkets, and gift-wrapped spending programs piled on it. And now it looks like Santa Claus wearing a sheriff's badge.

This is not a battle between detention and prevention. We need both.

The question before us is one of high public policy: What kind of Federal legislation best helps our society uphold the rule of law? This is a time of rising crime rates and rising public demands for action, but it is also a time of budget deficits, a time when every tax dollar must be spent wisely. That is why we ought to defeat this rule.

The rule does not allow us to say what is best and get rid of what is worst in the bill as it now stands. My colleagues, I believe we can craft a sensible bill that combines all the elements of detention and prevention. But if the rule passes, we will be asked to vote on a bill that would direct too many tax dollars into areas that may be politically useful for some of our Members but have little to do with fighting crime. In my opinion, we cannot afford such waste. Our constituents, who want safe streets and safe schools, cannot afford it.

Maybe one final word, particularly on my side of the aisle: This is a procedural vote.

□ 1650

It is a rule. How many times have we been had on our side of the aisle by the rules of this House?

This is a procedural vote, and it means whether or not we can make an impact and a difference on cleaning up a bad bill.

That is what it is all about, and my colleagues ought to take advantage of that opportunity. Do not let it slip through our fingers when it is right at hand.

Mr. Speaker, that is my message to my colleagues tonight.

With all due respect to my friend, the gentleman from New Mexico, who said vote down the rule and the bill is killed. I will take a different view with respect to our President because our President made a strong, impassioned appeal for a strong crime bill, and I respect that.

We want to do the same. We have our differences of opinion on both sides of the aisle and within our parties on how best to do it; that is what it is all about, and it is on the margin of whether or not we are going to get one more opportunity to clean it up the way it ought to be cleaned up or let it go by as it is.

I would plead with Members. Vote down this rule. Get us that one other opportunity.

Mr. LAZIO. Mr. Speaker, I rise today to express my opposition to the rule on the crime bill conference report, H.R. 3355, the Violent Crime Control and Law Enforcement Act.

For me, today's vote on the rule is not a statement in favor or in opposition to the crime bill conference report. Rather, it is about whether it is fair for the majority to apply a restrictive and repressive procedure that purposefully obviates the voice of a majority. In this case, the staff and a few members got together behind closed doors and added provisions to the bill that neither the House nor the Senate agreed to. That is how a bill passed by the Senate at $22 billion and the House at $28 billion became a $33 billion conference report. The minority was only give a few hours to review a 972-page bill, although the conference was reported almost 2 weeks ago. This type of procedure undermines the democratic process.

While I will not vote for the rule, I strongly believe this Congress must pass a crime bill that is truly effective against crime and is paid for in its entirety. This conference report had at least $3 billion in programs that were not paid for. Long Islanders sent me to Congress to fight this kind of irresponsible deficit spending, not to be a party to it.

Hoping that it could be improved in conference, I supported H.R. 3355 when it passed the House in April because it contained features similar to the alternative Republican crime bill, H.R. 2872, the Crime Control Act of 1993, of which I am an original cosponsor. H.R. 2872 calls for strong measures to combat the crime rate in our country, including additional funding for prisons and additional get-tough measures against criminals.

Instead, we got a bill that increases the deficit, lacks meaningful truth-in-sentencing provisions and does not allow for the tracking and registration of violent sex-offenders. Congress can do better. Defeating the rule and sending the bill back to conference will give us a chance to correct it.

This conference report leaves a lot to be desired, and Republican attempts to offer constructive amendments were rebuffed, severely weakened, or stripped entirely from the bill. However, I do support many of the important provisions within H.R. 3355.

For example, I strongly support the provisions to hire 100,000 additional police, increase prison funding, ban assault-weapons, and expand federal death penalty provisions.

As many as 40 members of the other party have expressed opposition to the assault-weapons ban in this bill. That is not the case with me. I voted for the assault weapons ban when it passed the House, I support the ban now, and I will support it when Congress finally passes a crime bill.

Therefore, my vote against the rule today will not be vote against a crime bill. Rather, it is a rejection of the highly partisan and undemocratic method that was used in pushing this bill through the conference process and to the floor.

Mr. GILMAN. Mr. Speaker, I reluctantly rise in opposition to the rule providing for consideration of H.R. 3355, the Violent Crime Control and Law Enforcement Act of 1994. My decision has been extremely difficult since, like many Americans, I believe that we must take action to prevent and rid our Nation's cities and towns of the violent crime that has become all too familiar. However, despite my real concerns, I am convinced that this weakened compromise will do little to accomplish this important, and much needed goal.

In order to effectively fight crime, I believe that we must get tough, and severely punish those who break the law. However, many of the provisions that are included in this omnibus legislation, will do nothing to combat the violent crime that plagues our communities. In fact, much of the funding that is included in the conference report is not even directly related to crime control. While these programs may have a positive impact on some of our communities, social spending should not be disguised as crime control. The American people deserve better than this. The $8 billion cost of these newly created programs are exorbitant, and have not even been proven to affect crime rates. For example, midnight sports will cost the American people $40 million, child safety grants will cost the American people $430 million, and the national community economic partnership will cost an estimated $300 million. Supporters claim that through community development, social services, job training, and recreational activities, potential criminals will be steered from a life of crime. However, further analysis demonstrates this is not a proven assumption. Since 1965, our Nation has spent over $5 trillion on welfare spending. Yet with crime rates at an all time high we know from experience that welfare spending has had no significant impact on crime.

Another source of concern, is that this massive $33 billion crime bill places a huge unfunded mandate on State and local governments. Supporters claim that $8.8 billion of funds will be available over the next 6 years for State and local governments to hire an additional 100,000 police officers. However, when we look closer, the figures do not add up. On closer inspection it is evident that the funding will guarantee the hiring of only 20,00 police officers, a 3 percent increase in our Nation's police force. In order to permanently place the additional police officers, State and local governments will be required to pick up the remainder of the tab since the funding for the police will be gradually phased out over the 5-year funding period. Having to pay additional salaries and pensions, combined with a substantial loss of funding will, no doubt, burden local governments. Unfortunately, this loss will be realized by raising taxes or cutting back on valuable services.

Furthermore, I remain concerned that this legislation retroactively drops mandatory minimum penalties for individuals who sell, possess, or import drugs. This sends a disturbing message to our Nation's youth by condoning the use and abuse of illegal narcotics. This will also tie up Federal prosecutors in reviewing these cases. At a time when drug abuse is on the rise, this is not the kind of message we need to be sending. Instead, we must remain steadfast in our determination to eliminate the drug abuse that in many instances, breeds violent crime. It is ironic that while the administration says it wants to fight crime, it has abandoned the war on drugs. With drugs contributing to one-third of the violent crimes committed in our Nation, and to one-half of the murders, we must not retreat from the battlefield.

As an author of one of the amendments that is included in this massive legislation, my decision to oppose the rule, and this legislation, has been even more difficult. Unfortunately, I believe that the many so called "crime control" provisions will do little to curb crime. My strong desire to protect and serve the citizens of our Nation outweighs my support for legislation that I authored, and which is included in this omnibus legislation. My legislation increases the criminal penalties for visa and passport offenses.

With this in mind, I extend my sincere appreciation to the chairman of the Judiciary Committee, the gentleman from Texas [Mr. BROOKS], for his unyielding commitment to the American people. I also thank the ranking member of the Judiciary Subcommittee on International Law, Immigration and Refugees, the gentleman from Florida [Mr. MCCOLLUM], the ranking member of the Judiciary Subcommittee on Civil and Constitutional Rights, the gentleman from Illinois [Mr. HYDE], as well as all the House conferees who held firm for the inclusion of my amendment.

The need for these tough new increased criminal penalties is long overdue. In fact, these penalties have not been raised in more than 45 years. With the many instances of massive visa and passport fraud and abuse, our system needs to be reformed. By toughening these criminal penalties, we will be assisting our Nation's law enforcement officials, especially our hard working diplomatic security and Immigration and Naturalization Service agents.

The New York Trade Center bombing, and other terrorist plots uncovered in New York City last year, set off an alarm bell. Out of the 35 original indictable counts, nine were for visa or passport related Federal offenses. Thus, demonstrating our Nation's vulnerability and exposing the clear link between visa and passport offenses and international terrorism. I am pleased that my amendment can aid our Nation's internal security and our citizen's safety and freedom.

With the defeat of this procedural rule, I am hopeful that the conferees, Democrats and Republicans, will now return to the conference committee, with one goal in mind—the development of strong "anti-crime" legislation that will enforce stiffer criminal penalties, will institute longer prison sentences for convicted felons, and will increase support for our Nation's law enforcement officers.

Mr. VENTO. Mr. Speaker, I rise today in support of the rule and the Violent Crime Control and Law Enforcement Act of 1994 as reported to the House.

The trust fund concept in this measure is an important new idea. The Federal Government is committed over the next 5 years to reduce Federal employees by more than 270,000 slots, with the savings dedicated to this crime reform measure which proposes to expend $33 billion over the next 6 years. In fact, the first appropriations are already in the House and Senate measures being considered and will be enacted for fiscal year 1995. I think this is important to point out to those of my colleagues who stand up here today calling this measure a budget buster. This argument looks more like a heat shield created to deflect criticism from the real agenda of these people which is to allow assault weapons to continue to spill out on America's streets, or to kill the prevention initiatives in this bill that will give our Nation positive alternatives to crime. The fact of the matter is this measure need not represent new expenditures—to date the money is in the budget.

This package will mean real assistance to State and Federal law enforcement efforts. Over the duration of this measure, $10.7 billion will be provided for prisons and $10.6 billion for State and local law enforcement—including a nearly 20 percent increase to the Nation's police force. Sorely needed prevention programs will receive $7 billion over the next 6 years to help change the direction of the culture of crime overshadowing America.

This measure contains provision like the three strikes and you're out for repeat violent offenders, the safety valve feature to give judges more discretion in sentencing first-time, nonviolent offenders, and the Violence Against Women Act. All of these provisions will be instrumental in reforming our criminal system to help better serve the law abiding citizens of this Nation.

Earlier this Congress, Natural Resources Committee Chairman GEORGE MILLER and I introduced a bill to expand park and recreation opportunities for at-risk youth in high crime urban areas. The bill recognizes the important role that urban recreation programs play in developing positive values in our young people and keeping them away from crime.

This particular crime prevention measure, and others like it, are included in this conference report—and with good reason. According to the Department of Justice, violent crimes committed by young people are growing at the fastest rate in this country. It is obvious to me if we are truly going to address our country's crime problem we must focus on prevention; we must give our young people hope and opportunity; we must give them a haven from the streets where they can develop values such as responsibility, teamwork, leadership, and self-esteem.

There are a number of programs included in this conference report that will work to achieve these goals: The Community Schools Initiative, Youth Employment Skills [Y.E.S.] Program, midnight sports programs, and my and Chairman MILLER's at-risk youth recreation grant, to name a few. I am pleased to see these initiatives included in this crime reform bill. I am not, however, satisfied with their low funding levels. However, because these measures are in the package we can in the future reallocate the trust funds from one program to another. Without such a feature, the programs provided would not have been easily funded. Because of the policy put in place by this feature, I am confident that the merit of these measures will command a portion of the trust fund and or appropriations.

The average cost of incarcerating each juvenile offender per year is $29,000. Today some will rise in the House and refer to these programs as government waste or pork. I suggest you sit down with a calculator and figure out just how many future offenders we will need to keep out of jail to actually save money by implementing these programs. Then maybe some questioning this policy would finally begin to realize that it is prevention not punishment this country needs for a safer society, and that is what should be emphasized by this Congress in 1994. Ironically, at the same time these critics will suggest that the $10.7 billion for prisons in this measure is too little; that we need more and that the mandatory minimum sentence reform is flawed. Such opponents want more prisons, longer sentence provisions and yet less money spent. This is the same reactive mode and failed policy path that was tried during the 1980's. Today, nearly one million people are in prison. Mindless incarceration and mandatory minimum sentences don't do the job. No one wants violent persons on the street, but we must act proactively to deal with the input side of the crime equation, not just react to the crime—both aspects are elements of a sound policy for our Nation.

Sadly some aspects of this bill are flawed such as the increase from 2 to 60 Federal crimes punishable by death. The cost of this policy alone, not to mention the demonstrated discrimination inherent in capital punishment today, can not be justified considering its dubious value as a crime deterrent in our society. Even though capital punishment has been statistically and historically biased against minorities, regrettably this measure remains absent a remedy to address this critical issue of racial bias. While a House passed provision could not be reconciled in the House-Senate conference, I am hopeful that President Clinton's executive order will meet this short fall.

After careful consideration of this measure, I find the positive far outweighs the negative in this conference committee report. The prevention programs are an important first step in providing men, women, and children in need an alternative to violence, gangs, and to crime. The assault weapon ban in this bill will take some of the most dangerous and unnecessary guns, virtually para-military weapons, off the streets of America and stop the carnage—saving lives without limits on legitimate sports and firearms collections. The long overdue Violence Against Women Act is a tremendous stride toward ending domestic violence and ensuring the safety of women in our society.

I rise in support of this conference report and urge my colleagues to do the same and support the rule which provides for its consideration.

Mr. DOOLITTLE. Mr. Speaker, I rise in strong opposition to the crime bill and the accompanying rule that come before the House today. The debate surrounding this legislation and the entire crime issue reflects what Thomas Sowell called a conflict of visions.

SOCIAL SPENDING IS NOT CRIME FIGHTING

There are some, including the current administration, who think violent crime can be eliminated from our society with a little rehabilitation, a little understanding, and lots of money—$32 billion in this legislation alone.

But if social welfare spending reduced crime, Mr. Speaker, America would have the safest city streets in the world. Since the war on poverty was launched in 1965, the Government has spent $5 trillion on new social programs, including community development aid, social services, job training, and recreational activities.

What effect has this massive social spending had on crime? Since 1960, the rate of violent crime has increased more than 500 percent and total crimes have increased over 300 percent. And while population has increased only 41 percent over this period, social welfare spending is up 800 percent. As the Heritage Foundation has noted:

> The evidence suggests that welfare spending, by promoting family breakup, has played a large role in increasing, rather than decreasing crime.

CLINTON BILL REPEATS PAST MISTAKES

Despite this horrible track record, Mr. Speaker, we are urged by the Clinton administration to support a $32 billion crime bill, which includes over $9 billion in new social spending programs. Among the new Federal programs are a midnight basketball league—with Federal rules detailing the composition of neighborhood teams—self-esteem classes, arts and crafts, dance classes, and physical training programs, and conflict resolution training.

Mr. Speaker, if the rate of crime continues at its current pace, 8 out of 10 Americans can expect to be the victim of a violent crime at least once in their lives. This result is intolerable.

Those who preach rehabilitation and criminal rights, and who see job training and social spending as solutions to our crime epidemic, have been at the helm of our country's social policy for too long. Every crime statistic available confirms their failure.

It is time for those with a different vision of criminal justice to have a turn. The people in my district, for example, have zero tolerance for crime. They are not concerned abut protecting criminals' rights; they are concerned about protecting victims' rights. They don't want more social workers; they want jails. They don't want to ban guns; they want to incarcerate criminals. And instead of parole and alternative sentencing, the people in my district want truth-in-sentencing.

WORST PROVISIONS IN A BAD BILL

A. HOLLOW POLICE FORCE

This bill fails on all counts. It authorizes $8.8 billion over 6 years to hire 100,000 new police in community policing programs, but passes the cost of maintaining this force onto localities. Thus, once Federal funding runs out, localities will either have to lay off a portion of the force or lobby Congress for more Federal money. Funding for only 20,000 positions, not the 100,000 promised, will be provided. Princeton University professor John DiIulio calculated that once these additional police officers are distributed over at least 200 jurisdictions, the actual street enforcement strength will be increased by just 10 cops per city.

Even President Clinton's hand-picked FBI Director, Louis Freeh, has criticized the officer funding provisions in the administration's bill. Mr. Freeh noted that the funding for these additional officers is going to require cuts at the FBI and DNA. Mr. Freeh said the cuts are "not consistent with * * * [the FBI's] expanding mission" and might cause the Bureau to "suffer law enforcement objectives"—The Buffalo News, Aug. 10, 1994.

B. POLICE DEPARTMENT QUOTAS

Worse than the officer funding provisions are the hiring requirements. The bill calls for State and local authorities to adopt racial, ethnic, and gender guidelines in police hiring. A guideline, like a goal, is merely a more politically palatable term for a quota—something the people of my district abhor.

C. MISSING PRISONS

As for building much-needed prisons, the final report earmarks $7.6 billion less than the original House bill. In a $32 billion crime package, it is an outrage that more money is being spent on new social programs than one building and maintaining prisons. In addition, the final bill weakens the popular requirement that Federal prison funds be tied to strict state truth-in-sentencing laws.

D. USELESS 3 STRIKES

The bill includes a three strikes and you're out proposal, a concept that I support, which allows a violent criminal three separate episodes in which to wreak havoc. Nevertheless, in any form, this provision is of limited value because State courts handle over 98 percent of all violent crime convictions.

E. MORE CAPITAL OFFENSES, LESS CAPITAL PUNISHMENT

Although the bill authorizes the Federal death penalty for over 60 new offenses, the enforcement procedures have been made criminal-friendly. In addition, no habeas corpus revision—the most desparately needed aspect of Federal crime reform—is included in the bill to limit convicted felons from tying up the court systems with endless appeals, so as to avoid having the death penalty carried out.

F. ASSAULT ON THE CONSTITUTION

Also, Mr. Speaker, I believe that the right to bear arms, protected by the U.S. Constitution, carries the same constitutional authority as any of the individual liberties found in the Constitution. Just as the first amendment doesn't preclude speech the Founding Founders might have deemed objectionable, the second amendment is not limited to firearms Washington deems appropriate. The burden is on the government, not law-abiding citizens, to justify abrogation of the individual liberties protected by the second amendment. In my mind, the ban on assault-style, semiautomatic weapons is a clear violation of the Constitution.

It is very telling that many of the same people who support the ban on semiautomatic weapons left out of the conference bill a provision that would establish mandatory minimum sentences for thugs who use guns when committing crimes. Thus, this bill punishes law-abiding citizens by taking their guns away and gives gun-toting criminals a break by not imposing a mandatory prison sentence for using a gun in the commission of a crime.

G. REVOLVING DOOR FOR DRUG DEALERS

Mr. Speaker, the conference report includes a so-called safety valve provision, which will effectively permit certain categories of convicted drug defendants to be invited back to court, to be given a retrial under retroactive law. This result will occur, Mr. Speaker, because the crime bill reduces minimum sentencing for drug criminals. No serious anticrime bill would put convicted drug kingpins back on the street.

A BETTER WAY TO FIGHT CRIME

Mr. Speaker, the champions of compromise in this body often remind us that the perfect is the enemy of the good. Yet, this criticism misses the mark—I am not holding out for a perfect bill, but this one does not qualify as even good. There is a better way. There are better alternatives.

The best ideas I've heard on crime, Mr. Speaker, have come from my constituents. Earlier this year, I held a series of town hall meetings on crime. Hundreds of people came out to share their suggestions on how to end our Nation's crime epidemic.

I incorporated my constituents' best ideas into a 269 page comprehensive anticrime package entitled the Citizens Crime Prevention and Punishment Act of 1994. Introduced before the House in April, my legislation reflects a get tough approach toward criminals and emphasizes the right of innocent victims.

RESPECTING STATES' RIGHTS

More important than any one provision, Mr. Speaker, is the fact that my bill does not increase the power and reach of the Federal Government. My bill toughens penalties for existing Federal crimes. It increases funding for regional prisons. But it does not extend Federal jurisdiction into areas that have been under local control. I think the position taken by the National Conference of State Legislature is significant. A spokesman for the group said, "We oppose the bill because it federalizes state crimes and is an unwarranted intrusion on state and local matters." Mr. Speaker, this bill is also opposed by the American Federation of Police, the Law Enforcement Alliance of America, and the National Association of Chiefs of Police.

CONCLUSION

Congress has a role to play in the war on crime, but it should not seek to micromanage. Instead, Congress should limit its role to supplying the States with resources they need to keep our neighborhoods safe.

Columnist George Will wrote recently in the Washington Post:

> This crime bill is a bipartisan boondoggle because of the cachet that currently accrues to any legislation with an "anti-crime" label. But the bill sprays money most promiscuously at Democratic constituencies, the so-called (by themselves) "caring professions"—social workers, psychologists, and others who do the work of therapeutic government.

Mr. Speaker, this bill and the rule should be defeated. To pretend that this bill will reduce crime will only make voters more cynical about Congress. They want and deserve a real crime bill. This bill isn't it.

Mr. Speaker, I urge my colleagues to vote no on the crime bill conference report and on the accompanying rule.

Mr. STOKES. Mr. Speaker, I rise in strong opposition to the rule on the conference report on H.R. 3355, the The Violent Crime Control and Law Enforcement Act of 1994. Let me state from the beginning that I recognize the challenge we face in curbing crime in our Nation. In fact I have been a longstanding advocate for strong congressional action to reduce and prevent violence and crime. Nonetheless, Mr. Speaker, I cannot support this measure before us today because the very belief upon which our judicial system was created—protection of individuals constitutional rights balanced with societies right to be free from harm—has yet to be achieved for many Americans.

The fact that the conference report does not include the Racial Justice Act is enough in terms of my conscience to vote against the rule. This critical provision passed the House, and now for reasons of racism, has been eliminated from the bill. This abolishes my general principle of voting in favor of a rule and letting a bill come to the floor to be voted on for its merits. Even though funding for prevention is included, this does not diminish the need for the Racial Justice Act.

Over the years, I have been a strong supporter of crime control measures. I have patrolled our streets as part of neighborhood watch efforts. I have seen first hand the effects that drugs and violence have had on our neighborhoods. Despite these experiences, however, I feel that I cannot support the unbalanced approach that H.R. 3355 represents.

The crime bill of 1994, among other things, would greatly expand the reach of the Federal death penalty, and fails to include any provisions of the Racial Justice Act. In fact, the bill makes more than 60 additional crimes subject to the death penalty. While I agree that strong measures must be taken to curb the crime epidemic, I do not believe that this should be done to the detriment of an individual's basic rights and constitutional liberties. Furthermore, many of the provisions in the bill will actually do very little to reduce crime.

I strongly supported inclusion of the Racial Justice Act in the crime bill. The provisions of the Racial Justice Act are consistent with the principles of fairness and equality that are fundamental to the administration of justice in America. The Racial Justice Act would have prohibited the imposition of the death penalty where statistically significant proof exists that the defendant's and/or the victim's race determined whether the death penalty would be imposed.

When closely examined, the sentencing history of the death penalty has generally been arbitrary, inconsistent and racially biased. It is my belief that the Federal death penalty is overly harsh, particularly because it fails to address the economic and social bias of crime in our most troubled communities. The fact is there has always been a racial double-standard in the imposition of capital punishment in the United States. Even after the black codes of the 1860's were abolished, blacks were more severely punished than whites for the same offenses in our penal system. By the time the United States Supreme Court deemed the existing process for imposing the ultimate penalty unconstitutional in 1972, more than half of the persons condemned or executed were African- American—even though they were never more than 15 percent of the population. The advances in statistical analysis of the last 20 years have allowed numerous experts to test the raw data with disturbingly consistent results.

In 1990, after 29 studies from various jurisdictions were reviewed, the General Accounting Office confirmed that there is a consistent pattern of disparity in the imposition of the death penalty in the United States and that race is often a crucial factor that determines the outcome. Since the resumption of executions in 1977, of the 236 persons who have been executed, 200 persons, or an alarming 85 percent, were executed for the murder of white victims. In fact, statistics show that blacks convicted of killing whites are 63 times more likely to be executed than whites who kill blacks.

In 1991, the United States Justice Department's Bureau of Justice Statistics reported that African-Americans accounted for 40 percent of prisoners serving death penalty sentences. In my home State of Ohio, of the 127 people on death row, 62—nearly fifty percent—are African-Americans. These statistics reflect how the African American community is disproportionately affected by the death penalty. Furthermore, in a Nation where the number one leading cause of death for young African-American males is homicide, further disproportional application of the death penalty will not resolve the epidemic of violence in our Nation.

Regardless of whether this double-standard is intentional or not, the result clearly establishes that there continues to be an impermissible use of race as a key factor in determining imposition of the death penalty. Because of the disproportionate number of minorities serving death sentences, it is of great concern to me that without the protective provisions of the Racial Justice Act the death penalty will continue to be applied in a discriminatory and disproportionate fashion.

It also alarms me that there is an important element that these statistics do not reflect. That element is the economic conditions which have crippled our Nation. Unemployment, poverty and homelessness can be directly linked to crime. In fact, the dismal economic conditions facing our country have driven many of our citizens to a life of crime as a last resort measure of survival.

In fact, it is the African-American community which has borne the burden of this crime epidemic. I am particularly distressed by the fact that homicide has become the number one killer of African-American males. Many of our young African-American males are being killed in our inner cities for drugs and in many cases, for no apparent reason at all. I believe that to win our war on crime, we must first deal with the underlying rage that fuels the violence plaguing our Nation. Then and only then can we effectively address the crime epidemic.

It is my belief that our judicial system's major focus should be to protect its citizens from crime and violence. However, as a Nation, we cannot afford to increase penalties while continuing to ignore the important underlying elements which often precipitate criminal behavior and the fundamental injustice of the disproportionate application of the death penalty that will surely occur as a result of this bill.

Mr. CLAY. Mr. Speaker, I rise in opposition to the rule because I am opposed to the bill. There are many worthy features in this piece of legislation and some of my colleagues have articulated them in the finest manner possible. But Mr. Speaker there are some provisions in this bill that are so immoral and so unjust and so inhumane that all the good and virtuous gestures enunciated become null and void. One of those Mr. Speaker is the authorizing of the death penalty for 50 or 60 criminal acts.

The imposition of capital punishment is a savage act only engaged in by those who live in cultures with savage-like mentalities. Capital punishment is murder sanctioned by the State which functions in the name of its citizens. Historically, race and poverty have been the dominant factors in determining who will or will not be executed. The ranks of the condemned are heavily populated by poor whites, poor blacks and poor Hispanics.

The race of the victim is equally important in dispensing the death sentence. A white criminal who kills a black victim or a black criminal who kills a black victim, invariably receive a lessor sentence. Capital punishments is exclusively reserved for white criminals and black criminals who kill white persons.

In 1994, we are on the verge of enacting legislation which continues the injustice of killing based on race and economics and then to add insult to injury this bill vastly expands the scope of the death penalty without including a provision which ensures its even-handed imposition. This is unfair, unjust, and deplorably un-American. I will not support any measure which imposes such an inequity on the American people. I will vote against the rule and the conference report and urge all reasonable and fair-minded Representatives to do so. To allow this bill to pass is to place this body's stamp of approval on a disgraceful and blatant act of discrimination. To embrace such a policy, in my judgement, is one step removed from endorsing lynch mobs. This I refuse to do.

Mr. REYNOLDS. Mr. Speaker, as a co-author of the assault weapon language in the crime bill, I rise in strong support of the rule for consideration of the crime bill and urge my colleagues to vote for it.

The vote today is not simply a procedural motion on the ground rules for consideration of the crime bill. Those who seek to kill the whole crime bill will argue that they were not opposed to the Bill per se, but were opposed to the Rule.

How convenient, and how disingenuous.

This vote is most certainly about crime—and more in particular, about guns.

Make no mistakes about it, Mr. Speaker, the forces of the National Rifle Association are hard at work to defeat the toughest crime bill this Congress has ever passed. The N.R.A. has once again shown its true colors in this debate. Don't be fooled, my colleagues. The N.R.A. is a wolf in sheep's clothing.

They obviously are not for tough crime measures, because this bill has them.

They wanted more police on the street, and this bill adds 100,000 of them.

They wanted a tough three strikes and you're out law, and this bill has one.

They advocated spending $8 billion for more prisons. This bill would spend $8.5 billion.

No, Mr. Speaker, the N.R.A. is only interested in the proliferation of assault weapons. That must be true because the Congress delivered on the other tough crime measures they supported, and yet the N.R.A. is dead set against this bill.

While I will support the rule and the crime bill, I must acknowledge my deep disappointment that the Racial Justice Act is not included in the conference report.

I support the death penalty, as long as it is fairly imposed. The Racial Justice Act would have helped to ensure that the death penalty is imposed in a race-neutral manner. It is a sensible provision that nonetheless is not included in the conference report. The work to enact a racial justice act should, and will continue, and I will continue to support its enactment.

However, one's decision on a piece of legislation must be made with regard to the whole bill. As an author of the assault weapon provision, I am pleased that the conferees voted to retain the ban on 19 types of assault weapons.

I also strongly support the billions of dollars in prevention funds for our cities, and for programs to help our children stay away from a life of crime. It is money well spent.

In sum, Mr. Speaker, the crime bill is not perfect. All of us would add or subtract something in order to tailor it to our liking. But we must face up to our responsibilities and make the tough decisions. The people of this Nation look to us for that leadership.

If we are to lead, we must vote for the rule and for the bill.

Mr. HASTERT. Mr. Speaker, the crime bill we have before us today will squander billions of hard-earned taxpayer dollars. The Conference Committee returned to the House and Senate an unwieldy 6 year, $33 billion bill which is light on crime control spending and heavily laden with social projects. In many cases, these social programs will duplicate existing programs and fail to provide any mechanism to guarantee results.

Mr. Speaker, just yesterday President Clinton's own FBI Director criticized this crime bill because it will seriously cut the resources of the FBI and the Drug Enforcement Agency at a time when we are actually increasing the crime fighting expectations of those two agencies.

In its current form, the Crime Bill does little to fulfill our goals of fighting crime and making our streets safe again. I voted for this Crime Bill when it first came to this House. I liked the fact that we were going to encourage States to create "Truth-In-Sentencing." That's a fancy way of saying if you're sentenced to 20 years you'll serve 20 years—or at least most of it—

and not be routinely out in five! We tried to give priority to building jail cells so we could back up our pledge to "three strikes and you're out"—out of circulation, off the street, not in a position to harm again—in jail. Although the House bill was weighed down with a number of weak provisions, I hoped through the Senate and Conference Committee we could improve the bill. But sadly the bill has come back to us today with its most glaring problems still unresolved and, even worse, its positive aspects reduced to little more than a skeleton.

Mr. Speaker, we can and should send this bill back to the Conference Committee and fix it. That process doesn't have to take months or even weeks, it could be done before we recess next week. The way we do that is to vote no on this rule and that's what I intend to do.

Some say we should support this bill because of the good things that are in it, like money for more prisons and police. But even those provisions are more talk than action. True, the bill provides more money, but it does so in an irresponsible manner.

To begin, the bill's proponents claim that it will put 100,000 new police officers on the street by spending $9 billion over the next six years. But in fact, $9 billion will only provide 20,000 police. The estimated cost of putting a new police officer on the beat is about $70,000. Therefore, the cost of putting 100,000 new officers on the street is at least $7 billion per year, or, $42 billion over the 6 years of the bill. Thus, to put 100,000 new police on the street will require local communities and States to come up with another $33 billion of their own funds, in essence doubling the cost to taxpayers of this crime legislation. Assuming that the local communities can find $33 billion, they then must follow new, bureaucratic quotas in the actual hiring process.

Mr. Speaker, this crime bill will also install a revolving door on our prisons. Every major public opinion survey shows that the public has lost confidence in our ability to arrest, detain and convict, and punish violent and repeat criminals. Republicans offered scores of tough amendments to strengthen this bill such as a "Three-Strikes-and-You're-Out" provision that would not require the felony convictions to come from separate episodes and even a "Two-Strikes-and-Your're-Out" provision that would have mandated life imprisonment for those convicted of two violent felonies.

While President Clinton calls this the toughest crime bill ever, it actually weakens some current laws. Unbelievably, to anyone who has studied this bill, important provisions to protect our families from sexual predators are actually weakened by this bill. This bill also provides a "safety valve" provision which would allow at least 5,000 convicted drug felons to immediately be eligible for a retrial, which could result in the reduction of their prison sentences by as much as a half or more. In fact, if this bill passes, this safety valve provision could apply to all of the roughly 15,000 so-called low level drug offenders in the Federal prison system.

This "Crime Bill" is also plagued by almost $9 billion in extravagant social spending including classes in dance, arts and crafts and self-esteem classes. Mr. Speaker, this is supposed to be a crime bill!

Interestingly, the money provided for these social programs will be considered mandatory spending and will go on indefinitely, while the money for the police is considered discretionary and will end in 6 years. The bill could, essentially, create two new social worker positions for every new individual police officer.

The General Accounting Office [GAO] recently reported that there already exists "a massive Federal effort on behalf of troubled youth" which spends over $3 billion a year. They go on to say that there are already seven Federal Departments sponsoring 266 prevention programs which currently serve delinquent and at-risk youth. GAO also reports that "it is apparent from the Federal activities and response that the needs of delinquent youth are being taken quite seriously." In this situation, additional spending without adequate safeguards and reporting requirements is not fiscally sound.

Mr. Speaker, in these days of continuing deficits and limited options, let's put our hard-earned taxpayer dollars where they belong and can do the most good: into prison construction, funding for new police and putting criminals where they belong, behind bars.

Ms. PELOSI. Mr. Speaker, I rise in support of the provisions of the crime bill dealing with midnight sports leagues. In my district of San Francisco, there are two thriving programs that are working to keep young men and women off the streets and into the classroom by using the power of sport. For a relatively small investment, these programs are making a large difference in the lives of San Francisco's young people.

In the Western Addition, a predominantly African-American community, the Ella Hill Hutch Community Center has a midnight basketball program that is taking nearly 100 young men—disadvantaged, unemployed, and at risk—and giving them a second chance at education and employment. Recently, at a nationwide conference on midnight sports, the Ella Hill Hutch basketball program was heralded as a model for the Nation.

In the Mission District, the heart of San Francisco's Latino community, the Columbia Park Boys Club and the YWCA are sponsoring "Midnight Soccer" for young men and women, and working actively to break the rising cycle of gang violence that is threatening the lives of so many young people.

By combining education, job training, peer counseling, and the discipline and enjoyment of sport, these two programs—midnight basketball and midnight soccer—are already making a valuable contribution to crime prevention and, more important, helping young people lead productive lives. The money earmarked in the crime bill for midnight sports is an investment that is more than justified by the results. I urge my colleagues to vote in favor of the midnight sports provisions of the crime bill.

Mrs. COLLINS of Illinois. Mr. Speaker, as a mother and a grandmother, as well as a resident of a large metropolitan area, I am as worried about and frightened by random and violent crime as are many Americans today. I share the concerns expressed by residents of my district for the safety of their children and the well-being of their families. I also understand the important role that this body must play in helping to reduce the incidence of crime nationwide.

However, let me say here and now that I am morally against the death penalty; I am against the very idea of treating 13-year-olds as adults even though they commit adult-like crimes because they are still children; and I am bitterly disappointed that the racial justice provisions of the House bill have been stricken from the Conference Report.

To repeat, I have serious concerns about this bill that invests more of our scarce Federal dollars to build and fill prisons rather than to effectively address the problems that necessitate their construction, this bill that creates more ways to punish rather than to provide, this bill that exponentially expands the death penalty without guaranteeing its fair application, this bill that condones warehousing some juvenile offenders as young as 13 years old and throwing away the key instead of unlocking the doors of opportunity for our most neglected and underserved youth.

However, there are a number of very beneficial provisions included in this conference report that I strongly support and that can help my constituents. The addition of 100,000 officers to walk the streets of our cities and towns, interacting on a daily basis with our citizens, can serve to strengthen the ties between law enforcement and local communities, thus creating a safer environment in which our children can grow. Residents of several neighborhoods in my district in Chicago, such as North Lawndale and Austin, have already been successful in organizing citizen partnerships with local authorities to tackle problems as they arise and ensure the continued vitality of the areas in which they live and work.

I am also pleased, Mr. Speaker, that the conferees agreed to include $1.8 billion of long-overdue funds for the Local Partnership Act to grant cities the resources necessary to implement proven, cost-effective, and much-needed health and educational crime prevention programs. I was successful in amending this Act to further assist in revitalizing distressed communities by setting aside 10 percent of the Federal payments awarded under the Act in each locality across the Nation for contracts and subcontracts with small minority or women-owned businesses as well as historically black colleges and universities. This provision will provide relief and the hope of a successful future to hundreds of small, disadvantaged enterprises and the neighborhoods in which they are located.

It is high time we recognize that giving individuals and families a greater stake in their communities through such initiatives is the best way to attack and deter lawlessness. We need to provide hope where there is little or none. The threat of punishment and retribution neither prevents nor stops crime from occurring. Only real opportunity does. In this regard, I am satisfied that the conferees accepted other preventive language of the House that encourages rehabilitation, education, and training of some nonviolent, first-time offenders as well as comprehensive drug treatment to move individuals down the path of recovery and toward self-sufficiency.

This conference report does contain a ban on 19 types of assault weapons as well as provisions making it illegal to sell a handgun to persons under 18 years of age. These common-sense measures should have been on the books years ago and their inclusion serves the "Not Really Attuned" NRA with a loud wake-up call that the American people are turned off by their attempts to block any and all rational gun control legislation.

Our children are at risk and we must begin to bring some sanity to our gun regulatory framework. In 1992 alone, in my city of Chicago, 741 youths 19 years of age and under were victims of gun injuries and early reports for 1993 and 1994 indicate rising numbers. At Children's Memorial Medical Center in Chicago, the number of children 16 and under treated for gunshot wounds skyrocketed 250 percent from 1988 to 1993. This is a disgraceful tragedy, Mr. Chairman.

Additionally of importance, this conference report signals to women of our country that we do care about their right to be safe, especially in their own homes. All too often in America today, women who are victims of violent assault, rape, or murder are victims at the hands of their husbands, boyfriends, or other acquaintances. Unfortunately, many times they become victims again when they seek assistance from law enforcement or the judicial system because these entities are insufficiently equipped to deal with gender-based crimes. With the inclusion of the Violence Against Women Act in this conference report, which will combat sexual and domestic violence with proper educational programs and police training as well as mandating higher penalties for gender-motivated crimes, we can rectify these inherent injustices that now exist.

Unfortunately, Mr. Speaker, despite these beneficial provisions, a portion of this bill is devoted to short-sighted, politically misguided, and, frankly, quite disturbing attempts to limit individual liberties and establish an eye-for-an-eye justice system in the United States. Such irrational cries for vengeance as a form of crime control do nothing but blind society to the real solutions to the problems with which we are confronted and inevitably heighten divisiveness among varying races and socioeconomic classes across our Nation.

The thirty-fold expansion of Federal death penalty crimes in this bill is indicative of this irrationality. No study that I am aware of has ever proven the deterrent effect of the death penalty, and simply increasing the number of crimes subject to government-sanctioned execution will accomplish nothing, except increase the chances that African-Americans and other minorities will continue to be disproportionately among those sentenced to death.

While there is overwhelming evidence of the discriminatory nature of death penalty sentencing, it seems that some of my colleagues in both chambers do not seem to care. While they call for truth in sentencing, they certainly are not calling for true fairness in sentencing, given the absence of any form of racial justice language in this bill.

Under the 1988 Anti-Drug Abuse Act signed into law by President Reagan, the death penalty was allowed for individuals involved in certain illegal drug activities. Since this law took effect, 75 percent of those convicted of participating in a drug enterprise under this statute have been white and only about 24 percent of the defendants have been African-American. However, of those chosen for death penalty prosecutions, 78 percent of the defendants have been African-American and only 11 percent have been white. Furthermore, the General Accounting Office, Congress' own investigating arm, concluded in a 1990 report that racism definitely affects the use of the death penalty in the United States.

Even Supreme Court Justice Harry Blackmun stated earlier this year that "the death penalty experiment has failed * * * it remains fraught with arbitrariness, discrimination, and caprice, and mistake."

Mr. Speaker, in the language of the High Court, I concur.

I cannot express more adamantly my grave concerns about the way African-Americans in general are treated by our criminal justice system. In those cases where the death penalty is not imposed, African Americans are more likely to receive harsher punishments for the same crimes committed by others. In fact, studies have repeatedly shown that African-Americans are 21 percent more likely to receive mandatory sentences than are whites. Given the fact that the conference report before us mandates stiffer penalties for a greater number of crimes, especially the three-strikes provision, it is incumbent upon us as policymakers to ensure that penalties are meted out fairly. Again, unfortunately, some of my colleagues see no need for this.

I have always believed that those who commit crimes of any kind should be punished appropriately. However, I am greatly distressed that when it comes to some of our most troubled youth, the conferees have admitted defeat by keeping provisions in this conference report that will allow 13-year-old children to be tried as adults in the Federal system. Once again, some adult men and women in Congress would rather take the politically expedient easy road of writing off these kids as lifetime felons rather than addressing the reasons why these kids have gone astray.

This is an absolutely unconscionable way to deal with kids that society has neglected, refused to educate properly, refused to provide economic opportunities for, and simply refused to take the time to understand.

Mr. Speaker, we must launch an attack on crime in America. But we must not let our zeal to attack this problem overshadow the fundamental civil liberties upon which we have relied for over two centuries. Disturbingly, parts of this bill, as I have stated, tend to do just that.

Nevertheless, my constituents are demanding action and I cannot deny them their right to representation in the U.S. Congress. We are all affected by the crime rate. Many among us are disproportionately affected. According to many studies, those areas composed of individuals and families of modest to lower economic means, areas that make up portions of my district, are the areas most likely to be victimized by crime. My constituents are concerned about making the streets safe and have elected me to be the voice of their concerns. They believe that, despite its shortcomings, this bill contains too much that is beneficial to them, good for Chicago, and good for the Nation, to contribute to its possible defeat by a vote in opposition. Therefore, even though it is extraordinarily difficult on my personal moral grounds to vote for the death penalty—and this will be the first and only time in my life that I have done so—I will cast my vote in favor of this rule and for the conference report on H.R. 3355, the Violent Crime Control and Law Enforcement Act.

But I firmly believe we must revisit many of the issues I have touched upon. I am pleased that the President intends to commission a study of racial disparities in death sentencing. We must also, however, continue to work tirelessly to provide greater resources for building up our schools and neighborhoods, continue to offer greater avenues of opportunity down which our neglected and underserved youth can safely travel, so that instead of talking about "three strikes and you're out" in the future, we will be talking about the home runs hit in the game of life by more of these youngsters.

Mr. HALL of Ohio. Mr. Speaker, I rise in strong support of both the rule and crime bill conference report. We, in Congress, have a great opportunity to vote for an anticrime strategy that strikes a much-needed balance between more law enforcement, swift and certain punishment, and innovative prevention programs.

Crime is one of the most pressing issues facing the American people. While new or increased Federal penalties have been enacted into law, crime continues to plague our communities. The people of my district in Dayton, OH, and across the country, are tired and scared of hearing about crime and the underlying problems associated with it. Even though communities across the country fight crime effectively on the local level, Congress also can contribute by ensuring that sufficient funds are available. These resources will provide communities flexibility to target funds toward those areas most in need. The crime bill reflects the important partnership between local, State, and Federal Governments. Many provisions in this legislation are devoted to this cooperation and coordination between local communities and the Federal Government to meet the anticrime challenge.

Mr. Speaker, obviously this bill contains some language that not all of us are in total agreement on. But, it does include so many worthwhile initiatives which will help communities fight crime in their areas. It would be foolish of us to let this opportunity slip through our fingers.

Putting more police officers on our streets is one of the most important provisions in the crime bill. These additional officers would increase police presence and provide local law enforcement officials with the assistance they need to fight crime.

Programs that help battered women and other crime victims cope with legal, physical, and mental trauma must be a top priority. The House passed an amendment I offered which extends funding to programs that assist victims of crime, language included in the conference report. This provision removes the 4-year limit on victims' assistance funding under the Byrne Memorial Fund. Providing this exemption will help worthwhile groups nationwide to continue dealing effectively with the target problems associated with domestic violence.

Our country needs this crime bill. It is time for us to put our partisan bickering aside and vote for a balanced and reasonable approach to the increasing violence in this country. This is the least that our young people deserve, who too are often neglected and witness the horror of violence at an early age.

I urge my colleagues to vote "yes" for the rule, and vote "yes" for the crime conference report.

Mr. HOUGHTON. Mr. Speaker, I will not take much time to inject myself into the crime bill rule debate. Much, maybe too much, has already been said, and I must say I have seldom seen such emotion—much of it partisan emotion—on the part of grown people. It makes one wonder about the objectivity.

In any event, I support the rule of the crime bill—not because I think it favors Republicans. It does not. I support it because, in this particular case, the rule is the bill. This is not so in many cases, but it is here.

The bill also is not perfect. I give it a C+ rating, but it is an issue whose time has come. It is a first step, an important one, a timely one. If you don't take the first step, how do you get to the second or the third or the fourth. And there are many additional steps needed to battle crime.

I just think that we should not delay. It's always easy to say hold on; don't act. I do this myself. Sometimes I guess I'm right—sometimes not. But here the debate has gone on for years. We know the issues. We've decided on the major points. Let's get at it and move, move. If we're wrong we can change, but let's not be paralyzed and do nothing.

Mr. DELAY. Mr. Speaker, I rise today in opposition to the rule on this touchy-feely conference report on the crime bill. As we all know, the conference report was not submitted until 7:30 last night and is 900 pages long. Mr. Speaker, this does not give Members an opportunity to review the legislation.

Nevertheless, what we do know of the crime bill should seal its fate on the floor today. This bill is not really about crime and it is certainly not what the American people have asked for.

Mr. Speaker, the American people would not approve of this crime bill. A new study by the Luntz Research Co., reports that when people were asked how Federal tax dollars are spent on various crime measures, 69 percent supported more cops and 44 percent supported new prisons, while 48 percent opposed midnight basketball and new social workers as a poor use or complete waste of Federal tax dollars.

With $32 billion in spending and 30 new social programs paid into a welfare system which has already cost taxpayers over $5 trillion since 1965, we should learn the lesson that throwing money at problems for social programs doesn't reduce crime.

We know that the best way to prevent crime is take the 7 percent of criminals who commit over two-thirds of all violent crime and take them off the streets. And we can do this by building new prisons, implementing truth in sentencing, putting more cops on the streets, stopping endless habeas corpus appeals and implementing a real "3 strikes and you're out" provision, measures which were all included in the House Republican crime bill.

Instead, we have a bill that spends, spends, spends: $1.8 billion for education, job training, and self-esteem programs, $100 million for anything tangentially related to crime, $630 million for children's arts and crafts, dance and other recreation, $10 million for public housing to supplement the $30 billion that HUD is already spending, $200 million for assorted inner-city youth activities, $6 million for urban parks and recreation, $270 million for schools to coordinate social workers and teachers, $50 million for youth development, $3 million to search for missing alzheimer's patients, and of course, $40 million for midnight basketball.

Mr. Speaker, I'm surprised the President didn't include his health care plan in the crime bill.

Moreover, the gun ban in this bill covers more than 180 firearms, affecting 50 percent of the gunowners in this country. Gun bans are fundamentally flawed because they affect the guns and not the criminals. I've never known a law that restricts law-abiding citizens decrease violent crime. We need to spend taxpayer resources keeping violent criminals off the streets, not levying more laws on law-abiding citizens. Let's crack down on the people who unlawfully pull the triggers.

Mr. Speaker, even the FBI Director, Louis Freeh has criticized this bill for downsizing two of the great crime-fighting organizations in our country: the Drug Enforcement Agency and the FBI.

I urge Members to defeat the rule on this bill. America doesn't need emptier pockets in the name of prevention. Let's take this bill back and give the American people a real crime bill.

Mr. YOUNG of Florida. Mr. Speaker, I rise in strong opposition to this rule and the conference report. In April, the House approved this measure as a modest effort to stem the rising tide of crime. Unfortunately, the bill has since returned from a House-Senate conference committee as a liberal's grab bag of social spending goodies, been given the name "crime bill" by the President and the House democratic leadership, and brought before us here today. Not since the 1960's and President Johnson's Great Society has the Congress of the United States considered such a broad social spending bill. In fact, not since Orson Wells broadcast of "War of the Worlds" has such a charade been perpetrated on the American people. It has been my frustrating experience that every attempt to enact strong anticrime legislation is blocked by the liberals of this House at every opportunity. It is clear that this is true again today.

As I said, Mr. Speaker, when the House began this effort earlier this year, the intentions of my colleagues and I, who support strong criminal reform legislation, was to pass a bill that would protect our people and our police by helping prosecutors and judges put away—and keep away—America's most violent offenders. We sought to put more police in our communities, strengthen the death penalty and limit the endless appeals process, provide life sentences for third-time violent offenders, enact truth-in-sentencing provisions that would ensure criminals serve out their prison terms, and provide funding to build prisons for their punishment.

During consideration of this legislation in April, we were successful in our efforts on several of these fronts. The House bill authorized funding for 100,000 officers on the streets, and provided grants to build and expand space in correctional facilities in order to implement specified truth-in-sentencing requirements. The bill imposed life imprisonment on persons who committed a third violent felony under Federal law and included language to end the seemingly pleasant treatment of prisoners. The bill prohibited the awarding of Pell higher education grants to inmates and strength training on weight equipment in Federal facilities. In addition, more than $14 billion was authorized for new prison construction. And in an attempt to address the growing problem of illegal aliens in our jails, the bill increased border patrols and included new deportation procedures to speed deportation of aliens convicted of crimes.

Unfortunately, the moment this legislation left the House, the usual efforts began to water down the progress made in these areas, and beef up the bill's prevention programs. The result of those efforts is the legislation before us today. Rather than putting cops on the beat this bill puts strings on the purse by requiring hiring quotas and other bureaucratic conditions for receiving grants to hire police. The funding mechanism for these grants, proposed cuts in the budgets of the Federal Bureau of Investigation and the Drug Enforcement Agency, have led our Nation's chief law enforcement officer, FBI Director Louis Freeh, to criticize this legislation.

For States that don't want to comply with the truth-in-sentencing guidelines, there are loopholes which allow them to get prison funds anyway. In addition, funding for prison construction was nearly cut in half. Even more ironic is the way in which this legislation seeks to combat crime by retroactively ending mandatory minimum sentencing requirements. An act which could lead to the release of 10,000 convicted drug offenders.

But the big news of course is "Stimulus II", the $9 billion in social spending which is essentially a reincarnation of President Clinton's 1993 pork-barrel stimulus bill which funds lots of "feel-good" programs that have no connection to crime. Lyndon Johnson called these programs the solution to ending poverty, today we're being told they will end crime. Even more outrageous is that all this money would go where the President or Cabinet Secretaries choose.

Here are some of the brilliant solutions to our Nation's crime problem contained in this bill. No doubt the mere mention of these programs will strike fear in the heart of the most violent criminal.

Youth Employment and Skills Crime Prevention (YES): A $900 million program intended to test the proposition that crime can be reduced through a saturation of jobs. Saturation indeed, when you consider this is in addition to the current $25 billion that the Government Accounting Office reports the Federal Government already spends on 154 job training programs.

The Local Partnership Act: $1.8 billion to local governments in areas with high taxes, high unemployment and high crime. The Act provides grants for education, substance abuse treatment and job programs. Unfortunately, there is no enforceable condition that the funds be used to fight crime. To say that these programs are going to be funded for the purpose of preventing crime does not change the basic idea that the whole purpose of this provision is another opportunity to spend money as fast as possible.

Drug courts: $1.3 billion to governments, courts and private entities chosen by the Attorney General to provide benefits to criminals who are drug addicts. The benefits include child care, housing placement, job placement, vocational training and health care. Who says crime doesn't pay? I am sure that many of my constituents could use help in paying for child care or finding a house or a job, let alone health care. It is unfortunate that we would encourage them to become convicted drug addicts so they might receive such benefits.

Midnight sports: $40 million to entities chosen by the Secretary of Housing and Urban Development to fund midnight sports leagues in high crime and drug use areas for youths that cannot sleep. I would suggest that we encourage our young to stay home, do their homework and get a good night's sleep before school the next day, not stay up until after midnight playing sports. There is plenty of time for organized sports after school.

Ounce of prevention: An interagency council made up of Cabinet Secretaries that will provide $100 million for programs that promote arts, crafts, dance programs, and "life skills training." These may be worthwhile programs, but let's consider them on their merits. Not cloaked in a bill that is supposed to fight crime.

Mr. Speaker, crime is a serious problem in this country. The American people demand a serious response by the Congress and are insulted by the masquerade underway here. They want a tough anti-crime bill, not a return to the social welfare spending of the 1960's and 1970's. If these programs were the answer to crime, the street corners of our Nation would be far and away the safest in the world. We have already spent $5 trillion on social welfare programs in 30 years. If the President wants these social programs he can request them in his budget and the House can vote up or down on their approval.

Mr. Speaker, we need to defeat this conference report and send it back to conference with the same message the American people are sending us—strip the social spending and focus on the good proposals we have already approved and which have a successful record in fighting crime. We did not come this far to pass an expensive economic stimulus package with an anti-crime label. Our constituents deserve better.

Mr. EWING. Mr. Speaker, I rise to oppose the rule on the omnibus crime bill. It is imperative that the conference committee renegotiate this bill to remove the expensive social programs and improve upon the law enforcement provisions. The conference committee's report has more to do with social welfare programs than it does with fighting crime.

I agree with FBI Director Louis Freeh's recent criticism of the crime bill because it redirects funds from the Federal Bureau of Investigation and the Drug Enforcement Agency to ineffective social programs. This Congress needs to get serious about fighting crime and pass a bill that assists law enforcement officials and keeps criminals behind bars.

The crime bill includes $9.1 billion for prevention programs such as self-esteem classes, midnight basketball, and arts and crafts training. Many of these prevention initiatives are duplicative of programs already on the books which have had little or no effect in reducing crime.

The conference committee removed tough crime fighting provisions from the bill. Most surprising is the fact that the conference committee removed a provision which would make it a Federal crime to carry or use a gun during a violent crime. This provision would have targeted the most violent criminals in the United States.

Congress needs to pass a bill with certain penalties for those convicted of committing violent crimes. Let's send this bill back to conference and demand a tough crime bill.

Mr. KYL. Mr. Speaker, I rise in opposition to the rule to H.R. 3355, the crime conference report. I support many of the provisions of H.R. 3355, but the process by which this crime bill has been developed was marked every step of the way with partisan roadblocks.

Attempts to improve this bill have been rejected by the Democrat-controlled Rules Committee, from consideration on the House floor and in conference. These roadblocks have obstructed efforts to produce many tough, meaningful reforms to our criminal justice system. The bill was filed at 7 p.m. last night, which means the Rules Committee had 1 hour to review the document before voting on its rule. For Republicans, there has not been a complete conference document to refer to in order to know about specific provisions.

The responsible vote is to oppose the rule and send the measure back so improvements can be made. Improvements which will correct some of the missed opportunities and respond to the needs of law-abiding citizens, police forces, prosecutors, courts and prison systems around my home State and the rest of the Nation.

The legislation I have supported throughout this process, H.R. 2872, includes measures, among other things, to set mandatory minimum prison terms for violent crimes; provide funding for additional police officers; limit probation and parole; limit death row appeals and expand the death penalty; provide funding to fight illegal immigration and strengthen criminal alien deportation laws; increase penalties for crimes committed with guns; provide funding for prison space to incarcerate violent offenders; and, provide a good faith exception to the exclusionary rule.

Some of the provisions of our bill were included in the conference report, but other important provisions designed to fight violent crime, including a measure to allow evidence of prior sex crimes of the accused to be admitted in sex/child molestation cases, were not included despite instructions to House to do so. I will continue to fight for their passage.

According to the Uniform Crime Report, the violent crime rate in Arizona increased 129 percent between the years of 1975 and 1993. To make the changes necessary to ensure the safety of our citizens, this crime bill should be improved. Defeating the rule will allow for that.

If we know that we could reduce the problem of violent crime by 70 percent with just a few actions, would we do it? According to researchers at the University of Pennsylvania, approximately 7 percent of criminals commit over 70 percent of violent crime. If we facilitate putting and keeping these criminals in prison, we eliminate the chance of being victimized by their actions.

The conference report, therefore, should be changed to more adequately provide prison construction funding for the States. The conference report includes only $6.5 billion in state funding for prisons. Of that amount, up to approximately $4 billion can be used by States for non-prison construction activities. The House is already on record instructing conferees to include $13.5 billion in prison construction. And, according to government data supplied by Michael Block of the University of Arizona, between 1980 and 1990, and 10 States with the highest increase in their prison populations, relative to total FBI crime indexes, experienced, on average, a decline in their crime rates of more than 20 percent, while the States with the smallest increases in incarceration rates averaged almost a 9 percent increase in crime rates. Clearly, we can take a big step to better help States keep violent criminals off our Nation's streets and in jail by providing more prison funding.

The crime bill should also be changed to encourage states to ensure that violent, repeat offenders are locked up under "three-strikes-you're-out" and "truth-in-sentencing" laws. The conference report requires that under its "three-strikes-you're-out provision the third strike be a Federal violent offense, which will result in only about 300 to 400 violent, repeat offenders being taken off our Nation's streets for good. According to Mr. Block, every day this year, 14 people will be murdered, 48 women raped, and 568 people robbed by criminals who have already been caught, convicted and then returned to the streets on probation or early release. The crime bill should be changed to increase the number of repeat offenders who will be put behind bars for good.

Another area in need of complete re-direction in the crime bill is the $9 billion allocated for social programs. Given that, among other things, the crime bill, (a) only allocates a part of what is needed for prisons, (b) will only fund about a fifth of the 100,000 local police officers promised, and (c) has been criticized by the director of the Federal Bureau of Investigation for taking needed agent resources from the FBI and Drug Enforcement Administration, the responsible action to take is to send the crime bill back to conference to prioritize the spending in this bill.

For example, the Youth Employment and Skills Crime Prevention program in the bill includes over $900 million for a jobs program for youth. The problem is that, according to the General Accounting Office, the Federal Government already spends $25 billion on 154 Federal job training programs, many of them specifically designed for disadvantaged youth. Many believe this is illustrative of duplicative, wasteful programs which are funded in this crime bill and should be eliminated.

Another provision of the bill which should be sent back to conference is the semiautomatic weapons ban, which passed the House by a vote of 216 to 214 earlier in the year, and which I voted against. The biggest difference we can make to reduce crimes committed with guns is not to infringe on law-abiding people's rights, but to significantly increase penalties for illegal use of guns. Several attempts were made to increase penalties in this bill for crimes committed with guns, and, even though the House has voted to instruct conferees to increase these penalties, ultimately they were rejected by the Democrat-controlled conference committee. That should be corrected.

There are other important issues, such as the "good faith" exception to the exclusionary rule, which allows evidence obtained by police in good faith to be admissible in court even if its seizure was beyond the technical scope of the Fourth Amendment. Several attempts were made to include this measure in the bill but, again, the Democrat-controlled House rejected those attempts.

The direction on this bill should be clear. The Congress should take this opportunity to be responsible, vote down the rule and send this bill back to the drawing board where the questionable provisions can be taken out, strengthening amendments can be added and the rights and safety of law-abiding citizens can be protected.

We have the opportunity. Do the right thing. Vote against the rule on this bill.

Mrs. ROUKEMA. Mr. Speaker, I rise in support of this rule and this conference report and would urge my Republican colleagues to do the same.

I know that many of my colleagues have discovered various reasons to oppose this legislation and there are portions of this bill that I do not support. But on balance, with our country facing an epidemic of violent crime, this legislation represents progress.

If we fail to act now, We will have to answer to the countless victims of a failed criminal justice system.

The American people know it. We must control crime and close the revolving door of the criminal justice system. Our laws must punish the criminal and safeguard law-abiding citizens. We must take back our streets.

This bill is not perfect.

Let me repeat: This bill is not perfect.

Do I support midnight basketball? No.

Do I think we should be handing $1.8 billion for the Local Partnership Act to the Clinton administration and big-city mayors. Absolutely not.

Yes, we need habeus corpus reforms. We need tougher truth-in-sentencing. Police should have a good faith exemption to the exclusionary rule. The provisions on sexual predators are not strong enough.

So why am I voting for this rule and this bill?

Because my constituents are being forced to look over their shoulder as they walk the dog in their own neighborhood, to worry about the security of their children's playground, and to huddle in their homes for fear of going to the nearby shopping center.

Because Jack and Arlene Locicero and sister Cary of Hawthorne, NJ are living today with the loss of a precious daughter killed at random by a madman on a commuter train last December and I promised the Lociceros that I would not let Amy be just another statistic, some good must come of their tragedy.

Mr. Speaker, the Lociceros and the American people are counting on us to take back our streets!

This bill puts 100,000 new cops on the streets many of them in community policing programs.

This bill hires close to 100,000 new border patrol agents to battle the rising floodtide of illegal immigration.

This bill contains the "three strikes you're out" provision to lock up repeat violent offenders.

This bill contains an expanded Federal death penalty.

This bill will build new prison space in every state in the Union.

That's precisely why it is supported by a range of law enforcement organizations: The National Association of Police Organizations, the Fraternal Order of Police, National Sheriff's Association, the National District Attorneys Association, the National Association of attorneys General, the International Brotherhood of Police Officers, the Police Foundation, the Federal Law Enforcement Officers Association, to name just a few.

The American people want us to act and act now. They can't wait. They should not have to. Pass the rule. Pass the crime bill.

Mr. KOLBE. Mr. Speaker, I rise in opposition to the rule on this so-called crime bill conference report. Since my constituents first sent me to Congress to represent them, I have pushed for crime control measures that put personal safety above political expediency. But, Mr. Speaker, I could not look my fellow Arizonans in the eye and honestly say that this bill puts people over politics. That is why I am voting against this rule; it is the only opportunity for us to send this bill back to conference and make the conferees fix this bill so that it attacks crime and gives law enforcement the tools to fight criminals.

I know about the terrible crime problem southern Arizonans face almost daily. I hear from them about their fears and frustrations. It is easy to understand why crime is America's number one concern. But despite their concern with crime, this crime bill has not been embraced by the public. Why? I think it is because people realize it will be ineffective in the fight against violent crime while costing taxpayers over $33 billion. Americans know this Nation has a dysfunctional criminal justice system—a system that releases dangerous criminals into the community when they should be serving their sentences, a system that gives more weight to the rights of criminals than to victims, and makes it impossible to carry out the death penalty when it is imposed. And this conference report is dysfunctional—like the system it seeks to reform.

Even key criminal justice experts have spoken out against the crime conference report. FBI Director Louis Freeh criticized the bill, saying it would hurt local and Federal law enforcement more than it would help by robbing them of funds. Princeton professor John J. DiIulio, Jr., a Democrat who is widely recognized as the Nation's foremost student of criminal justice issues, originally supported the administration's anticrime proposals. He supports a ban on assault weapons, and he supports some social spending. However, he argues that the bill reported by the conference should be abandoned. "It will do nothing to reduce the country's crime problem," he says, "In fact, it may actually add to it."

Let us look at why this bill will do nothing to fight crime.

First, this bill does not address what I, and Members from both parties, have fought for—procedural reform, not redistribution of wealth through grant programs. This conference report contains no habeas corpus reform, no exclusionary rule reform, and weakened Federal death penalty provisions. In short, this bill does nothing to ensure swift punishment for the guilty.

Additionally, the conferees stripped or weakened many of the tough anticrime provisions included in the original House and Senate bills. for example, provisions allowing prosecutors to treat violent juveniles 13 and older as adults in appropriate cases were eliminated. Provisions passed by the House to strengthen death penalty procedures were stripped. Mandatory HIV testing of accused rapists was erased. The provision allowing for the admissibility of evidence of similar crimes in sex offenses was dropped. These are just a few examples that were stripped from the bill.

The much praised cops-on-the-beat program will quickly become a huge burden for communities because the numbers do not add up for this program. The $8.85-billion community policing grant program will only provide enough funding to keep 20,000 permanent cops on the street over the next 6 years. To keep 100,000 cops on the beat for the next 6 years, States and localities will have to kick in over $30 billion to make up the difference. I have personally spoken to sheriffs and policr chiefs in my district who are wary of this too-good-to-be-true provision.

This bill is flawed because it could put twice as many social workers on the streets as it does cops. It authorizes $8.7 billion to create nearly 30 new crime prevention programs. This is added to the welfare state that already costs taxpayers $310 billion per year. The United States has spent $5 trillion on the War on Poverty since 1965, yet the national crime rate has not declined. The new programs created will duplicate at least 50 existing federally funded crime prevention grant programs. These programs are in the bill to garner support from an interest group within Congress, and these programs have escaped scrutiny. These programs are little more than infrastructure, social, and job training programs under a crime prevention label. Make no mistake; some social prevention programs have been successful, but if the Federal Government is to fund programs, we should at least make sure that the money will not be wasted on liberal social engineering.

I support the construction of new prisons, but the money for this purpose—$10.5 billion—is not what it is cracked up to be. Over $2.2 billion of that money is not financed and $1.8 billion of the funding goes to housing criminal illegal aliens. Although I support reimbursing States for the cost of incarcerating convicted illegal aliens, this money will go to States as decided by the Attorney General—not necessarily to those who need it. All told, the total trust fund funds going to build prisons is $6.5 billion. But there's more: States and localities are not required to actually build prisons, and can instead use the funds for any activity affecting prisoners postconviction. They could fund anything from half-way houses to macrame classes, as long as those utilizing the funds have been convicted.

I also oppose the assault weapons ban and the ban on gun magazines that hold more than 10 rounds of ammunition. I believe this ban is of at least dubious constitutionality, and will do nothing to make our streets safer.

This bill represents what my constituents are sick and tired of—politics as usual. This $32-billion bill is a perfect example of fiscal incompetence and a back-door channeling of taxpayers' dollars towards special-interest groups and political payoffs. Congress is authorizing more money than ever before for a crime prevention bill which is a product of dishonest government playing on the fears that every American is experiencing.

The process used by House leadership is just as dishonest. Members have had barely 6 hours to examine the 450-plus page conference report which just appeared in the CONGRESSIONAL RECORD. Just as the American people are demanding that they have a chance to examine health care proposals before they are voted on, they also demand that we have the opportunity to read and understand the crime bill before we vote on it.

We have a criminal justice system that releases dangerous criminals into the community when they should be serving their sentences, that gives more weight to the rights of criminals than to victims, and makes it impossible to carry out the death penalty when it is imposed. We need to defeat this rule and send the conference report back to the drawing board so that Congress can bring back a crime bill that will do the job. The Federal Government should be assisting States and local governments in their efforts to lockup criminals, protect victims' rights, and provide the tools to make law enforcement even more effective.

I urge my colleagues to defeat this rule.

Mr. DERRICK. Mr. Speaker, I yield the balance of my time to the distinguished Speaker of the House, the gentleman from Washington [Mr. FOLEY].

Mr. FOLEY. Mr. Speaker, my colleagues, I think everyone knows that it is relatively rare for the Speaker to leave the chair and to speak in the well in debate on an issue. it is also very rare for him to vote. That is the tradition of the House. Like everyone else, I have the right to vote, and I will exercise it in voting for this rule and in voting for this bill.

I do so because frankly I think it is a key vote, not for the President, and I was glad to hear our distinguished Republican leader talk about our President as "our" President. I have served here for 30 years. Richard Nixon was my President, our President, Ronald Reagan was our President, George Bush was our President, and Bill Clinton is our President.

But it is not about the President. It is about our responsibility as Members of the Congress to our constituents, the people in all the 435 districts and the 5 territories that are represented here in this Chamber. This is the great collection, the Congress of the American people.

And what are the American people telling us? They are telling us that after we have spent trillions of dollars rightfully, and I voted for those trillions of dollars to defend our country against foreign threat, their most deep concern is for their security and the security of their families on the streets of our own cities and not on the beaches or air space of other countries, or some foreign threat. We have conquered every reasonable threat that could be placed against our people from outside the country, but inside the country elderly people, and children, and families are afraid to go on the streets at night in their own communities. They have asked us to respond to that fear.

It always seems that we get to that point and something intervenes. We passed the bill in the last Congress. It was filibustered in the Senate. And now procedural objections suggest we should not even vote on this bill, we should not even respond "yes" or "no."

I have a respect for anyone on either side of this aisle who says that he things or she thinks this bill should be voted down, but I say, "Let the American people know your reasons, and let them know your vote. To govern is to choose on the issue that the American people believe is the most central to their immediate concerns, their most deeply felt concerns about security in the future."

This is a vote we cannot avoid and should not avoid. We should stand up, and cast our votes, and explain to our constituents the reasons for our actions. That is the very minimum of what our constituents expect us to do.

In all the years that I have been in Congress, and I have been here 30 years, I have seen times in my experience when I thought votes were, perhaps, even more crucial than the vote that we are casting today; not many, but some. But this is a truly crucial and seminal vote, and it will determine, I think, not only the confidence in the country in our ability as an institution to respond to their concerns and needs, but it will make a very real and tangible difference in the lives of my constituents in eastern Washington, in the towns and cities of this largely rural part of our country.

I used to be a deputy prosecutor. The days of my experience in law enforcement have been exceeded many, many times by the threats that exist in my communities as well as those of my colleagues. Let us not be a helpless giant in response to the demands and concerns of our people. Let us respond to their most deeply felt needs and concerns. The society that cannot protect the physical security of their citizens is a pretty useless society whatever else it can accomplish.

My colleagues, let us vote for this rule. Let us vote for this bill.

Mr. DERRICK. Mr. Speaker, I move the previous question on the resolution.

The previous question was ordered.

The SPEAKER pro tempore (Mr. RUSH). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. GOSS. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 210, noes 225, not voting 0, as follows:

[Roll No. 394]

AYES—210

Abercrombie
Ackerman
Andrews (ME)
Andrews (NJ)
Andrews (TX)
Applegate
Bacchus (FL)
Baesler
Barca
Barlow
Barrett (WI)
Becerra
Beilenson
Berman
Bevill
Bilbray
Bishop
Blackwell
Blute
Boehlert
Bonior
Borski
Brooks
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Byrne
Cantwell
Cardin
Carr
Clayton
Clement
Clyburn
Coleman
Collins (IL)
Collins (MI)
Condit
Conyers
Coppersmith
Coyne
Cramer
Darden
DeLauro
Dellums
Derrick
Deutsch
Dicks
Dingell
Dixon
Dooley
Durbin
Edwards (CA)
Edwards (TX)
Engel
English
Eshoo
Evans
Farr
Fazio
Filner
Fingerhut
Flake
Foglietta
Foley
Ford (MI)
Ford (TN)
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Gibbons
Glickman
Gonzalez
Gordon
Grandy
Green
Gutierrez
Hall (OH)
Hamburg
Harman
Hastings
Hefner
Hinchey
Hoagland
Hochbrueckner
Houghton
Hoyer
Hughes
Hutto
Inslee
Jacobs
Jefferson
Johnson (CT)
Johnson (GA)
Johnson (SD)
Johnson, E.B.
Johnston
Kanjorski
Kaptur
Kennedy
Kennelly
Kildee
Kleczka
Klein
Kopetski
Kreidler
LaFalce
Lambert
Lantos
Lehman
Levin
Lipinski
Lloyd
Long
Lowey
Maloney
Mann
Manton
Margolies-Mezvinsky
Markey
Martinez
Matsui
Mazzoli
McCloskey
McDermott
McHale
McKinney
McNulty
Meehan
Meek
Menendez
Meyers
Mfume
Miller (CA)
Mineta
Minge
Mink
Moakley
Montgomery
Moran
Morella
Murphy
Murtha
Nadler
Neal (MA)
Neal (NC)
Oberstar
Obey
Olver
Owens
Pallone
Pastor
Payne (NJ)
Pelosi
Penny
Pickle
Pomeroy
Price (NC)
Quinn
Ramstad
Reed
Reynolds
Richardson
Roemer
Rose
Rostenkowski
Roukema
Rowland
Roybal-Allard
Rush
Sabo
Sanders
Sangmeister
Sawyer
Schenk
Schroeder
Schumer
Serrano
Sharp
Shays
Shepherd
Skaggs
Slattery
Slaughter
Spratt
Stark
Studds
Swett
Swift
Synar
Thompson
Thornton
Torres
Torricelli
Towns
Traficant
Tucker
Valentine
Velazquez
Vento
Visclosky
Waxman

Wheat
Whitten
Woolsey
Wyden
Wynn
Yates

NOES—225

Allard
Archer
Armey
Bachus (AL)
Baker (CA)
Baker (LA)
Ballenger
Barcia
Barrett (NE)
Bartlett
Barton
Bateman
Bentley
Bereuter
Bilirakis
Bliley
Boehner
Bonilla
Boucher
Brewster
Browder
Bunning
Burton
Buyer
Callahan
Calvert
Camp
Canady
Castle
Chapman
Clay
Clinger
Coble
Collins (GA)
Combest
Cooper
Costello
Cox
Crane
Crapo
Cunningham
Danner
de la Garza
Deal
DeFazio
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Emerson
Everett
Ewing
Fawell
Fields (LA)
Fields (TX)
Fish
Fowler
Franks (CT)
Franks (NJ)
Gallegly
Gallo
Gekas
Geren
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Grams
Greenwood
Gunderson
Hall (TX)
Hamilton
Hancock
Hansen
Hastert
Hayes
Hefley
Herger
Hilliard
Hobson
Hoekstra
Hoke
Holden
Horn
Huffington
Hunter
Hutchinson
Hyde
Inglis
Inhofe
Istook
Johnson, Sam
Kasich
Kim
King
Kingston
Klink
Klug
Knollenberg
Kolbe
Kyl
Lancaster
LaRocco
Laughlin
Lazio
Leach
Levy
Lewis (CA)
Lewis (FL)
Lewis (GA)
Lewis (KY)
Lightfoot
Linder
Livingston
Lucas
Machtley
Manzullo
McCandless
McCollum
McCrery
McCurdy
McDade
McHugh
McInnis
McKeon
McMillan
Mica
Michel
Miller (FL)
Molinari
Mollohan
Moorhead
Myers
Nussle
Ortiz
Orton
Oxley
Packard
Parker
Paxon
Payne (VA)
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Porter
Portman
Poshard
Pryce (OH)
Quillen
Rahall
Rangel
Ravenel
Regula
Ridge
Roberts
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Royce
Santorum
Sarpalius
Saxton
Schaefer
Schiff
Scott
Sensenbrenner
Shaw
Shuster
Sisisky
Skeen
Skelton
Smith (IA)
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Snowe
Solomon
Spence
Stearns
Stenholm
Stokes
Strickland
Stump
Stupak
Sundquist
Talent
Tanner
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thomas (CA)
Thomas (WY)
Thurman
Torkildsen
Unsoeld
Upton
Volkmer
Vucanovich
Walker
Walsh
Washington
Waters
Watt
Weldon
Williams
Wilson
Wise
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

☐ 1714

Mr. HAYES changed his vote from "aye" to "no."

So the resolution was not agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

REQUEST BY MEMBER TO ADDRESS THE HOUSE FOR 1 MINUTE

Mr. GINGRICH. Mr. Speaker, I ask unanimous consent to proceed out of order for 1 minute.

The SPEAKER. Is there objection to the request of the gentleman from Georgia?

Mrs. COLLINS of Illinois. Mr. Speaker, I object.

The SPEAKER. Objection is heard.

REQUEST BY MEMBER TO ADDRESS THE HOUSE FOR 1 MINUTE

Mr. THOMAS of California. Mr. Speaker, I ask unanimous consent to proceed out of order for 1 minute.

The SPEAKER. Is there objection to the request of the gentleman from California?

Objection is heard.

REQUEST FOR GENERAL LEAVE ON HOUSE RESOLUTION 517

Mr. DERRICK. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks on the debate of House Resolution 517.

The SPEAKER. Is there objection to the request of the gentleman from South Carolina?

Mr. SOLOMON. Mr. Speaker, I object.

The SPEAKER. Objection is heard.

LEGISLATIVE PROGRAM

Mr. GEPHARDT. Mr. Speaker, I ask unanimous consent to address the House for 1 minute.

The SPEAKER. Is there objection to the request of the gentleman from Missouri?

Mr. BURTON of Indiana. Mr. Speaker, reserving the right to object, I would just like to make one comment. That is this, Mr. Speaker. We take it on the chin all the time, and I do not understand why the liberals cannot at least once in a while show a little tolerance.

Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER. Is there objection to the request of the gentleman from Missouri?

There was no objection.

Mr. GEPHARDT. Mr. Speaker, I would like to announce to the Members of the House that I think it would be advisable if we do not go forward with the remaining business on the schedule today, and return to it tomorrow.

I also would like to tell Members that a little later today we hope to be able to give a more definitive judgment on what will go on beyond tomorrow. We are not prepared at this moment to do that, but we will do that as quickly as we can a little bit later this afternoon.

Mr. Speaker, I think it would not be, perhaps, wise to go forward with more business this afternoon.

Mr. GINGRICH. Mr. Speaker, will the gentleman yield?

Mr. GEPHARDT. I yield to the gentleman from Georgia.

Mr. GINGRICH. Mr. Speaker, I appreciate the gentleman from Missouri yielding to me.

Mr. Speaker, all I wanted to say earlier was, this is one of several very serious national issues we are trying to deal with. We often have disagreements of a variety of kinds here. We would hope that we could go back to conference, as that is what this vote signals, and that we could work together and produce a bill on which we could vote for a rule.

Mr. Speaker, we sent a letter that the gentleman from Illinois, Mr. MICHEL and Mr. HYDE, the gentleman from Florida, Mr. MCCOLLUM, the gentleman from Texas, Mr. ARMEY, and I signed indicating what we would be willing to talk about and things we can work out together. I do not think the House should leave tonight with the feeling that this is at a dead end. I hope we can pick this up tomorrow and work in conference and produce something together.

Mr. Speaker, I appreciate the gentleman yielding to me.

Mr. Speaker, for the RECORD I include the letter just referred to, addressed to the President of the United States, dated August 9, 1994:

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, August 9, 1994.

Hon. WILLIAM J. CLINTON,
President of the United States, the White House, Washington, DC.

DEAR MR. PRESIDENT: Contrary to the assertions of some in your Administration, the crime conference report is not stalled because of the assault weapons provision, but instead due to the more than $9 billion in new social welfare spending. We are writing to offer our assistance in moving a real crime bill that will get more police on the street and more violent criminals in prison now.

Mr. President, you have been quoted in the press as touting this bill as the largest crime bill in history. But bigger doesn't necessarily mean better. In a matter of days or even hours, the law enforcement provisions of the crime bill could be beefed up and the social welfare spending dramatically trimmed down to produce a product that will crack down on violent crime, but not bust the budget.

Specifically, we are willing to work with you and congressional Democrats to revise the crime bill in the following ways:

Restore the new State prison funding to the $13.5 billion passed by the House, allocated under the terms of the so-called Chapman formula currently in the bill.

Restore the so-called Gekas provisions passed by the House to strengthen the death penalty procedures.

Follow the overwhelming view of the House shown by its motion to instruct conferees and restore the Dole-Molinari-Kyl provision on the admissibility of evidence of similar crimes in sex offenses,

Remove the hiring quotas and other bureaucratic conditions on receiving grants to hire police,

Remove the more than $9 billion in social welfare spending and replace it with the Senate's full funding for the Byrne grant program to ensure that the money we spend in this bill is truly directed at crime prevention.

Many Republicans have other concerns about this bill, but we believe that if you and congressional Democrats strengthen the crime bill along the lines suggested above, you would have overwhelming Republican support—and overwhelming support in Congress as a whole—for this truly tough, anti-crime legislation.

Because we realize that there are some in your party who feel strongly about the new social spending provisions, Republicans would be willing to support a rule allowing for the consideration of a social welfare spending package as a separate bill after we have passed the consensus crime bill outlined above. That means Congress would have an opportunity to both pass a tough anti-crime bill that puts more police on the street and more violent criminals in prison, and consider a package of new social welfare spending. This approach would avoid the gridlock that has developed within your party as a result of the current strategy of tying these issues together in one bill assuming that Members will hold their nose and vote for anything that has police and prison funding.

The American people are demanding action now on a tough anti-crime bill. We look forward to working with you to draft such a bill this week so that we can move immediately to consideration of a bill that commands overwhelming bipartisan support.

Sincerely,

BOB H. MICHEL,
Republican Leader.
DICK ARMEY,
Conference Chairman.
NEWT GINGRICH,
Republican Whip.
HENRY HYDE,
Policy Committee Chairman.
BILL MCCOLLUM,
Conference Vice Chairman.

Mr. MICHEL. Mr. Speaker, will the gentleman yield?

Mr. GEPHARDT. I yield to the gentleman from Illinois [Mr. MICHEL], the minority leader.

Mr. MICHEL. Mr. Speaker, if we are to have no further business today, and there is this consultation that will take place here that will give us some indication of the schedule for tomorrow or next week, would we have a notice, then, to the majority and minority rooms to get out a whip notice of how that will work?

Mr. GEPHARDT. Mr. Speaker, that is correct. As soon as we can do this consultation, we will be in consultation with the minority. Then we can make a joint statement available through the Cloakrooms.

Mr. MICHEL. I thank the gentleman.

GENERAL LEAVE

Mr. DERRICK. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on House Resolution 517.

The SPEAKER pro tempore (Mr. KILDEE). Is there objection to the request of the gentleman from South Carolina?

There was no objection.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of February 11, 1994, and June 10, 1994, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

URGING BIPARTISAN COLLABORATION ON THE HEALTH CARE REFORM BILL

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. HORN] is recognized for 5 minutes.

Mr. HORN. Mr. Speaker, we saw a dramatic event in the modern life of the House just a few minutes ago: A rule was turned down. It was not supported by a majority of the majority in this Chamber. That rule was turned down because it reflects one of the problems that a number of us have been talking about over the last week and a half, since we heard of the schedule that was set for consideration of the health care legislation.

Mr. Speaker, the various bills that relate to health care are among the most important that the 103d Congress will consider. Indeed, you could say, since it involves 14 percent of the American economy, it is the most important piece of legislation that the House of Representatives will have acted upon in a generation.

Many of us believe, and have long believed, that it is essential to have proper coverage for American citizens in terms of health insurance. Reasonable people can disagree on the way that goal is to be achieved.

Mr. Speaker, the shocking thing I have found in being a Member of this Chamber for a year and a half is that there has been very little bipartisan collaboration between the leadership of the majority party and the rest of us. However, there are two bipartisan bills which a lot of us support, the so-called Cooper-Grandy bill, and the Rowland-Bilirakis bill.

□ 1730

Hopefully they will not be preempted by the Committee on Rules which was overruled today, because many of us are unhappy with the authoritarian way legislation is considered in this House. Try to find out what the Committee on Rules said or was going to say, try to find the conference report as was well-described to the House this afternoon. The conference finished in late July. The first time we saw a printed report of the conference on the Republican side was at 3:20 p.m. this afternoon, August 11.

There is something wrong with a system where we constantly waive the mandate of the 1946 Legislative Reorganization Act which said reports ought to be available for 3 days prior to consideration in the House. Hopefully on health care, the current schedule will also be overthrown by the leadership that established it. Hopefully some of the people listening to the House proceedings will have written, phoned, faxed the leadership of this Chamber to say, we think our Representatives have a right to study the thousands of pages that are not yet printed, except in the CONGRESSIONAL RECORD, but in a formal bill sense, we think they have a right to analyze it and discuss it, but more important, to go home, to talk to the constituency that sent them here and hear from the people in your district as to the impact of this legislation before we have a vote in this Chamber. To have a vote on health care next week when nobody has read these bills but perhaps the author is an absolute insult to this institution. I would think that the degradation that has been brought to this institution by the type of arbitrary conduct we have seen in closed rules, few chances to amend, few chances to have amendments considered on the floor, I think back to the campaign finance reform effort. There was the Democratic bill, and there was the Republican bill. The bill that should have been considered was the bipartisan bill headed by the gentleman from Oklahoma [Mr. SYNAR] and the gentleman from Louisiana [Mr. LIVINGSTON] on our side, We had 5 or 10 bipartisan coauthors. Yet that bill, which would have passed this House, never was brought to the floor. The reason it was never brought to the floor was that it could pass this House.

As one friend of mine in the Democratic leadership said to me last year when I had a proposal to the Committee on Rules, "STEVE, you know we can't clear that. If we sent it to the floor, it would pass."

Well, the last I knew, not just from grammer school civics but from high school civics and political science was that the people's house was the place that ideas should be considered and should be voted up or down. We do not have the freedom to debate as they do in the Senate. We do not have the freedom to tie and place in knots as they do in the other body, but we do have the freedom to vote if only we can get the legislation before us. This is why we see over 25 discharge petitions. Thanks to the courageous leadership of the gentleman from Oklahoma [Mr. INHOFE], we have freed up the discharge petition process.

Mr. Speaker, we came as a class of reformers, Republicans and Democrats. I have not heard much from the Democratic side on some of these key reforms, but certainly the aroused Republican freshmen, upset about this schedule on health care and wanting to meet with our constituents, we hope the leadership will take the turndown of the rule on the crime bill, and I might say I support the crime bill but I voted against the rule simply because of the arbitrary actions being increasingly taken in this Chamber. The sooner the Democrats join the Republicans in wanting to liberalize the process of this Chamber, the better off this Nation will be.

THE UPCOMING MEXICAN ELECTIONS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Arizona [Mr. KOLBE] is recognized for 5 minutes.

Mr. KOLBE. Mr. Speaker, 2 days ago I took a 5-minute special order in order to discuss the forthcoming elections in Mexico with my colleagues. Considering all the critical issues that we are dealing with here, I know it is very hard for us to turn our attention to something which seems as remote as that and far removed from our own domestic policy concerns as well as our own domestic political concerns. But I want to take this 5 minutes just to continue to share a few observations based on my visit to Mexico this past weekend where I had an opportunity to meet with election officials as well as political party individuals and to see some of the work that is going on with regard to this election. Because, Mr. Speaker, I think this election is not only, as I said 2 days ago, the most important in Mexico's history, this election may also be one of the most important for the United States for our foreign policy in Latin America and certainly for our relationship with Mexico.

It is my view that the Government of Mexico has done everything that is conceivable to try to ensure a fair and open and free election, one that is devoid of the kind of manipulation that has characterized past elections in Mexico. That is not to say, Mr. Speaker, that there will not be inequities in the election, that there would not be things that would be characterized as illegalities or unusual procedures, but I believe that at the level of the Government of Mexico, every effort is being made to minimize those and to assure that that does not occur. But an election as we know consists of thousands and tens of thousands of people all over the country manning polling booths from the large cities to the small communities in that country as well as it would in this country. So some of inequalities and the illegal procedures that may creep in may be done at a very local level.

What is the outlook for this election? There are three major candidates and four others who are minor candidates who are running. The three major candidates represent the party of the government, the PRI; they represent the traditionally conservative market-oriented party called the PAN; and the leftwing, or more liberal party, the PRD. The PRI has not lost an election since 1927 when it was formed. It is likely this time, in my judgment, to come out on top with the vote but probably for the first time in its history without a majority. Obviously, I cannot say. My judgment is only based on conversations and polling data that I have seen, not on anything else that I could judge. But I believe that it is likely that we will see a victory by a plurality perhaps for the PRI but with very close following by both the PAN and the PRD. That is going to mean a very major change in the politics within the country of Mexico, because it will mean that this government for the first time cannot claim to have the mandate of the majority of the people of Mexico. We have had that historically in our country in many, many elections and, of course, our current President was elected with considerably less than 50 percent of the electorate. But that does not mean he cannot govern and it does not mean that the President of Mexico would not be able to govern. But it does mean reaching a different kind of consensus than has been done in the past in order to achieve a government that can work effectively with minority parties.

Mr. Speaker, I believe that these elections are of enormous importance to Mexico as they proceed with the transformation of their country to a democracy. The changes that have taken place in Mexico under President Salinas have been enormous, but they have been largely geared toward economic reform. Now we are seeing the next step. Even as I argued the other day in the China MFN debate that increased trade and increased economic activity will lead to increased political freedom, that is exactly what we are seeing in Mexico.

So I want to urge my colleagues as we finish up our work around here for the month of August, before we go home, to try to keep some of their attention on this absolutely critical election for our neighbor to the south of us, a neighbor with a rapidly growing economy, a neighbor with 85 million people in it, a neighbor which is vital to our own interests in Latin America and the world. I know that all my colleagues join in wishing the Mexican people well in this election as they move toward a transformation to democracy.

□ 1840

CONGRESSIONAL ACCOUNTABILITY AND HEALTH CARE REFORM

The SPEAKER pro tempore (Mr. LEHMAN). Under a previous order of the House, the gentleman from Washington [Mr. KREIDLER] is recognized for 5 minutes.

Mr. KREIDLER. Mr. Speaker, yesterday we passed the Congressional Accountability Act, which brings Congress under the same regulations as other employers. We also voted to add health care reform to the list of laws—so that whatever health care reform we pass will apply to Congress too.

This wouldn't have happened without pressure from those of us in the freshman class. We know that Congress ought to play by the same rules as everyone else. There's no excuse for letting Congress off the hook for the laws we pass.

It's about time. Congress enacted the Fair Labor Standards Act in 1938, the Civil Rights Act of 1964, the Occupational Safety and Health Act of 1970, the Americans with Disabilities Act in 1990. These are good laws, and all other Americans are supposed to follow them. Now Congress will too.

Next week we will decide whether every American family deserves the same kind of health coverage we and our families have. Members of Congress don't have a special health plan—we have the same plan as other federal employees. Members of Congress don't get free health care—we pay for part of our premiums just like other federal employees.

But there's no question that we have a good deal—shared responsibility, security, choice, and quality. And I think every American ought to get just as good a deal.

But some of the people on this floor don't agree with that. They don't want to guarantee health security for everyone. They think that means too much Government. They think health care reform is too tough, too hard, too complicated to pass. They're afraid of making the real decisions on this issue. But in my State of Washington we've already done this, and I'm here to tell you, if my State has the guts to confront this issue, then we ought to be able to do it here.

So I hope people who don't want reform this year, who don't think we need it, who think we ought to wait—I hope they'll be the first to volunteer to give up their health security, right after they vote to take it away from others.

I don't plan to vote that way.

I plan to vote for the Guaranteed Health Insurance Act, because it does what the American people want and deserve: Health security for everybody. Keeping the cost of care from spiraling out of control. Guaranteed choice of health plans and doctors. Maintaining the high quality of care in America. Keeping health insurance in the private marketplace. Letting States like Washington move forward with their own plans.

I hope my colleagues who don't share those goals will be the first to step forward and give up their health security.

THE CRIME BILL

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. DORNAN] is recognized for 5 minutes.

Mr. DORNAN. Mr. Speaker, there is nothing unseemly after a historical vote to come to the well and gloat, but there is nothing wrong with giving good advice that would serve the good of the commonwealth and the people of this country.

This rule that we just voted on on the conference report was on a bill called a crime bill. It was not titled a crime and criminal welfare bill, but obviously what caused it to go down by a vote of 225 to 210, with 11 Democrats voting the way Mr. FOLEY requested they vote and 58 Democrats, 88 days from the eve of an election, voting against the leadership of their party, 58 Democrats voting 88 days out from the evening before the November 8 election. That means that there was some fatal flaw in this crime bill, and the fatal flaw was the larding on of social and criminal welfare pork.

This bill started out about in the neighborhood of the billions of dollars of the defeated, so-called stimulus bill of Clinton, somewhere in the high teens of billions. Suddenly it was into the $22 billion, $25 billion, $28 billion a few weeks ago, and it ends up over $33 billion, and almost a half chunk of it for all of these bizarre new entitlement programs that, like all of the entitlement programs of the last 40 years, start on a growth and then suddenly on their growth charts they take off into almost a near vertical climb.

This was a good defeat for the rule on this, and as the minority whip, Mr. GINGRICH said just a little while ago, let us come back tomorrow, the leadership of both parties in an inclusive way of the loyal opposition here and come up with a crime bill.

If Members think there was tension here, if they think it was fair for the press to describe our Speaker's expression as distraught, Mr. FOLEY is distraught, think of how they feel at the White House, think of how they are coaching Dee Dee Myers to spin this major defeat for Bill Clinton who was for all of the pork just larded into the so-called crime bill. They are pretty distraught down at the White House.

I will give him advice that is good for his party and for any potential, as remote as it may be, for him having a second term, and that is if he wants a crime bill, then focus on helping victims and on locking up criminals. Liberal Democrats think it is a joke. But the average American cannot stand the thought of color televisions, color pornography, Nautilus equipment in gymnasiums in prison, college courses leading to degrees, and they sure as hell, Mr. Speaker, do not want dance programs in the prisons of the United States with murderers leading one week and child molesters leading the step dancing to good country music the next week.

No, this billion was one of the strangest thing we have ever seen.

The remarkable travesty of the crime bill is think like, look, Mr. Speaker, we have spent $5 trillion on social programs since President Johnson's so-called Great Society program and what do we have for that? We have a 500-percent increase in violent crime since we have been throwing money at all of the broken families of this country. Liberals on the other side of the aisle seem to be obsessed with society's root causes. According to them everybody who commits a crime is not a criminal but a victim of poverty, bigotry, societal injustice. It is a perverse, absurd continuation of the funny line from the great Leonard Bernstein Broadway musical where the tough kids in that show sing to Officer Krupsky: We ain't depraved, we're deprived," and that was in the middle 1950s that that musical won all of the Tony awards on Broadway.

There is such a thing in society and in all societies as good, as evil. There are people who look at all of the options and decide that that tail-end line of the great radio show, Gangbusters, when I was a kid that echoed in the chambers, "Crime does not pay," there are young men and now young women who look and say crime absolutely does pay.

□ 1750

One of the safest crimes is to rape somebody if they will not date you. You know, the odds are 99 out of 100 you will never see a day of time if you violently rape some human being who does not want, who does not know you, if they do know you, does not want any part of you.

Crime pays, and they are evil people opting for crime, and we must lock them up, Mr. Speaker. Bring back a real bill and watch it win overwhelmingly. You bring back a bill focused on criminals, you get 100 percent of us on our side of the aisle.

Mr. DORNAN. I repeat, the most remarkable travesty of the crime bill is the billions of dollars spent on social welfare schemes that have, time and again, proven to be a complete failure. This presumption of root causes is what motivated Democrats to come up with misguided resurrections of failed social solutions from the past. In fact, the crime bill adds $8.7 billion to fund 30 new social welfare spending programs, many of which duplicate already existing programs that have had no effect whatsoever on crime rates. That represents nearly one-third of the funding in this bill.

Some examples are the millions of dollars to be spent on "community-based organizations" that will shower crime-prone youth with programs like midnight basketball, dance classes, and arts and crafts. While I have nothing against teaching kids how to shoot hoops and knit afghans, why is the Federal Government footing the bill for such programs in legislation aimed at fighting crime? This is absolutely absurd.

But there is more. This bill also provides for "Model Intensive Grants" intended to bring "meaningful and lasting alternatives to involvement in crime" and relief to "conditions that encourage crime." So vaguely written, this program like most others in this bill, simply translates into petty cash for local communities—cash that was promised by Democrats in last year's "economic stimulus package" but never delivered.

Yet Bill Clinton and the Democrats are welcoming the crime bill with open arms, calling it the "toughest, largest, smartest federal attack on crime in the history of our country." It may be the largest, but it is soft and dumb. One of the toughest provisions, they claim, expands the list of crimes that are punishable by the death penalty. Yet while it does add dozens of new crimes to this list, Bill Clinton is going to make certain the death penalty is rarely, if ever, enforced. That is because he has quietly promised the most liberal members in the House that he will order federal prosecutors to consider racial inequities in cases involving capital crimes. With the introduction of racial quotas into the criminal justice system, we can expect this nation to see an end to death penalty as we know it.

Another celebrated component of the crime bill is the "three strikes and you're out" provision. While this may sound tough, it is not. In fact, this sentencing provision will only apply to 1 percent of the crimes that occur throughout the country, since the third crime occur on federal property for it to be eligible for this new punishment. If baseball adopted a similar rule, you would be out only if the third strike occured in, say, Fenway Park.

And though the president had promised to put 100,000 new police officers on the streets of America, only 20,000 positions are being funded through this bill. It is up to local governments to fund the remaining positions—another unfunded mandate. Therefore, at most we can expect an average of one extra police officer per department throughout the nation. Anybody feeling safer yet?

Democrats are also pretending that this bill will provide more space to lock up violent criminals. That is baloney. Republicans fought tooth and nail to ensure adequate funding for new prisons coupled with incentives for states to enact tougher sentences. But the Democrats changed the crime bill so that it now allows states to divert prison grants to other programs. And while it calls for longer prison terms by making "truth-in-sentencing" a condition for federal funding, there are numerous loopholes for states to avoid that requirement.

I am also opposed to the bill's prohibition on a number of assault weapons. Banning a handful of guns is not going to have any real effect on crime and my colleagues know it. It is just one more provision that diverts attention from true impact-on-crime solutions.

Mr. Speaker, the list goes on and on. This crime bill is a total sham that only empowers criminals and further exploits innocent victims. Furthermore, it provides little more than a means for Democrats to deliver pork to the folks back home in perfect time for the election. My colleagues should be ashamed. There is not one American who can expect to feel safer if this bill passes and is signed into law. Not one.

The problem is that liberals are so busy coddling the ACLU they refuse to give the American people what they really want—a tough and effective crime bill that provides genuine truth-in-sentencing, strengthens the death penalty instead of killing it, reforms the exclusionary rule, puts more cops on the beat, toughens the juvenile justice system, and reforms habeas corpus.

The American people deserve better than this crime bill and it is incumbent upon Congress to deliver. This is nothing more than a package full of goodies for the folks back home—none of which provide real solutions to the problem of crime in America. I therefore implore my colleagues to vote no on the rule and final passage. No crime bill would be far better than this one.

Mr. Speaker, I also would like to insert this LEAA handout titled: "Law Enforcement Does Not Support This Crime Bill."

The gun ban and magazine capacity prohibition in this crime bill will drive a wedge between law enforcement and honest citizens; it will turn some 20 million + law-abiding gun owners into potential felons because law enforcement recognizes it is impossible to determine which components (magazines) were legally owned prior to the effective date of this prohibition.

National leaders of select police organizations (such as Fraternal Order of Police and the International Association of the Chiefs of Police) are attempting to generate support by making grave misrepresentations to their members and they also have conflicts of interest:

IACP has recently received over $400,000 from the Clinton Administration (Law and Order Magazine, May 1994) prior to their announced support of this legislation; IACP also represents less than ⅓ of the chiefs in this country.

FOP is telling their members there is a "police exemption" for law enforcement, the truth is the so-called exemption does not cover officers' off-duty weapons, nor does it apply to retired officers; it will adversely affect every department in the country where officers purchase their own weapons.

If this legislation passes there will be a severe backlash from these officers who have been mislead into supporting this legislation, targeted both at their organizational leaders and their elected representatives in Congress.

Every major survey of America's police conclusively proves that police officers do not believe that more gun control will have any impact on crime or criminals.

National Association of Chiefs of Police, '94 Annual Survey: 88.7% responded that a ban on so-called "assault weapons" would not help reduce crime.

Southern States Police Benevolent Association, June '93: 96.4% strongly support firearms ownership for self-defense, 95.8% reject an outright ban on guns, they rated stricter gun control as the LEAST effective option for reducing violent crime.

Police Magazine, April '93: 85% did not support an "assault weapon" ban.

Law Enforcement Technology Magazine, August '91: 85% of "street officers" opposed gun control and 90% did not support an "assault weapons" ban.

This bill contains well over $8 billion worth of social welfare spending that has nothing to do with genuine law enforcement.

MOST CRIMINAL DEFENDANTS COME FROM BROKEN HOMES

The SPEAKER pro tempore (Mr. LEHMAN). Under a previous order of the House, the gentleman from Tennessee [Mr. DUNCAN] is recognized for 5 minutes.

Mr. DUNCAN. Mr. Speaker, before coming to Congress, I spent 7½ years as a Criminal Court Judge.

I tried primarily the felony cases, the more serious cases.

In that time, I suppose I went through 7,000 or 8,000 cases, because 96 or 97 percent of the defendants pled guilty, and most had more than one case.

The first day I was a judge, Gary Tullock, the Chief Probation Counselor for east Tennessee, told me that 98 percent of the defendants in felony cases came from broken homes.

In almost all the cases I handled, I would get detailed reports about a defendant's background.

Over and over, I would read "Defendant's father left home when Defendant was two and never returned;" "Defendant's father left to get pack of cigarettes and never came back."

I became convinced that the greatest problem we have in this Nation today is the fact that so many homes are broken, and more specifically, that so many boys are growing up without fathers or with no male influence in their lives.

A few months ago, I read a column in the Washington Times in which two leading criminologists had studied 11,000 felony cases.

They reported that the single biggest factor in crime, the single most consistent factor was father-absent households.

All of this is to explain why I was so very much impressed by a column in today's Washington Times by Mona Charen, the syndicated columnist and television commentator.

I wish every American could read this column. Its message is so very, very important to our survival as a nation.

Mona Charen wrote this:

REMAINS OF THE CULTURE

Two extremely active preschoolers keep me more or less permanently behind the times on the subject of movies. But I did recently see "The Remains of the Day" on tape.

The movie reminds one, once again, of the essential fragility of things that seem so enduring.

Look at the social hierarchy depicted, accurately I think, in that film. The code of duty, honor and responsibility that was so ingrained in generations of Britons—a code that was strong enough to keep the butler serving at table even while his father lay dying upstairs—all of that has been swept away in a heartbeat.

One of the differences between conservatives and liberals is that liberals tend to think you can tinker with social, economic and political arrangements endlessly, while conservatives believe that the veneer of civilization is actually quite thin—and too much tampering with the foundations will bring the whole thing down.

What puts our civilization at risk? What forces are at work that could make 1994 America look as antique 50 years from now as the butler's world looks to us in "The Remains of the Day"?

The forces that were unleashed by, roughly speaking, Woodstock—a lamentable anniversary—have been corroding the foundations of our civilization for 30 years. These years have witnessed a thorough-going attack on the American character. Instead of inculcating notions of honor, self-reliance, duty and responsibility, we have become a nation of self-pitying whiners, fast with a lawsuit and slow with child-support checks. We wallow in excuses for poor products and lousy test scores.

But the most worrisome aspect of the decline of character is reflected in families. To an unprecedented degree, American men are not performing their jobs as fathers.

David Blankenhorn directs the Institute for American Values in New York. Together with Don Eberly of the Commonwealth Foundation in Pennsylvania, he has launched the "Fatherhood Initiative."

There is, these men believe, nothing more important to the health of society than men undertaking the role of father. "There is very little you can do to sever the ties between women and their children," Mr. Blankenhorn notes. "Crack cocaine can do it, but that's about it. Otherwise, the emotional ties are firm."

But men are different. Men can detach themselves with their children, and our experience of the past 30 years has shown just how easily they can let go (and just how fragile are the foundations of civilization). Without the strong societal message that to be a good man means shouldering the responsibilities for your wife and children, many men are content to abandon their families.

And when they do, the results for children are catastrophic. Sixty percent of rapists, 72 percent of adolescent murderers and 70 percent of long-term prison inmates grew up in fatherless homes. Forty percent of American children now live in families without their biological fathers. Half of these have never been in their father's home.

But it isn't just at the pathological extremes that father absence works its mischief. Every child needs a father. A boy needs a father to show him what it means to be a man. He learns how to treat women by watching the way his father treats his mother. Girls derive ambition, self-confidence and a general attitude toward men from their relationship with Dad.

This is not to slight mothers. Mothers are crucial, too. But mothers are not abandoning their children. As Mr. Blankenhorn notes, it is not necessary for society to urge mothers to undertake their responsibilities.

But the data are quite clear that mothers alone have a tough time socializing their children, particularly their sons. And they have a tough time making ends meet. Seventy-five percent of children in single-parent families experience poverty before the age of 11.

For 30 years, our culture has been at war with fatherhood. It was claimed that fathers were stifling, emotionally remote, overly strict and, ultimately, superfluous. Feminists who see today's challenge as getting fathers to pay child support are missing the point. The great challenge is to return men to the business of being fathers.

Mono Charen is exactly 100 percent right in everything she says in this column.

Unless and until we heed her words, we can pass crime bills until we are blue in the face, and it will do absolutely no good whatsoever.

COMMUNICATION FROM THE HONORABLE JOHN L. MICA, MEMBER OF CONGRESS

The SPEAKER pro tempore laid before the House the following communication from the Honorable JOHN L. MICA, Member of Congress:

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, August 9, 1994.

Hon. THOMAS S. FOLEY,
Speaker, House of Representatives, Washington, DC.

DEAR MR. SPEAKER: This is to formally notify you pursuant to Rule L (50) of the rules of the House that my office has been served with a subpoena issued by the State of Florida, Division of Administrative Hearings, in connection with a civil case involving constituent casework.

After consultation with the General Counsel, I will determine if compliance with the subpoena is consistent with the privileges and precedents of the House.

Sincerely,

JOHN L. MICA,
Member of Congress.

THE HEALTH CARE PLAN: WE CAN DO MUCH BETTER

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan [Mr. HOEKSTRA] is recognized for 5 minutes.

Mr. HOEKSTRA. Mr. Speaker, I rise tonight to talk about the debate that we are about to enter, the health care debate, and I want to lay out the proposition that we can do much better than the plan that is out in front of us today.

Last night, nine health care bills were turned in to the Committee on Rules, nine new health care bills. I have to give the chairman of the Committee on Rules credit. He took those nine bills and inserted them into the House RECORD so that this afternoon we were able to receive copies of those nine new bills and begin the process of understanding what is in each of those bills.

Take a look at the process that is currently laid out in front of us. On August 10 we get nine bills. On August 11 we received the actual verbiage that is found in those nine bills.

I testified in front of the Committee on Rules this afternoon proposing an open rule, but knowing that that is probably very unlikely, and also knowing that today I had to propose two amendments, an amendment on wellness and an amendment on States' rights, providing States with the options to choose whether they wanted to participate in a national health care program without really knowing what is in the bills.

I am part of the Committee on Education and Labor. We went through the Clinton bill, the original Clinton bill. We had 29 days of hearings. We had 8 full weeks of markup where we actually went through the amendment process, and we went through the bill section by section. We had 4 weeks in subcommittee; we had 4 weeks in full committee. In full committee we had proposed 99 amendments: 44 Democratic amendments were accepted, and 11 Republican amendments were accepted, 55 improvements to the Clinton bill, and that is all gone now, because we have a new Clinton-Gephardt bill.

So what is the process going to be when we come to the full House? What took place for 8 full weeks in committee and subcommittee, at least the schedule that is right in front of us now says we are going to complete that same process for nine bills in 8 days.

□ 1800

This House may be good, but I do not think we are that good.

I got a summary today, about a 30-page summary, of the Clinton-Gephardt bill. What do we know is in it? We know there are employer mandates in it, we know there are new taxes in the bill, we know there are subsidies for small business, we know those subsidies will phase out by the year 2005.

Generally, we know that there are exemptions to the bill. In our Committee on Education and Labor we created perhaps one of the most unique exemptions, by name we exempted the State of Hawaii. When I glanced at the summary of the Clinton-Gephardt bill, I saw there was an exemption for States with single-payer systems. Does that mean this House language that we put in place, again, the basis for the State of Hawaii to exempt itself from the national health care plan?

There were waivers for parts of the State of Tennessee. There was a waiver for Milwaukee. Why are these in there? Do we again have to propose to the full House the amendment defeated in the subcommittee and in full committee that said no State shall become a participating State in a national health care plan unless the voters of that State decide through a referendum process to become part of the national health care plan?

We know that there are penalties in this bill, penalties because we have created more paperwork. We have gone to health care providers and said that on an annual or quarterly basis, "You will be mandated to provide these types of reports, and if you do not, you will be facing these types of penalties."

We know that there is tort reform, or so-called tort reform. The tort reform in this bill appears to say that the innovation in the tort reform that has gone on at the State level will be preempted by what we are going to do here on the Federal level. This is a significant victory for the trial lawyers.

I found these parts and these topics in the Clinton-Gephardt bill, from a 32-page summary of the bill. It appears that when I finally have the full bill, it will be close to somewhere between 1,000 and 1,500 pages.

What else is in the bill, and exactly how do we come up with mandates? How many new taxes do we have? Who do they affect? What kind of subsidies do we have? For how long? Who is exempted? How do other parts of the country become exempted? Who is facing penalties? Who is facing criminal charges?

Who really benefits from tort reform?

Just in the Clinton-Gephardt bill there are way too many questions to be answered in the next days. And remember that we have 8 other bills that we should fully consider.

Now is not the time to move from outside of the committee process. Now is the time to really utilize the committees and use the House to fully understand, debate, and move forward on health care, but not in 8 days.

As freshman Republicans, we laid out a schedule. We said when the bills are submitted, let us have each sponsor of the bill walk us through the bill here on the floor of the House for a full day, allow that Member or that group of Members to take us through the bill step by step, section by section; allow us to go home to our constituents for 2 to 3 weeks to talk to our elderly, to talk to those without insurance, to talk to our small business people, to talk to our doctors and hospitals, to see how these bills will impact them.

Then to come back, have 8 to 10 days of debate, to vote, to have a conference with the Senate, and still have a final vote before we adjourn in October. This is a better process, a process that this Congress can be proud of, that the American people can trust.

It is time to reform how we do business in Washington. The process that we set up for the health care debate over the next 2 months will say a lot about this Congress. Are we going to compress it into 8 days? Or are we going to let the House work its will through a process of 8 weeks?

I hope we go for the process 8 weeks, it is a process that we can be proud of, it is a process that the country can be proud of.

WHAT THE REPUBLICANS DID VOTE FOR OVER THE PAST FIVE DECADES

The SPEAKER pro tempore (Mr. LEHMAN). Under a previous order of the House, the gentleman from Michigan [Mr. EHLERS] is recognized for 5 minutes.

Mr. EHLERS. Mr. Speaker, yesterday I addressed the topic of health care reform and much along the lines Mr. HOEKSTRA has just elucidated, but I also pointed out a very important aspect of it. In the limited time available yesterday I could not do justice to the subject. Several Members have asked me to give more detail on the issue.

The point I was making is that the process that has been set up to handle health care reform is a process that basically eliminates the opportunity for Republicans, and particularly the freshman Republicans, to have an input into the process.

The freshman Republicans came here with an idea of reforming the way Congress operates. They are very interested in contributing to the process and representing their constituents in the process.

But what particularly dismayed me was to find out a few days ago that the Vice President of the United States made the comment that the Republicans did not vote for social security, they did not vote for Medicare and they are not going to vote for health care so, "We should ignore them in the process."

Furthermore I have heard that comment in the well of the House by a number of speakers over the past few days, making much the same point and trying to justify the fact that Republicans have been shut out of the process.

Now, I am not a terribly partisan person, never have been, and I do not suspect I ever will be.

I am actively interested in participating in the health care debate as a bipartisan coalition working on health care reform. I happen to think there is a great deal we can do in this country to insure that everyone has access to health care and that they get quality health care.

But in particular I want to respond to the comments that I have heard made in the well of the House by some of my colleagues from across the aisle in which they have said the Republicans did not participate in passing social security.

If you look at the first line of the chart, you see that is simply not correct. In fact, in 1935, when the Social Security Act was passed, 83 percent of the sitting Republicans in the House of Representatives voted for the bill.

When you go down some of the other major acts passed over the past half century, the Federal Highway Act, more Republicans than Democrats voted for it; Civil Rights Act, 81 percent of the Republicans voted for that landmark legislation, almost 20 percent more than voted for it from the party on the other side of the aisle.

Medicare, where we appear not to have voted, 47 percent of the Republicans vote for it. So on down to the Clean Air Act Amendments and Water Pollution Control Act.

So you can see, if we follow the course we are on now when we consider the health care bills next week, as Mr. HOEKSTRA just said, we spend just 8 days on it, it is going to be a Democratic bill, passed with Democrat votes, and the last line will become accurate. You might get a few Republican votes, but by and large you can expect 83 percent of the Democrats to vote for it and 2 percent of the Republicans if it passes.

I think that would be a very bad precedent. I think history shows Republicans are eager to participate in these debates, to provide input and to be contributors to the process and to the content.

I hope that we can follow that same process here. But as Mr. HOEKSTRA said, let us make it 8 weeks, not 8 days.

Let us have an opportunity for an open debate on the floor of this Chamber. Let us have an opportunity for a rule that will allow us to offer amendments to improve it, because we are sincerely and earnestly interested in improving it.

I yield to the gentleman from Texas.

Mr. ARMEY. I want to thank the gentleman for bringing this special order and this special information to our attention.

It is extremely important to me that we focus on this. What we were running into today in our political discourses is that the word bipartisan is being used more as an indictment rather than as a strategy. And here your historical evidence demonstrates some of the facts that are being told are simply not true.

I was particularly impressed with the fact that if you go to the Civil Rights Act—and many times I have been told how we Republicans did not vote for the Civil Rights Act—81 percent of the Republican Members of House voted for the bill, 63 percent of the Democrats voted for the bill. I believe there was a Democrat majority, clearly a much greater number of Democrats voted against the civil rights bill, they voted with Bull Conner, who stood on the bridge in Alabama and beat people with a club and then represented the State of Alabama as a national committeeman to the national Democrat convention.

□ 1810

Now I understand that the health care bill is up, but if there is a bipartisan bill that wins, I promise you there will be a greater percentage of Republican votes than there will be Democrat votes for a bipartisan bill.

Mr. Speaker, if I may, I just wish to conclude by thanking the gentleman from Texas [Mr. ARMEY] for his comments, and also I want to thank the gentleman from Minnesota [Mr. PENNY] who compiled many of these statistics originally, and I wanted to give him credit for that. I think the figures speak for themselves, and they demonstrate that the minority party is anxious and willing to participate in the major issues of the day, and we hope we will have an opportunity to do that in the health care debate.

KEEP AMERICA'S PATENT SYSTEM

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Maryland [Mrs. BENTLEY] is recognized for 5 minutes.

Mrs. BENTLEY. Mr. Speaker, the American patent system is being targeted by Japan and some multinational companies by including changes in the patent system in the Uruguay Round of GATT now under consideration in Congress. Our competitors understand how critical the patent system is to America's economic strength.

In the early 1900's the government of Japan wanted to determine what made the United States such an industrial power. A team of investigators was dispatched to determine why America was so successful and the team concluded it was because of the patent system.

The official report stated:

> We looked about us to see what nations are the greatest, so that we can be like them. . . . We said, what is it that makes the United States such a great Nation? We investigated and found that it was patents, and we will have patents.

In the early 1980's Japan again determined the patent system was critical to America's industrial strength.

The new GATT establishes the patent term for a minimum of 20 years from the time of filing. The United States agreed to this. Now, the changes being advocated in the legislation would change the patent term to a maximum of 20 years from the time of filing. Limiting a patent term from the time of filing would harm the inventors and small businesses because many patents would not make it through the system before the term expired.

Many patents are not issued for several years. It was 29 years before Gordon Gould received his patent for the laser.

A friend from Michigan called this morning to remind me that it took 6 years for his patent to come through. There are many more stories about the length of time it takes to receive approval of a patent application. These changes will put the inventor at the mercy of the patent office. It is the patent office that delays patents and requires more information. If the United States copies the Japanese patent term which is 20 years from the filing date—then delaying the issuance of a patent for 18 or 22 years would rob the inventor of the patent protection for his invention.

These changes which are being included in the GATT were originally agreed to by Bruce Lehman, Assistant Secretary and Commissioner of the Patent and Trade Mark Office in an agreement he signed with Japan in January. These changes to the patent term were agreed to without a public hearing and totally ignoring the wishes of the small inventor who is so important to our system.

Under that system only the wealthy and powerful profited. To avoid this in America, authors and inventors are protected in the Constitution. Now, we once again are attempting to change the system to reward the rich and powerful, the big corporations. Inventors and small business cannot afford the money it takes for an invention with a short patent life. We cannot afford to accept these changes.

Remember, foreign governments also have pushed to have the American patent system weakened because patents are one measure of a country's economic strength and future prosperity. High quality patents which often are cited in patent filings, signal the emergence of important new technologies which will be under a patent holder's exclusive control for many years.

In 1993 the United States led the world in influential patents with 59,588 which is almost twice as many as Japan, Italy, the United Kingdom, France and Germany. No wonder these foreign countries want to cripple the American patent system. We are winning the technology race for prosperity—so why are we throwing the race? These changes must not stand.

JULY FOURTH PARADE BY BERLIN BRIGADE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida [Mr. HUTTO] is recognized for 5 minutes.

Mr. HUTTO. Mr. Speaker, today I want to address the House briefly to pay tribute to a group of service people from our armed services who have served us valiantly overseas since the end of World War II. Specifically, I want to focus on the Berlin Brigade.

It was my good fortune to be in Berlin this past Independence Day and participate in the final July Fourth Parade for this fine unit of the U.S. Army. I was privileged to attend a preparade reception at the historic McNair Barracks and to meet some of the troops, as well as dignitaries from a number of nations.

Among those present were the Director of the Central Intelligence Agency James Woolsey; Vice Chairman of the Joint Chiefs of Staff Adm. William A. Owens; U.S. Ambassador to Germany Richard C. Holbrooke; the distinguished Mayor of Berlin Eberhard Diepgen; the Commander-in-Chief of the U.S. Army—Europe, Gen. David M. Maddox; and the Commanding Officer of the Berlin Brigade, Maj. Gen. Walter H. Yates.

This was a special time and an emotional one for many, including some 20-plus former commanding officers of the Berlin Brigade. The Fourth of July ceremony in Berlin would have made any American proud. As the troops marched by the several thousand people in attendance, each of the units was treated to great applause.

The speeches were outstanding and moving as the Berlin Brigade, which involved thousands of American officers and soldiers for the last 49 years, bade farewell to the once divided city.

The addresses were delivered by the final CO of the Berlin Brigade, Maj. Gen. Walter H. Yates; U.S. Ambassador to Germany Richard C. Holbrooke; the Commander of the U.S. Army-Europe, Gen. David M. Maddox; and Berlin Mayor Eberhard Diepgen.

Mr. Speaker, I insert for the RECORD the speeches of General Maddox and Ambassador Holbrooke.

REMARKS OF GEN. DAVID M. MADDOX AT THE BERLIN INDEPENDENCE DAY PARADE, JULY 4, 1994

Ambassador Holbrooke, Regierender Bürgermeister Diepgen, Herr Minister Rühe, Congressman Hutto, Mr. Woolsey, Herr Dr. Bergner, Herr Dr. Knoblich, Admiral Owens, General Naumann, former CINC's, distinguished guests, and citizens of Berlin and soldiers of the U.S. Army Berlin, today is an important and significant day for Americans. I am delighted—and humbled—to commemorate this day with you, an Independence Day that is shared by Berliners and its Brigade in a special way.

As Americans celebrate our Independence today, I decided to join the Berlin Brigade because of the added significance of today's ceremony in this city with you. I'd like to thank the people of Berlin for joining the Brigade—your Brigade—today.

Let me talk about the significance of today:

One. Obviously, the 218th anniversary of American independence.

Two. The 49th anniversary of our entrance into this city.

Third and lastly, this is the final opportunity we have for the U.S. Army, your Berlin Brigade, to share the celebration of our independence, in Berlin, with the citizens of Berlin.

In Berlin, today is also a day of reflection on the last 49 years, of sadness at the end of a great relationship between the city and the Brigade, but more importantly, a day of fulfillment, of triumph and hope—as we look to a new future together.

To the citizens of Berlin and friends of the American Army: You are the reason we are here today.

For nearly half a century, you have been the light of democracy behind the darkness of the Iron Curtain;

You have kept the faith through the adversity of blockade, of isolation, of confronting face-to-face oppression—and you have held firm; triumphed; and won the greatest of all prizes;

And in the process, you have been great hosts, great friends, and great supporters of our soldiers, civilians, and their families.

From teaching your language, culture, and customs to opening your homes and taking care of our families as if they were your families while your brigade was deployed—on behalf of the U.S. Army in Europe, I would like to thank you, the people of Berlin, for your support, the closeness of the relationship that you have built with us for those 49 years.

To the soldiers of the Berlin Brigade, you have made all of us proud—Americans and Germans—because you have succeeded magnificently in every mission you were given—from your entrance into Berlin as occupiers, to defenders, to providers, to protectors, to great friends.

You have stood firm against adversaries here in Berlin—and have deterred conflict. You have gained the peace, kept the peace. You have been providers of comfort and able sentries—on three continents.

You have led the way, from standing down threats at Checkpoint Charlie to ensuring the security of Kurdish refugees in northern Iraq. And most recently, preventing the spread of the Balkans conflict into the former Yugoslavian Republic of Macedonia.

Soon, we will say, "Mission complete; well done; and take your soldiers home." And I want you to know that all of us appreciate your superb work.

Yet to a great degree, you won't be going home; you'll be leaving home.

Citizens of Berlin, on behalf of the United States Army in Europe, I thank you for all that you have done for our soldiers, for those you see here today and for their forebears for nearly half a century. Words cannot express all that you have given us or the depth of our gratitude, but I can tell you, as Walt Yates has told you, that you have won their hearts—our hearts—forever. They are not just the Berlin Brigade, they are Berlin Brigade—and you have allowed them the honor to carry your name, a name they will treasure as they, too, will always say, "I am a Berliner."

Berlin Brigade, and Berliners, thank you for your tremendous efforts that allow us to celebrate freedom—together. Enjoy a great day. This should not be a day of sadness with the forthcoming departure of your Brigade, but instead a day of joy and hope, recognizing the continued growth and maturity of the relationship between Berlin and America.

God bless you.

TEXT OF AMBASSADOR HOLBROOKE'S REMARKS JULY 4, 1994, AT THE FINAL U.S. NATIONAL DAY PARADE IN BERLIN

Exactly 49 years and 3 days ago, Lt. Col. Frank Howley and a small unit of American soldiers entered Berlin and camped out in pup tents in the Grunewald. They found a city destroyed by war, blasted, blistered, and battered. Berliners were homeless, cigarettes had become the most stable form of currency.

Forty-nine years ago today—July 4, 1945—Sherman tanks of the Second Armored Division, the famous "Hell on Wheels" Division, lined up in front of the old Telefunken electronics factory—now McNair Barracks—opposite two companies of the Soviet army. In the presence of General of the Army Omar Bradley the Stars and Stripes was raised and the Russian flag lowered to begin the American occupation of Berlin.

What was to follow in the next 49 years could not have been imagined by any Hollywood screenwriter. The U.S. Army, turning from occupying force into defenders of freedom, recommissioned in 1961 by President Kennedy as the Berlin Brigade, would turn into the most powerful and simplest symbol of our nation's commitment to defend freedom, not only in Berlin, but wherever it was threatened.

Men and women of the Berlin Brigade: for nearly a half century your presence here told the world that America's engagement in Europe is essential to security and prosperity on both sides of the Atlantic. Your determination during the first difficult post-war years created the basis for the German-American partnership, shaped its tone, and defined America's commitment to Europe. In 1948, in the late 1950s, their Brigade gave us our focus. Time and again you have impressed us with your tenacity, with your dedication to freedom and openness.

Because of your common efforts, we can stand together today in a free and united Berlin. With great pride and great humility, on behalf of President Clinton and the American people, I thank the people of Berlin for their determination and freedom; I thank our British and French allies for their solidarity; I thank especially the men and women of the Berlin Brigade; and I reaffirm the solidarity of Americans with people everywhere who cherish the blessings of liberty, people everywhere who consider themselves Berliners.

But we still live in a violent and uncertain world. Drawing down our force levels in Europe does not mean we are disengaging from the continent. The U.S. military is leaving Berlin because it has completed its mission. But Americans are not leaving Germany. We have been asked to stay and 65,000 American soldiers will remain in Germany, the bulk of 100,000 troops we will continue to station in Europe as a whole. We remain committed to the German-American security partnership within the NATO Alliance.

And so, even though the Berlin Brigade is departing Berlin, we Americans are not saying goodbye to your great city. In fact, over 10,000 civilian Americans now make Berlin their home, and thousands of other Americans from all walks of life are coming to this great city, thousands of Americans were attracted by its vitality, it's energy and its opportunity.

The fall of the Berlin Wall did more than liberate the people of eastern Germany, eastern Europe, and many former Soviet republics. It also liberated the German-American relationship from the need to focus narrowly on a common external threat.

The Cold War is over, we have entered a new era. I believe it will be the greatest that Berlin, the greatest that Germany, the greatest that Europe and America have yet known. You are striving to fulfill the dream of the United States of Europe, a Europe united in democracy, a Europe that can serve as our partner in a global challenge to extend peace and prosperity. We share your aspirations for the future, just as we shared your struggles in the past.

Almost a half century ago Berlin became the birthplace of the modern German-American partnership. The attitude of the Berliners in the first difficult post-cold war years was decisive for the transformation of Germans and Americans from enemies into allies. Today, the signals that come from this great city can again set the tone for our partnership.

"People of the World," Berlin's courageous mayor Ernst Reuter implored at the height of the Berlin Blockade, "look unto this city." We did, and we stood by your side. We will continue to stand together in the future. Just as we worked to tear down a wall of concrete and barbed wire we can tear down the walls in people's minds—and we must.

I cannot conclude without thinking of one of our great Supreme Court justices, Thurgood Marshall, who throughout his life worked for peace by fighting for justice. "We can run from each other," he said, "but we cannot escape each other. Knock down the fences that divide. Tear down the walls that imprison. Reach out: freedom lies just on the other side."

Next Tuesday, President Clinton will make a historic visit to this city. He will speak as the first American President to address a united, free and democratic Berlin. He will speak from the eastern side of the Brandenburg Gate. It will be a historic day and it will be concluded by the inactivation ceremonies for this great military unit that has been so important in the history of the cold war.

To the people of Berlin, let me say this: do not mourn the departure of the Brigade. Rather, celebrate their achievement. Join with celebrating their historic contribution to freedom, a mission now accomplished. And remember: the U.S.-German partnership is just beginning, especially here in this great city.

WHAT THE AMERICAN PEOPLE WANT IN HEALTH CARE REFORM

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Maryland [Mr. CARDIN] is recognized for 5 minutes.

Mr. CARDIN. Mr. Speaker, I take this time to review one of the bills that was filed last night with the Committee on Rules as an alternative or substitute to the Majority Leader GEPHARDT's bill on health care reform. I know my colleague, the gentlewoman from Connecticut [Ms. DELAURO] will be taking more time later this evening in a special order for 1 hour to review the various proposals, but I thought it was important that we at least bring out the fact that many of us have been looking to what substitutes will be filed so we can compare those bills to the bill that was filed by the majority leader, the gentleman from Missouri [Mr. GEPHARDT], to see whether any of these substitutes live up to any of the standards that I think the majority of this House and the majority of the American people want in health care reform.

□ 1820

First and foremost, we certainly appreciate our colleagues being willing to get involved in this debate. One of the substitutes that were filed is the so-called bipartisan bill that was filed by my colleague, Mr. ROWLAND, that I would like to talk a little bit about, because I think many of us were encouraged by bipartisan efforts.

We want bipartisan efforts. We want Democrats and Republicans to work together on health care reform. But we also want to make sure at the end of the day that we have real health care reform, that the bill carries out our commitment to the American people to provide universal coverage and affordable health care.

The so-called bipartisan bill, unfortunately, fails any reasonable test. If you look at what we need to do in health care reform, it fails in each and every one of the essential ingredients that we think is important in health care reform.

Let me go through some of the standards that I hope my colleagues will look at in reviewing these alternative bills. First, universal coverage. Does the bill provide universal coverage? The Gephardt bill does, no mistake about it. We get universal coverage, 100 percent coverage.

Some of my colleagues have been urging that 100 percent is not realistic. Let us go to 95 percent. Many of the people on the bipartisan effort said we will accept the 95 percent as the standard. Yet the bill brought out by Mr. ROWLAND by his own admission would accomplish maybe 90 percent by the year 2002. That is assuming we get full funding for the subsidies in the bill.

Let me tell you, the prior bills that were filed by many of the people behind the bipartisan bill at least had the courage to have revenues in them. This bill does not. The Rowland bill does not. So we are led to believe that without revenues, the subsidies are going to be financed. Yet there is a provision in the bill that automatically reduces the subsidies if monies are not available.

So I think it is reasonable to expect we are not going to have enough money to subsidize at 200 percent of the poverty level that Mr. ROWLAND put in his bill, so we will not even accomplish the goal he set out, the 90 percent, let alone 95 or 100 percent of the people covered by insurance. There is still going to be over 30 million people without health insurance. Quite frankly, I think we might find in 10 years we have made no progress in getting the uninsured covered.

Why is that important? It continues cost shifting. It makes it impossible for us to really control any reasonable health care system for a more orderly way of organizing the system. It makes it difficult for doctors and health care providers to locate in poor neighborhoods and rural areas where a lot of people do not have insurance.

We continue the cost shift for those who have insurance to those who do not. The people that really get stuck under the Rowland bill will be the middle-income people. The poor will have subsidies, the wealthy can afford insurance, and the working person, middle-income person, is the person who has no benefits.

Let me just give you a couple of concrete examples. A working couple, husband and wife, they would have to pay $4,600 to get health insurance under the Rowland bill, or 22 percent of their income. Under the Gephardt bill, that same couple would only have to pay $351 a year.

Let's talk about a family, a husband, wife, and children. Under the Rowland bill that family may have to lay out of pocket $6,175 a year. I do not think that is reasonable to expect, that a working family can afford that. Yet under the Gephardt bill, they would be asked to pay a little over $1,000.

How about those people who have insurance today, the working people who do have insurance? Under the Rowland bill they have a very good chance to see their premiums go up by a substantial amount, because you cannot do insurance reform unless you have universal coverage. The Rowland bill does not have universal coverage. It attempts to do insurance reform, and that is a formula for increasing the burden for working people who currently have insurance today.

Another major goal of health care reform is cost containment. We all know that we cannot sustain the ever-increasing cost of health care. We must bring down the overall growth rate.

The Rowland bill does absolutely nothing. I hope my colleagues will take the time to evaluate these bills, and I think if they do, they will find only the Gephardt bill accomplishes real health care reform.

BOB WEHR: AN OUTSTANDING AMERICAN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Missouri [Mr. HANCOCK] is recognized for 5 minutes.

Mr. HANCOCK. Mr. Speaker, to listen to some of my liberal colleagues here in Congress, and to the biased liberal news media, you would think that businessmen are the root of all evil. We are always hearing about heartless businessmen who are oppressing the working man, polluting the environment, and so on.

Our popular culture—through movies, television shows, and political rhetoric—has developed a negative image of businessmen. Well, I am proud to be a small businessman in the real world. I am proud of the jobs our company has created. And I am proud of the hard work I did, prior to being elected to Congress, building up a going enterprise, providing a valuable service to our customers and society.

It is time we started to look at what is right with American business, instead of unfairly vilifying the people who take all the risks to provide the jobs and prosperity for our Nation. Oh, there are some bad apples, to be sure. But you get that with every sector of society. Even the U.S. Congress is known to have a bad apple or two. I think it is time we started paying honor and tribute to the good apples—the men and women who have lived the American dream, founded companies, and prospered by it.

Today I would like to pay special tribute to a constituent of mine: Mr. Bob Wehr. Bob Wehr, now 69 years old, founded his company, Aarons Automotive Products, in 1959. He had the vision and the initiative to take a risk and fill a unique niche in the marketplace, rebuilding automatic transmissions. He took the risks, started a business, and over the course of 35 years grew it to its present size—employing around 800 people. And, of course, he made some money. He was so successful that recently he retired and sold the business for a large sum of money to investors who want to expand his business and create even more jobs. And the company is in very good hands. His son, Jim Wehr, who has worked in the family business since he was a teenager, will succeed Bob as president.

But Bob Wehr also did another very generous thing. When he announced to his employees, all assembled on the shop floor of his plant, his plans to retire and sell the company, he also told them he was taking $2.5 million of the profits from the sale of his company and paying them all bonuses—in gratitude for their loyal service.

That is what America is all about. Working hard, taking risks, and reaping the rewards—while living by a code of rock-solid integrity and kindhearted generosity. Bob Wehr is definitely one of the good guys. And Bob Wehr is a lot more like the other business people and entrepreneurs I know than the evil characters dreamt up by left-wing politicians and our liberal friends in Hollywood.

Bob Wehr did not need union demands to treat his workers fairly or honestly—indeed, his workers, like most working men and women in America, never had a need or desire to unionize. In fact, when the option to unionize was proposed, the employees voted it down 2-to-1.

Bob Wehr did not need some government bureaucrat or know-it-all Member of Congress to tell him how to run his company cleanly, safely, and honestly—and, yes, he has provided his employees health care benefits. Like most American businessmen, he just did it.

When you see someone like Bob Wehr and you think about the Democrat rhetoric bashing the wealthy, calling for punishing taxes on the rich, you just want to shake sense into them.

There is nothing wrong with being successful. In fact, it is something this country used to encourage. Successful people should be praised and emulated. They deserve our respect for what they have accomplished. They are examples for us and our children. After all, don't we all at least aspire to be successful? Wouldn't we all like to be rich? Isn't that what we want for our kids and grandkids—financial security and success?

If we expect to prosper as a nation, we need to encourage people to do what Bob Wehr did, not tax and regulate them out of existence.

We need to encourage, foster, and nurture entrepreneurship. We need to look to the business sector again as the positive, productive sector of our society. We need to give credit where credit is due to Bob Wehr and outstanding Great Americans just like him.

HEALTH CARE ALTERNATIVES

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from West Virginia [Mr. WISE] is recognized for 5 minutes.

Mr. WISE. Mr. Speaker, today several alternatives to the House leadership proposal have been introduced. One is called the Republican alternative offered by the gentleman from Illinois [Mr. MICHEL]. There is one called the bipartisan compromise by the gentleman from Georgia [Mr. ROWLAND] and a number of Members of the Republican party. Of course, the House leadership proposal, and it is my understanding other substitutes have been offered.

I want to commend all those who have introduced legislative language. I think in my discussion and analysis of the partisan substitute, I do not happen to agree with provisions in there, or actually perhaps better said, I do not agree with the fact it does not go far enough.

□ 1830

But I do think it is worthwhile that those people have come together and crafted a proposal. There are some useful parts to it, but I think it is important to look at it in its entirety.

Now, the reality of the situation is that health care requires a comprehensive approach. It is not like the crime rule that was just defeated in which there are a number of very important proposals in one bill but any one of the proposals can stand on its own. Police officers on the street can stand on its own. The ban on so-called assault weapons can stand on its own. The funding for prisons can be voted on separately or together. It does not matter. It can stand on its own.

Not so in health care. Health care is like a giant sausage balloon filled up with water. Do you know what happens if you squeeze down over here, if you take some action here, pop something, something pops up over here. You have to deal with it comprehensively.

The problem with these proposals is that while some of them have laudable insurance reforms, they would permit you to carry your insurance from job to job; they would say that an insurance company cannot deny coverage because of a preexisting condition; in some cases they would enable small businesses to set up pools that they could all be in and thus have greater market advantage, those are all laudable. The problem is to do those without having universal coverage, without having every person in our society with guaranteed private insurance that cannot be taken away and thus to have everybody contributing is to create that sausage balloon where you do something over here and make it worse over there.

I would encourage the drafters of the bipartisan substitute, for instance, to look at the State of New York. It attempted many of these laudable reforms just 2 years ago. Insurance reforms, in which it specifically said that a person could not be denied coverage for a preexisting illness. The problem was that they did not make it universal. So what happened is that those people who had preexisting conditions, those who were ill, they rushed, understandably and justifiably, to get into the system.

Then what happened though is the pool of people involved was such that the rates went up sharply. Furthermore, young people, the most well of our society, they opted out. They said, if I can get in when I am sick, who do I want to pay for insurance now when I am well? So they chose not to buy.

The cycle continued in that then many of the younger people who were working and often making the lowest wages, who had insurance saw their premiums increasing sharply so they out also, further worsening the cycle.

So that is what happens if you attempt band-aid health care reform. So that is why I think it is important that in analyzing these reforms, these bills, that you have to look at it to see, does it meet the benchmark of universal coverage, not just for a moral reason, I happen to think it is morally right that every American have health insurance, but also for the economic reason, the system does not work unless you have it.

Finally, Mr. Speaker, to those who would say, let us delay, and point to the fact that these bills were introduced today, these bills were not introduced today. These bills and their concepts have been with us for years. Indeed, for the last year and a half there has been nothing but discussion about these various pieces of legislation. President Bush introduced some of these provisions several years ago himself.

So the concepts have been there. What we are finally getting down to in this chamber, and I think the American people should be delighted in this, we are finally getting down to real bills and real legislation instead of simply rhetoric. The concepts are there. The problems are there. The issues are there. Now it is time to resolve them.

I welcome the introduction of these various pieces of legislation because now I think the American people truly can analyze, truly can evaluate and truly can choose.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LEHMAN). Under the Speaker's announced policy of February 11, 1994, and June 10, 1994, the gentleman from New Jersey [Mr. SAXTON] is recognized for 60 minutes as the designee of the minority leader

ANOTHER PERSPECTIVE ON THE ECONOMY

Mr. SAXTON. Mr. Speaker, I take this special order tonight because of several things that have happened in the recent past. Late last week, in my home town, Mount Holly, NJ, I got a call from a friend. He is a small real estate person, very small business. He has been in business for a number years, and he called me to tell me that he was closing his business.

He said, "I am closing my business because interest rates have begun to climb again. I remember what it was like last time during the late 1970s and early 1980s when they climbed and I am not going through that again." He said, "I just want you to know before you read it in the newspapers, hear it from somebody else, that I am going to close my real estate business."

Then I came here and earlier in the week a group of my friends from the other side of the aisle had a press conference out in the triangle, with the Capitol in the background, and the press conference was to tell the American people that the economy is wonderful, that everything is on the upswing, that there is good growth, and I think they said interest rates were down. And I said, somebody needs to add some perspective, because what my friend in the real estate business said to me earlier, late last week, was not the same as my friends from the Democrat side of the aisle said earlier this week.

So I take this special order, and with the cooperation of Mr. HUNTER, the Republican research chairman, Mr. RAMSTAD, from the Joint Economic Committee, Mr. ARMEY, from the Joint Economic Committee, and others, to add a perspective to this economic debate.

I guess one could ask the question, is the economy growing and is it growing as much as my friends on the other side of the aisle would like to think it is? I guess we could say, what kinds of jobs are being created and what rate of growth is there in the economy? Americans would certainly be interested to know in an historical perspective whether the economy really is growing and what kinds of jobs we are producing and what that rate is.

We might want to ask some questions about Bill Clinton's economic plan, "Clintonomics," as it has come to be called in recent times. What does it mean to have high taxes and interest rates growing are really legitimate questions that the American people should have some answers to.

And, in an historical perspective, is what we are in now anything like what we had during the late 1970s during the Carter administration? That is a legitimate question to ask.

To begin to answer the first question, these charts are helpful, because it shows in the red bars what the average growth during an economic cycle is when we are on the upswing, or better known in economic terminology, as a recovery. And so we took the average of all the economic recoveries since World War II and the rate of growth is in those, the average rate of growth is indicated by the red bars.

This recovery is different. While we are in a recovery and while there is some growth, the blue bars indicate what that growth is.

This chart happens to be job creation after a recession, the average, and job growth creation in this recovery, which is obviously much less. And so from an historical perspective, we can see that the jobs today that are being created are certainly not the same as they have been in recent history.

The next chart shows something similar. It shows gross domestic product growth after a recession. Once again, the blue lines represent what the average has been since World War II and the red lines represent the growth in this recovery.

Obviously, once again, these charts tell a pretty vivid picture. So I agree with my friends on the other side of the aisle, we are in a recovery. We are getting some growth, but it is certainly not what we have come to expect as acceptable levels of growth. During the 1980s, we grew at 4 percent or better, and in this recession, we are at 2.5 to 3 to 3.1 percent growth, obviously cause for some concern.

What kind of jobs are being created? We are creating temporary jobs. We are creating service jobs, lower paid jobs. And so there is some clause for concern. We should not be surprised by this because all of us were here in 1990 when a big tax increase took place.

□ 1840

I stood at this podium with a lot of the people who were here with me today. This was in 1990. We said "To increase taxes by this amount in this kind of an economy will not help the economy, it will depress the economy."

In 1993 we came back here and said about Bill Clinton's tax increase, "Gee, we really should not do this, because if we increase taxes again for the second time, the biggest tax increase in our country's history, it will be bad for the economy." We as Republicans were not alone.

The chairman of the Banking Committee in the other House said this, and I quote, and this was back in 1993, July 1: "I have become concerned about the effect of the President's program," talking about President Clinton's program, "on jobs and economic growth. I am very concerned about the possibility of falling back into recession as a result of the very restrictive fiscal policy we are about to adopt." That was not a Republican, that was a Democrat.

He went on to say "Congress is about to enact a $500 billion fiscal constraint. We are doing the same thing we did in 1990, tying our fiscal hands behind our back."

Then he said something very key, that is today very important: "I worry what will happen if the Fed does not accommodate." Let me repeat that: "I worry about what will happen if the Fed does not accommodate." Sometime later I will come back to that Fed issue here in just a moment.

One of the other Members on the Democrat side of the Joint Economic Committee from the other House also was quoted on July 1, 1993, in the same forum, and said "Our efforts to reduce the deficit may be of such dimensions as to trigger an economic downturn." So we see that, again, there was some concern, and there still is, I'm sure, among these individuals about what was happening.

There is one other thing that has come to light, and remember, we are going to talk a little bit more about the Fed and printing money in a little while here. The President himself feared that his plan would produce downward pressure on the economy.

Bob Woodward, who has since written the famous book "The Agenda" which talks about issues that went on inside the White House, Bob Woodward said and vividly describes a January 13, 1993 meeting between President Clinton and his economic team. At the meeting, Alan Blinder, a member of the President's economic committee who is now a member of the Fed, warned the President that his new taxes and budget proposal would cause "a recession similar to the Bush recession." We have not seen that yet. There is a reason for it. It has to do with the Fed, and printing money.

Woodward goes on:

> The effect on Clinton was electric. The dangers of the emerging deficit reduction package seemed clear. If we do this, we will bleed all over the floor, and if Greenspan doesn't help, we will be * * * bleeding.

There are probably some young people listening, so I won't say it. The Vice President added his view that the key was the Federal Reserve.

What has happened is kind of interesting. Woodward's book points out that there was a tacit agreement made between the President and Alan Greenspan, the Chairman of the Fed. The deal was very simply that the President would raise taxes to try and do something about the deficit, and in order to accommodate economic growth, Greenspan would help keep interest rates down through the Fed.

In order to help keep interest rates down—and this gets into a little bit of economic theory, but it is not too difficult to understand, interest rates are the amount of money that we pay to borrow money, it is just that simple. Money in this sense is a commodity. So in order to borrow money, we pay interest rates.

Now, if there is a fixed supply of money, interest rates will be at a certain level. If we print more money and make more money available as a commodity, it means that there are more dollars available, and therefore, we do not have to pay so much to get them. That means interest rates are lowered.

The theory was we will raise taxes and we will print more money to keep interest rates down. That worked for a while, but here is what the problem is. As we print money to keep interest rates down, the economists say expand the money supply, as we print money to keep interest rates down, something else happens. Because there is more money and it does not have as much value, it creates inflationary pressures, and prices begin to go up.

As prices begin to up, people who are loaning money over the long haul, like a 30-year mortgage or a 20-year mortgage, or long-term bonds, they begin to look at what the future is going to be like and what their money that they are loaning today is going to be worth tomorrow. If it is going to be worth less tomorrow than it is today, they have to charge higher interest rates in order to get the return that they need.

Mr. Speaker, unlike what the President and Greenspan anticipated, I believe as long-term interest rates started to rise because we printed more money, it began to have a deleterious effect on the economy. The Fed increases in short-term rates were soon to follow. Greenspan continued to try to follow through on his promise, and did keep short-term rates down for quite some period of time, but now, as we all know, we anticipate that in the next few days the Fed is going to have a meeting, and we may see another increase in short-term rates as well.

Now, Mr. Speaker, going back to the original plan here, increase taxes and keep interest rates low, we all know that today interest rates are growing again. This chart shows what has happened to the trend in interest rates since January 1989. You can see that they were fairly high in 1989, and as economic growth took place and as good monetary policy was put in place, when we were not printing more money, the general trend in interest rates was down.

Then, Mr. Speaker, the Clinton tax hike occurred. The deal was made with Greenspan, and look at what happened to interest rates. They are spiking back up again.

Mr. Speaker, what happens when we have high taxes and high interest rates, which were not in the President's plan, what does that do to the economy? I asked the question in my opening here, "Is there anything similar about what we saw in the late 1970's and what we are beginning to see today?"

In the late 1970's, taxes were high. They were high for a different reason than they are today. This House played a part in increasing taxes here today, or recently. However, in the late 1970's there were two other reasons that taxes were high.

First was inflation, and marginal rates were not bracketed, so with inflation up went the amount of money that you sent to Washington.

Second, the wage taxes to support Social Security and Medicare were increased dramatically during those years. We all remember what interest rates were in those years.

Mr. Speaker, if the economy is doing as wonderful as our friends on the other side of the aisle might want us to think, then we want to look at these things very carefully, because we know that we are getting about 3 percent growth today. We know that during the good period of economic growth that we went through during the 1980's we were at 4 percent or above.

We know we have high taxes today. We know we are getting high interest rates. We know that Carter had high interest rates and high taxes, and so at least, at least, I would say to the Members on the other side of the aisle, ask these questions of the American people. Let us make sure everybody understands this.

Mr. Speaker, that is essentially how I wanted to kick this 60-minute special order off tonight.

Mr. Speaker, I yield to the gentleman from Texas [Mr. ARMEY].

Mr. ARMEY. Mr. Speaker, I thank the gentleman for yielding to me. Let me thank the gentleman from New Jersey for taking this special order at this time.

Let me also thank the gentleman from New Jersey for the job of leadership that he is doing on the Joint Economic Committee. As you know, I have had the privilege of being the ranking Republican on that committee for 2 years, and the gentleman from New Jersey is doing an enormous job of keeping the work of that committee moving.

Mr. Speaker, I have to tell the Members, this is extremely important that we get this question of the current performance of the American economy in perspective with respect to public policy. The President, just a few days ago, had quite an elaborate ceremony in the Rose Garden where he celebrated his good fortune in that the American economy still manages to sustain a, frankly, very modest economic recovery that was begun, very importantly, in March 1991.

My Speaker, I also had the rather dubious distinction of having been quoted, I am told, by the President in that Rose Garden ceremony as one of the critics of his economic package that in fact had not yet been proven correct.

□ 1850

I was thinking about that the other morning as I was driving to work and I was listening to a commercial on my car radio about the person who got the Jump-the-Gun award for the year and the commercial ended with that person saying he had already claimed the award and written his victory speech for next year. I think in terms of the President's celebration of the economic performance under this administration this year at this time, he might be a very well qualified challenger for that Jump-the-Gun award next year.

Let me tell Members what has happened here. At the time the President announced his economic recovery plan, quite frankly I was shocked. On February 17, 1993, I had the privilege of being at the White House when the President unveiled his plan that afternoon. It seemed clear to me that what we had was essentially the same plan that we had in 1990 where we raise Government spending by 20 percent over 5 years and raise taxes.

I told the President at that time that I felt that his plan would create very possibly the kind of economic malaise we had in the late 1970's where we had this phenomenon called stagflation. As I looked at his plan and look now at what has happened, I now realize that the President frankly knew something I did not know and got lucky, and thus far my prediction has not taken place.

What did he know that I did not know at the time? I now know after reading Bob Woodward's book "The Agenda" that the President had made a deal with the chairman of the Federal Reserve to continue an easy-money, low-interest-rate policy and fund the struggling recovery.

The chairman of the Fed knows and I know and you know that if, in fact, you have a rate of increase in the money supply that outstrips the rate of increase in the real performance of the economy, sooner or later we are going to achieve that phenomenon known as too many dollars chasing too few goods which of course is a principal cause of inflation. That, I think, is what we see happening now. The fact of the matter is the chairman of the Federal Reserve is not pushing interest rates up, the interest rates are going up in response to the market, and as they do, the Federal Reserve is being signaled to tighten down on the money supply. The question will be, can he react quickly enough and strongly enough to avoid inflation?

So the inflation component of stagflation, I am afraid, is staring us right in the face today and it will be a question of nip and tuck, can the Federal Reserve reverse itself on easy money quickly enough to avoid that?

Now what the President had in his package and where he got lucky was the President had a stimulus package of some $16 billion of additional Government spending that would have been funded with even additional Government borrowing and that stimulus package would most certainly have been inflationary. Since it would have come from borrowing, it would have come from a further monetization of the debt and, therefore, a further aggravated increase in the money supply, thus further aggravating inflation.

Thanks to the Republican votes primarily but a generous portion of Democrat votes as well that were alert to the dangers of this, this stimulus package was taken out of the President's economic package, and he got lucky. He also had a broad-based energy tax, a Btu tax.

One of the great cost drivers in the economy is the cost of energy. The fact is you cannot conduct any commercial enterprise at production, manufacture, wholesale, retail, or shipping without using energy. If, in fact, you slapped, as he had intended to do, a high tax on energy, you would have raised the cost of every good produced, every good shipped, every good retailed in America, and that would have had a multiplied effect, further aggravating a stimulus to inflationary pressure.

So the President knew he had help in the short run from the Fed that was dangerous in the long run for inflationary purposes; he knew that he had, or thought that he had further stimulus which could only have been inflationary, which he was saved from by Republican votes primarily but also some very good discerning Democrat votes; and he had a Btu tax that could have been extraordinarily inflationary except that again the same discerning Members of Congress, Democrat and Republican, voted him out of his package. Even with that repair to his package, he only passed it by one vote.

What we see happening today is the weak recovery beginning to dissipate as the Federal Reserve does what it must, which is respond to the excessive money supply, cut off the lifeblood of the modest recovery we have had with the hopes that we can avoid stagflation. I would still believe that the most likely outcome of this policy mistake will be a serious recession and very likely one accompanied by serious inflationary pressures next year. It is tragic.

Ronald Reagan took in his first 2 years of his Presidency with his first budget the necessary recession to break the back of inflation that had beleaguered the Nation since 1965. Even under those circumstances, he had a higher popularity than this President who took the easy road of false economic stimulus in the early 2 years of his presidency.

Why? Why would Ronald Reagan have had a higher popularity in the first 2 years of his presidency when the economy was in a recession than this President does when it is in a modest recovery? Because the American people know when someone is doing the right thing for the right purposes and they know clearly the President's policy is the wrong thing written for a political purpose and cannot sustain the endorsement of the American people that Ronald Reagan sustained by having done the right thing for a necessary policy purpose.

I want to thank the gentleman again for letting me address the issues.

Mr. SAXTON. Mr. Speaker, I thank the gentleman for the further explanation of the role that the Fed is playing and has played in the President's economic plan here. Obviously it becomes very important that we all understand that.

Mr. Speaker, I yield to the gentleman from Minnesota [Mr. RAMSTAD] for further comment.

Mr. RAMSTAD. Mr. Speaker, I thank the gentleman from New Jersey for yielding.

Mr. Speaker, I too applaud his leadership on the Joint Economic Committee. I also applaud the leadership of the ranking member, the gentleman from Texas [Mr. ARMEY].

Both preceding speakers, Mr. Speaker, mentioned Bob Woodward's recent book. In that book Mr. Woodward says that President Clinton called his own tax plan "a turkey." Well, the President apparently knows a turkey when he sees one and that bird has now come home to roost. The President's high-tax, high-regulation policies are an albatross around our struggling economy. I think the anniversary of the President's tax plan that we are marking today provides an excellent occasion to show through a frank and honest discussion of the results of this tax hike, the largest tax hike in the history of our country, that high-tax policies do not promote sustained economic growth. In fact, they cannot promote sustained economic growth. The President, as has been explained, has been the beneficiary of a normal business cycle recovery. I think we all agree on that.

The recovery, albeit it a weak one, was well underway before President Clinton assumed office and it is interesting to note that economic growth has actually slowed since his inauguration. Let me explain. The last recession, the Bush recession, officially ended in March 1991. Substantial growth then began in 1992. In 1993, after President Clinton was inaugurated, we saw growth slow abruptly in the first half of the year and then surge at the end of the year. But despite strong fourth-quarter growth in 1993, annual growth in 1992 outpaced that of 1993. So it is disingenuous at best for the Clinton administration to claim credit for an upswing in the business cycle that was clearly in place before Mr. Clinton became President.

We all remember how our friends on the other side of the aisle claimed, at least some of them, that this largest tax increase in history would send a signal that Washington was serious about deficit reduction. We remember how they said this would result in a steep drop in interest rates.

Let us look at what has happened. Bond yields began rising shortly after the tax bill was signed. Ten-year Treasury bonds rose from 5.3 percent in September 1993 to 7.3 percent this past July. Yet even with these increased rates, the dollar continues to fall. The continuing fall of the dollar in world markets shows that the recent increase in interest rates both by the Federal Revenue and the markets have not restored confidence in the stability of the dollar.

Mr. Speaker, all of us should be concerned that this free-fall further damages long-term economic prosperity for all Americans.

We look back to President Carter's economic policies, because they clearly illustrated the presumed trade-off between inflation and unemployment, that that tradeoff is nonexistent. Both of these harmful economic results can and will unfortunately coexist.

With inflation now as the gentleman from Texas explained so well in clear view, we face the real possibility of returning to the glory days, so-called, facetiously of Jimmy Carter.

□ 1900

We all remember the phrases malaise, the misery index readings, and stagflation. I am afraid we are headed that way again if we do not change the economic policy of this country.

Economists agree our economy should grow, and this is a consensus among leading economists from both political parties and of all ideological stripes, leading economists agree our economy should grow at 4 percent a year on average in real terms, with price stability.

While the economy has been growing at an annual rate of about 4½ percent for the three quarters, that growth has been artificially stimulated by an easy money policy that will launch us right back into Carter style economics.

Even the president is skeptical of long-term economic growth. The OMB's midsession review of the budget forecasts growth at below 2.7 percent in 1995 and next year and beyond 1995, 1996 and 1997 as well. OMB forecasts, in fact, project average annual real economic growth at only 2.6 percent between 1994 and 1999, a 5-year period of growth and real economic growth 2.6 percent. That should concern all of us.

The American people cannot afford nor do they deserve this kind of stagnation, this kind of slow growth.

We all know that the vaunted Clinton recovery is the weakest in the last 50 years, the weakest of any of the seven post-World War II recoveries. In fact, since World War II the U.S. economy has traditionally averaged 5.3 percent annual growth for the 3 years following the end of a recession. The current recovery though has only averaged 2.9 percent in the last 2 years, which is far below the average of the previous seven World War II recoveries. In fact, growth during the expansion has not even reached the average of 3.1 percent for all years since World War II. That is including the recession years.

Economist Lawrence Kudlow recently estimated that our gross domestic product would have grown by an additional $1.1 trillion and over 5.5 million new jobs would have been created if the economy had simply grown at the post-war average.

Mr. Speaker, we must look seriously at the reasons why our economy cannot shake off its doldrums. It seems to most of us on this side of the aisle that the clear reason is the Clinton high tax, high regulation, high spending policies are a heavy anchor on the economy, and it is time to cut this anchor loose.

Economist Larry Kudlow calls the difference between the weak economic growth we are now experiencing and the economic vigor seen in past recoveries, the performance gap.

Clearly the Clinton tax increases have made a significant contribution to the performance gap. They have taken money out of the productive, capital-investing sector of our economy and given it to the inefficient bureaucrats here in Washington.

But the real problem is the absence of the pro-growth reforms our economy so badly needs. We need a capital gains tax cut to stimulate investment and job creation. We need to look no further back than President Kennedy's era and look at what President Kennedy said and did in terms of cutting capital gains and look at the job creation and the economic growth that was resultant from that capital gains cut.

We also need to lower burdensome regulations which are increasing at the highest rate since the Carter years. Regulations are killing our small business sector which creates 85 percent of the jobs for the American working people. We must review and reduce the burdensome regulations on the entrepreneurs of this country, and above all, Mr. Speaker, we need a rational tax policy that quits penalizing the productive and rewarding the parasites.

Working with those of us who understand that economic growth comes from the private sector, nor from expanding government, this administration can close that performance gap. Congress and the President now need to work together to get the real economic growth, the real job growth that this country needs.

It is high time, Mr. Speaker, we put jobs first. It is high time we roll up our sleeves and work together in a bipartisan, pragmatic way to deal with this problem.

Finally, Mr. Speaker, I include for the RECORD the excellent article by our distinguished colleague, the gentleman from New Jersey [Mr. SAXTON], entitled "The 'Clinton Recovery' Is a Study in Self-Contradiction" from yesterday's Washington Times.

The article referred to follows:

THE "CLINTON RECOVERY" IS A STUDY IN SELF-CONTRADICTIONS

(By Jim Saxton)

On this first anniversary of the largest tax increase in U.S. history, President Clinton and his allies on Capitol Hill are singing its praises.

Using rhetoric that would make Clinton spin doctor Paul Begala blush, all good things in the economy are now attributed to Chairman Bill and his wonderful tax increase. The liberal Democrats are frustrated because they know practically no one in the real world believes their policies have boosted the economy, as evidenced in the president's 57 percent disapproval rating on his economic performance. This is not surprising. After all, even President Clinton himself called his budget plan a "turkey." This economic expansion belongs to the American people, not to politicians and P.R. consultants in the White House.

Actually, the truth is that congressional Democrats themselves don't believe the Clinton budget was good for economic growth. In 1993, Democrats and Republicans were united in the view that the Clinton budget plan would be a drag on the economy. For example, the liberal members of the Joint Economic Committee (JEC), in their 1993 annual report, were very explicit in stating of Clinton's budget that it "will continue to exert downward pressure on economic activity through the next five years." Earlier they said, "There is danger that the recovery could stall if monetary policy does not provide the stimulus needed to counteract the restraint imposed by contractionary fiscal policy." According to these liberal members of Congress, the Clinton budget plan was "contractionary," a drag on economic growth.

The always opportunistic Clinton administration, guided by budget war room chief Roger Altman, had crafted a different message in support of the budget plan. The cornerstone of the argument was that the Clinton budget plan would "grow" the economy by lowering interest rates. Lower interest rates were the key link defining exactly how Clinton policy would boost the economy. The only problem is that interest rates increased soon after the Clinton plan was enacted. For example, the 30-year Treasury bond yield jumped from 6.3 percent to a current level of 7.4 percent. The central linchpin of the administration's whole economic argument actually went in the opposite direction from the one the administration predicted. If lower interest rates from Mr. Clinton's policy were to be the central component pushing the economy forward, how can an increase in interest rates with continued economic growth be casually linked to the Clinton program?

Mr. Altman, the administration's "message czar" and point man on the budget, is presumably too preoccupied with other matters to square all these circles. However, there are certainly plenty of others following in his footsteps. Consider, for example, the argument that the Clinton administration promised to create 2 million jobs annually and is already ahead of schedule. First of all, the Clinton promise was recognized as bogus from the beginning, even inside the White House. According to Bob Woodward's new book, "The Agenda," before passage of the Clinton package, a marketing memo from Paul Begala stated, "This bill will create jobs—8 million of them." Mr. Woodward goes on to say, "In fact, the economy would create those jobs and the economic impact . . . Begala was not fully comfortable with the simplistic, happy-talk memo. He realized, somewhat painfully, that he had become a salesman for a plan that neither he nor Clinton really believed in."

Non-partisan economic forecaster Allen Sinai testified before the House Budget Committee on the Clinton plan in 1993. His conclusion was simple: "Overall, the Program does not create more jobs than what would have occurred without the Program." Moreover, the "contractionary" effects on the economy, as the JEC Democrats described, cannot create a basis for employment gain beyond those which would have occurred anyway. Just as Clinton cannot take credit for economic developments characterized by higher interest rates, he cannot take credit for the employment growth generated by the business cycle. The upside of the business cycle preceded Mr. Clinton, and the real challenge will be prolonging the cycle long enough to see Clinton exit the White House in 1997.

Finally, it is true that inflation has reached fairly low levels. However, past inflation is not the current worry, but the potential for future inflation. Disinflation is a process that has been under way for over 10 years. Even the most ardent supporters of Bill Clinton do not have the nerve to claim this as a result of Clinton policies. To the contrary, the rise in interest rates indicates that inflationary expectations have been stoked by Clintonomics' noxious mix of tax increases and easy money policies.

In conclusion, there was no partisan division in serious analysis of the economic effect produced by the 1993 Clinton budget. Both Republicans and Democrats correctly said it would be a drag on growth. Some members in both parties worried publicly about the possibility of a "contraction" or recession. The White House put all its eggs in the interest rate basket, and this argument turned out to be wrong. By so closely identifying the Clinton budget with lower interest rates, the White House cannot reasonably argue that its plan boosted growth under higher interest rates.

The business cycle that preceded Clinton's election continues. We are all pleased that the economy is growing and employment is rising. However, the American people know this does not have anything to do with Clinton's "contractionary" policies. The president is acting like the rooster who thinks that it is his crow that causes the sun to rise every morning. However, the sad truth that emerges from "The Agenda" is that Mr. Clinton regarded his own budget plan as a "turkey" that he did not believe in himself, but forced the Democratic controlled Congress to adopt it for political reasons.

Mr. SAXTON. Mr. Speaker, I thank the gentleman for very cogent remarks. I was particularly taken by the fact that the gentleman has alluded on several occasions during his remarks that we Republicans would do things differently, and that is obviously very, very clear, and will become clearer here on September 27 when we say formally what those things are that we would do different.

Let me say this in introducing our next speaker: The Clinton administration likes to hang its hat on the deficit and deficit reduction as a reason to increase taxes. I would like to point out with this chart that the statements that were made in 1990 about the deficit and how worried we were about it when the deficit was much lower than it is today, and of course in 1990 we had a major tax increase to do something about the deficit. In 1993 we had another increase that we did here in order to do something about the deficit, and at the end of 1994 the deficit was significantly bigger than it was before either of those tax increases. As a matter of fact, I think it is fair to say it is not the taxes, it is the spending. In other words, we have not put a cap on spending.

Our next speaker is an expert at knowing how to put a cap on spending. He is from New Hampshire, and he has become a household word. If I said he is author of the "A to Z program" everyone would know it is BILL ZELIFF from New Hampshire, and I yield to the gentleman from New Hampshire.

Mr. ZELIFF. Mr. Speaker, I thank my colleague from New Jersey for yielding.

Mr. Speaker, this week marks the one-year anniversary of the President's tax bill which was the largest tax increase in the history of the United States.

It is an especially memorable time for me since it was also the week I initiated what has now become known as the A to Z spending cuts plan. Believe it or not, folks, it has been a year.

The original letter to Speaker FOLEY that ROB ANDREWS and I sent out outlined our plan which was bipartisan. It was dated August 6 of last year, and we asked for additional spending cuts. This was the week before the vote on the economic plan, and we stand here today on the brink of discharging the resulting legislation, H.R. 3266. All we ask for in this legislation is a 56-hour debate on setting spending priorities, allowing every Member of this body to make a difference, to offer an amendment and to have a full discussion and up or down vote.

We stand just 14 signatures short of bringing A to Z to the floor. There are a group of Members who stand ready to sign on in case the Democratic leadership fails to follow through on their promise of having a full day of entitlement cuts before the August recess.

Tomorrow we will consider some legislation aimed at trying to fulfill that deal, but it has nothing to do with entitlement spending or real spending cuts.

We spend weeks debating the California Desert Protection Act, but according to the leadership, we just do not have the time to debate cutting spending, particularly entitlement spending.

This is what is driving the deficit, and this is what is dragging the country's economy down. But somehow the leadership prefers to keep out of control entitlement spending on auto pilot.

But we are here tonight to mark the one-year anniversary of the Clinton tax bill, a celebration for some and a deep concern for most of us.

Never in our history has a tax increase led to a strong economy. On the contrary, they have led to further destruction of the economy. We saw that happen in the Carter administration as well and yes, in the Bush administration in 1990. President Bush gave in to a tax increase of some $164 billion and put an end to the largest peacetime expansion in American history.

The facts are there, Mr. Speaker. The White House's own numbers show that growth and job creation are way behind schedule, and the numbers of my colleague from New Jersey show that for this stage in the business cycle.

□ 1910

The economy has been growing between 3½ and 4 percent for the last three quarters, but this growth is due to inflationary monetary policy, not any great economic wonders of the

Clinton administration. The policy being used by President Clinton and Alan Greenspan over at the Fed has been to raise taxes and print more money. This is not a sustainable policy to insure long-term growth. You cannot keep printing money and expect real growth to continue.

There is a threshold, and as soon as we hit that threshold, even this mediocre recovery will fizzle into high price inflation and high employment.

Further evidence of this is in interest rates. Contrary to what people believe, the Fed is not leading this increase in rates. It is merely following market pressures. This is driven primarily by fears of inflation because of the Clinton-Greenspan policy of raising taxes and printing lots of money.

About 3 weeks ago, Louis Rukeyser wrote in the "Wall Street Journal" a full-page letter to President Clinton and talked about the falling dollar, talked about the lack of confidence in the world, and basically, primarily indicated that the falling dollar is the result of our inability to settle and make a difference in terms of getting control of entitlement spending.

The bottom line is that this is a failed monetary policy, because we are just dragging money away from the private sector and into the public sector. There is no way that a free-market economy can insure long-term growth if the Government keeps eating up such a huge chunk of the gross domestic product. The Federal Government keeps spending and spending. The President and Congress are fooling the American people by saying they are bringing down the deficit. This is untrue because all we are doing is adjusting the deficit numbers to inflation under a baseline budgeting system that many of us think is a gimmick.

Sure, we can add a new category that shows the real budget, and we will talk about that tomorrow, by comparing this year's spending against last year's. This is the way we do it in the business world, but still allowing a baseline will continue to give the Democrats ammunition for fooling the American people.

I find it incredible that the President is taking credit for these policies which will raise the Federal debt $1 trillion over the next 5 years. The President and the Congress do not even mention that. They do not mention it for political reasons, and the end result of their continued failed policies will kill this country's economy. We cannot let this happen. We have to turn these policies around. We have to cut taxes and not increase them, and we need to bring Government spending under control.

The American people are no longer being fooled. It is here that we see the importance of A to Z, and this is not a gimmick, as the leadership in this body has claimed on an irresponsible basis. It is a serious program to cut Government spending in the face of increased taxes and inflationary policies.

A to Z is the very least that we can do and the very best we can do to start bringing this economy under control. There is a long way to go to pay off a $4.7 trillion debt and controlling the deficit and start living within our means, but we can start with reining in Government spending and getting the Government out of the hands of bureaucrats and into the hands of the private sector.

Many of us believe the private sector is where the job creation is and where the real growth potential for our country's future is. It is about time we understand low taxes come from, guess what, low spending. That is the way we do it in New Hampshire, and this is the State where there is no income tax and no sales tax. We keep our taxes down as a result of low spending. President Clinton believes that more taxes and more spending will reduce the deficit.

The American people know that this does not make sense, and they are not going to buy into this little gimmick. If President Clinton wants to brag about his failed economic policies, well, so be it. That is his privilege. But for this Member of Congress, I am very proud to have been one of many who voted against that plan which increased our debt $1 trillion over the next 5 years.

I thank my friend, the gentleman from New Jersey, and I appreciate being involved.

Mr. SAXTON. Mr. Speaker, I would like to thank the gentleman for his very articulate explanation of A to Z and other related matters.

The one thing the gentleman mentioned which I would just like to talk about here just for about 30 seconds, part of the press conference that I made reference to earlier that was held out in the triangle earlier this week was about the deficit and how wonderful it is the Clinton economic recovery tax program has somehow begun to reduce the deficit. That is simply not true, and the reason it is not true is because, while the deficit is coming down, there are some very good reasons the deficit has come down. We anticipated, for example, about $20 billion more in expenditures for the S&L bailout than we had to make, and, therefore, we did not spend that money.

As has been pointed out several times, the last three quarters of growth that have been 4 percent or better as a result of this loose-money policy where we are printing money has spurred the economy; we have gotten more economic growth and, therefore, we have seen money come into the Treasury. But that is not because of the President's economic plan. It is because of the deal that he has made with Alan Greenspan which, on this chart, shows very clearly that interest rates are on the rise again.

When interest rates get too high and taxes are correspondingly too high, we get into all kinds of problems.

Mr. ZELIFF. If the gentleman will yield further, I would just like to end my end of this by saying that, you know, we do this a lot in town meetings up in New Hampshire. If we came before this body or any group in this country and we talked as if we were talking to a banker and we said that we were $4.7 trillion in debt, soon to be $6 trillion over the next 5 years, our interest debt is $212 billion this year and will soon be $272 billion in the year 2002, and if we go further on to say that our average debt is a little less than $200 billion this year and projected to be that way throughout, can we borrow more money? The banker would normally say no. The problem we have with the management of this House, the leadership, they are saying that is OK, "Trust us, we are on automatic pilot. We do not need to deal with entitlements. We do not need to have a foolish A to Z thing that takes 56 hours of debate to cut spending and set priorities."

I think, frankly, they are wrong, and we are right. I think the day is going to have to come, and we certainly wish that President Clinton would take the initiative on this; we need to cut spending to start living within our means, and then the policies will start to work.

I thank the gentleman very much.

Mr. SAXTON. I now turn to the gentleman from Texas [Mr. DeLay], the chairman of our Republican Study Committee, a gentleman who has been involved in many economic matters in the 10 years that we have served here together.

I yield to the gentleman from Texas [Mr. DeLay].

Mr. DeLAY. I thank the gentleman for yielding.

Mr. Speaker, I must say that the gentleman from New Jersey has been a stalwart in bringing the truth to the American people.

The studies that he has initiated in his side of the Joint Economic Committee have been well-done studies that show that the reality does not match the rhetoric that is coming out of the White House. The gentleman has been incredible in proving that, unfortunately, we have a media in this country that just refuses to challenge the President on the things that he says.

During the campaign we may remember that the President said he was going to end welfare as we know it, and he comes out with a welfare reform package that expands welfare as we know it.

Just recently, just today, we sent the crime bill back to the conference committee. You remember this time last year the President did not support the crime bill in the Senate, and all of a sudden he jumped out in front of the parade and claimed it was a great bill. Then the bill got worse and worse, and he took credit for the bill that has been rejected by the People's House.

I think the gentleman from Virginia [Mr. GOODLATTE] put it beautifully when he was speaking on the rule on the crime bill when he said the President is trying to look like Dirty Harry, but he is turning out to be Barney Fife with this crime bill. The same thing is happening in the economy.

The gall of the President of the United States to stand out there and take credit for an economy that he had nothing to do with is beyond me. He ought to start writing fairy tales, because the myths that he is perpetrating on the American people are unbelievable, and what kills me is really interesting and funny to watch, the American people do not believe the myths that he is putting out.

For instance, the gentleman was talking about the first myth that the administration's economic policy has actually restored economic growth, and here we are now falling prey to economic revisionism by this White House, when your own study, the study by the gentleman from New Jersey, reports that the campaign of economic revisionism implies those who benefited from the 1980's did so improperly, even though an objective analysis of the data revealed that income gains were enjoyed across the board.

The administration is taking credit for the economy's 3 percent growth rate in 1993, and a 7-percent growth rate surge in the last 3 months, when anyone who has had Economics 101 knows that it takes more than a year to see the effects of new policies.

Myth number 2, the administration's economic policy has helped create new jobs. This one I just cannot believe that they would try to support such a myth. The President has said that his economic program has produced almost 4 million jobs in just 18 months, when the truth is, as we all know it, the economic recovery was well under way long before his economic program took effect.

□ 1920

And studies show that since the inauguration 84 percent of the jobs created have been in the lowest paying categories as compared to 69 percent during the Reagan and Bush years. I can remember Member after Member coming to this floor claiming that the Reagan and Bush jobs were nothing but hamburger-flipping jobs. Yet they run from that statistics when you find that the jobs that are claimed to be created by this administration are low-paying jobs.

According to the Bureau of Labor Statistics, right there on that chart, manufacturing jobs have actually decreased by 56,000 since President Clinton has taken office.

Mr. SAXTON. I would like to make reference to this chart. This chart shows the length of the average work week beginning in 1984 and coming through 1993. We can see that in 1993 the average work week for manufacturing jobs is significantly longer than the average has been. One might ask why is that? Is it because we are producing so much more? We all know that is not true. Is it because the economy is growing faster than it was during these years? We know that is not true. The answer has to be that employers would rather hire people to work longer and hire fewer people than they would to hire more people and work the average work week that we used to work.

I might digress here for just one other point. The reason, in my opinion, employers are doing this is because they do not know where to turn next, in terms of taxes, in terms of health care reform, mandates, additional responsibilities for employers. So, fewer workers mean less overhead and we just work a little longer.

Mr. DELAY. I think also, if the gentleman would yield, the opposite is true, workers are willing to work longer because they are having to work longer in order to maintain the same standard of living that they had in the years past.

In my district I know people are working two jobs just to pay for the standard of living that they enjoyed 5 to 10 years ago.

Why is that? It is because the Government is taking—the cost of Government is well over 51 percent of their income. The Government is taking more and more of the labor American workers in this country, and certainly it has been shown to be so in this.

Let me just say it is also interesting, other than the study the gentleman is laying out, that the Washington Times reported that since last year an average of about 170,000 jobs per month had been created, and compare that to between 200,000 and 250,000 jobs during same expansion period of the 1980's, per year.

So when they claim they are creating all these jobs, what they are claiming is creating all these jobs at a slower rate than had been created in a good economic expansion.

I might just say in April, when President Clinton's retroactive tax increase and the wealthy owning at least one-third of the tax hike that raised their rates from 31 to 39.6 percent, personal consumption expenditures fell and the personal savings rate dropped to its lowest level since 1987.

The problem is that 20 to 25 percent of all consumer spending comes from the wealthiest 5 percent of the population. Arnold Moskowitz of Moskowitz Capital Consulting of New York predicts that Clinton's scheme to soak the rich will actually slow the entire economy from 3 percent growth to 2.5 percent growth.

I just want to say that the American people are not buying these myths that are coming out of the White House. Fully 57 percent of the American people disapprove of the President's handling of the economy, while only 36 percent approve. Another 81 percent of the American people disapprove of the President's handling of the deficit, while only 28 percent approve. And 61 percent of the people disapprove of the President's handling of taxes, while only 31 percent approve.

This President is not doing anything to improve the economy; in fact, as the gentleman from Texas [Mr. ARMEY] said, he has just been lucky that it has not landed in the toilet.

Mr. SAXTON. I thank the gentleman for his statement, and, as always, an articulate and fine statement.

I would like to turn quickly to the gentleman from Illinois [Mr. MANZULLO].

Mr. MANZULLO. Let me just make a few comments on the economy.

I am not going to stick to my text on this. I do not think most Americans realize the extent of what this huge $4.7 trillion to $5 trillion debt, what this means in terms of ordinary day-to-day life.

Buried in the budget that was passed is something called generational forecast. We received an interesting article from Paul Tsongas and Warren Rudman, head of the Concord Coalition which analyzes different problems with the budget and gives their suggestions for putting this country into some type of financial order.

That is that for every child born in the year 1992 and thereafter, by the time that child is in the work force he or she will have to pay, because of the huge, growing national debt, an income tax rate equal to 88 percent, that is 88 percent. And that says nothing about State and local and county taxes.

When I talk to the folks back home in Illinois at our town meetings, in grocery stores, walking from business place to business place, it is apparent that people know this deficit is horrible but do not realize that we are just really the width of a whisker away from financial and economic collapse, if the debt and spending in this Nation continue.

That means we are going to reach a point where there will not be enough revenues to pay the interest on the national debt, and at this point the Government does one of two things: It either monetizes, which simply means it prints up or cranks up money; or, two, it declares all Government obligations to be fulfilled and paid in full without doing it.

Now, you can imagine collapse of the economy.

I just wanted to share that with the gentleman from New Jersey to sort of bring to a focus point the concerns that the gentleman has been sharing here during these special hours.

Mr. SAXTON. I thank the gentleman for bringing out what a serious issue the national debt poses to us as well as the fact that, you know, if you plotted out the revenue that we have had coming into our Federal Treasury over the last 10 years and you plotted out on the same graph or chart, the line representing the expenditures, you would see a revenue line down here, an expenditure line that goes like this, and they are simply getting further and further apart. Hopefully, we are seeing some tipping back together here during the last few months, again for some good reasons.

But if I may, I would like to yield to the gentleman from California [Mr. BAKER].

Mr. BAKER of California. I say to the gentleman I certainly appreciate being here this evening.

We ought to leave the economy to the economists because politicians have done a poor job.

During the 19-million-job-creation 1980's, the Democrats told us these were just hamburger-flipping jobs and nothing substantial was occurring.

Then we found out those people were paying taxes, the economy was growing, and revenue was increasing to the Federal Government. Instead, the Government is flat, the private economy is flat. What have we said about it? We said, "This is wonderful, Bill Clinton has said he has created all these jobs and things are just rosy."

Then we step to the microphone and say these are just hamburger-flipping jobs, these are not real. Probably half is about true. But why? What is it wrong with the economy? Why is it flat? Why is it not growing? Because we raised taxes over $100 billion a year ago today.

□ 1930

That is what the problem is, and everyone knows when you raise taxes and suck that much money out of the economy you are not going to be able to create jobs. The Government has to get out of the way so the private sector can lead. That is true in health care; it is true in the economy. So, we are not going to debate whether or not he has created so many jobs because we know that they had to raise in January 1993, the day Bill Clinton took office, the Labor Department had to raise, estimates of jobs created in that terrible year of 1992 under George Bush; 158,000 jobs, meaning that we have actually lost 58,000 jobs since then in manufacturing.

So, we can debate numbers, but what the American people want to know is are we leaving business alone? Are we giving the American public enough money to invest, to save, and to create those jobs? And the answer is no, this Government is growing like Topsy, and the real problem is more debt and more Government.

The reason the crime bill failed today was because it was $33 billion. That bill started out in the House at $22 billion. It went to the Senate at $28 billion. It came out of conference at $33 billion. If every cent of that was for crime control, we still could not have afforded it. So, that bill is now going back to conference for a quick diet, and it will come back a toughened, lean, and mean crime bill that puts police on the street instead of sensitivity trainers at the other end of the 911 call.

I say to the gentleman from New Jersey, It is a pleasure to be here tonight. Let's let Government get out of the way. Let's encourage the private sector to invest, to risk, and to create those jobs. Let's create the incentive to save in the minds of the American people, and we'll put this country back in order.

Mr. SAXTON. Mr. speaker, I would like to thank the gentleman very much for being with us here this evening to discuss threse very, very important issues, and I would also just like to say to all the Members that these issues are things that we are going to be dealing with in the future, and I hope that this special order tonight has shed some light. I tried not to be too partisan about it, but there are differences in the thought process or in the basic approach that, I think, that the two parties have here, and I hope that we have been able to point them out in an objective, in an objective way.

Mr. Speaker, the hour is growing late, and I know there is more business in the House, so at this point, I guess with very little time left. I conclude.

HEALTH CARE REFORM

The SPEAKER pro tempore (Mr. LEHMAN). Under the Speaker's announced policy of February 11, 1994, and June 10, 1994, the gentlewoman from Connecticut [Ms. DELAURO] is recognized for 60 minutes as the designee of the majority leader.

Ms. DELAURO. Mr. Speaker, before I get to my remarks tonight on health care reform and a discussion of health care, several of my colleagues were just on the floor talking about the economy, several of my Republican colleagues. I might just take a minute to note that I do not know where they got their facts from in terms of what the state of our economy is today, but let me just quote to you from some, if you will, nonpartisan folks who look at the economy on a regular basis, folks at Lehman Brothers.

To President Clinton's credit early last year he rejected an either-or construction for U.S. growth versus deficit reduction. Clinton's blueprint for economic revival had as its centerpiece a multiyear program of deficit reduction. It promised higher growth in the short, it promised higher growth in the short run. A move to restrain deficit spending, he wagered, would both lower U.S. long-term interest rates and energize U.S. interest-sensitive sectors. He goes on to say lower deficits, lower long-term rates and higher real growth was the overall promise. With the data now rolling in it seems clear that President Clinton delivered on all three counts over this second half of the year.

Allen Sinai of Lehman Brothers, again as reported by the Washington Post: This is the healthiest American economy has been in 30 years.

David Shulman of Salomon Brothers, as reported by the Washington Post: The economic recovery is now moving from Wall Street to Main Street. There will be less money flowing into the financial—in the financial economy and more flowing into real recovery.

I just felt the need to mention some of these things because in fact the economy is recovering, and we have had under President Clinton 2.8 percent growth 1993, 7.5 percent growth in the fourth quarter, 3.3 percent projected for this year. Jobs are up 1.7 million. New private sector jobs, 60 percent more than during the entire Bush administration. The deficit is down. It has been the largest deficit-reduction package in history. We have seen the lowest deficit numbers for the first time since Harry Truman held the office of President.

So, I do not know where my Republican colleagues are getting their data.

Furthermore, I just make one or two more points here. In this carbon Congress the House Democrats passed the largest deficit-reduction plan in history cutting $255 billion in spending cuts. Again, I do not know where they are getting their economic data, but in fact, I think it is more partisan rhetoric, and if you—some of my colleagues who were speaking are the same folks, in fact, who did not vote for the budget package. As a matter of fact, there was not a Republican vote for the budget package in this body last year.

These are some of the same folks who were telling you that we do not need or we cannot have a health care reform and that health care reform will, in fact, do in this Nation as the Democrats have proposed it.

They were wrong last year about the budget, and I might add that in fact they are wrong again about health care reform.

Mr. WISE. Mr. Speaker, if the gentlewoman would yield for just a moment.

Ms. DELAURO. I yield to the gentleman.

Mr. WISE. You bring up an excellent point because these are the same people that just a year ago in this Chamber were making dire predictions about the package, what would happen if the budget package passed. Indeed let us look. This is the third year of declining deficits, the first time since Harry Truman that we have had that situation in this country. The deficit this year is going to be 40 percent lower than anyone projected last year. The deficit package, deficit-reduction package, is working and working more than anyone even thought.

I was on the Committee on the Budget when it held a hearing just a couple of months ago with Alan Greenspan, not someone given to overeffusive optimism, who was saying the economy was in the strongest shape it had been in many years, and he saw the economy being in such shape that it could expect to grow in a good fashion for many more years. It was in the best shape he had seen it in in a long time.

Now our colleagues, not just those who just spoke, but many of the others on the other side of the aisle, same crowd that a year ago were saying that passage of the Clinton budget package would be a job killer. That was one of the main words used, and they stood in the well and would claim, based on a study they had from some group, Joint Tax Foundation or some Washington almost-think tank, that in each district, and they would name a district, there would be *x* thousand number of jobs lost because of this package. I had got good news for my district, bad news for their foundation. Jobs are only growing in my State and in other States, and indeed it has not been a job killer, it has been a job creator. They said it would be an immediate recession. Instead we have seen job creation at the rate of four times of those halcyon days of the Bush administration. We are seeing a recession that is steadily moving—seeing an economy that is steadily moving along, not in a recessionary mode, even though there has been deficit reduction at the same time that the Federal Reserve independently has been hiking interest rates, and the economy is still growing.

Those are all positive signs.

And finally, to the largest tax increase in history, they warned us about that. The fact of the matter is that for the 1,600 West Virginians, all over $140,000 a year that did pay more taxes as a result of that package, 105,000 working West Virginians families got a tax cut, and indeed that is giving them the ability to maybe buy health care; that would be nice, but also to be consumers and to be fueling this economy.

So, I think that, as we move to the health care discussion now for the special order you have scheduled, I am glad that we just had this discussion prior to this because this was the crowd saying no on the budget. They are now saying they do not want to do health care. Look at the record. Look at the record.

□ 1940

Ms. DELAURO. Amen. Let us get on to the discussion for this evening, and I am delighted to have my colleague join with me this evening as we talk about health care reform.

More than a year ago, we began our efforts to try to bring affordable health care to every American. At long last we have arrived at the moment when this House will begin that debate and vote on health care reform legislation.

I am proud to have several of my colleagues join with me tonight, people who have been at the forefront of the health care reform battle, and who support the plan that has been put forth by the majority leader of this House.

As hard as we have all been working, I think we would all agree that no one has worked harder than our majority leader, DICK GEPHARDT, and I would like to take a moment and commend him for his insight, his patience, and, most of all, for his persistence in putting together a plan that we can all be very, very proud of.

Let us be clear why we are here. We are here because this country in fact has a health care crisis. We are here because 40 million Americans are uninsured and 81 million Americans have preexisting conditions. We are here because small businesses are paying 20 to 30 percent more than their larger competitors. We are here because too many senior citizens are forced to make the choice between prescription drugs and their next meal. And we are here because we have listened. We have listened to these countless health care horror stories from every district and every State in this country.

Every single Saturday, I do office hours in my district. I go to a large supermarket in one of the 18 towns that I represent. People are notified. They come there and talk to me about what is on their minds, what are the issues that are of real concern to them.

The faces are different every weekend, every Saturday morning, but the stories are the same, the exact same stories. Mothers who cannot get health care for their children, fathers who lost their jobs, and with them the health care benefits that they need for their families.

So I believe we are going to pass health care reform in the House of Representatives. The question is whether or not we are going to pass real health care reform that will make things better for people, or are we going to pass some half-baked reform that could actually make things worse.

We have a choice to make. We will all be faced with a choice in the next several weeks.

Let us take a look at the health care plans that have been proposed, to see which of them begins to solve the problems that brought us to this point in the debate.

Yesterday the largest senior citizens organization in the country endorsed the Gephardt bill. The AARP, 33 million members, know what we are here to discuss tonight, and that under the Gephardt plan, that Medicare is safe, that a new prescription drug benefit will be available for seniors, that for the first time we will see the beginnings of long-term care and home health care for seniors, and that in fact insurance companies will not be able to discriminate against seniors because of age or because of preexisting conditions.

Simply put, what we are talking about here tonight is a program and a plan that would guarantee private insurance to every single American, that can never be taken away, and that is affordable.

The other plans that are offered only give us incremental reform, insurance reform, and nothing else. They rely on various insurance reforms and subsidies for some Americans, but what they do not do is guarantee coverage to all Americans. And that is why they are not going to work.

I would be delighted to yield to my colleague from Maryland.

Mr. CARDIN. I want to thank the gentlewoman for taking this time and yielding to me. We very much appreciate the effort you have made to try to inform the American people about the debates that have taken place here in the House of Representatives.

It is interesting the bill you are referring to, the bill that the majority leader has put together, is a bill that has been carefully scrutinized. It has gone through the normal committee process, with every committee that has had jurisdiction over any part of health care reform having the opportunity to work on the bill, having public hearings where the public had an opportunity to comment, where we had open markups that were carried live on C-SPAN where the American public had an opportunity to see both Democrats and Republicans working together on amendments to bills, trying to improve the bill, making reports to the House, and then the majority leader bringing together the work of the various committees in a coordinated way.

The gentlewoman is absolutely correct. We have really one option before us. That is a comprehensive bill that has been through the scrutiny of public comment and the Congressional Budget Office that scores all that work. The Gephardt bill, the bill that he has put together, is a comprehensive bill that has stood the test of very close scrutiny, that will, I think, live up to the objectives that the American public will demand, and that is universal coverage, that everyone is insured; effective cost containment, that it is fair to all of our people, it is affordable, affordable to small business, affordable to people who need to buy insurance, whether they work for a small company, a large company, whether they are in the work force or not in the work force, and that it is well-balanced. I wanted to really underscore the point that the leadership bill, the Gephardt bill, has been through all that scrutiny, it has been carefully reviewed.

Last night we received some substitutes that were filed by various individuals and groups. Those substitutes on quick review do not even come close to dealing with the problems. What I find very disturbing is that people, individual Members who have been identified with much more comprehensive approaches, it looks like they are backing off of that and going forward with a very incremental approach that will not even come close to dealing with the problems. It looks to me like we are only going to have one choice, the Gephardt leadership bill.

Ms. DELAURO. I thank my colleague for his comments. Earlier the gentleman from West Virginia made a similar point when he said there has been debate, there has been discussion, on a number of pieces that find themselves in the Gephardt bill. It has been put together. We have discussed these issues in this body.

The notion that there has been no discussion on health care is so far from reality. If people have not had an opportunity to discuss health care in this body for the last 18 months, I do not know where they have been. They have not been doing their job.

We have all had ample time, ample debate time, ample review time and opportunities to take the closest look at all of the various pieces of these health care plans that are being discussed. So it is really spurious for people to come forth today and say there has been no debate and discussion on these bills.

We need to point up additionally that the whole notion of universal coverage, which is where the Gephardt bill takes us, to make sure that all Americans are covered, is key and critical. If you begin to take a look just at these incremental pieces, the go-slow, halfway approach that has been advocated by the Dole, Michel, and Gingrich bills, they fail the American people. The Michel bill, for instance, would only require employers to offer, but not to contribute to the cost of insurance for their employees.

What kind of comfort does that give to those currently uninsured working Americans? Is it really an improvement over the status quo?

Clearly the American public, 72 or 75 percent, believe that critical to passage of health care reform is universal coverage.

The Rowland-Republican substitute would also preserve the status quo. The poor get health care, the rich buy insurance, and one more time, middle class America, middle class families, have got to go it alone.

Mr. CARDIN. If the gentlewoman would yield, I think that point needs to be underscored. We have the Gephardt bill, which will get us to universal coverage. No one disputes that. The objective scorekeepers have looked at it. The groups that have taken a look at it concede it will get us to universal coverage, that everyone, whether they are in the work force or not, whether they are wealthy, whether they are working people, whether they are middle income, whether they are poor, every one will be covered. And we expand private insurance under the Gephardt bill. There is no question about that.

Now, when we started this debate, I thought it was fairly well agreed that our goal would be to accomplish 100 percent. We would get every one covered by health insurance in our country.

All of a sudden, some of the people who have been speaking the loudest about universal coverage are changing the goals. We heard some people say, OK, we can get down to 95 percent and we are OK.

As I understand what you are saying, it is that the Minority Leader's bill and the Rowland-Republican substitute bill do not even get us to 95 percent by their own projections. They are down to 90 percent, which they are claiming, and people are looking at it objectively and doubt if they will even accomplish 90 percent. We are at 85 percent today with close to 40 million Americans without any health insurance benefits.

□ 1950

If I understand correctly the alternatives that are being brought forward, at best we will make very little change in those numbers and may, in fact, if I remember listening to you on the floor the other day, that if we do the insurance reform, if we increase the cost of health insurance for the average person who currently has insurance today, because we do not get universal coverage and we do insurance reform which brings higher risk to the insurance pools, we may, in fact, frighten people out of the insurance market. We may end up with less people insured rather than more, just compounding our problems.

Let me also point out the fact to the American people that if you have less people insured or if we do not significantly increase this 85 percent, if we end up with 30 million people uninsured, that the number I heard on the Rowland substitute, that there still will be 30 million Americans uninsured when the bill is fully implemented in the year 2002, that you and I, those who have insurance are going to continue to have to pay for those who do not have insurance.

We are not going to be solving the problems that we were sent here to do, to stop this cost-shifting, to have a fair system, a cost-effective system. How can we expect health facilities to locate in communities where there is a large number of people who do not have insurance? They are not there today because they are not getting reimbursed for the care.

If we do not get universal coverage, we cannot work for a more cost-effective health care system. We cannot bring costs down. So when the Republican substitute or the Rowland bill does not bring us to at least 95 percent, then we are not, I do not know why we should even really consider it health care reform.

Ms. DELAURO. My colleague is absolutely right. In the Michel bill, the minority leader's bill, it leaves more than 38 million Americans, most of them hard-working Americans, without insurance. That means that more than one in seven Americans, many of them children, most of them in working families, will have no health care coverage at all. What will we have accomplished?

If we move back into the same system we have today, which only continues to increase the cost to everyone else, who is insured and who is paying for their insurance? The whole point of this was to help to try to stabilize costs, bring costs down today to those who are carrying the largest burden.

If you only deal with the insurance reform portion of it, you then, once again, increase the cost for everyone else. I have a preexisting condition. I am a cancer survivor. If I am included in a pool, the risk goes up. If we only allow for the insurance reform and not make sure everyone else is included, then it will be those at the highest risk who will be in the pool; the healthy will opt out. And once that awful spiral will continue while the costs will continue to rise and rise.

Any of the substitutes that are being put forward, the minority leader's bill, the Rowland Republican substitute, leave millions and millions of Americans uncovered in insurance with everyone else picking up the cost.

Mr. CARDIN. If I could just emphasize one point, this is one area where people who have insurance or people who do not have insurance should be together on. Whether you are a person who has health care insurance today or you are a person who does not have health care insurance today, we are together in saying we must have universal coverage. The person who does not have insurance needs it, needs it so that that person can get access to care today. The person who does have insurance should be tired of paying the bills of people who do not have insurance. So it is critical that for all Americans that we get universal coverage.

Ms. DELAURO. I would like to make a point about, in terms of the Rowland Republican substitute, I mentioned that the middle class families are going to have to go it alone. I will just give an example. A typical middle income family earning about $37,000 could face premiums of almost $6,175 per year under the plan. The same family would pay $1,065 under the House leadership, under the Gephardt plan. That is a savings of $5,000 a year for families under the Gephardt plan.

You show me a family in this nation that does not want to save $5,000 a year.

I yield to my colleague from Utah, Ms. SHEPHERD.

Ms. SHEPHERD. I would like to point out that in my district, in Salt Lake County, UT, that as near as we can estimate that all the people that earn in between $20,000 and $75,000 a year, basically middle income families, each one of these families, and there are 120,000 of them in my district, each of these families will almost certainly pay $600 more a year for their insurance premiums, if we have an approach which simply eliminates preexisting conditions and really makes it impossible for insurance companies to manage their costs in any other way except raising insurance premiums.

If all we do is tell insurance companies that they can no longer exclude people from their policies, and that is the only thing that this Congress does, then what we are doing is absolutely guaranteeing that every American's insurance policy premium will be greatly increased.

And, at the time that it is increased, they are going to look at their checkbooks and decide whether or not they can continue to pay for their insurance and, if they cannot, they will drop it. And then when they get sick, they go to the hospital. And when they go to the hospital, after the hospital has taken their house and their car and everything they own, the hospital will pass the remaining costs onto the paying insurers and more insurers will drop.

This has already happened in New York. It happened in New York because in New York they decided they would reform insurance. They reformed insurance, but they did not ask all New Yorkers to be covered with insurance. And as a result, in New York, what is it, nine months later, they have fewer people insured. And those who are insured are paying a lot more money.

This is a formula for a disaster in America.

Mr. WISE. The gentlewoman from Utah makes a case study. Those who want to look, for example, at why incremental reform, why insurance reform by itself will not cut it need only look to the recent New York State experience.

Also I am fascinated by those who want to create some kind of generational war and say they are protecting young people by keeping them from having to participate in universal coverage. They are not protecting young people.

What happened in the case of New York State was that by enacting insurance reform, mainly saying you cannot deny people coverage because of preexisting illness but not making it apply universally, what happened is that young people could not afford the premiums any longer and opted out.

Some young people, actually people in general said, then I do not need to worry about preexisting coverage because I can get into the pool at the point I get sick. But many young people who were on the margin, as far as being able to pay premiums found that now premiums are rising so sharply, they could not afford it and they are not covered anymore.

We are all for insurance reform but we know, on this side of the aisle particularly, that insurance reform can only happen in the context of total universal coverage, guaranteed private health insurance that cannot be taken away, for everybody. Otherwise, insurance reform does not make the problem better; it makes it worse.

Mr. CARDIN. I think we should stress that both the Michel bill and the Rowland so-called bipartisan bill do not provide for universal coverage, try to do insurance reform and will lead to the results that we are referring to, that the gentleman from West Virginia just mentioned. That is, we run the real risk that our constituents who currently have insurance are going to find that their premiums will go up substantially because both of those substitutes fail is not providing universal coverage and try to do insurance reform.

Ms. SHEPHERD. If the gentlewoman would continue to yield, I would like to make a point about business, especially small business, since I owned a small publishing company for over a decade.

I was one of the people who purchased insurance for my employees, because I thought it was the right thing to do. I did it as soon as I started the business. I did it much in the same way as I signed up for the utilities that we had at our company. I really did not notice it, that anything was happening, until years later when all of a sudden the bills started to rise.

Then I also started losing bids in my publishing company. And I tried to figure out why I was losing these bids. And when I went out and investigated it, what I discovered is, I was the only publishing company that I bid against that had health care coverage for my employees.

□ 2000

So suddenly I realized we have a public policy which actually punishes businesses when they do the right things and carry health insurance for their employees.

Mr. Speaker, I was angry about that, because I thought it was very unfair that I should be asked to pay for businesses which chose not to cover their employees, and that is precisely what I was doing. It made my uncompetitive, and I believe we can actually take that small experience that I had in my business, apply it to all of America, and say that very same dynamic is making America uncompetitive in the rest of the world, because we are the only industrialized country that we compete against that does not have 100 percent of its people insured.

Mrs. UNSOELD. Would the gentlewoman yield?

Ms. DELAURO. I yield to the gentlewoman from Washington.

Mrs. UNSOELD. If your competitors had been required, had had an employer mandate so everyone was offering insurance to their employees, that would not have been a disadvantage for you, would it have?

Ms. SHEPHERD. No, No; it would have leveled the playing field, and then we would have been competing on level turf.

Mrs. UNSOELD. Mr. Speaker, in this House we hear over and over again the cry that we must cut the deficit, and yet some of the very people who are expressing that and say that "we've got to attack entitlements," the biggest runaway of entitlements, the only one is health care.

The single thing that would bring the cost of health care down is universal coverage, employer mandate. Why should there be 85 percent of those who are uninsured work for a living, or are part of a family that works for a living, and yet they are not covered.

Mr. Speaker, the small business employers who give benefits to their employees are put at an enormous disadvantage. The gentlewoman has illustrated it perfectly.

Mr. CARDIN. If the gentlewoman would yield again, to compare the different approaches we have as to how it would deal with the problem that the gentlewoman raised, the Gephardt bill would deal with that by putting every company on a level playing field, but even going further than that.

That is, the small businesses that have legitimate affordability problems, there is a very significant tax credit program that reduces the cost for small businesses that have a large number of employees that are of lower wage, where you could run into some of the affordability issues. That is provided in the Gephardt bill.

The problem that the gentlewoman referred to would be answered. Once again, looking at the substitute of the Republican leader, the gentleman from Illinois [Mr. MICHEL], looking at the so-called Rowland bipartisan bill, neither one of those bills deals with the problem of small business.

You would still be at a terrible disadvantage if you as a small business person attempted to insure your employees, and there is no help, no help at all to make insurance costs for small businesses more affordable. In that case, again, the substitute is——

Ms. SHEPHERD. It is even worse than that, if the gentleman will yield. It is so bad that not only is there no help, if we do simply insurance reform, and we keep the system basically as it is today, we can guarantee small businesses that their insurance premiums will rise and rise and rise, because businesses bear the brunt of this, really.

Ms. DELAURO. Mr. Speaker, I think it is interesting to note that with the Michel bill, insurance companies will be able to charge small businesses more for the same exact coverage, exactly the way it is in the current system. Small businesses are likely to face administrative costs that are up to 800 percent higher than those that are paid by larger businesses.

In the Rowland substitute, the premiums, once again, will be higher for small businesses. Those are the early predictions on what it will be. There are no discounts to assist small businesses, which you will find in the Gephardt bill, because there is an understanding. There are small businesses today that would like to cover their employees, and they are having a difficult time doing that.

Ms. SHEPHERD. Two-thirds of small businesses do, they are doing the right thing.

Ms. DELAURO. They do. There are some that want to do that and they can't. What we want to try to do is to make it as easy as possible for small business to do that through a tax credit, to make it possible for them not to go out of business, which is what some of the naysayers will do, and both of these substitutes that we are talking about provide no opportunity for a small business to get the kinds of discounts that would allow them to prosper in their business and at the same time to be able to provide coverage to their workers that they can share responsibility in, and their employees can share part of that responsibility for paying the cost of health care.

Mr. WISE. Will the gentlewoman yield?

Ms. DELAURO. I yield to the gentleman from West Virginia.

Mr. WISE. The gentlewoman from Utah, who ran a small business before coming here, has illustrated the problems well, I think. I think what might be infuriating to me, had I been in the gentlewoman's situation, is that you are doing exactly what people would ask of you. Meanwhile, you are also paying for the employees of other businesses, whether they be competitors of yours or fast food restaurants or whoever, that are not doing it.

Indeed, what is happening in the premium that you paid is that up to 30 percent of the insurance premium that the gentlewoman from Utah paid for her employees did not go for her employees, it was cost shifting. It was picking up the tab for all the other uninsured people who went into the hospital and got medical care, usually at four times the cost if they had been able to go into a doctor's office.

Mr. Speaker, I guess what concerns me is that the fast food pizza employees, the McDonald's employees, all of those, some of the most profitable corporations that we have, who are not covered by their employer, they take pride in what they do. The only problem is that they eventually have to go get medical care, and when they do, somebody else pays the tab. We are not getting off cheaply because McDonald's does not provide insurance for its employees. We may save 8 cents or 9 cents on a happy meal.

I like the happy meal. My children like the happy meal. We are not so happy, though, that the employee behind the counter does not have insurance, and we are not so happy that when we go out of that McDonald's store, and that employee goes into the hospital, then all of us as taxpayers and insurance consumers have to pay that tab.

Mr. Speaker, I would rather pay up front, and I do not think it is going to be very much, and the gentlewoman and I have demonstrated in past presentations that the cost to a business is very, very cheap, two pepperoni in the case of a $10 pizza. It is very cheap, and yet it provides so much of what is needed. It is good economically and it is also good morally.

Ms. DELAURO. Just one point with regard to that. It really winds up with that business that is doing the right thing, that is, helping to cover their employees, winds up paying twice. They pay twice.

Ms. SHEPHERD. Yes.

Ms. DELAURO. The Michel bill, the Rowland substitute, does nothing to stop that process, where in fact the Gephardt bill ends that process.

Mr. WISE. The Rowland bill does have a measure in it that indicates a recognition that this is the way to go. What it does, though, is it is a hollow statement.

It says that all employers are required to offer insurance, and indeed, offer a choice between a fee for service plan or a managed care plan. However, the employer is not required to pay for it. There are no subsidies to help the employee, so what you have got is this hollow promise out there.

The significant thing about the Gephardt House leadership plan is that it has in place, for businesses under 100 employees whose annual income is below a certain amount, that they can receive a tax credit, as the gentleman from Maryland [Mr. CARDIN] points out, of up to 50 percent. They are paying 40 percent of the premium, and the low-income employees can also get assistance based on their income.

Mr. CARDIN. If the gentlewoman will continue to yield, the Rowland bill makes it worse. Many employers will say "All we have to do is offer." So I may be providing the benefits today as an employer, so I say, "The law only requires me to offer it, and since everybody has the chance to buy insurance, and since my competitor is not required to buy insurance, why should I pay for its? You do it with your own money."

Let me just give a concrete amount of money we are talking about from Maryland. At the University of Maryland Medical Center, a fine institution in my district, the uncompensated care equals 16 percent of their total revenues.

That means the premiums, the rates that they have to charge for services at that facility are 16 percent higher in order to pay for the people who have no insurance. Those of us who have insurance, the premiums we pay for the rates at that hospital are that much higher to cover those higher rates.

So now you as a publisher, as a small business person, you had to compete with companies that did not provide health benefits. You were not only being asked to pay the cost of your own employees and compete, but you were being asked to pay for your competitor's employees and then compete against your competitor.

That is what the current system does, and the Rowland bill will not change that. It may make it worse. The Michel bill won't change that. It may make it worse.

□ 2010

Small business has a direct interest in health care reform and only the Gephardt bill addresses their problems.

Ms. DELAURO. I would like to also talk about what happens with another group of individuals in this Nation who are very, very concerned about health care and health care coverage and what it means to them, and that is our senior citizens. The Gephardt bill includes a new Medicare prescription drug benefit, the new beginnings of a long-term home health care program. The Michel and Rowland Republican bills both raid Medicare to pay other bills, or to bring other groups in. It does not turn anything back over to providing prescription drug benefits for seniors or any other services to seniors. So there is no benefits at all in terms of the older American population. In fact, the Gephardt bill is the only bill that, in fact, just maintains the integrity of the Medicare system.

I am sure you have the same experience that I do with seniors and prescription drugs.

Mr. CARDIN. If the gentlewoman would yield on that point, because the prescription drug issue is a cost-saving issue. There are many seniors today that their medicine that they take keeps them out of hospitals, keeps them out of more intense health care. Sometimes they do not have the money to buy those prescriptions and they do not take their drugs and they end up needing more expensive health care needs. So the fact that we are providing prescription drug coverage under the Gephardt bill to our seniors is not only of interest to our seniors, it is in the interest of having a more cost-effective health care system in this country. It is a very important expansion of the benefit package.

I know of many seniors in my district that spend $200, $300, $400, $500 a month on prescription drugs and have no protection under the current Medicare system. Under the leadership bill, they will be protected.

What does the Rowland bill do? What does the Michel bill do in this area? They do not do anything. They do not provide these benefits. But worse than that and what the gentlewoman pointed out, they take Medicare cuts and take that money and use it to expand the access for low-income people. So they are really taking the money that goes to providers and goes to our program for Medicare and using it for other purposes. At least the earlier drafts of the people who were behind the Rowland bill had enough courage to put more revenue in the package in order to use it for the purpose of expanding access, but now I am afraid that the option they have brought forward takes money from under Medicare and uses it to try to expand access and it should be used to expand the prescription drugs.

Mr. WISE. If the gentlewoman would yield, the gentleman from Maryland brings up a point, and it gets even more incongruous from that, because what the Rowland, or bipartisan bill does, it not only cuts Medicare without giving any increase in benefits from those cuts, but furthermore it cuts Medicaid and then says it is going to expand coverage for low-income persons after it just cut the program that covers low-income persons.

The Gephardt bill does not get into those kind of cuts with Medicaid and it does cut for Medicare but the savings from administrative efficiencies go to long-term care and prescription drugs. Senior citizens on the average pay about 65 percent of their prescription drug costs out of pocket, but there is another aspect to this long-term care. Any senior citizen or family who has come to grips with this knows that the average family of just a couple of years ago, the statistic was the average family putting somebody into a nursing home will be bankrupted in 13 weeks, at an average of $3,000 per month. This was the beginning of significant expansion of long-term care dedicated to home, dedicated to keeping people in their homes where they can function with care providers and others on a cheaper basis and, incidentally, a more therapeutic one. So that is what is covered in the House leadership plan.

The bipartisan bill, nothing. The Michel bill, nothing. And so seniors see Medicare cut under the bipartisan bill and the Michel bill. They see Medicaid which does affect some low-income seniors, they do not get anything for it, and they lose the benefits that are put into the Gephardt/House leadership package of long-term care and outpatient prescription drugs.

Mrs. UNSOELD. More than any other issue, I believe that the fear of not being able to pay for the prescription drugs haunts many of the seniors. Our colleague, the gentleman from Oregon [Mr. WYDEN] and I had a hearing on the prescription drug cost and particularly for seniors. The tragic stories of seniors who would pay for their prescription drugs as long as they could and then when they had to pay the rent or they had to replace or do some repair, some other need, they would cancel renewing their prescription drug. Pharmacists said they could predict who of their customers was going to end up in the emergency room, in the hospital because they had to forego the drugs that were going to keep them healthy, functioning and maybe even alive.

Ms. DELAURO. I would echo what the gentlewoman said. My experience is what seniors do is one of three things when they go to the pharmacy with their prescription. They ask for the cost first. If they deem it too much, they do not get it filled at all or they may get half filled. The third piece is that they get it filled and then because so many are on fixed incomes, that what they do is maybe scale back on what they are eating in the course of the week. So in all three instances, we watch a senior population, older American population, probably the most vulnerable population, seeing their health deteriorate further because of the cost of prescription drugs.

What is most incredible is that in terms of this Medicare effort, the Michel plan cuts the Medicare reimbursements to hospitals and doctors, but without relieving them of the burden of the uncompensated care because of the lack of universality, of including everyone, which just continues to compound problems.

Mr. CARDIN. If the gentlewoman would yield, it may be worse than that, because they also cut Medicaid. As the gentleman from West Virginia was indicating, they are cutting Medicaid. They are cutting the program to the poor. Under the Gephardt bill, we reimburse hospitals and doctors the same rates on the poor people as we do for everyone else. We bring that rate up so that hospitals and doctors are not discriminated against who are taking care of poor people. But under the Rowland bill, under the Republican bill, what they are doing is they are cutting the Medicaid program, reducing it, and it does not pay the right fees now, it is paying too little right now, they expect with less money they are going to be able to cover more people.

The original drafts of the managed competition and the people that were trying to work in a bipartisan fashion had new revenues in here. They had caps on how much you could deduct and they had tobacco taxes, they had money in the bill in order to try to deal with some of these problems. But it looks like they really have taken the lowest common denominator and now they are going to cause more problems for hospitals, for doctors, for our elderly, and for our poor.

Ms. SHEPHERD. If the gentleman would yield, I would like to point out that when we talk about Medicaid, we are talking about seniors, that is true. But we are most importantly, I think, talking about children. We are talking not about small adults, we are talking about children; children who need immunizations, children who need to be able to go to the doctor when they have an earache; children who may have childhood diseases that if they are not treated will become adult disabilities. We are talking about the seed corn in America. We are talking about the future work force of America. We are talking about the people that we most must keep healthy and strong and raise up to replace us. I think that the lack of health care to children is absolutely one of the greatest tragedies of all of this.

The Carnegie Foundation recently released a study that said that America was dead last among all industrial nations in the quality of life lived by its children. This has got to be because of our health care.

They have higher incidences of childhood disease, they have fewer immunizations. Obviously those two are very closely connected. They are far less likely to have preventative care of all kinds. They are far less likely to have check-ups when they need them. This is something that I think it is our absolute moral obligation to address.

□ 2020

Mr. KREIDLER. If the gentlewoman would yield, I would certainly like to point out in connection with it argument she has put forward here when we deal with children, I was a clinical optometrist before I was elected to Congress in 1992. As an optometrist I dealt with patients on a one-on-one basis. I dealt with mothers on welfare, and not infrequently, if not always invariably they would point out to me the reason they could not get off welfare is they needed to keep their health insurance, they needed to stay on the Medicaid program, so no matter what they did from the standpoint of finding jobs they never could find the jobs that would pay the kind of a salary that they could purchase their own health insurance. That is presuming it was even available to them, much less find a job that would cover it as a part of their work.

So, as a consequence, you saw a situation where it precipitated them staying on welfare. If we care about welfare reform, if we really care about what happens to children in welfare families, then you have to have universal coverage, which brings us back to the point that was being made earlier quite eloquently. Those who argue that what we need to do is just fix what is broken, meaning just a little bit of insurance reform, is so shortsighted. It leaves major gaps. It will never achieve universal coverage. It means that we take care of the wealthy, making sure we do not step on their rights to make sure that they always get health insurance. We may throw some bones to the poor. But the middle class is left out in the cold. Increasingly they find it difficult to continue to purchase health care, that they are being priced out of it, that they do not have the resources to purchase any longer. Their salary increases are being eaten up trying to maintain their health care benefits, and if they lose their job they find it that much more difficult to be able to keep their insurance, if they can afford it for the 18 months that they are able to continue it right now, much less have any other benefit.

Mr. WISE. If the gentlewoman will yield on the point the gentleman from Washington makes, not only are the middle class left out in the cold, they get burned. They get burned because in the recent Lewin-VHI study that was done for the Catholic Health Association, we analyzed incremental plans or reforms, meaning simply doing an insurance reform without universal coverage. What they concluded was for persons between $10,000 and $20,000 a year income they would pay annually $201 more, for persons between $30,000 and $40,000 a year they would pay $344 more, and from $40,000 to $50,000, $137 a year more.

The middle class gets burned if you just do insurance reform. You are going to tell them that it is insurance reform, this one is for you, and it is really for you, it puts it right to you, and that is why it is so important that we have to frame this debate.

I am glad that these proposals are now in writing, the Michel proposal, the bipartisan proposal, the Gephardt proposal. They are out there, and now the American public can analyze them and see where they come down. But I do not think the middle class are going to be very happy knowing they get insurance reform, and when they get that, they get reformed right out of their wallets.

Ms. DELAURO. The chart over here to my right displays precisely what my colleague was talking about and how that working middle-class family wind up paying increased costs without the advent of universal coverage, which is something that I would urge people to take a look at these various plans and understand what they are about.

There is a lot of rhetoric, granted, and these are studies that are independent studies of these plans which are making the determination of what happens when we do not have every person in this Nation covered by insurance.

There is another issue that I would like to raise. There is a contrast between what the Gephardt proposal talks about versus the minority leader's plan or the Republican substitute, the Rowland Republican substitute, and that is the issue of preexisting condition, which is prohibited in the Gephardt plan where insurance companies cannot say to you that because you have had the good fortune to survive a major illness, or because maybe your child has asthma that therefore you can no longer get insurance. That in fact is prohibited in the Gephardt bill, and it is not clear what the situation is in the other bills. That is of prime importance to the American people.

Mr. CARDIN. If the gentlewoman will yield, it is my understanding in the Rowland substitute there is a 6-month waiting period. I thought this was one area that we had agreement on. I mean, we have heard from all sides, both parties and all sides of the political spectrum that we were going to do insurance reform and eliminate the discrimination against people who have preexisting conditions. And it looks like they did not even put that in their bill.

Ms. DELAURO. Exactly. If you are going to talk only about insurance reform, then for heaven's sake make sure we do not continue to put people in jeopardy.

I met a young woman at one of my office hours, a most incredible story. She has multiple sclerosis and she is now covered. Her neurologist said to her that she ought to be taking as quickly as possible the new drug, Betaseron. She said to me, she was asking please support health care reform. She said I will not talk to my employer, nor will I talk to my insurance company about this because I am frightened to death that it will be over, that they will not provide any kind of service for me, and that I will not be able to get this.

It is most incredible. This is a woman with a deteriorating disease, and every day that goes by makes it more difficult for her to live her life. And she is frightened to death to bring this to the attention of anyone who might be able to help her. This is the wrong system.

Our colleagues have put together programs that say that we are not even going to go the full measure on preexisting condition in what they characterize as a limited reform in any situation. It really needs to be looked at by the American public, and you wonder what these folks are trying to accomplish here.

Mr. CARDIN. We knew it was going to be a limited bill, but I thought at least we were going to see that provision in the bill. And it looks like they have sort of opted out on the side of the insurance and decided to give a way out so insurance companies do not have to pay for preexisting conditions.

Ms. DELAURO. In addition to that, there are mechanisms within the Gerhardt bill to also say to the insurance companies that while they maybe accept someone with preexisting condition, they cannot charge any price they want for that preexisting condition. What price for heart disease? What price for a cancer survivor? So this is critically important.

As I said earlier, I am a survivor of ovarian cancer. If I were to try to get insurance it could cost me up to $12,000 to $14,000 a year. Who can afford to pay that kind of money for insurance?

So these plans fall short on even the limited measures that they are willing to move forward on.

Mrs. UNSOELD. The sponsors and proponents of those plans give lipservice to removing this problem, this burden that hangs over Americans and denies to those who work hard for a living and have a right to guaranteed insurance, denies them that right while they give lipservice to remedying their problem.

You have very well described it.

Ms. DELAURO. I think the choice is clear. I think the halfhearted approaches in fact do not measure up to the Gephardt bill, and if we can, we really need here to summon up the courage to pass the Gephardt bill and not be blindsided, if you will, by these limited bills. If we do that, then my view is that we will have failed in this mission, and my colleague from Maryland was talking about that earlier, we will have failed the American public with a year and a half of debate and discussion.

Mr. CARDIN. I was just trying to take some notes here on Gephardt. We have universal coverage. In Michel or the Rowland substitute we do not get universal coverage. We have been through that. On small business, the Gephardt bill helps business, eliminates discrimination in the current marketplace, provides help on the affordability to small business, whereas the other two bills do not deal with that at all. The Gephardt bill helps our seniors by providing prescription drugs and long term care which is fully paid for in the legislation. The other bills take from the Medicare Program and give our seniors nothing in return. The Gephardt bill has full insurance reform. We can eliminate the preexisting conditions, we live up to a commitment I think we have given to the American people on health care reform. The other bills do not do that.

We have not talked cost containment, but we have effective cost containment in the Gephardt bill. The other bills do not do anything to bring down the overall growth rate of health care costs.

□ 2030

It seems to me that we do not have any choice. There is only one bill that is going to provide meaningful health care reform that we are going to have a chance to vote on.

Mr. WISE. There is another choice, and the choice is to do nothing. That is what some are urging us to do, delay, stretch it out, have another study, have a good time, do not come back, and the reality is doing nothing. Where does that leave each of the categories? You mentioned for the senior citizen, on Medicare today, that means they are going to have to continue to watch while Medicare gets eroded because of deficit-reduction pressures, and yet nothing is done to enhance the entire system. There certainly will not be any long-term care or prescription drugs for the small business.

The gentlewoman from Utah was eloquently describing the challenges she faced as a business person. I think it is going to mean a lot of small businesses having to opt out of health care because they simply cannot afford it. They cannot afford to continue to pay for their competitors who do not provide it, and they see the rates continuing to rise to them.

The middle-class person, they are the ones getting squeezed all the way through.

Mr. CARDIN. I will respond to the gentleman from West Virginia. As the gentleman from Washington pointed out, if we do nothing, how do you get to welfare reform? How are you going to reform a welfare system if we do not take care of one of the major problems that someone on welfare has today of taking a job and losing their health care benefits?

Mr. WISE. Secretary Shalala estimates that 1 million people come off the welfare rolls over the next few years if you pass comprehensive health care for the reason the gentleman says, because now people do not lose their medical card, low-income medical card, by going to work. We penalize a lot of people by not acting. You do not help anybody. You penalize them.

Mr. KREIDLER. I would like to point out that listening to the arguments that are coming forward right now are really disappointing from the standpoint of what the gentleman from Maryland pointed out. There are those who are arguing right now to do nothing, to delay, to postpone, take another year.

The longer we take, the worse the problem gets, more people that are denied access to health care, the more difficult it becomes to make a correction in the system. What are we talking about for change?

You know, those that will talk about government takeover of health care, it is so ridiculous that it is patently almost humorous in its own way, because we are talking about private insurance, private insurance. All you are doing is trying to establish some game rules so that there is some kind of understanding so that some people over here do not kind of game the system and others over here have to pick up the tab.

It is kind of like the airline industry in a way. You can sit in a seat on an airplane and maybe you have gotten the rock-bottom price and so forth, and the next person over is paying the maximum price. It is much like that today in the kind of cost-shifting that takes place in our health care system.

If we want to get a handle on our health care so we bring about some rules so we eliminate the cost-shifting, we get rid of all the bureaucratic overhead that is built into it, administrative overhead, the overcapitalization that has taken place in high-specialty medical equipment, the overspecialization that has taken place in medical specialties; if we want to get back to where people really get the health care they need, then it means setting up some rules, but keeping it private. Keep Government out of it; minimize Government's impact, and it will not happen overnight.

We are talking about a system phased in over a number of years.

Mrs. UNSOELD. Not only are we talking about private insurance, but we are talking about giving people the choice of what doctor they go to, what hospital they go to, not their employer making that decision, not the Government making that decision, not politicians making that decisions, but the individual selecting their health care, their doctor.

Mr. KREIDLER. How frequently now, if most workers out their find that their choices with their employer have been continually narrowing, there have been fewer and fewer choices, that they have had less quality options, they have been more or less dictated to what they are going to receive. We are giving them some real opportunities.

Ms. DELAURO. If I might summarize. Our time is coming to a close.

I think what we have all talked about here is the effect of the substitutes and what they offer, and on all scores the Rowland Republican substitute, the minority leader, the Michel substitute shortchange, if you will, middle-income families, older Americans, small businesses. They do not get near to controlling costs, and, in fact, leave the insurance companies in charge and do not meet the first test of any health care reform, and that is to make sure that every single American is covered under private guaranteed health insurance that can never be taken away, and that is affordable.

The only bill, the only proposal that addresses all of those problems is the Gephardt bill.

I know I have said to many groups, my colleagues have said to many groups that they are meeting back home with, that the most important piece of legislation that we are going to work on in this body is passing health care reform. If we do not pass the Gephardt bill, we are not going to be able to face those mothers and fathers that I talked about earlier on who are frightened to death that they are not going to be able to afford health insurance for themselves or their kids or that they are going to be trapped in their jobs without having the opportunity to have health care benefits.

We cannot go home from this Congress and not pass the Gephardt proposal and pass guaranteed health insurance for everyone in this Nation.

I want to say "Thank you" to my colleagues for joining with me in this special order tonight. I am sure we will find ourselves on this floor again several nights to come in the next several weeks.

HEALTH CARE REFORM PLANS MUST BE THOROUGHLY UNDERSTOOD

The SPEAKER pro tempore (Mr. LEHMAN). Under the Speaker's announced policy of February 11, 1994, and June 10, 1994, the gentleman from Michigan [Mr. KNOLLENBERG] is recognized for 60 minutes.

Mr. KNOLLENBERG. Mr. Speaker, this evening we are going to continue a matter that was brought up a couple of days ago in a special order regarding the process regarding what appears to be, and I just heard some comments from the other side as to the urgency that seems to prevail over there as to the fact that we have to do something now; we cannot wait; we cannot wait a week or 2 weeks or a month. We have got to do it now.

Mr. Speaker, I would tell you that informed consent is something that I believe is very dear to the American people. It is something that everyone who makes a decision, whether it is an individual decision, and it is certainly an individual decision, they make it after doing some study, assessment, analysis. No one buys a home, for example, unless they spend some time checking things out, looking things over, and coming to some conclusions as to what they can afford, what is best for them, and what meets their purposes.

Individuals make those decisions. Localities do. Cities, towns, whenever any issue comes before a city, wherever it might be across the country, they do not jump into it. If it is a matter of a bond issue or a rezoning, that is something that goes before the people, and the people are invited to take a look at the situation and make some judgments and, in effect, offer their opinions so the constituency is served. They get their day, so to speak, and everybody comes out with a reasoned decision, or at least it is a decision that is based upon some information that is provided from a number of sides.

The Federal Government should be no different. It should be no different than what individuals go through in the reasoning process or what localities do.

Frankly, this afternoon we saw an example perhaps that might fit. I do not want to talk about the crime bill. I do not want to talk about the rule except to say a rule, a crime rule, failed today, and it failed, I believe, in large part because a number of Members of Congress, and I am talking about both sides of the aisle, it was both Democrats and Republicans, felt there was too much they did not know about this bill, and for example, when a couple of things started trickling out like $10 million for a college down in Texas, that really does not fit into the purview of the crime bill. That becomes something else. That question was raised. There were many others.

So I believe that we have to spend some time looking over what it is that we are making a decision on that affects one-seventh of our economy and affects every man, woman, and child in this country.

So I do not believe that we should hurry up just for the sake of hurrying up. I believe we can do a better job if we stop, look, listen, assess, analyze, and come up with the best idea.

I am glad to hear from the other side of the aisle that they recognize now there are some bills other than the Gephardt bill in the House and the Mitchell bill in the Senate. There is a bipartisan effort, and very honestly, it is truly bipartisan. It is one that embraces some concepts the American people have been telling us they want.

As we look at poll results from around the country, we find that they do not want any kind of slam-dunk process. They want to be very careful about how we change this system. Reforms, yes, but not to completely turn it upside down and indicate to the American people that they do not care about what their thoughts are.

I think we have a job here to be reflective of what the people in our own constituencies want. The overwhelming polling results tell us they want to go slow, "Let us fix it right," and in that regard this evening, we are going to involve a number of people who have positions, who support certain bills, who have views about how this should be done.

I want to turn to these people one by one. But first of all, I would like to have us welcome the gentleman from Arkansas [Mr. HUTCHINSON] who will talk to us about the process, reform, or anything that meets your approval.

Mr. HUTCHINSON. I thank the gentleman for yielding. I thank the gentleman for organizing this special order this evening on this very, very important subject.

As we enter into the debate on a social issue that will impact the lives of every American, every man, woman, and child in this country, what could be more important than taking time to discuss the pros and cons?

I was delighted, as I am sure my colleagues were, today to see that the bipartisan negotiations that have been going on for weeks now, many, many hours in length, were rewarded, were fruitful in coming out and announcing today a bipartisan health care proposal.

So we really have a debate now. We have a Clinton-Gephardt; we have a Clinton-Mitchell bill; and we have a health care reform bill with bipartisan support that deals with the health care crisis in this country from the standpoint of private sector reforms to expand coverage to more Americans than ever before and to begin to control the spiraling costs in health care.

□ 2040

I think there are a number of things out there in the public sector right now to assist us as we look at this health care debate.

One of the books recently published, written by Dr. Jane Orient. She is an internist in Tucson, Arizona, and she heads the Association of American Physicians and Surgeons, with over 4,000 members nationwide. The title of her book is, a very timely book indeed, "Your Doctor Is Not In." I think she provides us some important insights. Let me share a few of them.

She says, first of all:

> The proposed remedies for the health care crisis are snake oil, and you shouldn't swallow them. Further, the private doctor is an endangered species. In the end, we will have a herd—a nice, placid, socialized, tamed, cud-chewing herd. Readers should care about the plight of doctors for one and only one reasons; Some day they might need one.
>
> You may think you know what the Hippocratic Oath says, but you probably don't, and you should learn about it before they do away with it entirely.
>
> The Hippocratic Oath is built on physician autonomy. It reads, "I will prescribe regimen for the good of my patients according to my ability and my judgment."
>
> Further, do you want your doctor to place society or the Department of Health and Human Services ahead of his being independent?

She says, further:

> Managed care is about preventing medical care in order to make money for third-party payers or to save money for the government. Behind the slick advertising, managed care is little more than prepayment for rationed health care." Rationed care is one of the most disastrous things that can ever happen to the health care practice in this country.

Then I conclude with her insight:

> There is no utopia. I will only maintain that a free market in medicine is the best of the available alternatives and the one that does the least harm.

That is what doctors do, the least harm. That is what the Hippocratic Oath says. The way we do the least harm, although it is not perfect, is to maintain a free market in the health care system.

Another recent book, a novel published entitled "Fatal Cure," by Robin Cook, a best-selling novelist.

He as a physician. As a doctor, imagines what will happen to the health care service industry in this country should we resort, should we go in these coming weeks, to Government-run health care system. I only share with the listeners this evening and with my colleagues a couple of paragraphs of the dialog that he imagines might take place some day.

He says, "Everyone knows that doctor/patient relationships are the cornerstone of medical care." One of the characters says, "Maybe that's passe. The current reality is determined by a new army of medical bureaucrats being created by Government intervention. All of a sudden, economics and politics have reached the ascendancy in the medical arena. I am afraid the major concern is the bottom line on the balance sheet, not patient care.

"The problem is Washington. Every time the Government gets seriously involved in medical care, they seem to screw things up. They try to please everybody and end up pleasing no one." Dr. Cook is absolutely right. That would be the result of Government-run health care.

In the Washington Post, not exactly an advocate of free-enterprise health care, certainly one that has espoused the Government-run health care in its editorial policies. Dana Priest, in a front-page story entitled "Health Bill May Have No Substitute for Bureaucracy," he writes just recently,

> President Clinton and members of Congress last week hailed the Senate Democratic leadership's health bill as a vast improvement over the bureaucracy-laden 1,462-page plan produced by the White House.
>
> But the 1,410-page bill proposed by Senate Majority Leader GEORGE J. MITCHELL (D-Maine) also would create dozens of new federal and state agencies. They would have untested authority to centralize, reorganize, monitor and enforce the way medical care is bought, sold and, to a lesser extent, practiced in this country.

And indeed the Post is right. They would have untested authority to centralize, reorganize, monitor and enforce. I understand that the Clinton-Mitchell bill in the Senate has over 20 new Federal bureaucracies that will be created.

Now, before I yield back to the gentleman, I want to share a letter—I am from the State of Arkansas, I have served 8 years in the Arkansas Legislature with now-President Clinton, our President was then my Governor, our chief executive in the State of Arkansas.

Many times during those 12 years that he was our Governor, the issue of abortion, and more specifically the issue of public funding of abortion, arose in various debates. In Arkansas, as it has been throughout our country, a major issue, and it continues to be a major bone of contention and a major issue in the health care debate. In every major Government-run health care plan that has been presented to this Congress, the provision for reproductive services or abortion services, if you will, has been included. That means that every American under a Government-run health care system would be subsidizing the practice of abortion regardless of what their moral conscience or religious convictions would be.

September 26, 1986, Governor Clinton, then Governor, wrote in a letter to the Arkansas right-to-life people a letter in which he said, in part,

> Because many of the questions do concern the issue of abortion, I would like for your members to be informed of my position on the state's responsibility in that area. I am opposed to abortion and to government funding of abortions. We should not spend state funds on abortions because so many people believe abortion is wrong.

That was Governor Clinton who is now President of the United States saying he not only opposed abortion but he opposed public funding of abortion and believed it was wrong to require people who believe it is wrong to pay for abortions. And yet today he has included that, insisted on including that in every Government-run health care program that he has advocated and supported.

Then I would conclude—and I am indebted to our colleague from the other side of the aisle, the gentleman from Minnesota, TIM PENNY, Democrat, for his "Dear Colleague" letter in which he points out something that I think is vital in this debate in the coming weeks. He points out that major votes of the 20th century on large social policy changes have always been accorded overwhelming bipartisan support. He enumerates some of those: The Social Security Act of 1935, 96 percent of the Democrats supported that, 81 percent of the Republicans supported that, and it passed by a vote of 372 to 33. The development of the interstate highway system, Federal-Aid Highway Act of 1956, major policy change in our country, 93 percent of the Democrats supported it, 98 percent of the Republicans supported it, passed by a vote of 388 to 19.

Now, the Civil Rights Act of 1964, what more significant social change has this Congress enacted than the Civil Rights Act of 1964? Sixty-one percent of the Democrats supported the civil rights bill, 80 percent of the Republicans supported the Civil Rights Act, and it passed by a vote of 290 to 130.

I could go on, the Clean Air Act, the Medicare Act, the Water Pollution Act, all of these passed by overwhelming bipartisan majorities.

Here we are told that we must in the coming weeks, have a health care reform bill that is going to affect the lives of every American, the biggest social change in 50 years, and we are going to do it with the barest of majorities. It is going to be forced through in spite of overwhelming opposition not only by the Republican Party but, the polls indicate, by the American people.

When the buscapade came to town, I saw the big banners on the side saying, "Pass It Now." And I said to myself, "Pass what now?" At that point we did not even have a bill. No one had read a bill.

Yet they say we have got to hurry it through, we have got to do it now. Yet the polls say 65 percent of the American people say they want to wait, they want to read it, want to study it, want to react to it, and that is the way major social change ought to take place.

□ 2050

It ought to take place with the American people aware of it, the American people supportive of it and with a large bipartisan majority supporting it in Congress. We do not have that, and that is why we ought to wait on health care reform.

I thank the gentleman.

Mr. KNOLLENBERG. Mr. Speaker, I thank the gentleman from Arkansas [Mr. HUTCHINSON] for his comments and his reference to the Government intrusion, the bureaucracy that appears to be a part of both the Gephardt bill; not just appears, is, and also the Mitchell bill.

As my colleagues know, we did finally get, not the CBO figures in total, but we did get a preliminary analysis on the Mitchell bill, the one that is still forthcoming on the Gephardt bill, and there is something interesting in that analysis, and it is purely that. This is not the final product.

But I want to just quote from a paragraph that has to do with the budgetary treatment of the mandate, and it says it is a mandate, and they are talking about this whole process of requiring people to buy insurance, that they must buy insurance. A mandate requiring that individuals purchase health insurance would be an unprecedented form of Federal action. The Government has never in history required individuals to purchase any goods or service as a condition of lawful residence in this country.

So, as a part of that bill, in order to live in this country, just to live here, before you do anything else, before you make a wage, or buy a car, or buy a house, or whatever, before you do anything, you must buy something, and that something is insurance, and that is a part of the Gephardt bill. It is a part of the Mitchell bill. At least in this regard we are talking specifically now about the Mitchell bill.

I want to go on to welcome the gentleman from the western part of Michigan who sits on the Committee on Public Works and Transportation and the Committee on Education and Labor, and that is the gentleman from Michigan [Mr. HOEKSTRA].

Mr. HOEKSTRA. Mr. Speaker, I thank my colleague, the gentleman from Michigan [Mr. KNOLLENBERG] for yielding. I would also like to clarify the comments of my colleague from Arkansas.

I am sure that what my colleague meant, that we do not want to wait on health care and postpone it. We want to go through a deliberative process that can make this House proud of the work that we are doing and make the American people confident in the result that we are going to achieve. And we want to do it in a bipartisan way.

Let me outline for my colleague here the process that we went through on the Clinton bill in the Committee on Education and Labor:

We had 29 hearings. We had 8 weeks of markup. We had 4 weeks of markup in subcommittee. This is where Members can propose amendments. We discussed them. We debated them. And then we voted on them. We then had another 4 weeks of markup in full committee. In full committee we debated 99 amendments on the Clinton bill. Forty-four Democratic amendments were accepted, and 11 Republican amendments were accepted. So, we spent 8 weeks.

Now what is the process that we are looking forward to on the next portion of the health care debate? What we are looking at is last night, August 10, we received nine bills. We received a Clinton-Gephardt bill, we received a Mitchell bill, we received a bipartisan bill, we received a single payer bill and five other bills. In total nine bills were submitted.

I have to give the Printing Office credit in that they were able to get them printed overnight so over the next few days we can read them, but now we have been told that the process that was outlined at the beginning of the week says, well, we know the work on the Committee on Education and Labor, and we only dealt with a portion of the jurisdiction of the bill. We know it took you 8 weeks. But we are going to give the full House 8 or 9 days to go through the process.

I do not think that is a good way to legislate. Nine new bills and 8 days to finish the work. No time to go back to our constituents.

Some of our colleagues here earlier tonight are saying now that we have the bills we can learn them, we can read them, and understand then, and talk to our constituents about them. The question is: When are we going to go through that process? There is a better process.

Today I went to the Committee on Rules. I asked them for an open rule, enough time to debate the issues, to propose amendments on all of the bills, asked them not to have a king-of-the-hill rule where the last bill that wins, even something that may only have 218 votes, is the law of the land, but the version that has the most votes becomes the law of the land. I do not know whether that will be the process that we go through or not.

But let me go through the Clinton-Gephardt bill to take a look at why it is important for us to have this dialog in this debate—

Mr. HUTCHINSON. If the gentleman would yield before you go into your analysis, let me pick up because you were clarifying my comments regarding whether we should wait or whether we should pass it now, and let me just expand that because I began my remarks by saying that today I was delighted that there was a bipartisan incremental approach, free market approach, to health care reform that was presently with the support of Republicans and Democrats. I think we need to do health care reform, but the polls indicate that the American people, if the choice is between radical, Government-run health care as presented in the Clinton-Gephardt, the Clinton-Mitchell and all the variety of bills thereof, if the choice is that or doing nothing, they would rather us wait and start over in the next Congress.

And so what I support is a deliberative process, I support action, I support reform now, if it is the right kind of reform.

The American people are saying, and I think we all agree, if the reform is the wrong kind of reform, it would be far better to wait than to make radical changes in the health care system without knowing what kind of impact that is going to have on the lives of individual Americans.

Mr. HOEKSTRA. I agree with the gentleman. I think what the American people are afraid of is that we will go after health care, and we are going to do it in 8 days, and everybody knows, or should know, that this Congress is not good enough and is not smart enough to do health care reform or to reform 14 percent of our economy in 8 days. We may be good, although the American people would dispute that sometimes, or maybe frequently. There is no way that any group could restructure 14 percent of the economy that quick.

And the other thing is we, as freshman Republicans, we laid out another process. We said, "Let's go through the bills this week. Let's allow the sponsors a day on the floor to go through their bill section by section to explain how it works. Let us go back home, not for vacation. Let us go back to our constituents to talk to the elderly, to talk to the uninsured, to talk to the small business person, to talk to the doctors, talk to the medical community, to get their input on these new versions."

We do not have that opportunity.

We could go through that deliberative process, 8 or 9 days of debate on the floor, conference committee with the Senate, and still pass out a bill by October 7 rather than trying to cram one through the process by August 19.

Here is why it is important. Paging through the Gephardt bill, and, just like the Democrats are going to page through the Michel bill and find sections that they do not understand, there is a mandate. Employers are required to contribute to health insurance. What is that going to mean to employment in my district? What is that going to mean to the average American? There are new taxes.

This is small print. That is why the Clinton-Gephardt version is only 250 pages. But I am going to have to bend over to read it because it is small print.

Here in the text, 25 percent of the wages paid during such months by such employer to such employee. What does that mean? How is that going to affect employment?

There is more taxes, small business subsidies. We hear so much, we are going to do this for small business. The subsidies phase out zero for calendar year 2005. What is that going to do to the engine of growth in this country where a lot of innovation has taken place? Small business is in trouble.

Here we have standards for State managed competition programs. It is gobbledegook in here. I know what this language meant in the Committee on Education and Labor. It meant that our national health care program was going to be a continental United States program because the language in the Committee on Education and Labor, and I do not know if it is the same language exactly, but this type language in the Committee on Education and Labor exempted Hawaii.

Here is one that I love. As I go back and I talk to the leading employers in my district, the people that have really aggressively contained costs, and, TIM, you have had the opportunity to talk to some of those people at those companies, they have effectively gotten health care under control, and what do they say? They talk about wellness, and, when they are talking about wellness, they tell the Secretary of Labor to put together a study on wellness and report back to the Congress in 2 years whether wellness programs are the right way to go.

So, in 8 weeks, or excuse me, in 8 days, we are going to reform health care, 14 percent of the economy, and it is going to take us 2 years to study whether wellness programs have any validity. There are new enforcement provisions about how we are going to pay for the bill or what types of programs we can put in place.

□ 2300

There are exemptions. Let me see if I cannot find the exemptions section. Who is exempted from this bill? What people do not have to participate?

Well, we know that the Texas Frail and Elderly Demonstration Project does not have to participate. We know the HMO in Dayton does not have to participate. They may have a great program. They got an exemption. I do not know how they got an exemption. I wish I had an opportunity to exempt some of my people who thought that they had a good program. The Tennessee Primary Care Network has a Medicaid waiver. There is another one here for the Health Services Insurance Corporation of Milwaukee, Wisconsin. They have an exemption. The extension of the Minnesota Prepaid Medicaid Demonstration Project.

Mr. GEPHARDT or the President did not call me and ask if I would like any people considered for exemptions. Those people are exempt.

There is new amendments to criminal law, health care fraud, false representations, bribery and graft in connection with health care. Should we not spend more than eight days talking about those kinds of things?

Health benefits may not be provided under a cafeteria plan. Another innovation in the free market, in the private sector, and what do we say? We may not have cafeteria plans. An employee cannot sit down with his spouse and say here are our needs as a family, or here are my needs as an individual for health care, so I am going to take dental, I am going to take some extra life insurance, I am going to take this and I am going to take that, and that is going to be my health care plan. The person next to him working on the other machine is saying my needs are different. Boy, am I glad that my employer has provided me with the choice. I am going to take eye coverage, and, rather than get this rich package, I think I will take $30 per week and a Medicaid cap.

Cannot do it. That is the way I read it right now.

Here is a really interesting one. Davis-Bacon, the place where we say prevailing wages, primarily on construction projects, Davis-Bacon is now part of a health reform bill.

How in the world you are on public works with me, maybe you can tell me how Davis-Bacon would get into this type of a bill. Any ideas?

Mr. HUTCHINSON. I wish I could give an answer for that. I cannot imagine how Davis-Bacon gets in some other bills. But how it would be included in a health care reform act is beyond me, and I think beyond the imagines of most Americans.

Mr. HOEKSTRA. Does that mean the Gephardt bill is bad? I think we are concerned because it demonstrates government taking over health care. And we have a lot more faith in the free market system.

Even to knowledgeably talk about mandates, taxes, state exemptions, wellness enforcement, criminal law, no cafeteria plans, Davis-Bacon, new fraud provisions, it takes a whole lot more than eight days to understand this, to get input from our constituents. That is one bill. There is eight other ones.

Mr. HUTCHINSON. A thought struck me as you were presenting your analysis, a preliminary analysis, indeed, of the Gephardt bill. As you thumbed through it, I thought what an advantage you have to millions and millions of Americans who do not have a copy of that bill to thumb through and look at.

For months I would go into book stores around the country, and the airport book stores as we fly through to our districts, and see the Health Security Act, the Clinton health care bill on the shelves, with analyses, explanations. But the Clinton Health Security Act has now been long dead. With eight days, we have been presented a new bill that is not on the book stores of America, that has not been analyzed that we have the advantage of analyzing for eight days, as little as time as that is. But the American people have not had. why not give them the time to study this bill? The Republican Conference is having task forces, study groups, to analyze, if need be 24 hours a day, that bill and other bills that come before us in the next eight days. What an impossible task to do justice to the American people to have eight days to study and analyze a great social change in our country.

I thank the gentleman for yielding.

Mr. HOEKSTRA. The biggest part we are going to miss, I agree. I do not think we will be able to fully understand this in eight days, but, more importantly, the American people will not have the opportunity to review it, to provide us input. My guess is when we actually start debating and discussing this bill on the floor of the House, it will be limited time, we will not have the same opportunity that we have in committee to make 99 amendments. There will probably be just a vote up or down on eight substitutes, and the last one will be the Clinton-Gephardt bill. If it gets 218 votes, it passes, even though something like the Rowland-Bilirakis bill, the bipartisan bill—they keep calling it the Rowland bill, it is a bipartisan effort, 5 Democrats, 5 Republicans put together a bill—no new taxes, significant reform, significant progress, that may end up being the solution. It will be buried somewhere in the process.

I will yield back to the gentleman from Michigan and look forward to participating in the dialogue a little later.

Mr. KNOLLENBERG. I thank the gentleman from the western side of Michigan, as opposed to the eastern side where I am from. I notice he talked at some length about the size of the Gephardt bill. And maybe you pointed out that there was 253 pages of fine print. I would like to suggest to you it is probably 253 pages, three columns. I do not know if this can be seen by the television camera, but it is smaller than most footnote text type.

Mr. HOEKSTRA. If the gentleman will yield, maybe they can see the difference between how the Clinton-Gephardt is 250 pages, three columns, small print, and the traditional way we write bills, which is much larger text. My guess is that the Clinton-Gephardt bill, when it will be printed in bill form, will be close to 1,500 to 2,000 pages.

Mr. HUTCHINSON. The same thing would be true with the Mitchell bill, I believe. Would you not say?

Mr. HOEKSTRA. Yes.

Mr. HUTCHINSON. Thank you.

Mr. KNOLLENBERG. The interesting part, too, on that subject is the bipartisan bill that you spoke of really is less than—it is about one-fourth the size, and I am going by, again, what was printed in the CONGRESSIONAL RECORD. I might mention that the Mitchell bill, which is another alternative, a substitute that will be offered, we have been told, has been about the same size as the bipartisan bill.

So it seems to me that we have within our midst enough material to keep us going for weeks, if we are going to get through all of this newly laid upon us 253 pages, to soon climb to some 1,400/1,500 pages.

I want to now go to the gentleman from Kentucky who is the newest Member of the freshman class. Before I do though, I want to cite that a lot of the information and a lot of the views that we have are based upon communicating with our own constituents. I know that Mr. HUTCHINSON has done it in Arkansas and Mr. HOESTRA has in his part of the State. So have I.

I have had some nine health care forums. Two of those were attended by over 500 people. I can tell you that those individuals that came, came with a mission. They wanted to hear. But they wanted to speak, and speak. And we gave them that opportunity. They told us what they wanted. It was not just in those settings, but particularly in those settings. It was also, from all the communications we have had, all the phone calls, cards and letters, and from my own particular district I know overwhelmingly they do not want government intrusion in their health care system. They like in a great majority of cases what they have. It can be improved, take care of the portability fashion, preexisting conditions, and some other matters, which the bipartisan bill does.

I wanted to go to the gentleman from Kentucky [Mr. LEWIS] to get some sense of his constituency, what he has gleaned from dealing with them in the short time he has been in Congress. So I welcome Mr. LEWIS from the grand State of Kentucky.

Mr. LEWIS. Thank you for yielding your time.

Well, Kentucky is very much like what you are saying. Today we had calls in our district office all day long saying wait, wait, wait on the health care plan. Make sure you do it right. Don't hurry something through. And on August 4, the Newsweek article showed that in an over two to one margin, Americans believe that it would be better for Congress to start over on health care rather than pass something quickly that could be hazardous to their health care.

The American people want us to go slow, and they want us to do it right. And why do they want us to take our time and do something that is going to be beneficial and not hazardous?

So what are the problems with the Mitchell-Gephardt-Clinton plan?

□ 2110

Well, mandates, employer mandates. It is going to cost them anywhere from 600,000 to 3.5 million jobs. Both the Mitchell bill and the Gephardt bill include these mandates, and you cannot have mandates without someone paying the price. And guess who pays the price? It is the middle class.

Higher paid individuals will be able to still survive with these mandates, but the lower paid Americans are protected by the large government health care entitlement that will be created. So that leaves the middle class to take the brunt of these mandates.

Another problem that they are having with the Gephardt-Mitchell plan is the threat of rationing. The Clinton-Mitchell-Gephardt plan can lead to rationing our health care services through those mandated cost controls.

These bills sneak price controls in through the back door of these plans, and they are disguised as measures that will keep the cost of premiums down for Americans but, in effect, requiring the costs to be kept to a certain level, they will lead to rationing health care and benefits for the American people.

The Mitchell bill will impose taxes on health care premiums that exceed rates set by the government. Obviously, health care providers are going to have to cut expenditures to meet these levels. As any business owner knows, cutting spending means cutting back on services and cutting back on services means cutting back on health care for the American people.

Taxes, that is another thing that the American people are not liking about these bills. The Gephardt and Mitchell plan, they raise taxes on every American family and business owner in this country. These plans will initiate up to 20 new taxes on everything from retiree health care benefits to taxing ammunition.

What is something from my district that the people do not want? Of course, I have an agricultural-based district, and tobacco is the number one crop.

Well, these plans include a tax on tobacco. Specifically, a tax on a commodity that is singled out, singled out among all the others, this is the one that they are picking on. And with a huge tax, not a moderate tax, started out with a 75 cent tax with the Clinton bill, but now it is a 45 cent tax with these two bills.

Well, our district cannot afford, our farmers in our district cannot afford taxes on tobacco. Tobacco is already taxed more than their fair share, and they are paying for a lot of programs that the government, I do not know what they would do to make up the money if tobacco is taxed out of existence. I think it would go back again to the middle class to make up the difference.

Increased bureaucracy. The Gephardt and Mitchell plans impose more big government control over the lives of individuals and businesses. In fact, these plans create 20 new bureaucracies and these bureaucracies are charged with determining what health care coverage we can have. They will determine what medical procedures and what will be necessary. This could result in lower coverage and less choice for employers/employees. By mandating what services must be provided, some employers will have no choice but to include the Federal plan.

These new boards will have advisory power over a substantial part of the health care operations and it even goes as far as to regulate the number of specialities we have in schools, the medical schools. Further, the various board members will not be elected. They will be comprised of politically-appointed officials, and their meetings do not have to be open to the public. And these committees are exempt from the sunshine regulations provided under the Federal Advisory Committee Act.

I think that the American people are saying, wait. I think they are saying, we want a plan that is going to work. And this bipartisan plan that has been introduced, I think, is a very good plan that we can look at and say, this might be what we need.

But we need time to study it. We do not need to rush something through. Because when I go back to Kentucky, as the gentleman just said a little while ago, the folks in my district are lining up and they are talking to me about health care. They are lining up, just as the people in your district, and they are saying, why are you not waiting? Why are you not taking your time? Why can you not take time and have a national forum wherever everyone can see what is on the board and we can make educated decisions about what we want?

Personally, I think what is happening here with the Gephardt-Mitchell plan is that it is a political thing. It is something that is trying to be rushed through. It is something that is supposed to make our colleagues across the aisle look better for some reason, if they can get a plan through. But we have got to start thinking about what is good for the American people, not what is politically beneficial, but what is going to be good down the road, years from now, when my children and my grandchildren are going to need health care.

The people of this country do not want their coverage, their opportunities for health care coverage to be ruined. And the most common phrase I hear back in my home district is, do not fix what is not broken. So the people want us to make educated, thorough decisions about health care here in this House, and they want us to do it right. They do not want us to rush through and make some bad mistakes.

Mr. KNOLLENBERG. I thank the gentleman from Kentucky. I think the gentleman is right in terms of the mandates which involve, of course, in the Gephardt bill, the Mitchell bill, new taxes, new mandates and tax caps, meaning that certain premium plans that are in force with various companies could not raise their benefit level above a certain point or it would be taxed. Of course, that one size fits all would be applied against some of the plans that are in existence around the country.

Those people then would have to pay a tax on the excess.

One nice part about the bipartisan effort that is being constructed and architected here in Congress is that it has none of that. It has no taxes. It has no mandates. And it has no tax caps. So the gentleman from Kentucky commented about tobacco.

Well, there are any number of things they can tax. Of course, whatever moves or does not move could ultimately be the source or could be the target of the Federal Government in terms of taxing to raise that money.

I would just cite one thing. These are the preliminary estimates of the Mitchell bill. This is not really official yet, but they are talking about the mandates that are a part of that bill.

I wish I had something from the Gephardt bill, I would be talking about that.

Mr. HOEKSTRA. Would the gentleman clarify exactly how much information we have on any of the nine bills about how much they will raise in new taxes and what the net result will be on the deficit for any of the nine bills?

Mr. KNOLLENBERG. I can tell you one thing at the moment, I have the facts sheet on the Mitchell bill in terms of the mandate.

Mr. HOEKSTRA. But we have nine different bills here in the House. What numbers do we have on any of those nine bills?

Mr. KNOLLENBERG. The gentleman makes a point. I am talking about a bill that I will not even have to deal with. The reason I am is because we have nothing for the Gephardt bill. We have only facts and not really facts yet, they are just preliminary estimates of what the Mitchell bill's costs will be.

Mr. HOEKSTRA. We will be debating these nine bills and there were colleagues on the floor for an hour before saying how great the Clinton-Gephardt bill was, how bad some of the other bills were. And we do not have any independent verification of what the numbers are yet.

Mr. KNOLLENBERG. Let me give you one example: Mandates—with mandates—talking about the Mitchell bill again. I would love to talk about the Gephardt bill, but I have nothing to talk about.

It states, for example, that 10 years from now in the year 2004, with mandates in place, we are still going to have $165 billion, $165 billion in subsidies.

Now, if you take the mandates out, it would be $194 billion. The point is, even with mandates in place, we are going to run up $164 billion in deficits.

□ 2120

Now, how do you finance that? You could tax the tobacco of Kentucky, you could tax a lot of things. That is the problem with the Mitchell bill. I wish I could tell you what is totally wrong with the Gephardt bill, but I have to wait for those numbers. This is just preliminary.

Mr. HUTCHINSON. Will the gentleman yield?

Mr. KNOLLENBERG. I am glad to yield to the gentleman from Arkansas.

Mr. HUTCHINSON. It is my understanding that the CBO came out with numbers on the Mitchell bill, but they have not yet produced numbers for this Congress in regard to the Gephardt—the Clinton-Gephardt bill, so the gentleman is exactly right. We do not have numbers on what the Clinton-Gephardt bill will do, how it will impact the deficit, how it will impact the pocketbooks of the American people.

I might add also, in my initial analysis of the Gephardt bill, we have the Medicare Part C, which is established, which has been called the largest entitlement ever created in American social policy. It would bring over 90 million Americans under Government-run health care, direct Government-run health care, in Medicare Part C. That is rather incredible.

In fact, Mr. Speaker, we just started a commission to study—I appreciate the gentleman from Kentucky [Mr. LEWIS], whose first official act on this floor was walking over to this desk and signing a discharge petition for the A to Z, because of his personal concern about the deficit in this Nation, and the national debt.

We have an entitlement commission that is supposed to come back and make recommendations, because we have entitlements now that are bankrupting the country and exploding in their costs, and yet we are getting ready, if we pass the Gephardt bill, to create the largest entitlement ever, at the very time we are now beginning to acknowledge what the entitlements are doing to our deficit situation.

Mr. HOEKSTRA. Mr. Speaker, I think we have a preliminary report on the entitlement commission that says that by the year 2011, or something, all of the revenues that we collect in taxes will be used to pay for two things, entitlements, and interest on the debt, and that by now, if we create this whole new entitlement program, we are going to either be looking at one of two things, more debt, or higher taxes. I believe that was the preliminary report. I'm not sure.

Mr. HUTCHINSON. PETER, if you will yield back, I think you are exactly right. I just think it is the highest of ironies that at the time we get this preliminary report, and there is general, broad acknowledgment that something has to be done on entitlement spending; that we are preparing now, or it is being proposed, it is being advocated, that we create the largest, the mother of all entitlements. I think that is a high irony.

Mr. HOEKSTRA. And we will spend 8 days talking about it.

Mr. HUTCHINSON. Eight days. I thank the gentleman.

Mr. LEWIS of Kentucky. Will the gentleman yield?

Mr. KNOLLENBERG. I am glad to yield to the gentleman from Kentucky.

Mr. LEWIS of Kentucky. The Congressional Budget Office, have they come up with a figure on the Gephardt bill at all and what it is going to cost?

Mr. KNOLLENBERG. It is my understanding, and I may have to yield to someone with more current knowledge, that they do not have those numbers, that is forthcoming, we have been told. But at this point, and this is Thursday evening, we do not have them. I would yield to anybody who has better information.

Mr. HUTCHINSON. You are exactly right, the numbers are not there. I have been told, Mr. Speaker, by those involved in the process more directly than myself, that it is physically impossible for all of those numbers to be produced for this Congress in the next 8 days, which in itself is a compelling argument for a more deliberative process, for more time to be taken so proper numbers can be presented to this Congress, so we will know exactly what we are voting on.

The CBO, because of the number of bills that have been introduced, and the demands upon them, physically will not be able to give us the kind of accurate data we need to make an intelligent, deliberative decision on health care reform.

Mr. KNOLLENBERG. If I could just interject, it is us, of course, that need information, but we have an obligation to funnel that back to our constituents, too, so they can make some judgments about this and provide us with input.

I just wanted to relate a story that appeared on the AP wire this evening about calls from angry senior citizens who have been clogging the switchboards of AARP, the American Association of Retired Persons, after the group's board of directors—who are an inside-the-beltway kind of group, I guess they suffer from the same malaise as some other people, too—after the group's board of directors stated its support was going to be for the Democratic bills. Most of the callers were incensed that the AARP leadership made that decision without surveying the some 33 million AARP members.

Mr. HOEKSTRA. Will the gentleman yield?

Mr. KNOLLENBERG. Yes, Mr. Speaker.

Mr. HOEKSTRA. It is interesting, regarding the callers, it may be unfair to attack the AARP here in Washington, because there would have been no way possible for AARP to poll its members, because the bill did not exist. The bill did not exist until 9 o'clock last night, so it is unfair of those callers to tell them to poll their members before they endorsed, because the bill did not exist.

In reality what AARP did is they endorsed the bill based on an outline and some broad concepts, without understanding what is in this thing.

Mr. KNOLLENBERG. The gentleman makes a valid point. It just illustrates the problem that all of us seem to have, not just the Members of Congress, but the people inside the beltway.

Of course, it does, I think, frame properly the real difficulty we have here this evening in coming to grips with what is it, where is the bill.

Mr. HUTCHINSON. If the gentleman will yield, in regard to the decision that the AARP made, I think that one of the—again, one of the ironic aspects of their decision to support a Government-run health care system, and in particular, the Clinton-Gephardt, Clinton-Mitchell bill, is that all of these health care plans depend very heavily on Medicare cuts in order to fund their particular health care plans.

That may or may not be a wise decision, but it is something that needs to have a very close scrutiny. The hospitals in my State, the State of Arkansas, many of them, and I mean by that dozens of them, have communicated directly with me with this message: "Please wait," because they are concerned about how drastic, radical Medicare cuts will affect rural hospitals in this country, who are so dependent upon Medicare reimbursement.

So for AARP, which is supposed, of course, to have the interests of our senior citizens at heart, to endorse a bill that relies so strongly upon drastic Medicare cuts to fund the bill is, again, very ironic, and it needs to be looked at very, very closely, and the hospitals in the State of Arkansas have said "Let us wait. Let us look at it closely. Don't do anything drastic. Don't do anything right away. Look at how this is going to impact rural health care."

I think they have made a wise decision in sending that message to Washington. I thank the gentleman for yielding.

Mr. KNOLLENBERG. As we wind down here in the last couple of moments, if any of the gentlemen want to make some final comments, I yield to the gentleman from Kentucky.

Mr. LEWIS of Kentucky. I have looked at some interesting statistics the other day in an investment paper, that 38 percent of the gross domestic product in this country is made up of Government.

It said that if we go on, we are moving very close to that 50 percent mark where, if we pass a Mitchell or Gephardt bill, we would go over the 50 percent of our gross domestic product. That would take us past where Russia is right now. It would move us close to Sweden. It would take us over the edge. One-seventh of our economy would be made up of the health care plan.

Mr. Speaker, we cannot continue on like this. We cannot continue on with more taxation. The 17 to 20, the taxes of the Mitchell-Gephardt plan, for the average family with local, State and Federal taxes, 40 percent of their income, and when you include the hidden taxes, you are getting close to 50 percent.

We are getting close to the point of putting the straw on that is going to break the camel's back, and I don't think the American people are wanting this. I don't think they are ready to go to a system that is going to be so overburdened by the Government in every area of their lives that they cannot have the freedom to make their own choices.

Mr. KNOLLENBERG. I thank the gentleman.

Mr. HOEKSTRA. Just a couple of final points, if the gentleman will continue to yield. When we are taking a look at the health care debate, we really do want health care reform, but we want a process that is going to enable creativity and innovation.

We already see that some of the plans are doing away with wellness plans, where they are saying "We are going to have to study them for two years." They are doing away with cafeteria-type plans. The States are the hotbed for innovation. They have been innovating on legal reforms, so what does the new Clinton-Gephardt bill do? It preempts all State laws on liability.

What is the end result we want, Mr. Speaker? We want to go through a good process, one that we have gone through a deliberation, an opportunity to input, an opportunity to hear from our constituents. We want a plan that can get broad bipartisan support.

I would love to pass a health care reform bill that has over 300 votes. We want to build on what we have. Our health care system works for 85 percent of the American people. Let us build on what we have and let us start including the other 15 percent into that 85 percent.

□ 2130

If we go through that kind of process, if those are the principles that we use, we will end up with a result that is good for the American people and that they will be proud of.

Mr. KNOLLENBERG. Mr. Speaker, I thank the gentleman. I think he is right on target in terms of suggesting that we not provide a 100-percent solution for a 15-percent problem. Of course, that falls in line with the statement that we should fix what is wrong with what is right. Let us not throw the baby out with the bath water. We have got a great health care system here. It can be better, we can make it better. There is a bipartisan effort being made right now to do just that.

Mr. Speaker, I would just like to close by saying the only partisan bill that I can recall in this Congress, in the 103d, was the budget bill. It was the only bill where there were Democrats and Republicans massed together. I believe in the health care debate, which is so important, to Republicans, to Democrats, to every man, woman, and child in this country, it should be a bipartisan effort that prevails and I believe we can get there and I believe the concepts that we have talked about this evening are what the American people want.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. UNDERWOOD (at the request of Mr. GEPHARDT), for today through the close of business on Tuesday, August 16, on account of official business.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. KOLBE) to revise and extend their remarks and include extraneous material:)

Mr. HORN, for 5 minutes each day, on August 17, 18, and 19.

Mr. DUNCAN, for 5 minutes, today.

Mr. HOEKSTRA, for 5 minutes, today.

Mr. EHLERS, for 5 minutes, today.

Mrs. BENTLEY, for 5 minutes, today.

(The following Members (at the request of Mr. PENNY) to revise and extend their remarks and include extraneous material:)

Mr. OWENS, for 5 minutes, today.

Mr. DERRICK, for 5 minutes, today.

Mr. KREIDLER, for 5 minutes, today.

Mr. HUTTO, for 5 minutes, today.

(The following Members (at the request of Mr. WISE) to revise and extend their remarks and include extraneous material:)

Mr. WISE, for 5 minutes, today.

Mr. HANCOCK, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

(The following Members (at the request of Mr. KOLBE) and to include extraneous matter:)

Mr. HORN in two instances.

Mr. BOEHLERT.

Mr. GUNDERSON.

Mr. COLLINS of Georgia.

Mr. RIDGE in two instances.

Mr. GILMAN.

Mr. RAMSTAD.

Mr. BALLENGER.

(The following Members (at the request of Mr. PENNY) and to include extraneous matter:)

Mr. MILLER of California.

Mr. LANTOS.

Mr. STARK.

Mr. FRANK of Massachusetts.

Mr. MANTON.

Mrs. MALONEY.

Mr. REYNOLDS.

Mr. BROWN of California.

Ms. SHEPHERD.

Mr. KILDEE.

Mr. BARCIA of Michigan.

Mr. BILBRAY.

Mr. HOCHBRUECKNER.

Ms. ESHOO.

Mr. GONZALEZ.

Ms. WOOLSEY.

Mr. RANGEL.

(The following Members (at the request of Mr. KNOLLENBERG) and to include extraneous matter:)

Mrs. BENTLEY.

Mr. GOODLING.

Mr. ROTH.

Mr. GILMAN.

Mr. YOUNG of Florida.

Mr. YOUNG of Alaska.

Mr. SAXTON.

SENATE BILL REFERRED

A Bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 2218. An act to provide authorization of appropriations for the Federal Emergency Food and Shelter Program for fiscal years 1995 and 1996; to the Committee on Banking and Finance.

ADJOURNMENT

Mr. KNOLLENBERG. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 9 o'clock and 31 minutes p.m.), the House adjourned until tomorrow, Friday, August 12, 1994, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

3675. A letter from the Acting Director, Office of Management and Budget, transmitting the cumulative report on rescissions and deferrals of budget authority as of August 1, 1994, pursuant to 2 U.S.C. 685(e); to the Committee on Appropriations.

3676. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 10-316, "District Government Land Use Temporary Amendment Act of 1994," pursuant to D.C. Code, section 1-233(c)(1); to the Committee on the District of Columbia.

3677. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 10-317, "Recycling Fee and Illegal Dumping Temporary Amendment Act of 1994," pursuant to D.C. Code, section 1-233(c)(1); to the Committee on the District of Columbia.

3678. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 10-318, "District of Columbia Board of Education Fees for Select Adult, Community, and Continuing Education Courses Temporary Act of 1994," pursuant to D.C. Code, section 1-233(c)(1); to the Committee on the District of Columbia.

3679. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting notification of a proposed manufacturing license agreement with Italy (Transmittal No. DTC-29-94), pursuant to 22 U.S.C. 2776(c); to the Committee on Foreign Affairs.

3680. A letter from the Assistant Secretary of State for Legislative Affairs, transmitting copies of the original report of political contributions by Robert L. Gallucci, of Virginia, to be Ambassador at Large, and members of his family, pursuant to 22 U.S.C. 3944(b)(2); to the Committee on Foreign Affairs.

3681. A letter from the Chief, National Forest Service, transmitting various boundary descriptions and maps; to the Committee on Natural Resources.

3682. A letter from the Secretary of Labor, transmitting a report on the evaluation of the pilot program of off-campus work authorization for foreign students—F-1 Nonimmigrants—pursuant to Public Law 101-649, Section 221(b) (104 Stat. 5028); to the Committee on the Judiciary.

3683. A letter from the Secretary of Health and Human Services, transmitting a report on participation, assignment, and extra billing in the Medicare Program; jointly, to the Committees on Ways and Means and Energy and Commerce.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. DINGELL: Committee on Energy and Commerce. H.R. 4111. A bill to authorize appropriations for the National Railroad Passenger Corporation, and for other purposes; with an amendment (Rept. 103-698). Referred to the Committee of the Whole House on the State of the Union.

PUBLIC BILLS AND RESOLUTION

Under clause 5 of rule X and clause 4 of rule XXII, public bills and resolutions were introduced and severally referred as follows:

By Mr. BARRETT of Nebraska:

H.R. 4938. A bill to provide the members of the Armed Forces held as hostages in Iran after the seizure of the United States embassy in Tehran on November 4, 1979, shall be treated as having been prisoners of war during the period that they were in a captive status; to the Committee on Armed Services.

By Mr. EWING:

H.R. 4939. A bill to designate the U.S. courthouse located at 201 South Vine Street in Urbana, IL, as the "Frederick S. Green United States Courthouse"; to the Committee on Public Works and Transportation.

By Mr. GLICKMAN:

H.R. 4940. A bill to require the specific identification of intelligence construction projects in annual budget submissions and the authorization by law of such projects; to the Committee on Intelligence (Permanent Select).

By Mr. SERRANO:

H.R. 4941. A bill to repeal the Cuban Democracy Act of 1992; to the Committee on Foreign Affairs.

By Mr. WILSON (for himself, Mr. BRYANT, Mr. MEYERS of Kansas, Mr. ZIMMER, Mr. NEAL of Massachusetts, Mr. THOMAS of California, Mr. ROYCE, Mr. FROST, Mr. FRANK of Massachusetts, Mr. HASTINGS, Mr. PARKER, and Mr. EMERSON):

H.R. 4942. A bill to amend title 28, United States Code, to provide for the use of volunteer's for Federal Bureau of Investigation tours and at the Bureau's training facilities, and for other purposes; to the Committee on the Judiciary.

By Mr. YOUNG of Alaska:

H.R. 4943. A bill to regulate fishing in certain waters of Alaska; to the Committee on Merchant Marine and Fisheries.

By Mr. MILLER of California (for himself, Ms. PELOSI, Mr. HAMBURG, Mr. BILBRAY, and Mr. GALLEGLY):

H.R. 4944. A bill to authorize the Secretary of the Interior to conduct studies regarding the desalination of water and water reuse, and for other purposes; jointly, to the Committees on Natural Resources and Science, Space, and Technology.

By Mr. MANTON:

H.J. Res. 401. Joint resolution designating the months of March 1995 and March 1996 as "Irish-American Heritage Month"; to the Committee on Post Office and Civil Service.

By Mr. KLEIN:

H. Con. Res. 280. Concurrent resolution expressing the sense of Congress with respect to protections for persons changing their names to avoid domestic violence; to the Committee on the Judiciary.

By Mr. SHAW (for himself and Mr. JOHNSTON of Florida):

H. Con. Res. 281. Concurrent resolution expressing the sense of the Congress that the United States Embassy in Israel should, at the earliest possible date, be relocated to the city of Jerusalem; to the Committee on Foreign Affairs.

MEMORIALS

Under clause 4 of rule XXII.

457. The Speaker presented a memorial of the Senate of the Commonwealth of Massachusetts, relative to the One Dollar Coin Act of 1993; to the Committee on Banking, Finance and Urban Affairs.

ADDITIONAL SPONSORS

Under clause 4 of rule XXII, sponsors were added to public bills and resolutions as follows:

H.R. 193: Mr. BAKER of California, Mr. BARTON of Texas, Mr. DORNAN, Mr. PACKARD, and Mr. SKELTON.

H.R. 488: Mr. BONIOR.

H.R. 672: Mr. BARTLETT of Maryland, Mr. RUSH, and Mr. POSHARD.

H.R. 857: Mr. DORNAN.

H.R. 959: Mr. GEJDENSON.

H.R. 1277: Mr. CALVERT.

H.R. 1671: Mr. DE LUGO.

H.R. 1725: Mr. DOOLITTLE.

H.R. 1921: Ms. SCHENK.

H.R. 2420: Mr. YATES.

H.R. 2717: Mrs. Meyers of Kansas.

H.R. 3492: Mr. LEACH, Mr. HALL of Ohio, Mr. ARCHER, Mr. BRYANT, Mr. TORKILDSEN, and Mr. SLATTERY.

H.R. 3739: Mr. SAXTON.

H.R. 3854: Ms. FURSE.

H.R. 3943: Mr. BARCA of Wisconsin, Mr. CANADY, and Mr. HERGER.

H.R. 3971: Mr. ANDREWS of New Jersey.

H.R. 4000: Mrs. MEYERS of Kansas, Mr. DOOLITTLE, Mr. HERGER, and Mr. HANCOCK.

H.R. 4051: Mr. BRYANT.

H.R. 4115: Mr. DEUTSCH and Mr. PAXON.

H.R. 4318: Mr. CLINGER and Mr. CALVERT.

H.R. 4325: Mr. BLACKWELL and Mrs. UNSOELD.

H.R. 4413: Mr. BILBRAY.

H.R. 4517: Mr. MINETA.

H.R. 4585: Mr. CRAPO, Mr. PACKARD, Mr. BACHUS of Alabama, and Mr. LIVINGSTON.

H.R. 4654: Mr. BACCHUS of Florida and Mr. FOGLIETTA.

H.R. 4786: Mr. LIPINSKI.

H.R. 4805: Mr. POMEROY.

H.R. 4831: Mr. SUNDQUIST.

H.R. 4860: Mr. CHAPMAN.

H.R. 4919: Mr. COOPER, Mr. KING, Mr. DEUTSCH, Mr. SWIFT, Mr. DOOLEY, Mr. ROHRABACHER, Mr. LINDER, Mr. DELAY, Mr. GRAMS, Mr. DICKEY, Mr. CUNNINGHAM, Mr. DORNAN, Mr. WALKER, Mrs. FOWLER, Ms. ROS-LEHTINEN, Mr. PORTMAN, Mr. LEWIS of California, Mr. KIM, and Mr. POMBO.

H.J. Res. 389: Mr. ANDREWS of Maine, Mr. TORKILDSEN, Mr. MAZZOLI, Mr. SHAYS, Mr. OWENS, Mr. NEAL of North Carolina, Mr. ROMERO-BARCELÓ, Ms. KAPTUR, and Mr. SKEEN.

H. Con. Res. 35: Mr. FRANKS of New Jersey, Mr. FORD of Michigan, and Mr. BARRETT of Wisconsin.

H. Con. Res. 148: Mrs. LLOYD.

H. Con. Res. 186: Mr. HUFFINGTON.

H. Con. Res. 245: Mr. OWENS.

H. Con. Res. 247: Mr. DIXON, Mrs. JOHNSON of Connecticut, Mrs. BENTLEY, Mr. SOLOMON, Mr. RUSH, Ms. ROYBAL-ALLARD, Mr. MARKEY, Mr. HUFFINGTON, and Ms. PELOSI.

H. Con. Res. 257: Mr. VENTO and Mr. WAXMAN.

H. Res. 213: Mr. DOOLITTLE.

H. Res. 266: Mr. CALVERT.

PETITIONS. ETC.

Under clause 1 of rule XXII,

117. The Speaker presented a petition of the Attorney General, Commonwealth of Kentucky, Frankfort, KY, relative to State health care fraud control units; to the Committee on Energy and Commerce.

EXTENSIONS OF REMARKS

A GREAT "UNDELIVERED" SPEECH

HON. GEORGE E. BROWN, JR.

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. BROWN of California. Mr. Speaker, President Clinton was invited to be the featured speaker at UCLA's 75th Anniversary Convocation on May 20 of this year. In the event that the President might have to cancel at the last minute, the planners of the anniversary festivities had invited Harold Shapiro, president of Princeton University, to prepare and be ready to deliver a stand-in address.

President Clinton came to UCLA and gave an inspiring talk that was well received. We are, however, also lucky to have the insightful but "undelivered" remarks of Harold Shapiro. In his speech entitled, "Creating A Future," Shapiro makes us reflect on the universal unwillingness to welcome the messengers of change and embrace their message. He reminds us of the importance of reexamining our goals, and of the need to search for new solutions to old problems. I commend these remarks to all of my colleagues.

CREATING A FUTURE

"I've got to be moving along . . ." (Woodie Guthrie)

It is with some considerable trepidation that I rise to speak—yet once more—to this distinguished assembly. Although I had some forewarning that I might be asked to speak in President Clinton's stead, you did not! While I am honored to assume this role, I am acutely sensitive to the fact that I'm not really the speaker you were hoping to hear! Moreover, I can hardly disguise that fact that my speaking skills haven't been honed by innumerable campaign stops, electronic town meetings, or even MTV! How can a humble scholar even begin to step into the shoes of his nation's leader? What would President Clinton have said on this occasion?

Surely he would have congratulated the faculty and students of UCLA, the Regents of the University of California, and the citizens of the state of California for the many contributions they have made to the world of education and scholarship and to our nation. What, however, would the President have said next? How could I approach this large assignment? It was clear to me that I needed some inspiration from somewhere!

First, I decided that perhaps I could prepare myself for the awesome task of filling the President's shoes by rising at dawn and taking a morning jog, and supplementing my usual "California" breakfast of yogurt and granola with some Egg McMuffins—and fries—and, to get in the swing of things, a Whopper—also with fries. Fulfilling as this gastronomic approach was, I decided I had to look elsewhere for inspiration. I hit upon the perfect academic solution to the problem of how to speak in the place and the voice of a speaker who's much better known. Let me explain.

Recently, I was reading with the students in my Freshman Seminar the *Apology* of Socrates. Now, I'm sure you will all read that the *Apology* (which was Socrates' speech of self-defense before the jurors when he was put on trial in Athens) was in fact not *written* by Socrates. What has come down to us, instead, is a speech written by Socrates' pupil, Plato. So, it occurred to me that what I'm actually confronted with here today is a kind of Platonic task—to speak in the place of another.

Now I do not confuse myself with Plato or even with Homer—whose epic poetry spoke not for one but for an entire pantheon of heroes. Nevertheless, I decided that I could certainly look to one of them for inspiration. I chose Plato, both because Socrates is one of my heroes and, in some ways, so is President Clinton. In addition, in this great democracy we always think of our leaders—like Socrates—as "on trial"—although we may now be taking this idea rather too literally. Moreover, it is clear that President Clinton and Socrates share other intriguing characteristics.

For example, I thought about the fact that Socrates' marriage—to a woman who was considered extremely outspoken for the time—seems to have been a source of considerable controversy among his fellow citizens. Socrates also had quite a reputation among his friends for enjoying and celebrating life, although these activities seemed to have no discernible impact on his other capacities. Like President Clinton, Socrates was not from an elite background, and he had to tolerate snide comments about how his wonderful mother was "just" from the working class.

Moreover, Socrates—as has President Clinton—took his message directly to the people, where they worked and talked, in the public square of Athens. In addition, Socrates did not have a "classical" Greek build. He is said to have had a notoriously round (probably pink) face. Socrates also spent part of his days in the gym with friends (jogging wasn't in vogue in Athens) and—like President Clinton—he spent part of every day reading and talking with anyone from whom he thought he could learn something. Most important, Socrates viewed Athens—very much as President Clinton views America—with both admiration and a critical eye.

Despite these striking "similarities," there are more important and substantive ways in which Socrates' situation shows correspondences to the situation we face today as a country and President Clinton faces as our leader. Of course, there is the small (and inconvenient) matter that the context of the Apology is not one of celebration: it's a court case. And I wish to celebrate not only UCLA's anniversary but also President Clinton's leadership. Let's overlook this difference, though, and focus instead on the fact that Socrates stood accused of the "crime" of "introducing new ideas."

The "Socratic situation," therefore, remains a symbol for all those leaders—like President Clinton—who are trying to move a nation to a new and better place. New ideas—then and now—are both dangerous and essential to our vitality. Too often, however, we allow our leaders to shoulder the full burden of change. If I try to imagine myself in President Clinton's place today, I think I might want to make a number of points which are really very much like that speech that Plato put in the mouth of Socrates twenty-four centuries ago—in order to put my case for change before the people of California—and the nation.

First, Plato realized that the first thing that confronted Socrates—and has confronted many outspoken leaders since then—is that some portion, perhaps even a great deal, of the opposition to new ideas derives its energy not only from the need for "those in charge" to defend existing privileges, but also from the echoes and shadows of attitudes inherited a long time ago that too often cause us to leave almost unexamined new paths we are being urged to take or new ideas presented to us.

Perhaps the most important and influential single idea that's come down to us from Plato's Apology—and perhaps from the whole corpus of Platonic work—has to do with what gets left unexamined. I mean the famous claim in the Apology that "The unexamined life is not worth living." This is a lesson that we in universities take especially seriously and consider to be central to our mission. What does it mean? Well, when Plato advanced it, he made it clear that he meant something pretty radical. He meant that what was most important in life, what was most important for young people to learn, wasn't necessarily how to make the most money or how to gain the most prestige in the society of the day, but instead how to recognize and work toward what he called "the good" or what it was that made life worth living.

This idea—attractive as it sounds—was not tremendously popular among the elite in Athens of the 5th century B.C.E. And I think it would be fair to say that, in America of the 20th century, it is *not* necessarily "and idea whose time has come." Nevertheless, from Socrates' time to the present, there have been those leaders who have continued to bring this ideal before the public.

This role—of reminding citizens of goals that are larger and more transcendent than most of our everyday concerns, are more compelling than our old habits, and ask us to take the concerns of others into account—has never been a very welcome one. To this day, most of us, just as was true in Socrates' time, find it easier and more natural to look to the state of our bank accounts and our individual needs than to the state of our souls and the needs of others in formulating our views or making our individual choices and public policy decisions. Moreover, current arrangements always seem more natural to those enjoying their special benefits and privileges.

In 399 B.C., Socrates was put on trial for having "new ideas" and for "corrupting the young" with them. And his fellow Athenian citizens voted to be rid of this disturbing individual who kept insisting that they should care more about doing good than about doing well. President Clinton has inspired us all with his new initiatives, his rhetoric, and his ideals, but we must all hope that this time we—unlike the Athenians—will be moved to embrace his ideas and to bring America to a better place.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

I think it's important to notice—if we think about what we might learn from his story—that Socrates himself—like President Clinton—doesn't claim to be perfect, doesn't claim to have the solutions. In fact, his only claim is that it's of the utmost importance to continue to search for answers. This questing, this continually urging his fellow citizens to confront enduring questions of human values and the well-being of society so discomfits them, is so intolerable that—in the end—they cannot tolerate him. Better to get rid of him they think, than to have to—as he insists—examine their own lives and their own responsibilities.

Our own society, sadly, is often not welcoming to those who have had a new dream. We too often react with skepticism, cynicism, and self-satisfaction, to those who would confront us with uncomfortable questions, questions like: Who are my neighbors? (And are they only within my own nation's boundaries?) What are my responsibilities to others? (And do they include concern for the preservation of their health and well being?) What do I owe my fellow citizens? (And is it not only taxes, but "taxing" myself to recognize and protect the human dignity of those who differ from me?)

When questions like these troubled the Athenians, they thought they had a solution, namely: condemn the messenger. Our nation's leaders often face the same response when they ask us to take on new attitudes and new responsibilities.

Luckily, Socrates' message was not at all silenced by the Athenians. In fact, his pupils—like Plato—continued to write it and speak it, so that it has echoed down through the centuries. It is an uncomfortable message, which stresses a lack of complacence—with ourselves and with our nation—and calls us to continual reexamination of our goals.

When Socrates took this path in public life, he knew he was taking risks. The public man or woman today who calls us to high ideals—independent of his or her personal history or characteristics—is also taking risks, some would say is courting "political suicide." It is always easy to find reasons why such individuals are not blameless themselves, or can't claim total knowledge, or don't have all the answers for the future—and so we manage, often, to discount them. And this allows us to remain set in our old ways, to avoid taking on the burdens of change and re-direction and vision.

But I'd like to think that we've actually made some progress since the days of the ancient Athenians. I'd like to think that, rather than condemning those who seek to rouse our democracy today, we might actually be thankful that there are such people—people like President Clinton—who have the courage to try to move us to examine our principles and our policies. Perhaps "free trade agreements" and "tax reform" and "welfare reform" and "health care policy" don't sound quite as grand to us as Socrates' quest for "justice" and "virtue." But they are the concrete examples of our public lives today of adopting new ideas and taking on new responsibilities. Rousing a democratic people to face such challenges has lost none of its importance; it still takes courage, and it deserves—in my opinion—our greatest respect and our gratitude. Answers to such issues may be difficult to find, but they cannot be found at all without leaders who compel us to seek them, not only at the level of public policy but at the level of our individual reexamination of our own actions and commitments.

Well, I certainly can't fill the shoes of the President—any more than Plato could take the place of his teacher, Socrates. There was about Socrates a certain charisma, an ability to affect people deeply, that a mere citizen—faculty or student—could hardly claim. But as President Clinton has often noted, there is a critical role for us, as we are confronted with the kind of leader who challenges, maybe even irritates some among us, but at the very least rouses us to re-examine those aspects of our society that for too long we have accepted without question. Perhaps that role is to accept the challenge, to be willing to listen and reflect—and also willing to act upon our reflections.

For my own part, I'm grateful to President Clinton for being, if you will, an American Socrates—challenging our nation as Socrates challenged Athens, and I wish him well. I also want to thank you here today for your kind reception of my "Apology" that your speaker on this occasion was not exactly what you had in mind.

SONDRA SIMONSON DAY

HON. JIM RAMSTAD

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. RAMSTAD. Mr. Speaker, I rise today to pay tribute to a very special friend and constituent.

Governor Carlson has proclaimed today, August 11 of 1994, Sondra Simonson Day in Minnesota.

Sondra Simonson has been very active in her community of Bloomington, MN, and has truly served as an inspiration to many for her public service.

She has served as the first woman Chair of the Bloomington Chamber of Commerce, and has been a member of the Metropolitan Council. In those positions, she has been a leader in developing aviation and transportation policies for our region.

Sondra was born and raised on the site of what is now the Minnesota Valley Wildlife Refuge visitors' center. Her commitment to the quality of life in Bloomington and to our region is exemplified in her work with the Metropolitan Parks and Open Space Commission.

I am extremely proud and pleased to join the people of Minnesota on this very special day in saluting an outstanding public servant and visionary leader. Sondra has established a legacy of excellence in helping others and providing future generations with the resources to reach for their dreams.

I applaud her, and thank her for all her service.

EARTHVISION: OUR FUTURE IS NOW

HON. JAMES A. BARCIA

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. BARCIA of Michigan. Mr. Speaker, I rise today to pay tribute to the EarthVision Program being conducted by the Environmental Protection Agency, in conjunction with Saginaw Valley State University. The objective of this program is to leverage the investment made in the intellectual and physical resources held by our Federal agencies, to provide further educational opportunities for our Nation's students.

EPA Administrator Carol Browner and I had a chance to see this program in action early in June and meet the 24 students and teachers who participated this year. We were tremendously impressed by their ability to deal with matters that only a few years ago were thought of as dreams for the future. This past year every single high school in Michigan was invited, to participate in the competition for an EarthVision team slot, and over 60 responded to this growing scientific endeavor. In this coming year, the invitation list is expected to be expanded to include every single high school throughout the Great Lakes region.

The EarthVision Program is composed of two elements. During the academic year teams of teachers and students learn specific skills needed to conduct environmental research using computational science. Each of these teams is assisted by a mentor and the Saginaw Valley State University support team. These skills are learned through hands on training at the National Environmental Supercomputing Center in Bay City. Additionally, the student/teacher teams attend Saturday tutorials, during which they are assisted in the preparation of proposals required for admission to the second component of the program, the Summer Research Institute.

During the Summer Research Institute competitively selected teams participate in a 3-week educational program. The centerpiece of this educational program is instruction in conducting an environmental research project of their own design. Through the use of a computer workstation, and a telecommunications link to the National Environmental Supercomputing Center, participants in the Summer Research Institute conduct environmental research activities at their high schools during the following academic year.

Through this computer link the teams analyze data, conduct environmental modeling and use scientific visualization to complete their research., These teams then prepare a paper describing their research and their results.

A TRIBUTE TO MARGARET KAJECKAS

HON. DALE E. KILDEE

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. KILDEE. Mr. Speaker, I want to pay tribute to Margaret Kajeckas, who is leaving my subcommittee staff to pursue graduate study at Columbia University.

Margaret began her 8-year career with the House Committee on Education and Labor as a staff member of my Subcommittee on Human Resources and, currently, serves on the staff of my Subcommittee on Elementary, Secondary, and Vocational Education. Throughout her years of service, and in relation to a variety of topics—Head Start, community services, older American volunteer programs, child nutrition, school lunch, and coordination of health and social services with education—she consistently has carried out her responsibilities with intelligence, dedication, enthusiasm, and a caring concern for the people served by these Federal programs. Additionally, her professionalism is complemented by a personal warmth and kindness that she extends to all. Margaret is well-liked and has earned the respect of everyone with whom she has come in contact.

I have always considered myself to be blessed with excellent staff and, without doubt, Margaret is among the finest I have had in my employ. While I am sorry to see her leave, I am glad that she has the opportunity to continue her education and I know that she will be successful in whatever she chooses to do.

TRIBUTE TO BARON VON STEUBEN AND DEDICATED VOLUNTEERS

HON. SHERWOOD L. BOEHLERT

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. BOEHLERT. Mr. Speaker, more than ever before, the people of the Mohawk Valley region of central New York are rediscovering their local heritage and the amazing contributions their leaders made to secure the freedom we enjoy today.

From the first European settlers to the leaders of the Iroquois tribes, this very land was host to among the greatest battles for independence as well as significant diplomatic achievements in the building of a diverse, multiethnic experiment in democracy.

Indeed, in this area, Indians and Europeans, from differing religious and ethnic backgrounds, struggled together to carve out a life on a difficult frontier.

Baron Frederick von Steuben is such a character from this past. This year marks the 200th anniversary of his death, and the people of the valley are honoring him and recounting his special achievements as the "Drillmaster of the Revolution."

The Baron came to America from Prussia. He volunteered for service in the Continental Army, only asking to be paid if America won the war. He worked his way to the position of George Washington's Chief of Staff. There, during the hardship of battle, during the cold of Valley Forge, despite the fact that he spoke no English; he managed to write new regulations for the Army, by modifying and forging new tactics. In so doing, he won the respect and admiration of his men, and transformed the Continentals from a disorganized unit into a proud, progressive, disciplined, and successful fighting force that won, against all odds, its struggle for independence.

The Baron is only one of many such personalities from the northern frontier region who made an extraordinary contribution to liberty. They are people who came with different beliefs, from different places, but mostly from poverty, seeking opportunity. They relied on hard work, faith, help from friendly Indians, and together built a home in the wilderness. More than a home, it was a multiethnic democracy, and it remains the freest and strongest the world has ever known.

Such stories are worth telling again and again, from generation to generation. It is our duty to remember and honor these achievements and pass them along in ways that reach people and touch their hearts. These stories are relevant. They're about living and working and surviving under the harshest of conditions. This exercise will educate people and yield inspiration, hope, and a pathway for a better future—a future in which individuals will strive to lead, take charge of their situation the way the Baron did, overcome obstacles and hardships, and promote decency and civility. In this way, the freedom and democracy that our ancestors worked so hard to build may last.

From July 9 through September 30, the Rome Historical Society, under the able direction of Dr. William Forbes, is hosting an exhibit on the Baron and his work, brilliantly prepared by Curator Barbara Schafer. The exhibit features artifacts donated by West Point and the State of New York.

On July 30 and 31, the town of Steuben, NY, hosted an 18th century military encampment in its namesake's honor, and will also host a Steuben Society National Convention in the last weekend of August on the grounds of the Baron's home.

The Steuben Memorial State Historic Site is owned by the State of New York, but has been closed since 1991. Luckily, the area's volunteers have worked together to manage and care for the site. Many dedicated people contribute to this cause, among them: Maynard Anken of Remsen, Chris Anken of Remsen, Ruth Dean of Remsen, Bunny Doolittle of Barneveld, Jimmie Doolittle of Barneveld, Alex Dubinsky of Remsen, Sophie Dubinsky of Remsen, Eva Ebert of Remsen, James Ebert of Remsen, William Gerrard of Holland Patent, Margaret Gerrard of Holland Patent, Lucille Gorres of Remsen, Jane Harris of Remsen, Susan Heuser of Remsen, Ellen Huey of Remsen, Lorena Jersen of Remsen, Maj. Edward Jones of Remsen, Mary Helen Jones of Remsen, Russell Kaufman of Remsen, Richard Kaufman of Remsen, Hobart Kraeger of Holland Patent, Jean Kraeger of Holland Patent, Harry Landman of Remsen, Francis T. Martin, Jr., of Remsen, Jennifer Ann McCune of Holland Patent, Theresa Merritt of Remsen, Kathy Peterson of Remsen, David Peterson of Remsen, Jane Piatkowski of Remsen, Lorraine Post of Frankfort, John Pratt of Hinckley, Howard Prevost of Hinckley, Jeanne Prevost of Hinckley, Jim Roberts of Holland Patent, Lucinda Roberts of Remsen, A. William Roberts of Remsen, Carol Setter of Remsen, Ellye Slusarczyk of Prospect, Stanley Slusarczyk of Prospect, Kathy Snell of Utica, Dorothy Squire of Remsen, Nancy Squire of Remsen, Cyril Tatham of Remsen, Alice Thomas of Remsen, James Ure of Barneveld, Norma Ure of Barneveld, Joan Villeneuve of Remsen, Emogene Walter of Remsen, Brian Walter of Remsen, Barbara Ward of Remsen, Faith Williams of Remsen, Leonard Wynne of Remsen, Dorothy Wynne of Remsen, and Rose Marie Zimmer of Westernville.

DEDICATION OF HAMPTON SYNAGOGUE

HON. GEORGE J. HOCHBRUECKNER

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. HOCHBRUECKNER. Mr. Speaker, I rise today to pay tribute to the Hampton Synagogue located in Westhampton Beach, NY, which will be celebrating its dedication ceremony on Sunday, August 14, 1994.

As founding Rabbi Marc Schneier said, "It is the synagogue that embodies Jewish continuity and makes that continuity possible; the Hamptons are now linked with that historic continuity." The Hampton Synagogue is the first traditional synagogue built in the Hamptons, and most of its interior is from Israel, including large stones that were shipped in from Jerusalem.

Famed director Steven Spielberg and the Honorable Gad Yaacobi, Israeli Ambassador to the United States, are the two guest speakers who will celebrate the dedication with the congregants. During the ceremony, Mr. Spielberg will also be invited to join Rabbi Schneier in a rededication of the community Torah scroll of Domazlice, Czechoslovakia. This scroll was one of many that was destroyed during the holocaust. It will serve as a permanent memorial to the more than 6 million jews who were massacred by Hitler's regime.

There is much excitement in the community surrounding the completion of the new synagogue, and an enormous turnout is expected on September 5, when the Jewish New Year, Rosh Hashanah, will be celebrated. I wish them happiness during that celebration and commend each person involved in the foundation of the synagogue for making it possible with their time, effort, and caring attitude.

Mr. Speaker, it is quite evident that the Hampton Synagogue will be a special place. I ask my colleagues to join me in recognizing the historic dedication of the Hampton Synagogue.

KEN ARVEDON—A FIGHTER FOR SOCIAL JUSTICE

HON. BARNEY FRANK

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. FRANK of Massachusetts. Mr. Speaker, when I began my full-time political work in the late 1960's, one of the people who made a deep, favorable, and long-lasting impression on me was a man named Ken Arvedon. He was then a lobbyist in a New England regional level for the National Council of Senior Citizens, and I learned from him that tough-minded pragmatism and determined idealism were quite far from being inconsistent, as many had told me, but were in fact complimentary—indeed, two essential halves of anyone who would be a whole, integrated, advocate for effective social change.

In Boston politics at the time, and in much of the rest of the country as well, there then existed an unfortunate view that the political universe was divided between idealists who had no sense of how to accomplish things, and tough-minded pragmatists who were skillful at getting things done but had no particular interest in what those things were. Ken Arvedon was one of the first people I met who showed me how false this dichotomy was. He cared deeply about social justice, as he had for his whole life. From his service in the European theater during World War II, through his work in the American Veteran's Committee and for fair housing policies after the war, through his participation in the march to Selma on behalf of civil rights, to the period when I knew him as a forceful, thoughtful, and effective advocate for the National Council of Senior Citizens, Ken Arvedon showed that he could be as good as the most hard-headed pros at the game of politics while professing the idealistic credo that had always motivated him.

Ken Arvedon scored a number of significant victories in his fights for fair treatment for older people at that time, and he always made sure that the fight for fair treatment for older people was put in the context of fair treatment for all of those in need. I am proud to have learned from him, and worked with him. I was sadden recently to learn of his death but his grandson Abraham of whom he was so proud and others can look back at his life with a deep pride that I hope will alleviate their sense of loss.

TRIBUTE TO REPRESENTATIVE BOB MICHEL

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Ms. ESHOO. Mr. Speaker, I rise today to pay tribute to House minority leader BOB MICHEL who was awarded the highest honor that can be given to an American civilian, the Medal of Freedom. Since arriving in Congress in January 1993. I've grown to admire this gentleman who has given great service to his constituents, this institution, and our nation.

BOB MICHEL has lived the American dream. He was born and raised in Peoria, IL, the son of a French immigrant. During the early years of his life, BOB MICHEL attended public schools and worked in a factory, as well as on a farm. He left his hometown to serve as a combat infantryman during World War II, earning two Bronze Stars, the Purple Heart, and four battle stars as he fought across France, Belgium, and Germany. After being wounded at the Battle of the Bulge, he returned to Peoria to earn a B.S. degree in Business Administration from Bradley University and marry his wife, Corinne.

BOB MICHEL first arrived in Washington, DC to work as an administrative assistant for his predecessor. In 1956, his constituents elected him their representative of Illinois' 18th Congressional District. He has served his constituents and his country with distinction in that position since that time. BOB MICHEL was first elected to a leadership position as chairman of the Republican Congressional Campaign Committee in 1972, chosen as Republican Whip in 1974, and minority leader in 1981, a position he has won seven consecutive times. In addition, he has served as Permanent chairman of the 1984, 1988, and 1992 Republican National Conventions.

During his many years of congressional service, BOB MICHEL has earned a reputation as an outstanding leader on national security, agriculture, and economic issues. The dignity and intellectual prowess he has brought to House debate on these and other matters have allowed him to win the respect and affection of Representatives on both sides of the aisle. Regardless of how partisan Congress has at times become, BOB MICHEL consistently has risen above the fray as a voice of moderation and reason.

Mr. Speaker, BOB MICHEL has been described as "a man of old-fashioned personal decency" by "the Almanac of American Politics," and I agree. From Peoria to Washington the basic American values he has brought to his job will sorely be missed when he retires at the end of the 103d Congress. I ask my colleagues to join me in congratulating BOB MICHEL for earning the Medal of Freedom and thank him for his distinguished service to our Nation and for being an extraordinary role model for all Members of Congress, past, present, and future.

TRIBUTE TO CHARLES "ED" OSBORNE, JR.

HON. MICHAEL A. "MAC" COLLINS

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. COLLINS of Georgia. Mr. Speaker, I rise to honor the memory of Columbus Police Officer Charles "Ed" Osborne, Jr., who was fatally shot in the line of duty in the early morning of August 7.

A former Columbus Police Officer of the Month, Officer Osborne was a model for others to follow. He was one of the "good" guys, an officer that daily put his life in harm's way for the safety and protection of the people he served. On Sunday, Mr. Speaker, he paid the ultimate price.

What saddens me most is the senselessness of his death. While returning two youths, ages 15 and 13, to their homes after midnight, they ambushed Officer Osborne and shot him in the head. The disregard for human life displayed by the youths points to a greater problem in our society that Officer Osborne was defenseless to prevent.

The real victims of this tragedy will be Charles Osborne's family. He leaves a widow and three children to grow up without their father. He leaves a sister and grandparents to tell his children about their father.

Mr. Speaker, I salute the bravery and the honor with which Officer Osborne carried out his duties. His children must always know that their father's death was in the service of others, and that the people of Columbus will always be grateful for his ultimate sacrifice.

God bless Ed Osborne, and God bless his family who is left to go on without him.

TRIBUTE TO DON PATCH, A CAREER CIVIL SERVANT

HON. HENRY B. GONZALEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. GONZALEZ. Mr. Speaker, I rise today to bring to the attention of our colleagues and to acknowledge 36 years of distinguished Federal service of Don I. Patch. Mr. Patch retired on July 29, 1994 after 34 years serving the Nation at the U.S. Department of Housing and Urban Development and its predecessor, the Housing and Home Finance Agency.

Don Patch's career typified all that was right with respect to our country's commitment to housing and community development. Countless individuals and organizations concerned with the Nation's housing needs were cognizant of Mr. Patch's personal commitment, expertise and exemplary contributions. As chairman of the Subcommittee on Housing and Community Development, I deeply appreciate his hard work and dedication to our Nation's communities.

From 1981, until his retirement, Mr. Patch was Director of the Office of Block Grant Assistance, overseeing the $4 billion Community Development Block Grant [CDBG] Program and the Section 108 Loan Guarantee Program.

In 1966, in the early days of Mr. Patch's service, he designed the delivery systems at HUD to maximize the use of the Department's programs to aid model neighborhoods in 147 Model Cities across the country, including my home city of San Antonio.

In 1972, Mr. Patch designed the policy framework for use of Urban Renewal funds for long-term disaster recovery in six States. He was instrumental in obtaining White House approval of an allocation of $550 million for this effort. He's been there for every disaster since, like the earthquake in California, the hurricane in Florida and the floods in the Midwest.

Mr. Patch directed the closing out of the Urban Renewal and Neighborhood Development Programs during the 1974–80 transition to the CDBG Program. He directed the staff implementing the Housing and Community Development Act of 1974, establishing the CDBG Program for entitlement communities. In 1982 Mr. Patch directed a successful transfer to 48 State governments the responsibilities for administering $1 billion in CDBG funds for small cities.

He also has been instrumental in implementing economic stimulus legislation when our communities and our Nation's citizens were in deep economic slumps. The $1 billion 1983 jobs bill add-on to the CDBG Program was made available to State and local governments within 2 months largely due to the leadership provided by Mr. Patch.

Mr. Patch influenced the evolution of the Section 108 Loan Guarantee Program by providing guidance to congressional staff in reformulating the program in 1977 to make it a viable tool in financing community and economic development projects. In 1986, he devised a compromise to the administration's thrust to terminate the program by persuading decision-makers to take it off-budget, saving over $100 million per year in Federal budget outlays. The 1990 legislation, which expanded the Section 108 Program to States and small cities and made loan terms more flexible, was designed with Mr. Patch's guidance. Over 300 communities have borrowed more than $1.5 billion without default under this program since 1978.

Mr. Patch received his B.A. degree from Oberlin College, Oberlin, OH, in 1948 and his M.A. degree from Mexico City College in 1950. Prior to entering Federal service, Mr. Patch was administrator of the Inter-American Housing and Planning Center in Bogota, Colombia. Earlier he served 2 years in the U.S. Armed Forces.

His Federal civilian career in housing began in 1960 in public housing where I, too, began my career in housing in San Antonio. It began with the old Public Housing Administration at HHFA which became the Department of Housing and Urban Development in 1966. In 1988, Mr. Patch was given a Presidential Rank Award [Meritorious Executive], and in 1991 he received the National Association of Housing and Redevelopment Officials' [NAHRO] highest honor, the M. Justin Herman Memorial Award, an award which I have proudly received.

While several other HUD programs were cut in years past, it is no small tribute to Don Patch's stewardship that the CDBG Program survived and still remains popular today. Although corruption tainted several other aspects of HUD during some very dark years, the national administration of the CDBG Program remained untouched.

Intelligence, integrity, policy timeliness, and common sense were Don Patch's hallmarks. Don Patch has retired, but his legacy for American communities will endure.

IRISH-AMERICAN HERITAGE MONTH

HON. THOMAS J. MANTON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. MANTON. Mr. Speaker, today I am introducing a resolution to designate the months of March 1995 and March 1996 as "Irish-American Heritage Month." This is the fifth consecutive year I have proudly introduced legislation in celebration of the over 40 million Americans of Irish descent. I hope my colleagues will join me in sponsoring this resolution as they have the past 4 years.

Mr. Speaker, next year will mark the 150th anniversary of the great hunger that devastated Ireland between 1845 and 1851. In 1845, a fungus struck Ireland's primary subsistence crop, the potato. The potato blight quickly spread, destroying the country's main source of food. Within 5 years, the famine reduced a population of 8.1 million by almost half through death and mass emigration of the Irish to the United States, Canada, and England.

In the decade following 1845, more people left Ireland than had emigrated in the previous 250 years. They risked their lives traveling great distances on "coffin ships" rife with typhus. Most emigrated to the United States, arriving in New York City, Boston, and other east coast port cities. By 1851, the end of the famine exodus, 1,712 emigrant ships had sailed up the narrows into New York harbour.

These Irish immigrants of the mid 19th century and those who followed in later years dedicated themselves to helping build this Nation. They took jobs building railroads, canals, and schools. Their legacy continues to be a part of today's American mainstream as the 44 million Americans of Irish ancestry, like their forbearers, continue to enrich all aspects of life in the United States.

Mr. Speaker, it is my honor to introduce this resolution which remembers the millions of Irish who died or were forced to flee Ireland during the great potato famine and pays tribute to their descendants in the United States who continue to contribute to all facets of American culture. I urge my colleagues to join me in supporting this important resolution.

IN HONOR OF DR. BRADLEY S. REITZ

HON. JAMES H. BILBRAY

OF NEVADA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. BILBRAY. Mr. Speaker, it is with immense pride that I rise today to honor an educator who has continually given both time and effort to the Las Vegas community. The outstanding individual that has earned my utmost respect is Dr. Bradley S. Reitz, current principal of the Bartlett Elementary School.

Dr. Reitz earned his bachelor's degree in special education at Glassboro State College in 1977. He later completed his master's degree and his doctorate in educational administration at the University of Nevada, Las Vegas, in 1981 and 1986, respectively. He and his wife, Diane, have a 3-year-old daughter, Alexandra.

The National Distinguished Principals Program reflects the key role that a principal plays in shaping the learning environment within a school. Dr. Reitz has earned this award through his demonstration of strong educational leadership, recognition of the critical importance of the first years of schooling, and strong pursuit of excellence.

Dr. Reitz has performed a wide variety of tasks, which include training for elementary principals and central office personnel on student data bases, spreadsheets, and telecommunications as well as other aspects of computer use. He also has been the coordinator of the "Restructuring Public Education" Conference. Under his direction and leadership, Harley Harmon Elementary School was nominated for the National Blue Ribbon Schools Award. Dr. Reitz' examples of service and achievements are above and beyond what is expected of an elementary school principal.

Dr. Brad Reitz is an individual who makes a difference in our schools and the lives of young people. It is my honor to congratulate Dr. Reitz for his achievements, and thank him on behalf of my constituents for his continuing efforts.

MUSICAL CHAIRS

HON. HELEN DELICH BENTLEY

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mrs. BENTLEY. Mr. Speaker, 2 years ago, the Congress passed the Housing and Community Development Act of 1992. That act contained many important programs which I support, including, among others, project-based accounting, family unification, public housing vacancy reduction, reform of public housing management, termination of tenancy for criminal activity and rental assistance fraud recoveries. Tucked inside the 425-page document was "Moving to Opportunity," or MTO, a program designed to encourage families to move from areas of high concentration of poverty to areas of lower poverty levels.

It is not the intent of MTO, but the method in which it is being implemented in my, and other Members' districts, that has our constituents crying foul!

My constituents are being told, in the newspapers, that MTO will have little impact on existing neighborhoods. Therein lies a major problem. There appears to have been no effort on the part of HUD to communicate directly with either the local governments involved, or the neighborhood organizations.

In two letters written to Secretary Cisneros, I questioned the lack of information and notice about the program. I also questioned what planning had been done for support services for MTO participants such as transportation, education, and additional social services requirements. In my letter I ask the Secretary or his designee to meet with the affected communities to directly address those concerns.

Secretary Cisneros claims this redistribution of the poor from one political subdivision to another will make for a better society.

Instead, MTO programs are creating massive resentment in neighborhoods where couples are working two jobs to afford their home only to see a neighbor on section 8 living in a similar home being paid for not by the sweat of that neighbor's brow, but, by the couple's tax dollars.

Even the U.S. General Accounting Office has noted the unfairness of the plan by writing that:

> The high rents and quality of section 8 housing invite resentment on the part of the taxpaying public who see their subsidized neighbors living in better accommodations than they themselves can afford.

One of my constituents spoke for many of his neighbors when he demanded that the Government stop punishing achievement.

MTO was, we were told, a pilot project that would run for 10 years, then be assessed. However, Mr. Cisneros has made it clear he wants to provide freedom of choice in housing in every major city and the Congress already is being asked to approve an expansion of this effort. This time it is being called the Housing Choice and Community Investment Act. We must not allow this current strategy to expand. This policy of musical chairs, moving poor Americans from jurisdiction to jurisdiction which fails to address the real problems.

The administration has put too much emphasis on moving the poor out of deteriorating cities and not enough emphasis on rebuilding those cities.

Under MTO, a section 8 recipient could receive rent of up to $603 per month for a two bedroom apartment in Baltimore County. In Prince George's Frederick, Calvert, and Charles Counties in Maryland, HUD will pay up to $1,385 a month in rental subsidies per apartment, even though there are few, if any apartments in those counties with rents that high.

Section 8 now serves only about one-third of those eligible. Instead of subsidizing the entire cost of housing for the few at above-market rental rates, why not split the available dollars among all of those eligible?

And, if the intent really is to break the cycle of poverty, why not take a cue from President Jimmy Carter's Habitat for Humanity and use the millions in subsidized rents now handed over to well-off landlords to help rehabilitate poorer neighborhoods and provide home ownership opportunities? History tells us that pride of ownership is the only way to turn a neighborhood around, and our cities need this kind of transformation.

In his Wall Street Journal essay August 4, 1994, James Bovard noted that:

> The notion that HUD can give away housing to some people without having any adverse effects on their fellow citizens and neighbors is the ultimate liberal pipedream.

WE CANNOT AFFORD TO ALLOW EMERGENCY ROOMS TO BE MISUSED AS CLINICS

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. STARK. Mr. Speaker, most of our mail these days seems to be preprinted mailgrams or one sentence postcards—and that makes it doubly wonderful when one receives a thoughtful, sensitive letter.

Following is a great letter I've just received from a man in San Jose—an eloquent, moving call for health care reform:

> In 1985 my wife drove me to a local hospital. I had symptoms of coronary distress. She parked at the entrance of the emergency room and found a wheel chair. She wheeled me into the bedlam of an emergency room. It was filled with the sight, sound and smells of children and adults too poor to visit a doctors office: those addicted to alcohol and drugs, victims of domestic abuse, the homeless. Those on the edge, are drawn to emergency rooms like moths to the light.
>
> The heart team assembled quickly. Within minutes, I was hooked up to an EKG device and breathing oxygen. Soon I was feeling better. So much better that I convinced myself, and was trying to convince those attending that it was a false alarm. Suddenly several of the staff rushed at me. Startled I asked what was wrong. I was told my heart had stopped. The surprise restored that vital function.
>
> Saying heart attack, and displaying insurance documents may have influenced the rapid response my problem received.
>
> The appalling way the emergency room was being used by those without alternatives, has stayed with me long after I was discharged. After reacting to the misery of the situation, I began to calculate the wasteful expense of using a million dollar facility, and millions of dollars to talent, to deliver ordinary everyday health care. The equivalent of a DOD $120.00 hammer.
>
> We can afford to deliver universal health care, because the alternative is too expensive.
>
> We cannot afford to allow emergency rooms to be misused as clinics.
>
> We cannot afford to alienate the poor, the homeless, the minority, the immigrants by denying them access to a decent life. Without hope they become wards of the courts and the penal system, and its billion dollar, non-refundable price tag.
>
> We cannot afford an economy with runaway medical expense that grows larger every year, even while the infrastructure is folding in on itself.
>
> With your support this country can become a better place to live. None of the legislation before the Congress seems perfect, but no one in that body claims perfection.

CONDEMNING THE SHODDY WORK AND POOR BUSINESS PRACTICES OF MCT CUSTOM TRUCK BODIES OF MEMPHIS, TN

HON. TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. LANTOS. Mr. Speaker, I wish to draw the attention of the U.S. Congress to a serious contract dispute that harbors grave implications for U.S. export policy and for the reputation of American-made products in the world marketplace. This is a story of greed and incompetence whose impact reaches far beyond the confines of North America, to the shores of distant customers in newly emerging markets.

Konsumex North America, Inc., of San Mateo, CA, a multiproduct export-import company without expertise in armored vehicles, contracted with a Hungarian buyer for the shipment of an armored Ford Aerostar van to Hungary. The vehicle would be a demonstration model which would hopefully lead the Hungarian buyer to purchase a fleet of 20 to 25 vehicles. The Aerostar van sent to Hungary was supposed to be a sample of American quality and workmanship, a taste of things to come. What Konsumex, Inc., did not know, however, was that their subcontractor for the armor modifications, MCT Custom Truck Bodies, Inc., of Memphis, TN, a self-declared expert in armored vehicles, would create a disaster out of the Aerostar van. Through its incompetence, broken promises, and shoddy workmanship, MCT cost Konsumex valuable business opportunities and damaged the reputation of American products and craftsmanship in the eyes of new, European customers.

Although Konsumex, Inc., met all of its obligations under its contract with MCT, MCT nevertheless shipped to Hungary a modified Aerostar van far exceeding the permissible gross vehicle weight, yet lacking the extensive strengthening of the suspension, axles, and related parts necessary for the proper operation of the vehicle. Upon examination by the buyer—a subsidiary of the Hungarian Government—and in the presence of high ranking government and industry representatives, the Aerostar van was rejected as unsafe and inoperable.

Despite repeated promises to Konsumex, Inc., from MCT of high quality workmanship and timely delivery, neither of which were met, MCT delivered a vehicle which "MERTCONTROL," a neutral Hungarian quality institute, rejected as shoddy, overloaded, and unsafe. Upon its return to the United States, the vehicle was examined by the U.S. National Highway Traffic Safety Administration, which declined to get involved in the contract dispute, but confirmed that the vehicle severely exceeded the manufacturer's assigned gross axle and vehicle weight ratings. In addition, the tires and braking system were inadequate for a vehicle of such weight. MCT knew this vehicle was leaving the country and was completely unconcerned with the serious issues of safety and quality.

In a further outrage, not only did MCT fail miserably to modify the Aerostar van to the contract specifications, but it also refuses to refund the over $31,000 invested and lost by Konsumex, Inc., in this venture. Furthermore, MCT avoids communication with Konsumex, Inc., as much as possible. Although MCT has offered to repair the vehicle as best it can, the opportunity to sell vehicles to the Hungarian buyer has passed. The Hungarian buyer—disappointed with the initial model—declined to pursue further purchases.

In the end, the Hungarian buyer was cheated, Konsumex, Inc., was cheated, and American exporters will be cheated out of future sales because of the greed, incompetence, and gross negligence of MCT of Memphis.

Mr. Speaker, when an American company cuts corners on products for export, delivers shoddy goods after lengthy delays, and otherwise treats foreign customers as if they are cash cows to be milked and then discarded, all American exporters and all American products suffer. MCT's blatant disregard for the importance of quality work for a fair price and the cultivation of an honest and reliable business relationship with its clients presents an embarrassing image of American business practices.

NEW YORK NATIONAL THRIVES ON FAMILY TIES

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. RANGEL. Mr. Speaker, I rise to recognize Mr. Serafin Mariel, the founder and president of New York National Bank. Mr. Mariel is the epitome of leadership and commitment. Mr. Mariel has demonstrated through hard work and faith that one can encourage economic growth in economically depressed minority areas.

By investing in his community, Mr. Mariel is an American who is a part of the solution and not the problem. It is Americans like Mr. Mariel who will save our economically depressed communities by investing in the American people. I am thankful that Mr. Mariel's grandmother had such a positive impact on him because Mr. Mariel is an asset to his community.

I am especially proud of Mr. Mariel's achievements in my congressional district because he is an example of an individual who has given back to his community.

Mr. Speaker, I present the following article written by Austin Evans Fenner for the Daily News, on July 7, 1994.

N.Y. NATIONAL THRIVES ON FAMILY TIES.

Serafin Mariel credits his grandmother for his banking success.

Mariel, 50, still keeps her old savings account passbook. He is founder and president of New York National Bank (NYNB), which owns the old Manufacturers Hanover branch on Second Ave. and 116th St., where his grandmother deposited her money.

"I'm planning to frame it and hang it on the wall of the branch," said Mariel.

NYNB acquired the branch in 1964. It has another branch in the South Bronx, started in the mid-1980s when the larger commercial banks pulled out of economically depressed minority areas.

"I want to be there," said Mariel. "I have no problem holding mortgages in those neighborhoods."

Mariel wants to take his bullish attitude and open additional branches in Central Harlem and the South Bronx.

New York National has more than $62 million in assets, and is one of four minority-owned commercial banks in New York City. The others are EastBank, $72 million in assets; Golden City Commercial Bank, $61 million, and Banco Popular de Puerto Rico, over $1.3 billion.

"When someone says they want to do something in the minority community, that's music to my ears," said Mariel, who added that he is always extending.

"If someone is having a difficult time getting a mortgage, I don't say 'why are you calling me?' I make the calls necessary to help where I can," he said.

New York National is one of the success stories in the South Bronx, said Clint Roswell, spokesman for Bronx Borough President Fernando Ferrer. "They are a very community-minded bank and have done a lot to spur growth in the area."

Mariel's grandmother raised him after his parents died when he was young.

He says her lessons of "respect for ourselves and others and a need to work hard" made the difference in his life.

As a child, he did everything from selling bags at the La Marquetta on Park Ave. to shining shoes.

Mariel studied biology and history at Hunter College, but did not finish due to marriage.

After a stint with the Post Office, he took a pay cut and got a job as a teller with Bankers Trust at the South Bronx branch.

Mariel eventually graduated from the Stonier Graduate School of Banking at Rutgers.

After rising quickly through the ranks at Bankers Trust—eventually becoming vice president of its International Department—he decided to strike out on his own.

After assembling partners and investors, he founded New York National in 1962.

"I wanted to continue banking that would serve my community," he said. "I have a love and affection for my community . . . and they reciprocate."

WATER SHORTAGES AND CONTAMINATION

HON. GEORGE MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. MILLER of California. Mr. Speaker, many areas in the United States and around the world have water problems that will never be solved simply by building dams and destroying more natural river systems. There are many locations where we can use new advances in technology to help solve problems of water shortages and contamination. Some examples are:

The continuing drought in California and elsewhere in the West; contaminated surface groundwater supplies; over-appropriated surface water supplies; and limited sites and environmental problems associated with new storage reservoirs.

Just a few years ago, the United States was a world leader in developing desalination technology and putting that technology to work where it was needed. Unfortunately, programs to sponsor critical research and development of desalination technologies were stifled and cut back or eliminated over the last 14 years.

Budget cuts since 1981 have all but eliminated funds for desalination research.

No program exists now to provide Federal assistance when it is needed to build desalting plants.

Legislation I am introducing today will address these pressing water resource needs by allowing the United States to more actively pursue desalination technologies. This legislation will:

Renew U.S. leadership in desalination research and development; authorize the Secretary of the Interior to conduct studies to determine the best and most economical processes for converting saline water into water suitable for beneficial uses; and authorize demonstration projects and construction of facilities for desalination, in cooperation with Federal, State, and local governments and the private sector.

I welcome the views of my colleagues and experts in this field as we consider this legislation.

MAINTAINING FAITH WITH AMERICANS STILL UNACCOUNTED FOR

HON. WILLIAM F. GOODLING

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. GOODLING. Mr. Speaker, I rise today in support of continued efforts to determine the fate of those individuals classified as prisoners of war or missing in action in southeast Asia.

In January, 1993, the Senate Select Committee on POW–MIA affairs concluded a massive investigation of the fate of 2,264 servicemen listed as missing in the Vietnam war. I supported these efforts to investigate the whereabouts of those individuals who put their lives on the line in service to this country.

I strongly encourage support, and endorse a policy where all captured and missing persons should be released or accounted for by Vietnam, Laos, Cambodia, Russia, or any other Government which has information on these individuals. Furthermore, I encourage the administration to take appropriate measures to negotiate the release of any individuals who may remain in captivity and determine the fate of those who do not.

Mr. Speaker, we owe it to this country and to the friends and families of these individuals to finally resolve the fate of these servicemen. The Vietnam war was one of the most divisive times in this Nation's history. We should never forget those who sacrificed their time and their lives on behalf of our country.

KATMAI NATIONAL PARK LAND USE REVISION LEGISLATION

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. YOUNG of Alaska. Mr. Speaker, I am pleased to offer legislation today at the request of the Alaska Federation of Natives, the Bristol Bay Native Association, and the descendants of Katmai residents who live within what is now designated as Katmai National Park.

Since time remembered, residents who lived within the boundaries of the Katmai National Park have participated in the annual harvest of the red fish fishery from August to early October. When the Katmai National Monument was created in the 1930's, a prohibition was placed on taking of salmon except for sportsfishing with a rod and reel, and local residents were banned from the further taking of red fish.

My bill would allow local residents, approximately 30 to 40 people, to again fish for red salmon from August to October of each year. I am pleased to offer this bill at this time to begin the legislative process.

RECOGNITION OF J. FRANKLIN JONES

HON. TOBY ROTH

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 11, 1994

Mr. ROTH. Mr. Speaker, it is my honor to rise today to pay tribute to the memory of J. Franklin Jones, an outstanding citizen from Oconto County, WI. In recognition of his commitment to the citizens of Oconto County, the 1994 Oconto County Fair is being dedicated to his memory.

J. Franklin Jones was elected to the Oconto County youth fair board in 1958. For the next 35 years he served in many capacities from committee memberships to chairmanships. His wide variety of interests, from animals and buildings to music and guitars, greatly benefited everyone who attended the Oconto County Fair.

Frank took an interest in the fair at many levels, including promotion and organization, as well as insuring the safety and comfort of the people who visited. His generous time and effort in maintaining the standards of the fair followed in the footsteps of his motto: "To make the best better is the whole reason behind it all."

In addition to his involvement with the Oconto County Fair, he also was a significant role model for the 4-H Club for many years. In his own words, the thing that made him happiest about being a 4-H leader was seeing the kids grow up to be good, responsible citizens.

Frank set a strong example of community involvement by working with both the school board and the church council. While farming, he worked for the promotion and betterment of the dairy industry by working with the Morning Glory and the Badger Breeders Boards.

Frank will always be remembered for the generous sharing of his time and talents with the Oconto County Fair and most importantly with Oconto County's youth. His legacy lives on in the hearts of everyone who knew him. Thank you, Frank, for your many contributions which have benefited so many.

ONE YEAR LATER: HOW THE CLINTON TAX HIKE IS HARMING AMERICA

HON. JIM SAXTON

OF NEW JERSEY
IN THE HOUSE OF REPRESENTATIVES
Thursday, August 11, 1994

Mr. SAXON. Mr. Speaker, I commend the following article to my colleagues:

[From the Heritage Foundation Backgrounder, Aug. 10, 1994]

ONE YEAR LATER: HOW THE CLINTON TAX HIKE IS HARMING AMERICA

(By Daniel J. Mitchell, McKenna Senior Fellow in Political Economy)

INTRODUCTION

This week marks the first anniversary of 1993's record tax hike and the ill effects already are becoming apparent. The Clinton Administration's own numbers show that economic growth and job creation remain considerably below levels normally found at this stage in a business cycle. The White House figures also reveal that if any deficit reduction does occur, it will be only temporary and largely unrelated to the President's economic policy. Worst of all, the Administration's budget numbers confirm that government spending remains out of control, with rising deficits in future years entirely due to the unchecked growth of domestic spending programs.

These dismal results should not be surprising. Other Presidents who have followed high-tax policies also have experienced disappointing economic performances as a result. Large payroll tax increases and bracket creep during the Carter Administration, for instance, helped stifle a robust economy and create the phenomenon known as stagflation. George Bush also inherited a strong economy, but his acquiescence to a large tax increase in 1990, combined with other significant reversals of his predecessor's policies, helped put an end to the longest peacetime expansion in America's history.

DÉJÀ VU ALL OVER AGAIN

The Clinton Administration insists that its tax plan is working and that history will not repeat itself. Unfortunately, the rosy picture being painted by the White House falls apart upon closer examination. Consider the following claims:

Claim No. 1: The Administration's economic policy has restored economic growth.

Reality: This assertion ignores the fact that the recession ended in the spring of 1991. And even though President Clinton's tax plan did impose retroactive tax increases on small businesses, investors, upper-income individuals, and the estates of dead Americans, even the White House is hard-pressed to argue that a tax increase beginning January 1, 1993, caused a recession to end nearly two years later. The Administration can legitimately claim that 1991 should not count as a recovery because the economy experienced almost no growth, expanding by less than three-tenths of one percent during the year. The same cannot be said for 1992, however, since the economy expanded at a 3.9 percent clip. Growth in 1993, the year of the Clinton tax increase, slipped back to 3.1 percent and the Administration's new projections show only 3.0 percent growth in 1994. As such, the best the Administration can claim is that last year's budget deal has not yet caused the economy's performance to slow down much compared to the growth levels President Clinton inherited.

The real story, however, is that the recovery under both Bush and Clinton has been woefully inadequate. In the post-World War II period, the U.S. economy traditionally has experienced strong recoveries after an economic downturn, with real growth averaging 5.34 percent for the three years following a recession's end. But the economy's performance this time has fallen far short of past recoveries, with growth averaging only 2.94 percent in the last three years. In other words, economic growth has been barely half as strong as that normally experienced at this stage of a business cycle. Average growth during this expansion has not even reached the average of 3.1 percent for post-World War II era—a figure which includes recession years.

Instead of taking credit for ending the recession and restoring economic growth, the Administration should be trying to explain why the economy's performance has been so weak. The reason for the poor growth figures, of course, is that the White House is pursuing policies similar to those that helped cause the recession in the first place. Presidents Bush and Clinton both raised taxes. They both increased government spending and they both increased the burden of regulation and imposed costly mandates. As a result, the economic downturn and subsequent weak recovery should not come as a surprise. Policies which raise the cost of productive economic activity inevitably result in less job creation, lower savings, and reduced investment.

Claim No. 2: The Administration's economic policy has helped create new jobs.

Reality: As is the case with economic growth, job creation has been unusually weak during this expansion. If the current expansion were producing an average number of jobs for a recovery, total employment would have jumped by 11.79 percent since the recession ended. But with tax increases and new regulations raising the cost of hiring new workers (not to mention the threat of an employer mandate in health reform), total employment has increased by only 3.19 percent in the last three years. Thus, while the White House likes to boast that more jobs have been created to date during the Clinton years than were created during the entire Bush Administration, officials should instead be trying to explain why the nearly identical economic policies of the two Administrations have caused the rate of job creation in this recovery to be less than one-third the usual rate at this stage of a business cycle. This poor performance means millions of Americans are unemployed today who would have been working during an average recovery.

Claim No. 3: The Administration's fiscal policy is bringing down the deficit.

Reality: Projected short-term reductions in the budget deficit are largely unrelated to the President's policies. If final figures bear out the Administration's estimates, the three-year decline in government borrowing will be the result of three factors. First and foremost, the deficit is falling because the economy has finally climbed out of the recession, albeit slowly. And even though the expansion is very tepid by historical standards, incomes have risen slightly, some jobs have been created, and corporate profits have staged a mild recovery. All these factors mean the government collects more tax revenue. The expansion also has caused a slight decline in how fast some government programs, such as unemployment insurance and food stamps, are growing. But as discussed earlier, the economy is growing much slower than normal. As such, the White House's economic policies actually are causing the deficit to be higher than it would be if normal economic conditions applied.

The second reason for projected lower deficits is the cost shift for the bailout of the deposit insurance system. The large one-time costs of the savings and loan (S&L) deposit insurance bailout artificially swelled the deficit between 1989 and 1992, adding $149 billion to the national debt in that four-year period. The government now is selling off the assets of seized S&Ls, however, and this is expected to generate $60.3 billion of revenue for the government between 1993 and 1997. This huge shift, from a big budget expense to a significant revenue source, lowers the reported budget deficit. Bill Clinton had the good fortune to capture the White House just as the shift took place, but it certainly is not due to his policies. More important, it clearly has no impact on the long-term deficit.

The third reason the budget deficit is falling, and the one reason the Administration can take credit for, is the large reduction in defense spending. The Pentagon's budget is expected to go down from $292.4 billion in 1993 to $257 billion in 1997, a decline of $35.4 billion. With the Administration's foreign policy in disarray, these sharp cuts may not be wise policy, but they do contribute to deficit reduction.

Claim No. 4: The Administration's tax bill has produced low interest rates.

Reality: Interest rates actually have been rising steadily ever since the Administration's budget package was approved. As indicated in Chart 3, interest rates began a steady decline in 1989. This trend came to a halt, however, with the enactment of the President's budget package. To be fair, the increase in interest rates following adoption of the tax increase has very little to do with fiscal policy and is related more to fears in financial markets of future inflation. Nonetheless, the White House can hardly claim that its fiscal policy is resulting in lower interest rates when rates actually have been rising.

THE REAL STORY

The White House has been trying to convince voters that last year's tax increase is working. But, every claim made by the Administration proves false upon closer scrutiny. Yet the problem is not merely the lack of good news on the consequences of 1993's record tax hike. What is of greatest concern is that, as has been the case with previous Administrations steering through large tax increases (such as those of Hoover, Carter, and Bush), the Clinton tax hike is imposing heavy costs upon the economy. Most notably:

Rising budget deficits: According to the Administration's own forecast, the budget deficit resumes its upward climb in 1996. The Congressional Budget Office, estimates that budget deficits will swell to more than $360 billion by the year 2004.

Surging domestic spending: As Chart 4 shows, the reason for rising deficits is the alarming growth of domestic spending programs. These programs, which are rising 78 percent faster than needed to keep pace with inflation, are projected to increase by a total of $229 billion over the four years of the Clinton Administration. Significantly, if spending for these programs simply held to the rate of inflation beginning in 1995, the five-year savings would be more than $367 billion and the budget deficit would fall to $70.1 billion by 1999.

Soak the rich tax hike backfiring: The lion's share of new taxes in last year's tax package is supposed to come from increased income taxes on small businesses, savers, investors, and the well-to-do. Critics of the proposal pointed out at the time that higher tax rates would discourage productive economic activity and could actually cause tax revenue to be lower than it would be if taxes were not boosted. Known as the supply-side effect, this revenue shortfall results when taxpayers reduce their work effort, change their behavior, shift their investments, or take other steps to protect their earnings from excessive taxation. As a result, projects of tax revenues based on models which assume taxpayers are oblivious to changes in the tax code almost always will be grossly optimistic. This effect was seen after the 1990 tax increase. Compared with projections made before the tax increase was approved, the 1990 deal actually caused tax revenues to fall by more than $3 for every $1 the 1990 tax bill was supposed to raise.

Since the Clinton economic program is so similar to that enacted during the Bush Administration, it should come as no surprise that history seems to be repeating itself. According to the Treasury Department, personal income tax revenues are growing slower than other sources of tax revenue this fiscal year. Nine months into the fiscal year, personal income tax revenues are only 7.2 percent above their level at this point last year. Tax revenues from other sources, by contrast, are coming in at 11.2 percent above last year's levels. Revenues from the tax that was raised the most have been growing far slower than revenues from tax sources which were increased by lesser amounts or not at all. The gap between personal income taxes and other taxes is concrete evidence that "soaking the rich" simply does not work. What makes these numbers particularly significant is that some of the income tax revenue came from the retroactive tax increase, which is one tax increase that avoids the supply-side effect since it raised rates on income that was already earned.

The Administration should have anticipated that higher income tax rates would be associated with slower income tax collections. In the 1980s, when tax rates were slashed, income tax collections soared, and the share of taxes paid by the rich rose.

Out of step with world trends: In an increasingly global economy, changes in domestic policies can have a significant impact on international competitiveness. During the 1980s, policy makers in the U.S. understood and took advantage of this phenomenon, cutting tax rates and encouraging a surge in job-creating foreign investment in America. In recent years, other countries have followed the U.S. example, lowering their tax rates, oftentimes dramatically. Tragically, U.S. politicians seem to have forgotten the lessons of the 1980s. As seen in Chart 6, the United States has been raising tax rates during a period when most other nations are doing just the opposite.

CONCLUSION

Policies that did not work for Herbert Hoover, Jimmy Carter, and George Bush are not working any better for Bill Clinton. The economy's weak performance, the dismal job creation numbers, and projections of higher spending and deficits are the inevitable results of a fiscal policy based on this flawed model. Critics maintained that the 1993 tax hike would harm the prospects for a solid recovery, not enhance them. They are already being proved correct.